

## Chapter 2.3.1

### **BOUNDARIES AND BALANCE: MANAGING RELATIONSHIPS IN RURAL PRACTICE**

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#### **Introduction**

*It is Saturday morning and you and your family are on your way out of town for a much-anticipated family weekend together. You leave your spouse and children in the car as you run into the local corner store to buy some snacks for your two-hour drive. The store owner, whose family are your patients, asks if you will take a quick look at their four-year old son, a child with cystic fibrosis. When you step through the back door of the store into their home, it is apparent that the child is quite ill and will require aggressive treatment. (1)*

In the same way that training prepares learners for the illnesses that they will diagnose and treat, it should also prepare them for other aspects of life as a physician<sup>1</sup>. In the past, personal and professional boundary issues were rarely taught formally in medical curricula, yet they are often at the core of physicians' and their families' satisfaction or dissatisfaction with practice in a rural community.

Personal and professional boundaries and work-life balance are similar to other clinical issues, in that situations can arise suddenly and can need immediate decision making. In contrast to many clinical management issues which get easier over time with more experience ('practice makes easy'), the issue of personal and professional boundaries can become increasingly difficult as more and deeper personal and professional relationships are formed over time.

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<sup>1</sup> A rural physician is a generalist doctor who works in rural areas with no proximate specialist support. The words 'physician' and 'doctor' are used interchangeably in this chapter.

This chapter is based on our experience with learners, as well as patients who are colleagues and friends. It is adapted from our chapter entitled 'Relationships and Boundaries' in 'Community-based medical education: A teacher's handbook' (2).

The learning objectives include reflecting on approaches to personal-professional boundary issues, to finding and keeping balance and to the elements of physician resilience.

### **Practice pearls**

- Practices where physicians know many of their patients in other roles (such as neighbours, colleagues, staff members, close friends, etc), are ideal for demonstrating the issues of personal-professional boundaries.
- These multi-faceted doctor-patient relationships can include complexities such as confidentiality breaches, omissions, assumptions, identification, loss of objectivity and blurred boundaries.
- Physicians and their families, by definition, have complex multi-dimensional doctor-patient relationships when they themselves become patients.
- Awareness and discussion of alternatives for medical treatment in multi-faceted relationships make expectations and obligations of the relationship more explicit.
- Learners should understand the change in role from their familiar social role to a new professional role, and be aware of the power differential in the doctor-patient relationship as well as the concepts of boundary, boundary crossing and boundary violation.
- The need for balance in the life of the physician is crucial and needs to be explicitly discussed.

**What to do**

- Share with the learner the richness of rural practice where the physician is well connected within the community and is often very aware of the patient's life context in the community. Share the joys and challenges.
- Discuss various boundary alternatives to patient care and make this process conscious for the learner.
- Discuss professionalism and the inherent power differential in the doctor-patient relationship.
- Model professionalism during patient encounters (see Table 1: Professionalism in patient encounters).
- Make learners aware of high risk situations, high risk patients, and high risk physicians, and red flags for boundary violations (see Table 2: Red Flags for Boundary violations).
- Urge learners to pay attention to their 'gut feeling' (inner sense), and to seek advice whenever they are unsure.
- Demonstrate to the learner strategies for finding and keeping balance and maintaining resilience compatible with their physician roles (3).

