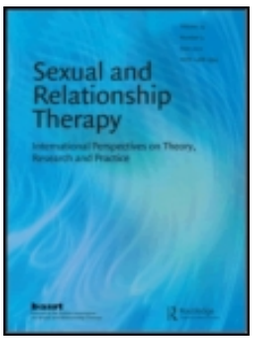

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S. Michael Plaut

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EDUCATION

Sexual and nonsexual boundaries in professional relationships: principles and teaching guidelines

S. Michael Plaut*

Department of Psychiatry, University of Maryland School of Medicine, USA

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Healthy professional relationships require that certain boundaries be maintained, especially if there is a power differential between the parties (e.g., physician – patient; faculty – student). Boundary violations can be generally divided into three types: sexual harassment (e.g., requests for dating, sexual innuendo, gender discrimination), sexual misconduct or exploitation (i.e., intimacy between professional and either patient or student), and nonsexual dual relationships (e.g., exchanging personal gifts, excessive disclosure, seeing students as patients while in a teaching role). Medical students may be victimized by faculty or residents who violate appropriate boundaries. They are also at risk for being potential offenders in the future. Both students and residents need to learn about risks and preventive measures in a way that is appropriate for their level of training. Both didactic teaching and discussion of relevant case vignettes can aid in this process.

Keywords: gender issues; sexual trauma; relational disorder

In the normal course of professional life, we are likely to meet colleagues, students, or clients to whom we are sexually attracted. How we handle these feelings is one of the great challenges for the health care professional. If these feelings are unrecognized, denied, or mishandled, we may cross what are considered to be appropriate provider – client boundaries. Such boundary crossings may occur in many ways, ranging from social contact outside the practice setting to excessive personal disclosure to overt sexual contact. In the most serious boundary violations, the resulting personal distress can include severe feelings of betrayal, loss of primary relationships, clinical depression, and even suicide (Bloom et al., 1999; Plaut, 2003).

Are such relationships always harmful? Probably not, just as exceeding the speed limit does not always result in harm to self or others. However, the risks of harm are considered high enough that the prohibition is absolute, at least in certain settings (Bisbing, et al., 1995; Wertheimer, 2003).

In conducting rehabilitation programs for professional offenders over the last 20 years or so (Plaut, 2001), it has become clear that we are not preparing our students well enough for such boundary challenges. Even if ethics are taught and concepts such as transference and countertransference are addressed, these do not necessarily prepare the student for the risks that can lead to professional transgressions at any stage of professional life.

*Email: mplaut@som.umaryland.edu

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As distant as many of these eventualities may seem to the student, recent research by Papadakis and her colleagues (2004) clearly demonstrates that evidence of unprofessional behavior among medical students is predictive of later difficulties with disciplinary boards. Therefore, there may be a direct relevance between traits possessed by students and risk for unprofessional behaviors in the future. Professional education may thus be able to draw useful parallels between student experience and later situations.

In this paper, I will briefly review the principal concepts regarding professional-client boundaries, suggest some techniques for addressing these issues at various stages of medical training, and highlight a few preventive strategies. Although medical education is provided as a model, these same general principles can be applied to any area of professional education.

Boundary standards

What then, are the standards regarding boundaries for physicians and why are they necessary? First, it must be acknowledged that boundaries are important in all relationships, including committed partners in an intimate relationship. In her book, *Grown-Up Marriage*, Judith Viorst (2003) encourages her readers to "figure out how intimate you can be without suffocation and how separate you can be without alienation." Relationships can become so enmeshed that each member of the couple loses his or her individuality and privacy.

When we talk about the relationships of physicians to their patients, students, or employees, however, we are usually not talking about 'peer' relationships, where conflicts can be resolved by a sense of 'distributive justice' (Wertheimer, 2003). We are talking about a professional who has a fiduciary duty to a client; we are talking about people who are involved in a trust-based relationship with a person to whom they are providing a service. In his recent book, *1776*, David McCullough (2005) quotes General George Washington as having advised his junior officers as to how to relate to soldiers under their command. "Be easy," he said, "but not too familiar, lest you subject yourself to a want of that respect, which is necessary to support a proper command." What we see here, as with the Viorst example, is the importance of a spectrum – a balance that one must find between closeness and caring on one hand, and necessary distance on the other.

