

maintaining

boundaries

with patients



Do you think a lot about a particular patient? Do you share your personal problems with your patients? Be careful. You may be allowing your professional boundaries to become blurred.

A recently qualified family physician moves to a new town and sets up a practice. One of her patients, a middle-aged man, has a long history of panic attacks and depression following the death of his wife. At several appointments, the patient talked at great length about the loss of his wife. The patient sent the physician some flowers with a note thanking her for taking the time and being sensitive. The physician thought this was a nice gesture and didn't really think anything of it. More flowers came and then small gifts. At this point, the physician had an uneasy feeling but decided that if she ignored it, the patient would get the message and stop. A short time later, the patient called to ask some questions about medications – this conversation rapidly turned to his asking questions about her hobbies, relationships and where she lived. The physician was working one night, when the patient called requesting a home visit. He described feeling breathless, sweaty, and nauseous. She was concerned that he may be faking a panic attack to get her alone, so she told him that a house call would not be necessary and suggested that he use some of the anxiety reduction techniques they had talked about. The patient eventually staggered to a neighbour's house and an ambulance was called immediately. He was having a myocardial infarction and later made a complaint about the physician.

This example illustrates what can occur when physicians allow the boundaries with patients to become blurred. Medical care can be compromised because objectivity diminishes to the same degree that feelings – both positive and negative – develop between a patient and a doctor.

To help doctors in this regard, the College →

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has developed a self-assessment tool that physicians can use to assess their awareness of boundaries and identify the early warning signs of boundary crossings and violations. The tool focuses on those areas most vulnerable to boundary blurring – i.e., gift-giving, physician's self disclosure, physical contact, and dual relationships.

Dr. John Lamont, chair of the Patient Relations Committee – the College committee which developed the self-assessment tool – says the tool was designed to be informative and educational for physicians, with the hope that it will sensitize doctors to the issue of boundaries.

"We don't want people to perceive this tool as a test or as the College making a judgement. This is simply a tool intended for a physician's private use so that he or she can reflect on these issues and be alert to identifying them when they arise in practice."

And according to Dr. Lamont, it is a given that boundary crossings will arise. "They are unavoidable. They happen to all doctors. Patients will cross boundaries, whether on purpose or by mistake. It happens. Physicians need to know when they are happening, so they can protect both themselves and their patients," he said.

Some may argue that in the example used earlier, it was the patient who was inappropriate, and, that the physician was just trying to be polite. However, the nature of the physician-patient relationship is such that the physician must take the responsibility for maintaining boundaries. Within this fiduciary relationship, there is an inherent power imbalance. Since a patient believes the physician knows more about the matter in question than he or she

EXAMPLES OF POSSIBLE BOUNDARY CROSSINGS:

- Attend/frequent same places
- Sharing mutual friends or people in common
- Self-disclosure
- Establishing dual relationships (professional/social relationships)
- Hugs/touching

EXAMPLES OF BOUNDARY VIOLATIONS:

- Giving or receiving inappropriate gifts¹.
- Ignoring established conventions by making exceptions for certain patients: for example, providing care in social rather than professional settings, not charging for services rendered where you would usually do so, scheduling treatments outside office hours, providing or using alcohol during treatment.
- Assuming a patient's values are the same as your own.
- Excessive self-disclosure or self-disclosure that is not for the purpose of helping the patient.
- Intruding verbally on your patient's personal space. This may include breaching patient confidentiality, making value judgements about your client's body or lifestyle, probing for inappropriate personal information, using intimate words (such as dear or darling) or allowing their use by your patient.
- Inappropriate touching.

does, the patient tends to defer to the physician's judgement. It is this tendency that puts the professional in a "one up" power position relative to the patient.

In understanding boundaries, it is important to differentiate a boundary crossing from a violation. A boundary can be crossed without necessarily being violated, Dr. Lamont explains. In fact, many crossings are quite benign. "For example, you may get a

¹ "While small gifts such as cookies...may represent benign boundary crossings rather than serious violations...more significant and expensive gifts may be problematic from two standpoints. First, gift giving may be a conscious or unconscious bribe by the patient... Second, there is often a secret or even explicit expectation of some reward or acknowledgment involved in performing services or bestowing a gift. The same can apply to the doctor who gives patients gifts or refrains from charging a fee for a particular patient." "Boundaries in the Doctor-Patient Relationship", *Theoretical Medicine and Bioethics*, 2002;23(3): 191-201. Nadelson C; Notman M.

