

Teaching Boundaries to Physicians of all kind

Part of the symposium on Boundaries Education: An expert update on diverse approaches and settings

Chair : Gregg Gorton MD, Jefferson Medical College, Philadelphia

Gregg Gorton, Samuel Steven, Zivin Gail: Effective boundaries education

Gary R. Schoener: Tools for preventive and remedial boundaries training

Nancy A. Bridges: Supervision of intense affective reactions to patients and construction of optimal boundaries

Werner Tschan : Teaching Boundaries to Physicians of all kind

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This paper is dedicated to my friend and colleague Bruno Bucheli MD, MPH, who died prematurely on January 1st this year. As the State Health Commissioner he was deeply involved in my own work, and we shared a lot of personal and professional insight into the topic of PSM. He stimulated and supported my approach to the subject. It would be his vision for us to continue training and educating physicians in this highly problematic and controversial field.

Abstract

All medical professionals are confronted with boundary issues in their daily practice. Whether Radiologist, Gynaecologist, ENT specialist, Internist, General Practitioner, Surgeon or Psychiatrist - all must scrupulously maintain professional boundaries with their patients. As increasing reports about physician sexual misconduct have emerged over the last several years, it has become more clear in parts of Europe that the practice of medicine involves significant risk of personal or even sexual relationships developing with patients. In Basel, Switzerland, the State Medical Association implemented a pilot program of postgraduate boundaries education for physicians. The current presentation will describe the multi-disciplinary curriculum utilized in this program. It includes medical ethics, legal issues, trauma to victims, risks to physicians, and techniques for preventing boundary problems. Teaching personal include judges, forensic experts, state health authorities, and members of a consumer support network, as well as an expert psychiatrist (the current presenter). Thus, the concept of professional boundaries is addressed from a variety of perspectives in order to portray the complexity of boundaries phenomena and also in order to have maximal impact on physician-learners participating in the training. Program evaluation data thus far clearly show both interest in and need for more education of this kind. It also reveals the need for further discussion of all kinds of boundary issues, not just those involving physician-patient sex.

The breach of duty element, which defines the standard of care, assumes that there is a line of competent practice below which no professional should descend (Schefflin in Brown et al. 1998, p. 527).

Boundaries

Every doctor patient relationship is defined by boundaries. The professional relationship is considered as a fiduciary relationship based on two main ethical principles, „do the best for your patient“, and „do not harm your patient“. If a professional relationship turns into a sexual one it may have devastating effects on patients. Both Attachment Theory and psycho-traumatology give us a clear conceptual framework to understand the resulting effects of sexual abuse when professional boundaries are violated. Boundaries of doctor-patient relationships are defined by the individual patient or client, by professional standards and state of the art, by law, by society and culture, and by the professional capacity as well.

The violation of boundaries has attracted attention for nearly 50 years. Although major reforms of medical formation have taken place in recent years, the traditional curriculum failed in integrating boundary aspects. Medical training still focuses more on strange and curious things, like Chorea Huntington (with an estimated incidence of 5/100'000), than on boundary violations and sexual violence of all kinds. The patho-physiological effects of sexual abuse are not known among clinicians. Although the prevalence of sexual violation of all kinds is widely reported (see e.g. British Medical Journal 1992), physicians in general do not feel competent in diagnosing and treating persons, whose boundaries have been seriously violated. Without doubt, they feel even more incompetent if the boundary violation occurs in a professional setting - especially when the accused professional works in the same discipline. It also has become clear that boundary violations do not only occur in psychotherapeutic settings, but in all medical professions, including that of doctors, nurses, physiotherapists and social workers.

Task Force of the State Medical Association

Two task forces of the State Medical Association in collaboration with the State Health Department have been implemented, to conceptualize:

- A. Support and Counseling for victims of PSM and their relatives
- B. Responding to professionals who violate boundaries

Both issues are far from simple. First of all, the members of the Medical Association have to be convinced that the maintaining of professional boundaries is their responsibility; and furthermore, if the Association's members violate boundaries and sexually abuse patients, it is of high concern for the Association. It has become clear that the problem of PSM cannot be managed just by operating personal pathology models. The systemic view of the underlying problem clearly shows that a sexual affair within a professional relationship always besmirches the entire professional body, the health care system and society in general. Therefore, a duty exists to protect patients

from unprofessional medical doctors and other health care professionals.