Our patients and students depend upon us for our skill, knowledge, and advice and are thus, by definition, dependent upon us and vulnerable to us. This dependency gives the physician a power over the patient or student that is inherent in the relationship itself (Feldman-Summers, 1989). It is therefore incumbent on the physician not to exploit that dependency. The physician's objectivity depends on a certain level of distance, so that conflicts of interest or personal bias do not interfere with his or her ability to evaluate or treat in a way that is in the student's or patient's best interest.

Concern with sexual boundaries in particular dates as least as far back as the original Greek version of the Hippocratic Oath. This short document, laying out the obligations of the physician when visiting the sick, included a specific prohibition against "sexual relations with both female and male persons, be they free or slaves" (Edelstein, 1943). Yet, the great sensitivity of this issue allowed a virtual conspiracy of silence until the last quarter century, when concerns about all forms of sexual violations, including rape, incest, and sexual harassment, were increasingly addressed in codes of professional ethics, licensing statutes and regulations, and civil and criminal statutes (Bisbing et al., 1995; Plaut & Nugent, 1999; Rutter, 1997).

Dimensions of professional boundaries

Sexual boundary violations can be divided into two categories, based largely on how they are defined in law, codes of ethics, and institutional policy. These are sexual harassment and sexual misconduct. As with other kinds of sexual abuse, men are the offenders most of the time and women are the victims. However, sexual boundary crossings in the professional realm occur in all four gender combinations.

Sexual harassment is defined under U.S. federal civil law (Rutter, 1997) as sex related behavior that is unwanted and that may be done either as a condition for institutional status (e.g., grades, advancement) or which creates a hostile work environment. Sexual harassment may occur between peers or when there is a power differential or even a perceived power differential between the parties involved. Sexual harassment may also involve gender discrimination.

Sexual misconduct (or sexual exploitation) is a phenomenon that is defined as occurring in trust-based or fiduciary relationships, i.e., relationships in which one person has an obligation to provide a service to another (e.g., health professionals, attorneys, teachers, clergy). Standards of behavior vary somewhat in ethics, law, and policy. In the health professions, and medicine in particular, the standards are clear, at least in terms of relationships between physicians and patients. Sexual relations between physicians and patients are unethical (Council on Ethical and Judicial Affairs, 1991). The definition of 'sexual relations' varies, but in terms of ethical standards is pretty broad, often including even discussions of a sexual nature that are not within the standard of care for a given clinical setting.

Sexual misconduct has been divided into three general types (Plaut & Nugent, 1999): (1) sexual activity in the context of an examination or procedure, (2) sexual activity recommended with the pretense of therapeutic benefit, and (3) what is by definition a sexually exploitative relationship, i.e., any sexual relationship between a physician or a patient, regardless of who initiates it, and whether or not the patient has consented to that relationship. In such cases, the power differential between physician and patient renders the consent of the patient invalid (Bisbing et al., 1995; Plaut, 1995; Wertheimer, 2003). By some standards, a sexual relationship even with a family member or partner of the identified patient would be considered equally inappropriate. Medical ethics also caution against relationships with former patients, since the dependency between physician and patient does not necessarily end when the clinical relationship ends (Council on Ethical and Judicial Affairs, 1991).

Standards regarding relationships between teachers and students are less clear, but include many of the same risks. Even though the student may consent to the relationship, the teacher may still be in a position to evaluate the student and perform other teaching functions. In addition, there may be an emotional dependency between teacher and student. This creates a conflict of interest and is thus not in the best interest of the student (Plaut, 1993). The level of risk for boundary violations may be increasing at the present time, as the number of women medical students grows in proportion to the percentage of women in teaching roles.

