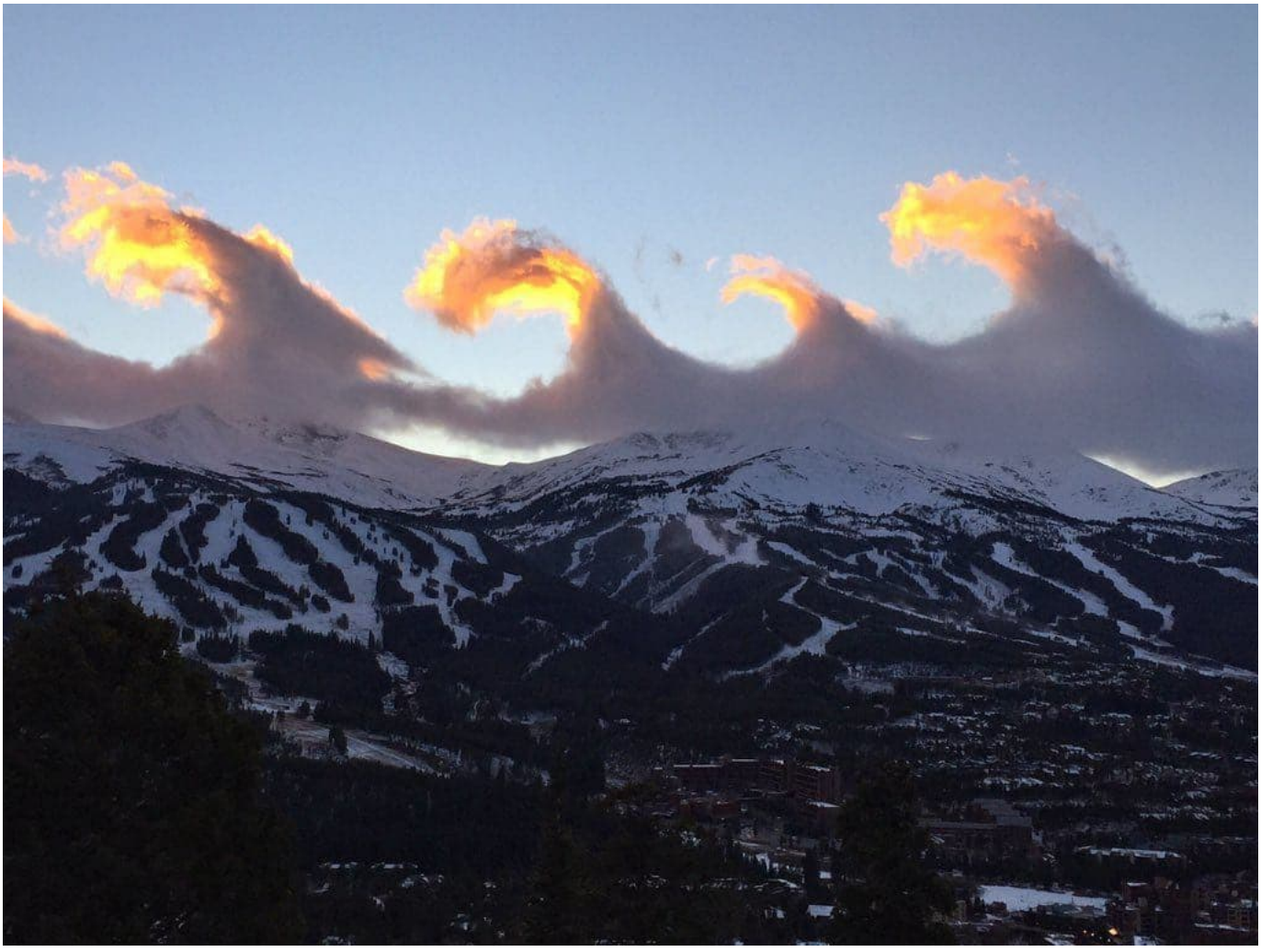
Presentation Materials

Blocking Subpoenas:

HOW TO KEEP MENTAL HEALTH CLINICIANS TREATING, NOT TESTIFYING

Casey Frank JD, MPH

CBHC Behavioral Health Training Conference
10:30 am, Friday 27 September 2019
Session 403, Coppertop 2



Kevin Helmholtz Clouds, Breckenridge Colorado 2015
Courtesy ABC11 News, 4 November 2015

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BLOCKING SUBPOENAS

How to Keep Mental Health Clinicians Treating, not Testifying

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10:30 am, Friday 27 September 2019

Session 403, Coppertop 2

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31 July 2019

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CASEY FRANK | JD, MPH Attorney Counselor

Since 1991, Casey has tried cases in the Courts of Colorado. He keeps community mental health clinicians out of court, and helps forensic psychiatrists & psychologists work there.

Education:

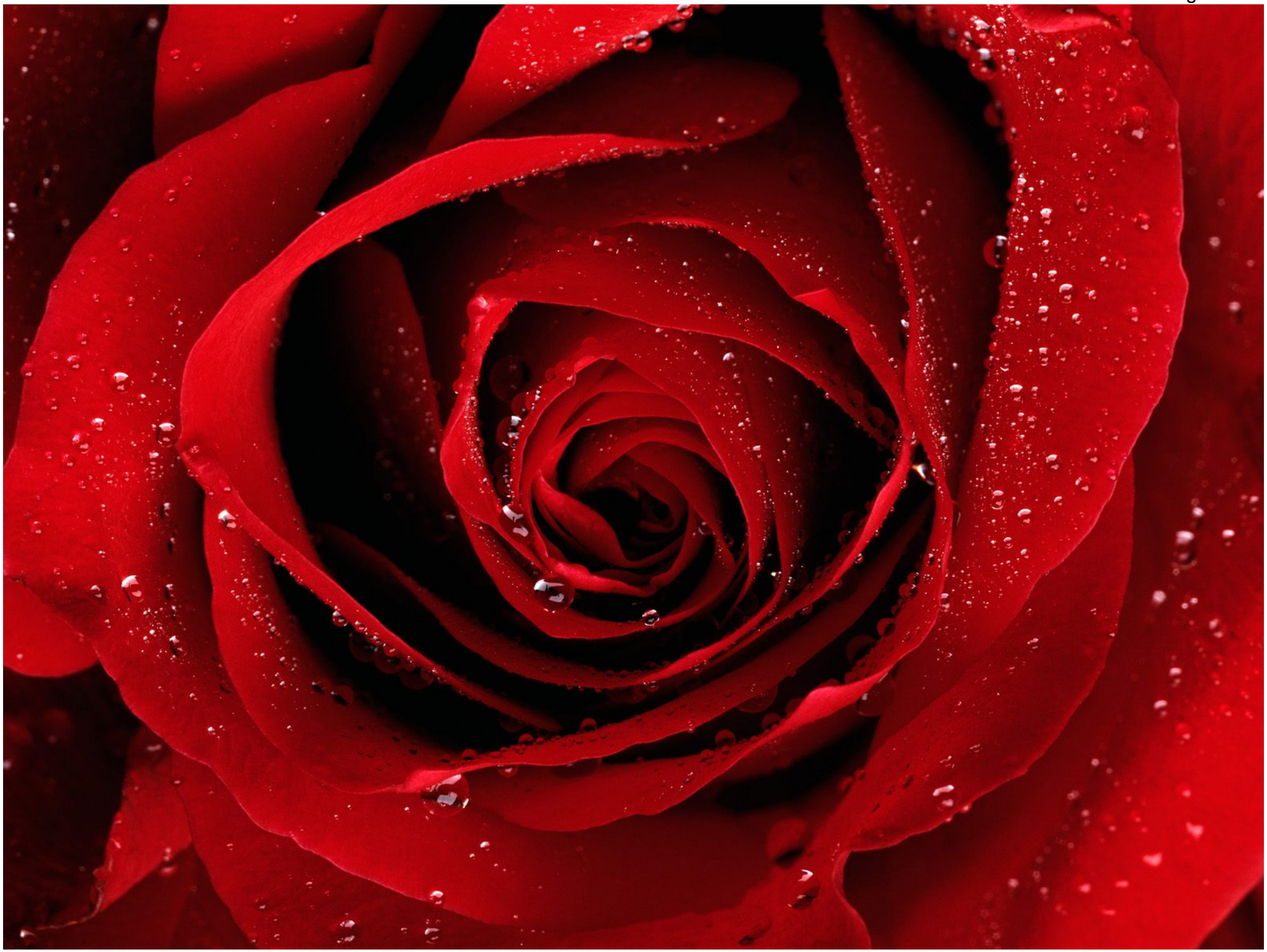
- JD from Northeastern University School of Law, 1991
- MPH from the Colorado School of Public Health, 2012

