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A Proposed Approach to Allegations of Sexual Boundary Violation in Health Care

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Background: Sexual boundary violations in the health care setting cause harm for victims, threaten an organization's culture, and create extraordinary organizational risk. The inherent complexities of health care organizations present unique challenges for the initial triage and response to reports of alleged violations.

Methods: A group of experts with experience in law, leadership, human resources, medicine, and health care operations identified processes for organizations to triage and implement an early response to allegations of sexual boundary violations. The group reviewed a series of 100 reports of alleged violations described by patients and coworkers from a 200-hospital professional accountability collaborative to identify the elements of an ideal initial triage and management approach.

Results: The group identified three domains to guide early triage and response to reports of boundary violations: (1) severity and acuity of the alleged violation; (2) roles and relationship(s) of the complainant, respondent, and other affected individuals; and (3) contextual information such as prior activity or other mitigating factors. The group identified leadership engagement; coordinated responses; clear articulation of values, policies, and procedures; aligned data reporting; thoughtful reviews; and securing appropriate resources as essential elements of an organization's response.

Conclusion: A structured systematic approach to classify and respond to allegations of sexual boundary violation is described. The initial response should be guided by assessment of the severity and timing of the reported behavior, followed by assessment of roles and responsibilities with involvement of all relevant stakeholders. Contextual issues and special circumstances of relevance should be identified and incorporated into the response. Systems to identify, store, and retrieve behavior of concern should be improved and integrated.

Sexual boundary violations in the health care setting,[1,2] defined as exploitation by a professional of any aspect of a person's sexuality for personal gain, cause tremendous harm for victims,[3–6] threaten an organization's culture of safety and respect,[7] and create extraordinary financial and reputational risk for organizations.[8–13] Concerns from patients and family members, coworkers, or trainees captured through reports or other mechanisms are often the first signal an organization receives about a potential sexual boundary violation.[3–6,14–16] Organizational responses often vary according to the route and manner in which a report brings awareness of a potential boundary violation to responsible organizational parties,[17] and some leaders may not know to collaborate with appropriate experts on an initial response and approach.[7,18] The resulting silos and inconsistent responses can implicitly endorse behaviors and allow behaviors to continue unchecked, resulting in sustained and tragic harm to subsequent victims.[9–13]

Health care organizations must have reliable systems for individuals to report concerns about potential sexual boundary violations that encourage reporting supported by a sense of physical and psychological safety, and a consistent and reliable process for triaging, reviewing, and addressing reports. When concerns are reported, health systems need to have an immediate triage and management process that guides decisions of whether the report requires investigation, assessment of the relationship between the person making the report (complainant), the potential victim(s) (if the complainant is reporting on behalf of someone else) and the person whose conduct is being reported (respondent), and consideration of other contextual issues that might inform triage and response. Little is known, however, about specific strategies for the initial steps organizations should take in responding to reports of alleged sexual boundary violations or the essential organizational elements that best support a consistent and equitable process.

The goals of this study were to refine an existing coding convention developed for unprofessional behaviors[19,20] to specifically focus on identifying reports alleging sexual boundary violations and to identify supporting practices for a reliable process for appropriate triage and management of specific circumstances around allegations of sexual boundary violations in the health care setting informed by applicable laws, regulations, and policies.

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METHODS

Expert Review

A group of experts from health care organizations with experience in law, health system leadership, medicine, and human resources [W.O.C., J.J.F., G.B.H., A.J.R.F., K.R., S.S., J.C.M., I.D., J.A.] convened in a series of meetings to describe processes that should be in place to enable health care organizations to capture concerns and then to triage and implement a timely response to allegations of sexual boundary violations in the health care setting. The group first considered the existing literature related to identification, coding, and acute triage of alleged sexual boundary violations in the health care setting, including laws, regulations, and policies that guide a health care organization's response to such allegations. The group then identified elements that might be considered in triaging and guiding an early response. The group coalesced on the need for a standard approach to early assessment of the potential severity and acuity of the alleged behavior; understanding the roles and relationships of involved individuals as complainants, the respondent, witnesses, or others potentially affected; and assessing the context of the alleged event.

