Alabama State Board of Medical Examiners and Medical Licensure Commission

MEDICAL DIGEST

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THE PROFESSIONAL BOUNDARIES ISSUE

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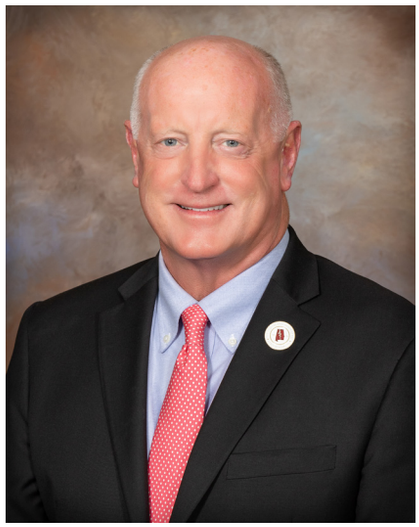
A WORD FROM THE CHAIR

A Reminder for Licensees

Physicians and Advanced Practice Providers should always remember what is at the core of their calling and profession – a person. Not "the patient in 302" or "the ankle," but a person who needs comfort, support, and compassion.

We often judge a colleague based on thoughts like, "Would I want this person to treat my mother/father/child?" While this judgment includes an assessment of the colleague's skill and experience, it is likely to be based largely on whether that person would treat your family member with the respect and dignity every individual deserves.



Dr. Charles Rogers

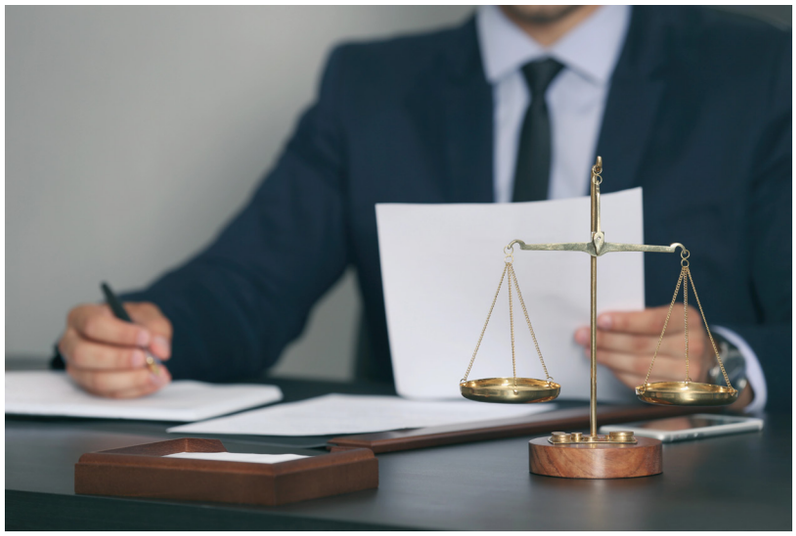
All of us must continually seek guidance and pray for discernment to know when to display empathy and the strength to meet our patients' most challenging situations with grace and compassion.

However, healthcare professionals must also know the difference between offering comfort and empathy and crossing a boundary. Having no awareness that an innocent hug could be interpreted as a serious privacy violation could result in serious professional consequences. You might think giving your cell phone number to a patient is a sign of being available and responsive, but you might not know that a patient could see it as an overture to a relationship outside of the office.

In the last decade, the number of professional boundaries complaints against Alabama medical practitioners has steadily increased. In 2020, a joint consultant group of the Board and Commission studied this issue, and as a part of the continuing effort to protect the health and safety of patients and educate licensees, mandatory professional boundaries education has been implemented for all physicians, physician assistants, and anesthesiologist assistants licensed in Alabama. The only licensees exempt from this requirement are limited licensees who are enrolled in a residency training program or a clinical fellowship.

We hope you will readily and enthusiastically participate in this one-time, free, online course with a mind and heart open to increasing your ability to safely practice while remaining that person that your colleague would recommend to their family member.

SEXUAL MISCONDUCT



The relationship between a physician and patient is inherently imbalanced. A physician is in a position of power in relation to the patient, and the patient is in a position of vulnerability which is heightened in light of the patient's trust in their physician.

When there is a violation of mutual trust through sexual misconduct, such behavior and actions can have a profound, enduring, and traumatic impact on the individual being exploited, their family, the public at large, and the medical profession as a whole.

