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Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation

Cherrie A Galletly

Maintaining clear professional boundaries is an important aspect of patient care. However, medicine has deliberately become less formal, and doctors are increasingly urged to focus on developing just, respectful relationships with their patients, rather than rigidly adhering to rule-based systems of ethics.¹ With this approach, doctors may cross professional boundaries more often. Regular boundary crossings may increase the risk of doctors developing inappropriate relationships with patients — boundary violations. The distinction between boundary crossings and boundary violations is important. Crossings are departures from usual practice that are not exploitative, and can sometimes be helpful to the patient, while boundary violations are crossings that are harmful to the patient.²

One of the most serious violations of professional boundaries is a sexual relationship between doctor and patient. While sometimes a result of the predatory behaviour of “rogue” doctors,^{3,4} these relationships often develop as the final stage of a series of boundary crossings. Here, I explore this form of sexual exploitation and its prevention.

Is there a problem?

In overseas surveys, 3%–10% of doctors admit to a sexual relationship with a patient.⁵⁻⁷ In Australia, an anonymous mail survey of psychiatrists found that 7.6%, almost all male, reported erotic contact with patients during or after termination of treatment.⁸ Based on NSW Health Care Complaints Commission information, about 4% of male psychiatrists in NSW have been reported for sexual abuse of patients.⁹ There is a lack of local prevalence data for doctors other than psychiatrists, but annual reports of the New South Wales and Victorian state medical boards include accounts of sexual exploitation of patients by doctors practising in many different areas of medicine.^{10,11}

It is likely these represent a small proportion of cases. Patients who have been sexually exploited are often reluctant to complain, because of feelings of guilt and shame, fear they will not be believed, and, sometimes, continuing concern for the doctor.^{9,12} Complaining to a medical board and participating in the investigation and legal proceedings is very stressful. Further, as these offences occur in private, proof is often lacking.

Cherrie Galletly has been involved in the medicolegal assessment and treatment of a number of patients who have been sexually abused by health professionals.

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ABSTRACT

- While some cases of sexual exploitation involve predatory doctors, many other cases represent the culmination of a series of boundary crossings (non-exploitative departures from usual practice).
- The deliberate move to reduce formality in medicine has increased the likelihood of boundary crossings and violations.
- There are also individual doctor risk factors; boundary violations appear more likely when doctors are under stress, with insufficient emotional support.
- Preventive strategies include continuing education about ethics and the management of professional boundaries, along with appropriate psychological support structures for doctors.
- Doctors are often involved in other professional relationships as teachers, supervisors and team leaders; inappropriate sexual behaviour in these relationships is harassment.
- Public pressure for more punitive responses is likely if the profession is not seen to be doing all it can to deal with these issues effectively, and to be cooperating with other responsible agencies.

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This problem is not unique to the medical profession. Teachers' and nurses' registration boards deal with similar complaints, and churches have been inundated with cases of sexual abuse, often involving children.

Does it matter?

The patient

Sexual exploitation by their doctor has very destructive effects on patients. There are similarities to incest in the nature of the relationship and patient response. Doctors are powerful authority figures who, in exploiting patients' trust to serve their own sexual gratification, transgress a position of trust in a similar way, and with similar effects, to a parent abusing a child. Intense shame, guilt, depression, post-traumatic stress disorder, suicidal thoughts, increased drug and alcohol use, break-up of relationships and loss of employment have been reported among patients after sexual misconduct by doctors, therapists, and other practitioners.^{9,13,14} In addition, these patients often have difficulty trusting the medical profession again, thus compromising their future healthcare.

The doctor

The consequences for the doctor of sexual boundary violations can be devastating, including the trauma of the investigation and legal hearing, loss of medical registration, financial hardship and media publicity. There is also considerable impact on the doctor's family, friends and colleagues.