Creation of Classification Scheme

The expert group subsequently considered a series of cases derived from two national professional accountability programs coordinated by the Vanderbilt University Center for Patient and Professional Advocacy (CPPA). CPPA oversees a ~200 hospital network of health systems that send electronic reports of unsolicited patient complaints and safety event reports alleging unprofessional behavior directed toward coworkers as a part of the Patient Advocacy Reporting System (PARS) and the Coworker Observation Reporting System (CORS).[19,20] PARS and CORS use validated coding algorithms to identify and classify disrespectful and unprofessional behaviors, including allegations of sexual boundary violations.[21,22]

From 2017 to 2022, PARS and CORS processed ~358,000 patient complaints and coworker concerns. Among these reports, ~0.1% contained information suggesting a possible sexual boundary violation. The expert group reviewed a sample of 50 deidentified PARS and CORS reports that had been flagged by the coding algorithm as possible sexual boundary violations. During the first round of review, experts identified themes that described severity and acuity, the role of the complainant and respondent, and the potential context, then gathered to group themes around common elements. The group reviewed and refined the draft coding convention and characterization of cases using the initial group of 50 examples. Next, the expert group tested the classification scheme with a separate set of 50 PARS and CORS reports and refined categories and classification for the scheme described below.

Supporting Practices for Triage and Early Response

As a part of their deliberations, the expert group also reviewed practices for health care organizations in identifying, triaging, and implementing an early response to allegations of sexual boundary violations. The group reviewed current practices at various types of health care organizations, including consideration of applicable policies, laws, regulations, and practices. The group identified potential sources for variations and additional risks that might result from alternative approaches in creating the recommended flow to guide responses, by considering a variety of scenarios.

Human Subjects Considerations

The expert group reviewed deidentified reports that had been formatted in a way to prevent identification of individuals or organizations where the alleged events occurred. Individuals involved in the deidentification of reports for the study were not involved in the conduct of the research, signed and updated annually confidentiality agreements, and observed strict data security procedures. The Vanderbilt University Institutional Review Board reviewed the study procedures and determined that the study met 45 CFR 46.104(d) category (4ii) for Exempt Review.

RESULTS

Expert Review

The group reached consensus on three key domains to consider in triaging and planning an early response to allegations of sexual boundary violations occurring in the health care setting. The first domain addresses the severity and acuity of each alleged behavioral allegation. Severity ranges from inappropriate speech or gestures and sexual privacy violations through unwanted physical and/or sexual contact. The acuity considers whether the event is immediate, recent, or remote (ranging from weeks or months to years), which guides whether immediate action is needed for an imminent safety threat or a remote event that represents a potential serious threat to individuals or the organization. The second domain addresses the roles and relationship(s) of the complainant, respondent, and other affected individuals at the time of the alleged event. The roles and relationships domain considers whether the event occurs in an employment, patient care, or educational setting, and the role expectation for each of the involved individuals within the organization's settings. The roles and relationships domain is particularly important in understanding organizational obligations and coordinating the involvement of various stakeholders (for example, Title IX Officers, Medical Staff Officers, Faculty Affairs, law enforcement). The third domain considers contextual information, which guides interpretation of the alleged event and potential early response pathways. Examples of relevant context include whether

Table 1. Examples of Cases Used to Refine Classification Scheme for Allegations of Sexual Boundary Violations in the Health Care Setting

Complainant/Respondent	Relevant Text of Report	Complexities Illustrated by the Report
Patient/Clinician	*"He reached across me to look in my ear while pushing his genitals into my knees—pressed against me for 20–30 seconds."*	With no witnesses or other corroborating evidence, can be difficult to investigate.
Patient/Clinician	*"Dr. XXXX put his whole hand in my vagina and took his phone out, said he was using the light on his phone to see better."*	Could represent boundary violation, poor judgment, or lack of clear explanation.
Patient/Clinician	*". . . at the end of the exam he slid his hand up under my shorts and brushed my penis. I said 'that's my penis.' He didn't respond and quickly left the room."*	Unclear if inappropriate or misinterpretation of appropriate behavior in medical context.
Patient/Clinician	*". . . Dr. AAAA came in while I was asleep and touched my breast."*	Events are often reported to occur in the middle of the night or early morning, when few people may be around.
Patient/Clinician	*"My ankle area was sore . . . they thought I might have blood clots. Dr. DDDD massaged my leg from my ankle to my thigh."*	Unclear if inappropriate or misinterpretation of appropriate behavior in medical context.
Nurse/Clinician	*"The physician commented on another staff member, 'Boy does she have a pair on her.'"*	Comments about others that could make an individual feel uncomfortable.
Nurse/Clinician	*"On multiple occasions Dr. YYYY has given back rubs without my permission . . . making me uncomfortable."*	Unwanted touching that may or may not be of a sexual nature.
Nurse/Clinician	*"Dr. XXXX kept making jokes about how another employee and I were having sex. I asked Dr. XXXX to stop. They told me I needed to relax and kept joking about it."*	Comments of a sexual nature directed toward an individual that persist after being asked to stop.
Trainee/Clinician	*"We were at a bar celebrating the end of the rotation. My attending, Dr. ZZZZ, got really drunk and started telling me stuff about his divorce. I got a weird vibe."*	How to interpret contact in a nonprofessional setting that makes the trainee feel uncomfortable.
Trainee/Clinician	*"My attending said, 'There's something likeable about you. I think it's that piercing in your ear. It tells me you're into doing some weird things.'"*	Comments to a trainee that make the trainee feel uncomfortable.
Trainee/Clinician	*"Dr. Attending poked me in the middle of the chest right above my bra and said, 'Don't ever surprise me on rounds again.'"*	Contact in a sensitive area that may or may not be intentionally sexual.

