

Professional Boundaries and Sexual Misconduct in Medicine

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- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
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Faculty

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Faculty Disclosure

Contributing faculty, Mary Franks, MSN, APRN, FNP-C, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all physicians and physician assistants in all practice settings.

Accreditations & Approvals



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Course Objective

The purpose of this course is to provide physicians and physician assistants with the knowledge and skills necessary to ethically and appropriately avoid boundary violations.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define professional boundaries in the context of physician-patient relationships and the scope of the problem of boundary violations and physician misconduct.
2. Describe the impact of professional boundary violations on patient health, professional care, and the integrity of the healthcare system.
3. Recognize common boundary challenges in various clinical settings and implement strategies to address them ethically and effectively.
4. Utilize reflective practice and self-assessment techniques to identify personal vulnerabilities and strengths regarding professional boundaries.
5. Implement practical guidelines and ethical frameworks to navigate boundary-related dilemmas and make informed decisions in complex situations.



Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

The medical profession has long recognized the importance of maintaining professional boundaries in order to ensure the integrity of the physician-patient relationship, foster interprofessional collaborations, and maintain trust in the healthcare system. However, defining these boundaries can be challenging, as they are influenced by a variety of factors, including cultural norms, personal beliefs, and organizational policies.

The physician-patient relationship is a fundamental aspect of health care, and it is based on mutual trust, respect, and open communication. Professional boundaries are an essential component of this relationship, as they define the limits of what is appropriate and acceptable behavior for both the physician and the patient. In the context of interprofessional collaborations, professional boundaries help to establish clear roles and responsibilities, facilitate communication, and promote teamwork. Finally, professional boundaries are critical in relationships with the healthcare system, as they ensure that physicians act in the best interests of their patients and maintain the integrity of the system. This course will explore the concept of professional boundaries in the context of physician-patient relationships, the implications of blurred boundaries, examples of boundary violations, and strategies for maintaining appropriate boundaries.

PHYSICIAN SEXUAL MISCONDUCT AND BOUNDARY VIOLATIONS: SCOPE OF THE PROBLEM

Although efforts have been made in the past few years to better quantify the incidence of physician misconduct, the extent of the problem remains unknown. A 2022 analysis of data in the National Practitioner Data Bank identified 1,721 reports of physician sexual misconduct between 2000 and 2019, which represents an average of 10.78 reports per 100,000 U.S. physician licensees [1]. A Public Citizen report found that of 1,354 physicians in the United States who had faced reportable sanctions or malpractice payments due to sexual misconduct between 2003 and 2017, 38% continued to hold active licenses and clinical privileges in the states where they faced these consequences [2].

A 2017 study examined 101 cases of sexual violations in the medical field using a mixed-method, exploratory design [3]. The study involved analyzing the content of these cases to understand the characteristics of the physicians involved, the patient-victims, the practice setting, the types of sexual violations, and the consequences for the perpetrators. All of the physician perpetrators were male, and the majority were older than 39 years of age (92%) and not board certified (70%) practicing in nonacademic settings (94%) where they always examined patients alone (85%). However, three factors differed significantly across different types of sexual abuse: suspected antisocial personality disorders were commonly associated with cases of rape; physicians were more frequently board certified in cases of consensual sex with patients; and patients were more commonly vulnerable in cases of child molestation. The most common types of abuse were touching/comments only (33%) and sodomy (31%); less common forms included rape (16%), child molestation (14%), and consensual sex (7%). The majority of victims were female (89%) adults (60.4%). The duration of abuse was two years or greater in more than 58% of cases.

It is important to note that this study relied on data from reports and investigations of physician sexual abuse. It is possible that other perpetrator and/or victim demographics are less likely to be identified, reported, and/or investigated [3; 4].

A 2020 study examined the perceptions and practices of boundary-crossing behaviors among practicing primary care physicians in the United States [29]. A total of 1,562 physicians responded (743 at grand rounds presentations and 819 to a national survey). Various scenarios of boundary crossing were presented, including actions like giving a patient a ride home, paying for medication, helping a patient find a job, employing a patient, going to dinner with a patient, and providing care to personal friends. The study found that a significant proportion of physicians considered benign and engaged in boundary-crossing behaviors [29]:

- 34% had given a patient a ride home
- 34% had paid for a medication
- 15% had helped a patient find a job
- 7% had employed a patient
- 10% had gone to dinner with a patient
- 59% had provided care to personal friends

There were variations based on demographic, professional, and regional factors. Physicians who were older, male, White, practicing in a solo or smaller clinic, and located in a rural area were associated with a history of giving a ride home, helping find a job, or caring for a friend. Older, male, and Latinx physicians more commonly had paid for a patient's medications; older physicians and those practicing in solo or smaller practices had a higher likelihood of having employed a patient [29].

Notably, scenarios involving romantic or sexual relationships with patients were generally deemed unacceptable, and going to dinner with a patient was the least accepted behavior. The study suggests

that prevailing strict, rules-based approaches to professional boundaries may need reevaluation based on these findings. Geospatial analysis highlighted regional differences in attitudes and practices, with rural practitioners more likely to blur boundaries. The study highlights the complexity and varying perspectives surrounding appropriate boundaries in physician-patient relationships.

