This issue’s lead article on Professional Sexual Misconduct is co-authored by Dr. Gregory Skipper, Medical Director for the Alabama Physicians Health Program. Dr. Skipper is one of the many talented and dedicated leaders in the constellation of physicians’ health programs. This article is an example of the sharing of information that exists among the members of the Federation of the State Physician Health Programs. The Missouri Physicians Health Program (MPHP) is proud to be an active member in this vital organization.

Education is an important aspect to the work of the MPHP. Our staff travels the state of Missouri to provide current and vital information to medical staffs, hospital administrations, residents and medical students. Please avail yourself of this service.

Sexual misconduct by physicians is a difficult subject. However, it does exist. Through education we hope to prevent such misconduct. But, should it occur, we can be of help and we do encourage referrals for this reason.

This type of misconduct rarely involves predatory behavior. Usually there are co-occurring issues such as depression, substance abuse, immature relationship skills and lack of understanding about boundary issues. Please remember, forewarned is forearmed! If you have a question or concern, call the MPHP for consultation.

I also wish to address our 2009 Fund Raising Campaign. Financial support is the life blood of any physician health program. All of our worthy goals will not be reached unless we have the resources to meet them. I wish to thank our supporters and friends who each year consider the MPHP worthy of their financial recognition. Those who have contributed thus far to our current campaign for 2009 are listed in this issue (page 3).

I know these are difficult economic times. However, patient care and the need for physician well-being does not cease. Our program addresses both patient safety and the physician shortage. When you support the MPHP, you are providing good care to patients and acknowledge the value of retaining our physicians. Please continue to support your physicians and your patients.

**Continued on Page 4**
Common Myths about MPHP

Myth #1
MPHP is only for those with substance abuse problems.

Reality
MPHP assists with a wide variety of personal situations or problems such as family, marriage, emotional problems, behavioral issues, and professional boundary issues.

Myth #2
If you go to MPHP, the Board of Healing Arts will be informed.

Reality
MPHP does not disclose the identity of, or information about, any current or former participant without a written release of information except in rare instances.

Myth #3
MPHP is only for physicians.

Reality
MPHP serves physicians, residents, medical students and their families.

Myth #4
MPHP provides treatment.

Reality
MPHP refers participants for recommended evaluations and/or treatment. MPHP conducts interventions where necessary. In addition, MPHP provides support services for family members. MPHP utilizes treatment programs and other resources based on individual needs.

Professional Sexual Misconduct: A new paradigm of understanding

An overworked married pediatrician was attracted to a single mom in his practice. They became friendly and one day he offered to help if she ever needed anything fixed around the house. Eventually she called and asked him to come over to fix a leaky faucet. This started an affair that lasted several months. When his wife discovered the affair, he broke it off. The mother became angry, felt exploited and retained an attorney. Comment: It’s important to realize that family of patients can be considered patients too, especially in pediatrics, where the parents are considered patients along with their children.

A general surgeon kissed an employee, who was also his patient, when she came to him crying about a problem she was having. Word got out in the office and a formal complaint was made to the medical board. Comment: Treating an employee, neighbor, or anyone else, means that the person then becomes a patient.

A family practitioner finally gave in to a seductive patient who brazenly seduced him. Comment: Claiming that an affair was the patient’s fault doesn’t work. It’s the doctor’s sole responsibility to set limits and act professionally. If you are uncomfortable with a seductive patient, refer them.

(These are but a few fictional examples drawn from compilations of real cases.)

Betrayal and exploitation are among the most egregious of human offenses, and when they involve a health professional preying on a vulnerable patient, the most basic of ethical principles are violated. When the patient-physician relationship is exploited and Professional Sexual Misconduct (PSM) occurs, it is particularly problematic because it strikes at the core spirit of the profession. The breach of trust associated with PSM is damaging to the patient, the health professional and to the medical profession at large. It’s damaging to the patient, who is exploited and may never trust a health professional again. It’s damaging to health professionals, who often lose their reputations, find their finances plundered, licenses revoked, and in more than two dozen states, find themselves subject to criminal charges and imprisonment. Finally, it’s damaging to the medical profession at large because of degradation in the perceived legitimacy of the profession each time this happens.

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Donors to the 2009 Fund Raising Campaign

Missouri Physicians Health Program is proud to recognize the following individuals and organizations who have participated in our on-going annual fund drive. We are truly grateful for their generosity, which helps provide crucial support as we strive to provide high quality physician health care services and meet the growing demand for our services throughout the state of Missouri. We encourage you to contribute to this effort as we reach toward the goal for this year.

