This book is a unique approach to boundary setting for professionals in healthcare and counseling. It includes examples of problematic behavior that helps the professional avoid and maintain ethical boundaries in the relationship.

The Ethical Risks of Professional Boundaries: When to Say Whoa, When to Say No

By R Dean White DDS MS and James C "Jes" Montgomery MD

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THE ETHICAL RISKS OF PROFESSIONAL BOUNDARIES

When To Say **WHOA,** When To Say **NO**

R DEAN WHITE DDS MS
JAMES C "JES" MONTGOMERY MD

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Montgomery MD
Print ISBN: 978-1-64719-794-0
Ebook ISBN: 978-1-64719-795-7

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Published by BookLocker.com, Inc., St. Petersburg, Florida.

Printed on acid-free paper.

BookLocker.com, Inc.
2021

First Edition

Library of Congress Cataloguing in Publication Data
White DDS MS, R. Dean and Montgomery MD, James C "Jes"
The Ethical Risks of Professional Boundaries, When to Say Whoa, When to Say No by R. Dean White DDS MS and James C "Jes" Montgomery MD
Library of Congress Control Number: 2021919168

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James C. “Jes” Montgomery, MD

Dr. Montgomery began his career in medicine as a Family Physician in 1983 after graduating from LSU School of Medicine in New Orleans in December 1979. Changes in the face of practice in Oil Industry laden South Louisiana led him to a transition to Addiction Medicine in 1987, receiving his certification in treating Addictions in 1987 by the American Medical Society on Alcohol and Other Drug Dependencies (AMSAODD), which became the America Society of Addiction Medicine (ASAM). He worked in Addiction Medicine until 1992, when he entered psychiatry residency at LSU Medical Center in New Orleans. Upon graduation, he moved to Dallas and began a private practice while working part-time positions with the Chemical Dependency Unit at the VAMC, in the Psychiatric Emergency Room and as Adjunct Faculty at the University of Texas Southwestern Medical Center. He also began a private practice of General Psychiatry. In 1996, he was the founding Medical Director at Sante Center for Healing in Argyle Texas, a residential treatment center which treated all addictions, but focused on healthcare professionals with addictive disorders and sexual boundary violations. Between 1995 and 1997, he worked with the Ross Institute for Trauma Treatment at Timberlawn Hospital and, in 1997, became the Medical Director at the Pride Unit, a program of Addiction Treatment for the LGBTQ population at Millwood Hospital. In 2003, he returned to Sante Center for Healing and transitioned into Medical Director, also participating in the “Maintaining Proper Boundaries Course” under the guidance of

Vanderbilt University and UTSW until 2011, when he assumed the psychiatric directorship of the Gentle Path Sexual Addiction Program at Pine Grove Behavioral Health and Addictions in Hattiesburg, MS until 2016, continuing as a consultant to the present. Dr. Montgomery had served two terms on the Board of the Society for the Advancement of Sexual Health and was awarded the Carnes Award for Achievement in Sexual Addiction in 2010. He was also awarded the President's Award for contribution to the field by the National Association for Lesbian and Gay Addiction Professionals, also in 2010. He has presented at numerous medical societies and conferences on topics related to boundaries, sexual health and problematic sexual behaviors over the years. He continues to provide input into psychosexual evaluation of healthcare providers for Pine Grove and directly to Physician Health Programs.

Chapter 1:
Boundary Crossings and Violations

We are all human, and for the most part, we are complex social beings. This is a good thing. We are all products of nature and nurture. We have different ethnicities, cultures, belief systems, sexual orientations, degrees of intelligence and education, and personalities. We do not and should not automatically shed everything that makes us unique when we become licensed to provide healthcare, therapy, or counseling services to our fellow human beings. However, keeping these human strengths and weaknesses apart from our professional roles is what maintaining proper boundaries is all about. At its core, this is not a simple task.

In the healthcare setting, boundaries are defined as the expected and accepted psychological and social distance between practitioners and patients. Boundaries are defined by ethics, culture, morality, and law. It is often difficult to make a clear distinction between where your boundary ends and where a patient's or client's boundary begins.[1] The Texas Medical Association states that boundaries are "mutually understood, unspoken physical and emotional limits of the professional relationship between a patient and the physician or student, or the supervisor and student."[2]

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[1] Gutheil T.G. and Simon, R.I. (2002) Non-sexual boundary crossings and violations: The ethical dimension. *Psychiatric Clin N Am*, 25, 585–92.
[2] Committee on Physician Health and Rehabilitation, Texas Medical Association. (2012). Challenges of Professional Boundaries (for Medical Students).

Jane Barton, a noted author and speaker on "compassion fatigue" for the caregiver, particularly in palliative care environments, defines boundaries as "the limits that protect the space between the professional's power and the patient's vulnerability."[3] Boundaries are fluid, rarely well-defined, nearly always situational, and prone to misinterpretation. There are non-sexual boundary crossings and violations and there are sexual boundary crossings and violations; however, the former often leads to the latter, making an in-depth knowledge of crossings and violations a critical tool for all caregivers.