From *The Exploitation Index: an early warning indicator of boundary violations in psychotherapy*²³

- Have you accepted for treatment individuals known to be referred by a current or former patient?
- Do you tell patients personal things about yourself in order to impress them?
- Do you take great pride in the fact that such an attractive, wealthy, powerful or important patient is seeking your help?
- Do you disclose sensational aspects of your patient's life to others (even when you are protecting the patient's identity)?
- Do you accept gifts or bequests from patients?
- Do you join in any activity with patients that may serve to deceive a third party (eg, insurance company)?
- Do you ever use information learned from patients, such as business tips or political information, for your own financial or career gain?
- Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient attractive, appealing, or impressive?
- Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?

The profession

The medical profession, through its medical boards, attempts to ensure that doctors are competent and will maintain high ethical standards. Societal attitudes toward the professions, including medicine, are becoming increasingly negative.¹⁵ Reports of the sexual abuse of patients reinforce public perception that medicine as a profession is not meeting its obligations and that doctors are more interested in meeting their own needs rather than those of their patients.

Why do doctors cross professional boundaries?

Medical practice risk factors

With the decreasing formality in medicine, doctors are more likely to encourage the use of first names, and to develop a relaxed, collaborative relationship with their patients. This can make it difficult for doctors to simultaneously maintain clear professional and personal boundaries. A more casual style may be misinterpreted by patients. Patients may feel hurt and angry if the doctor retreats to a more detached approach.

Medical practice has been conceptualised as involving a balance between intimacy and power.¹⁶ Doctors often work closely with patients for many years, participating in their lives during stressful and traumatic periods. Highly confidential issues are discussed. Doctors have a responsibility to ensure that the patient's needs are met where appropriate, without compromising their professional role.

Doctors' risk factors

Canaris, an Australian psychiatrist involved with Encompass (an assessment and treatment service for clergy who have violated boundaries "sexually exploited . . ."), comments on "the potential within each and every one of us to breach boundaries".¹⁷ This is likely to happen when doctors are under stress themselves, with insufficient emotional support.¹⁹ In addition, a small number of doctors behave in a predatory manner and sexually exploit

multiple patients.^{3,4} Rarely, mental illness, such as mania or psychosis, results in disinhibited sexual behaviour.

Care of children and the disabled is a large part of medical practice, but there have been few reports of sexual abuse in these situations. However, on epidemiological grounds, it is unlikely that medicine differs from professions such as the Church and teaching and is free of paedophiles. Indeed, a case report of a paedophilic paediatrician in the United States raises the possibility that abuse of these patients may be under-recognised.¹⁹

Poor communication by the doctor can result in complaints of sexual assault in the context of a physical examination.²⁰ The reason for each component of the physical examination must be clearly understood by the patient.

Patients' risk factors

Usually, but not always, unethical relationships involve male doctors and female patients, suggesting that traditional gender roles contribute to the interpersonal environment in which exploitation takes place.⁹ The most vulnerable patients are women who have previously been sexually abused: the "sitting duck" syndrome.¹³ A recent newspaper report relates how a sexual relationship between a male doctor and female patient began after she told him about her childhood sexual abuse.²¹ A survey of 40 Australian women who had experienced sexual abuse in psychotherapy found that two-thirds had a history of childhood abuse.⁹

Dependent and borderline personality disorders are also risk factors. Patients with borderline personality disorders have often been subject to childhood abuse and neglect. They have considerable difficulty with interpersonal relationships and maintaining consistent and appropriate boundaries. Their care can be challenging even for very experienced practitioners.²²

Can boundary violations be prevented?

The doctor

The need to improve doctors' own psychological health and supports is increasingly recognised. Canaris comments that doctors at risk of breaching boundaries may find themselves with "nowhere to turn".¹⁷ Measures such as doctor-doctor programs, doctors' health advisory services and peer support programs can potentially help reduce vulnerability. Improved support systems within training programs and the clinical colleges are important.

As sexual relationships between doctor and patient are often the culmination of a series of boundary crossings, early warning of this process may help doctors manage the risk. A self-assessment questionnaire for practitioners to identify boundary crossings and violations has been developed in the United States²³ (Box). Although this questionnaire is primarily directed at psychotherapists, it provides a useful framework for considering the slippery slope between boundary crossings, which may be harmless or even beneficial to the patient, and boundary violations. It would be helpful to have similar questionnaires for Australian doctors, taking into account the diversity of medical practice.