The Board and Commission are committed to addressing sexual misconduct by physicians through sensible standards and expectations of professionalism, including preventive education, as well as through meaningful disciplinary action and law enforcement when required.

The joint rule of the Board and Commission stating our policies and guidelines concerning sexual misconduct follows.

540-X-9-.08 Sexual Misconduct in the Practice of Medicine: A Joint Statement of Policy and Guidelines by the State Board of Medical Examiners and the Medical Licensure Commission of Alabama.

(1) The prohibition against sexual contact between a physician and a patient is well established and is embodied in the oath taken by physicians, the Hippocratic Oath. The prohibition is also clearly stated in the Code of Medical Ethics of the American Medical Association. The reason for this proscription is the awareness of the adverse effects of such conduct on patients. The report of the Council on Ethical and Judicial Affairs of the American Medical Association indicates that most researchers now agree that the effects of physician-patient sexual contact are almost always negative or damaging to the patient. Patients are often left feeling humiliated, mistreated, or exploited.

(2) Further, a patient has a right to trust and believe that a physician is dedicated solely to the patient's best interests. Introduction of sexual behavior into the professional relationship violates this trust because the physician's own personal interests compete with the interests of the patient. This violation of trust produces not only serious negative psychological consequences for the individual patient but also destroys the trust of the public in the profession.

(3) Sexual conduct with a patient occurs in many circumstances ranging from situations where a physician is unable to effectively manage the emotional aspects of the physician-patient relationship to consciously exploitative situations. Underlying most situations is a disparity of power and authority over a physically or emotionally vulnerable patient.

(4) The prohibition against sexual contact between a physician and a patient is not intended to inhibit the compassionate and caring aspects of a physician's practice. Rather, the prohibition is aimed at behaviors that overstep the boundaries of the professional relationship. When boundaries are violated, the physician's patient may become the physician's victim. The physician is the one who must recognize and set the boundaries between the care and compassion appropriate to medical treatment and the emotional responses which may lead to sexual misconduct.

(5) The Board of Medical Examiners and the Medical Licensure Commission is each charged with responsibilities for protecting the public against unprofessional actions of physicians and osteopaths licensed to practice medicine in Alabama. Immoral, unprofessional or dishonorable conduct is a ground for discipline of the license of a physician or osteopath under the provisions of Code of Ala. 1975, §34-24-360(2). A physician's sexual contact with a patient is a violation of this statute.

(6) The Board of Medical Examiners investigates allegations of sexual misconduct against physicians. The Medical Licensure Commission makes decisions following a hearing concerning disposition of formal complaints filed with it by the Board of Medical Examiners. It is the goal of each organization to ensure that the public is protected from future misconduct. In some cases, revocation of license is the only means by which the public can be protected. In other cases, the Board or the Commission may restrict and monitor the practice of a physician who has actively engaged in a rehabilitation program. Rehabilitation of a physician is a secondary goal that will be pursued if the Board and the Commission can be reasonably assured that the public is not at risk for a recurrence of the misconduct.

"A physician should have a chaperone present during the examination of any sensitive parts of the body for the protection of both the patient and the physician. A physician should refuse to examine sensitive parts of the patient's body without a chaperone present if the physician believes the patient is sexualizing the examination."

(7) The Board and the Commission remind physicians of their statutory duty to report sexual misconduct or any conduct which may constitute unprofessional conduct or which may indicate that a physician is unable to practice medicine with reasonable skill or safety to patients. It is the individual physician's responsibility to maintain the boundaries of the professional relationship by avoiding and refraining from sexual contact with patients.

(8) Physicians should be alert to feelings of sexual attraction to a patient and may wish to discuss such feelings with a colleague. To maintain the boundaries of the professional relationship, a physician should transfer the care of a patient to whom the physician is attracted to another physician and should seek help in understanding and resolving feelings of sexual attraction without acting on them.

(9) Physicians must be alert to signs indicating that a patient may be encouraging a sexual relationship and must take all steps necessary to maintain the boundaries of the professional relationship including transferring the patient.

(10) Physicians must respect a patient's dignity at all times and should provide appropriate gowns and private facilities for dressing, undressing and examination. In most situations, a physician should not be present in the room when a patient is dressing or undressing.

(11) A physician should have a chaperone present during the examination of any sensitive parts of the body for the protection of both the patient and the physician. A physician should refuse to examine sensitive parts of the patient's body without a chaperone present if the physician believes the patient is sexualizing the examination.