Most boundary crossings could be considered normal social interactions. Complimenting someone else's attire, inquiring about his or her family, using first names or nicknames, and patting someone on the shoulder to comfort or reassure are all examples of boundary crossings. These small acts seem innocent enough, yet, all of these examples could signal the potential for future boundary violations if nonverbal communication is considered. Physical proximity, eye contact, speech volume and tone of voice during any of these examples could convey a potential boundary violation.

It takes two to communicate, and we may not be able to discern what the other person is thinking, feeling, or trying to convey. Humans take all their social clues—what is heard, seen, and felt—and create a guess of the other person's intentions and what he or she is trying to convey (i.e., where the other person is "coming from"). As the professional in the equation, it is your responsibility to communicate without harm and with your

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[3] Barton, J. Professional Boundaries: Discerning a line in the sand. Life Quality Institute.

patient's best interest at heart. Many non-sexual crossings are everyday occurrences in our practices. Having patients who are friends, seeing family or staff members as patients, entering in a business venture with a patient, forwarding an inappropriate email, liking a patient's social media status update, or telling a joke are all examples of crossings. Standing too close to someone while speaking or remaining in a standing position when the other person is seated are also examples of crossings. Excessive cologne or perfume can be a crossing bordering on a violation as well. The list is endless.

Sexual crossings are determined by the intent and context. The margin of error here is much too narrow for most of us to navigate effectively. The difference between patting someone's shoulder for comfort and squeezing it is not all that great, nor is the difference between a pat on the knee versus a hand resting on the knee, or the sideways upper-body hug versus the full-frontal hug, but they are all examples of boundary crossings teetering on the edge of violation. Obviously, sexual touching or a sexual relationship with a patient or client is the ultimate breakdown of a professional boundary and in most locales is not only viewed as unethical, but also illegal. There is no place for mutual consent because the patient is never in a position to consent; the innate power differential between professional and patient or client keeps the patient/client too vulnerable to make clear and appropriate decisions.

History and Research of Violations

One would think that everyone would agree that sexual contact between a practitioner and a patient would be at the least unethical and, for the most part, illegal. After all, beginning in 4th century B.C., the Hippocratic Oath stated an unequivocal position on the matter: "Whatever houses that 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 relationships whether male or female persons, be they free or slaves." However, the American Medical Association's Council on Ethical and Judicial affairs statement in 1990 appears to address the same conundrum but curiously uses the pesky word "may:"

> *Sexual contact which occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and may ultimately be detrimental to the patient's wellbeing.* [emphasis added]

Unfortunately, literature on the topic of sexual boundary violations has been written mostly by psychiatrists discussing other psychiatrists. The literature concerning sexual boundaries written by physicians is scarce, and the literature for other healthcare professions is practically non-existent. The clergy has a few references on the issue, but not many. In recent years, the public press has certainly been diligent in reporting current

and past abuses of pastoral and celebrity power. So, what can we learn from this?

A quick look at the literature that does exist highlights that the problem doesn't just lie within one specialty, gender, or level of education. It also indicates that what seems inappropriate to some seems perfectly acceptable to others.

The prevalence of inappropriate physician-patient contact was described in an article by Gartrell.[4] In 1992, researchers sent an anonymous survey of four questions to 10,000 family practitioners, internists, obstetrician-gynecologists, and surgeons.

In total, 1,891 surveys were answered and sent back. Nine percent of the respondents admitted to having sexual contact with one or more current patients. Of those 9%, 89% were male physicians having relations with female patients. The survey respondents were also asked:

1. Is it professionally acceptable to have sexual contact with a current patient?
2. Is it professionally acceptable for a physician to have sexual contact with a patient still taking medication prescribed by that physician?
3. Is it professionally acceptable to have sexual contact with a patient whose treatment has stopped and who has been referred to another physician?
4. Do you favor state licensing boards prohibiting physician-patient sexual contact?

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[4] Gartrell, N.K., Milliken, N., et al. (1992). Physician-patient sexual contact-prevalence and problems. *West J Med*, *157*, 139–143.

Amazingly, 63% of the total number of respondents thought the contact was "almost always" harmful to the patients. Although the vast majority of respondents (94%) opposed sexual contact with current patients, that figure leaves 6% who would appear to approve. That leaves about 113 professionals who did not oppose sexual contact with patients. When asked whether participants found it professionally acceptable to become the physician of a current or former sexual partner—being a romantic or sexual partner first, then a patient—39% said yes. Out of this 39%, men (41%) were more likely than women (26%) to consider it acceptable.

Importantly, 63% (or 1,173) of the respondents thought it was acceptable to have a romantic or sexual relationship after the professional patient-provider relationship had ceased. The research regarding having a romantic or sexual relationship with a former patient—having a professional relationship before a romantic or sexual one—led researchers to adopt the Ontario Task Force's recommendation[5] that at least two years must have elapsed since the last episode of patient care, with no social contact in the interim, to make a sexual relationship acceptable between a physician and patient. The problematic portion of this conclusion, however, is that the power differential has not necessarily disappeared after two years. Context here might serve as crucial guidance. What if the patient-provider relationship consisted of a one-time dermatology appointment or an emergency appendectomy?

