A Continuing Medical Education Approach to Improve Sexual Boundaries of Physicians

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Introduction: Physician sexual boundary violations are a public health problem. Few resources exist to address physicians who behave inappropriately with patients. In response, the Center for Professional Health at Vanderbilt University developed a three-day continuing medical education (CME) course about proper professional sexual boundaries in 2000. The mission of this CME course is to offer an educational intervention for those physicians whose professional sexual misconduct has required such education as part of a larger accountability sanction. Previous studies suggest that when such education is offered through non-traditional medical education, it is effective in promoting behavioral change. This paper describes the three-day intensive educational experience offered by a CME course with a particular focus on lessons learned from more than 7 years of experience working with these physicians.

Methods: Over 381 physicians from 40 states and Canada have attended. Data about course participants was collected by self-report and aggregated into three categories: demographics, results of assessment tools administered, and quality of the experience. Assessment tools used include the Family Adaptability and Cohesion Evaluation Scale II (FACES II), the Trauma Symptom Inventory (TSI) and the Sexual Addiction Screening Test (SAST).

Results: Most physicians were referred to the course from physician health programs and board of medical examiners. The majority of physician participants were male and in group or solo practice. A full range of medical specialties was represented with most physicians

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being internists, psychiatrists, obstetricians and surgeons. Results of assessment tools administered indicate that physicians referred for sexual boundary violations often come from dysfunctional families and demonstrate symptoms indicative of trauma related problems and possible sexual addiction. Physician attendees report being highly satisfied with the new knowledge attained in this course.

Discussion: Curriculum aimed at addressing sexual boundary violations should address family of origin issues, trauma coping skills and sexual acting out. Satisfaction data continues to support a small group, experiential, and confidential format as an effective means for intervention.

Conclusion: A CME course offers a model for future training experiences for faculty, residents, medical students and community physicians to teach skills that may help prevent and remediate professional boundary crossings.

Introduction

Since 2000, the Center for Professional Health (CPH) at Vanderbilt University Medical Center has offered the continuing medical education (CME) course, *Maintaining Proper Boundaries*. This course was designed to meet the needs of Boards of Medical Examiners (BME) and Physician Health Programs (PHP), which were eager to have an educational resource to which they could refer physicians with sexual boundary crossing problems. While the focus of its work has been primarily on teaching, the CPH faculty has collected preliminary and descriptive data about the physicians who attend this course. The purpose of this paper is to describe the three-day intensive educational experience offered by a CME course with a particular focus on lessons learned from more than 7 years of collecting data and experience working with these physicians. This information is important as initial evidence of the role that a CME course can play in addressing the behavior of offending physicians. It has also helped shape development of the curriculum.

Background

The profession of medicine has categorically prohibited sexual misconduct for more than 2000 years, by the Hippocratic Oath, and more recently by the ethical codes of almost all medical specialties

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Table 1. **Summary of FSMB Types of Professional Sexual Misconduct**

Sexual violation: may include physician-patient sex, whether or not initiated by the patient, and any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to:
Sexual intercourse
Kissing in a romantic or sexual manner
Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination
Encouraging the patient to masturbate in the presence of the physician
Offering to provide practice-related services, such as drugs, in exchange for sexual favors
Sexual impropriety: may comprise behavior, gestures, or expressions that are seductive, suggestive, or sexually demeaning to a patient, including but not limited to:
Examining the patient intimately without consent
Disrobing or draping practices that reflect a lack of respect for the patient's privacy
Subjecting a patient to an intimate examination in the presence of medical students or other parties without the explicit consent of the patient
Examination or touching the genitals without the use of gloves
Using the physician-patient relationship to solicit a date
Initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician

[1]. As institutional climates have become less tolerant of sexual misbehavior, there has been a greater emphasis on legal interventions and less emphasis on ethical sanctions[2].