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Self-Assessment Tool

This self-assessment tool consists of 27 questions. The goals of using this tool are to help raise awareness and encourage self-reflection, as well as to promote open discussion among physicians about boundary issues.

When answering a question, try to think about how often some of the things mentioned below occur, i.e., seldom, routinely, occasionally or often. After you have finished, review the discussion points provided on page 11. The discussion points will illuminate the reasoning behind the questions and how they relate to boundary issues.

1. How do I feel if certain patients leave my practice, and why do I feel that way?
2. Do I feel that I would like to discontinue treatment with patients that seem ungrateful?
3. Do I avoid terminating the physician-patient relationship with patients who are emotionally dependent on me?
4. Do I favour patients who comply with my recommendations?
5. How do I feel and act towards patients who get an expected treatment outcome but still complain?
6. How do I deal with cultural taboos that conflict with my opinion of effective treatment?
7. Do I spend a disproportionate amount of time thinking about particular patients?
8. Do I inadvertently or advertently, in words, tone or attitude, prevent patients from participating in the decision-making process in relation to their health care?
9. Do I accept inappropriate gifts from patients?
10. Do I seek advice for personal benefit from a patient during a clinical encounter?
11. Do I pay more attention to my personal appearance if I know that I will be seeing a certain patient?
12. Do I seek more personal details than I clinically need to, in order to find out about a patient's personal life?
13. Do I routinely do favours or make special arrangements for certain patients (i.e., schedule off-hours or off-site appointments, extend usual appointment length, etc.) and why?
14. Do I treat patients differently if I find them physically attractive or important?
15. Do I share my personal problems with patients?
16. Do I have thoughts or fantasize about becoming personally involved with a certain patient?
17. Do I seek social contact with certain patients outside of clinically scheduled visits? If so, why?
18. Do I tell patients personal things about myself in order to impress them and if so, why?
19. Do I feel a sense of excitement or longing when I think of a patient or anticipate her/his visit?
20. When a patient has been seductive with me, do I experience this as a gratifying sign of my own sex appeal?
21. Do I find myself prescribing medication or making diagnoses for my social acquaintances?
22. Do I ask patients to do personal favours for me?
23. Do I undertake business deals with patients?
24. Do I explain what I am about to do before I examine patients or perform an intimate examination?
25. Do I ensure the patient's comfort and privacy by appropriate draping or by leaving the room when the patient undresses?
26. Do I ensure that the patient is comfortable during intimate procedures and exams?
27. Under appropriate situations, do I ask patients if they would like a third party present at an examination?

What should you do if you are concerned that you may be at risk?

- Document any inappropriate behaviour on the part of the patient.
- Focus objectively on the patient's needs and best interests.
- Establish and maintain appropriate boundaries; look at the relationship from three perspectives – the physician's, the patient's, and the neutral observer's.
 - The physician's: Be clear about your own needs and experiences in the relationship.
 - The patient's: Try to understand how the patient is experiencing your behaviour. Empathize with what she or he is experiencing.
 - The neutral observer's: Step outside the relationship. Try to understand what an outsider would see when observing your relationship. Strive for objectivity and fair solutions to problems in the patient's best interests.
- Treat all patients equally - function compassionately and free of preferences for some patients.
- Encourage patients to take responsibility for their own health. Don't impose your knowledge and authority.
- Do not accept inappropriate gifts from patients. Patients who offer gifts of great value should receive a sensitive explanation as to why the gift cannot be accepted. The frequency of gifts given by the patient, regardless of their value, should also be considered.
- Do not imply that patients are obligated in some way. Do not expect patients to return kindnesses or to be thankful.
- Ask yourself why you are acting in a particular way, i.e., stress, burnout, failed relationship, depression, etc.
- Discuss the situation with a colleague (of course, adhering to patient confidentiality) and document the discussion in the patient's chart.

If you have concerns and wish confidential advice, please call (416) 967-2600 x629 to speak to the Intake Coordinator or when more information is needed, call the Physician Advisory Service at extension 606.