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[5] McPhedran M., Armstrong H., Edney R., et al. (1991). The Preliminary Report of the Task Force on Sexual Abuse of Patients, Toronto, Ontario, College of Physicians and Surgeons of Ontario.

These instances create a much different relationship than a long-term professional relationship a primary care provider or psychiatrist might have with a patient. Still, the power differential does not dilute with time for most relationships.

And if, for instance, a male or female practitioner has had boundary issues in the past, then that individual would be wise to avoid all contact with former patients. Sometimes, others' perception becomes reality. Sometimes what appears innocent could be construed as a violation. If the physician has had a past transgression or allegation, then he or she may be judged by different standards than those who have not had this experience. Thus, a perception becomes a reality for the healthcare professional, even if her or she did nothing wrong. A healthcare professional with a past has to be more vigilant and aware of boundaries.

An excellent article by Brooks[6] studies the breadth and depth of boundary violations within healthcare by surveying Colorado physicians who had been referred to the state physician health program between 1986 and 2005. Physician health programs are organized by hospital staff or state societies to advocate, support, and monitor professionals whose personal issues affect their professional performance, including boundary issues. Referrals can be mandatory or voluntary. The sample size consisted of 1,133 physician who had been referred for a myriad of reasons, including substance abuse, mood disorders, stress, and boundary violations. There were 120

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[6] Brooks, E., Gendel, M.H, et al. (2012). Physician Boundary Violations in a Physician Health Program: A 19 Year review. *J Am Acad Psychiatry Law*, *40,* 59–66.

physicians referred specifically for boundary violations. The vast majority of these physicians (93%) were men between the ages of 40 and 49; 63% of the offenders were married. A variety of specialties were represented: 22% were psychiatrists, 18% were family practitioners, 15% were internists, and 8% were Ob-Gyns (the other 37% comprised a variety of specialties). Thirty percent of the 120 physicians with boundary issues had a personal history of physical or sexual abuse.

Researchers found that the most common boundary violations were prescribing violations (25%), followed by 14% of physicians having sexual relations with a former patient, and 11% having sexual relationships with a current patient. Researchers also reported that physicians who were referred to the physician health program for inappropriate prescribing and sexual harassment (defined as harassment that is sexual in nature but does not involve touching or contact, such as inappropriate language or creating a hostile work environment) had a tendency to elevate the violations to actual sexual relationships with current or former patients. The good news is that upon completing the program, which provides physicians with contracts that usually hold them accountable for their transgressions (for example, loss of medical license), 88% of the physicians had no further boundary transgressions.

No Provider Is Immune

All practitioners have vulnerabilities. This applies to some more than others. The practitioner who has a history of healthy, long-term relationships, grew up in a positive and healthy family environment, has developed a secure attachment

template, and is healthy from a mental, social, and psychological standpoint may be in a better position to have broader and more lenient boundaries. A professional with prior boundary violations or complaints, or a background and history that indicates that person is a potential boundary violator will need tighter and more confined boundaries. Some might see this as an unfair protocol, but to continue to provide healthcare services, professionals are responsible for staying on the correct side of the boundary line. We have the power; thus, we have the responsibility. Keep in mind that boundary violations negatively affect the trust between professionals, patients, and colleagues, creating breaks that are incredibly difficult to mend.

The following clinical scenarios illustrate the differences between boundary crossings and violations. Many readers will find nothing wrong or unethical with most of them. However, perhaps after reading this book and considering all the different factors that influence patients, readers will see a potential for them to be boundary crossings, if not violations. As you read them consider the following questions:

1. Is this a boundary crossing or a violation?
2. Whose needs are being met?
3. What could have been done differently?
4. Can you find yourself in any of these scenarios?

Scenario A

A 40-year-old single female dermatologist has been seeing a 37-year-old male for contact dermatitis for the last two years. They see each other at a mutual friend's New Year's Eve party and start to discuss common interests of modern art. At his next

appointment, he brings her a coffee table book from the Guggenheim Museum as a gift for helping him with his dermatologic problems. She is flattered. She accepts the gift and places it in her waiting room.

Scenario B

A baby-boomer-aged dentist is referred a well-known rock star from the 1980s for a consultation for a dental implant. At the initial appointment, the patient brings in signed CDs for the dentist and all his staff members. Everyone is excited. The dentist instructs his front office appointment clerk to give the special patient the last appointment of the week so that he wouldn't be bothered by other patients.

Scenario C

A female family therapist has a thriving practice in a moderately sized Midwestern town. Since the inception of her practice, she would call selected clients to check on them before the weekend to be sure they were doing okay. When questioned by her staff whether this was appropriate, she responds, "It keeps me from being called over the weekend, and I can head off any problems before they develop."

Scenario D

The mother of a cardiothoracic surgeon is referred to her son by a university cardiologist for coronary bypass surgery. Her son is the chair of the department and heads a large heart team of attendings, fellows, and residents. His mother is elated

that her son is willing to take care of her. After all, she knows "he is the very best."