quid pro quo is implied or explicitly stated and whether the event is a part of a previous pattern that might create a hostile work environment, including whether the respondent has been associated with prior complaints that may have been vague or unfounded but, in aggregate, suggest a potential pattern.

The expert group also identified several potential challenges that might arise in the triage and early response process for allegations of violation of sexual boundaries in health care organizations. A well-designed and sustainable triage and response plan should explicitly consider these challenges and tailor them to the specific health care environment. For example, several factors might lead to varied and siloed reporting, including fragmentation of reporting systems, lack of knowledge of required processes by local leaders, and minimization of some reports based on the complainant (for example, individuals with delirium, dementia, or behavioral health conditions) or the respondent (for example, a respected individual who "would never do something like that"). In particular, some academic health systems may have separate reporting and response systems for the clinical, teaching, and research enterprises. Siloed reporting increases the chance that the first leader who receives a report of alleged sexual boundary violation may respond in ways that do not fully account for prior reports and are inconsistent with the organization's desired approach, including the individual determining without further review that the allegation is unfounded and warrants no further action. Early responses may also be more likely to create challenges if the organization's leaders do not consider the full breadth of the report, the roles and relationships, and other contextual factors, including how previous reports, even vague allegations, might be instructive.

Classification Scheme

Following the two rounds of reviews, the group created a preliminary classification scheme for reports of alleged sexual boundary violations to guide triaging and early response. In some instances, the initial triage may lack a full set of information related to context, roles, relationships, and so forth. but the organization's response should follow an iterative approach, through which leaders can use additional information that emerges to subsequently adjust the response.

Final Classification Scheme

Severity/Acuity

- **Severity**
  - Inappropriate/unexpected speech, communication, or gesture
  - Flirtatious behavior or touching in front of others (who observe but are not involved in the activity)
  - Invasions of sexual privacy for a sexual purpose:
    - watching or enabling others to watch the complainant's nudity/sexual acts; or
    - making or attempting to make photographs (including videos) or audio recordings, or posting, transmitting, or distributing such recorded material, depicting the complainant's nudity/sexual acts
  - Inappropriate, unexpected, or unwanted physical contact
  - Inappropriate, unexpected contact with sensitive areas, face, neck, breasts, legs, genitals
  - Forced sexual activity
- **Acuity**
  - Recent event
  - Remote event
  - Chronic history of event(s)—including a range of unprofessional behaviors

Roles/Relationships (consider all that apply)

- **Employment context**
  - Supervisory relationship between complainant and respondent, or respondent has a leadership role
  - Bullying or assertions of physically being stronger
- **Patient care context**
  - Patient or patient caregiver, or occurs in care environment
  - Patients who may misinterpret a standard examination procedure
  - Patient as respondent
  - May require consideration of medical necessity and/or appropriateness of clinician actions
- **Educational context**
  - Educational supervisor
  - Trainee in any role
  - Active teaching/evaluating role
- **Other role and relationships issues**
  - Interactions that occur in a nonprofessional setting (for example, social setting or another context)
  - Events invoking multiple regulatory requirements that may require prioritization and collaboration (for example, criminal law, Title IX, medical staff processes)

Context

- **Relationship Elements**
  - Hierarchy implied or invoked or affects reporting or response
  - Quid pro quo assertions
  - Hostile environment
- **Prior History**
  - Respondent: Repeated events (consider all reporting sources). Consider how to address prior reports that may have been vague or unfounded after investigation but still may represent concerning prior behaviors. Evidence that the behavior was specifically driven by intended sexual gratification.
  - Complainant: Ensure that reports from patients with language or other information suggesting the patient has a behavioral health condition are addressed consistently and adequately.