For your information, the College offers a course on boundary issues called "Understanding Boundary Issues and Managing the Risks Inherent in the Doctor-Patient Relationship." Information on the course can be obtained by calling (416) 967-2600 x346. We have an article on the course on page 16 of this issue of *Members' Dialogue*.

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box of cookies from a sweet old lady whom you have been taking care of for years. This is how she expresses her gratitude. You don't need to reject the gift, but you need to be aware and alert to the fact that it is a crossing," he said.

If a physician is made uneasy in being given, for example, a box of chocolates by a particular patient, he or she can defuse the situation by keeping the gift in the clinic and treating it as if it were intended for the whole staff, said Dr. Lamont. If the gift-giving continues, the physician will need to document the crossings in the patient's chart and let the patient know that it is inappropriate for physicians to be accepting presents for providing medical services.

There is good reason not to take a crossing too lightly. A pattern of crossings could be the first step in the slippery slope toward boundary violations. And, violations should be of concern to physicians, in that most cases of sexual abuse of patients by health professionals are preceded by boundary violations. Between January 1998 and July 2002, the College referred 84 cases with allegations of sexual misconduct or related allegations to the Discipline Committee. Allegations were proven in the majority of cases and the penalty applied in 50 out of the 49 cases was revocation of the physician's certificate of registration. The prevention of sexual contact starts with the careful attention to boundary crossings that may escalate into sexualized behaviour.

Dr. Lamont acknowledges that the situation becomes more complicated for rural and geographically isolated physicians who may have no choice but to develop friendships and socialize with people who also happen to be their patients. "The way that rural or isolated physicians differ is that they have to

accept the fact that there will be more boundary crossings in their environment. There should not, however, be more boundary violations. Going curling with your patient is no excuse for boundary violations."

Discussion Points on the Self-Assessment Tool

Questions 1 - 4

How do I feel if certain patients leave my practice, and why do I feel that way?

Do I feel that I would like to discontinue treatment with patients who seem ungrateful?

Do I avoid terminating the physician-patient relationship with patients who are emotionally dependent on me?

Do I favour patients who comply with my recommendations?

It is important to address a physician's emotional reaction to a patient's non-clinical behaviours. We recognize that, at times, physicians may have negative emotions, such as anger or frustration, towards patients. As professionals, we must try not to act on these thoughts and feelings in a hostile or destructive manner. In addition, we must ensure that the degree of emotional responsiveness to such situations is not excessive and does not spill over to other aspects of our personal or professional lives.

Question 5

How do I feel and act towards patients who get an expected treatment outcome but still complain?

Even though the anticipated outcome may not always be favourable, it is your responsibility as the patient's physician, to respond accurately when asked about expected outcomes. What is most important is to be very cognizant of the particular



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individual to whom you are speaking and couch your response accordingly. Some people are able to accept information in a very direct manner, whereas others need to be approached in a more gentle way.

As caregivers, we can often be the target of our patients' anger or complaints, but we must remember that it is much more constructive to defuse such a situation than to ignite it by becoming angry ourselves. It is human nature to be annoyed with patients that complain about an expected treatment outcome, but this should not interfere with ongoing clinical interactions with the patient.

Question 6

How do I deal with cultural taboos that conflict with my opinion of effective treatment?

Although cultural taboos may interfere with what we consider to be the most appropriate treatment, we must respect the boundaries of the various ethnic groups that live in our country. For example, clinicians must be cautious and respectful when any physical contact is involved (i.e., touching), recognizing the diversity of cultural norms with respect to touching, and cognizant that such behaviour may be misinterpreted. We are also obligated to refer the patient to a physician who may be able to complete the necessary treatment that had been refused.

Question 7

Do I spend a disproportionate amount of time thinking about particular patients?

When physicians develop long-term relationships with patients, the time spent thinking about certain patients could be considerable. It is important to reflect how this thinking impacts upon daily life outside of practice and whether this distracts you from family and other social responsibilities.

As well, think about whether you are distracted from your responsibilities to other patients.

There will also be cases that will be very concerning and absorb an excessive amount of time, but these should generally be transient throughout your practice. If a physician is going beyond the usual concern about a patient or thinking excessively about a patient, especially for non-clinically pertinent reasons, they may be heading towards a boundary crossing or violation.

Question 8

Do I inadvertently or advertently, in words, tone or attitude, prevent patients from participating in the decision-making process in relation to their health care?