(12) To minimize the misunderstandings and misperceptions between a physician and patient, the physician should explain the need for each of the various components of an examination and for all procedures and tests.

(13) Physicians should choose their words carefully so that their communications with a patient are clear, appropriate and professional.

(14) Physicians should seek out information and formal education in the area of sexual attraction to patients and sexual misconduct and should in turn educate other health care providers and students.

(15) Physicians should not discuss their intimate personal problems/lives with patients.

(16) Sexual Misconduct. Sexual contact with a patient is sexual misconduct and is unprofessional conduct within the meaning of Code of Ala. 1975, §34-24-360(2).

(17) Sexual Contact Defined. For purposes of §34-24-360(2), sexual contact between a physician and a patient includes, but is not limited to:

(a) Sexual behavior or involvement with a patient including verbal or physical behavior which:

1. *May reasonably be interpreted as romantic involvement with a patient regardless whether such involvement occurs in the professional setting or outside of it;*
2. *May reasonably be interpreted as intended for the sexual arousal or gratification of the physician, the patient or both; or*
3. *May reasonably be interpreted by the patient as being sexual.*

(b) Sexual behavior or involvement with a patient not actively receiving treatment from the physician, including verbal or physical behavior or involvement which meets any one or more of the criteria in Section 1 above and which:

1. *Results from the use or exploitation of trust, knowledge, influence or emotions derived from the professional relationship;*
2. *Misuses privileged information or access to privileged information to meet the physician's personal or sexual needs; or*
3. *Is an abuse or reasonably appears to be an abuse of authority or power.*

(18) Diagnosis and Treatment. Verbal or physical behavior that is required for medically recognized diagnostic or treatment purposes when such behavior is performed in a manner that meets the standard of care appropriate to the diagnostic or treatment situation shall not be considered as prohibited sexual contact.

"A patient's consent to initiation of or participation in sexual behavior or involvement with a physician does not change the nature of the conduct nor lift the statutory prohibition."

(19) Patient. The determination of when a person is a patient for purposes of this policy is made on a case by case basis with consideration given to the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services from a physician is not determinative of this issue. A person is presumed to remain a patient until the patient-physician relationship is terminated.

(20) Termination of Physician-Patient Relationship. Once a physician-patient relationship has been established, the physician has the burden of showing that the relationship no longer exists. The mere passage of time since the patient's last visit to the physician is not solely determinative of the issue. Some of the factors considered by the Board in determining whether the physician-patient relationship has terminated include, but are not limited to the following: formal termination procedures; transfer of the patient's care to another physician; the reasons for wanting to terminate the professional relationship; the length of time that has passed since the patient's last visit to the physician; the length of the "professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's medical problem; the degree of emotional dependence that the patient has on a physician...; the extent of the physician's general knowledge about the patient".

(a) Some physician-patient relationships may never terminate because of the nature and extent of the relationship. These relationships may always raise concerns of sexual misconduct whenever there is sexual contact.

(b) Sexual contact between a physician and a former patient after termination of the physician-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of "the exploitation of trust, knowledge, influence or emotions" derived from the professional relationship.

(21) Consent. A patient's consent to initiation of or participation in sexual behavior or involvement with a physician does not change the nature of the conduct nor lift the statutory prohibition.

(22) Impairment. In some situations, a physician's sexual contact with a patient may be the result of a mental condition that may render the physician unable to practice medicine with reasonable skill and safety to patients pursuant to §34-24-360(19).

(23) Discipline. Upon a finding that a physician has committed unprofessional conduct by engaging in sexual misconduct, the Commission will impose such discipline as the Commission deems necessary to protect the public. The sanctions available to the Commission are set forth in §34-24-361 and §34-24-381, and include restriction or limitation of the physician's practice, revocation or suspension of the physician's license, and administrative fines.

OTHER KINDS OF PROFESSIONAL BOUNDARIES

Dual Relationships

These exist any time you and the patient have a relationship other than only clinician and patient.

This could be a business partner, a colleague, or a friend.

A dual relationship weakens the primacy of the patient-physician relationship and can cloud your judgment. Treating colleagues can impact your working relationship.

The Board and Commission know that providers in small towns and rural areas almost always know their patients outside of the office.

These providers should be constantly be vigilant and direct the patient to another provider if appropriate boundaries cannot be maintained.