Scenario E

A young family practitioner in a small rural town in east Texas is starting to develop his practice. His empathy and listening skills are commendable. As each staff member joins his team, they have their medical records transferred to their new employer so that he can be their physician. It would seem a betrayal for them to stay with the other family practice in town, and he is grateful for the confidence they have in him.

Scenario F

A female psychiatrist has an attractive younger female patient that continues to demand just a little more time at each appointment. The patient is always asking questions of the psychiatrist's personal life and requests a hug at the end of each session. The psychiatrist has agreed to meet the patient for lunch after her next appointment in an attempt to change this behavior.

Scenario G

An internist volunteers at a local charity clinic once a week in a nearby city. All of the patients are indigent, and many don't appear to have the means to follow up with his instructions or prescriptions. One day, the social worker that was assigned to him was unavailable to help with the proper forms and referrals for a 67-year-old hypertensive patient who needed help obtaining an important prescription. The patient was frustrated,

and so was the internist, so he gave her $20.00 to use at the local Wal-Mart to have the prescription filled.

Scenario H

A nurse practitioner (NP) from a large internal medicine clinic is away on vacation with her family in the mountains close to where she practices. The first morning of the week-long vacation, one of her daughters has what appears to be an acute maxillary sinus infection. The NP gives her daughter some Augmentin samples she had with her, as well as some over-the-counter antihistamines and decongestants. The next morning, the daughter is complaining of significant infraorbital pain. Her mother gives her hydrocodone tablets to help with the pain.

Scenario I

One of the extra benefits of working for a busy cosmetic facial plastic surgeon is the office camaraderie. They celebrate office birthdays with after-hours cocktails every month. The surgeon's annual bonus for employees is a trip to Cancun for an extended weekend with him and his wife. Everyone is on a first-name basis. The surgeon has also operated on most of his employees to provide what he calls "walking advertisements."

Scenario J

A hospice nurse has become quite attached to her elderly patient, Emma, and Emma's family. Emma reminds the nurse of her grandmother who passed away last year. The nurse collects Fostoria antique glassware, and the family has a large collection of the same glassware that the nurse noticed in the

family home. Emma's family has decided to give it all to the nurse in appreciation for her compassionate care of their mother.

Scenario K

Dr. Lee, an orthodontist, has an active Facebook page and twitter accounts. She encourages all of her patients to "friend" her and follow her on Twitter. She routinely posts her social activities, trips, and purchases. Her patients love her for including them in her life. Through this social media connection, her practice is growing by leaps and bounds secondary to patient referrals.

Which of these scenarios did you find troubling? Do you consider any of them boundary violations? Which do you think have the potential to cause trouble for the practitioner and/or patient down the road? Do any of these scenarios seem innocent or non-problematic?

That providers should avoid empathetic interaction with patients to provide healthcare isn't what should be inferred from these scenarios. Rather, this exercise was to highlight that boundaries are situational and contextual. All healthcare professionals cross boundaries daily, and some providers truly benefit from the physician-patient relationship. Thus, for the most part, this has a positive effect on patients' care and outcomes. Providers, of course, can be kind and caring human beings. We all would benefit from knowing each other better. That might involve a hug, a pat on the shoulder, conversations about loved ones, etc. But it is also easy to see which of these

scenarios could constitute boundary violations if not moderated.

The point of keeping boundaries is to not lose sight of our primary goal as healthcare providers, which is to help the patient. Boundaries are critical to this goal, but if your intent is well placed, crossing the boundary will more than likely be beneficial to both of you.

Take the case of a true story published in *The Man with the Iron Tattoo* by John Castaldo, MD, and Lawrence Levitt, MD, both neurologists.[7] The story is that of an elderly female patient with cognitive decline of unknown origin. Dr. Levitt is a young neurology resident who discovers that the decline is the result of an anti-diuretic hormone. During the patient's stay, her husband will not leave her bedside. He sleeps in his clothes on a cot the entire time she is in the hospital and appears to not have money for a hotel. Dr. Levitt recounts the story of the loyal husband to his wife, who suggests having the husband over for dinner. Dr. Levitt invites the husband and they enjoy a dinner filled with conversation. The husband is quite pleased to be included in dinner. The patient improves and is discharged.

A few days later, the CEO of the hospital calls Dr. Levitt to his office to inform him that his dinner guest was the wealthy owner of a large chemical company and has pledged $1 million to the hospital. This man later donates even more to underwrite a neurology center that both physicians work at for the next 30 years. This extraordinary experience leads the authors to urge doctors to "look around and notice people who seem anxious,

[7] J Castaldo, L Levitt, The Man with the Iron Tattoo, BenBella Books, Dallas, 2006

frightened or lonely... to sit down, take the time to hear what matters to them."

