Looking into the too hard basket:
Dual relationships and professional boundaries in rural practice

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***Lucy O'Hagan** has been a part-time, shared care, GP in Wanaka for 11 years. She says that she mainly gives out tissues and condoms and puts plasters on. She recently had 10 patients to dinner. She wrote this article as part of the Ethics paper for the MGP.*

Introduction

She was the new GP in town. She was young and conscientious. People pointed to her in the street. But sometimes she got dirty looks. One day she heard someone mutter *'she's the one'*. Only later did she realise she had a look-a-like in town...the woman who had an affair with a married man. *Lesson number one for rural GPs: you can't control anyone else's behaviour. but you can control your own.*

How can we better deal with the complex nuances of small town life?

On the one hand the New Zealand Medical Council tells us *'it is generally unwise for medical practitioners to treat people with whom they have a personal rather than a professional relationship*.'[1]

On the other hand, dual relationships cannot be avoided in rural communities. Patients are seen in the supermarket, at the school gate, in your book club, at parties. Patients may do your accounts, teach your children, build your house and work in your medical centre. Patients may also be your best friends.

It seems to me that there is a tension between the patient's rights to a safe, effective and accessible service and the doctor's need to have a fulfilling and enriching life as a community member. The quality and sustainability of rural practice depends on managing this tension effectively.

Much of my comment is based on my personal experience as a rural GP in Wanaka for over 12 years. My experience and the way I have managed these issues is greatly influenced by the characteristics of my practice population, my style of doctoring and how I see my life outside of medicine. Thus rural doctors may resolve these issues in a variety of ways. What seems important is that we come to our conclusions in a thoughtful, informed way. I hope my reflections provoke some discussion and debate.

The doctor as a person

The doctor as a person with needs has to come into focus in this discussion. As a profession we value selflessness and altruism and we have a slight discomfort with articulating our own needs.

However, if we want doctors to work in rural communities they need to have a life outside their work, where they have free time, develop friendships and can express their individuality. Furthermore there is evidence that doctors are much more at risk of boundary violations when they are themselves lonely, unhappy or struggling with something in their personal life.[2]

Do doctors have the rights of other citizens or does their profession limit their personal freedom outside their work? When I first started rural practice I had this idea that outside work I was supposed to behave in a certain way; reserved, sensibly dressed, have clean fingernails and a nice car...I've since discovered that it is better just to be myself. But what if my actions outside my work harm others?

Consider this example. A female doctor is playing a heated netball game (with a whole lot of patients of course; it's a small town) At one stage she spits into a patients face *'give me the f...ing ball'*. Clearly the motive is to intimidate. The patient decides to change doctors.

Most GPs are familiar with the ethical model of the 'four principles' and here we are concerned with the principles of beneficence and non-maleficence.[3] The difficulty is trying to predict whether our actions will be beneficial or harmful.

Take the example of Dr Slinky, a male GP. He performs the part of a

woman at a local concert. He is in a slinky dress being the sexy back-up dancer for a Meatloaf impersonation. Some people in the audience may feel uncomfortable and choose not to see that doctor for their sexual health problems. Some will think he's just the sort of doctor they would to talk to about sexual issues. Others will see that his motive is purely to entertain. Predicting consequences is an imprecise science.

Indeed Dr Slinky might argue that he needs to be himself outside work and he has a talent for making people laugh. As long as he behaves respectfully and professionally at work, what happens outside is his business; assuming he is within the law and acts with human decency.

Dr Slinky is also asking for some reciprocity. He wants patients to respect his rights to autonomy and to be valued as an individual.

Dr Slinky might also argue that he is modelling the value of being true to oneself, being comfortable in your own skin, being the best person you can be. He might argue that patients want to relate to a real person not a cardboard cut-out of Dr Nice-small-town.

We also need to understand context to evaluate Dr Slinky's dance routine. What we would discover is that Dr Slinky has been a GP in this town for 20 years and is highly respected for his ability and professionalism. His performance is just a snapshot in the middle of a long movie. While the snapshot might look R18 the movie is in fact GA.

The patient's rights and saftey

The New Zealand Code of Health and Disability Services Consumer Rights puts a high value on the principle of patient autonomy. The code states that patients have a right to choose their doctor. They also have rights to access good quality care that protects their psychological safety and privacy. Both these types of rights can be threatened by dual relationships.

Treating friends, staff members and colleagues can result in inadequate care. For example, a friend arrives at the doctor's house with a slightly dirty infected cut. The doctor is reluctant to make the patient come in to the surgery, so makes do with what is in the bathroom cupboard. The friend gets a poorly cleaned wound, inadequate dressing and expired antibiotics. There are no notes recorded, no ACC form completed and the doctor feels reluctant to ask for money. When the wound becomes grossly infected requiring hospitalisation, the relationship becomes strained.

