Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$565.00
	$565.00

Address Maintenance

Demographic Information

Please provide your Date of Birth.

03/27/1946

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license on-line.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailalbe but critical in identifying and addressing healthcare workfoce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status

What is your current work status in Medicine?

Retired from the profession

Workforce Survey

In the next 12 months, do you plan to (please mark all that apply):

If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

Gender

Race: Choose all that apply:

Ethnicity: Please choose one:

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

Address 1

Address 2

City

State

Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

Medicare

Medicaid

Self-Pay

Private Insurance

Other

Attestation

Have you been convicted of a felony since your last application?
No

Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

I attest that I am in compliance with the mandatory continuing education requirements, and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$565.00
	$565.00

Address Maintenance

Demographic Information

2. Please provide your Date of Birth.
   03/27/1946

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license on-line. It IS NOT necessary that you mail your hardcopy renewal application to the Department after you have renewed online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailalbe but critical in identifying and addressing healthcare workfoce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status

3. What is your current work status in Medicine?
   Retired from the profession

Workforce Survey

4. In the next 12 months, do you plan to (please mark all that apply):

5. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

6. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

7. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

8. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

9. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

10. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

11. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

12. Gender

13. Race: Choose all that apply:

14. Ethnicity: Please choose one:

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

15. Address 1

16. Address 2

17. City

18. State

19. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

20. Medicare

21. Medicaid

22. Self-Pay

23. Private Insurance

24. Other

Attestation

25. Have you been convicted of a felony since your last application?
No

26. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month. DO NOT submit the hardcopy renewal application with an additional fee.

To continue processing your renewal, please click "Next" below.

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, you will be given the option to **"Pay Invoice"** or **"Print Invoice."** When you are ready to pay the renewal fee, choose **"Pay Invoice"** to process your credit card payment.

Thank you for processing your renewal online.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$565.00
	$565.00

Address Maintenance

Demographic Information

2. Please provide your Date of Birth.
   03/27/1946

Workforce Survey Introduction

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The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

3. What is your current work status in Medicine?
   Retired from the profession

Workforce Survey

4. In the next 12 months, do you plan to (please mark all that apply):

5. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

6. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

7. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

8. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

9. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

10. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

11. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

12. Gender

13. Race: Choose all that apply:

14. Ethnicity: Please choose one:

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

15. Address 1

16. Address 2

17. City

18. State

19. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

20. Medicare

21. Medicaid

22. Self-Pay

23. Private Insurance

24. Other

Attestation

25. Have you been convicted of a felony since your last application?
No

26. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

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Thank you for processing your renewal online.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$565.00
	$565.00

Demographic Information

1. Please provide your Date of Birth.
   03/27/1946

Workforce Survey Introduction

Dear Licensee:

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Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

2. What is your current work status in Medicine?
   Retired from the profession

Workforce Survey

3. In the next 12 months, do you plan to (please mark all that apply):

4. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

5. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

6. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

7. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

8. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

9. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

10. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

11. Gender

12. Race: Choose all that apply:

13. Ethnicity: Please choose one:

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

14. Address 1

15. Address 2

16. City

17. State

18. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

19. Medicare

20. Medicaid

21. Self-Pay

22. Private Insurance

23. Other

Attestation

24. Have you been convicted of a felony since your last application?
No

25. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

Important Note

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month. DO NOT submit the hardcopy renewal application with an additional fee.

To continue processing your renewal, please click "Next" below.

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, you will be given the option to **"Pay Invoice"** or **"Print Invoice."** When you are ready to pay the renewal fee, choose **"Pay Invoice"** to process your credit card payment.

Thank you for processing your renewal online.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information

1. First Name
   ROBERT

2. Middle Initial

3. Last Name
   CROOTOF

4. Maiden Name

5. Please provide your Date of Birth.
   03/27/1946

6. Gender
   Male

7. Ethnicity: Please choose one:
   Not Hispanic or Latino

8. Race
   White

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

9. What is your current work status in Medicine?
   Retired from the profession

Workforce Survey

10. In the next 12 months, do you plan to (please mark all that apply):

11. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

12. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

13. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

14. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

15. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

16. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

17. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

18. Address 1

19. Address 2

20. City

21. State

22. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

23. Medicare

24. Medicaid

25. Self-Pay

26. Private Insurance

27. Other

Attestation

28. Have you been convicted of a felony since your last application?
No

29. If yes, please provide details here

30. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

31. If yes, please provide details here

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

32. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
02/27/2014

Important Note

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

Thank you for processing your renewal online.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information-Renewal