University of Colorado:

- Faculty in the *Forensic Psychiatry Fellowship* (jointly with the *Forensic Psychology Fellowship* from OBH/CMHI-Pueblo, and the *Forensic Psychology Fellowship* at DU/FIRST)
- Faculty Associate at the *Center for Bioethics & the Humanities*
- Member of the Hospital *Medical Ethics Committee*

Senior editor of the Health Law Column in the *Colorado Lawyer* (the state bar journal)

His writings and many legal resources are free for download at www.caseyfrank.com



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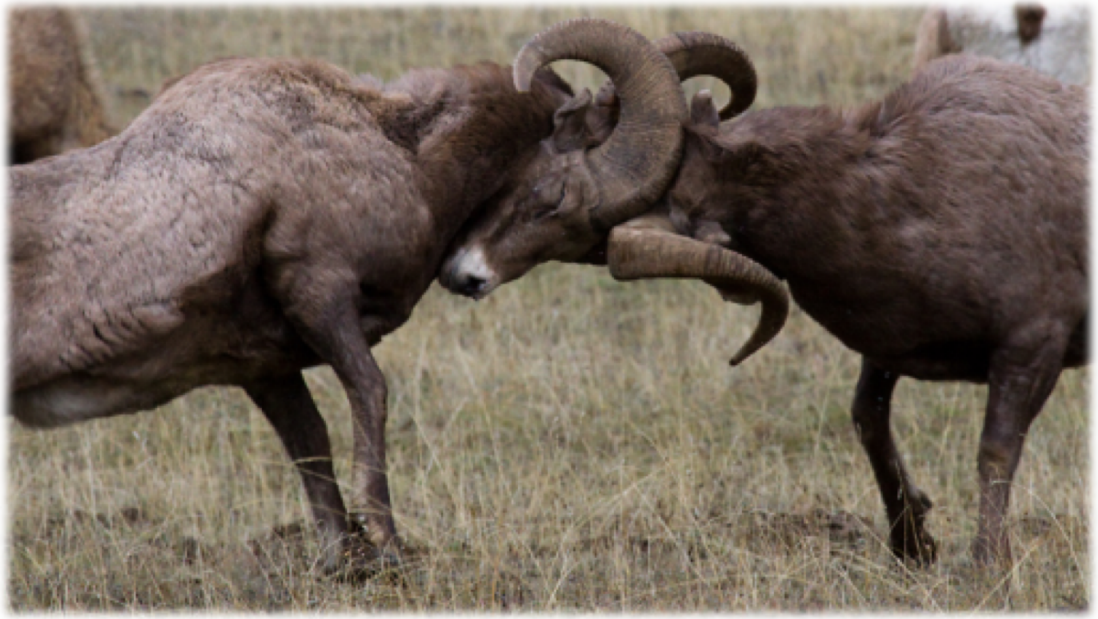

Avoid sclerosis of our life stories

Better to say *I practice medicine (or practice law)*

Avoids dogmatic professional positions

Critical use of words leads to a more nuanced self image

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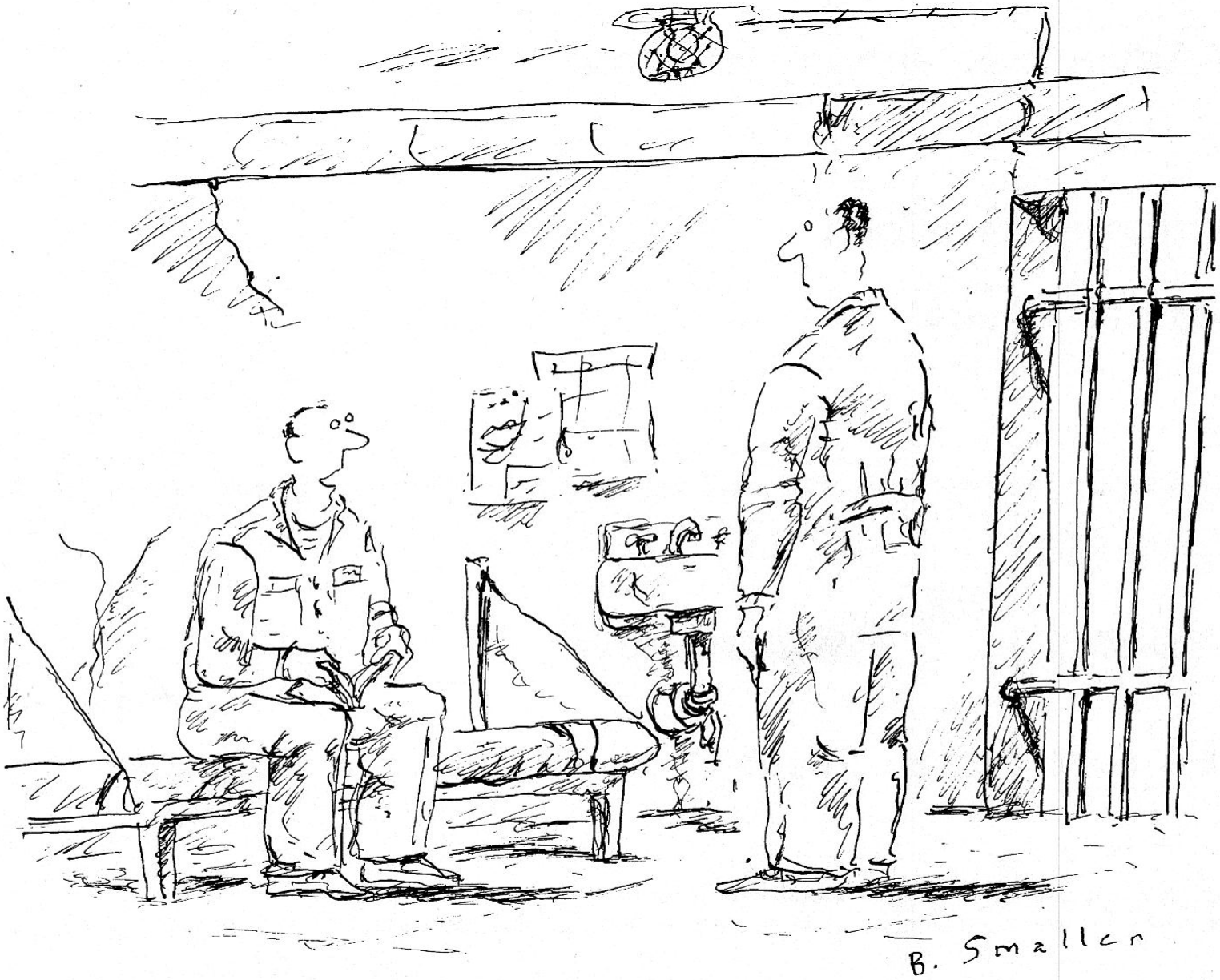

"Don't call yourself a murderer—you're just a person who happened to murder someone."

