Boundaries in family practice

What is the right distance?

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Dear Colleagues,

Physician sexual boundary violation was the theme at this year's Federation of Medical Regulatory Authorities of Canada annual meeting, where many excellent presentations shed light on the challenges faced by regulatory authorities in ensuring public safety.

Sexual boundary violation is

> a situation in which professional boundaries are crossed and sexual actions and feelings are allowed to enter into a relationship which is supposed to be for the interest of the patient, and which, by virtue of the patient's vulnerability, is inherently unequal.[1]

Research on perpetrators is difficult (confidentiality, under-reporting, etc). One Canadian study found sexual misconduct to be the most common offence (20%) among physicians disciplined by medical regulatory authorities between 2000 and 2009.[2] Most perpetrators are male, older than age 39, not board certified, and practise in non-academic settings where patients are examined alone.[2-4] Sexual misconduct might involve different physicians for different reasons. The most treatable physicians are those who have a sense of entitlement or of being irreplaceable, as well as those who might have become isolated professionally or personally. The prognosis might be more guarded for those with a severe mental illness, such as psychosis, severe depression, or personality disorder.

During his presentation, Dr Hartley Stern, Chief Executive Officer of the Canadian Medical Protective Association (CMPA), reported that between 2009 and 2018, 3% of CMPA's 37 000 closed cases were related to sexual impropriety (average of 111 per year)—comprising inappropriate behaviour or remarks (22%), inappropriate touching of a sexual nature (57%), or violation involving physician-patient sex (21%). Disposition included advice on behaviour or remarks (69%), suspension of licences for inappropriate touching (34%), and suspension and revocation in cases involving a sexual act (68%).[5] He explained the effects of these situations on complainants (eg, emotional toll), as well as on physicians named in such allegations (eg, reputational damage). Dr Stern emphasized that the CMPA does not tolerate sexual abuse; it supports appropriate and fair regulatory practices; and it is prepared to collaborate on joint efforts toward action geared at improvement, education, and support in this important area.

To ensure adequate training of residents, the CFPC's accreditation standards require family medicine programs to demonstrate how they are doing in areas of assessment (as defined by the evaluation objectives, **www.cfpc.ca/EvaluationObjectives**, which include professionalism features), as well as curriculum (teaching the CanMEDS–Family Medicine roles, which include professional: **www.cfpc.ca/ProjectAssets/Templates/Resource.aspx?id=3031&terms=canmeds**).

Other strategies to help incorporate boundary learning at medical schools, as described by Drs Bruce Fleming and Janette McMillan from the University of British Columbia, include prioritizing curricular content on this issue, having teachers model best behaviour practices, intervening early, and, in the context of being a self-regulated profession, working closely with licensing authorities.[6] Goulet et al found that it is possible to teach boundary issues and level of awareness in a continuing professional development workshop.[7]

Family practice, by its very nature, involves a deep relationship with patients. With respect to ensuring boundaries, consider the following questions: Is what I am doing part of accepted medical practice? Is it solely in the interest of the patient? Am I revealing too much about myself or my family? Is what I am doing secretive? Would I be happy to share with my spouse or colleagues?[8] Maintaining balance in professional and personal relationships is important. The CFPC supports collaboration and efforts in the areas of education, resilience, and supportive environments.

Cet article se trouve aussi en français à la **page 591.**

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