DEFINING PROFESSIONAL BOUNDARIES

Professional boundaries are the appropriate limits that define the interactions between healthcare professionals and their patients. These boundaries help maintain a safe and ethical therapeutic relationship and ensure that the focus remains on the patient's well-being and care. This encompasses a variety of dimensions, including emotional, physical, communication, financial, time, and online/social media boundaries.

The severity of boundary violations can be conceptualized on a spectrum, with patient exploitation and abuse on one end. One of the most severe cases of boundary violation is sexual misconduct. The Federation of State Medical Boards (FSMB) provides the following definition of sexual misconduct [5]:

...physician sexual misconduct is understood as behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in person or virtually, and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that a patient or surrogate may reasonably construe as sexual.

Physician sexual misconduct can be categorized along a continuum of escalating severity. The continuum includes “grooming” behaviors that aim to gain a patient’s trust and compliance, often involving gift-giving, special treatment, and sharing personal information. These behaviors may not be considered misconduct on their own, but they set the stage for more severe violations [5].

More serious misconduct comprises sexually inappropriate gestures or language, which can be seductive, sexually suggestive, or demeaning to the patient, and may not involve physical contact. These actions can be embarrassing and humiliating to the patient and can occur through various means, like in-person interactions, online communication, mail, phone, or texting [5].

Further escalation involves physical contact, such as conducting intimate examinations without proper clinical justification or informed consent. The severity increases significantly when the physical contact is explicitly or reasonably interpreted as sexual, even if initiated by the patient. Any “romantic” behavior between a physician and a patient is inappropriate and should be considered grooming or actual sexual misconduct, regardless of the patient’s appearance of consent [5].

The American Medical Association (AMA) addresses the issue of sexual harassment and misconduct in its Code of Ethics. Opinion 9.1.1 states, “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”

[6]. According to AMA ethical guidelines, a physician should end the patient-physician relationship before starting a dating, romantic, or sexual relationship with a patient. Further, even nonsexual, nonclinical contact with patients should be avoided if there is a possibility that it may be perceived as or lead to romantic or sexual contact. Additionally, engaging in sexual or romantic relationships with former patients can be problematic if there is any potential for the previous professional relationship to influence the new relationship. Such relationships are considered unethical if the physician uses trust, knowledge, emotions, or influence from the previous relationship, or if the romantic involvement could harm the individual [6].

Opinion 9.1.2 extends this guidance to include romantic or sexual relationships with key third parties in the patient-physician relationship, defined as spouses or partners, parents, guardians, or surrogates [7]. This is particularly true when such relationships would “exploit trust, knowledge, influence, or emotions derived from a professional relationship with the third party or could compromise the patient’s care.” The AMA recommends that any physicians considering entering into a relationship with a key third party should consider the following [7]:

- The nature of the patient’s medical problem and the likely effect on patient care
- The length of the professional relationship
- The degree of the third party’s emotional dependence on the physician
- The importance of the clinical encounter to the third party and the patient
- Whether the patient-physician relationship can be terminated in keeping with ethics guidance and what implications doing so would have for patient

Sexual misconduct that involves patients and/or key third parties is part of the more general issue of sexual harassment in the workplace. In addition to adhering to strict guidelines to avoid blurring boundaries in the physician-patient relationship, physicians should adhere to strict sexual harassment policies in the medical workplace, including avoiding inappropriate relationships with trainees, supervisees, and other persons who might be affected by an imbalance in power [8].

THE IMPACT OF BOUNDARY VIOLATIONS

As noted, in the realm of health care, the physician-patient relationship is the cornerstone of effective medical care. This bond is built on trust, confidentiality, and ethical standards, ensuring that patients feel safe and comfortable seeking help for their ailments. However, when this relationship is compromised through boundary violations, the consequences can be severe and far-reaching. Blurred professional boundaries can have serious implications for patient care, interprofessional collaborations, and the healthcare system as a whole. For example, when a physician engages in a romantic or sexual relationship with a patient, it can compromise the trust and integrity of the physician-patient relationship, create conflicts of interest, and violate ethical standards. When interprofessional boundaries are blurred, it can lead to confusion about roles and responsibilities, misunderstandings, and conflicts that can compromise patient care.

ETHICAL IMPLICATIONS

Boundary violations in medical relationships challenge the fundamental principles of medical ethics. When physicians cross the professional boundaries with patients, they risk eroding the patient's trust and confidence in the medical profession as a whole.

The sanctity of the patient's autonomy and privacy is compromised, leading to a breach of professional integrity. Such ethical lapses can impact the reputation of the healthcare institution and even the entire medical community, eroding the public's trust in healthcare providers [9].

EMOTIONAL AND PSYCHOLOGICAL CONSEQUENCES

Patients who experience boundary violations may suffer profound emotional distress, with feelings of betrayal, vulnerability, and exploitation. When a patient's trust in their physician and the medical community is broken, it can lead to feelings of powerlessness, anger, and emotional trauma, negatively impacting their mental health and overall well-being. Some patients will develop acute trauma responses, post-traumatic stress disorder (PTSD), depression, and suicidal ideation [9].