In discussing professional boundaries, most of the focus has been on sexual boundaries, as it should be. Sexual boundary crossings are the most devastating to a patient or student for many reasons, including such things as risks to ongoing relationships, possible violations of previously held moral values, and the possibility of previous sexual victimization of the student or patient (Plaut, 1995, 1997). However, there is another area of boundary violation, of which sexual acts may be the end-point, and these are often referred to as dual or multiple relationships.

Dual relationships are addressed in the ethical standards of both psychology and social work (Gabbard & Nadelson, 1995; Peterson, 1992; Wertheimer, 2003) and are of concern for at least two reasons: (1) they may themselves represent conflicts of interest, and (2) they are often precursors of sexual boundary crossings. Examples of nonsexual boundary crossings may include disclosure of personal problems, blurring of professional and personal roles, giving or accepting gifts, and favoritism. None of these behaviors is necessarily wrong from an ethical or legal point of view. However, it may be useful to consider the implications of each of these in terms of its possible impact on our role as clinician or teacher. The take-home question in all cases is ''Whose needs are ultimately being met?'' Appropriate boundaries are always the result of a constant, daily search for a golden mean; we can also be too distant by not providing the closeness and caring that makes for a supportive, trusting, clinical or mentoring relationship.

Standards of behavior

As illustrated earlier, professional boundaries, and sexual boundaries in particular, are addressed not only in our ethical standards, but also in civil and criminal law, primarily because of the high level of public and institutional concern with sexual abuse. It is important to be aware of boundary standards expected of us in any particular professional setting. For example, sexual harassment is defined in U.S. federal civil law and is typically reflected in institutional policy. Sexual contact between certain professionals and clients is considered a criminal offense in over 20 states (Bisbing et al., 1995). Licensing statutes and regulations dictate both sexual and non-sexual boundary standards to varying degrees, depending on the state. Hospitals and clinics may regulate behaviors such as dress codes, giving and accepting gifts, and other kinds of dual relationships. Colleges and universities may have policies that prohibit teacher-student intimacy under certain conditions. We must also always be aware of what is called the 'standard of care,' i.e., the consensus among our colleagues regarding any kind of professional behavior in a given setting.

In considering how we relate to people and conduct our professional lives in general, it is sometimes useful to reflect on what an attorney colleague of mine calls 'the Sandbox Rules:' Among these are: Share everything. Play fair. Don't take things that aren't yours. Hold hands and stick together. Be aware of wonder. Live a balanced life. Take a nap every afternoon (Fulghum, 1986). This is where it all begins.

Recommendations for training

For purposes of teaching about boundary issues, it may be useful to distinguish three stages of training – preclinical and clinical years of medical school, and residency.

At all stages, it is helpful to review basic principles about professional boundaries as outlined earlier, as well as any institutional, departmental, or clinic policies that may be relevant. Three general areas may be covered: boundaries between peers, teacher-student boundaries, and provider-patient boundaries. Each of these has its unique characteristics as well as similarities. Issues to be addressed may include difficulties discussing this sensitive topic, responding to patient advances, appropriate dress and demeanor, and the awkward realization that attractions to students and patients come pretty close to home for many of us.

It may also be useful to discuss alternatives to professional-professional dilemmas. For example, how do students feel about a physician they have seen in the student health service also serving as their instructor in a course or as a preceptor on a clinical rotation? Is

such a dual relationship appropriate for the faculty member to be engaged in? What are the risks and conflicts involved?

The opportunity for trainees to discuss specific case vignettes as a group will provide an invaluable opportunity to share perspectives and to think through possible reactions to specific situations that may confront the student, resident, or physician (Bridges, 1995; Plaut, 1997, 2003). In most cases, the same vignettes will apply to more than one stage of training, but the trainees may be more likely to identify with one party or the other. Vignettes may be general or specific, as illustrated by the examples in this paper.

