Professional Boundaries in the Physician-Patient Relationship

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THE SUBJECT of professional boundaries (and boundary violations) has received a great deal of recent attention in the psychiatric literature. The emphasis on defining guidelines for professional conduct has expanded beyond the confines of ethics committees and has worked its way into licensing boards charged with disciplining physicians whose behavior jeopardizes the well-being of patients. The Massachusetts Board of Registration in Medicine, for example, has recently issued detailed guidelines on such matters as self-disclosure, dual relationships, sexual relationships with patients, and other professional boundaries to help define for the public and for the profession the parameters of professional conduct in the practice of psychotherapy by physicians. While specialists in psychiatry have been debating the pros and cons of issuing such guidelines, nonpsychiatric physicians have yet to involve themselves so extensively in similar discussions. In this article, we will provide a conceptual framework for discussion of professional boundaries in the physician-patient relationship and offer our view of measures the profession can take to prevent serious violations of these boundaries. We will use instances from our own clinical experiences or those of our trainees to illustrate the relevant issues.

WHAT ARE BOUNDARIES?

Professional boundaries in medical practice are not well defined. In general, they are the parameters that describe the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service. Boundaries imply professional distance and respect, which, of course, includes refraining from sexual involvement with patients. While sexual contact is perhaps the most extreme form of boundary violation, many other physician behaviors may exploit the dependency of the patient on the physician and the inherent power differential. These include dual relationships, business transactions, certain gifts and services, some forms of language use, some types of physical contact, time and duration of appointments, location of appointments, mishandling of fees, and misuse of the physical examination. The transgressions of some of these boundaries may at times be necessary and helpful. For example, it would certainly be appropriate to hold the hand of a patient who reaches out to a physician after losing a family member. One can differentiate minor boundary crossings from devastating boundary violations that ruin professional careers and seriously damage patients. Similarly, some problems arise from corrupt and unethical physician behavior, while others arise from honest misunderstandings.

Much of the medical profession’s increased interest in boundaries has derived from the awareness of the damaging effects of sexual misconduct. Examination of instances of physician-patient sexual relationships has revealed that sexual exploitation is usually preceded by a progressive series of nonsexual boundary violations, a phenomenon generally described as the “slippery slope.” In this regard, what appear to be trivial violations may in reality be considerably more serious when viewed in the context of a continuum. Attention to nonsexual boundary issues may therefore be an effective way to prevent sexual boundary transgressions. This approach is especially salient because it has become clear that many of the nonsexual boundary violations may in and of themselves cause harm to patients irrespective of the possibility that they also may lead to sexual involvement.

As a result of the intense concern that has been generated by sexual exploitation in the physician-patient relationship, much more research has accumulated on sexual boundary violations than on nonsexual boundary violations. Hence, our discussion of professional boundaries will begin with a consideration of sexual misconduct and progress from there to an examination of other forms of professional boundary transgressions.

Sexual Boundary Violations

Six studies have sought to determine the prevalence of sexual misconduct in the physician-patient relationship (Table). A comparison of the US studies with the survey from the Netherlands and with the studies from Canada suggest that the problem is one that is not unique to US physicians and that it occurs with roughly the same frequency in the United States as in other countries where sexual misconduct has been studied. The problem is not unique to medicine. Other professions are also vulnerable, including other health care professionals, the clergy, and the law. Research aimed at psychologists, social workers, and teachers reveals that sexual exploitation is a pervasive problem in fiduciary relationships.

The studies listed in the Table must be viewed as less than definitive because of the fundamental methodological problems inherent in questionnaire surveys. These include low return rates, raising the possibility that the sample is by no means representative. Other problems include the possibility that some practitioners might not answer the questions honestly because they question the anonymity of the method. Also, some who have engaged in sexual misconduct may not return the questionnaire. On the other hand, other professionals who have transgressed sexual boundaries might feel the need to anonymously confess. In essence, we do not know the true prevalence of sexual misconduct.
While the data suggest that sex between a male physician and a female patient is the most common, all gender configurations also are seen with some regularity. In a series of more than 2000 cases of therapist-patient sex, Schoener et al. noted that approximately 20% of cases involved a same-sex dyad, and 20% of the therapists were women (some overlap was present in these two groups). Concern about sexual exploitation by physicians in Canada has resulted in major task force reports in British Columbia,1 Alberta,12 and Ontario.13 In the United States, the American Medical Association (AMA) Council on Ethics and Judicial Affairs considered the problem extensively and issued a 1991 statement: “Sexual contact or romantic relationships concurrent with the physician-patient relationship may be unethical.”