In this chapter, you have learned that:

- Boundaries are defined as the expected and accepted psychological and social distance between professionals and patient
- Boundaries protect the space between the professional's power and the patient's vulnerability
- Boundary crossings can easily slide into boundary violations
- Context is critical in determining whether a situation crosses or violates boundaries
- The professional is always responsible for maintaining appropriate boundaries
- No professional or provider is immune from making mistakes or crossing boundaries occasionally

Chapter 4:
The Influence of Empathy

Empathy is a necessary, meaningful, and critical skill to the delivery of compassionate healthcare. However, it is a double-edged sword: too much is a potential problem for the caregiver, too little is a potential problem for the patient. A caregiver's empathy can be a gift, but as in most things, an overabundance can be a substantial risk and a burden. The overly empathetic individual many times is without boundaries, even to the point of codependency. Conversely, the narcissistic provider who lacks empathy can be an ineffective provider and possibly harm the patient. Neither extremes are helpful in the therapeutic relationship; in fact, they pose a risk to everyone involved. This chapter explains empathy and its relationship to boundaries. More importantly, we discuss how to use empathy to enhance care.

The Importance and Benefits of Empathy

The importance of empathy probably needs no explanation, but providers must recognize that our reputations as healers depend on our ability to be empathetic. Dr. Helen Reiss, the director of the Empathy and Relational Science Program and associate professor of psychiatry at Harvard Medical School, summarizes literature on the topic to these points:

- Medical professionals who communicate with empathy have higher patient satisfaction ratings.[16]

[16] H Reiss, 2012, Why Empathy, http://empathetics.com/why-empathy

- More than 80% of malpractice claims are the result of communication failures, and the likelihood of an unhappy outcome is correlated to low physician empathy.[17, 18]
- Patients who experience empathetic care have better medical outcomes.[19, 20, 21]
- Adherence to treatment recommendations increases when medical professionals deliver patient-centered, compassionate care.[22]
- Communicating empathetically increases clinician job satisfaction and reduces burnout.[23, 24, 25]
- Enhanced empathetic care and physician well-being are highly correlated.[26]
- Empathetic clinician communication improves the quality of interactions with others, including patients, their families, colleagues, and loved ones. [27]

Empathy is what distinguishes us from computers practicing medicine. The good news is that empathy and

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[17] Hickson,GB,Federspiel CF, Pichert JW, JAMA, 2002, 2951-2957

[18] Levinson W, Roter D, Mullolly J, JAMA, 1997,553-559
[19] Hojat M, Louis DZ, Markham FW, Acad Med, 2011, 359-364
[20] Rakel DP, Family Med, 2009, 494-501
[21] Kaptchuk TJ, Conboy LA, Kelly JM, BMJ, 2008, 999-1003
[22] Halpern J, J Gen Internal Med, 2007,696-700
[23] Krasner MS, JAMA, 2009, 1284-1293
[24] Shanafelt T, JAMA, 2009, 1338-1340
[25] West C, JAMA, 2011,952-960
[26] Shanafelt T, J Gen Internal Med, 2005, 559-564
[27] Halpern J, Med, Health Care Philosophy, 2014, 301-311

empathetic communication are learnable skills that can be taught both in the classroom and by mentoring.

Acceptance and Evolution of Empathy in Healthcare

A discussion of empathy must involve how we view ourselves, and more importantly, how we view others. George Bernard Shaw may have said it best in his play *Pygmalion*, “The great secret, Eliza, is not having bad manners or good manners, but having the same manner for all human souls. In short, behaving as if you were in heaven, where there are no third-class carriages, and one soul is as good as another.”

NJ Rohrhoft, a senior medical student, clearly understood the role empathy plays in care when he wrote in a 2012 issue of the *New England Journal of Medicine*, “The caring of patients should begin with caring *about* them. We must not forget to ask ‘how things are going.’ It is the central challenge of our time as medicine evolves.”[28] Empathy, as it was first described by EB Titchener, an Australian psychologist, meant mimicking another’s feelings. His theory was that empathy evolved from one imitating the distress of another. Sympathy, on the other hand, is acknowledging the distress of another without actually sharing what the other person is feeling.

Empathy in the clinical setting has evolved as medicine has evolved. Sir William Osler in 1912 said, “Physicians should neutralize their emotions to the point that they feel nothing in response to suffering.” In 1964, Herrman Blumgart, a noted professor of medicine and medical historian at the Harvard

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[28] Rohrhoft, NJ. (2012). What Life is Like. *New Eng Journal of Medicine*,366:8.

Medical School stated in the *New England Journal of Medicine*: "Neutral empathy involves carefully observing a patient to predict his responses to illness. The neutrally empathetic physician will do what needs to be done without feeling grief, regret, or other difficult emotions." This approach, which required physicians to ignore or put aside empathy, was more than likely harmful to all involved, but was an attitude many physicians adopted.

Empathy Defined

Empathy has been defined in many ways by many authors, and it is often used interchangeably with sympathy; there is no universal agreement on what either means. In general, empathy is defined as the ability to identify with or understand another's situation or feelings (key word is "feelings") by putting yourself in someone else's shoes. Sympathy on the other hand is less personal and is defined as a feeling of pity or sorrow for the distress of another.

