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...
物质许可，罚款，许可限制，受限制的控制物质许可，训斥，教育，将不良行为者登记到一个有缺陷的医师项目或酒精或其他药物治疗项目，终止和停止命令，对医师的实践进行监控，参与社区服务，以及从Medicare（只有卫生部和人类服务部可以采取这项行动）中排除（在大约三分之一的命令...）。大约在三分之一的命令中...州医学协会在单一的纪律命令中实施了多于一种的行动[4]。

违反性行为的纪律处罚的严重程度因违反的严重程度而异，包括加重和减轻因素。一些医生在处罚的最严厉端接受处罚，而另一些医生会发现他们在事件和与委员会的和解后重新开始，还有一部分医生的案件是“他-说-她-说”型的，从未超过投诉阶段。到1998年，23个州有法律独立于和在医疗委员会处罚之外，处罚各种性边界违规行为的医生[19, 20]，而在已发现为“掠夺性”行为或“性成瘾”的案件中，将一般包括医生必须接受精神科护理的要求[4]。

教育、补救和判断的培养

教育性的补救计划可以是纪律命令中的一种组成部分，这既满足了职业和社会的要求。自20世纪90年代初以来，有一种趋势，即政府机构提供医疗委员会使用的程序来评估专业能力，表现，或神经心理学状态[21]。1992年，应新泽西州医疗检查委员会的要求，我和三位同事开发了这样的一个项目用于为州医学许可委员会及其医师许可者。我们称之为ProBE计划，一个“职业道德问题导向”的缩写，它成为委员会可以将其应知行医者转介的资源来作为纪律命令中的一部分补救措施[2]。ProBE是划时代的且其重点是职业道德和具体违规行为对转介的个人是独特的。因此，不难理解为什么是我们教育的最常见主题是边界。1992年至2013年间，11.4%的ProBE参与者被转介为性不当行为，包括38%的被转介为一般性边界违规

ProBE对性边界违规的转介不包括掠夺性或成瘾性性行为。通常，我们所看到的都是在专业环境中遇到一个有吸引力的潜在性伴侣，表现出吸引，发现这是被回应的。通常，不是规定的关系本身，而是其不幸的结束会触发投诉。我们的前伴侣都知道规则，并且正在为性不当行为向州医学报告[2]。

ProBE转介的性违规行为不包括掠夺性或成瘾性性行为。相反，我们所看到的通常都是在专业环境中遇到一个有吸引力的潜在性伴侣，表现出吸引，发现这是被回应的。通常，不是规定的关系本身，而是其不幸的结束会触发投诉。我们的前伴侣都知道规则，并且正在为性不当行为向州医学报告[2]。我们的前伴侣都知道规则，并且正在为性不当行为向州医学报告[2]。
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 nonexploitative 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.

References


Joseph C. d’Oронзio, PhD, MPH, is an associate faculty member in the master of science in bioethics program and a retired associate clinical professor at the Mailman School of Public Health at Columbia University in New York City. He is founding director of the ProBE Program, which for 22 years has addressed the ethical remediation of physicians charged with unprofessional conduct in the practice of medicine. He was the 2003-2004 Raoul Wallenberg Professor in Human Rights at Rutgers University and was a consultant for the New Jersey State Bioethics Commission and New Jersey and New York hospital ethics committees and residency training programs.

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