According to recommendation of the first task force, the State Medical Association implemented a hot-line and a counseling service for victims of PSM. At last year's APA meeting in Philadelphia, both the counseling service and the policing of physicians were presented by the author (The policing of physician-patient boundaries: some international perspectives). Today's presentation focuses on boundary training that physicians received to enable them to do their diagnostic and counseling work. As boundaries can be defined by different perspectives, only an interdisciplinary training approach can be useful.

The recommendations of the second task force related to the counseling of physicians, are currently under evaluation by the Swiss Medical Association. The conceptual framework how the professional community can handle colleagues, who are accused of PSM, is based on an integrated three pillar model, consisting of :

- formation
- consequences
- help

The recommendations have been presented in a 85 page-report (www.medges.ch -> patientenberatung). The first pillar, which is formation, means that boundary issues have to be integrated on a curricular basis. As almost no model for medicine in general exists, the current curriculum for postgraduate teaching boundaries to physicians of all kinds can serve as an important experience and create a framework of what physicians have to know about boundaries.

Curriculum : Teaching Boundaries to Physicians

Both the curriculum and the accompanying reader were conceptualized by the author. All physicians received a 400 page-reader containing summaries on the main topics that were presented during the teaching program on boundary issues. Furthermore, the reader contained leading international literature about the topic. All participants were invited to prepare them individually for each session, or to clarify the different issues after the oral presentations, respectively. Then participants were invited to participate in case-supervision on a regular basis, where they could present and discuss their own experiences.

Day 1

- Introduction
- Definition, Epidemiology of PSM
- Psychotraumatology and Attachment Theory
- Victims of PSM
- Diagnostic issues and pathophysiology of victims
- Presentation of Maryland Department of Mental Health and Hygiene's teaching video (1999) : Broken Boundaries

- Discussion of own experiences

In order to deliver a consistent approach, I decided to present the entire introduction by myself, with the exception of diagnostic issues and pathophysiology of victimisation. Many taboos are simultaneously challenged if we start talking about PSM in the health care system. Victims of sexual abuse - whether they suffer from PSM or sexual violation in general - are confronted with unfairness due to stereotypical beliefs, according to the explanations of C. L'Heureux-Dubé, Supreme Court of Canada. Those charged with administering the system (health care authorities, justice system, health care professionals, forensic experts) may be biased by one of the well known myths, including :

(1) It is the patient who seduces the physician, especially if the victim is a woman. A woman will never experience sexual intercourse against her will - if she really wants to prevent the sexual relation, she can ... Therefore, she (= the victim) is responsible.

(2) PSM is considered a romantic affair - where you always need two people for it to happen. Therefore, the physician can never be responsible alone.

(3) Men cannot be sexually abused. A systemic bias, which you will find, for example, in current gender discussions or the criminal justice system.

Society's inaccurate perception of the victims of PSM harms the victims and their relatives. Physicians have to be aware of this fact.

When the first speaker, clinical gynaecologist, Johannes Bitzer, presented his data on victims of sexual abuse, he focused on the pathophysiology of traumatic events, with emphasis on somatics. I had focused on psychotraumatic aspects, based on my knowledge on forensic victimology and offender treatment experience, the PTSD concept, the attachment theory and the neuroendocrinologic research findings. Maryland's excellent teaching video delivered a comprehensive and somewhat shocking awareness of traumatisation by professionals, when sexual abuse of their patients occurs. It was a mind-opener for all participants because some of them had not known how PSM takes place. It provided them with a deeper and more sophisticated understanding of the interaction pattern and resulting victimisation, when an abuse takes place within a professional relationship. Towards the end of the day's seminar, the participants were given time to discuss their own experiences, and also to share their impressions before leaving. Later in the training program it would become clear to everybody how important it is for professionals to maintain a good work-life balance when they are confronted with these stories, especially if they accompany victims of PSM or even offender-physicians. We addressed this issue as "professionals' internal waste management", which is intended as a processing of their personal experiences in order to keep up a healthy internal balance.