The Federation of State Medical Boards (FSMB) has defined two levels of sexual misconduct by physicians, representing incremental difference in the degree of sexual transgression. These two levels of misconduct are *sexual impropriety* and *sexual violation* [3]. The corresponding behaviors for each category are summarized in Table 1. Physician/patient misconduct generally falls under the jurisdiction of the BME. Workplace sexual harassment is regulated by federal guidelines [4].

The prevalence of sexual misconduct by physicians in North America is not known exactly [5]. Many state BME's publish data about disciplinary actions in their states, but the National Practitioner Data Base is inaccessible to the general public by act of Congress [6]. In a review of the literature over a thirty year span,

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it was estimated that between 3-10% of practicing physicians have had at least one episode of sexual boundary misconduct [7].

Some attempts at understanding the etiology of such physician misconduct have been reported, but currently the evidence is unclear about why physicians sexually offend [8] [9] [10] [11]. The literature is also unclear about the role of gender, specialty, ethnic background, or locale of the physician practice as risk factors in this particular kind of professional misconduct [12] [7]. The impact and influence of the physician's family background (family of origin) is recognized as a risk factor contributing to incidences of physician error [13]. Unrecognized and unresolved trauma can resurface in behavior that is both unhealthy and risky [14]. Among treating therapists in this field, it is widely held that both the influence of family of origin issues and the role of unresolved emotional trauma intertwine to influence these sexual misconduct behaviors [15] [16].

Physicians are always held responsible for their sexual misconduct, regardless of the provocation [17]. The FSMB has recommended to the state medical boards several options for action after a physician has been found guilty of sexual misconduct. One of these interventional options is to complete a CME course in sexual boundaries. While didactic methods may be effective in some cases, the better way to teach this kind of information is through the use of group process, preferably a small-group setting away from the traditional medical classroom [18] [19] and through narrative-based and reflective experiences which provide the physician the opportunity to internalize the ethics and tradition of professional medicine [20]. Branch suggests that this type of learning "leads to reinforcement of participants' sensitivity and commitment to upholding their personal values." [18]

Prevention of sexual boundary violations has also become an important issue in medical training. The Accreditation Council for Graduate Medical Education (ACGME), at its February 1999 meeting, endorsed six core competencies for residents; number five is "professionalism." [21] The issue of physician sexual boundaries falls within that context in medical practice. As medical technology advanced over the latter decades of the twentieth century, Coulehan writes, "the *minds* of our students became sharper than ever, (but)

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their *hearts* appeared to be listless, and their moral compasses adrift." [22] Whitcomb, citing Sullivan, asserts that in order to foster professionalism, medical education must provide opportunities for physicians to "acquire an understanding of the ethical standards, social roles, and responsibilities of the profession so that they grasp the meaning of the profession's fundamental purposes." [23]

The fundamental purpose of medicine is to act in the best interest of both patient and public health [23], a concept deemed as "fiduciary" or in some cases "altruistic" or as a "trustee." [5] [22] The hallmark of such a fiduciary relationship is the balance of power, which enables trust. The power attributed to a physician because of his or her education, status, and role relative to the patient's vulnerability always tips the scale in the direction of the physician. When a physician fails to internalize this concept, or perhaps never knew it to begin with, the physician is unable to truly respect him or herself as a professional [18], and is unable to balance the "central paradox in medicine which is the 'tension between self-interest and altruism.'" [22]

Course Description

CME courses have emerged as a unique and effective way to offer a brief and non-stigmatizing intervention to address problematic behaviors among physicians [24] [25]. The Center for Professional Health (CPH) at Vanderbilt University Medical Center was formed in late 1997 as a new educational, research and prevention resource to address matters of physician health by providing CME courses. The content and format for the Maintaining Proper Boundaries course were developed over a six month period, modeled on CPH's successful parallel program for physicians who misprescribe narcotics [26] [27]. Nationally known consultants from medicine, psychology, nursing, and family therapy reviewed the core content and made site visits to CPH relative to the boundaries course. To date, more than 1000 health professionals from throughout the United States and Canada have been referred to the CPH for CME courses

The objectives of the boundaries course are for the physician attendee to:

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1. Understand sexual boundary issues, including current laws and rules;
2. Identify risk factors in the education and training of physicians who have violated sexual boundaries;
3. Identify family of origin issues and core personality issues that may contribute to sexual boundary violations;
4. Review office organization and policies that promote appropriate practice boundaries;
5. Understand about addictive disorders in general and sexual addiction in particular as a risk factor for this kind of misbehavior;
6. Identify appropriate treatment resources in the United States.

