12 Sexual and other boundaries

From the time of Hippocrates, the medical profession has acknowledged that the special relationship of trust between patient and doctor must not be abused by the doctor establishing any type of improper or sexual relationship. As stated in the Hippocratic Oath:

> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations, with both female and male persons, be they free or slaves [1].

This prohibition has been widely restated in recent times in Australia and elsewhere, and is enforced by the threat of suspension or removal of the name of the doctor from the medical register if found guilty of such serious professional misconduct [2-6]. In Australia, the prohibition is addressed initially in the Medical Board of Australia's code of conduct in the following terms:

> Never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient [7].

The responsibilities of doctors are described more fully in the Board's document *Sexual boundaries: guidelines for doctors* [3]. Despite this clear prohibition, there is considerable evidence from Australia, North America and Europe that sexual boundary violations remain a problem [8-13].

This chapter defines sexual misconduct and summarises what is known of its incidence. It discusses the apparent causes of these violations of professional boundaries, emphasising the psychological dynamics for the patient/complainant, who is usually female, and the doctor, who is usually male. An understanding of the psychodynamics of the doctor–patient relationship where these breaches of trust have occurred leads to an appreciation of the frequently harmful outcome for patients. This potential for harm, together with other ethical arguments, explains the need for continuation of the strict prohibition of such relationships. The chapter describes a manner of response to allegations of sexual misconduct that is designed to meet the best interests of the complainant, the community and the medical profession. It briefly touches on the use of chaperones for intimate examinations, and false allegations of sexual misconduct.

© Australian Medical Council

The chapter also addresses several other problematic boundary issues for doctors including social and financial boundaries, use of social media, and the receipt of gifts from patients.

12.1 What are boundaries in clinical medicine and why do they exist?

The term *boundary* has gradually arisen in the medical literature, most often in the context of the best-recognised boundary, the prohibition on sexual relations with patients. In the *Macquarie Dictionary*, the term is defined as 'something that indicates the bounds or limits; a limiting or boundary line'. Boundaries exist primarily to protect people who seek medical care as patients, who enter an unequal relationship and are potentially vulnerable to exploitation. Boundaries also exist to protect and promote the trust that the community needs to have in its doctors and can help protect doctors (from their own human weaknesses and from some patients). All types of boundaries that are now identified are based firmly in the ethical principles of medical practice, most notably the principle of non-maleficence or doing no harm (see Chapter 3).

Boundaries have been defined in medical practice in regard to sexual contact, financial dealings and social intercourse. The most clearly defined boundary relates to sexual contact, and this chapter focusses extensively on this topic. Financial boundary issues arise less often in clinical practice, but there are doctors who misuse their professional relationship with patients to pursue their own financial interests, ignoring the influence of that relationship in making it difficult for patients to decline to participate.

Social boundaries are less clearly defined and are often very context sensitive. They are critical to the effective practice of psychiatry and counselling and in any area of medicine where patients are particularly vulnerable both to exploitation and to their own misunderstanding of the nature of the therapeutic relationship. This boundary includes matters of self-disclosure within therapy and socialisation outside of therapy. Crossings of this boundary may be a harbinger of crossing of the sexual boundary. In the context of clinical practice in small rural communities, crossing social boundaries is clearly unavoidable, but nevertheless, doctors in these environments need to be alert to when such crossings could lead to harm to patients and to the reputation of the doctor and the medical profession.

© Australian Medical Council