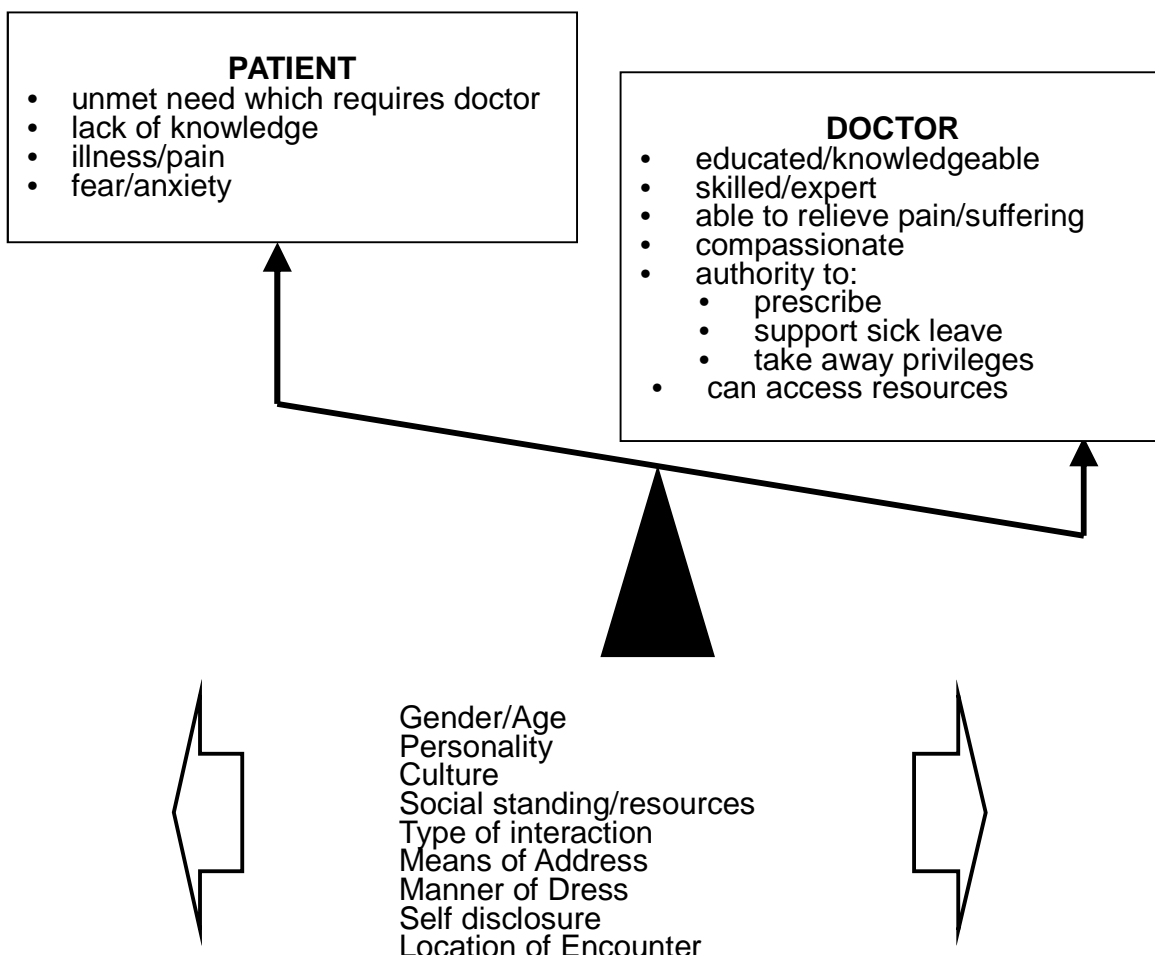
***The concept of boundary, boundary crossing, and boundary violation***

Boundaries can be defined as the accepted social, physical and psychological spaces between people. They are explicitly and/or implicitly defined by culture, jurisprudence and ethics, and are influenced by individual, personal and environmental factors. Examples of boundaries include clothing, form of address, gifts, touch, access (such as time, place, social media, etc), physician self-disclosure, personal opinions and values, and post-therapeutic contact. Boundaries are often a continuum.

A boundary crossing occurs when there is a blurring of personal and professional roles, and/or role reversal occurs where the physician's needs take precedence over the patient's needs, and/or the behavioural rules expected of people in a given role are broken ('behaviour outside the box'). A boundary crossing becomes a boundary violation when the result is harm to the patient (3). Boundary violations are more likely to occur with high-risk patients, high-risk situations, and high-risk physicians (4).

- The **highest risk patients** are victims of abuse or those with borderline personality disorder, who already have experienced problems with boundaries. Those of intermediate risk are patients with chronic neediness, dependence, or prior relationship problems. However even low-risk patients are at risk in times of stress. Due to the inherent power differential in the doctor-patient relationship, in all cases it is the doctor's responsibility to avoid boundary violations. (see Figure 1: Balance of power).