Protection Factors

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"KEEP MENTAL HEALTH CLINICIANS TREATING PATIENTS"

Form Risks

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"RISKS IN PROVIDING INFORMATION TO THIRD PARTIES"

Casey Frank JD, MPH
Hisae Tsurumi, MSN, WHNP-BC

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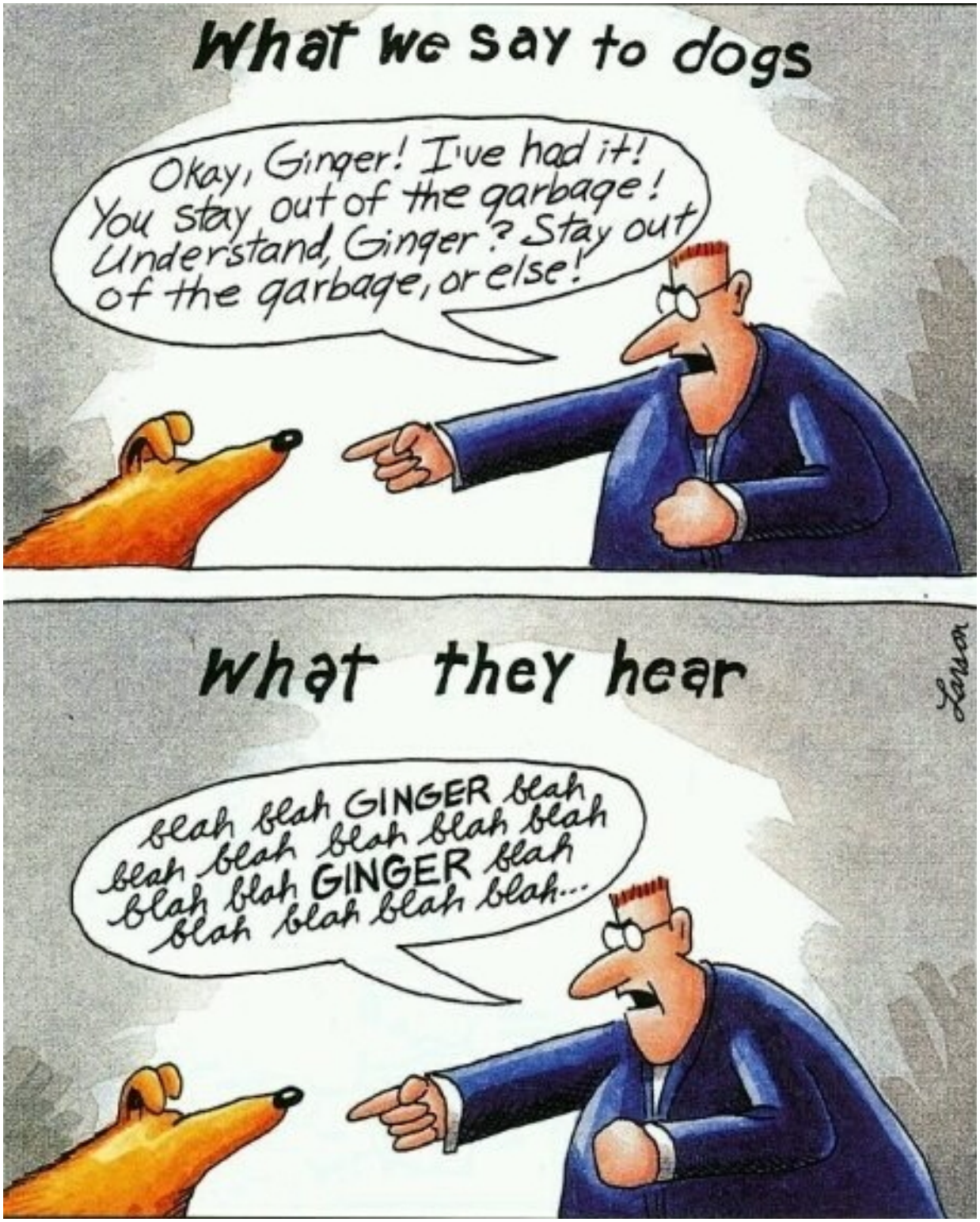
Richard Martinez, MD, MH
University of Colorado School of Medicine
Director, UC Forensic Psychiatry Fellowship



Courtesy of Gary Larson 1983

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Ancient Dovecote, Tarn-et-Garonne, France

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KEEP MENTAL HEALTH CLINICIANS TREATING PATIENTS

Casey Frank, 26 July 2019

Animating Principles

Treating plus testifying is a solvable conflict of interest.
Actions outside the scope of competence are unwise.
Consent is a contract between autonomous persons.[1]
Informal legal-ish advice may lead to subpoenas.

1. **Quickly Re-Direct Incoming Information**

   Report or forward ASAP all legal threats, contacts or subpoenas to more-experienced superiors.

2. **Determine Exceptions**

   Identify any clients upon intake that include a duty to report to outsiders. This includes clients with a specific treatment contract, or on probation. These obligations supersede most objections.

3. **Testify by Affidavit or Phone**

   Some court appearances are for mere authentication of documents. This can often be accomplished by an affidavit. Even appropriate testimony can be by phone. This often takes negotiating.

4. **Mutual Understanding at Hiring**

   At the first job interview, stress the scope of the job. Refer to the professional codes of ethics.

5. **Mutual Understanding from first clinical encounter**

   At the first meeting of clinician and patient, set informed consent on the scope of the clinician's role.

6. **Be Wary of Requests to Complete or Sign Third-Party Forms**

   Filling out a form or writing a letter can lead to entanglement with outsiders, and to subpoenas.

7. **Reject Waivers / ROI created outside of the clinical setting.**

   Only those emerging from treatment are *possibly* based on informed consent.

8. **Construe Subpoenas Stingily**

   Take broad and aggressive advantage of privilege in The Rules of Procedure. Interpose a lawyer between a clinician and the person issuing a subpoena.

9. **Embrace Professional Ethics**

   This is the heart of the defense against subpoenas. *Once a Patient, Always a Patient*. The key is extending it to a judicially respected form using the laws establishing the professional boards.

10. **Disseminate new Standards Internally**

    Change the default standard to only providing treatment, but never just because "the lawyer won't let me." Don't let internal anecdotes confuse these issues with cagy ploys.

11. **Don't Try to Convince Others**

    Don't explain to poachers who treat clinicians as free resources. It just encourages them.

12. **Get Help from the Court**

    If needed, file a *Motion to Quash* in court, and go from there.

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[1] For example, see *Principles of Medical Ethics of the AMA*, Section 6: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."

RISKS IN PROVIDING INFORMATION TO THIRD PARTIES

Casey Frank JD, MPH and Hisae Tsurumi, MSN, WHNP-BC, AGPCNP-BC

18 April 2018

Requests that are Risky

Assurances of safety (it shifts the risk to you)

Prediction of future behavior (you become an implied monitor)

Federal government program (even inadvertent misleading can be prosecuted)

Inappropriate person asked (see if anyone is more suitable)

Non-standardized forms (less predictable without a history)

Examples of Risk

"If necessary, would you be willing to testify under oath, in a court of law . . . .?"[1]

Assert that the patient "is safe to practice nursing."[2]

Predict a disability "lasted, or do you expect it to last, 12 months or more?[3]

Context Matters:

Ongoing job[4] more serious than time-limited benefits[5]

Intervening in a child abduction can be especially dangerous

Getting into the Bronco's Training Camp is harmless

Options

- Follow explicit institution policies
- Consult with mentors or supervisors
- Use your own judgment (while careful of bias)
- Consult with an attorney
- Adopt a denial letter to fit

Always provide copies of documents to the EHR Department

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[1] Denver Archdiocesan Housing Management Services, *Verification-Disability . . .*

[2] Colorado Board of Nursing, *Health Care Provider Reporting Form*.

[3] U.S. Dept. of Homeland Security, *Medical Certification for Disability Exceptions*.

[4] USDA, *Pre-Employment Medical Evaluation.*

[5] Healthcare Assessment for Federal TANF benefits.

SALIENT POINTS

Anderson v. Astrue 696 F.3d 790 (8th Cir. 2012)

Casey Frank, 27 May 2019

Checkboxes on a form can lead to unexpected consequences

- Dr. Cooper was a treating neurologist
- He checked boxes on a form for social security disability benefits
- He was not doing a full assessment for that purpose
- Dr. Cooper's opinion was challenged
- Dr. Cooper was not an expert in vocational assessment
- Dr. Cooper's conclusion was thus rejected
- However, disputes over the case continued

Dr. Cooper was involuntarily drawn into the following actions

- Treatment notes and the medical record were subpoenaed
- He had to personally appear for a deposition
- He was subpoenaed for a hearing before an Admin Law Judge
- He was subpoenaed for a hearing before an Administrative Appeals Council
- For review by a Federal District Magistrate, asked to consult by counsel
- Review by the U.S. Circuit Court of Appeals, asked to consult by counsel

This is all unprotected by privilege or patient preference

CASEY FRANK | JD, MPH
Attorney
Counselor

27 May 2019

Clinicians are not Available for Non-Therapeutic Functions

Dear Attorney

Mental health treatment does not produce objective information that can serve other purposes. Treating professionals lack training, education, and expertise except for prescribing and monitoring mental health treatment regimens.