The opposite problem is where loss of objectivity in treating a friend results in over-treatment and over-investigation. The closer the relationship the more tricky these issues can be but in a small town you may be the only doctor on call. I have certainly had to treat my children in an emergency. To say we should never treat our family is just putting the problem in 'the too hard basket'. Treating family effectively requires a sort of self-aware objectivity in which the doctor is constantly evaluating their own actions. We need to understand better how to do this.

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If patients have a right to choose doctors, does this mean they have a right to choose a doctor who is their friend? To say, as the New Zealand Medical Council does, that patients who are friends should be referred to another doctor seems simplistic. In the patient's eyes one doctor is not the same as another and there may not be many options in a small town.

However, having chosen a doctor who is a friend, the patient needs to be aware of how this might impact their care. They may not access care because they feel uncomfortable disturbing the doctor or they don't want to discuss some issues with their friend or they may later want to change to another doctor but don't want to upset their friend. I think that in small towns we should always give permission-in-advance for patients to attend another doctor at any time. This seems more respectful of their autonomy than simply directing your friend, staff member or colleague to see another doctor.

The patient's other important right is to their psychological safety. The patient will always be more vulnerable than the doctor because there is always a power imbalance in the relationship. This is because the patient discloses personal information and exposes their physical body to the doctor. The doctor does neither of these things.

This power difference requires trust. The patient has to trust the doctor with their secrets. In considering how doctors behave outside of work we might then ask, *'am I behaving like a trustworthy person?'* I think there is a level at which rural doctors do need to model behaviour outside their work that is respectful of others and engenders this sort of trust. In many ways rural practice has made me a much nicer person. I am much more respectful of people's secrets, I try not to gossip and I am less likely to make quick superficial judgements of others.

Providing boundaries using a therapeutic frame

'Boundaries are mutually understood, physical and emotional limits of the relationship that define how the two parties may acceptably interact with one another.'[4] Boundaries protect both doctor and patient. Having a clear boundary between work and home protects me from feeling overwhelmed by my work.

Boundaries protect the patient from exploitation by providing some limits to the doctor's power. Much has been written on sexual exploitation, an ex-

treme form of boundary violation. In New Zealand the Medical Council has a policy of zero tolerance. The literature tells us that most sexual relationships with patients occur at the end of a slippery slope that started with minor boundary violations. Furthermore these more minor boundary violations are harmful in themselves.[5]

I like the idea of a therapeutic frame, a sort of physical space that contains the doctor-patient relationship and shields the slippery slope. What is used in the construction of a therapeutic frame?

Most literature cautions against bartering…I can see that it could get tricky if I was unhappy with the quantity of whitebait or the patient felt compelled to exchange his last kilo

Time and place

The slippery slope can be exposed in consultations that involve special arrangements outside the normal setting or out clinic hours.

Personally, I have taken an extreme position of not talking about medical issues outside of work. I don't bring it up with patients and they don't bring it up with me. This means I get some time off. It also protects patient's privacy. But it's not that simple. What do I do when the dinner host introduces me to my suicidal patient saying *'have you met…?'* Basically I do a lot of smiling.

My receptionist once saw a patient whom she knew had just come back from hospital following a still birth, at the gas station. She had a decision to make. It seemed humane to acknowledge what had happened, especially as the patient had not been to the medical centre since the event. She knew she did not want to expose and upset the patient in a public place. She made eye contact and smiled and waited for a cue from the patient. No cue was forthcoming so she saved her condolences for inside the medical centre.

Confidentiality

Confidentiality is complex in small communities.

Firstly the medical centre staff are also members of the community and know patients. The receptionist at the garage is herself a moral agent. To create safety for patients the whole medical centre needs to understand confidentiality and boundary issues.

Secondly anything the doctor says socially about anyone can be perceived as a breach of confidentiality. For example, if I participate in a social conversation about patient Mary's pregnancy, this might be reported back to Mary, with the accuracy of a Chinese Whisper. Mary is left then wondering, *'if the doctor talks about this, are my secrets really safe?'*

Some rural practitioners share patient information with their spouse.[6] This gives the doctor a support person, but by holding such information the spouse then becomes a moral agent as well. Rural spouses frequently report feeling socially isolated. Is it not better for the doctor to get their support professionally and the spouse to remain blissfully unaware of people's secrets so that the patient feels that their stories are safely stored?

Financial relationship

Most literature cautions against bartering. We have had the odd kilo of whitebait in exchange for fixing an ingrown toenail. But I can see that it could get tricky if I was unhappy with the quantity of whitebait or if the patient felt compelled to exchange his last kilo. Charging friends can be difficult, but at least if I charge friends it is clear the interaction is within the doctor–patient framework.