**Figure 1:**  
**Balance of Power in the Doctor-Patient Relationship**  
 (Adapted from Dunn)



- **High risk situations** include the sexual history, the physical examination (especially the breast, pelvic, rectal and genitourinary examination), psychotherapy, and care in unusual settings (time and place). Professionalism during patient encounters minimises boundary problems and can be discussed with, modeled for, and expected of learners. (See Table 1: Professionalism during patient encounters.)

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**Table 1:**  
**Professionalism during patient encounters**  
[Adapted from Dunn] (4)

1. Know yourself, your values, your biases, and your use of language with your patients.
  2. Be aware of and develop your own approach to boundary issues.
  3. Know your patients, and recognize and respect their boundary issues.
  4. Strive to be technically good at what you do.
  5. Know your limits and consult when appropriate.
  6. Respect the patient's privacy with undressing and draping.
  7. Give the patient some control during examinations and procedures. Explain and ask permission before and during examinations or procedures.
  8. For breast, pelvic, rectal or genitourinary examinations or procedures, consider, offer or obtain third party presence.
  9. Do not do a sexual history during breast, pelvic, rectal or genitourinary examinations or procedures.
  10. If the examination or procedure causes pain, stop, fix the situation, and do not continue without the patient's permission.
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- **Physicians at risk** for boundary violations are more likely to be paternalistic, grandiose, authoritarian, or entitled; or have an impulse control problem; or be naïve with a blind-spot; or have unmet physical, emotional, sexual needs (4). Physicians have vulnerabilities, as do all people. Being a medical expert does not exempt doctors from their own physical, mental, emotional or social problems. Thus self-awareness for self-care in handling stress and in maintaining physical, mental, emotional and social health is important for physicians. Self-assessment tools, such as by the College of Physicians and Surgeons of Ontario, promote awareness of risk for both preceptor and learner (5). Increasingly, medical organisations are developing resources for physician health and well-being (6,7,8,9).

Ensure that learners can recognise red flags for boundary violations (see Table 2: Red Flags for Boundary violations.)

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**Table 2:**  
**Red Flags for Boundary Violations**  
[Adapted from Dunn] (4)

- Making exceptions: “I don’t usually do this.”
  - Any activity with the patient you wouldn’t want your colleagues to know about.
  - Having a desire to impress the patient with your accomplishments or “specialness”.
  - Wanting to “rescue” the patient.
  - Being energized by a sense of power when a patient’s actions are controlled through your advice or treatment.
  - Accepting inappropriate gifts, business tips, or special services from the patient.
  - Responding to patient pressure to share personal information about yourself.
  - Divulging your own problems to the patient.
  - Intrusive thoughts, especially sexual, about the patient.
  - Looking for contact with patients socially or doing therapy during social situations.
  - Arranging after-hours appointments, especially if usual staff and colleagues are not present.
  - Driving the patient home.
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### ***What not to do***

- See the red flags (Table 2 above) regarding situations to avoid.
- "Hi, how are you?" Physicians often greet patients in community settings with this automatic phrase, and then struggle when they respond with a literal answer re their health issues? "Hi, nice to see you" is a more appropriate greeting.
- Don't make assumptions that your patients who are also friends and colleagues will have the same doctor-patient relationship issues as you do. From their perspective, they may see the multi-faceted relationship as more, or less, challenging than do you.
- Don't assume that your learners have a similar outlook on work-life balance, and that your challenges and solutions are suitable for them. Some learners may need to learn how to limit their work to allow personal time, and others may need to learn that medicine is not a '9 to 5' job. Discuss these issues explicitly.

## What's the evidence?

The importance of addressing these issues is illustrated in a study by Fairburst and May showing that general practitioner satisfaction with individual patient consultations was more related to the relationship with the patient than with the technical aspects of diagnosis and treatment (10). Thus challenges to doctor-patient relationships that occur with personal-professional boundary issues can significantly affect a physician's ultimate contentment with practice.