Filling out a form, writing a letter, or having a conversation can lead to disputes with outside parties, or to a subpoena. Outside communications must be objective and neutral. Testimony in court must be in the interest of justice. These standards are incompatible with the treatment relationship, which must always be based in the best interest of the patient.

Clinicians cannot respond to such requests, for the protection of the continued or past treatment relationship with their patients.

This diminishes no rights under HIPAA for a patient's direct access to medical records.

Respectfully,

Casey Frank, Esq.
Representing a Clinical Professional

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27 May 2019

Treating Clinicians Should Stick to their Core Competence

Dear Clinician

I want to reduce extraneous demands on your core efforts to alleviate mental health disease.

People have a qualified right to their medical record. But neither patients, nor their agents, have any right to your clinical expertise outside of the treatment setting, which is defined by informed consent. The sharing of your clinical expertise — except for diagnosis & treatment — is normally not your job.

The clinician's relationship with a patient is always based upon the latter's best interests. Communications in external settings must be objective, neutral and unbiased — not pro patient. One does not translate into the other. Codes of professional ethics stress this conflict of interest.

It is not possible to limit involvement to an initial phone call (or a simple form). Once you are giving information about treatment related to an external, though related, activity, you lose control of the narrative. This may generate unforseen demands upon your time, eventually by subpoena or court order. It creates risk outside the scope of clinical competence, and often damages or destroys the alliance with the patient — even if he or she requested it.

An exception if where is an agreement to provide outside advice from the beginning. A patient referred as a condition of probation includes the need for sharing. An institutional contract can require someone to send a written report or even appear in court. That still does not require the treating clinician to do it. Better to use a professional colleague not treating that specific patient.

If anyone not your patient wants to talk, just obtain contact info, and confer with Senior Staff.

Respectfully,

Casey Frank, Esq.
Representing a Mental Health Center

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Ethical Human Sciences and Services, Vol. 2, No. 1, 2000

A Model for Boundary Dilemmas: Ethical Decision-Making in the Patient-Professional Relationship

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University of Colorado Health Sciences Center
Program in Health Care Ethics, Humanities & Law

The current "slippery slope" concept in boundary dilemmas is linked to a rule-based approach to ethical decision making. The author reviews the current "slippery slope" concept and professional ethics pertinent to boundary dilemmas. A graded-risk model for boundary dilemmas is introduced to offer a "process" approach to ethical decision making in boundary dilemmas. This model divides boundary crossings into four categories. Each category considers six variables: (a) the potential harm to the patient, (b) the potential benefit to the patient, (c) the presence or absence of coercive and exploitative elements in the boundry crossing, (d) the professional's motives and intentions, (e) the professional's aspiration to professional ideals, and (f) the context of the boundary crossing. This model of boundary crossings introduces complexity and specificity necessary for clinical decisions, teaching, retrospective judgements, and research in boundary dilemmas.

El concepto actual "slippery slope" en los dilemas fronterizos se agrega a un acercamiento reglamentado para hacer decisiones éticas. El autor repasa la perspectiva actual "slippery slope" y provee una reseña de las éticas profesionales pertinentes a los dilemas fronterizos. Un modelo de riesgo gradual para dilemas fronterizos se introduce para ofrecer un acercamiento de "proceso" para hacer decisiones éticas en los dilemas fronterizos. Este modelo divide los cruces fronterizos en cuatro categorías. Cada categoría consiste en seis variables: (a) el daño potencial al paciente, (b) el beneficio potencial al paciente, (c) la presencia o ausencia de elementos coercitivos y explotadores en los cruces fronterizos, (d) los motivos e intenciones del profesional, (e) la aspiración del profesional a los ideales profesionales, y (f) el contexto del cruce fronterizo. Este modelo de cruces introduce la complejidad y especificidad necesarias para las decisiones clínicas, la enseñanza, los juzgamientos retrospectivos y las investigaciones en los dilemas fronterizos.

Dans les dilemmes face à l'établissement de limites entre client et psychothérapeute, le concept de la "pente glissante" est lié à une approche réglementaire envers le processus décisionnel éthique. L'auteur discute de ce concept et de l'éthique de ces dilemmes. Un modéle de risque échelonné est introduit à l'intérieur d'une approche dite "de processus" envers la prise de décisions éthiques dans ces situations. Ce modéle divise les situations où les limites sont outrepassées en quatre catégories, chacune appellant à considérer six variables: (a) le danger envers le client, (b) le bénéfice envers le client, (c) le degré de coercition ou d'exploitation, (d) les motifs du professionnel, (e) l'aspiration du professionnel aux idéaux de sa profession, ainsi que (f) le contexte. Ce modéle injecte la complexité et la spécifité nécessaires à la prise de décisions cliniques, à i'enseignement, aux judgements rétrospectifs et à la recherche dans ce domaine.

R.N. is a 50-year-old male physician. He has been divorced once, and has raised two teenage children for 10 years as a single parent after his former wife developed emotional difficulties. He entered therapy after becoming depressed following the death of an old friend. R.N. was neglected in early childhood: his mother was episodically depressed, his father was emotionally distant. Both parents and a younger sister are dead, and R.N., with few friends, is quite isolated. His one pleasure is fishing. Shortly after beginning therapy, he asked his male psychiatrist if he could bring his children to a session; family therapy lasted 2 months and was quite helpful. Shortly after family therapy stopped, and while his own individual therapy continued, R.N. asked the psychiatrist to a family dinner—a trout dinner. He said he would like the psychiatrist to see his home and celebrate, with his two children, the success of the family work.

The "slippery slope" model in boundary dilemmas dominates current understanding of boundaries in the professional-patient relationship[1] (Gutheil & Gabbard, 1993). This model is linked to a rule-based ethical decision-making approach in boundary theory. It is promoted in the literature as a way to assess risk and manage boundary dilemmas in psychotherapy. The "slippery slope" model helps to understand exploitation of patients and boundary violations (Gutheil & Gabbard, 1993; Strasburger, Jorgenson, & Sutherland, 1992), but not to fully understand the larger arena of boundary crossings (Lazarus, 1994).

The usefulness of the "slippery slope" model in boundary crossing cases such as R.N.'s is questionable. The slippery slope model fails to distinguish between those crossings that are potentially beneficial and those that are potentially harmful to patients. In Charon and associates (1996), ethical analysis of R.N.'s case resulted in the psychiatrist accepting R.N.'s offer to dinner. Many authors writing on boundary theory would discourage this behavior.

A "graded-risk" model for boundary dilemmas is presented in this article as an alternative to the slippery slope model. The graded-risk model requires a "process" approach to ethical decision making. It is designed to help members of state medical and grievance boards in their deliberations, to challenge existing boundary theory, and to aid professional societies in communicating with and advising professionals within their organizations.

A graded-risk model can enhance clinical decisions, improve teaching and retrospective assessments of boundary crossings, and stimulate research in the area of boundary dilemmas and professional values.

This article also introduces the idea of an obligation in certain cases to cross boundaries. Boundary dilemmas present opportunities to uncover and articulate values essential to professionalism. An ideal of the patient-professional relationship is presented in order to define elements of professionalism that are intrinsic to psychotherapy. An obligation is a situation where the failure to extend oneself (i.e., to cross a boundary) may constitute substandard care, even a potential for malpractice liability.

In pain management of the dying, regulatory agencies and professional societies have contributed to a culture of fear and ignorance among physicians who prescribe medications for the dying (Buchan & Tolle, 1995; Hill, 1996). Recent trends in palliative care and the law are helping reverse the practice of inadequate treatment of pain (Block & Sullivan, 1998). Similarly, current attitudes, education, and awareness about boundary dilemmas may contribute to a similar culture of fear among professionals. The present author's bias is toward professional obligations that advocate for patients and their needs, while opposing professional paternalism.

