

# Boundary Violations and Departments of Psychiatry

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**Objective:** To explore a number of issues related to boundary violations in psychiatry, including the relationship between the individual physician and his or her patient and broader issues related to various dilemmas arising in academic departments of psychiatry.

**Method:** Several potentially troublesome scenarios are presented and discussed in the contexts of 1) the doctor–patient relationship, 2) sexual boundary violations, and 3) nonsexual forms of exploitation, such as finances, confidentiality, dual relationships, and relationships with industry.

**Conclusions:** A number of examples of boundary problems involving psychiatrists have been explored, and although some of these behaviours are clearly forbidden and harmful, others are less clear and require careful consideration if the profession is to arrive at a thoughtful consensus.

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**Key Words:** boundary violations, doctor–patient relationship, academic departments

In this paper, we explore the effect of a variety of boundary transgressions not only on the individual treatment relationship but also on the profession and on academic departments of psychiatry. Strictly speaking, such boundary transgressions most frequently relate to a particular practitioner, but their occurrences and especially the manner in which they are addressed may have a great impact on the whole of psychiatry. Addressing the issue of boundary transgressions may be a special responsibility for academic departments of psychiatry, which are entrusted with shaping the development of knowledge, attitudes, and skills of the next generation of practitioners.

Though we begin this discussion with a consideration of sexual contacts, which represent the most extreme and publicly noted form of boundary violation, a wide range of other physician behaviours will also be considered.

A significant factor in the occurrence of boundary violations is the view that one is “above the rules” and therefore has special entitlements to broaden the parameters of

physician privilege and professional conduct. In departments where these behaviours are not properly confronted, an ethic evolves whereby morality is seen to exist on a variably applied scale. A special burden of vigilance falls on academic settings, where failure to prevent or respond to violations increases the likelihood of such behaviours and fosters their generalization by means of a modelling phenomenon. Acknowledgement of, respect for, and management of boundary issues serve as a model for students, who typically shape their identities and patterns of practice around the attributes of admired teachers and supervisors.

Our goal in this communication is not to define absolute rules but rather to draw attention to some larger issues with respect to professional boundaries and to use the opinions expressed here to provoke more general discussion so that the profession as a whole may develop a consensus regarding these parameters of professional conduct.

## The Doctor–Patient Relationship

The concept of boundaries in psychiatric practice is rooted in the nature of the relationship between physician and patient. Gabbard and Nadelson (1) have recently defined boundaries as the parameters that “describe the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service.” This contractual agreement contains for physicians an ethic of care and a tradition of comfort and healing that cannot be attained without the

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provision of a secure framework that delineates the purpose and meaning of the relationship and a set of expectations necessary for comprehending the experience. The parameters of the doctor–patient relationship are at the core of the capacity to treat. Physicians are taught early in clinical training to provide care only according to the patient’s needs, not their own; to avoid harm to the patient; to respect the individual; to avoid exploiting the dependency of the patient on the physician; and to maintain privacy and truthfulness. Trust, integrity, and a commitment to the patient’s well-being are essential to the provision of safety in the therapeutic environment.

Most problems with boundaries derive from difficulties in one or more of these areas. Many physicians who ultimately experience serious difficulties in boundaries with patients are unaware of the early subtle signs that problems are developing. In this regard, Gutheil and Gabbard (2) have described the “slippery slope” (a progressive series of nonsexual boundary violations) that can affect well-meaning but inattentive clinicians. They stress that many boundary crossings may not always constitute malpractice or misconduct; rather they reflect poor training, lapses in judgement, or variations in cultural conditioning. They note, however, that gross examples of misconduct most frequently evolve from relatively minor boundary violations. In response to both the empirical evidence that a specific pattern of boundary violations precedes sexual misconduct and the need to educate clinicians regarding this tendency, Epstein and Simon (3) developed an Exploitation Index. This scale evaluates the feelings, attitudes, and behaviours of therapists in the maintenance of the therapeutic framework, as well as the level of risk for boundary problems. This index appears useful as an educational and research tool.

In our experience, the “slippery slope” phenomenon is open to further investigation and interpretation and, in some cases, is perhaps better understood as the “test the waters” phenomenon. In this model, minor transgressions are an early indication not of inadequate education or inattention but of an underlying willingness on the physician’s part to transgress the boundaries; this willingness begins in a tentative fashion, “testing the waters,” before moving on to more serious violations. The importance of this distinction is that the problem may not be simply one of inattentiveness or poor education but rather the breakthrough of impulses rooted in characterological deficits that may be broadly termed narcissistic, in which therapists perceive themselves to be special, beyond the rules, and justified in whatever actions they take. Such a formulation may be particularly applicable to therapists who are repeat offenders.