Family Members

The reasons for not treating family members are numerous, including a lack of objectivity, delivery of sub-standard care by going beyond your area of expertise or scope of practice, and failure to maintain proper medical records.

Prescribing or dispensing a controlled substance to a person where the physician's professional objectivity, the patient's autonomy, or informed consent are substantially compromised, unless such prescribing is necessitated by emergency or other exceptional circumstances, is specifically a violation of Medical Licensure Commission rules.

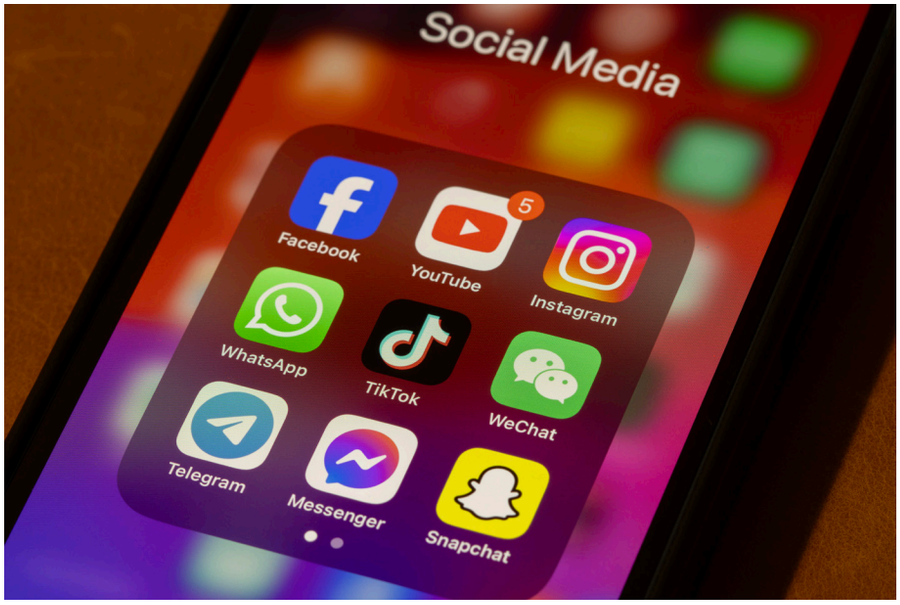
Self-treatment is almost never appropriate.

USE OF SOCIAL MEDIA AND ELECTRONIC COMMUNICATIONS – TRAPS AND PITFALLS

By Patrick J. O'Neill, M.D.

Article originally published in the July 2019 Medical Digest

With the significant increase of physicians and the public in general using social media in recent years, there has also been an increase in accusations of unprofessional conduct against physicians and other healthcare practitioners in their use of such platforms.



Participation in social media is, for many, a personal activity. However, due to the potential impact on a physician's practice, the care of their patients, and the profession as a whole, personal use can often extend into the professional domain.

The Board has adopted the Federation of State Medical Boards' April 2019 policy on social media and electronic communications. Some recommendations are:

- Do not disclose identifiable patient health information without the express written consent of the patient.
- Maintain appropriate professional boundaries with patients and colleagues.
- Consider all online content as open and accessible to anyone and permanent, even after it has been deleted.
- When discussing general medical issues online, identify yourself as a physician, do not misrepresent your training, expertise, or credentials, and avoid commenting on controversial topics such as abortion or vaccines.

Traps and Pitfalls to Avoid

- Connecting with patients through personal accounts.
- Posting while emotional or under the influence of alcohol.
- Participating in heated exchanges on any topic and commenting in a disruptive manner.
- Responding to online harassment personally or professionally.

It is recommended that you always comment online as if you were commenting publicly in your professional or personal capacity, and by doing so you will avoid the possibility of serious repercussions for unprofessional online conduct.

POLICY ON CYBER HARASSMENT

It is the position of the Alabama State Board of Medical Examiners (“the Board”) that cyber harassment by a licensee constitutes unprofessional conduct.