THE CURRENT CONCEPT OF BOUNDARY DILEMMAS

The concept of boundary in psychotherapy is used to discuss various clinical and ethical aspects of the professional-patient relationship (Epstein, 1994; Gutheil & Gabbard, 1998). Historically, sexual misconduct in psychotherapy has increased attention to boundary dilemmas (Schoener, 1995; Strasburger, Jorgenson, & Sutherland, 1992). Reports of professional misconduct created challenges in the training of health professionals and eroded public trust. Various professional associations revised their ethical codes and regulations (American Psychiatric Association, 1998, 1992; Council on Ethical and Judicial Affairs, American Medical Association {AMA}, 1991). Others recommended guidelines for assessing and rehabilitating individuals who exploit patients (Frick, McCartney, & Lazarus, 1995; Jorgenson, 1995).

Placed on a continuum, boundary dilemmas range from sexual misconduct with patients at one extreme, to accepting small gifts or reducing fees at another extreme (Epstein, 1994; Gutheil & Gabbard, 1993). Given therapists' involvement in intimate relationships, their understanding of boundary dilemmas is essential for good patient care (Anderson & Kitchener, 1998). Other physicians and professionals, including lawyers and members of the clergy, also attend to boundary dilemmas (Blevins-Knabe, 1992; Gabbard & Nadelson, 1995; Kagle & Giebelhausen, 1994; Kitchener, 1988; Rutter, 1989).

Ethically, issues of patient exploitation and coercion are the central concern (Epstein & Simon, 1990). The distinction between boundary "crossings" and "violations" involves judgments about two central ethical concerns: whether and to what degree patients have been exploited and/or coerced by professionals. Where exploitation is suspected, the distinction rests on the assessment of the seriousness of the harm. With significant harm and exploitation, the crossing is then labeled a violation. The slippery slope model maintains that boundary

crossings are likely to lead to violations, and thus stresses vigilance and care in assessing and managing these interactions (Gutheil & Gabbard, 1993), preferably by refraining from a boundary crossing.

Some authors argue that boundary management is an "empathic, dynamic structure that is sensitive to the patient's changing needs" (Epstein, 1994, p. 17), but rules and guidelines abound in this area (Gabbard, 1992; Gutheil & Gabbard, 1993). Gutheil and Gabbard (1993) offer headings that summarize instances when boundary dilemmas are likely to arise: role; money; time, space, and place of therapy; gifts, services, and related matters; language; clothing; self-disclosure; and physical contact such as hugs with patients. Gutheil and Gabbard (1998) intend for professionals to better anticipate potential harms in psychotherapy while promoting flexibility and innovation. Unfortunately, many clinicians, educators, and others in positions to judge professional misconduct interpret the slippery slope model in the direction of reduced flexibility (Lazarus, 1994). Since the slippery slope model is derived from cases of professional misconduct where patient exploitation and coercion have occurred, it is argued that these cases are not adequate comparisons for professionals who cross boundaries and benefit patients and the relationship.

Rules and guidelines are ostensibly intended to protect patients, guide professionals, and support public trust in professions, but may overly simplify the complex processes by which professionals balance professional and personal values. *Rule-based decision-making in boundary dilemmas joined with the slippery slope model can leave many clinicians confused in their decisions, and discourage boundary crossings that are potentially beneficial to the patient.* Professional anonymity and neutrality in psychotherapy, sometimes considered harmful to patients, is inadvertently supported by this model (Renik, 1995). The intersubjective dimension of psychotherapy is marginalized (Chessick, 1992). Cultural, racial, gender, religious, and ethnic considerations are diminished (Heyward, 1993; Rogers, 1995).

ETHICAL ISSUES IN BOUNDARY DILEMMAS

Boundary dilemmas involve ethical themes central to professionalism: (a) principles of medical ethics including beneficence, nonmaleficence, justice, and respect for persons and their autonomy; (b) professional integrity, and the motives that influence professional behavior; (c) professional virtues and ideals that define character and integrity, guide duties and obligations, and influence supererogatory acts; and (d) those aspects of professional motivation involved in the calling to a profession (Beauchamp & Childress, 1994; Pellegrino & Thomasma, 1993). Furthermore, the importance of trust and the recognition of the patient as vulnerable underly all boundary dilemmas (Pellegrino, 1990).

Principles

Principles of health care ethics guide professional behaviors in negotiating boundaries (Lazarus, 1995). A professional, in deciding whether to cross a boundary with a patient, should consider the likelihood of benefit or harm to

the patient—the principles of beneficence and nonmaleficence. Concerns about fairness and respect for patient autonomy are equally important. Respecting the patient, opting for beneficial interventions, and avoiding harmful interventions cannot be disputed.

The practice of obtaining informed consent and disclosing conflicts of interests are obligations that emerge from respecting patient autonomy. Sharing information with patients that increases the patient's informed choice, and decreases the differential of knowledge and power between patient and professional are the rationale for these principles. Disclosure of conflicts of interest and informed consent about treatment alternatives are desired standards in health care practice. However, as a therapeutic procedure, psychotherapy is much different from other medical interventions. Unique problems in the implementation of these ethical principles can occur, sometimes encouraging paternalism in psychotherapy (Brace & VandeCreek, 1991; Culver & Gert, 1982). Therefore, unlike many medical interventions, the nature of psychotherapy requires that we understand the motives and intentions behind professional decisions if we are to reduce professional paternalism.

Desires, Intentions, and Motives

The analysis of a patient's complex nature, conscious and unconscious desires, motives, and intentions may be an active part of psychotherapy. However, the professional's desires, intentions, and motives ("countertransference") are less rarely analyzed and, certainly, minimally shared with the patient. Boundary dilemmas can be understood in part by understanding countertransference (Gabbard, 1995; Gutheil & Gabbard, 1998), though the latter is rarely discussed as a means to understand ethical issues in therapy.

A broader view of the professional's desires, motives, and intentions is needed, which considers psychotherapy to be an ethical enterprise (Lipson & Lipson, 1996). Professional and patient are involved in a moral drama. We must understand the professional's desires, motives, and intentions if we are to support both the patient's autonomy and the professional's integrity. Assessments of boundary dilemmas usually consider this subjective domain. It is not uncommon, in cases of sexual misconduct and other forms of patient exploitation, that professionals use the justification of "good intentions." Intentions are the most elusive and subjective of the criteria proposed in the graded-risk model below, but these must be considered if we are to develop a more comprehensive model to assess boundary dilemmas.

Role of the Professional

In the slippery slope model, the professional is viewed as "in a role" (Gutheil & Gabbard, 1993). This role determines professional behavior by demarcating what is and is not acceptable behavior while acting within the role. Boundary violations, and many boundary crossings, are seen as activities outside of the

usual professional role (Gabbard & Nadelson, 1995; Kitchener, 1988). To accept gifts from patients, to attend a patient's wedding, to barter, or to agree to reduced fees are judged by whether one "in the role of the professional" usually would act in such a manner. Whereas boundary violations are seen as clear abuses of the professional role, many issues of boundary crossings and multiple role relationships are considered "changes" in professional role (Gabbard, 1994). The ethical consideration then involves deciding whether these changes lead to greater potential of benefit or less risk of harm to the patient (Kitchener, in press).

The concept of role can guide the professional by supporting minimum expectations and obligations to the patient. However, a view of role applied narrowly can lead to harm and neglect of both the patient and the relationship (Hardimon, 1994). A broader view of professionalism, one that considers internal norms of the profession and professional aspirations toward moral ideals, has been neglected.

Beyond Role: Professional Integrity

With the concept of professional role, the tension between personal and professional morality is neglected. Miller and Brody (1995) present a professional integrity model that informs the discussion about boundary dilemmas. These authors link personal integrity to personal identity, life activities that cultivate or harm trust, and the qualities of wholeness and intactness. Three elements are necessary for integrity: (a) a set of stable, coherent, and well-regarded values and principles; (b) verbal expression of those values and principles; and (c) consistency between what one says and what one does. Rigid adherence to values and principles and inflexibility in behavior can work against personal integrity in Miller and Brody's model. They argue for personal qualities that involve tolerance and openness to other points of view.