The essence of an empathetic person is the innate or learned ability to step out of your experience and into another person's. To do this, one must recognize it, feel it, understand it, and relay it to the other person. The experience can be physical, mental, emotional, intellectual, spiritual, or all of the above. Empathy arouses compassion in most of us, allowing us to connect and care about others. It is a critical attribute or skill for making good relationships, whether they are with patients, patients' families, friends, spouses, children, parents, partners, or co-workers. Everyone benefits from your empathy. It is based in part on the skill of active listening and not being distracted by

your own parallel emotions, prejudices, or pre-conceived evaluations of the patient or their presentation in your treatment room.

The Neuroscience of Empathy

For many years, empathy was thought to be a personality trait, similar to good bedside manner. You either had it or you didn't. Behavioral and neuroscience disciplines now agree that it not only has a physiological basis mediated by the brain, but it can (and should) be taught and modeled. Jean Decety and Philip Jackson wrote in 2006:

> *There is strong evidence that, in the domain of emotion processing and empathetic understanding, people use the same neural circuits for themselves and for others. These circuits provide for a functional bridge between the first-person and third-person information, which paves the way for intersubjective transactions between self and others. These circuits can also be activated when one adopts the perspective of the other. However, were this bridging between self and other absolute, experiencing another's distress state as one's own experience could lead to empathetic over-arousal, in which the focus would then become one's own feelings of stress rather than the other's need. Self-agency and emotion-regulatory mechanisms thus play a crucial role in maintaining a boundary between self and other.*

The authors went on to state that based on functional MRI research, the insula—the lobe in the center of the cerebral

hemisphere that is situated deeply between the lips of the sylvian fissure—is involved in monitoring the physiological state of the body. It receives direct input from the body's major pain pathway. Interestingly, both the anterior cingulate cortex and the insula are found to be activated by the mere sight of pain in others.[29]

A study published in *The Journal of Neuroscience* in 2013 enhances the previous research by identifying that the tendency to be egocentric is innate for human beings, but that a part of your brain recognizes this fact and corrects itself. This occurs in the right supramarginal gyrus. The right supramarginal gyrus of the brain is the junction that connects the thinking, feeling, and action portions of the brain. When it is disrupted, it is difficult to exhibit empathy. For example, the brain is much less apt to correct this lack of empathy when it does not function properly or when we have to make particularly quick decisions. When given the chance, the right supramarginal gyrus helps us distinguish our own emotional state from that of others and is responsible for our empathy and compassion. This area of the brain is part of the cerebral cortex and approximates the parietal, temporal, and frontal lobes. Tania Singer, the principal investigator of the study, stated:

When assessing the world around us and our fellow humans, we use ourselves as a yardstick and tend to project our own emotional state onto others. While cognition research has already studied this phenomenon in detail, nothing is known about how it works on an emotional level. It was assumed that

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[29] Decety, J., Jackson, P. (2006). A Social Neuroscience Perspective on Empathy. *Current Directions in Psychological Science*, *15*, 54–58.

our own emotional state can distort our understanding of other people's emotions, in particular if these are completely different to our own. But this emotional egocentricity had not been measured before.

The right supramarginal gyrus ensures that we can decouple our perception of ourselves from others. When the neurons in this part of the brain were disrupted in the course of the research, the participants found it difficult to stop projecting their own feelings and circumstances onto others. Quick decisions also disrupted their accuracy.

Researchers concluded that when we are in a comfortable and agreeable situation, it is more difficult to empathize with another person's suffering. The participants' own emotions distorted their assessment of the other people's feelings. The participants who were feeling good themselves assessed their partners' negative experiences as less severe than they actually were. In contrast, those who had just had an unpleasant experience assessed their partners' good experience less positively.[30]

Along the same line as this research, an article published in 2014 in the *Journal of Psychiatric Research* by Stefan Ropke found that individuals who suffer from narcissistic personality disorder have less gray matter in the left anterior insula of the cerebral cortex. Their conclusion, which is not yet proven, is that narcissistic traits are the result of structural abnormalities of the brain. The researchers found that the degree to which a person was able to exhibit empathy was tied to the volume of

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[30] Bergland, Chris. (2013). The Athletes Way [blog].

gray matter in this area of the brain, both in the group of healthy individuals and among those with narcissistic personality disorder. The finding suggested that regardless of personality type, the left anterior insula plays an important role in feeling and compassion.[31]

Research conducted by the Department of Psychology of the University of Chicago and published in *Frontiers in Human Neuroscience* in 2013 found the neurobiological roots of psychopathic behavior—which is partly defined by a lack of empathy. Researchers wrote:

When highly psychopathic participants imagined pain to themselves, they showed a typical neural response within the anterior insula, anterior midcingulate cortex, somatosensory cortex, and the right amygdala. The research suggested the increase in brain activity in these regions was unusually pronounced, suggesting that psychopaths are sensitive to the thought of pain but are unable to put themselves in someone else's shoes and feel that pain. When participants imagined pain to others, these regions failed to become active in highly psychopathic individuals. In a sadistic twist, when imagining others in pain, psychopaths actually showed an increased response in the ventral striatum, an area known to be involved in pleasure.