IMPACT ON PATIENT CARE

Boundary violations can also have direct implications on patient care. Patients who feel uncomfortable or violated may be hesitant to disclose critical information about their health or lifestyle, leading to suboptimal diagnoses and treatment plans. Furthermore, it can deter patients from seeking timely medical attention, resulting in delayed interventions and worsened health outcomes [9].

PROFESSIONAL AND LEGAL CONSEQUENCES

Violations of professional boundaries are considered serious misconduct and can lead to disciplinary actions, loss of licensure, and even criminal charges. Boundary violations in medical relationships expose healthcare providers and institutions to legal liabilities, and patients who have been victims of boundary violations may pursue legal action, claiming emotional distress, malpractice, or breach of confidentiality [9].

IMPACT ON OTHER PATIENTS AND THE MEDICAL COMMUNITY

The fallout from boundary violations extends beyond the individual patient and physician. Knowledge or rumors of a boundary violation by a healthcare provider can create an atmosphere of mistrust and suspicion among other patients. This can lead to a decrease in patient admissions, reluctance to engage with healthcare professionals, and a general decline in patient-provider relationships. Incidents of boundary violations can also lead to increased scrutiny from regulatory bodies. The medical community may also face public criticism and negative media attention, potentially impacting funding and resources for healthcare services [9].

COMMON BOUNDARY VIOLATIONS IN VARIOUS PRACTICE SETTINGS

Examples of boundary violations in medicine include physicians engaging in romantic or sexual relationships with patients, physicians accepting gifts or other forms of compensation from patients or drug companies, and physicians disclosing confidential patient information without consent. Boundary challenges in clinical settings are complex and multifaceted, affecting healthcare practitioners across different disciplines and specialties. In certain practice settings, including primary care, gynecology, emergency medicine, and pediatrics, professionals must navigate unique obstacles to provide optimal care while upholding ethical standards. Time constraints, emotional bonding, gender dynamics, and high-stress environments are just a few of the many factors to be considered. Recognizing and addressing these challenges is crucial to maintaining the highest standards of patient care and promoting the well-being of both patients and practitioners.


PRIMARY CARE

Primary care physicians often have limited time per appointment due to the sheer volume of patients they see daily. These time constraints can challenge the ability to build rapport and meaningful relationships with patients, leading to a superficial understanding of health needs and the potential for miscommunication. Over time, primary care practitioners may develop emotional connections with their patients, particularly those with chronic conditions. This emotional bonding can strengthen the physician-patient relationship, but it can also lead to difficulties in maintaining a purely professional relationship and negatively impact objective decision-making. As boundaries become blurred, the risk of entering into harmful relationships increases [10].

Boundary violations are often only discussed in the context of the clinical setting, but providers (especially those practicing in rural areas) should also consider the role of boundaries in the community. In this setting, primary care physicians may face dual relationships, whereby they provide medical care to individuals with whom they have personal or social connections. Dual relationships present a complex ethical challenge for physicians, but they can be navigated effectively with a commitment to professionalism, integrity, and patient welfare. By adhering to the core ethical principles of autonomy, beneficence, non-maleficence, justice, and veracity, physicians can safeguard the therapeutic alliance with their patients while avoiding harm and conflicts of interest. Transparency, open communication, and the establishment of clear boundaries are fundamental in maintaining ethical standards and ensuring that dual relationships do not compromise the quality of care provided [10].

GYNECOLOGY

Gynecologists often perform intimate examinations that require a high level of sensitivity and professionalism. Maintaining patient comfort and dignity while performing these procedures can be challenging. Intimate gynecologic examinations can evoke feelings of vulnerability, anxiety, and embarrassment in patients. Further, individuals may feel exposed or apprehensive about discussing their personal health concerns. Recognizing these emotions and acknowledging and validating patients' feelings are vital for developing a sensitive and empathetic approach to patient care.



According to the American College of Obstetricians and Gynecologists, feelings of physical and psychological safety are paramount to effective care relationships with trauma survivors, and obstetrician-gynecologists should create a safe physical and emotional environment for patients and staff.

(<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/04/caring-for-patients-who-have-experienced-trauma>. Last accessed August 17, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Healthcare providers should maintain a non-judgmental attitude, irrespective of the patient's medical history, lifestyle choices, or reproductive health status. Respect for patient autonomy and dignity is essential throughout the examination process. Physicians conducting gynecologic examinations and care should maintain open communication, actively listening to patients' concerns and addressing any questions they may have. Before conducting any examination, take time to explain the entire process in clear and understandable terms. This should include detailing the purpose of the examination, what to expect during the procedure, and addressing potential discomforts [11; 12].

Prior to performing any intimate examination, explicit informed consent should be obtained from the patient and documented. Patients should be given sufficient time to ask questions and provide consent voluntarily. Informing patients of their right to withdraw consent at any time can empower them to make informed decisions about their health care [11].

Ensuring a private and comfortable examination space is crucial for preserving patient dignity. Offering the option of having a chaperone present during the examination can provide additional support and comfort. Providing gowns or drapes to maintain modesty during examinations can significantly enhance the patient's sense of comfort. Take care to position the patient comfortably during the examination, respecting their preferences and physical limitations. Maintaining eye contact and using touch with the patient's consent can further promote a sense of reassurance.