Case vignettes may also be based on actual situations from one's own university or teaching situation. Some examples have been published previously (Plaut, 1997; Wertheimer, 2003) and a number of brief vignettes are appended to this paper. These have been divided into two categories, based on whether they are more likely to be relevant across the educational continuum or during specialty training. Since there may be considerable overlap among the stages of training, suggestions about emphasis should be taken as only general guidelines. The most effective vignettes are likely to be ones that do not have a readily apparent 'correct' answer. This encourages the student to consider some of the 'what ifs' that are a part of everyday professional life.

More extended case presentations may allow for consideration and discussion in greater depth. The following example can be extremely powerful since it highlights the victimization of a medical student by a physician in a teaching role. This is abridged (and slightly modified) from an actual e-mail received by the author in his role as Assistant Dean for Student Affairs:

> I have a friend who is interested in going into surgery. Her grades are average and so in order to improve her chances, she was introduced by her fiancé's father, also a surgeon, to a prominent surgeon in the community. He suggested that she volunteer under his supervision. She's been there a total of three times and it has been little short of hell. The first time, he made many crude jokes. He asked her if it was okay, to which she answered, "Yes." She didn't want to impose on his freedom, and besides, it was tolerable. The once tolerable crude jokes became extremely offensive and then went beyond jokes. He opened porn e-mails and showed them to her. He hugged her, squeezed her chest close to himself and licked her ear. She felt powerless to do anything for fear of losing his recommendation. She mentioned this to her fiancé (aside from the ear licking part – she didn't because she was afraid he'd never kiss her again) to which he said, "Just bear it because you need him." I feel that her safety and emotional wellbeing are at stake. Please help me with suggestions of how to advise her.

This unfortunate situation presents a number of considerations that frequently arise in cases of sexual harassment and sexual misconduct and raises a number of pertinent questions: When confronted by such a situation, how can a student balance her discomfort with the physician's behavior with her concern for grades and evaluations that may determine her ability to enter a competitive residency? The student is also faced with the lack of support from her own fiancé. Does the fact that the student tolerated the jokes on the first day make her responsible for the escalation of his sex-related behavior on the subsequent two visits? Why or why not? What if this student had accepted the physician's sexual advances? Would his behaviors then have been excusable and appropriate? If you, either as a health professional or friend, hear about a relationship like this that you feel is inappropriate, what obligation, if any, do you have? Was it appropriate for this student to write to her student affairs dean about her classmate, as she did? Would the dean have now had an obligation to report this incident and would it have mattered that the surgeon was not a member of the medical school faculty? Do you think that students are made sufficiently aware of how to seek counsel about such events, to report them if they wish,

what the consequences of reporting might be, and how they may be protected from any retribution that may result?

There are times when cases discussed may be aptly based on current news events, popular novels, or cinema (Gabbard & Gabbard, 1999). The 1991 film *Prince of Tides*, based on the novel of the same name by Pat Conroy, is a classic example, as it clearly illustrates a wide spectrum of boundary violations. The psychiatrist in the movie, played by Barbra Streisand, wears very short skirts and serves coffee in her office to her patient, played by Nick Nolte. She invites him to her home for dinner and allows him to coach her son in football. The closeness she and her patient develop over time eventually leads them into an intimate relationship.

The 2005 film *Prime* presents a somewhat more subtle boundary dilemma. Dr. Lisa Metzger, a psychotherapist played by Meryl Streep, is treating Rafi Gardet, a 37-year-old divorcee, played by Uma Thurman. The patient describes a new relationship she is in with David Bloomberg, a 27-year-old artist, played by Bryan Greenberg. At least Rafi says he is 27, somewhat embarrassed by the age difference. Eventually, she discloses that he is really only 23. In the process of learning more about him and the relationship, Dr. Metzger realizes that Rafi is dating her own son. (Since Dr. Metzger uses her maiden name professionally, the relationship would not have been immediately obvious to Rafi). Unbeknownst to Rafi, this presents a ''dual relationship'' situation, in that Dr. Metzger is both therapist and ''mother-in-law,'' as it were. In addition, the good doctor is learning things about her son that she might not have otherwise, such as how many sex partners he has had and who they were, not to mention how David feels about his mother and her attitude toward this relationship. Dr. Metzger appropriately seeks counsel from a senior colleague, wondering if she should not immediately terminate her therapy with Rafi. While realizing that continuing the therapy might be technically inappropriate, Dr. Metzger's consultant reasons that the relationship is not likely to last, given the 14-year age difference, and that seeing the relationship through might in the long run be in the best interest of both Rafi and the therapy.