Whereas personal integrity is highly connected to individual identity, professional identity and integrity are more socially determined. They are tied to the community, which defines expectations and places restrictions on individual expression while one is "in the role" of the professional. However, here again, a more dynamic understanding of the interplay of personal morality and professional morality is needed than is provided by the current professional role concept that dominates discussion in boundary dilemmas.

Professions possess an internal set of goals, duties, values, and ideals that are essential for professional identity and integrity. Whether as physician, teacher, or therapist, professional obligations to those we serve are derived in part from both external codes and rules, and from the particular profession's internal standards and norms. Just as personal integrity is connected to a certain consistency over time, a profession possesses tradition and an "historical narrative" of the goals, duties, values, and ideals of the profession (Miller & Brody, 1995).

The historical narrative, which informs our understanding of professional role, anchors the profession in those goals, duties, values, and ideals that resist the vagaries of social and situational forces, especially when those forces place pressure on the professional to behave contrary to the historical narrative. An example is the recent resistance of many American physicians to agree to "gag clauses" in contracts that limited their ability to reveal to their patients alternative treatments not covered in certain managed care plans. Physicians believed this behavior was contrary to their historical obligations to patients (Council on Ethical and Judicial Affairs, AMA, 1995).

In addition, individual professionals' personal values shape their professional identity and integrity. We cannot and should not expunge from professional morality these personal values and beliefs, but find ways to balance these with obligations to the profession and those we serve. In controversial issues such as abortion and physician-assisted suicide (in Oregon), boundary dilemmas involve personal values that allow individual physicians to make choices independent of the stated values of the profession. The question of what is the right thing to do for my patient is coupled with the question of what sort of professional I am. Professional integrity, then, flows from a dynamic tension involving the individual professional's obligations to those served and their needs, to the historical traditions and values of the profession, and to the professional's own values.

Virtue and Professional Ideals

Virtue and moral ideals tell us how to be, which is necessary in order to decide what to do. The current view on boundary dilemmas is concerned almost exclusively with specific behaviors rather than ethical considerations that can help in understanding those behaviors. Virtue and professional ideals are important to a profession in crisis. Indeed, with managed care, the physician must balance professional responsibilities with institutional obligations (Wolf, 1994). This challenges the medical profession to examine its goals and duties during a time that individual professionals are more confused and uncertain about the nature of their professionalism.

Pellegrino and Thomasma (1993) review the place of virtue in medicine. Human virtues are dispositions to act, feel, and judge that are developed from innate capacity by proper training, practice, and commitment. Virtues and moral ideals help a human being to be a good person, live a good life, and fulfill creative and moral potentials—three components of a meaningful life, of "the good." In modern virtue theory, discernment and judgment, along with temperance and wisdom, are necessary qualities to understand and manage boundary dilemmas. Because the flourishing of trust in the professional-patient relationship is highly valued in health care, honesty, truth-telling, and fidelity—all virtues related to the modern principle of autonomy and respect of persons—are essential to moral professional-patient relationships. Compassion, integrity, and self-effacement expand the description of the ideal physician.

Lastly, moral ideals include supererogatory acts (beyond the call of duty, often with risk to the agent). Authors have written about professional self-effacement and obligations in the treatment of AIDS patients (Clarke & Conley,

1991; Emanuel, 1988), but very little has been written about supererogation in the context of boundary dilemmas. Court decisions in sexual misconduct and "false memory" cases have led to extreme caution and fear of innovation on the part of many professionals (Appelbaum & Zoltek-Jick, 1996), and certainly to avoiding to take risks that go beyond the call of duty. Virtue and moral ideals argue for a new approach toward boundary dilemmas, and in some situations, create new obligations to our patients.

The Calling to a Profession

From the early Hippocratic tradition to the recent call for a biopsychosocial model of medical practice, there have been reminders of what characterizes medicine as "a calling." The view of calling here includes the individual personal morality (whether determined by religious or secular values) that professionals bring to their work. Modern medicine's emphasis on "value-free scientific objectivity" can marginalize personal morality in the professional-patient relationship.

Professional calling involves the influence of early mentors and ideals, pleasure and desire in work, hope in the professional-patient relationship, and individual creativity. A common element remains the service commitment to others. This view of calling may lead professionals to look upon boundary dilemmas differently.

Pleasure and enjoyment in professional work hover above the issue of boundaries. Boundary crossings can be creative opportunities, the delicate and intimate moment between two people when the professional's moral and clinical capacities are joined together, and the experience of the calling is defeated or realized. The movement toward creative thought, discernment, and judgment shapes and defines the moment. For the professional who aspires to professional ideals, the boundary dilemma is an opportunity to unfold meaning and understanding about the calling to his or her work, while placing the needs of the patient first.

A GRADED-RISK MODEL FOR BOUNDARY CROSSINGS

The current "slippery slope" model and rule-based decision-making approach emphasize negative consequences of boundary crossings while inadvertently minimizing potential benefits. However, many boundary crossings are motivated by and result in constructive developments in the professional-patient relationship. A model that supports broader obligations to patients, nurtures professional ideals, improves clinical decisions and teaching, and stimulates research is needed.

Table 1 presents such a graded-risk model. Instead of supporting general rules or categories of prohibited professional behaviors, it offers a "process" approach for ethical decision making in individual situations. It is not intended as a check list for assessing boundary dilemmas, but summarizes and considers the ethical variables involved in each and every boundary dilemma. The slippery slope approach offers a methodology for limiting harm and managing risk, but does not inform the professional about his or her position upon the slope in particular cases, nor does it discriminate degrees of risk in cases of similar circumstances.

For example, seeing a patient outside of the usual time and place of therapy is usually discouraged, typically as follows: In many cases in which professionals eventually have unethical sexual relationships with present or former patients, the therapists began to cross boundaries earlier in the relationship, commonly by meeting the patient at the end of the day, staying over the usual time of the session, and eventually having lunch or dinner with the patient. Therefore, the rule-based approach warns against participating in these patterns.

The graded-risk model provides criteria to enhance understanding of one's position on the slippery slope, while delineating those types of boundary crossings that are beneficial to patients, or at least, have a low risk of harm. Guidelines around particular professional behaviors can be preserved in this model, but it systematically evaluates the professional ethics involved for a comprehensive risk assessment of boundary crossings. Professionals can better examine those dilemmas where the professional is either prohibited, justified, or obligated to cross a boundary by monitoring six ethical elements: (a) the potential harm to the patient and the relationship, (b) the potential benefit to the patient and the relationship, (c) the presence, absence, or degree of coercive and exploitative elements in the boundary crossing, (d) the professional's motives and intentions, (e) the professional's aspiration to professional ideals, and (f) the context of the boundary crossing (which includes elements considered by other authors, such as an assessment of the patient's psychological strengths and weaknesses, the type of therapy and nature of the professional-patient contract, the experience of the therapist, and cultural variables including race, ethnicity, and gender).

Type I Boundary Crossings

Type I crossings include the vast majority of boundary violations in the rule-based slippery slope model. Professional behaviors liable to criminal and civil litigation often fall under this category. Sexual behavior between professional and current patient is considered unethical in all situations, and in some states open to criminal as well as civil action. Breaches in the duty to care, misdiagnosis, and other negligent treatments are obvious examples where boundary violations are sometimes involved. In *Hammer v. Rosen* (1960), the defendant's claim that occasionally beating his schizophrenic patient was a form of treatment was judged by the courts as grounds for malpractice liability, not as an acceptable boundary crossing or experimental therapy.

In Irvin Yalom's (1996) novel, *Lying on the Couch,* Dr. Marshal Streider is a a training analyst who engages in both unprofessional and possible illegal activity under the initial claim of being "well-intended." The analyst invests funds based on information given to him by one of his wealthy patients. Streider accepts the patient's "insider information" as an expression of gratitude, but it is clear that this decision is based on his greed rather than on any benefit to the patient. In a strange twist of fate, the patient turns out to be scamming Streider, and his self-interest not only compromises his professional judgment and usual adherence to patient concerns over his own, but blinds him to the fact that he is being cheated.