1. First Name
   ROBERT

2. Middle Initial
   E

3. Last Name
   CROOTOF

4. Maiden Name

5. Please provide your Date of Birth.
   03/27/1946

6. Gender
   Male

7. Ethnicity: Please choose one:
   Not Hispanic or Latino

8. Race:
   White

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

9. What is your current work status in Medicine?
   Retired from the profession

Workforce Survey

10. In the next 12 months, do you plan to (please mark all that apply):

11. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

12. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

13. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

14. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

15. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

16. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

17. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

18. Address 1

19. Address 2

20. City

21. State

22. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

23. Medicare

24. Medicaid

25. Self-Pay

26. Private Insurance

27. Other

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

28. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.

Attestation

29. Within the last year, have you been convicted of a felony?
No

30. If yes, please provide details here

31. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

32. If yes, please provide details here

33. **By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.**
01/21/2015

34. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
01/21/2015

Important Note

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

Thank you for processing your renewal online.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$575.00
	$575.00

Demographic Information-Renewal

2. First Name
ROBERT

3. Middle Initial
E

4. Last Name
CROOTOF

5. Maiden Name

1. Please provide your Date of Birth
03/27/1946

6. Gender
Male

7. Ethnicity: Please choose one
Not Hispanic or Latino

8. Race:
White

Email Address Verification

Please be advised that in the future, the Department will no longer be mailing hardcopy renewal notices. Rather, renewal notices will be sent via email. After you complete this transaction, please select the 'My Account' link at the top right of the homepage and make sure that your email address on file is correct. If it is not correct, please update it. Thank you.

9. By entering a date in this field, I confirm that I have verified that the Department has my correct email address on file.
03/08/2016

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

10. What is your current work status in Medicine?
Retired from the profession

Workforce Survey

11. In the next 12 months, do you plan to (please mark all that apply):

12. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

13. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.

14. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.

15. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.

16. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.

17. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.

18. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

19. Address 1

20. Address 2

21. City

22. State

23. Zip Code

Primary Source of Payment

What percent of your patients have the following source of Payment?

24. Medicare

25. Medicaid

26. Self-Pay

27. Private Insurance

28. Other

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

29. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.

Attestation

30. Within the last year, have you been convicted of a felony?
No

34. If yes, please provide details here

31. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

35. If yes, please provide details here

32. **By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.**
03/08/2016

33. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
03/08/2016

Important Note

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PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your renewal online.

Fee

Pursuant to Public Act 15-5, the Connecticut General Assembly passed legislation that increased license renewal fees by $5.00. The additional $5.00 fee is allocated for services provided by the Health Assistance InterVention Education Network (HAVEN), a confidential program designed to assist qualifying health care practitioners who suffer from chemical dependency, emotional or behavioral disorders, or physical or mental illness to maintain their license while receiving the support necessary to practice safely and effectively. To learn more about HAVEN, please visit their website at http://www.haven-ct.org/.

Review

Renewal - 1.015326

Name	ROBERT E CROOTOF
Credential	1.015326

Fee Details

Renewal Application Fee	$575.00
	$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
   03/27/1946

2. Gender
   Male

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   White

Email Address Verification

Please be advised that the Department will no longer be mailing hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date. After you complete this transaction, please select the 'My Account' link at the top right of the homepage and make sure that your email address on file is correct. If it is not correct, please update it. Thank you.

5. By entering a date in this field, I confirm that I will verify that the Department has my correct email address on file.
   02/02/2017

Medical Education

6. Medical School
   New York Medical College

7. Year of Graduation
   1970

Specialty/Board Certification

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	11/11/1977

Current Workforce Status in Medicine

9. What is your current work status in medicine?
Retired from the profession

10. In the next 12 months, do you plan to (please mark all that apply):
None

11. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:
Other

12. If your response to the previous question was other, please enter additional comments here.
Not actively practicing

Physician Attestation

34. Within the last year, have you been convicted of a felony?
No

35. If yes, please provide details here

36. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

37. If yes, please provide details here

38. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

39. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
02/02/2017

American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association's Code of Medical Ethics related to common reasons for discipline on Connecticut physicians' licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships wth Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

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