It is the physician's role to inform and advise patients on medical and health issues. This advice is best delivered in a diplomatic and tactful way. It is inappropriate to talk down to your patient in a condescending or overly paternalistic way. Both this question and question 24 attempt to demonstrate that by doing things that may "increase a physician's power" in relation to a patient, you increase the possibility of crossing a boundary.

A good physician will inform and advise his/her patients concerning health and medical care issues. Nevertheless, the doctor must realize that the patient is an autonomous individual who is free to make his/her own lifestyle decisions – even if these are poor decisions. It is not the physician's role to diminish the patient's control over his or her life. Rather, physicians are to be used as expert consultants and advisors who must remember that the ultimate decisions are the patient's own.

Questions 9 and 10

Do I accept inappropriate gifts from patients?
Do I seek advice for personal benefit from a patient during a clinical encounter?

Accepting gifts or services from patients may change the dynamic of the doctor-patient relationship by creating a sense of obligation towards the patient or conversely towards the physician, especially if the gift giving is ongoing or significant. Gifts include exchange of services or advice from a patient in their specialized field i.e., financial guidance or work in the house. By accepting gifts you may be subtly inviting your patients to take care of you.

Questions 11 and 12

Do I pay more attention to my personal appearance if I know that I will be seeing a certain patient?
Do I seek more personal details than I clinically need to, in order to find out about a patient's personal life?

If you are thinking about how you look or wonder about a patient's personal life, you may not be able to focus objectively on your patient's needs.

Question 13

Do I routinely do favours or make special arrangements for certain patients (i.e., schedule off-hours or off-site appointments, extend usual appointment length, etc.) and why?

You should not make unusual exceptions for patients whom you think are "special" or "needy." You may unknowingly identify with "special" patients' needs or try too hard to make some of them appreciate you. It is important to be appropriate in terms of tone or demeanour with your patients and to focus on your role in the physician-patient relationship.

Question 14

Do I treat patients differently if I find them physically attractive or important?

It is important to function compassionately and free of certain preferences. The patient may feel uncomfortable with your preference for him or her.

Question 15

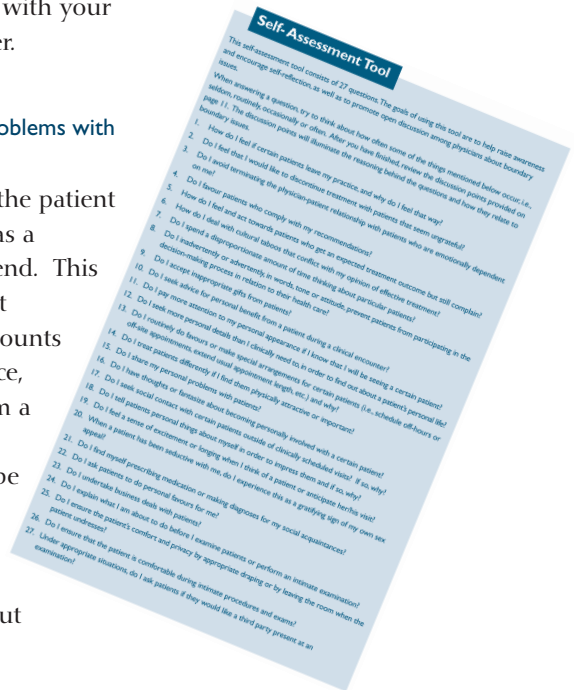
Do I share my personal problems with patients?

By your self-disclosure, the patient may no longer see you as a professional but as a friend. This might lead to the patient expecting increasing amounts of advice and reassurance, much as one would from a close friend. As well, patients' needs have to be put first. Do not allow your own needs to become a factor in the decisions you make about your patient's care.

Question 16

Do I have thoughts or fantasize about becoming personally involved with a certain patient?

There is a big distinction between feelings and actual behaviour. You are free to fantasize all you want about anything and no one has a right to control or censure this activity. Nevertheless, it is prudent to be aware of your fantasies since inappropriate behaviour often does follow from uncontrolled fantasies. If you find yourself obsessively thinking about a certain patient, it is best to reflect on why. It is also useful to be extra careful not to allow your behaviours to cross boundaries with these people. If your obsessions reach an intense level, it is best to refer the patient to a



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colleague or to consider seeking outside help for yourself (e.g., from a colleague, supervisor, counsellor).