The ethics standard proposed by the Council subsumes a wide range of situations encountered in medical practice. These would include, but would not be limited to, the following categories:

1. Predatory physicians with serious personality disorders who systematically attempt to seduce patients.
2. Those who claim to use sex for therapeutic purposes.
3. Cases involving abuse of the physical examination procedure (eg, a physician who does a breast or pelvic examination when not indicated, or a physician who does an appropriate examination in an inappropriate, erotized manner).
4. Situations in which a physician asks a patient on a date during the initial visit to his or her office or to an emergency department.
5. Cases in which a long-standing physician-patient relationship evolves into an intense lovesickness or infatuation.
6. Situations in which a rural general practitioner who is the only physician in town dates a patient because virtually anyone who is a potential romantic partner is also a patient.
7. Cases in which patients are raped or fondled (while awake or under anesthesia) in the operating room or office.
8. Cases related to sexual harassment in which the physician makes erotic or suggestive comments to the patient.

The Medical Council of New Zealand has recognized the spectrum of sexual misconduct by dividing the behaviors into three categories: (1) sexual impropriety, (2) sexual transgression, and (3) sexual violation.

Sexual impropriety refers to expressions or gestures that are disrespectful to the patient’s privacy and sexually demeaning to the patient. This category would include such behaviors as inappropriate draping practices, sexualized comments made by a physician to a patient, or sexually demeaning remarks about a patient’s body or undergarments.

Sexual impropriety as defined by the Medical Council of New Zealand would also include instances of sexual harassment. According to the US Equal Employment Opportunity Commission,2 any unwanted and repeated verbal or physical advances, derogatory statements or sexually explicit remarks, or sexually discriminatory comments made by someone in the workplace is sexual harassment if the recipient is offended or humiliated and job performance suffers as a result. Although these guidelines do not apply legally outside the employment context, the situation of the physician-patient relationship involves a person in a less powerful position at risk for being subjected to harassing behavior by someone who is more powerful, the classic paradigm of sexual harassment. It is important to note that there are gender differences in the perception of sexual harassment.21 While many male physicians may view sexual comments as humorous, a female patient or health professional observing such remarks is not as likely to view them in the same way.

The second category in the New Zealand set of definitions, sexual transgression, refers to inappropriate and sexualized touching of a patient that stops short of overt sexual relation. This category would include such items as sexualized kissing, touching of breasts or genitals when not appropriate for the physical examination, or performing a pelvic examination without gloves.

The third category, sexual violation, involves physician-patient sexual relations, regardless of who initiated the relationship, and would include genital intercourse, oral sexual relations, anal intercourse, and mutual masturbation.

Regarding sexual relationships between former patients and physicians, the AMA Council on Ethics and Judicial Affairs is less absolute, implying that individualized case review is necessary to ascertain whether exploitation of a still emotionally dependent patient is involved. A one-time contact with a specialist or an emergency department physician may be quite different from an ongoing physician-patient relationship of many years’ duration. However, a focus on the length of the relationship alone misses other dimensions of equal importance. For example, a patient may only see a surgeon for one procedure, but if that procedure is lifesaving, the patient may retain a persistently idealized and dependent attitude toward that surgeon, which would compromise the capacity for mutual consent. Likewise, an obstetrician may have a single contact with a patient during a difficult delivery and capture the patient’s fantasy as a hero or rescuer.

These considerations lead us directly into an examination of why physician-patient sex is considered unethical. Several reasons have emerged from case law, from the deliberations of ethics committees and licensing boards, and from clinical work with patients who have been exploited by their physicians. First, it is a breach of the trust that is fundamental in a fiduciary relationship. Second, it calls into question the physician’s capacity for objective professional judgment. A third reason derives from the psychological state of the patient induced by the clinical situation. Patients rapidly develop feelings toward their physicians that have been called “transference.” This involves the displacement of feelings derived from past relationships.

<table>
<thead>
<tr>
<th>Source, y</th>
<th>Sample Size</th>
<th>Specialties</th>
<th>Return Rate, %</th>
<th>Men Acknowledging Contact, %</th>
<th>Women Acknowledging Contact, %</th>
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</thead>
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<tr>
<td>Kardener et al., 1973</td>
<td>1000 male physicians</td>
<td>Gynecology, psychiatry, internal medicine, surgery, general practice</td>
<td>46</td>
<td>12</td>
<td>Not applicable</td>
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<td>Garrell et al., 1986</td>
<td>5574</td>
<td>Psychiatry</td>
<td>26</td>
<td>7.1</td>
<td>3.1</td>
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<tr>
<td>Garrell et al., 1992</td>
<td>10000</td>
<td>Family practice, internal medicine, gynecology, surgery</td>
<td>19</td>
<td>10</td>
<td>4</td>
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<td>College of Physicians and Surgeons of British Columbia, 1992</td>
<td>2082</td>
<td>All specialties</td>
<td>69.5</td>
<td>3.8 (8.1*)</td>
<td>0.3 (4.3*)</td>
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<tr>
<td>Wilbers et al., 1992</td>
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<td>Gynecology, ENT</td>
<td>74</td>
<td>4</td>
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<tr>
<td>Lamont and Woodward, 1994</td>
<td>792</td>
<td>Gynecology</td>
<td>78</td>
<td>3</td>
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</tbody>
</table>