In evaluating such patterns and risks, we must also consider the particular exigencies of a psychotherapeutic practice. Therapists with poor impulse control, exaggerated views of their own specialness, great needs for affirmation, or unacknowledged longings for care, nurturance, and a sense

of completion to mitigate an underlying sense of aloneness may be particularly susceptible to the intimate enticements of the psychotherapeutic encounter. Working in relative isolation and with few external safeguards, a frankly psychopathic therapist has every opportunity to exploit the intensity and dependency of the transference-based relationship for his or her own emotional and sexual gratification. For patients, the power differential, the disturbances that brought them to therapy, and the inevitable emergence of historically based, infantile feelings in the transference create the context in which boundary violations may readily occur. Not infrequently, highly sensitive patients, attuned to the therapist’s needs and wishes, including wishes for self-repair through merger with an idealized (patient) object, become entrapped by an unconscious reenactment of a role-reversal in which they become the caretaker of the exploitive therapist. Whatever psychodynamics are motivating the patient, however, boundary transgressions are not the responsibility of the patient. Rather, they are fully the responsibility of the therapist, who has failed to work earnestly and consistently in the interest of the patient’s therapeutic needs, permitting self-interest, ignorance, or personal need to supervene.

### Sexual Boundary Violations

The recent professional and public awareness of the frequency of sexual misconduct in psychotherapy has fuelled the wish to understand the origin and maintenance of these behaviours. Surveys in America have revealed that between 6% and 10% of psychiatrists have engaged in erotic activity with their patients (4,5). Canadian investigations have found similar rates of these behaviours; 8% of male physicians acknowledged sexual contact in a study conducted by the College of Physicians and Surgeons of British Columbia (6). Most cases involve a male therapist and a female patient, while approximately 20% of cases involve a same-sex dyad, and in 20% of cases the therapists are female (7).

When these violations occur, there is immense difficulty if the behaviours are ignored by the profession or a department of psychiatry. Even if they are hushed up, knowledge of their occurrence spreads. Students become acutely aware of the double standard, and teaching about the doctor–patient relationship and the covenant of care becomes impossible. Since the essence of modern psychotherapy is based on the integrity of the therapeutic relationship, the teaching of psychotherapy in a department that has not addressed the instances of sexual boundary problems becomes inauthentic and “hollow” (that is, do as I say, not as I do). Thus the capacity of even otherwise admirable supervisors to provide effective role models for trainees may be nullified by their collusion and avoidance in addressing boundary violations. This position may leave students confused and disillusioned or with a conscious or unconscious sense of permission regarding violations with their own patients.

Many issues that relate to sexual boundary violations are clear-cut and require consideration only for emphasis and education; however, several aspects still require more detailed debate within the profession. Posttermination involvement has already received a great deal of attention, but there has been no clear definition of guidelines by the profession. Some have emphasized the duration from last involvement, with one year being a typical timeframe (8). The American Medical Association Council on Ethical and Judicial Affairs (9) has stated that individualized case review is necessary to detect whether exploitation of a still emotionally dependent patient is involved. Often what is thought to be important in this type of assessment is the notion of duration of contact and duration since treatment.

From our point of view, it is very difficult to support any particular time after which it becomes ethically permissible to become romantically involved with an ex-patient. Rather, 2 other issues are paramount: 1) whether a doctor-patient relationship that places the patient in a vulnerable position ever evolved and, 2) whether there is a capacity for mutual consent. These issues are removed from time elements and are much more related to concepts of transference and its effects on idealization, identification, and dependence. All therapeutic encounters are evocative of transference feelings, and even in psychoanalysis, the transference neurosis is thought to be never fully resolved. An ongoing intrapsychic representation of the therapist is in fact considered to be an essential component in the consolidation of the gains of the psychotherapeutic treatment. In addition, the transference belongs to the realm of unconscious processes and is therefore governed by the rules of timelessness and existential longing. It is thus illogical to presume that there is ever a time frame within which mutual consent would be possible once a doctor-patient relationship is established. Romantic involvement would always imply a breach of trust.