Figure 1: This figure shows the final classification scheme for initial triage of reports alleging sexual boundary violation.

The expert group then tested the preliminary classification scheme with 50 additional cases to refine the three domains. Examples of cases are shown Table 1. Cases included a patient complaint in which the concern described a clear sexual boundary violation, as well as cases involving patient complaints in which it might be reasonable to consider that a medically necessary examination had simply been misunderstood by the patient. A third case type included coworker concerns about an obvious boundary violation, and a fourth type suggested a more subtle sexual boundary concern. The second set of cases informed creation of the final classification scheme, which included three elements: the severity and acuity of the alleged behavior; the role(s) of the complainant, respondent, and other parties; and contextual issues that might inform the triage and initial management (Figure 1).

The classification scheme also described some important factors that leaders should consider in its application (Figure 2). For example, reports from patients with delirium, dementia, or behavioral health conditions, or which contain language that suggests one of these conditions, could result in a leader diminishing the severity of the report or dismissing it altogether. All reports, including those that are vague or very brief (for example, "It just seemed kind of creepy" or "The doctor touched me") should receive full consideration, including the collection of any further relevant information, which may indicate the need for a formal investigation, specifically directed by law, regulation, or policy. Behavior suggestive of sexual boundary violation that occurs in settings outside of the institution (for example, a work-related social gathering at a bar or party, encounters between a clinician and a patient outside of work, interactions between a patient or a family member) should be considered in the appropriate context, particularly if prior vague reports suggest a concerning pattern of behavior when viewed in aggregate.

Supporting Practices

Following design, testing, and refinement of the classification scheme, the group identified a set of supporting practices for identifying concerns and having necessary infrastructure to guide triage and early response (Figure 3). The first supporting practice focuses on having the right leadership support and people to implement and sustain the organization's triage and early response. Key leaders need to be informed of the need and the intent to implement a unified approach, ensuring that all appropriate stakeholders are connected to guide a coordinated review and response process. Individuals appropriately placed in the organization to guide the work and ensure fidelity to the effort should be identified as champions to lead and sustain the effort.[23,24] Individuals should be identified from each stakeholder group to participate in aligning, implementing, and sustaining the process. Stakeholder groups could include