The lesson plan and course schedule as well as the content of all lectures are published on the CPH website so that all eligible enrollees can review what they will be learning [28]. Program elements are outlined in Table 2.

The faculty uses multiple teaching methods over the three days, including lectures, structured group process, insight focus groups, directed exercises/ homework, and assessment of the enrollees using both observation and psychometric testing. Enrollment in each course is limited to 12 physicians and a faculty of four, including two physicians, a licensed professional counselor, and a nurse practitioner.

Some aspects of the curriculum have changed over time including some core lectures. The curriculum changes for the most part are the result of feedback from the enrollees and from the faculty's experience with the groups. For instance, teaching the participants to have empathy for the victim of the offense was considered a very important goal in the first few years of the course, but the faculty encountered such resistance to this activity that we reevaluated and substituted a new segment that was geared more to developing personal insight and self-empathy. This has been much more successful in terms of the healing process of the physician attendees, which we have learned has to occur before the physician can understand or internalize a victim's plight.

Occasionally there have been "unscripted teachable moments" that we could not have anticipated or planned but which have yielded rich material for that particular group of course

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Table 2. **Program elements of the maintaining proper boundaries CME course**
Shame/guilt development and styles of coping
Family of origin genograms, with special emphasis on the socialization of the physician-to-be in his/her family of origin
Collateral addictions and recovery programs
Lectures and homework
Small group interaction
Guidelines for ethical professional practice
Intent to change exercise

participants. For example, a physician attendee emotionally "exploded" because of untreated recurrent Post Traumatic Stress Disorder (PTSD) resulting in some very tense moments. The faculty was able to model behavior for de-briefing and regaining safety for that enrollee and to complete the course successfully for all attendees. On another occasion, a physician attendee "imploded", withdrawing emotionally and occasionally physically from the group as more content was discussed. As before, the faculty modeled a joining-in process that allowed this physician to finally disclose previously unknown information and to guide him to seek more comprehensive care.

Methods

Information gathering about the participants attending the course begins at referral when both the offending physician and the referral source are interviewed about the reason for referral to the program. During the opening session, the physician's insight and honesty are assessed when asked to disclose the situation that precipitated their attendance to the group. In later sessions, in both large and small groups, the attendees may give more information in response to the course content or in response to the exercises and the assessment tools. The formal assessment takes place at the end of the first day, during homework time away from the classroom. Three areas of course participant needs are assessed: types of communication patterns in their families of origin; the effects of trauma on their emotional makeup; and the risk of sexual addiction as a

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Table 3. Demographic data for physicians referred to the maintaining proper boundaries CME course

Total Participants - 381	Practice Type (N = 362)	Specialty (N = 342)
Age Range - 31-77	Solo – 43%	Family/Internal Medicine – 42%
Average Age – 49	Partnership/Group – 41%	Psychiatry – 11%
Gender - 97% Male; 3% Female	Hospital-Based – 15%	Surgery – 11%
	Other – 1%	Obstetrics/Gynecology – 8%
		Cardiology – 4%
		Anesthesiology – 3%
		Neurology – 3%
		Other – 6% *

* Other Health Professionals

possible diagnosis that may not have been previously noted. The attendees return the questionnaires the next day and staff scores them during the morning session. The score sheets are returned to the participants that afternoon so that they can participate in their own self-learning. As a part of the course closure, each participant presents a three point written intent to change plan with specific actions and dates highlighted [29]. These are critiqued by the faculty and peers in session. Participant satisfaction is assessed using a standardized tool created by the CME office at Vanderbilt University. Only aggregate data collected from physicians who have consented is reported. Data collection and publication is overseen by the by the Institutional Review Board (IRB) at Vanderbilt University Medical Center.