A further troublesome issue in this debate is the recent Canadian requirement to report one's colleagues to the licencing body when one directly learns of their sexual involvement with patients. While the obligation to report has the desirable effect of emphasizing the serious nature of such behaviours and possibly identifying offenders, it has the potential for deleterious effects. Typically, patients involved in exploitive relationships have profoundly ambivalent feelings about the abusing therapist and may thus be inhibited about revealing the true nature of the previous relationship for fear of causing harm and shamefully exposing themselves. In addition, some patients may experience a threat to their autonomy and involvement in purposes beyond their own best interests, both of which connect thematically with the dynamics of the previous abuse. Mandatory reporting may also provide a forum for accumulating rumour and speculation, convicting some people without a just opportunity for investigation and response. The profession would benefit if the governing bodies that introduced "mandatory reporting" provided

follow-up data on the benefits and problems of this approach as soon as they have accumulated data from several years of experience with it.

Why did the profession not act quickly to expose the small group of errant practitioners in the past? Penfold (10) has postulated a "conspiracy of silence" stemming from a complex of professional and psychological issues. Professionals have often banded together to support each other, and the conspiracy of silence may be an extreme example of this phenomenon. Professionals may dismiss even repeated reports of sexual involvements by labelling them unfounded rumours or gossip or by using the rationalization of protecting patients' or colleagues' confidences. At times, when senior clinicians have been involved, people have been particularly reluctant to act because of past loyalties. A previous analytic, supervisory, or collaborative relationship may create anxiety, confusion, and a sense of disbelief in response to knowledge of boundary violations. Sometimes the offending physician may behave coercively and force colleagues into an ambivalent collusion in which no attempt is made to clarify or objectify the behaviour. It is not uncommon in these instances to hear colleagues say that the possibility of this behaviour must be weighed against the large amount of good the practitioner has done over the course of his career, as though this can somehow obviate the seriousness of the transgressions.

Compounding these problems is the fact that many in our field have generally not believed patients' accounts of erotic activity and have discounted them as evidence of the patient's psychopathology or difficulties in the management of the transference, as occasionally they may well be. It should be noted, however, that Stone (11) reported that none of the women who had consulted him regarding erotic involvement with a therapist had been found to be fabricating, and he described the preoccupation with false allegations as "the profession's own wish-fulfilling fantasy." Similarly, early formulations that defined sexual relationships as acceptable if the patient initiated the activity or gave consent and those which proposed that abusing therapists had fallen prey to seductive borderline patients who provoked sexual acting out have been refuted by data which show that no patient characteristic predicts sexual involvement with a therapist (7). Despite the large body of literature documenting the enormous harm to patients erotically involved with a therapist (12,13), a few practitioners may still rely on the emphasis of experiential techniques to support a view that erotic contact may be helpful to specific individuals, proposing a benefit to self-esteem or a corrective emotional experience. This rationalization is striking, given the common situation of an older male therapist and a young, physically attractive female patient.

Most patients who have suffered sexually exploitive therapeutic relationships are very hesitant to come forward and complain because of the devastation they have experienced and the dynamic forces of guilt, self-doubt, ambivalence, and impaired ability to trust. Victims are also inhibited by realistic

fears of exposure and the possibility of further abuse and humiliation during the investigation and legal proceedings. Such experiences have been all too common, especially before the widespread public and professional concern about sexual boundary violations and the development of comprehensive guidelines for physician behaviour and the investigation of complaints. There are reports in the literature of disastrous multiple agency abuse occurring as various authorities failed to act in the patients' interests (14). The reluctance of patients to lodge formal complaints has been used by some psychiatrists to remove themselves from a professional obligation, the logic being that if there were truth to the rumours and the stories being told to new therapists, then the patients would have filed the complaints themselves.

Any of the mythologies giving licence to sexual boundary violations may be retained by silent agreement among members of professional groups or a department of psychiatry in a collusion intended to minimize or trivialize the issues and therefore protect colleagues and, in particular, preserve a needed sense of group integrity and professionalism. Another factor that may contribute to the problem is that many feel their primary, almost exclusive, duty is to their individual patients, and they rely on their own integrity in therapeutic relationships to support a sense of professional ethic insulated from the concerns of the larger health system. Psychiatrists often struggle with the very important ethical issue of their duty to the patient versus their duty to society and the larger health system. To some extent, the psychiatrist operates at the interface of these 2 responsibilities. Whatever answers are found, these serious issues will be dealt with more effectively if the profession expresses its collective concern and shares the responsibilities.

