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Professional Codes, Public Regulations, and the Rebuilding of Judgment Following Physicians' Boundary Violations

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"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 pleasures of love with women or with men."
Hippocratic Oath [1]

The phrase "physician-patient boundary violation" conjures up the image of a physician taking sexual advantage of a patient—the physician with wandering hands who improperly touches a patient or who makes suggestive entrées of a sexual nature—actions repulsive and demeaning to the patient and fundamentally inconsistent with the role of the clinician. The physician has simultaneously overridden the normal requirements of ethical interpersonal behavior and undermined the integrity of his or her profession.

Much as high-profile cases grab headlines, sexual coercion is not the only violation of boundaries in the practice of medicine. Prior or current social or emotional attachment to patients (as when treating a family member or special friend) disrupts the required objectivity; so does favoring a VIP patient or forming dual or reciprocal relationships such as business partnerships. Any motive not related to the patient's care radically disrupts professional objectivity and trust in the profession. These are all boundary crossings that often rise to the level of violations.

Neither demographic data nor prevalence of specific boundary violations is conclusive. The sources for such information come from state-specific disciplinary records in which sex-related offenses are more clearly identified than other general boundary violations. The formal classification of what counts as other boundary violations differs from jurisdiction to jurisdiction and is often generalized as "unprofessional" or "unethical" conduct, and thus is difficult to specifically quantify [2]. Moreover, the actual extent of sexual violations and perhaps other boundary violations is difficult to determine. Disciplinary action data is generated by complaints registered by the offending physician or his or her colleagues and by patients, sources that can be compromised and unreliable. In the former cases, the professional and career ramifications of a report are an inhibiting force, and in the case of patient complaints, physician sexual misconduct is thought to be even less likely to be reported than sexual assault by other individuals [3].

That said, some generalizations can be made from research and analysis of disciplinary records focused on sexual misconduct summarized over the period from 1989 to the present [4-6]. The number of licensed physicians in the United States disciplined for sex-related boundary violations in 1989 was 42; in 1996 the number rose to 147 [4]. This reflected a rise in the percentage of all disciplinary actions for such violations from 2.1 percent in 1989 to 4.4 percent in 1996 [4], a range that is representative of state-specific percentages. The incidence in some states is twice this rate (10 percent of disciplinary orders in California) [5]; in others it is negligible [5, 6].

Some medical specialties and practice settings are at greater "risk" of sexual or other boundary violations. Psychiatry is often identified as a specialty with a higher-than-average percentage of membership cited for sexual misconduct [4, 7, 8], and various reports and analyses have also pointed to high incidence in the primary care specialties [2, 9-11]. The ambulatory or office-based setting is thus the most common venue for boundary-violating behavior [12], perhaps due to there being less scrutiny in this domain where the physician is the sole authority [2].

Where might a patient who has experienced this bad behavior turn?

Professional Codes and their Limits

One might turn to the medical profession itself for guidance. Professional associations codify principles of ethics and their applications to current and past practices for their members. While the proscription on sexual relations seems obvious and, indeed, reaches back to the Hippocratic Oath, so, as we observe, does the violation of that proscription. Indeed, the very existence of codes is evidence that professional associations must attend to the possibility. A recent survey revisits the issue, finding a decline among physicians who would rule out the possibility of physician-patient romance [13].

Thus, the American Medical Association (AMA) proscription concludes, "A sexual relationship with a former patient is unethical if the physician uses or exploits the trust, knowledge, emotions or influence derived from the previous professional relationship" [14]. And the American College of Physicians (ACP) adds practical advice: "Because it may be difficult to judge the impact of the previous professional relationship, the physician should consult with a colleague or other professional before becoming sexually involved with a former patient" [15]. And still, the problem continues.

These codes are perfect expressions of professional self-regulation and autonomy—what the profession expects of its members. Thoughtful and exacting, such codes posit the profession's interests and ideals and the standards that members are expected to maintain. Professions, however, are limited in dealing with violations of code: generally, neither their investigative power nor their enforcement mechanisms are very robust.

Violation of a professional code may result—at worst—in censure and loss of association membership.

This is where the licensing boards come into play. The facile historical truth is that the failure of professions to self-regulate has generated the need for public regulation. State medical boards function in a way that is contrapuntal to the professions, implementing a "social contract" model of accountability [16]. The boards have investigative power and the ability to impose punitive measures through regulatory statute (each state's Medical Practice Act [17]), which, while often consistent with professional codes, is aimed at protecting public health and the welfare and rights of patients, along with the integrity of the professions. It is instructive, in this regard, to note that since 1984, when Wisconsin first criminalized sexual boundary violations, subsequent state initiatives aim to strengthen the role and prerogatives of the board's administrative powers. Rather than mandating direct police intervention, they allow, or require, the public board itself to remand a case to criminal jurisdictions [18-20]. This legislation is a perfect expression of state regulation of professional integrity—what society expects of the profession.

Another alternative for a patient experiencing physician misconduct is to register a complaint with the state medical licensing board. What happens next?

How State Medical Boards Respond to Patient Complaints

An investigative process is set in motion that aims at determining the veracity of the claim and exploring all its dimensions. Interviews are conducted; patient charts are audited; undercover agents may be deployed to pose as hapless patients, perhaps with concealed audio or video tapes; charges are issued; and hearings and legal encounters ensue in which the complaint is refined and the physician offers defenses both factual and mitigating.