Functional MRIs have been used to determine high activity in the anterior insula and ventral striatum, both areas that have been associated with feelings of empathy. In one study, when

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[31] Chow, Denise. (2013). Live Science [blog]. Retrieved from www.livescience.com/37684-narcissistic-personality-disorder-brain-structure.html

physicians felt like they were relieving pain, their brains responded positively. In other words, relieving pain was both positive for the patient and the physician.[32]

Neuroscientists now believe that the information from this research will allow them to design interventions that will change the brain's circuitry. This belief stems from the facts that the brain is malleable, and one's tendency to be empathetic or compassionate is not fixed. Indeed, empathy can be learned.

Active Listening and Empathy

For one to be truly empathetic, one must learn to listen to others. Most of us, including myself, are not good at listening. When we meet someone for the first time, we can't even remember the person's name after the introduction. We are too busy processing the interaction and trying to make a good first impression.

There is a wealth of literature that describes how quickly a physician makes a diagnosis after interviewing a patient for the first time. A recent study[33] revealed that most physicians let patients speak for an average of 22 seconds before they interrupt. The majority of physicians (64% of primary care physicians and 80% of specialists) did not even ask the patient the purpose of his or her visit.

Empathy requires active listening. A physician should orient him- or herself physically to face the patient. Providers should be on the same level, either seated or standing (or kneeling in the instance of a small child). Your body posture

[32] (2013). *Molecular Psychiatry*
[33] *Journal of General Internal Medicine* (Jan. 2019, Vol 34, pp. 36-40)

should be open, with shoulders square to the patient, arms at your sides or active, but not folded over your chest. Eye contact should be as close to 100% of the time as possible. It is worth noting that it is difficult to actively listen to someone if you are busy entering data into your computer, walking in and out of the room, concentrating on how *you* look, or what you are going to say next.

When we engage someone in a meaningful way or even in a light conversation, we often concentrate on what our next comment is going to be, not what the speaker is saying. Active listening requires that you acknowledge what the speaker is saying. This would take the form of nodding your head, saying "hmmm," "ah," smiling, and of course, paying attention to the point of what the person is saying and asking questions when you're unclear about what they mean. The visual and audio feedback caregivers provide to patients trying to communicate is critical to the care process. It helps to encourage the speaker by saying "I understand," and "I know how you feel." Paraphrasing what has just been said also opens the conversation and makes it empathetic. Remember, you, as the professional, are responsible for the communication and its meaning. Carol Jones, PhD, noted clinical psychologist and author of *Overcoming Anger,* states that "Empathetic listening can keep you from making erroneous or pejorative judgments. Remember everyone is just trying to survive, doing the best that they can, and you need to recognize their struggle."[34]

[34] Jones, Carol. (2004). *Overcoming Anger*. Avon, MA: Adams Media.

Achieving the Correct Balance

An excellent article published in 2014 by Martin Lamothe and others in the *British Medical Journal of Family Practice* entitled "The Combined Role of Empathetic Concern and Perspective Taking in Understanding Burnout in General Practice" discusses the violation of boundaries in practitioners. They write "Good doctor-patient relationships are fundamental for better patient outcomes.[35] It is a meaningful understanding of both the patient's cognitive and affective states; in other words, the patient's knowledge versus feelings."[36] In this context, both empathy and sympathy appear to be crucial components in the doctor-patient relationship. Empathy has been defined as a cognitive (rather than an affective) attribute that involves the practitioner understanding the inner experiences and perspectives of the patient, combined with a capability to communicate this understanding to the patient.'[37] Sympathy has been defined as a predominately emotional state that involves feeling the patient's pain and suffering. The goal of empathy is to know the patient better while the goal of sympathy is to feel the patient's emotions better.[38] It is important to distinguish the two concepts because they may lead to different outcomes.

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[35] Larson, EB. (2005). Clinical Empathy as Emotional Labor in the Patient-Physician Relationship. *JAMA*, *293*, 1100–1106)
[36] Hojat M, et al. (2001). The Jefferson Scale of Physician Empathy. *Educ Psychol Meas, 61,* 349–365
[37] Hojat, M, et al. (2003). Physician Empathy in Medical Education and Practice. *Semin Integr Med*, *1*, 25–41
[38] Hojat, M, et al. (2011). Empathetic and Sympathetic Orientations toward Patient Care. *Acad Med*, *86*, 989–995.

For example, in a 1991 study, researchers asked physicians to select either the sympathetic response or the empathetic response to a hypothetical patient's misfortune (death of a spouse) and to state their preferences for intubating a hypothetical end-stage lung-disease patient. For each physician, hospital records were retrospectively reviewed to assess the mean number of laboratory tests ordered per clinic patient and the mean duration of cardiopulmonary resuscitations he or she performed before declaring his or her efforts unsuccessful. As hypothesized, physicians who selected the sympathetic option had a greater mean preference for intubation, ordered more laboratory tests per patient in clinic, and performed cardiopulmonary resuscitation for longer periods of time before declaring their efforts unsuccessful than did physicians selecting the empathetic option. It was concluded that a physician's levels of empathy and sympathy have a measurable influence on their practice behavior. Sympathetic physicians used more healthcare resources, and it's worth questioning whether the sympathetic actions actually helped or hurt in the long run.[39]

Some authors believe that empathy leads to personal growth, career satisfaction, and optimal clinical outcomes, while sympathy could be detrimental to objectivity in decision making, and lead to compassion fatigue and burnout.[40] Sympathy can be detrimental if it leads the physician to take his

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[39] Nightingale SD, et al. (1991). Sympathy, Empathy and Physician Resource Utilization. *J Ben Intern Med*, *6*, 420–423.

emotions home with him or her at the end of the day and, over time, can emotionally wear out the caregiver.