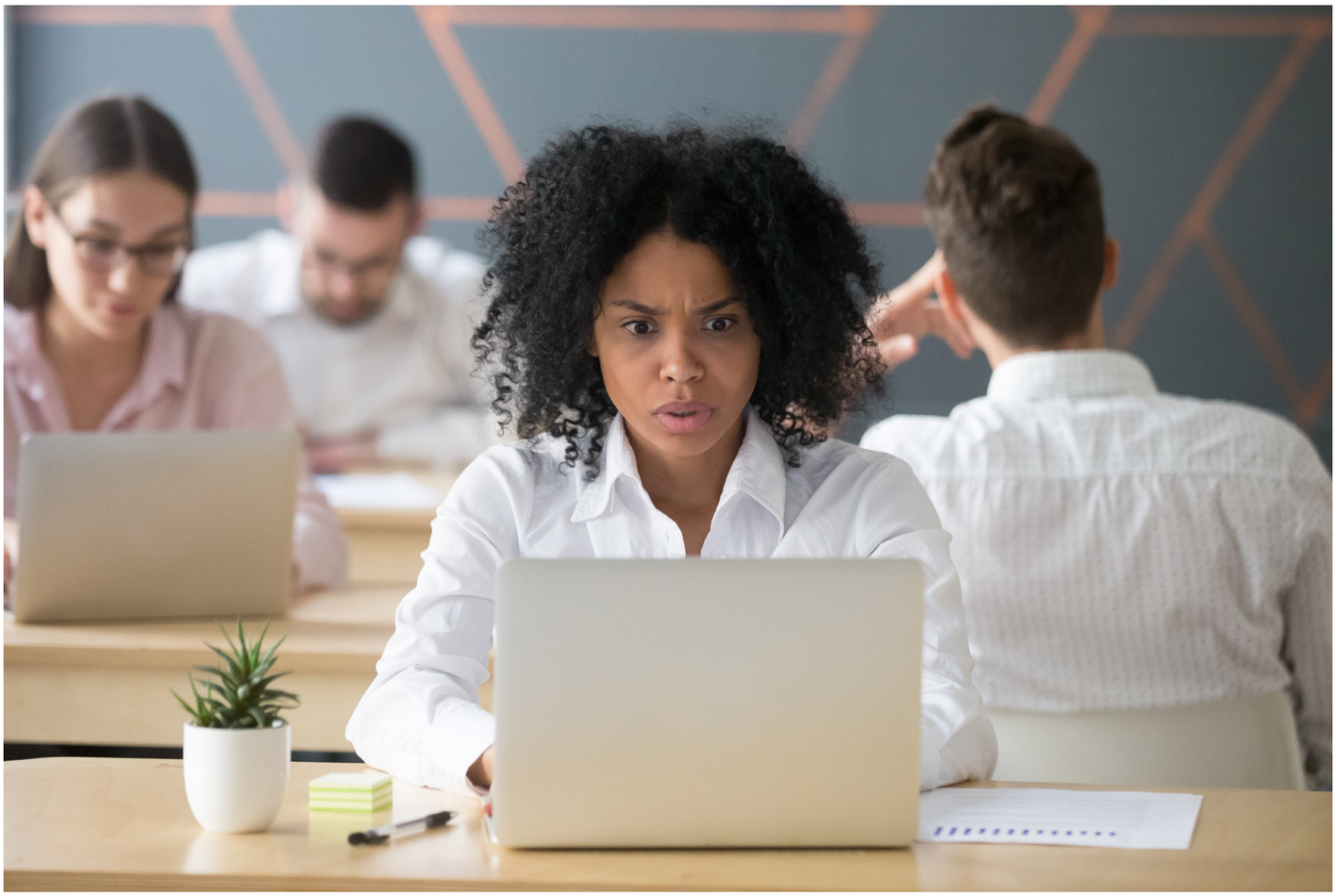
The Board condemns all forms of harassment. The rising number of incidents of licensees using electronic means, including social media, texting, and email, to harass or intimidate another person requires acknowledgement by the Board.

The Board does not intend to review or regulate all online conduct by its licensees. However, any person who uses his or her status as a physician, physician assistant, or anesthesiologist assistant, either express or implied, their professional network, or any information, knowledge, or instrumentality gained from his or her professional practice to harass or intimidate another person is guilty of professional misconduct.

Harassing or intimidating conduct includes, but is not limited to: doxing, mobbing, swatting, flaming, review bombing, cyberstalking, bullying, shaming, and dogpiling.

Such behavior violates the high standards of honesty, diligence, prudence, and ethical integrity demanded from physicians, physician assistants, and anesthesiologist assistant licensed in the State of Alabama.