If the physician is found culpable, the medical board report details the relevant particulars of the incident(s) and cites the section(s) of the state Medical Practice Act that have been violated. The board then issues an order that aims to match the infraction with a punishment. Boards have at their disposal a broad range of possible retributive sanctions. In one analysis of medical board responses to sexual boundary violations, the authors counted two dozen possibilities, which are, from most to least severe:

> revocation of license, surrender of license, disallowance of the right to renew a license, revocation of controlled substance license, surrender of controlled substance license, disallowance of the right to renew a controlled substance licensed, denial of a license, denial of license reinstatement (from a revocation or surrender), reinstatement (from a revocation or surrender), suspension, suspension of controlled substance license, emergency suspension, license probation, probation of controlled

> substance license, fine, license restriction, restriction of controlled substance license, reprimand, education, enrollment into an impaired physicians program or alcohol or other drug treatment program, cease and desist order, monitoring of the physician's practice, participation in community service, and exclusion from Medicare (only the department of Health and Human Services can take this action). In about one third of the orders...state medical boards imposed more than one action in a single disciplinary order [4].

The severity of the discipline meted out for violation of sexual boundaries varies with the severity of the infraction, including aggravating and mitigating factors. Some doctors receive sanctions on the most punitive end of the spectrum, but a larger group finds itself back in practice after an encounter and settlement with their board, and there is still another cohort for whom the case, generally of the "he-said-she-said" variety, never gets past the complaint stage. By 1998, 23 states had laws that criminalized various sexual boundary violations by a physician independently of and in addition to board sanctions [19, 20], and in cases that are found to be "predatory" behavior or "sexual addiction," action will generally include a requirement that the doctor receive psychiatric care [4].

Education, Remediation, and the Cultivation of Judgment

Remedial educational programs can be one component of disciplinary orders that satisfies both profession and society. There is a trend since the early 1990s of agencies' offering programs for medical boards to use to assess competence, performance, or neuropsychological status [21]. In 1992, at the request of the New Jersey Board of Medical Examiners, three colleagues and I developed such a program for state medical licensing boards and their physician licensees. We named it the ProBE Program, an acronym for "Professional Problem-Based Ethics," and it became a resource to which a board might refer errant physicians for a kind of ethical rehabilitation as part of a disciplinary order [2]. ProBE was groundbreaking and is unique in its focus on professional ethics and the specific infraction for which an individual is referred. Thus, it is not surprising that boundaries are the most common topic about which we educate physicians. Between 1992 and 2013, 11.4 percent of ProBE participants were referred for sexual misconduct, included within a total of 38 percent referred for boundary violation more generally [2].

ProBE referrals for sexual boundary violations do not include predatory or addictive sexual behavior. Rather, what we characteristically see are physicians who encounter an attractive potential sexual partner in a professional setting, act on the attraction, and find that it is reciprocated. Typically, it is not the proscribed relationship itself, but its unhappy demise that triggers the complaint. Our physicians' ex-lovers know the rules and are seeking revenge by filing a sexual misconduct complaint with the state medical

board. In these instances, the famous power differential favoring the physician over the patient is suddenly and decisively reversed. We do not know how many physicians have relationships or breakups that do not result in complaints. We do know that almost all of the 11.4 percent of clients referred to us by the boards for sexual misconduct simply exercised poor judgment in a personal relationship that created a professional vulnerability.

Physician accountability comes from these two sources—the professional code and the state medical board—and, while they rarely intersect in practice (I have never seen a medical board disciplinary order refer to a professional code), in the ProBE Program we speak both languages. That is, the physician behavior that generated a patient complaint and led the physician and the board to negotiate this discipline is both ethically and legally problematic, against both professional and regulatory rules. Physicians who are able to benefit from such an educational intervention internalize this new understanding, translating, as it were, these two sources of accountability into the language of judgment.

This is an ongoing theme of ProBE interventions that applies to virtually all of its cases: the importance of the role of judgment and self-regulation rather than mere knowledge of the "rules." The maintenance of appropriate physician-patient boundaries is largely a matter of judgment by the professional, who is (correctly) assumed to be in control. With this authoritative role comes the responsibility to manage the myriad sensitive interactions that are part of medical practice and that may pose a boundary dilemma.

Not all boundary crossings are violations, even though nonexploitive behavior can well become "harmful and untrustworthy." This is where mindful judgment, careful introspection, and clear communication come into play. Merely addressing the ambiguous distinction between boundary violations and harmless boundary crossings tends to undercut the strict, rule-based approach to professional boundary maintenance that stresses uniformity, vigilance, obedience, and external controls. Paradoxically, the "graded-risk" approach to boundary dilemmas, as developed by Martinez [22], which focuses on careful analysis of risks and benefits to patients in negotiating patient-physician relationships, may speak more directly to professional integrity than obedience to rules. This approach has the virtue of stipulating an active and thoughtful examination of the relevant boundary and has the potential to reduce the power differential in the patient-physician relationship that underpins the "absolutist," rule-based approach. The flip side of the paradox is that the rule-based approach puts the physician in a position of "power" and control that is not always realistic.

Future Directions

This examination of boundary crossings and boundary violations, drawn from my experience directing the ProBE Program, elucidates the need for reconsideration of how

we define as well as how we address boundary violations. Whatever the violation, there needs to be an emphasis on enhancing the value and power of physicians' judgment rather than on promoting obedience to strict rules. This suggests a parallel with basic clinical training in which we provide essential information and best practices, but at the same time, discourage and disparage "cookbook" medicine. In professional ethics, to the degree that the principles get calcified in their application, their validity is compromised. Between the broad articulation of ethical standards that cannot be enforced by the profession and the narrow codification of the administrative law applied by regulatory agencies lies the domain of judgment.

In medicine, clinical judgment gets played back into and informs the best practices, redefining them in light of experience and application. Similarly, the flux and alterations in the physician-patient relationship and the general transformation of the social and moral context of health care delivery needs to be taken into account here. We need to find ways to organize this experience and redefine our ethical concepts and the ways in which they are applied to enhance both the integrity of the profession and the public expectations of physicians.

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