Results

Demographics

The demographic data of attendees is displayed in Table 3. The majority of physician participants were male and in group or solo practice. A full range of medical specialties was represented with most physicians being internists, psychiatrists, obstetricians and surgeons. Table 4 summarizes the referral source for participating physicians. The pool of eligible enrollees is mostly referred from

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Table 4. **Referral source for physicians participating in the maintaining proper boundaries CME course (N=322)**

Physicians Health Program– 31%
Board of Medical Examiners – 29%
Self/Web – 11%
Treatment Center – 3%
Attorney – 3%
Other – 23%

state medical boards or from state physicians' health programs. A few attendees are self-referred. The reasons for attendance are summarized in Table 5. Some physicians attended for multiple reasons.

Assessment tools

A. The Family Adaptability and Cohesion Evaluation Scales (FACES II) [30] measures by self-report the characteristics of cohesion and flexibility exhibited by the participant's family of origin. This instrument describes a pattern of either balanced (healthy), mid-range (somewhat healthy), or extreme (unhealthy) family traits [30] [31]. Previous studies on the use of the FACES II in a physician population have not been reported. Three-hundred twenty nine or 86% of the 381 total physician participants who completed this instrument consented to having their scores kept in the aggregate data, which is shown in Table 6. Thirty-four percent of the consenting physicians received scores showing that they were raised in families that were balanced, thirty-two percent were in the mid-range, and another thirty-four percent were in the extreme range. Of note, among those who were in the last group, 93% of the families of origin were both disengaged and rigid, the largest subset of physicians taking the FACES II questionnaire. The faculty hypothesizes that family patterns which are imprinted early in life have an effect on the ways those physicians handle problems and manage stress in their practices and that the more extreme the variable the more likely the physician will react to personal vulnerabilities in negative ways.

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Table 5. Reasons for physician participation in the maintaining proper boundaries CME course

Unethical conduct
Affair with patient
Affair with office nurse/staff
Additional training after treatment for sexual, alcohol and/or drug addiction
Complaints from patients, family members, nurses
Flirting
Cybersex (Internet pornography)

B. The Trauma Symptom Inventory (TSI™) measures ten clinical scales relative to the effects of trauma-related symptoms for the past six months [32]. The results of these tests are displayed in Table 7. Along with frequent findings of anxiety, depression, and sexual concerns, the faculty also observed characteristics of anger, feeling embittered, fear, isolation, and burn out in most attendees. Thirty-two percent of the physicians had one score over 65, which is a 1.5 standard deviation from the norm. Although the TSI only looks for trauma symptoms in the last 6 months, extensive psychosocial and trauma histories are obtained through the genogram exercise.

C. The Sexual Addiction Screening Test (SAST) measures the number of positive endorsements to twenty-five statements that may indicate a pattern of problematic compulsive/addictive sexual behavior [33]. The CPH faculty has long observed that some physicians sexually misbehave in ways that are similar to problematic gambling and other recognized behavioral disorders. Three-hundred twenty attendees completed this instrument and 50 or 16 % scored at or above the cutoff score of 13, indicating the need for further screening to rule out the presence of sexual addiction.

Quality of the Experience

All participants (N=381) have completed the Vanderbilt Division of Continuing Education evaluation questionnaire. Using a five point Likert scale, measuring from least (1) to most (5), the course has consistently ranked highest in satisfaction among attendees at all Vanderbilt CME courses (Table 8).