Question 17

Do I seek social contact with certain patients outside of clinically scheduled visits? If so, why?

Seeking social contact with patients outside of clinically scheduled visits is never a recommended activity. Such a social relationship with a patient might interfere with a suitably objective, caring, yet somewhat clinically detached doctor-patient interaction. This is because personal intimacy could detract from the physician's ability to provide his or her patient the highest level of medical treatment. In some situations, a more formal and structured and socially sanctioned involvement with a patient (such as attending their wedding) is less likely to interfere with the doctor-patient relationship.

Question 18

Do I tell patients personal things about myself in order to impress them and if so, why?

If you find yourself trying to impress patients with your special talents, it is important to understand why. Do you need to feel more important or powerful? Are you stepping outside the confines of the physician-patient relationship and seeking a personal relationship? We must be aware that by trying to extol our own status as physicians, we might risk appearing to lessen the status of our patients. In widening that power differential; it may become easier to breach the boundaries of the patient-physician relationship.

Questions 19 and 20

Do I feel a sense of excitement or longing when I think of a patient or anticipate her/his visit?

When a patient has been seductive with me, do I experience this as a gratifying sign of my own sex appeal?

One of the unspoken parameters of the professional relationship between physician and patient is the provision of objectivity. That is, we are expected to be able to put our patients' needs first and not allow our own needs to enter into the decisions we make with respect to care. Our patients respond by trusting we will do only that which is in their best interests.

These questions refer to focusing on and/or fulfilling our own needs. In doing so, we may not be able to focus on our patients' needs and may fail to provide the objectivity described above.

Question 21

Do I find myself prescribing medication or making diagnoses for my social acquaintances?

It is essential that the line between the professional and the personal is not blurred – once this line is blurred there is an increased risk of boundary crossings and violations because the objectivity found in the physician-patient relationship has been obscured. All physicians are at risk and prevention involves knowing what the boundaries are and when risk is increased.

Questions 22 and 23

Do I ask patients to do personal favours for me?

Do I undertake business deals with patients?

The questions address the issue of playing dual roles with patients. Recognizing that in some settings it may not always be possible to avoid dual relationships, it is important to understand the impact dual roles may have on patients. Entering into a business deal with patients or asking patients personal favours may make them feel

pressured to agree or concede to our wishes or requests for fear they would receive inferior care or jeopardize the relationship with the physician.

Questions 24 and 25

Do I explain what I am about to do before I examine patients or perform an intimate examination?

Do I ensure the patient's comfort and privacy by appropriate draping or by leaving the room when the patient undresses?

Inherent in the practice of medicine and the care of our patients is the need to take a history, perform a physical examination and undertake certain procedures. Being asked personal questions, being touched by another person (particularly one perceived as more powerful) and experiencing procedures that may be embarrassing or painful can be stressful for our patients. It is essential that we explain what is going to be done and why, ask permission to proceed (i.e., obtain informed consent), ensure an appropriate environment is provided, that comfort measures are undertaken, and encourage patients to ask questions and communicate their concerns. All of these things can help to prevent misunderstandings and increase the likelihood the experience will be less daunting and more positive for patients.

Question 26

Do I ensure that the patient is comfortable during intimate procedures and exams?

This question raises similar issues to questions 24 and 25, but also directs us to think about how we view our patients. Sometimes the things we do to patients, by way of physical examination, surgical procedures, etc. may be frightening or stressful because they are uncomfortable or

painful. Periodically asking if patients are comfortable or managing throughout a procedure relays our concern and compassion and may simply help a patient get through a difficult experience. If we dehumanize our patients by failing to see them as autonomous beings who have needs and rights, it may be easier to cross or violate the boundaries of the relationship we have with them. In addition, if we can help our patients to feel that we respect their opinions and emotions, they will be more likely to trust in the advice we offer and to follow it.

Question 27

Under appropriate situations, do I ask patients if they would like a third party present at an examination?

For examinations of a sensitive nature, it is advisable to offer to have a third party present during the examination to safeguard the rights of the patient and the professional integrity of the doctor-patient relationship. If you have concerns about boundary violations, you should always have a third party present. 