### **Nonsexual Forms of Exploitation**

Most commonly, boundary violations involve the psychiatrist at some level other than overt sexual involvement. Several authors have described categories of nonsexual exploitation including power seeking, self-gratification, overinvolvement, greediness, excessive self-disclosure, and dual relationships (1,2,15), all of which may have particular relevance for departments of psychiatry.

#### *Finances*

Boundary violations involving finances usually occur in the form of compensation beyond the payment of a fee for service. The ethical principle of beneficence informs the nature of the fiduciary doctor-patient relationship. The physician must be prepared to place the patient's interests above his or her own and, in exchange, to receive an appropriate form of compensation. A variety of problems can arise. For example, patients may be asked to pay a fee beyond the rate reimbursed by third-party payers. Such a fee may or may not be appropriate, depending on when it is negotiated and how it is described. At times, the issue of an additional fee for

uninsured services may be presented in a way that the patient does not readily understand, which is therefore coercive. One patient in this situation was required to pay a fee for "countertransference analysis," although such a billing was not defined or permitted by the governing body and was not understood by the patient at a time when he was very depressed. He felt that he could not refuse the fee and must continue with his much-needed treatment. Themes of greed, entitlement, and grandiosity (being above the rules) may be communicated to residents in a training program as they become aware of supervisors' billing practices, especially around patients seen by trainees. Boasting, or even subtle intimations about billing practices, may convey harmful messages to residents regarding money and power.

A special example of such a difficulty may involve payment for psychoanalysis. Candidate analysts may be required to pay significant fees beyond the normal reimbursement rate. Since their compliance is necessary if they are also to become analysts, they may accede in such a circumstance even if additional fees are not permitted by the governing body. While this may strike some as a less than critical issue in psychiatry, it is of some importance if a significant number of psychoanalyses have as their initial basis a form of intellectual dishonesty that involves collusion between analyst and analysand. What message does this give to those clinicians who will later practise psychoanalysis and dynamically oriented psychotherapy and supervise students in these techniques?

Often, extra payments are initiated by grateful patients. This may have a number of meanings in therapy, but frequently implies a form of unconscious control that can impede the autonomy of the psychiatrist in making clinical decisions. Psychiatrists may be offered gifts of money or travel, or they may be asked to join the boards of companies controlled by patients. Patients with experience in the financial world may reveal information that confers a financial advantage or offer to invest the therapist's money with a promise of rich returns. Psychiatrists may be asked to consult to a patient's business enterprise. In each of these instances, the significant boundary crossings may impede the therapeutic relationship between doctor and patient as the physician loses a sense of independence, objective distance, and ability to provide counsel. Some colleagues will assert that they have the capacity to be involved at several levels without compromising clinical judgement or care. It is not clear, however, when these are rationalizations to justify lucrative contracts and mutually gratifying special relationships. As in the debate regarding posttermination romantic relationships, some practitioners believe that other business and personal connections are justifiable after certain intervals (for example, one or 2 years) following termination. It seems probable, however, that unless the therapist can relinquish the possibility of ever obtaining anything from the patient beyond the direct compensation for therapy, the possibility of future gratification

may distort the process of therapy. We have little systematic knowledge of the impact of a subsequent personal or business relationship on the feelings stimulated by therapy, and in particular, whether such involvement might refuel infantile feelings and conflicts otherwise previously resolved. One would be concerned that patients, as in cases of sexual liaisons, might initially feel positively supported and then disillusioned if they sense that the therapist has forfeited his or her capacity to provide further treatment in order to satisfy his or her personal interests.

Multiple roles inevitably lead to overinvolvement, increased self-disclosure, and personal enhancement beyond that which is implied in the therapeutic contract. Self-disclosure and multiple involvements, although initially satisfying, may become burdensome to patients. A psychiatrist's need to maintain a sense of special connection greatly interferes with the process of limit setting and confrontation of difficult issues such as hostility, envy, entitlement, or self-destructiveness. Seeking admiration and gratification from relationships with accomplished, influential, or financially successful patients may be an attempt by the psychiatrist to increase personal or departmental prestige, but departments that condone the personal acceptance of large gifts and business opportunities by their members run the risk of ultimately discrediting themselves in the larger business and professional community.

