Boundary violations in medical practice: what should be done?

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The relationship between patients and doctors is considered to be the most sacred one in terms of trust, confidentiality and smooth therapeutic rapport. Very often cases are reported where the relationship between patient and doctor has been questioned. A number of patients have made unofficial complaints about improper advances made by doctors which threatened not only their psychological but also physical health. In a country like Pakistan, such incidents are buried and not allowed to surface in view of massive corruption. It zis often heard of that a number of doctors in their training and service life have had physical relationships with colleagues from allied health care and patients. Many such incidents were reported and remained subject of inquiry with the concerned hospital chiefs but nothing happened. There also seems to be a 'conspiracy of silence' as professionals have often bonded together to support each other and may even dismiss such reports as rumours or gossip. If senior clinicians are involved then there is particular reluctance in terms of taking any action because of past loyalties. Even the Pakistan Medical and Dental Council (PMDC) the only regulatory body of the country has not been very effective in addressing such issues. There is a clear provision in PMDC's code of ethical conduct[1] which is being reproduced as "Personal relationships: Any form of sexual advance to a patient with whom there exists a professional relationship is professional misconduct. A practitioner's professional position must never be used to pursue a relationship of an emotional or sexual nature with a patient, the patient's spouse, or a near relative of a patient. Sexual misconduct: Sexual contact with patient or patient's spouses, partners, parents, guardians, or other individuals involved in the care of the patient is liable to lead to exclusion from the register". In scientific terms any violation which may even not be of sexual nature is called "Boundary Violations" and a milder term "Boundary Crossing" that signifies broken borders between professional and personal identity. In order to understand this issue microscopically, it is not only a full sexual relationship which would come under this domain but a number of other acts fall under this purview like: inappropriate touch, failure to render the appropriate therapy, failure to refer for other services, creating unhealthy dependency, breach of trust and interference in family relationships etc. Some warning signs for this issue include: obvious therapist distress or upset, shifting style of approach to a given patient, lack of goals, therapy exceeding normal length of time, exceeding areas of competence, special fee arrangements, allowing telephone calls between

sessions, calling each other by first name, treating the patient as a friend, adoption of unwise techniques like; routine hugs, excessive touch, socializing with patients, direct intervention in client's life and excessive self disclosures.[2] While this problem is widely prevalent among all grades and specialties of doctors, the highly vulnerable group is that of the psychiatrists. The important principle is that there can be only one type of relationship that is doctor-patient relationship and any attempt to enter into a dual relationship is detrimental for both the doctor and patient. In the case of psychiatrists, the pertinent issue is the choice by selection committees for medical schools and postgraduate psychiatric training schemes who at times ignore the psychological and emotional stability of the candidates and focus on academic achievements only.[3] It is a huge responsibility which these committees should take on board in order to avoid future consequences. There are different reasons described as to why the psychiatrists are more prone and some of these are: psychotic individuals whose behaviour may be affected by delusions, the antisocial characteristics and the neurotic or character-disordered individuals.[4] It has also been described that some patients who are suffering from borderline personality disorder take initiative in violating the boundaries that include sexual acting out and may also falsely accuse therapists of sexual involvement. Kroll[5] went on to consider this issue as that of a Culture-Bound syndrome which may not be applicable in the local context. In USA, half the money in professional malpractice cases is spent on settlements and awards for complaints of sexual intimacy.[6] Self-report studies[7] of health care professionals, which ask about any history of sexual involvement with patients, suggests a prevalence range of 1-10%. Most of the reported cases involve male doctors. Sarkar[8] describes some harmful consequences to the patient of boundary violations like: emotional turmoil, shame, fear or rage, guilt and self-blame, isolation and emptiness, disengagement from services, cognitive distortion, identity confusion, emotional lability, sexual dysfunction, mistrust of authority, paranoia, depression, self-harm and suicide.