However, being too empathetic toward patients can lead to a myriad of boundary crossings and violations. "Beyond a certain point, empathy could actively hinder a physician's performance and affect medical decision making. Sharing the patient's emotions can lead to empathetic overload and personal distress. Physicians that share patients' emotions may have difficulty maintaining a sense of ownership regarding whose emotions belong to whom. To complement the effect of empathy, professionals need a high level of emotional regulation skills." [41]

Codependency is detrimental to the physician-patient relationship. Codependency is an emotional and behavioral condition that is learned and can be passed down from one generation to another. It is also known as "relationship addiction," because people who are codependent often form or maintain relationships that are one-sided, destructive, and/or abusive. It is usually applied to spouses of alcoholics and substance abusers or those individuals raised in dysfunctional families where codependency was normal. Codependency in a caregiver-patient relationship can be subtle but still have dire consequences for both parties. The physician, nurse, therapist, etc., who has issues of low self-esteem and wants to please all people all the time is in the perfect situation for this problem to evolve. The practitioner who tries to fix problems that the patient is experiencing even though they do not have the

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[41] Hojat M. (2007). *Empathy in Patient Care*. Berlin, Germany: Springer.

expertise may indicate a tendency toward codependency. The provider who continues to think or obsess about a patient's illness or situation after the provider is removed from the case may also indicate an unhealthy lack of boundaries.

As previously discussed in Chapter 2 on family systems, the child that is reared in an enmeshed family system that is chaotic, closed, and has no boundaries may also produce an adult with poor or absent boundaries. These individuals may have little or no concept of personal space or what is taking place on either side of the equation. The flip side of this is the family that is rigid. These families tend to build walls and barriers instead of healthy boundaries. They isolate themselves physically and emotionally and may show a complete lack of empathy. Codependent families may have a combination of both, which produces adults who have no concept of what healthy empathy or boundaries involve.

Then there are those who swing the opposite way: the narcissists. These individuals routinely violate the boundaries of others due to their almost complete lack of empathy. Individuals who are diagnosed with this disorder meet five of the following criteria:

- Shows a lack of empathy and is unwilling to recognize or identify with the feelings of others
- Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

- Has a sense of entitlement (i.e., unreasonably expects people to show them favorable treatment or automatically comply with his or her expectations)
- Exploits people (i.e., taking advantage of others to achieve his or her own ends).
- Envies others and believes others envy him or her
- Requires excessive admiration
- Demonstrates arrogant or haughty behaviors or attitudes
- Believes that he or she is special and unique and can only be understood by, or should only associate with, other special or high-status people
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love[42]
- Does not consider the pain they may inflict on others; simply put, they do not care about thoughts, emotions, or feelings of others. Their world revolves around them.

The Endgame of Empathy

Empathy should benefit the patient and the provider. Empathy can be exhibited in many ways, but the key is that the patient, client, staff, or family member recognizes that you are "on their side." This could be simply listening a little longer, saying you understand, or maintaining eye contact instead of looking down at your computer. It could be answering the same

[42] (2014). BPD Central [blog]. Retrieved from https:/bpdecentral.com/narcissistic-disorder/hallmarks-of-npd

question twice without an exasperated look on your face. It might be patting someone on the shoulder or holding the hand of an elderly patient who has just lost her husband. It could be accepting a hug from a grateful parent. All of these encounters require knowledge of boundaries. Some are crossings, but remember that boundaries are contextual, and our humanity is critical to empathetic and effective care.

In his study cited above, Bergland postulates that there are ways an individual can start to alter his or her neural pathways to increase empathy. He suggests "mindfulness meditation" in which a person takes a few moments every day to have good thoughts about the self and others. Oxytocin, which is called the feel-good neurochemical, is released when you pet a dog, give a gift, or meditate while focusing on others. It is produced in the hypothalamus and secreted by the posterior lobe of the pituitary gland. He also suggests physical exercise to release epinephrine. Seeking or studying disagreeable situations may help you avoid overreacting or feeling overly empathetic to the point that it is unhealthy. Lastly, he recommends volunteering to help others in order to help cultivate feelings of empathy.

As in most things, moderation is a worthwhile target for empathy. An overabundance or lack of empathy may cause patients to accuse a practitioner of boundary violations. Understanding empathy and its ramifications is an absolute must for maintaining proper boundaries.

Take Aways

- Empathy increases patient satisfaction and clinical outcomes.

- Empathy improves the physician's and provider's wellbeing.
- Empathy is a learned skill.
- Be aware of co-dependency in your professional relationships.
- Ask unscripted questions of your patients.
- Practice "active listening."

THE ETHICAL RISKS OF PROFESSIONAL BOUNDARIES

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