TABLE 1. Boundary Crossings*

Type of Boundary Crossing	Risk of Harm to Patient and Professional-Patient (P-P) Relationship	Coercive and Exploitative Elements	Potential of Benefit to Patient and P-P Relationship	Professional Intentions and Motives	Professional Ideals	Recommend-ations
I	High	Present	None-Low	Professional Self-Interests over Patient-interests	Absent	Discouraged and Prohibited
II	High	Ambiguous	Low	Professional Self-Interests Blur Patient-interests	Absent or Minimum	Highly Discouraged. Rarely Justified
III	Low-Middle	Absent	Middle-High	Patient-Interests over Professional Self-Interests	Present. Discernment and Judgment Important.	Encouraged as Benefit Increases. Justified. At times, above call of duty.
IV	None-Low	Absent	Middle-High	Patient-Interests over Professional Self-Interests	Present Ideal Model of Care	Strongly Encouraged. Justified. Obligated as Benefit Increases

*All boundary crossing dilemmas should consider contextual elements.

The university professor who engages in a romantic relationship with a student while evaluating the same student would constitute a Type I crossing. The student's decision to participate in a romantic relationship is tied to the evaluative nature of the relationship. The university professor is responsible for protecting the fiduciary relationship, and if complicating his role with the student compromises his judgment, it is difficult to justify this boundary crossing as anything less than a Type I crossing.

Types II, III, and IV boundary crossings involve activities that are intended for the benefit of the patient and the relationship, and *do not involve obvious or reasonably foreseeable coercive and/or exploitative elements.* The contextual elements described previously need to be considered. Although these three types are labeled crossings rather than violations, this does not mean that they are justified or should be looked upon as inconsequential. Indeed, a professional can participate in a Type II boundary crossing that warrants disciplinary action by state boards and professional societies.

Type II Boundary Crossings

These include activities, such as helping a patient falsify an insurance form, that involve high risk of harm and low opportunity of benefit to the patient and the relationship. Here, coercion and exploitation are not part of the initial activity or remain ambiguous. The professional does not intend harm (i.e., as a claim at least), but harm can and does occur. The professional might believe that he or she intends to strengthen the therapeutic relationship, but in some cases, the activity violates the relationship's fundamental values and conditions. Professional judgment and discernment are absent or minimal. It is assumed that professional ideals and professional judgment must be linked to such universal values as honesty, truth-telling, and respect for the law. Falsifying an insurance form might have immediate benefits for both patient and therapist but it fails to model universal values that animate professional ethics.

Trading psychotherapy for menial services might be included under Type II crossings:

> Mr. M is a 42-year-old African American male with a history of alcohol abuse who works at night for an "office cleaning company" and some days picks up extra work in the construction industry as a laborer. Although Mr. M has a college education, several setbacks in his life have left him with financial and employment problems. He enters therapy with Dr. S, a White male psychiatrist in private practice. Dr. S prescribes a drug treatment, and develops a rapport that allows Mr. M to "talk about his losses" for the first time. Mr. M has health insurance, but no outpatient mental health benefits. Several weeks into the treatment, while discussing Mr. M's inability to pay for his sessions, Dr. S offers Mr. M the "opportunity" to work around Dr. S's home as payment for treatment. Dr. S is remodeling a portion of his home, and thinks that both he and Mr. M could benefit by offering Mr. M this arrangement.

This case illustrates the ambiguity often present in the motives and intentions of professionals facing boundary dilemmas. Like the analyst in Yalom's novel, Dr. S will benefit, but unlike Yalom's analyst, no more than if he hires

someone else to do this work. Assuming he compensates Mr. M fairly, he will not save money, and in some ways, creates problems for himself (i.e., by having a patient intrude into his privacy, or because Mr. M's work might be less than desirable). Dr. S appears to consider the potential benefits to Mr. M. However, a patient who cleans or works at his psychotherapist's home or tends his psychotherapist's laundry is likely to experience humiliation and exploitation. The discrepancy between Dr. S's hourly charge and the wages for Mr. M's labor is made obvious. Racial differences are not only symbolic, but potentially exploited in this case. The patient's capacity to choose freely, necessary for noncoercive decision making, seems to be nonexistent. While Dr. S might be well intended, the risk for exploitation, the potential damage to the relationship by increasing Mr. M's dependency and thus enlarging the power difference between the two participants (i.e., Mr. M, the patient, now becomes also an employee to Dr. S), argue for avoiding this arrangement and finding alternative strategies to solve the economic problem between these two participants.

Placing patients in high-risk situations is not compatible with professional judgment and aspirations toward professional ideals. In the above case, too many unpredictable variables could result in harm. With limited information in this case, the outcome is highly uncertain. Uncertainty combined with high potential of harm argues for professional restraint. On the other hand, if such a case results in a "good" outcome, we might judge the situation retrospectively as a Type III boundary crossing. The graded-risk approach is intended to guide both prospective decisions within the clinical domain, and to serve retrospectively as a guide in judging already performed boundary crossings in training and deliberative situations.

Type III Boundary Crossings

These crossings involve low to middle risk of harm and middle to high opportunity for benefit to the patient and the relationship. This type of crossing is broadly conceived, and likely categorizes many of the boundary dilemmas that many professionals encounter. Type III crossings can lead to minor harm to the patient and the relationship, but do not require disciplinary action by state or professional bodies, nor do they reflect substandard care or grounds for malpractice liability. They frequently involve the therapeutic occasions noted by Gutheil and Gabbard (1993): self-disclosure; time, space, and place of therapy; gifts, services, and related matters; language; clothing; and physical contact. Here, there are reasonable intentions and expectations of benefits to the patient and the relationship. However, uncertainty of benefit, combined with the nature of the crossing and the variability of outcome, places Type III crossings in the low to middle range of risk.

Type III crossings involve situations where the professional's discernment and judgment are crucial. Evaluation of context is especially important. The assessment of the situation, the decision, the boundary act or omission itself, and the management of what follows require sensitivity, judgment, and discretion. Going to a patient's wedding, having lunch with a current or former patient, significant disclosure of personal information, and other activities intended to sustain integrity in the relationship are included.

Activities above the call of duty are included in Type III crossings. These are activities in which the professional intends to support an opportunity for both patient and therapist to grow, while focused on the patient's healing. The professional's personal morality and aspiration to professional ideals are present and can be made explicit. For some professionals, strictly separating professional life from personal life and minimizing intrusions into one's personal life are important values. For others, attending a patient's wedding or meeting for lunch with a former patient—assuming these activities benefit the patient—are not an imposition, but enlivening. The case of R.N. introduced at the beginning of this article is a Type III crossing. This group of crossings is commonplace, yet poorly understood, inadequately studied, and infrequently discussed among colleagues.

Type III boundary crossings are particular, unique, and ambiguous by nature. Where there are clear benefits in hindsight, we judge these crossings as justified and praise the professional behavior (as in the case of the therapist who attends the wedding of a patient after the patient and therapist have agreed on the benefits of such activity). The following case illustrates a more complicated dynamic, but one where professional aspiration cannot be minimized:

> Dr. A is a 50-year-old psychologist in private practice, self-described as a therapist with "Christian beliefs." She has been treating Mrs. C for some months after Mrs. C left her physically abusive husband. Mrs. C met Dr. A at church services over a year ago. They know each other casually through several church activities. Mrs. C is unemployed, taking care of two young children while proceeding with a divorce. Mrs. C's husband has failed to forward his court-ordered child support for the second month. Legal action is pending. Mrs. C is crying, demonstrates panic and anxiety, and is worried that her electricity will be turned off if she is unable to pay the $100 due. Other debts worry her. Dr. A offers to provide reduced fees for several months and loan Mrs. C $200 with the agreement that the loan and payments for therapy will be paid back in several months when Mrs. C is in a better financial situation. Mrs. C and Dr. A spend considerable time discussing this arrangement and come to the shared view that this temporary increased dependence on Dr. A feels supportive, provides "some breathing room," and encourages Mrs. C to "finally stick to my decision to end this marriage." Mrs. C's estranged husband learns of this and reports Dr. A to the state grievance board with a complaint that Dr. A "crossed boundaries" and behaved "unprofessionally."