Students might be asked what they would do in such a situation and why? Who bears the ultimate responsibility for whether or not to continue therapy, the consultant or the treating therapist? Suppose the therapy continued and the relationship did in fact break up. How would the therapist know how much of her true motivation for continuing therapy was related that what was in her patient's best interest and how much might have been an interest in learning more about her son or influencing his relationship with a much older woman? How might the patient feel if she learned at some point that her therapist had been her former boyfriend's mother and that she was aware of it during at least part of the therapeutic process? Might she regret having disclosed all that she had? Might she feel that her therapist had lost at least some of her objectivity? Might she feel betrayed?

Clearly, adequate education in this area must go beyond the teaching of principles and standards. Actual examples of boundary dilemmas, as illustrated by the vignettes, illustrate for the student the kinds of real life situations they are likely to encounter. In some cases, it may be possible to have an actual offender speak with students or residents, providing a powerful, personal experience. In addition, it is useful to consider certain preventive strategies that the student can begin to incorporate into their lives as they develop as professionals.

Suggestions for prevention of boundary violations

Be aware of your fantasies and feelings

Do we value men and women equally as competent professionals? As Rutter (1997) suggests, when we see someone of the opposite sex in the professional environment

(assuming that we are heterosexual), to what extent do we see a valued colleague and to what extent do we see a potential sexual partner?

Be sensitive to the values and sensibilities of those with whom you interact

How do people respond when we touch, hug, or kiss or make a sex-related joke? If we are sensitive to the often subtle nonverbal responses around us, inappropriate boundary crossings may be more easily prevented.

Avoid intimate relationships with people over whom you have professional influence

Although specific ethical standards are generally firm only with regard to interactions with patients, intimate relations with students or those we supervise in work settings may also create conflicts of interest, cause harm, reflect poor respect for those over whom we have responsibility, and create a work environment that is uncomfortable for all those who are aware of the relationship (Peterson, 1992; Plaut, 1993; Rutter, 1997).

Be cautious about non-sexual boundary crossings; anticipate possible consequences

What are the risks in hiring a patient to work for us, accepting certain gifts or seeing a student in a clinical setting who we may also be teaching or evaluating? How do we address those dilemmas? When we consider crossing a non-sexual boundary, do we consider what has been called ''progressive boundary analysis'' (Plaut, 2003) – the possible consequences of a boundary crossing and how we might address them? For example, hiring a patient in need of a job might seem like a humane thing to do, but what if they do not do well as an employee?

Take a professional approach to the sexual advances of patients

When patients make sexual advances, do we first take into account the loneliness and fear that accompanies being a patient in an institutional setting (Assey & Herbert, 1983)? Is it possible that we may contribute such advances by our own dress, jewelry, or scents that we wear or by verbal innuendo? This may be an excellent time to discuss appropriate professional dress with students.

Be aware of laws, ethics, policies, guidelines, and local practices regarding professional boundaries

It is especially important never to feel that we are above the need to comply with professional or legal standards. Professionals who have ethical problems often rationalize their behavior or display a sense of 'entitlement' (''I am senior/important enough that no one will be concerned about what I am doing.'').

Know the personal and situational risk factors that may lead to boundary violations

Does a particular patient or student have a reason to be especially dependent on us (e.g., low self-esteem)? Do we have any issues in our own lives, such as relationship problems (White, 1997) or clinical depression (Plaut, 2003) that may make us more vulnerable to crossing boundaries? Do we work in a 'closed system' (e.g., small town, medical center,

military setting) where it may be more difficult to avoid dual relationships (Plaut, 1997, 2003; White, 1997)? If so, how can we best address those dilemmas?