Hospital Administrations

Audrain Medical Center
Barnes Jewish Hospital, West County
BJC *
Bothwell Regional Health Center
Callaway Community Hospital
Cameron Regional Hospital
Cardinal Glennon Children's Hospital
Centerpoint Medical Center
Children's Mercy Hospital
Cox Health
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Heartland Regional Medical Center
Lake Regional Health System
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Pershing Memorial Hospital
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Research Medical Center
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* Committed donation, not received as of 6/30/09
through your financial support of the Missouri Physicians Health Program
Your tax-deductible contribution should be mailed to Missouri Physicians Health Program, 680 Craig Road, Suite 308, St. Louis, MO 63141. Thank you.

From the Editor

I have had a few conversations lately with Medical Staff Coordinators who have told me that they are not receiving the newsletters that are emailed every other month, possibly due to spam filters that block group emails. If you are not receiving yours, please call me at 800-958-7124 X23, or email me at nmorton@themphp.org.

If you know of others that would appreciate receiving the newsletter, please let me know.

We hope you enjoy our new format. If there are any subjects you wish us to address, please let me know. Your valuable input would be appreciated!

Speakers Available

We travel the state extensively to educate healthcare professionals about impairment, the role of MPHP, and the confidential services we offer. If you wish to schedule a presentation for students, medical staffs, administration, or your organization please contact Nancy Morton at 800-958-7124 X23.

DVD Now Available

The Missouri Physicians Health Program has released our first DVD. The DVD contains the personal narrative of a Missouri physician who was impaired and suffered many losses because of his condition. However, with the assistance of the MPHP and its resources, he has returned to the practice of medicine. Usually we talk in general terms about statistics and anecdotes. However, now we have a courageous physician who is so grateful to have survived his impairment, that he has agreed to come forward with his personal history. The DVD lasts less than 30 minutes and is now available. You may wish to show it to medical students, residents or at your general medical staff meetings. Please contact us if you are interested in ordering the DVD.
Unfortunately, claims of PSM are not rare. A confidential survey found that 8% of physicians admitted committing some degree of PSM with one or more patients, and most physicians acknowledge they’ve been tempted. Despite this, there is a generalized denial in the health professions regarding the risks and/or existence of PSM and a taboo regarding discussing it. Even with the “sexual” nature of the offense, it turns out that health professionals who’ve committed PSM rarely have any type of sexual disorder. Very few are true sociopaths. Most of the time, in fact, these physicians simply lose good judgment and believe they’ve “fallen in love” with the patient. Most physicians who commit PSM do so in times of personal trauma or professional crisis, when judgment is diminished. Unresolved vulnerabilities may arise associated with overwork or professionally dissatisfaction. The turbulent times of midlife often trigger PSM. To flee the pain of parental death, a failing marriage or empty nest issues with the departure of children to college are times when physicians may “act out” inappropriately.

All this becomes more relevant by the fact that PSM is preventable. Educating physicians about good boundaries and helping them become more aware of their vulnerabilities and risks and ways of setting up their practice to protect patients and themselves is critical. Not only is PSM preventable but doctors who commit PSM are usually treatable, and relapses are rare when good treatment and education occur and precautions are taken.

Considering the very damaging real life consequences of PSM it is surprising how casually PSM is depicted on TV and in movies. The discordance between how professional boards and criminal agencies view PSM versus its media portrayal is troubling and may contribute to the risk of PSM because it creates a false sense of acceptability for inappropriate relationships with patients. Additionally, there are many stories about relationships between doctors and their patients leading to successful marriage, without any apparent harm. These, however, are the exceptions. More typically, the patient eventually becomes aware of a sense of exploitation and becomes very angry. Not uncommon are cases in which a physician-patient marriage ends in divorce at which time the ex-spouse files a complaint and law suit… and wins. It’s tragic that as terrible and devastating as PSM is, it is essentially a taboo subject; little or nothing is taught regarding PSM in medical schools, and it’s rarely a subject for postgraduate training.

To help prevent PSM it’s important to have a basic understanding of boundary theory and the dynamics that underlie boundary violations, to develop vigilance for early warning signs of potential boundary problems with patients, and to gain insight into professional and personal vulnerabilities and risk factors. Excellent CME based courses are available for further in-depth training.

PSM (synonymous with “sexual boundary violation”) can be defined as any action of a sexual nature that oversteps or disregards ethical or legal limits of professional behavior. For our purposes, sexual refers to any erotic physical contact, and may also include sexual behavior involving language or gesture. Even the use of sexual humor or informal speech can be deemed misconduct. The somewhat vague concept of “boundary” is made more explicit by reference to professional ethical and legal norms.

Ethical prohibition against sexual relations with patients dates back at least as far as the Hippocratic Oath of ancient Greece. An abbreviated version of the passage states: “[I] will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen or slaves.” Most professional societies have a code of ethics which contain clear statements regarding what constitutes appropriate sexual boundaries.
The major area in which these codes differ is regarding how long, if ever, it is necessary following termination of the patient-physician relationship before a relationship can be pursued. On the subject of where the lines are drawn inside the professional relationship, they are essentially identical.