*Percentage of sexual contacts with former patients.
†This figure is for gynecologists. Only five female ear, nose, and throat (ENT) specialists were in the study.
onto the current physician-patient relationship. The physician can thus be viewed as an all-knowing parent, and a great deal of power is turned over to the physician by the patient.

Brody has pointed out that the physician may have greater power because of greater knowledge and skills regarding diagnosis and treatment, because of higher socioeconomic and educational status, and because of an inherent social or charismatic power. The patient, on the other hand, "gains power only by virtue of being surrounded by boundaries that the physician cannot cross without egregiously violating moral rules." The combination of transference and the power imbalance between the physician and the patient makes mutual consent, in the usual sense, highly questionable. As Johnson has stressed, those who argue that mutual consent is possible between physician and patient stand "in sharp contrast to the implied presumption of disproportionate professional control underlying the AMA's opinion on sexual misconduct." Finally, studies find that there is the potential for considerable harm to the patient as a result of such sexual relationships.

Dual Relationships

An essential element of the physician's role is the notion that what is best for the patient must be the physician's first priority. Physicians must set aside their own needs in the service of addressing the patient's needs. Other kinds of relationships that coexist simultaneously with the physician-patient relationship have the potential to contaminate the physician's ability to focus exclusively on the patient's well-being and can impair the physician's judgment. As noted herein, patients can transfer residual longings from other relationships onto the person of the physician, and they can view the physician as parent, spouse, lover, adversary, or friend. If the physician tries to maintain both roles with the patient, objective decision making may be jeopardized. For example, financial relationships or business transactions may lead to resentment or dependency that interferes with the physician's ability to be empathic, sensitive, and selfless in the physician-patient relationship. Similarly, romantic ties or intimate friendships with patients may make it difficult for the physician to confront noncompliance with treatment or to bring up unpleasant medical information. The long-standing practice of referring family members to another physician grows out of similar considerations regarding compliance and compromised objectivity. Even in the case of a rural family practitioner who treats everyone in the community, a romantic relationship that begins with a patient should result in referring the patient, if possible, to another physician in a neighboring town for care.

Gifts and Services

Grateful patients often wish to show their appreciation by bringing gifts to their physician. In other instances, a patient may offer to perform services for the physician in lieu of payment or in addition to payment. A range of services, such as filing, typing, baby-sitting, and cleaning, have been offered and accepted by physicians. In some places, barter is a common form of payment when patients without insurance coverage or financial means wish to pay the physician in goods or services. An example is a farmer who gives a chicken to the physician for delivering a baby. Different forms of barter involve different boundary issues. While the provision of poultry may not violate any significant boundaries, services that involve contact with confidential records or with the physician's family may present problems. For example, if a physician's baby is injured while a patient is baby-sitting, the physician-patient relationship may be permanently damaged. If a patient paints the physician's house, but the physician is dissatisfied with the quality of the work, the ensuing tension may also adversely affect the alliance between physician and patient.

While small gifts may represent benign boundary crossings rather than serious violations, services and more significant and expensive gifts may be problematic from two standpoints. First, gift giving may be a conscious or unconscious bribe designed to keep aggression, negative feelings, or unpleasant subjects out of the physician-patient relationship. Second, there is often a secret quid pro quo involved in performance of services or bestowing a gift. As implied by the saying, "There is no free lunch," expectations arise from gifts. The same can apply to the physician who gives patients gifts or refrains from charging a fee for a particular patient. Although done with the best of intentions, the patient may feel burdened by a sense of obligation that can never be openly discussed with the physician. Similarly, physicians who receive expensive gifts may feel an obligation that influences their clinical judgment in much the same way the gifts from drug companies may.