Day 2

- Forensic concepts
- Paraphilias
- Circle of Abuse
- Grooming
- Medical Ethics

- Doctor-Patient Relationship
- Victim Treatment concepts

First the clinical forensic expert, Anneliese Ermer, presented the current forensic perspective of the underlying problems. For a variety of reasons professionals who commit PSM should be subsummarized under paraphiliacs because they abuse their position of power analogous to the majority of child sexual offenders. In her presentation of the circle of abuse (adapted from Steven Wolff, 1984 and Joe Sullivan, 2002) and the grooming technique, she explained how sexual abuse occurs. Then the ethical expert, Christoph Rehmann Sutter, chair of the National Committee on Bioethics, talked about the nature of the doctor-patient relationship and the ethical consequences, if this space of trust is violated by a professional himself. He broadened the perspective by discussing the consequences of today's scientific thinking, which can be characterized by omitting relationship aspects in their approaches. And finally, psychologist Udo Rauchfleisch discussed the different victim treatment approaches, the treatment process and some major pitfalls. Pointing out the fact that nobody will ever be able to transform the abusive experience into something that never happened had a great impact on the participants. This concept challenges everybody working with victims of PSM, because it deeply hurts narcissistic feelings of therapeutic grandiosity (and medical doctors are especially vulnerable to that) - and is considered, on the other hand, to be one of the main avenues for professional abuse.

Day 3

- Consumer Network Support
- Trauma Therapy, Crisis Intervention
- False accusations
- Task Force presents their recommendations
- State Medical's Association Council of Honor
- State Health Commissioner

First, Consumer Network Support's Christine Jauslin, presented her experiences based on many years of case management of traumatized women. Her contribution clearly showed, that a victims' counselling facility, offered by the Medical Association, will never attract all victims of PSM because many have lost all confidence and trust in medical care. Offering different opportunities for advocating and counselling provides the victims with a choice. It also gives them a feeling of having decisions under their own control, which is often of crucial importance for victimized persons. Then, trauma-treating-trained gynaecologist, Angelika Schwendke, presented her experience in crisis intervention and long term care for abused women. She also talked about medical diagnosis in cases of sexual abuse, and outlined possible treatment strategies. Anne-Catherine Guex, internal medicine, and Pierre Périat, general practitioner, both members of the State Medical Association Task Force, presented the outcome of the report and discussed the various recommendations. Then, psychosomatic gynaecologist Noemi Deslex explained the tasks and procedures of the Medical Association's Council of Honor, which mainly serves as a self-regulating ethical committee. Finally, the State Health Commissioner and Master of Public Health † Bruno Bucheli (see remark at the beginning of the paper),

outlined the policy of the authorities in the topic. Contrary to the USA, his office serves as the state licensing board, and therefore has the duty to investigate all kinds of allegations made against physicians. The national assembly of state health commissioners (related to this issue Switzerland can be regarded politically as a federation comparable to the USA) has currently implemented a task force to conceptualize procedures in case of PSM.

Day 4

- Rehabilitation Program for physicians
- Law enforcement and justice
- Allegations and the role of the lawyer
- Risk Management
- Incestuous workplace
- Personal Work - Life Balance
- Course Evaluation

I started the last day with a presentation of a rehabilitation program, divided into 24 modules, for impaired physicians based on a boundary training concept. Then the current President of the State Criminal Justice Court, Chantal Hell, outlined the law enforcement procedures in case of civil or criminal allegations, and how justice currently handles PSM. By an unexpected coincidence, she had sentenced a GP accused of PSM two weeks previously. The case attracted the media and the professional community due to the circumstances. It was a great advantage for all participants to see how the court came to its decision in this case. The next presenter, Esther Wyss, a lawyer, pointed out the allegation procedures and the role of the lawyer from the perspective of victims. She also discussed the various laws : civil - criminal - administrative, with different limitations of time and a variety of details, which are important to know. The burden of proof - beyond all reasonable doubt - is often a great hurdle in criminal cases. It became clear for all participants how important it is to establish legal counseling early in a consultation process.