Physicians should be mindful of patient preferences, cultural differences, and sensitivities related to gynecologic examinations. Some patients may prefer healthcare providers of the same gender or have specific cultural norms that impact their perceptions of modesty and healthcare practices. For patients with physical disabilities, healthcare providers should make reasonable accommodations to ensure a dignified and comfortable examination experience.

Providing gynecologic care to survivors of sexual trauma requires an exceptionally sensitive and empathetic approach. Healthcare providers should be educated on the impact of trauma, including its potential long-term effects on survivors' mental and physical health. Understanding the ways trauma can manifest in medical settings, such as triggers, dissociation, or flashbacks, is crucial for creating a safe and supportive environment. Healthcare providers should be prepared to address potential triggers and offer emotional support throughout

the process. Encouraging survivors to express their feelings and providing validation can help them cope with emotional distress. Survivors of sexual trauma may experience heightened physical sensitivity and discomfort during the examination. Healthcare providers should prioritize minimizing pain and discomfort by using smaller-sized instruments, providing adequate lubrication, and taking breaks as needed. A patient-centered approach to pain management is crucial to ensure a more positive experience. In some cases, survivors may require additional support from mental health professionals with expertise in trauma [13].

EMERGENCY MEDICINE

Emergency physicians, who often deal with high-stress and time-sensitive situations, must be vigilant in upholding professional boundaries and adhering to ethical guidelines to ensure patient safety and trust. Those providing emergency care hold a position of authority and power over patients, particularly during moments of vulnerability and distress. This power imbalance can create opportunities for exploitation of patients' trust for personal gain, leading to inappropriate behavior or sexual misconduct. In some emergency department settings, there may be a lack of oversight or inadequate mechanisms to monitor physician behavior. This can create an environment in which inappropriate conduct may go unnoticed or unaddressed. Implementing regular performance evaluations and peer reviews can help monitor physician behavior and identify any concerning patterns or trends [14].

Emergency departments are fast-paced and high-pressure environments, leaving physicians with limited time to establish rapport and engage in thorough communication with patients. Under these conditions, judgement errors, miscommunications, and blurring of professional boundaries are possible.

Emergency physicians frequently encounter traumatic and emotionally taxing situations. Prolonged exposure to distressing events may lead to emotional fatigue and burnout, potentially impacting one's ability to maintain appropriate boundaries. Distressing events that require debriefing with colleagues may make it difficult to strike a balance between discussing experiences and maintaining confidentiality.

Creating an environment in which physicians can seek support and counseling and drafting policies regarding mental health support can help prevent breaches in confidentiality. Hospitals and emergency departments should foster a culture that values respect, empathy, and patient-centered care, reinforcing the importance of maintaining professional boundaries.

PEDIATRICS

Sexual misconduct and boundary violations in pediatrics are highly concerning issues that can lead to severe emotional and physical harm to young patients. Understanding the factors that contribute to such misconduct is crucial for developing effective approaches to address and prevent these breaches.

The extent of sexual abuse of pediatric patients by healthcare providers is unknown, and the literature almost entirely focuses on sexual contact between adult patients and physicians. Several high-profile court cases have brought attention to the issue of child sexual abuse by physicians, including the cases of Larry Nassar, who was convicted of assaulting hundreds of girls in his care during his tenure as USA Gymnastics team physician; Johnnie Barto, who was convicted in 2019 of abusing 31 children; and Earl Bradley, who was convicted in 2011 of 471 charges of child molestation involving 103 patients [15].

In cases of child sexual abuse involving pediatricians or other healthcare providers, the first sign is often grooming behavior employed to gain the trust and compliance of the child and/or caregiver before escalating to abusive acts. The intrusiveness of these activities may escalate over time, starting with seemingly innocent touches and progressing to more overt contact. Examples of grooming behaviors include giving gifts or favors to the child and having unsupervised contact with them. Emotionally vulnerable, intellectually or developmentally delayed, physically disabled, or attention-seeking children may be at increased risk for abuse [15].

The prevention of child sexual abuse in healthcare settings can be approached through external and internal measures. External measures involve screening all medical and healthcare staff and volunteers who interact with children during the recruitment process to identify any past allegations of abusive behavior with children. Background checks and criminal record searches are part of this screening, but they are not foolproof, as most people who abuse children do not have a criminal record. Therefore, relying solely on external measures like background checks is insufficient to ensure children's safety [15].

Internal measures play a crucial role in preventing child sexual abuse by reducing opportunities for perpetrators to access potential victims. These measures focus on increasing the perceived effort and risk for potential perpetrators. Explicit rules, expectations, and standards of care related to sensitive examinations or procedures, such as those involving the perianal area, can be established. Training all personnel to recognize and report inappropriate behaviors sends a clear message that such actions will not be tolerated. By eliminating internally generated justifications for abusive behaviors, these measures further deter potential perpetrators. Examples applicable in healthcare settings include emphasizing the paramount importance of children's safety during personnel on-boarding and explicitly stating a zero-tolerance policy for inappropriate behavior, boundary violations, or sexual abuse of children [16].