Time and Duration of Appointments

Maintaining an orderly schedule of patient appointments is an aspect of professional conduct that is often neglected. While all physicians must cancel or delay appointments periodically because of an emergency or other extenuating circumstances, some practitioners keep patients waiting while extending their time with others, perhaps those they find fascinating, charming, or attractive. The special patient may be flattered by the extra time but also may wonder which of the physician's own needs are being gratified by extending the appointment. Those patients who are kept waiting may feel their physician has uttered a lie for their needs and concerns, as well as their schedules.

Related problems may occur around the time of day at which appointments are scheduled. A female patient scheduled to see her male internist at 9 PM, after the office staff have gone home, may wonder why she is being seen so late without anyone else around. She may feel sufficiently uncomfortable that she will not return to see that particular physician. It is noteworthy, in this regard, that attorneys have discovered that some cases of sexual misconduct occur with patients who are scheduled during the last appointment of the day when no one else is around. As a result, they view such scheduling as reflective of the possibility of other boundary violations. In general, unless an emergency occurs, physicians are wise to see patients only during office hours with someone else in the office.

Language

An essential component of professional conduct is respect for the patient's dignity. Within this framework, the physician's language is a boundary that should not be overlooked. In general, patients feel some loss of dignity merely by being in the patient role, by having to disrobe and wear a gown, and by depending on the physician's knowledge to explain what is going on with them. Addressing patients by first name or by last name, when they are not well known to the physician, may be experienced as a further loss of dignity. Similarly, avoiding slang names that may be offensive also maintains a sense of professionalism and respect in the relationship.

One variant of this boundary is the use of language in a seductive or erotic way designed to make the patient uncomfortable or to sexually excite the patient. One male pediatrician told a 16-year-old female patient, "You're developing a very nice set of breasts!" The patient felt embarrassed and humiliated, and she reported the comment to her mother. When the mother called the pediatrician to complain, he defended himself by insisting that he was complimenting her. This vignette is typical of some sexual harassment scenarios mentioned.

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previously in which a man in a position of power may think he is being humorous or flattering, while the woman on the receiving end of the comment may feel intensely uncomfortable.

Self-disclosure
While physicians commonly chat with their patients about matters of mutual interest in an effort to build rapport and put the patient at ease, excessive self-disclosure may create difficulties for the patient and strain the rapport. A common starting point on the slippery slope to sexual involvement with a patient is a role reversal in which the physician starts disclosing personal problems to the patient. Even if revealing personal issues to a patient does not lead progressively to more extreme boundary violations, self-disclosure is itself a boundary problem because it is a misuse of the patient to satisfy one’s own needs for comfort or sympathy. It is also inappropriate to try to extract care for oneself when a patient is paying for the physician’s time. Moreover, the patient may find sharing health concerns extremely difficult if the physician is perceived as needy and vulnerable.

The Physical Examination
Patients are often anxious and uncomfortable during a physical examination but willingly go along with whatever the physician asks them to do. One female patient seeing her physician for a sore throat submitted to a breast examination even though she couldn’t see the purpose of it. She later said that at the time of the examination she felt as though she were being raped but felt paralyzed to stop the examination. Another female patient described how her gynecologist asked her about her sexual history during a pelvic examination. She experienced the questioning as an indication that her physician was “noisy and intrusive.”

At the very least, the physician should explain to the patient why examining the genitals, breasts, or other sensitive areas is necessary. If the patient hesitate, the physician should encourage questions or expressions of concern that can then be clarified, empathized with, and understood. Body areas that are draped should remain draped whenever possible. The relevance of sexual history questions also should be made clear to the patient.

What about situations in which the physician encounters sexual arousal on the patient’s part while conducting a physical? One female medical student was examining an elderly male patient when she noticed that his penis was erect. She completed the examination without remarking on the erection but later consulted her clinical tutor about the situation. Her tutor explained to her that she had done precisely the right thing. The medical student commented that nothing on this subject had been taught in the classroom and that if she had not had a mentor with whom to consult, she would have continued to feel insecure about the appropriate response.

The presence of a chaperone during the physical examination may also be reassuring to the patient. However, guidelines on when to use a chaperone are not well established. While traditionally within medicine a female chaperone is present when a male physician is examining a female patient, this advice is too general and does not allow for problems that arise in other gender constellations. The use of chaperones is always a matter of good clinical judgment, but we would strongly recommend having a chaperone present in the following situations: (1) with a patient who has a known history of sexual abuse; (2) with a patient who has extreme anxiety or a psychiatric disorder; (3) with a litigious patient; (4) with a patient undergoing a pelvic examination; and (5) with a patient who for any reason raises concerns in the physician.

Some of these recommendations may be modified for long-standing patients when a good physician-patient alliance exists. A nurse who is in and out of the room during the course of the examination may be sufficient.