When a doctor is having difficulty managing boundary issues with a particular patient, discussing the problem with colleagues or a peer review group may be helpful. Medical defence associations can give useful advice. Deliberately adopting a more formal and professional approach, without being punitive, can help to reinstate boundaries. Referral of the patient to another doctor,

even though the patient might be reluctant, can be in their best interests.

Regulatory bodies

It has been suggested that sexual exploitation by psychotherapists (psychiatrists, psychologists, psychoanalysts and social workers) should be a criminal offence, with penalties including fines and imprisonment.²⁴ A similar argument could be made with regard to the medical profession. Public pressure for more punitive responses is likely to increase if the profession's response is seen as inadequate. Besides undertaking investigations and hearings, and deciding on appropriate penalties, the profession must adopt measures to reduce the incidence of this behaviour. These include accessible, supportive complaints procedures, education of the profession as a whole, and improved support for doctors who are struggling.

Unprofessional conduct by a colleague

Patients will sometimes disclose sexual misconduct by another doctor. For example, over 60% of Australian psychiatrists had been informed by a patient of sexual misconduct by a previous therapist (not always doctors); indeed, over 50% stated that at least two patients had described abuse in previous therapeutic relationships.¹⁴ This is a difficult situation if the patient does not wish to complain to a regulatory body. Guidelines of the Australian Medical Association (AMA) state that doctors have an obligation to report suspected unethical or unprofessional conduct by a colleague to the appropriate peer-review body.²⁵ Sometimes, representatives of such a body will meet with the practitioner and discuss his or her alleged unprofessional behaviour. However, an investigation generally cannot be undertaken without a patient complaint.

A risk-management approach

Practical guidelines have been developed for the management of "rogue" doctors — those with serious sociopathic behavioural deficiencies.^{3,4} Behaviours of concern include dishonesty, intentionally harming a patient, sexual harassment, and substance misuse. These guidelines provide a structured management approach to removing these doctors from the system in which they work, but no studies of their effectiveness have been reported. The problem is, of course, that such doctors may obtain other employment. Medical employers would be wise to check with previous employers to ensure that there is no past history of professional misconduct.

Education

Education about ethics, beginning at medical school and continuing into practice, is essential.^{26,27} In addition to imparting ethical standards, it should present tools to evaluate ethical dilemmas, such as arguments for zero tolerance of sexual contact between doctors and patients.²⁸ There are obvious grey areas that can be discussed. For example, for rural practitioners, virtually everyone they come into contact with is also a patient. There are also issues with past patients — when is a patient no longer a patient?

Rehabilitation of offenders

Canaris has described an independent evaluation and treatment program for Australian clergy who have breached sexual bounda-

ries.¹⁷ The program uses a multidisciplinary team approach and includes individual and group therapy, from both psychodynamic and cognitive perspectives. Clergy who have responded well to treatment may then negotiate a return to restricted ministry. Canaris proposes that a similar program would be helpful for doctors who have breached boundaries.¹⁷ At present, offenders may be treated by a colleague, who is in the awkward position of providing treatment and providing reports to a medical board. Full disclosure within such a relationship is unlikely.

Problems in fiduciary relationships

A fiduciary relationship is a relationship in which one person (usually with special expertise) agrees to act in the best interests of the other (eg, the patient or client), generally in exchange for monetary reward. Besides the doctor-patient relationship, doctors are often involved in a range of other fiduciary relationships, as medical teachers or supervisors, team leaders or senior colleagues. Inappropriate sexual behaviour in these relationships is considered sexual harassment. The AMA states that a doctor should "refrain from exploiting students or colleagues under your supervision in any way."²⁵ Harassment by doctors who are in a position of relative power has been reported in studies of medical students and registrars.^{29,30} This is potentially damaging to the individuals involved and the profession as a whole. However, given the long working hours and restricted social life many doctors experience, especially when they are training, it is not surprising that they sometimes meet future partners in the workplace. Many specialty training programs now have procedures that should be followed in these situations.³¹

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