THE ROLE OF REFLECTIVE PRACTICE

Engaging in reflective practice allows practitioners to gain insights into their strengths, vulnerabilities, biases, and areas for improvement concerning professional boundaries. Reflective practice is a deliberate and systematic approach through which healthcare professionals thoughtfully analyze their experiences, actions, and interactions with patients and colleagues. It involves self-examination, critical analysis, and the consideration of emotional and psychological aspects that influence their decision-making and behavior. Reflective practice and self-assessment foster self-awareness in healthcare professionals. Understanding personal vulnerabilities and strengths allows practitioners to make conscious efforts to enhance their professional boundaries continually. Engaging in reflective practice can also improve empathy and communication skills. Empathy helps practitioners recognize patients' emotional needs, promoting a positive therapeutic relationship. Through self-assessment, healthcare professionals can identify situations or patient populations that may challenge their ability to maintain boundaries effectively. This knowledge enables them to establish clear personal boundaries and seek support when necessary [17].

One aspect of reflective practice is to review past interactions with patients, colleagues, and other stakeholders. By analyzing these experiences, one can identify instances in which boundaries were appropriately maintained or potentially compromised. In addition, physicians should explore their emotional responses to various situations. This heightened emotional awareness can help identify personal vulnerabilities that may affect one's ability to act appropriately. Healthcare practitioners can learn valuable lessons and implement strategies to prevent similar occurrences in the future [17].

SELF-ASSESSMENT TECHNIQUES

Creating a culture of open communication and peer support encourages healthcare professionals to engage in self-assessment and reflective practice without fear of judgment. Clinical settings can integrate reflective exercises into training programs and continuing education initiatives. Healthcare professionals can participate in group discussions or journaling activities to share experiences and insights. In addition, healthcare organizations can offer access to professional counselors or mentors who specialize in boundary management. These experts can provide personalized guidance and support in navigating complex situations. Self-assessment involves an honest and objective evaluation of one's knowledge, skills, and attitudes related to professional boundaries. Various self-assessment techniques can assist healthcare professionals in identifying their personal vulnerabilities and strengths in this domain [18].

Boundary Scenario Analysis

Healthcare professionals can review hypothetical boundary scenarios and assess their responses and decision-making processes. This exercise helps uncover potential vulnerabilities or areas of strength concerning professional boundaries.

360-Degree Feedback

Seeking feedback from colleagues, superiors, and patients can offer valuable insights into how others perceive one's boundary management. This feedback can reveal blind spots and provide an opportunity for growth.

Ethical Dilemma Reflection

Self-assessment can involve contemplating ethical dilemmas that healthcare practitioners face in their daily work. By reflecting on their responses to these dilemmas, practitioners can identify their values and biases, which may impact boundary management.

NAVIGATING SPECIFIC BOUNDARY-RELATED DILEMMAS

As noted, boundary-related dilemmas can arise when dealing with patient confidentiality, dual relationships, social media interactions, gifts from patients, and other delicate situations. To ensure optimal patient care and uphold professional standards, healthcare practitioners must adhere to practical guidelines and ethical frameworks. The FSMB has established comprehensive guidelines that offer valuable insights to address such dilemmas effectively [5]. In addition, the AMA Code of Ethics should help guide resolution of potential boundary violations [6; 7; 8].

AVOIDING INAPPROPRIATE RELATIONSHIPS WITH PATIENTS

In the medical profession, the physician-patient relationship forms the foundation of quality healthcare. However, there may be circumstances in which a physician develops feelings for a patient, leading to a potential ethical dilemma. Initiating a romantic or personal relationship with a patient can compromise the integrity of the physician-patient relationship, raise concerns about patient autonomy, and breach professional boundaries [19].

The physician-patient relationship is inherently unequal, with the physician possessing specialized knowledge and power over the patient's well-being. This power dynamic can lead to vulnerable situations for patients, especially when personal emotions come into play. A romantic or personal relationship between a physician and a patient can erode the foundation of trust that is vital for effective health care. Patients confide in their physicians with sensitive information, trusting that it will remain confidential and solely used for medical purposes. When a romantic relationship is pursued, this trust can be jeopardized [20; 21].

Emotions can also cloud a physician's judgment and objectivity when making medical decisions. Objective and evidence-based decision-making is crucial for accurate diagnoses and appropriate treatment plans; this can be impaired when the relationship is complicated by a romantic or sexual relationship. In the context of a personal relationship, obtaining genuine informed consent can be challenging due to the inherent power imbalance.

As discussed, physicians should engage in regular self-reflection to recognize and acknowledge their emotions and vulnerabilities. This is just the first of several proactive steps physicians can take to address any potential ethical concerns. If a physician finds themselves struggling with feelings for a patient, seeking consultation with a trusted colleague, supervisor, or an ethics committee can provide guidance and support. These individuals can offer an objective perspective on the situation and assist in making ethical decisions. Physicians should also familiarize themselves with the ethical guidelines and codes of conduct set forth by relevant medical associations or regulatory bodies. These guidelines often include explicit provisions on physician-patient relationships and can provide clarity on what constitutes ethical behavior [5; 6; 7].

The following approaches are recommended in all physician-patient relationships to help minimize the risk of boundary violations and inappropriate relationships [19; 20; 21; 22]:

- Establish boundaries: Maintain clear and professional boundaries with patients at all times. Avoid engaging in discussions or behaviors that may blur the line between a professional and personal relationship.