The Canadian Psychiatric Association (CPA) in its position paper[9] has identified some issues of grave importance which include; psychotherapy with its special problem of transference and counter-transference, circumstances may arise where a psychiatrist and former patient may develop a non- professional relationship, the specific circumstances there may be the assumption that the primary offender is the patient, who may be described as seductive, dependent, or histrionic but here again it is the physician in question who is under pledge for ethical practice, understandable reluctance to report colleagues is augmented by the belief that patients may distort or fabricate complaints and that ethical physicians could be seriously hurt by their actions. In addition, once a case is reported, medical licensing bodies may be more severe than a court of law where the accused is presumed innocent. This may deter some patients from reporting incidents, especially when this aspect of the proceedings is made known to them. Patients who report sexual activity with their physicians face similar dilemmas to all sexually assaulted individuals. Society unfortunately often blames the victim. Patients trying to obtain redress, and physicians reporting on suspected unethical conduct by their colleagues, may be treated as if it were they who had behaved unethically. . Identification of predisposed physicians is not yet possible because indicators are not clearly defined. Age, status, the extent and quality of residency training or the undertaking of personal psychotherapy are not related to the occurrence of this behaviour. Under the circumstances, the CPA makes some recommendations in its position paper which are in line with an effort to address this issue.

A. Professional Psychiatric Education

It is expected that the Code of Ethics will be engrained by the time the doctor or specialist graduates. It is the responsibility of universities to adequately teach undergraduate and graduate students the principles of ethical practice. It is therefore recommended that psychiatric residency training programmes institute a compulsory course on ethical issues in which the subject of the proper doctor/patient relationship is addressed. Questions on ethics should be incorporated into specialty examinations. Copies of the CMA Code of Ethics annotated for psychiatry should be made available to all residents from the beginning of training. Psychiatric education never ends and, therefore, the Canadian Psychiatric Association encourages the submission of papers at the Annual Meeting to review moral issues and to raise consciousness regarding ethical obligations.

B. Patient Education

A simplified précis of the Code of Ethics should be prepared by the CPA that all psychiatric practitioners would be encouraged to display in their offices in order to enhance patients' awareness of their physician's responsibility.

C. Disciplinary Action

The Canadian Psychiatric Association recognizes the dilemma faced by physicians who become aware of possible infractions by a colleague. Every psychiatrist who is provided with credible information by a patient about sexual exploitation should proceed as follows:

1. Inform the patient of the channels available to seek redress, including reporting the situation to the local

medical/legal disciplinary body.

2. Seek the consent of the patient to permit the physician to report such complaints to the appropriate licensing body. In some jurisdictions, this may be required by law, even without the consent of the patient.

D. Friend of the Patient

The Canadian Psychiatric Association also urges that provincial licensing bodies establish a "friend of the patient" to act as a resource or supportive advisory person for the patient during the investigative period.

The Royal College of Psychiatrists[10] recommends few principles for adoption in order to ensure good practice in therapeutic relationships that include: development of self-awareness in the service of patients, respecting and encouraging the patient's autonomy, sharing up-to-date knowledge and recognize self limitations, observing doctor-patient boundaries and avoiding boundary violations, be clear about roles, be aware of values but do not seek to impose them on the patients, maintaining privacy, managing risk in the interest of the patient and to develop a contract of mutual respect.

In the light of the above, something is to be done at local level and for that matter PMDC is the perhaps the only organization which can address this issue rather than any professional association mainly for the simple reasons of organizational make up and subtle politics at different levels. With a precise code of conduct, there is a need for guidelines, procedure and publishing of reports by PMDC and introduction of appropriate disciplinary actions that could include suspension of license. There should be emphasis on teaching ethics at both undergraduate and postgraduate levels. Moreover, patient education and awareness about their rights should be on display at health institutions. Doctors in general should remain aware of early subtle signs that may complicate into the problem of gross boundary violations. A scale developed by Epstein and Simon[11] by the name of 'Exploitation Index' evaluates the feelings, attitudes and behaviours of therapists in the maintenance of the therapeutic framework as well as the level of risk for such problems. This scale is useful also as an educational and research tool. Vamos[12] has described a training package for psychiatric registrar in an Australian setting which may be helpful in preventing and addressing this issue based on educational perspective.

Should we now urge the PMDC to set the ball in motion?

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