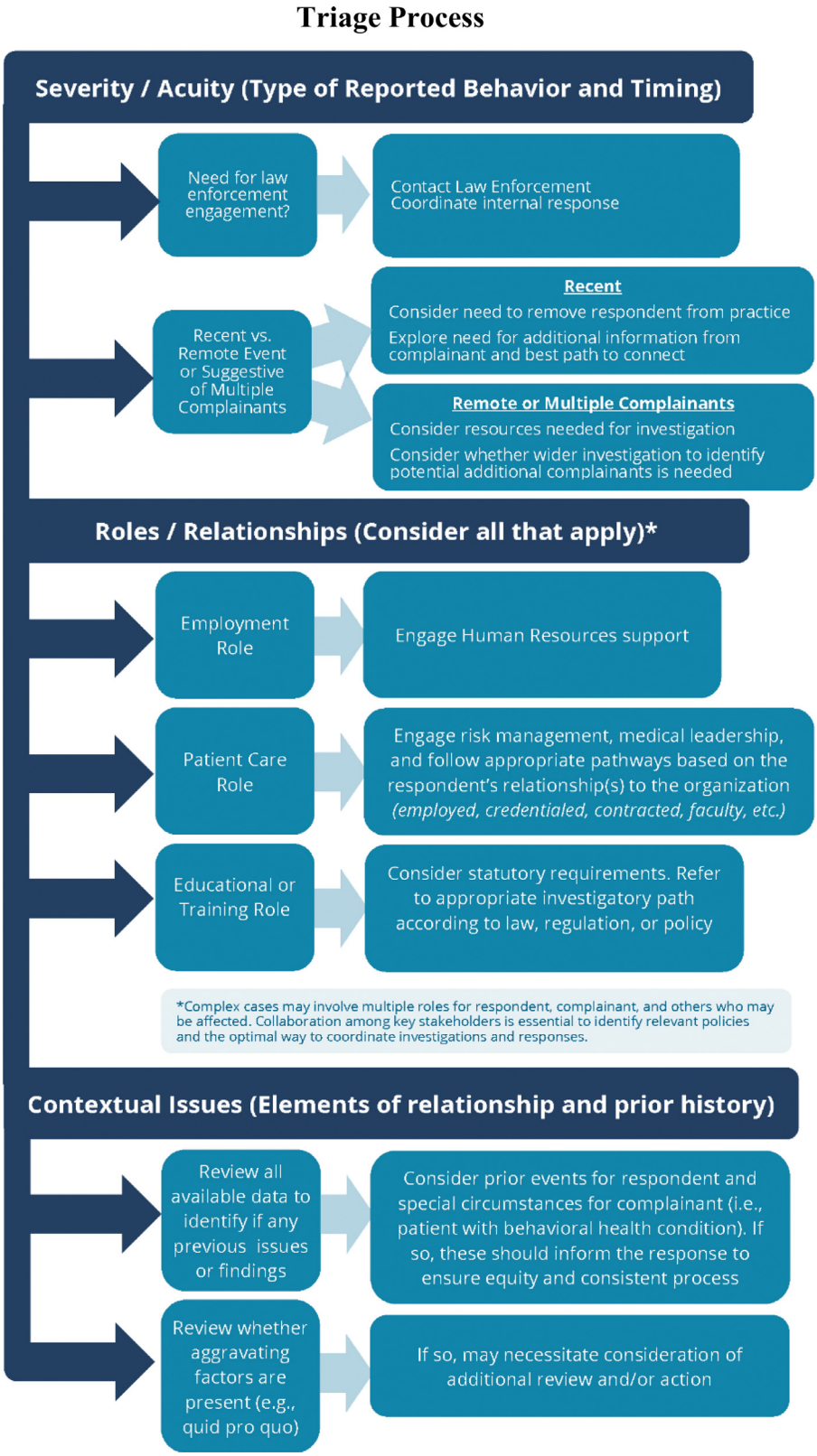


Figure 2: Shown here is the triage process for initial review and management of reports of sexual boundary violations in the health care setting.



Figure 3: This figure illustrates the supporting practices needed for sustainable processes for triaging/responding to reports alleging sexual boundary violations in the health care setting.
Source: Adapted from Hickson GB, et al. Balancing systems and individual accountability in a safety culture. In The Joint Commission: From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed. Oak Brook, IL: Joint Commission Resources, 2012, 1–35.

human resources; risk management; legal affairs; physician, nursing, and other staff leadership; hospital or health system leadership; trainee and student leadership; and security/police.

The organization should review and align the policies and procedures pertaining to interpersonal boundaries that apply to all persons who function in the health care environment (including patients). Policies and procedures should specifically address and include performance expectations for appropriate interpersonal sexual boundary interactions, including chaperone policies for sensitive history and physical examinations, as well as standards to guide the timing and procedural rules for investigation of complaints. Different subtypes of sexual boundary violations need to be considered in following policies and procedures. For example, boundary violations involving a student or trainee and faculty as respondent or complainant necessitate considering policies relevant to the student or trainee and the relevant policies for the faculty member (for example, faculty manual, academic institution policies, medical staff bylaws). Review processes should include appropriate key stakeholders to guide which policies and procedures need to be considered and the potential order in which issues need to be resolved. The steps to follow to report, and the implications of the findings, should be guided by the organization's values. Resources to address well-being concerns of individuals affected by the reported violation as well as resources to investigate and adjudicate potential cases should be identified and made readily available as needed.

Supporting practices include identifying all sources of stories and reports about potential sexual boundary violations and attempting to align them, including new mechanisms for sharing concerns that emerge as the organization evolves. Some sources of information about potential events requiring consideration may be quite informal (for example, a student confiding in another student), others may be reported through mechanisms that are siloed from one another. Another supporting practice includes a consistent and well-designed approach to triage and to ensure that all potential events are recorded in a central repository. Some organizations use a huddle, similar to an acute safety event huddle (Figure 4). Limiting the huddle to only those individuals who have a right or need to know about the event is one strategy to protect the privacy of complainant and respondent, while balancing the need for important perspectives from key stakeholders. Additional supporting practices include periodic review of aggregate data, including successes, and refinement of the process and ongoing training of leaders and the workforce on the process and outcomes.