I then talked about hospital risk management and how important it is, especially for the human resource department, to consider PSM. I also outlined the strategies for an institution, implementing preventive programs, and the kind of reactions that can usually be encountered. The analogy of the incestuous workplace offers an excellent model to explain the underlying difficulties. I finished by pointing out the importance of an adequate work-life balance as a very important aspect in everybody's professional life, especially for those, who either have already sexually abused patients, or who feel urge to do it.

A course evaluation was the culminating point of the program. The State Medical Association will offer this kind of postgraduate training on a biannual basis. On an open agenda, we also offer workshops and seminars on related subjects. The first workshop with Henriette Haas (2001) was on a survey of 21'314 young Swiss men about their violent experiences (Rekrutenbefragung 1997). This is one of the largest surveys worldwide in the criminal field, investigating the unknown criminal rate. About 70% of the

entire age-cohort of young Swiss men were questioned. 12% of the participants showed violent behaviors in the past 12 months before being interviewed.

Other seminars were planned for the treatment of traumatized persons, forensic concepts on how abuse takes place (circle of abuse), sexual offender treatment, medical diagnostics and procedures in case of sexual abuse - just to name a few. We fully agree with Joe Sullivan (2002), as he pointed out: *It is impossible to effectively intervene in a process, which you do not understand.* The overall concept of the postgraduate training is based on a multidisciplinary approach, which provides multiperspective knowledge on a subject, which is not just a medical problem. The training is addressed to all physicians, including psychiatrists, internal medicine, gynaecology, pediatricians and general practitioners. Our hope is twofold : first we want to offer training in a subject omitted by traditional medical formation; and second, we want to contribute to find a common language to overcome the “single disciplinary ghetto“ effect the traditional professional formation still has today.

The aim of the curriculum is not to enable all kinds of physicians to treat victims of PSM in a psychotherapeutic approach, but rather to offer the necessary knowledge for diagnosing and referring these patients to colleagues who are trained and experienced in psychotherapeutically treating victims of PSM. Therapeutically treating accused physicians is another task which should be done only by experienced (and preferably forensically trained) therapists.

Another primarily unexpected effect became evident as participants of the training program were invited to present their knowledge in the training of judges, hospital managers, hospital staff, and a variety of other medical disciplines. It is also hoped to enlarge the knowledge and increase the competence of physicians in diagnosing sexual abuse of all kinds. The latest data from the WHO show, that about 20% of all women, and up to 10% of all men suffer from sexual violence. The urge to train physicians in this field has therefore become evident. This information should not be kept only for the professionals, rather the public has to be informed as well. It is the duty of professional bodies, health care authorities and consumer protecting agencies to explain professional boundaries in order to be effective in terms of patient safety. This also provides some new approaches in the risk management in the health care system as well as in the accreditation process of health care institutions.

Summary

PSM is a severe problem which besmirches the entire professional community and health care systems. PSM deeply affects all medical disciplines, not just psychiatry. A concept, how to handle PSM was first developed by the State Medical Association. Based on that concept, a boundary training program was designed and implemented in the form of a pilot postgraduate training course. As boundary dilemmas occur all the time in daily practice, only a continuous training model is applicable. This is guaranteed by an ongoing supervision focusing on the topic. Furthermore, a biannual update, and lectures from an interdisciplinary perspective keep knowledge up to date. Psychiatrists play a crucial and important part in this pilot program, due to their knowledge in psycho-traumatology, attachment theory and their treating experience and supervisory

capacity. This kind of a multidisciplinary approach also helps to create a common language, not only for different medical disciplines, but also to related fields. Therefore, it helps to overcome the single disciplinary view provided by traditional professional education and formation.

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