Physical Contact
Physical contact outside the context of the physical examination varies widely. Some physicians routinely shake the hands of their patients on greeting them, a practice that is well within the scope of professional conduct. Others hold the hand of a patient when delivering stressful news. When hugs and kisses enter into the picture, the situation becomes murkier. Some patients experience a hug or a kiss as a promise of a different kind of relationship. Maybe the physician will be a parent or lover who will make up for disappointments with others in those roles from the past. In these cases, the physician has raised false hopes in the patient, who will ultimately be disillusioned.

Other patients, particularly those with histories of sexual abuse, may experience a hug or a kiss as an insult, a repeat of early boundary violations that have left scars on the patient’s psyche. One physician was charged with sexual misconduct by a patient who insisted that he had had “genital contact” with her. The physician adamantly denied it.

When further inquiry was made, it became clear that during a hug the patient had experienced the pressure of the physician’s genitals on her pelvis as “genital contact,” reawakening old trauma.

There are, of course, cultural variations on the appropriateness of hugs or kisses. However, cultural differences can be used to rationalize behavior that patients perceive as offensive. Licensing boards frequently encounter physicians who claim that they are unfamiliar with American customs regarding touch. They may claim that within their culture, the kind of contact they had with the patient is entirely acceptable. A critical issue in these situations, of course, is that the patient may not be from the same culture and may feel extremely uncomfortable with the kind of contact initiated by the physician.

Beyond hugs or kisses, other forms of physical contacts may be viewed as a violation of the professional relationship. One woman reported that her gynecologist sexually rubbed her back while discussing the findings of her pelvic examination with her. Regardless of his intent, she perceived him as deriving sexual gratification from his contact with her.

PREVENTION OF BOUNDARY VIOLATIONS
The key to preventing boundary violations lies largely in education, although certain physicians whose characterological defects lead them to this behavior may not be deterred by such efforts. Medical students and residents should be taught the concept of professional conduct in conjunction with learning interviewing and physical diagnosis. Sensitivity to professional boundaries should be as routine as auscultating the chest. These issues should be discussed, not exclusively in the context of ethics courses, but in all clinically oriented courses. They are the fabric of the physician-patient relationship.

Information about the widespread prevalence of sexual abuse and its connection with subsequent revictimization also should be taught in medical school as part of this preventive education. It is well known that patients who have been sexually abused are at high risk for being sexually exploited by physicians and psychotherapists. While we do not intend to blame patients for the boundary transgressions of their physicians, medical students need to be aware of the common dilemmas presented by sexually abused patients, particularly the rescue fantasies they inspire in physicians, who may gradually become overinvolved in an effort to repair the damage from the past.

Another area of education that would
be productive in the prevention of boundary violations is sensitivity to gender issues and gender differences. Professional conduct should take into account differences in the gender configuration of the physician-patient dyad and how this influences the perception of the physician and the content of the physician's communication. A corollary to this principle is the need to be empathic and nonjudgmental when taking into account differences related to sexual orientation and sexual preference.

A crucial component of education is sensitivity to the diversity of the population and the associated cultural and individual differences, particularly regarding the meaning of touch and other forms of physical contact. What is therapeutic touch to one patient may be experienced as assaultive by another. Because the physician cannot know how a certain patient is likely to respond to various aspects of touch inherent in the physical examination, clear communication is of paramount importance. Physicians also must develop an empathic attunement to their patients so that they can sense the impact of any aspect of the examination that might be routine from the physician's perspective but unusual or uncomfortable for the patient. This attention to careful communication about examination procedures has enormous significance in a managed care era in which patients are routinely seeing new physicians with whom no sense of trust has developed. Similarly, following our previously mentioned guidelines for the presence of a chaperone may be particularly important for new patients.

Role modeling cannot be overemphasized in medical education. The obverse of professional misconduct is, of course, professional conduct, which encompasses all the features of a humane physician-patient relationship as well as the sum total of professional boundaries. This overarching demeanor can best be learned by watching role models relate to their patients in the course of rounds, examinations, and other clinical settings. Teachers also must make it clear to their trainees that they are available as supporters or consultants when students find themselves attracted to patients and are confused about how to manage such feelings.

In the midst of our enthusiasm for preventive education, we must also acknowledge that it is not a panacea. Some unscrupulous practitioners with severe personality disorders will be completely unaffected by our measures. Their predatory behavior with patients is simply an extension of predatory behavior outside their professional lives. The best we can hope for is that such individuals, who constitute a relatively small number of physicians, can be identified early in the medical school process and redirected toward other careers.

References