A related area involves the acceptance of funds from patients for research. Clearly, psychiatric patients may be strongly motivated to see that research is conducted, as are people in all fields of medicine. The complexities of the transference-based feelings that evolve in therapy and the vulnerabilities of some patients may make it very difficult for individuals to refuse direct requests from their psychiatrists, and thus they may feel coerced into contributing. For this reason, we consider it to be unwise for the clinician to invite patients directly to donate money for research. Such a process would also open the therapeutic relationship to countertransference distortions based on the therapist's appreciation of the patient's financial and social status and judgement of ability or obligation to contribute. On occasion, wealthy philanthropic patients may make spontaneous offers of support for research or academic programs known to be important to the clinician or department. Such offers are incredibly seductive, but direct acceptance or negotiation by the therapist opens the relationship to all the hazards described for business and financial transactions and diminishes the opportunity to explore the patient's unconscious wishes and needs.

A department of psychiatry may take several steps to ensure the provision of a consistent and ethical boundary with respect to patient donation for research or academic endeavours. Awareness that contributions are being received by the hospital or program should be made by means of signs or brochures. Requests for information and all funds received should be handled by an independent body, such as a founda-

tion or the board of a research fund. These administrative bodies should then be responsible for the allocation of the funds according to terms agreed upon by all concerned. While the donor should have an important voice in how the monies are to be used, this should not compromise the university's stated principles, which are clearly described in writing and are an integral part of the negotiating process. With such an arm's length relationship in place, no patient should feel coerced or in danger of forfeiting care if he or she does not contribute to the department, and no physician should feel a loss of autonomy in receiving such funds.

### *Confidentiality*

There can be many other circumstances in which patients are used for the gratification of the therapist. The issue of confidentiality has particular relevance for psychiatric departments, whereas the use of clinical material is integral to resident education, academic case conferences, and scholarly publications. Discussing patients usually occurs with the best of intent—to learn from one another and to improve standards of care. At times, however, identification of patients to others, especially revelation of sensational material or evidence of the patient's importance, may serve as a form of self-aggrandizement. This lack of respect for patient privilege and display of personal power are of greatest concern when they reflect a persistent pattern of grandiosity. Concerns have been expressed recently about inappropriate communications in general medical settings and their effect on patient care (16).

In psychiatric settings, there may be an accentuated desire to review clinical issues with one's colleagues because of the relative isolation of the work. It is important that the openness of communication in departments or other collegial groups not become an opportunity for the careless disclosure of information that may identify a patient or for the exhibitionistic self-enhancement of the therapist. All members of such groups have a responsibility to maintain appropriate standards regarding communication and to confront lapses that may be harmful to patients.

Another facet of the self-aggrandizing phenomenon occurs when a therapist unduly prolongs the therapy of a particular patient because of the perceived emotional or financial value of the patient to the therapist. This exploitation involves betrayal of the trust that the psychiatrist will act in the patient's best interests. Frequently, these individuals are known to others through their social status or achievement, and it may be around these cases that the self-gratifying therapist is most prone to break the boundary of confidentiality. This is an area, like others described in this paper, in which consultation with colleagues may be especially beneficial.

### *Dual Relationships: The Special Patient*

We have all been asked to treat certain patients who, for various reasons, may be considered special by virtue of another coexisting aspect to the relationship. This may occur through family ties, close working relationships, or intimate

friendships. A common situation is the referral of medical colleagues with whom one has an ongoing professional relationship. Friends, relatives, and associates of such individuals may also be problematic, depending on the context and quality of the various connections. Other examples of conflicted interests include senior government officials and administrators of the health care system. When dual relationships exist, it may not be possible for the clinician to maintain essential distance and objectivity in clinical judgement. It is natural in departments of psychiatry or other professional groups for clinicians to request that their known and respected colleagues treat loved ones or highly valued associates and, similarly, that colleagues wish to oblige out of a sense of professional courtesy and concern. Care must be taken, however, to ensure that the coexisting relationships do not exclude the possibility of an uncontaminated doctor-patient relationship. In addition, there is evidence that therapists who repeatedly involve themselves in dual relationships and do not respect the boundaries of family members and social acquaintances are gratified by a sense of power and control over patients (3).

Ideally, patients should be referred to clinicians with whom no possibility of a dual relationship exists. Obviously, there can be no absolute rules regarding this, and there will be circumstances in which the nature of the illness, the availability of other competent practitioners, and the capability of the clinician to provide independent advice, unimpaired by the other dimensions of the relationship, will dictate the course of action. Optimum care will be provided when thorough consideration is given to these issues and there is a conscious effort to minimize the potential for loss of objectivity.

#### *Relationships with Industry*

Although this issue is in some ways peripheral to the maintenance of boundaries between doctor and patient, we view the relationship between the pharmaceutical industry and individual physicians or departments of psychiatry as having many of the same dynamics. In this instance there are 3 interfaces that resonate with one another: 1) the direct boundary between physician and patient, 2) the direct boundary between physician and industrial donor, and 3) the indirect boundary between industry and patient. Industry donors are in a special position both to foster academic work and to determine what work is conducted. As well, relationships with industry have a major influence on the physician's decision making with individual patients.