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Table 6. FACES II Data for physicians participating in the maintaining proper boundaries CME course (N = 328)

Balanced: N = 111 (34%)
- Separated Structured – 19
- Separated Flexible - 12
- Connected Structured – 27
- Connected Flexible – 53

Midrange: N = 107 (32%)
- Disengaged Structured – 18
- Disengaged Flexible – 5
- Separated Rigid – 36
- Separated Chaotic – 2
- Connected Rigid – 14
- Connected Chaotic - 9
- Enmeshed Structured – 6
- Enmeshed Flexible - 17

Extreme: N = 111 (34%)
- Disengaged Rigid – 102*
- Enmeshed Rigid – 1
- Enmeshed Chaotic – 8

*Disengaged: extreme emotional separateness, very low involvement or interaction. Rigid: authoritarian leadership, parents highly controlling, unchanging rules and limited negotiations.

Discussion

The Maintaining Sexual Boundaries CME course continues to develop based on experience and data collection. The goal of the program has been to impact the participant in positive ways that foster change and awareness in their professional and personal lives around the issue of sexual boundary crossings. Our experience and data continues to support:

1. A small group (5-8) in a confidential setting facilitated by diverse faculty with medical and mental health backgrounds who guide the group with cognitive and experiential training has been found by participants to be the most effective way to present the material and foster group adhesion and accountability.

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Table 7. Trauma Symptom Inventory™ for physicians participating in the maintaining proper boundaries CME course (N=173)

55 or 32% of Participants Scored > 65
Number of Scores >65 per Clinical Scale
AA Anxious Arousal = 16
D Depression = 24
AI Anger/Irritability = 12
IE Intrusive Experiences = 11
DA Defensive Avoidance = 21
DIS Dissociation = 9
SC Sexual Concerns = 17
DSB Dysfunctional Sexual Behavior = 17
ISR Impaired Self-Reference = 15
TRB Tension Reduction Behavior = 9

2. Family of origin issues are an important factor in boundary violating behavior that should be addressed. Further research is needed to determine which family patterns most contribute to violating behaviors.
3. Consistent with the research literature, there is a high rate of trauma symptoms in perpetrators of sexual boundary violations. Our findings are limited however, in that trauma symptoms reported on the TSI assess only those symptoms present in the past 6 months and may represent the trauma of confrontation, intervention and disciplinary action as opposed to the result of childhood trauma. Our experience from the genogram exercise, however, suggests a high rate of childhood trauma, but it is unclear how to that trauma relates to perpetrating behaviors,
4. Compulsive sexual behavior should be screened for in all physicians accused of sexual boundary violations. Physicians identified with addictive sexual behaviors should be referred for more intensive treatment.
5. For some physicians, poor education around sexual boundaries remains the principal problem. Anecdotally, physicians attending the course are of the opinion that they are not properly educated or trained about their

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Table 8. Course evaluation for physicians participating in the maintaining proper boundaries CME course

Scale 1-5	1 = Poor 5 = Excellent
Quality and Effectiveness of Presenter	4.76 (Range 4.50 - 4.92)
Usefulness of Information Presented	4.72 (Range 4.27 - 4.83)

vulnerability, the seductive patient or the power differential. Physicians fail to recognize non-sexual boundary crossings including dual relationships, gifts and services from patients, and a loose unprofessional atmosphere in the office that form a slippery slope toward sanctions. Careful attention should be paid to make sure that claims regarding lack of education are not a defense for inappropriate behavior. Academic medicine should include boundary information as part of the core competency of professionalism in various courses throughout a physician's training.

Conclusion

We believe the Maintaining Sexual Boundaries CME course offers a promising model for both intervention into and prevention of unprofessional behavior in physicians. The strengths of this CME course continue to be the faculty; the setting; the experience of large and small group process for the participants; the family of origin exploration; and the opportunity to have a second chance to correct one's mistakes. The challenges facing the course include: limited funding to develop appropriate research projects including measuring of outcomes; self-reported data on the attendees; limited opportunities to compare this program with other similar programs; outcome measures not being built in from the beginning; and limited ability to determine the exact role the CME course plays in changing behavior. Future research should be directed at determining what role the CME course plays in changing physician behavior and which elements of the curriculum and process are most instrumental in facilitating change.

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