Self–disclosure

Of course patients in rural areas know a lot about their doctors, but this is different from self-disclosure within the therapeutic interaction. Self-disclosure can take the focus of attention away from the patient and, at its worst, may result in role reversal where the patient is helping the doctor with their problems.

Food

Food seems an odd thing to put into the therapeutic frame but I have noticed that I feel uncomfortable drinking tea or coffee in the consultation. I wonder if this is about seeming casual or not giving full attention to the problem.

Language

One of the subtleties of consulting patients who are friends is that the language and content can become casual and this seems to make the consultation less effective. Again there seems to be a level of respectful attention required for a successful consultation.

Clothing

Most literature suggests that the doctor should dress in a way that does not leave room for misinterpretation of sexual innuendo. Does this mean I can't go to a cocktail party in a short skirt and with a large cleavage? And what if have a few too many and spill a margarita over the patient I gave Viagra to yesterday?

Physical contact

Physical contact is obviously problematic in terms of boundaries and needs to be considered. For example if I hug a person, even though that seems the natural and humane thing to do, can I predict how they will respond to that physical contact? If I am unsure, are there other ways of expressing my concern for them? What if the patient initiates the hug? In dual relationships it may be that the doctor normally greets their friend socially with a hug. Should he then hug his friend at work? I think the answer to these questions is very contextual.

Two scenarios

Consider these two scenarios:

A patient, who is not a friend of the doctor, is recently bereaved and

lonely. He has the last consultation on Friday, discusses highly emotional issues and then asks the doctor to go for a beer. Instinctively the doctor knows this isn't right, she feels the discomfort of moving the doctor-patient dynamic outside the therapeutic frame.

The second patient who is a good friend of the doctor turns up for the last appointment on Friday, pulls out a bottle of wine and two glasses and says *'I've got a lot to talk about so I've booked an hour.'* They both drink wine, get through the patient's list of health problems, the patient pays the appropriate fee and is very happy with the service.

On paper this seems slightly risky behaviour! However, it is entirely initiated by the patient expressing their autonomy. He would have felt slighted if the doctor had told him to put the wine back in the bag. The doctor drank very little and felt his judgement was not impaired. The relationship was otherwise straightforward, e.g. the consultation wasn't about the patient's alcoholism! The therapeutic frame was largely intact in terms of time, place, confidentiality, self-disclosure, language and paying a fee.

We can use Narrative Ethics to see this Friday night scene in context. Brody eloquently describes this:

'1. *The choice the patient is now making, or the way the doctor now behaves towards the patient, is going to be one episode in the unfolding narrative of the patient's life, and will acquire meaning within the context of that narrative.*
2. *The action the doctor is now about to take will also become an episode in the doctor's life narrative, and will reflect upon the doctor's core commitments and values.*
The action that the doctor and patient are about to take is embedded in the context...and a full understanding of the action requires that it be interpreted within that context. The 'right course of action'...is not necessarily the action that conforms to an abstract principle; rather it might be the action which, without violating any moral principles, most successfully navigates all the contextual factors to move the situation in a direction that best serves the major interests or all involved parties.'[7]

Handling dual relationships in rural practice

Looking into 'the too hard basket' can we draw any conclusions?

1. Dual relationships and professional boundaries are complex and I'm not sure that there is always a right answer. Different doctors will resolve these complexities in different ways with different patients. What I think is true is that we will be safer for ourselves and our patients if we are consciously aware and can articulate why we are choosing a particular path.
2. In practice I think we respond to these situations intuitively – we just sense when it isn't right, we sense we are operating outside our therapeutic frame. These intuitions are a constellation of previous experience, modelling, ethics and a sharp sense of the patient and doctor as people. The more we discuss dual relationships and professional boundaries with our patients, colleagues and staff, the more informed our intuitions will be.
3. I think we need to negotiate the therapeutic frame with the patient a lot more. The longer we are in rural practice the more comfortable we are with dual relationships. But this does not mean the patient is comfortable. In fact we know very little about what patients think about dual relationships with their doctor and it's about time we started asking them.
4. It seems to me that dual relationships seem to call for tighter boundaries, a clearer therapeutic frame. This might mean that we don't talk about medical things outside of work. This frame protects the privacy and safety of the patient.
5. Paradoxically, tighter boundaries may also protect the doctor in rural towns by providing a clear distinction between the place of work, which requires certain behaviours, and the place out of work that provides some freedom to live.
6. Doctors need support to practice well. We know that boundaries can become blurred when the doctors are themselves needy. Doctors are human and can respond to their need for intimacy, their need to feel special, their need to be needed. Mentoring and supervision are now more common but it can be tricky finding a mentor who isn't a patient, a colleague or a friend! I think we need to maximise the support we get from our closest colleagues. For me, the whole practice I work in is a supportive unit. I could not survive rural practice without my colleagues and staff; their 'other' perspective, their humour, their acceptance of my bad moments!

Competing interests

None declared.

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