If in doubt, seek consultation

If we feel a sexual pull toward a patient or student, how willing are we to seek counsel from a colleague about how to best handle the situation? If we feel that we are being victimized, how willing are we to explore avenues for addressing these concerns? This is probably the single most important suggestion among all that have been made. Those who cross sexual boundaries often isolate themselves from those who might provide support and 'reality testing' when an ethical dilemma arises. Discussion of this topic is a good time to remind students that our professions are grounded in a firm tradition of peer review. It is unrealistic to think that we can always remain objective and in touch with our professional obligations, especially when sexual feelings are involved, and even more so when we are experiencing personal stresses.

Conclusion

The ability of a physician to be caring, while objective, requires that care be taken to maintain appropriate boundaries, not only with patients, but with students and colleagues as well. Although sexual attractions to colleagues, students, and even patients are to be expected, it is generally best that the physician's intimacy needs be met outside the professional setting. In all considerations of boundary crossing, it is important to consider the possible consequences, to consult with others about appropriate standards of behavior, and to be honest with ourselves about whose needs are ultimately being met. These considerations should be addressed in medical training in ways that are relevant for both students and residents. Education should include discussion of principles and standards, pertinent case vignettes, and guidelines for prevention.

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Notes on contributor

S. Michael Plaut, Ph.D., Associate Professor of Psychiatry, Assistant Dean for Student Affairs.

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Appendix: Case vignettes

Applicable throughout the educational continuum:

A medical student is on rotation. Her attending physician asks her out, and she complies. They begin dating and the relationship rapidly includes sexual involvement. (Advanced trainees could discuss senior resident – intern involvement.)

A Junior medical student on the inpatient internal medicine service is asked out by the chief resident (or attending physician).

A student wears skirts that when she sits rise to mid thigh or higher, or spaghetti strap tank tops.

A physician (or medical student) sitting at the bedside of a dying patient feels an urge to hold the patient's hand.

A hospital nurse in distress goes to the ER, where a physician performs a pelvic exam. The next day, he calls the patient and asks her out on a date.

An attending physician on clinical rotations only gives eye contact to male students, and appears to ignore comments made by women students. His behavior is obvious and upsetting to all the students in the group.

A patient who has been in the care of a physician (or medical student) for some time brings her a gift.

A woman presents to her family physician with neck pain. He says, ''Perhaps next time you should let him get on top.''

A female resident on call is studying in the team room. Two male residents are also on call and playing around on the computer. The female resident hears hysterical laughter and looks up to see the men watching a pornographic movie on the computer.

A medical student has been referred to a faculty member as a patient. Although the faculty member has never met this student, he is aware that this student will be taking a required course with him next year.

A faculty member at a medical school is supervising a medical student in a research project. The faculty member considers inviting the student to travel with them to a professional meeting. (In this and other vignettes, to what extent might relative gender or age be a relevant consideration?).

Applicable primarily to advanced trainees:
A patient is experiencing marital difficulties and her physician wonders whether to share his/her own similar problems with the patient.

A psychiatrist suggests to his patient that if she masturbates on the couch in his office, it will help her become more comfortable with her body and her sexuality.

A patient falls in love with an anesthesiologist who has treated her chronic pain, and expresses her feelings to him. (Other specialties and medical conditions may be easily substituted here.)

A surgeon kisses each of his female nurses after each procedure, to show his gratitude for their assistance (or so he says). At least one of the nurses is uncomfortable with this practice and files a complaint with the hospital.

The mother of a pediatric patient is a single parent. The child's physician asks the mother out on a date. (A variation of this vignette might involve the surviving partner of a terminally ill patient.)

A patient on a psychiatric inpatient unit thinks that the resident spends more time with a certain other patient because he likes the other patient better.

A patient tells her physician that she needs a job. The physician has just lost his receptionist.

A gynecologist uses a vibrator to stimulate his patient to orgasm during a pelvic examination.