- Transition of care: If a physician realizes they have developed personal feelings for a patient, it is crucial to transfer the patient's care to another qualified healthcare provider. This transfer should be handled with sensitivity and respect for the patient's well-being.
- Time and distance: In cases where a patient expresses feelings for the physician, it is essential to maintain professional distance and avoid reciprocating or encouraging such emotions. Over time and with proper communication, these feelings may naturally dissipate. In some cases, avoiding being alone with these patients is best, if possible.
- Support systems: Physicians should have access to support systems, such as mentors, peer support groups, or counseling services, to help them navigate emotionally challenging situations and maintain ethical conduct.
- Education and training: Medical institutions should provide ongoing education and training to healthcare professionals on maintaining appropriate professional boundaries and recognizing potential ethical dilemmas.

MANAGING PATIENT DISCOMFORT DURING INTIMATE EXAMINATIONS

As a physician, one of the most important aspects of patient care is building trust and ensuring patient comfort during clinical examinations. While touch is an integral part of many medical procedures, it is essential to recognize that some patients may feel uncomfortable with the level or type of touching during an examination. In such situations, it is crucial for the physician to navigate the situation with sensitivity, empathy, and clear communication. Prioritizing patient comfort not only enhances healthcare delivery but also reinforces the ethical foundation of medicine—patient-centered care.

Sensitive or intimate medical examinations can often evoke feelings of vulnerability and discomfort for patients. Effective communication approaches play a vital role in fostering a supportive and reassuring environment that enables patients to feel safe and respected. By establishing trust, active listening, explaining the procedure, obtaining informed consent, respecting privacy, and offering ongoing support, healthcare professionals can create a supportive and reassuring environment. Prioritizing patient dignity, autonomy, and emotional well-being fosters a sense of safety that enhances the overall quality of care and strengthens the patient-provider relationship [12; 23].

Acknowledge Patients' Feelings and Autonomy

The first step in handling a patient's discomfort is to acknowledge their feelings and concerns. Patients might experience anxiety, fear, or embarrassment during an examination, and it is essential to validate these emotions. Demonstrating empathy and understanding can help build positive rapport with patients and create an environment in which they feel comfortable discussing their discomfort openly.

Respecting patient autonomy is crucial during sensitive examinations. Healthcare providers should honor patients' preferences and accommodate them whenever possible. Allowing patients to retain a sense of control over their bodies fosters a safer and more comfortable environment.

Communicate Effectively

Clear and effective communication is paramount in addressing patient discomfort. One of the primary building blocks of effective communication during sensitive examinations is establishing trust and rapport with the patient. Healthcare providers should take the time to introduce themselves, address patients by their preferred names, and explain their role in the examination process. Demonstrating

empathy and compassion can go a long way in putting patients at ease and making them feel valued as individuals. Maintaining open and approachable body language, making eye contact, and smiling when appropriate can help convey warmth and empathy, enhancing the patient's feeling of security [12].

Physicians should openly discuss the purpose of any examination, explaining the necessity of certain physical touches, and the expected benefits of the procedure. Using non-medical jargon and simple language can help patients understand the procedure better, making them feel more in control of the situation. By sharing this information, patients are more likely to understand and accept the need for specific types of touching. Healthcare providers should also inform patients of each step before proceeding, ensuring that they are comfortable throughout the process. Offering supportive phrases like "We are almost done" or "You're doing great" can help alleviate anxiety and reinforce the patient's sense of safety.

After the sensitive examination, it is crucial to follow up with patients to address any lingering concerns or questions they may have. This post-examination communication further emphasizes the provider's commitment to patient care and can help mitigate any anxiety or uncertainty that patients may experience after the procedure.

Listen Actively

Active listening is a critical skill that helps physicians better understand patients' concerns and emotions. Encouraging patients to express their feelings and anxieties openly allows providers to respond appropriately and address any fears or misconceptions they may have. Listening attentively also empowers patients to feel heard and respected, fostering a sense of safety and comfort.

Obtain Informed Consent

Informed consent is a fundamental principle in medicine, and it is especially vital when dealing with sensitive situations. Before beginning any examination, the physician should explain the procedure in detail, including the areas that might require physical contact. By obtaining the patient's informed consent, the physician respects the patient's autonomy and ensures they are actively participating in their healthcare decisions [12; 23].

Utilize Chaperones

To further promote patient comfort and reduce anxiety, physicians can offer the presence of a chaperone during examinations. A chaperone, such as a nurse or another staff member, can provide emotional support to the patient and act as a witness to the procedure. The patient should be given the option to have a chaperone present or decline the offer without any pressure or judgment [12].

Adjust the Examination Technique

Flexibility in examination techniques is essential when a patient expresses discomfort. Physicians should consider alternative approaches that achieve the same diagnostic goals while minimizing physical contact or exploring less invasive options. Using smaller devices and swabs can minimize discomfort and feelings of invasiveness. Moreover, explaining these alternatives to patients can help them feel more involved in the decision-making process [12].

Monitor Non-Verbal Cues

During the examination, the physician should be attuned to the patient's non-verbal cues. Signs of discomfort may include tense body language, avoiding eye contact, or verbal hesitation. Being observant of these cues can help the physician adjust their approach and provide reassurance as needed.