The expert panel also identified guiding principles for the use of supporting practices. For example, the triage and response should consider and balance several factors, including safety for all individuals, the risk of recurrence during the triage and investigatory period, and the rights and responsibilities of the complainant, respondent, and others involved. A response that considers only the rights of the respondent (for example., "Dr. XX has been here for 30 years and would never do this") may fail to identify the substantial risk for the complainant and others if the allegation is indeed founded but left unaddressed. These types of responses may increase the risk for future and more severe behaviors, as the respondent could feel emboldened to continue to behave in inappropriate ways. It is also important to ensure that wellness resources are made available to the respondent, complainant, and other affected individuals at all stages of the process, regardless of the outcome of the investigation, including if the respondent is found to have been falsely accused.

Elements of a Huddle

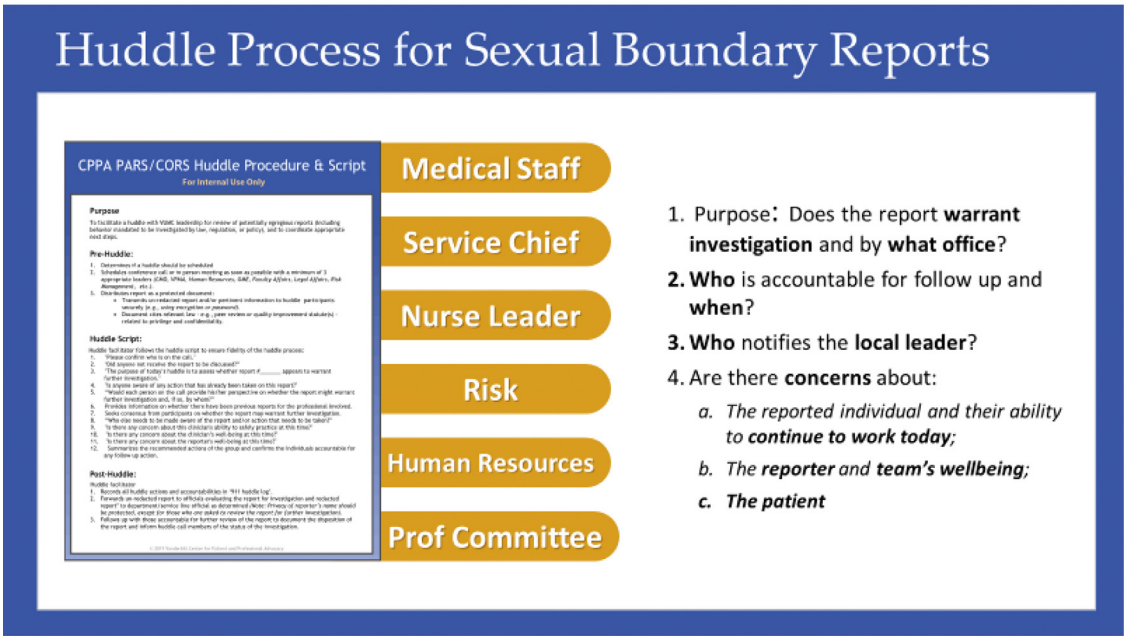


Figure 4: Shown here are elements of a huddle to coordinate the organization's response to reports alleging sexual boundary violations in the health care setting. CPPA, Center for Patient and Professional Advocacy; PARS/CORS, Patient Advocacy Reporting System / Coworker Observation Reporting System.

DISCUSSION

In this study, we were able to refine an existing coding algorithm for a broad range of unprofessional behaviors to support the initial triage and management of reports of alleged sexual boundary violations in the health care setting received from patients, family members, coworkers, and trainees. The triage and response process included assessment of the severity of the alleged behavior, the relationship(s) of individuals involved and/or affected, and other important contextual elements. The study then reviewed and considered best practices supporting a sustainable triage and initial management process.

Our consideration of the triage, management, and response to reports of sexual boundary violations within health care organizations and the identification of essential supporting elements was guided by the characteristics of several previous high-profile cases involving sexual abuse of patients and students that appeared to have several common elements.[8–13] One common element of prior cases included the lack of a systematic, centralized approach to handling all reports of sexual boundary violations with a consistent process. In several cases, local leaders had received reports but appeared to have decided that the reported behaviors were medically indicated or did not happen based solely on the institution's internal review. One essential element of an effective triage and management plan includes ensuring shared responsibility for considering whether reports warrant further investigation or action.[18] One factor contributing to the variability in response is the lack of definitional clarity on what constitutes a sexual boundary violation and various subcategories of violations.