October 2021



BOUNDARY DRIFT, CROSSINGS, AND VIOLATIONS

From Being a 'good' doctor: Understanding and managing professional boundaries is challenging and can lead to stress and burnout - Lisa Lampe, Rita Hitching, Trent Ernest Hammond, Jeannie Park, Dominique Rich, 2023 (excerpt; edited for American English and continuity)

'Boundary drift' has been described as contemplation of a potential boundary crossing, or a behavior that is close to the boundary.

In a boundary crossing, the health professional engages in an interaction with a patient that is outside of indicated therapeutic interventions or the professional's usual practice. Boundary drift and boundary crossings may not necessarily be intentional nor cause harm to the patient. However, harms may be subtle, including loss of objectivity, conflicts of interest, distorted patient expectations, or a perception of patient exploitation. They may increase the risk of future boundary violations (the 'slippery slope').

Boundary violations, by accepted definition, cause or have the potential to cause harm to patients and involve a behavior that prioritizes the health professional's wants or needs over the patient's. In the medical profession, even the perception of a boundary crossing can harm a doctor's reputation. In health settings, the focus on boundary violations and crossings has traditionally been on sexual transgressions. However, many non-sexual categories of boundaries are described in the literature, mainly according 'special' patient status, providing clinical favors to non-patients, dual and multiple relationships, accepting and receiving gifts, physical contact, self-disclosure, and social media interaction.

Various influences on boundary crossing behavior have been described, including the health professional's own emotional vulnerability, 'moral weakness', exploitative character traits, and ignorance.

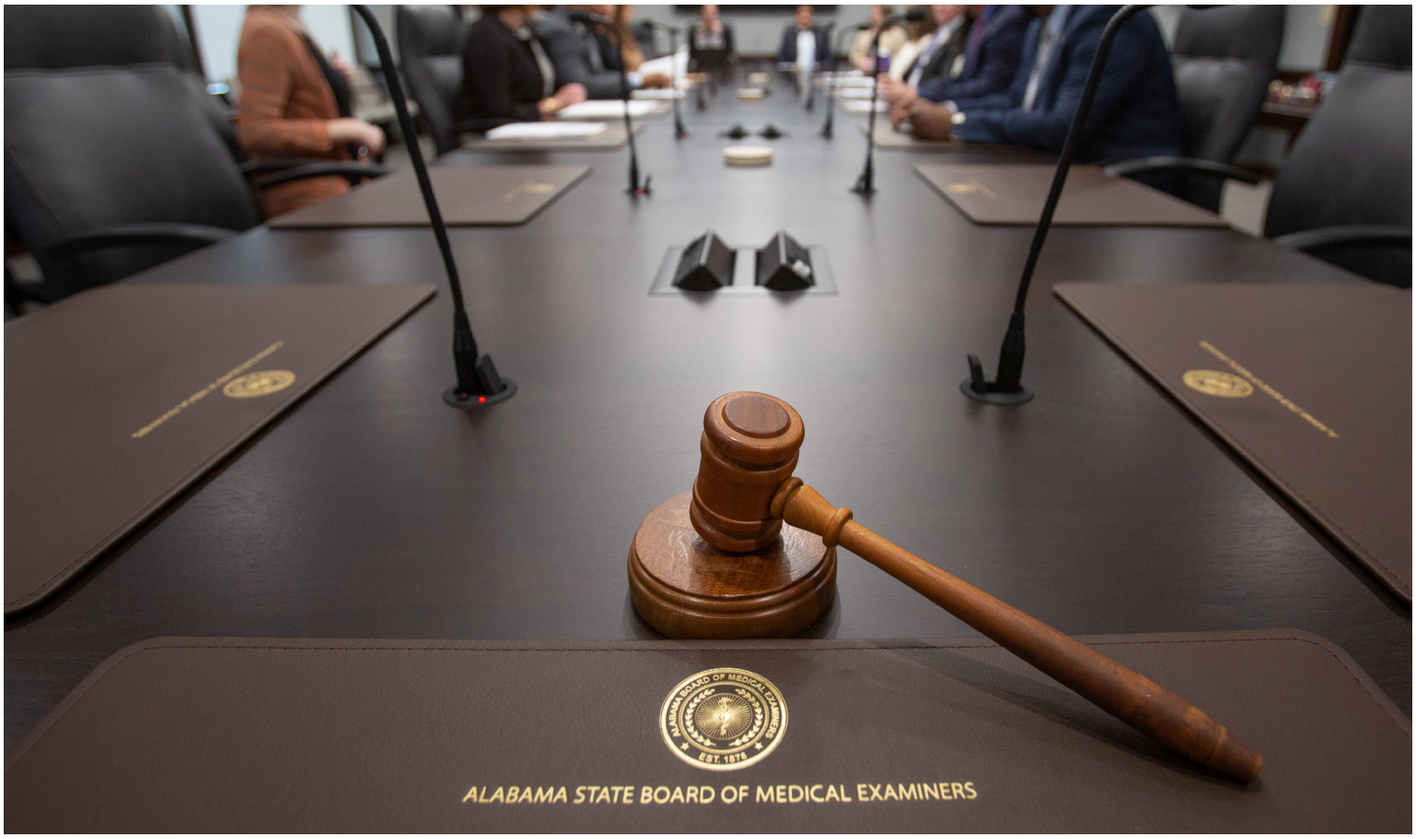
Boundaries in different contexts, locations, and specialties