Physicians are often unaware of the impact that these involvements have on their behaviour. Woollard (17) recently stated this premise well: "There are few beliefs in current medical practice that are held with greater passion than physicians' confidence in their ability to resist the influence of the pharmaceutical industry on their professional behaviour." Hodges (18) has recently surveyed the attitudes and activities of postgraduate students at the University of Toronto. He

found that house staff generally reported that they would not maintain the same level of contact with pharmaceutical representatives if they did not receive promotional gifts. At the same time, the more money and promotional perks a physician received, the more likely he or she was to rationalize that discussions with drug representatives did not affect prescribing. One-third of the group believed that discussions with representatives would have no impact on their prescribing practices, while one-half felt that receiving gifts would not influence treatment decisions. By contrast, there is significant evidence that pharmaceutical companies' funding of continuing medical education "all expenses paid trips" to meetings and drug-detailing seminars have significant impact on the prescribing patterns of physicians (19-21). As a result, many guidelines have been developed; these generally emphasize that only gifts of "no substantial value" be accepted. But Waud (22) has presented a more rigorous standard: "Can any physician really believe that patients would be happy to know that their doctors were taking bribes, no matter what size?"

Naturally, the principle duties of the pharmaceutical industry are to their shareholders, maximizing shareholder profit. This may or may not coincide with the scholarly goals of an academic physician or group. Here, we feel there is an evolution of opinion that is appropriately demanding more clarity around the boundaries and interactions between academic groups. While we are not advocating the total separation of the academic community from industry, as was recently encouraged by Gyatt (23), we are recommending that a more careful examination of this complicated relationship be undertaken.

We believe that gifts should not be accepted and that "educational" funds for travel are not appropriate (for example, travel to a conference at which the physician is not a speaker). Funds provided to speakers should be acknowledged in some fashion, so that people know that industry has contributed in order to make any possible conflict or bias readily apparent, and the content of the talk should in no way be influenced by the source of funds (recognizing that this includes other sources of funds as well, such as those from government, which can also present potential for bias). Research funds from industry can be accepted when there is a clear acknowledgement of the relationship in all communications derived from the work. Increasingly, we believe that academic physicians should participate in such research when they maintain the rights to define how the study will be conducted and communicated. It is hard to understand why scholars would become involved in research that is not within their control, especially with regard to the use and publication of the data.

When industry funds are received, care must be taken to ensure that proper accounts of how such funds have been spent are kept and made available to both the donor and the institution. Educational programs may receive industry support, but the agenda should be set by the academic group.

## Conclusions

In this communication, we have given a number of examples of boundary problems involving psychiatrists. In no way should these be considered a complete list; rather, we have selected more common problems that we have observed directly. Our purpose in this communication has been to stimulate a broad and open debate about these issues. Although some behaviours are clearly forbidden and harmful, other boundary issues (industry funding, for example) require careful consideration if the profession is to arrive at a thoughtful consensus. We have included these in a single discussion because they relate to the special role of the doctor in providing care. Especially important is that these issues be examined and addressed publicly when they occur. Future practitioners and the public are greatly influenced by the psychiatric profession's seeming embarrassment and perplexity or, at times, lack of willingness to confront such problems directly. Each of us has a bias in this type of debate; it is important for us to declare our conflicts and biases openly and then work toward a common position that will benefit both our patients and the profession.

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## Résumé

**Objectif :** Étudier un certain nombre de questions liées à la transgression des interdits en psychiatrie, y compris la relation entre le médecin et son patient ou sa patiente et des questions plus vastes liées à divers dilemmes qui surviennent dans les départements universitaires de psychiatrie.

**Méthode :** Plusieurs scénarios risquant de se dégrader sont présentés et débattus dans les contextes suivants : 1) relation médecin-patient, 2) transgression d'interdits sexuels et 3) types d'exploitation non sexuelle, comme les finances, la confidentialité, les relations duelles et les relations avec l'industrie.

**Conclusions :** On a étudié un certain nombre d'exemples de problèmes concernant les interdits et, même si certains de ces comportements sont à l'évidence prohibés et nocifs, d'autres sont moins tranchés et il faut les examiner de près pour former un consensus professionnel à la suite d'une mûre réflexion.