In this case, religious beliefs shared by patient and therapist are key to evaluating this boundary crossing. The parable of the Good Samaritan is central to Dr. A's personal and professional identity; Mrs. C sees her offer as generous and caring. Dr. A's aspiration to a professional ideal combines with an assessment of significant short-term benefit and possible long-term benefits for both Mrs. C and the therapeutic relationship, and minimum risk of harm if she helps her patient reduce this financial hardship. Mrs. C's anxiety about her financial dependency upon her husband will subside temporarily, providing her some breathing room while she finds a more reliable solution to her financial situation. When Mrs. C previously tried to leave her husband, financial dependency factored in her decision to return to the troubled marriage. Dr. A and Mrs. C agree that her "temporary increased dependence" and indebtedness to Dr. A could provide Mrs. C with a transition that supports the long-term goal of greater independence and "healthier" relationships.

However, one could anticipate many possible outcomes in this case, some of which would argue against Dr. A's loan, as would a rule-based approach. Entrepreneurial, secular, and contractual values characterize many of the biases shaping the boundary dilemma debate. Should professional psychotherapists loan money to patients? Can clients benefit from therapy that is free or at reduced fees? Isn't psychotherapy a contractual fiduciary relationship involving payment for services? Are Dr. A's judgments about Mrs. C's marriage incorrect? What if Dr. A's own countertransference to "save" Mrs. C is influencing her decision, making it difficult to assess the potential for harms and benefits in this situation? Will Mrs. C's "indebtedness" make it difficult to work on other important issues later in the treatment, including occasions where she might disagree with Dr. A, or fear disappointing Dr. A? These legitimate questions ought to be considered by Dr. A before her decision.

In the graded-risk model, evaluating the six ethical variables, Dr. A and Mrs. C would be able to decide on this activity in the privacy of the therapeutic relationship without fear of violating a rule pertaining to boundary crossings and money. The absence of coercion and exploitation, the intention of benefit for the patient and low to middle risk of harm, the patient's interests placed above the professional's interests, the aspiration toward a professional ideal shared with the patient, and the context of shared religious values allow for these two individuals to make a decision and take full responsibility for its outcome—including the potential outcome of a "mistake."

"Mistakes" are likely in areas with great need for development of knowledge and skill. "Mistakes" indicate decisions that other competent well-intended professionals in similar situations might make. They do not reflect substandard care, malpractice, or require disciplinary action. This view of mistakes has a legal correlate in medical malpractice through the principle of "the respectable minority" (Packman, Cabot, & Bongar, 1994), where a minority view from respected professionals is a legitimate and successful defense in malpractice liability.

Type III crossings involve situations where scientific or clinical knowledge is lacking. Without further research, boundary dilemmas remain ambiguous and require meticulous decision-making in each situation. Values and attitudes that recognize the inherent ambiguity and uncertainty of psychotherapy practice create opportunities for ultimate benefits in the relationship and in treatment. These values include professional humility, disclosure and open discussion about uncertainty and biases, willingness to be flexible and innovative, and always encouraging and listening to the patient's perspective when faced with boundary dilemmas.

Type IV Boundary Crossings

Type IV crossings involve low to no risk of harm and middle to high opportunity for benefit to the patient and the relationship. Thus, the assessment of benefit determines not only whether the professional crosses boundaries, but creates new obligations toward patients. Where potential for benefit is high, the professional must ask whether he or she has some new and positive obligation to the patient. These crossings are not only justified and encouraged, but in some cases, may be obligated.

Some Type IV crossings also involve professional behavior that is beyond the call of duty. The tradition in certain professions, such as firefighters and police work, where self-effacement is obligatory, can help us understand these boundary dilemmas. Sliding fees with some patients, bartering in certain situations, and making a home visit, might be included. Innocuous activities such as making a cup of tea for a patient, or revealing certain types of personal information, are included. These can have a positive impact on the relationship because they cultivate humane elements in psychotherapy. Often, these reflect the style and temperament of the therapist. The benefit may be considerable, even immeasurable. There are no coercive or exploitative elements, and the professional who is sensitive to these activities often is aspiring to and modeling ideals of the profession.

BENEFITS AND LIMITS OF A GRADED-RISK MODEL

Problems with the graded-risk approach include the following. First, and most worrisome, it might add ambiguity to an area of professional-patient behavior that needs more clarity. However, to grapple with boundary dilemmas means assessing ethical, not just clinical problems. As with most ethical dilemmas, the problem in the boundary debate is not a conflict about principles, but a conflict over how to weigh conflicting values and beliefs on each side of shared principles. For example, in a former debate about the treatment of AIDS patients, principles of concern for patients, physicians' obligations to take certain risks, and nonabandonment of patients were weighed against principles of the physician's obligations to family and other patients, and the physician's right to choose whom to treat (Emanuel, 1988). Those on either side did not deny the validity of these principles, but disagreed over their relative weighing in the specific situation of an AIDS crisis.

While ambiguity is not reduced in each case, this model for boundary dilemmas allows closer scrutiny of the six essential ethical principles and values that influence boundary decisions, and offers a systematized ethical evaluation of these situations after they have occurred.

The model might be used to justify professional misconduct in cases where professional intentions and motives are difficult to ascertain. For professionals who exploit their patients, the deflection from a rule-based approach allows more rationalization for inappropriate behavior. The current slippery slope approach does often consider professional intentions and motives in order to discriminate "ethical" from "unethical" boundary crossings. In the graded-risk approach, however analysis of professional intentions and motives is formalized and weighed in relation to the other five variables for consistency. The assessment of harm, benefit, degree of coercion, professional ideals, and context inform the validity of the professional's claim. Thus, the claim that a professional "intended to do no harm" must stand the test of the other elements. This supports professional responsibility that is reflective and individualized, yet holds professionals accountable to a comprehensive process of decision making. Such an approach is respectful of individual variation in the weighing and interpretation of the moral realm.

Another potential criticism of this model involves the failure of its categories to be more predictive of outcome. What is the value of a model that allows changes in the categories of boundary crossings when we move from a prospective to a retrospective evaluation of a particular instance? This approach demands that we struggle with the particulars of cases. In surgical practice, mortality and morbidity conferences joined to postmortems are designed to reassess the prospective view of risks to a procedure, reassess the patient's preoperative capacity to tolerate those risks, and review the surgeon's preparation and understanding before and after the procedure. The graded-risk model poses the dilemma that our prospective judgment and our retrospective judgment will vary in certain cases. Those who use this model for retrospective judgments and evaluations must keep this in mind. The graded-risk model is not a tool to determine culpability, but can be used to discuss and learn more about boundary crossings.

What does the graded-risk model add to the slippery slope approach? It supports broader obligations to patients and encourages professionals to consider "unique" rather than "special" patients. Therapeutic strategies anchored in the concept of the patient as a "person who is suffering," rather than in the treatment of diseases, are promoted. Aspiring to professional ideals nurtures humanistic patient care. Rule-based decision making, unfortunately, leaves many professionals focused on what is the minimum of effort rather than exploring innovative ways of helping patients. The intersubjective nature of decisions in the moral realm of the patient-professional encounter is acknowledged, and the hidden paternalism in psychotherapy is discouraged.

Informed consent and disclosure of conflicts of interest are conceptualized more dynamically. The clinician's personal morality can be made explicit in the psychotherapeutic encounter. Positive and constructive developments in the patient-professional relationship are encouraged. Clinical decisions in health care, psychiatry, and psychotherapy, education and training, and research in the area of boundary dilemmas can be enhanced by this graded-risk model. Lastly, professional societies, state medical and grievance boards, and educators can use this model for evaluation and judgments pertaining to boundary crossings.

NOTES

[1]Throughout this paper, I will use the terms "professional," "therapist," and "patient" consistent with my medical background. I intend to be inclusive of the term "client" when referring to "patient," and intend for the labels "professional" and "therapist" to include all professionals who practice psychotherapy. Also, some of the concepts and arguments in this paper are intended to inform physicians other than psychiatrists and other professionals involved in practices that resemble psychotherapy.

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