Some practice contexts may offer particular challenges to maintaining boundaries, including rural, remote, or isolated practice, where social relationships outside the professional one are common and often unavoidable, thus creating 'dual' or 'multiple' relationships with a patient. Other contexts include doctors in highly specialized practice or specialties with relatively small numbers of practitioners, whose expertise may be sought out by friends, family members, or colleagues. It has also been suggested that as the population ages, doctors in specialties such as oncology and palliative care may increasingly come across patients with whom they have existing social, collegial, or family relationships.

Professional boundaries also apply to roles not directly concerned with patient care, for example, in relation to medical and non-medical colleagues ('hallway consultations' and requests for prescriptions), and teaching and mentoring of students and junior colleagues. There is limited research on professional boundaries in relationships such as supervisor–trainee, faculty–student, and mentor–mentee. A potential for boundary violations arises from the power differential in the faculty–student (and supervisor–trainee) relationship which resides in the teacher's (or supervisor's) professional status and responsibility for evaluating the student's (or trainee's) skills, and the student's vulnerability and dependence on the teacher for guidance and pass/fail grading.

Effective management of non-sexual boundary challenges could contribute to a reduction in stress and burnout, help keep doctors in the profession, and increase patient safety.

REPORT OF PUBLIC ACTIONS OF THE MEDICAL LICENSURE COMMISSION AND BOARD OF MEDICAL EXAMINERS



January 2025

• Jan. 2 - John P. Cimino, MD (MD.23304), Huntsville - the application for reinstatement of certificate of qualification to practice medicine is denied.

• Jan. 15 - Trung Nam Nguyen, DO (DO.1864), Tyler TX - the license is restricted and administrative fine is assessed.

• Jan. 28 - Delicia A. Vanterpool, CRNP (NP 1-114022), Birmingham - the Qualified Alabama Controlled Substances Certificate is placed on probation.

• Jan. 31 - Charles T. Nevels, MD (MD.25226), Tuscaloosa - the license is reprimanded and an administrative fine is assessed.

February 2025

• Feb. 20 - Divya A. Carrigan, MD (MD.37650), Birmingham - the license is voluntarily surrendered.

• Feb. 25 - Dane O. Monnin, PA (PA.1546), Pace FL - the license is suspended.

March 2025

• Mar. 3 - Dev M. Gandhi, MD, (MD.48755), Mobile - Voluntary Restriction on certificate of qualification and license entered.

About MedicalDigest

MedicalDigest is the official publication of the Alabama Board of Medical Examiners and Medical Licensure Commission. It is published four times per year.

Past issues are archived and available on the Board's website at www.albme.gov.

Questions? Please contact the Board of Medical Examiners at (334) 242-4116.

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Alabama Medical Licensure Commission

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Upcoming BME Meeting Dates

Apr 10 & 12 • May 15 • June 12

The public portion of each meeting is scheduled for 10 a.m. CT (unless otherwise indicated) in the Dixon-Parker Building at 848 Washington Avenue in Montgomery, AL.

Meeting agendas and a full list of meeting dates and times can be found online at www.albme.gov.

Upcoming MLC Meeting Dates

Apr 16 • May 28 • June 25

Meetings are held in the Dixon-Parker Building at 848 Washington Avenue in Montgomery, AL unless otherwise indicated.

Read the 2024 Annual Report here
https://www.albme.gov/about/annual-reports/

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