Pause and Ask for Feedback

Throughout the examination, it is crucial to check in with the patient regularly. Physicians can ask open-ended questions about their comfort level or inquire if any specific touch made them uncomfortable. This approach encourages patients to communicate their feelings openly and facilitates a more patient-centered examination.

Practice Respectful Touch

When physical contact is necessary, physicians should always maintain a respectful and professional touch. Inform the patient before initiating any contact, and ensure that it is done in a gentle and noninvasive manner. This can help alleviate the patient's concerns and foster a sense of trust in the physician's approach.

Offer Support Services

For patients who continue to feel uneasy or anxious about the examination, offering access to support services can be beneficial. These services may include counseling, patient education materials, or online resources that address common concerns about medical procedures.

Document Patient Preferences

In the patient's medical record, it is crucial to document any expressed discomfort, the patient's preferences regarding the examination, and the agreed-upon approach. This information can serve as a reference for future encounters, ensuring that subsequent examinations are tailored to the patient's comfort level [12; 23].

MAINTAINING PATIENT CONFIDENTIALITY

It is essential to handle patient information with utmost care to avoid breaching confidentiality, even in challenging situations. This includes avoiding discussing patient cases in public spaces, such as elevators, cafeterias, or public transportation. In addition, encrypted email services or secure messaging platforms should always be used when discussing patient information with colleagues or healthcare team members. This not only is ethically sound practice, it is in compliance with HIPAA requirements [24]. Patient records should be accessible only to authorized personnel, and all employees should be aware of the importance of maintaining confidentiality.

HANDLING DUAL RELATIONSHIPS

Dual relationships occur when healthcare providers have multiple roles with a patient beyond their professional relationship. Such relationships can lead to conflicts of interest and compromise the quality of care. Examples of dual relationships include being both a patient's physician and friend; entering into a teacher/student relationship; becoming sexually involved with a current or former patient; bartering services with a patient; or being a patient's supervisor. Even when entering into a dual relationship seems to offer the possibility of a better connection to a patient, it is not recommended. Dual relationships can cause confusion and a blurring of boundaries and risk exploitation of the patient [25].

In some cases, dual relationships can be difficult to avoid, particularly when practicing in rural areas or areas with limited healthcare services. At a minimum, physicians should avoid providing care to close friends or family members. Treating individuals with whom one has a pre-existing personal relationship can blur professional lines and may hinder objective decision-making. It is also important to set boundaries with all patients

to ensure that the professional relationship is not compromised by personal or social connections. If a dual relationship arises unexpectedly, consider transferring the patient's care to another qualified healthcare provider to maintain objectivity [25; 26].

ENGAGING PROFESSIONALLY ON SOCIAL MEDIA

Social media has become an integral part of modern communication, and healthcare professionals should be mindful of their online presence and conduct, as one's social media presence can affect professional relationships and boundaries. In a survey of psychologists, social workers, and physicians, 59% of the practitioners indicated they maintained a Facebook account and 75% of users reported using a privacy setting [27]. However, practitioners were ambivalent about what to do when patients contacted them through a social networking site. It may appear to be an innocuous request, but it can bring up many ethical issues. If the practitioner accepts the patient as a friend, the patient may have access to personal information, blurring professional boundaries. If the practitioner does not accept the request, the patient might misconstrue this as rejection, potentially harming the therapeutic relationship.

AMA Code of Ethics Opinion 2.3.2 suggests that physicians consider the following when curating their online presence [28]:

- Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy, and informed consent.

- When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
- If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethics guidance, just as they would in any other context.
- To maintain appropriate professional boundaries, physicians should consider separating personal and professional content online.
- When physicians see content posted by colleagues that appears unprofessional, they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
- Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

CONCLUSION

As illustrated in this course, maintaining professional boundaries and effective communication are vital components of providing ethical and patient-centered care. Physician sexual misconduct is a serious ethical issue that requires ongoing education and awareness in order to protect patients and maintain the integrity of the medical profession. Such misconduct can take various forms, including but not limited to sexual advances or solicitations, inappropriate comments or jokes of a sexual nature, non-consensual physical contact, and misuse of position or authority for sexual purposes. It is essential for physicians and other healthcare professionals to understand the detrimental impact that boundary violations, and sexual misconduct in particular, can have on patients' well-being, trust in the medical profession, and the overall quality of medical care. By understanding the scope of boundary violations, following guidelines for examinations, and maintaining open and respectful communication, physicians can foster trust, promote patient well-being, and uphold the integrity of the medical profession.