The findings of this study also highlight the importance of workplace culture on prevention and management of sexual boundary violations.[7] Organizations should clearly articulate cultural values and expectations for respect and dignity, particularly in organizations where senior or high-profile individuals may receive preferential treatment when vague or unspecified sexual boundary behaviors are described.[7] Preferential treatment of these high-profile individuals gives implicit endorsement of continued and potentially escalating behaviors, and in some cases may facilitate continued violations with the same and subsequent victims. Similarly, local leaders might choose to minimize concerns that are shared with them for individuals on their team, resulting in variability in responses throughout the organization. Employing a huddle as described in this article or following a similar approach to the initial triage and response increases shared accountability throughout the organization to observe essential practices.

Lessons Learned

In designing and refining the triage and management process, we identified that interprofessional collaboration among key leaders is essential. Interprofessional collaboration among system leaders, physician leaders, nursing leaders, human resources leaders, legal and risk leaders, and other key stakeholders increases the chance that the group will recognize the nuance and complexity of each situation.

In addition, having an equitable process ensures that the rights of all parties, including the respondent, are carefully considered. Collaboration and trust among leaders promote trust in all team members that the organization is committed to supporting a safe and respectful place to work, train, and receive health care. Supporting a safe and equitable environment also increases the likelihood that individuals subjected to sexual boundary violations will share their concerns. In considering optimal supporting practices, the group identified that interdisciplinary conversations among individuals with varied expertise strengthens the skill set of all involved leaders.

The initial triage and management process described in this study can also be a key element of prevention. Other studies have shown that giving candid feedback about unprofessional behaviors prevents subsequent behaviors 80%–90% of the time,[19,20] and may reduce the chance that behaviors will escape detection or escalate to repeated or more severe behaviors for the majority of respondents, as the respondent will remain under surveillance. Furthermore, the group identified that a similar triage guide and process could be used for other serious events that may require investigation and management, including violence, discrimination based on other protected categories (for example, race, disability, religion), and reports of suspected impairment by drugs, alcohol, or illness in the workplace setting. Careful surveillance and triage could also support identification of potential sexual predators.

Balancing the Rights of Key Stakeholders

One important finding of the group is that potential triage and management pathways should consider the rights and perspectives of key stakeholders, including the complainant and/or potential victim, the respondent, and the organization. A response that considers only the rights of the respondent might be more likely to dismiss a report from a complainant who is deemed to have less credibility (for example, a patient with a behavioral health condition). A response that considers only the rights of the organization might quickly separate respondents from the organization following a single unfounded complaint, without due process, while failing to recognize and appreciate the impact of such decisions on the respondent and their ongoing practice. A balanced response also carefully weighs the likelihood that the report was submitted in good faith and represents that reporter's best recollection of the events described in the report. Dismissing certain reports without adequate assessment of the allegations could decrease the effectiveness of the organization's response and decrease trust among key stakeholders. Collaboration among leaders increases the likelihood that the organization will take a fair and balanced approach to the triage and management of alleged sexual boundary violations.

Limitations

Much of the existing literature related to the management of sexual boundary violations describes violations in the behavioral health care setting.[25,26] The focus of this article was on the potential gaps in the initial triage and management of violations in a broader health care setting. The PARS and CORS data do not routinely include information about the resolution and management of reports, so we were unable to explore the outcome of investigations or other processes within health care systems.

CONCLUSION

To support an organization's response to critical events such as reports of alleged sexual boundary violations in the health care setting, organizations need a process that is consistent; equitable; guided by law, regulation, and policy; and sustainable. Leadership commitment and a dedicated team to ensure fidelity to the process are essential. Furthermore, organizations need robust data, including reporting systems that are aligned and promote trust and psychological safety for the reporter.

Conflicts of Interest. The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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REFERENCES

1. Hook J, Devereux D. Sexual boundary violations: victims, perpetrators and risk reduction. BJPsych Adv. 2018;24:374–383.
2. Vesentini L, et al. Dealing with sexual boundary violation in mental healthcare institutions by government policies: the case of Flanders, Belgium. BMC Med Ethics. 2022 Apr 9;23:40.
3. Freischlag JA, Files K. Sexual misconduct in academic medicine. JAMA. 2020 Apr 21;323:1453–1454.