The Federation of State Medical Boards, in a policy statement in 2007, clearly defines what it considers sexual boundaries, and states that disciplinary action should be taken against any physician who violates them. Here are some salient excerpts from that document:

“Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. This behavior … may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual. … There are primarily two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action by a state medical board …. Sexual violation may include physician-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient.” The documents goes on to state, “Findings of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician’s medical license, although a lesser action may be considered for cases of sexual impropriety.”

It is important to know that most acts of PSM occur following progressive problems with boundaries that precede the PSM. Often these steps are referred to as “boundary crossings,” which may be initiated with the best of intentions, but progressively tumble down a “slippery slope” of professional destruction. While these precedent behaviors are not necessarily unethical in and of themselves, they are major warning signs. In order to prevent sexual boundary violations it is important to understand this progression and the precedent boundary disturbances. Sometimes these boundary disturbances are limited to one patient or one particular type of patient, and in other cases they may characterize the clinician’s general practice style. In the context of rehabilitation from sexual boundary violation(s), it is incumbent on the professional to address all of these boundary issues.

Precedent boundary problems can include time issues, such as extending the time of office visits (often by scheduling at the end of the day), conducting the visit during non-business hours or by extending the visit from the last appointment of the day into non-business hours (after the staff leave the office). Another category of precedent behaviors includes “concepts of place and space.” For example, making home visits (except when clearly part of regular practice), meeting a patient at a social occasion or agreeing to share a meal with a patient at a restaurant. Another area, giving or receiving gifts, can be a problem if it tends to “deprofessionalize” the relationship, encourage romanticizing of the relationship or interferes with therapeutic aims. In general, it is a good idea to have an office policy that gifts from patients are not accepted (except to the office as a whole). Physical contact is another area of concern. There are times in the course of clinical practice where touching the patient outside of a physical examination is accepted, such as a handshake at the beginning or end of an appointment, or the placing of a hand on the shoulder as a comforting gesture. Some practitioners also feel it is permissible to hug patients at times, though, depending on the characteristics of the patient, this can be very dangerous. Context is clearly important in determining to what extent a hug may be thought of in this way. Hugging can cause serious confusion in the professional relationship, be interpreted or experienced in a romantic way by the patient, and can lead to greater intimacy. An important adage to remember is that when it comes to boundaries,
“perception is everything.” The misinterpretation of a therapeutic hug as romantic may be impossible to defend.

Boundary issues involving money can precede PSM. Examples include lending or borrowing of money from patients, business activities with patients or even bartering in place of the standard fee. It’s also important to be careful with language with patients. Using the title of doctor, for example, helps establish the professional relationship. The use of too familiar a tone of voice, the use of inappropriate colloquial language or the use of first names can be risky, especially in some settings. Wearing a white coat re-enforces the professional image. Informal dress may convey the opposite. Finally, the issue of self-disclosure should be mentioned. While it is not uncommon for clinicians to occasionally share a story with a patient or to reveal selective aspects of their personal experience, the injudicious sharing of private information is clearly a boundary crossing and interferes with the aim of the professional relationship. The disclosure of personal problems is virtually always inappropriate. Sharing by the doctor with the patient that he has an unethical attraction to them is highly inappropriate. This type of boundary crossing commonly precedes PSM.

Preexisting vulnerabilities afflicting the physician, such as psychiatric illness, alcohol and/or substance abuse disorder, paraphilias, personality disorder, mood disorder, sexual compulsion or addiction and/or insufficient support, supervision, oversight or accountability make PSM more likely to occur. Other factors that can predispose the physician to PSM include marital/family problems, midlife or late midlife stage-of-life crisis and burnout. Similar preexisting vulnerabilities affecting a patient can also increase risk. Patients with histories of sexual abuse appear to be particularly vulnerable.

It’s important for every physician to know that PSM is unethical and can carry harsh consequences. Physicians should recognize inappropriate behaviors and not act inappropriately due to their emotional attractions to patients. Ultimately, it’s best to refer the patient causing concerns to another physician. Before pursuing a relationship with a patient, contact your specialty society and/or the Alabama Board of Medical Examiners [Missouri Board of Registration for the Healing Arts] for more guidelines to be sure it is ethical and safe. Consulting a good therapist prior to taking any action is also a good idea. We physicians are also ethically responsible to protect our colleagues. If we see red flags of an evolving boundary problem in another physician, we must consider an intervention. Stepping in can save a professional and protect a patient. Failing to follow these recommendations is very likely to be costly to everyone involved.

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Stephen Schenthal, MD, Founder, www.professionalboundaries.com, Destin, FL

* Bayer T, Coverdale J, Chiang E.A National Survey of Physicians’ Behaviors Regarding Sexual Contact with Patients. SMJ October 1996