Works Cited

1. Sindhu KK, Schaffer AC, Cohen IG, Allensworth RH, Adashi EY. Honoring the public trust: curbing the bane of physician sexual misconduct. *J Law Biosci.* 2022;9(1):lsac007.
2. AbuDagga A, Carome M, Oshel R. 15-Year Summary of Sexual Misconduct by U.S. Physicians Reported to the National Practitioner Data Bank, 2003–2017. Available at <https://www.citizen.org/wp-content/uploads/2523.pdf>. Last accessed August 8, 2023.
3. DuBois JM, Walsh HA, Chibnall JT, et al. Sexual violation of patients by physicians: a mixed-methods, exploratory analysis of 101 cases. *Sex Abuse.* 2019;31(5):503-523.
4. AbuDagga A, Carome M, Wolfe SM. Time to end physician sexual abuse of patients: calling the U.S. medical community to action. *J Gen Intern Med.* 2019;34(7):1330-1333.
5. Federation of State Medical Boards. Physician Sexual Misconduct. Available at <https://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf>. Last accessed August 8, 2023.
6. American Medical Association. Code of Ethics Opinion 9.1.1 Romantic or Sexual Relationships with Patients. Available at <https://code-medical-ethics.ama-assn.org/ethics-opinions/romantic-or-sexual-relationships-patients>. August 8, 2023.
7. American Medical Association. Code of Ethics Opinion 9.1.2 Romantic or Sexual Relationships with Key Third Parties. Available at <https://code-medical-ethics.ama-assn.org/ethics-opinions/romantic-or-sexual-relationships-key-third-parties>. Last accessed August 8, 2023.
8. American Medical Association. Code of Ethics Opinion 9.1.3 Sexual Harassment in the Practice of Medicine. Available at <https://code-medical-ethics.ama-assn.org/ethics-opinions/sexual-harassment-practice-medicine>. Last accessed August 8, 2023.
9. Goertzen J. Preceptor-Learner Boundaries: Optimizing Professional, Educational and Personal Relationships. Available at <https://www.nosm.ca/wp-content/uploads/2019/06/E2-Preceptor-learner-boundaries-Handout.pdf>. Last accessed August 8, 2023.
10. Mantova MC, Metcalfe NH. Professional boundary violations in primary care. *InnovAiT.* 2022;15(5):301-306.
11. Rizk BRMB, Olsen ME. *Challenging Office Cases in Obstetrics and Gynecology*. New Delhi: The Health Sciences Publisher; 2016.
12. American College of Obstetricians and Gynecologists. Committee Opinion 796 Sexual Misconduct. Available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/sexual-misconduct>. Last accessed August 8, 2023.
13. American College of Obstetricians and Gynecologists. Committee Opinion 825: Caring for Patients Who Have Experienced Trauma. Available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/04/caring-for-patients-who-have-experienced-trauma>. Last accessed August 8, 2023.
14. American Academy of Emergency Medicine. AAEM Principles of Ethics. Available at <https://www.aaem.org/about-us/code-of-ethics>. Last accessed August 8, 2023.
15. Laskey A, Haney S, Northrop S; Council on Child Abuse and Neglect. Protecting children from sexual abuse by health care professionals and in the health care setting. *Pediatrics.* 2022;150(3):e2022058879.
16. Hagan JF Jr, Shaw JS, Duncan PM (eds). *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017.
17. Fronek P, Kendall M, Ungerer G, Malt J, Eugarde E, Geraghty T. Too hot to handle: reflections on professional boundaries in practice. *Reflective Practice.* 2009;10(2):161-171.
18. Bulman C, Schutz S (eds). *Reflective Practice in Nursing*. 5th ed. Oxford: Wiley-Blackwell; 2013.
19. Medical Defence Union. Maintaining Patient Boundaries. Available at <https://www.themdu.com/guidance-and-advice/guides/maintaining-patient-boundaries>. Last accessed August 8, 2023.
20. Aravind VK, Krishnamam VD, Thasneem Z. Boundary crossings and violations in clinical settings. *Indian J Psychol Med.* 2012;34(1):21-24.
21. Gabbard GO. Prevention of boundary violations. *Psych Times.* 2008;25(4).
22. Medical Indemnity Protection Society. Keeping within Professional Boundaries. Available at <https://support.mips.com.au/home/keeping-within-professional-boundaries>. Last accessed August 8, 2023.
23. American Association of Orthopaedic Surgeons. Opinion on Ethics and Professionalism: Sexual Misconduct in the Physician-Patient Relationship. Available at <https://www.aaos.org/contentassets/6507ec63e5ac4ea48375ad96d154daac/1208-sexual-misconduct.pdf>. Last accessed August 8, 2023.
24. U.S. Department of Health and Human Services. Summary of the HIPAA Privacy Rule. Available at <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>. Last accessed August 8, 2023.
25. Haddad A, Doherty R, Purtilo R. Professional boundaries guided by respect. In: *Health Professional and Patient Interaction*. 10th ed. St. Louis, MO: Elsevier; 2023: 28-40.
26. Sharma P. A case of a patient/physician boundary issue in rural practice and measures to avoid or maintain dual relationships. *Prim Care Companion CNS Disord.* 2015;17(2):10.4088.
27. Anderson SC, Guyton MR. Ethics in an age of information seekers: a survey of licensed healthcare providers about online social networking. *J Technol Hum Serv.* 2013;31(2):112-128.

28. American Medical Association. Code of Ethics Opinion 2.3.2 Professionalism in the Use of Social Media. Available at <https://code-medical-ethics.ama-assn.org/ethics-opinions/professionalism-use-social-media>. Last accessed August 8, 2023.
29. Reyes Nieva H, Ruan E, Schiff GD. Professional-patient boundaries: a national survey of primary care physicians' attitudes and practices. *J Gen Intern Med.* 2020;35(2):457-464.

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