4. Dzau VJ, Johnson PA. Ending sexual harassment in academic medicine. N Eng J Med. 2018 Oct 25;379:1589–1591.
5. King PA, Chaudhry HJ, Staz ML. State medical board recommendations for stronger approaches to sexual misconduct by physicians. JAMA. 2021 Apr 27;325:1609–1610.
6. DuBois JM, et al. Sexual violation of patients by physicians: a mixed-methods, exploratory analysis of 101 cases. Sex Abuse. 2019;31:503–523.
7. National Academies of Sciences, Engineering, Medicine. Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine, Washington, DC: National Academies Press, 2018. Accessed Sep 5, 2023 https://nap.nationalacademies.org/download/24994.
8. Lewin T. Yale Medical School Removes Doctor After Sexual Harassment Finding. New York Times, Nov 4, 2014. Accessed Sep 5, 2023 https://www.nytimes.com/2014/11/15/us/yale-medical-school-sexual-harassment.html?_r=1.
9. Winton R. UC Pays Record $700 Million to Women Who Accused UCLA Gynecologist of Sexual Abuse. Los Angeles Times, May 24, 2022. Accessed Sep 5, 2023 https://www.latimes.com/california/story/2022-05-24/heaps-settlement-312-patients-takes-cost-of-his-abuse-to-700-million.
10. Hubler S, Arango T, Hartocollis A. USC Agrees to Pay $1.1 Billion to Patients of Gynecologist Accused of Abuse. New York Times, Mar 25, 2021. Accessed Sep 5, 2023 https://www.nytimes.com/2021/03/25/us/usc-settlement-george-tyndall.html.
11. Szilagy S. Ohio State Settles with 57 Additional Strauss Victims. The Lantern, Apr 15, 2022. Accessed Sep 5, 2023 https://www.thelantern.com/2022/04/ohio-state-settles-with-57-additional-strauss-victims/.
12. Harding H. UM Finalizes $490M Settlement with Victims of Dr. Robert Anderson. Detroit News, Sep 16, 2022. Accessed Sep 5, 2023 https://www.detroitnews.com/story/news/education/2022/09/16/um-finalizes-490-m-settlement-those-abused-anderson/10401762002/.
13. Gabriel T. Hospital Agrees to Pay $190 Million over Recording of Pelvic Exams. New York Times, Jul 21 2014. Accessed Sep 5, 2023 https://www.nytimes.com/2014/07/22/us/johns-hopkins-settlement-190-million.html.
14. Federation of State Medical Boards. Physician Sexual Misconduct: Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct, May 2020. Accessed Sep 5, 2023 https://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf.
15. AbuDagga A, Carome M, Wolfe SM. Time to end physician sexual abuse of patients: calling the U.S. medical community to action. J Gen Intern Med. 2019;34:1330–1333.
16. AbuDagga A, et al. Crossing the line: sexual misconduct by nurses reported to the National Practitioner Data Bank. Public Health Nurs. 2019;36:109–117.
17. Caughill A. Preserving the art and science of psychotherapy for advance practice psychiatric mental health nurses. Issues Ment Health Nurs. 2016;37:268–272.
18. Sanchez S, et al. Sexual misconduct arising out of student health, athletic medicine, and academic medical centers. NACUANotes. 2022 Jun 22;20(10):1–18.
19. Pichert JW, et al. An intervention model that promotes accountability: peer messengers and patient/family complaints. Jt Comm J Qual Patient Saf. 2013;39:435–446.
20. Webb LE, et al. Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. Jt Comm J Qual Patient Saf. 2016;42:149–164.
21. Hickson GB, et al. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad Med. 2007;82:1040–1048.
22. Martinez W, et al. Qualitative content analysis of coworkers' safety reports of unprofessional behavior by physicians and advanced practice professionals. J Patient Saf. 2021 Dec 1;17:e883–e889.
23. Pinto JK, Slevin DP. The project champion: key to implementation success. Project Management Journal. 1989;20(4):15–20.
24. Brenner MJ, et al. Honesty and transparency, indispensable to the clinical mission—part I: how tiered professionalism interventions support teamwork and prevent adverse events. Otolaryngol Clin North Am. 2022;55:43–61.
25. Kröger C, et al. Combining rules and dialogue: exploring stakeholder perspectives on preventing sexual boundary violations in mental health and disability care organizations. BMC Med Ethics. 2022 May 3;23:49.
26. Dickeson E, Roberts R, Smout MF. Predicting boundary violation propensity among mental health professionals. Clin Psychol Psychother. 2020;27:814–825.