Equally important is the evidence that physicians leaving rural practice often cite their and/or their family's discontent with work hours/personal-professional balance issues (11, 12, 13, 14).

## Discussion

Patterns of professional behaviour are set early, therefore during training there needs to be explicit discussion about changes in role from familiar social roles to new professional roles that includes the inherent doctor-patient power differential, and the concepts of boundaries, boundary crossing, and boundary violation.

### ***The challenge of multi-faceted doctor-patient relationships***

Multi-faceted doctor-patient relationships – in which the physician and patient might know each other in other roles such as neighbours, colleagues, staff members, close friends, learners, etc - can include challenges such as confidentiality breaches, omissions, assumptions, identification, loss of objectivity, and blurred boundaries ( 2, 15, 16, 17). Doctors and their families also have complex doctor-patient relationships when they become patients.

- Complex relationships can result in ethical dilemmas for doctors when weighing patients' expectations of *confidentiality* against other moral dilemmas, including the need to disclose sensitive information when required. Confidentiality breaches occur easily in group social settings, sometimes inadvertently triggered by questions from or comments by the friend or colleague who is also your patient.
- *Omission of relevant information* can occur by either patient or doctor. Patients may omit history that they think the doctor is already familiar with outside the professional relationship, or history that is painful, private or troubling. Doctors may find it harder to inquire about relevant sexual or psychological problems.

- *Assumptions* can result from familiarity with the patient in other non-patient roles. The doctor may assume a patient's desire for investigation or treatment based on their knowledge of the patient's approach to other aspects of their life. The patient may assume communication about medical issues happens in the same way as with other non-medical facets of their relationship.
- Friendship may lead doctors to *identify* more closely with the patient and could result in counter-transference, where previous repressed emotions are revived with the patient as the object.
- *Loss of objectivity* can occur, especially in critical situations or serious illnesses. 'Caring practice is the need to walk a tightrope, being neither heartless nor paralysed by emotion' (18). Heightened emotional involvement can cloud judgement. Alternately doctors sometimes counter this by learned emotional distancing. When repeated emotional distancing spills into other aspects of life, the emotional depth of personal relationships can be affected.
- Finally these multi-dimensional relationships, with patient's increased access to the doctor, can result in *blurred boundaries* and difficulty between personal and professional limits.

Other than for romantic relationships with patients, which in most contexts are forbidden, there are four alternatives for medical treatment with the patient who is also a personal friend:

1. do not treat friends;
2. treat friends in a more limited way than usual patients;
3. treat friends in a more available way than usual patients; and finally
4. attempt to treat all patients equitably (2, 16).

More than one alternative can be used at different times, even with the same patient.

1. ***The physician does not treat friends:*** In many rural areas, due to the lack of other health provider options, this may not be feasible. Does the physician opt for very few patients or very few friends? (19,20). With time, more personal relationships develop, and even in a larger community, on-call coverage for colleagues results in more professional-patient relationships, so rigid adherence to this is untenable.



- However, professional care can be compromised in certain circumstances, as described well by LaPuma and Priest when discussing physicians treating their own families (21). For friends, these include: if the physician is too close to probe the intimate history and physical being; if the physician cannot cope with bearing bad news if needed; if the physician cannot be objective enough to not give too much, too little or inappropriate care; or if the friend does not comply with medical care as they might with a non-friend physician.
2. The physician or patient may opt for more **limited care with stricter boundaries**, such as for sensitive examinations (pap, breast exams) or counselling for mental health issues.
  3. Frequently, due to friends' special access to the physician, the physician ends up treating friends in a **more available way than usual patients**. This can result in less comprehensive care (such as when the friend phones the doctor at home, or the colleague stops the doctor in the hallway); overly comprehensive care (such as over investigating as one is less comfortable with uncertainty); or inappropriate care with boundary crossings and violations.
  4. The physician can strive to treat **all patients equitably**. Although this should be the goal for most patient encounters, depending on the patient's expectations, this approach might affect the friendship.

### **Reflections on finding and keeping balance**

It is important for the rural physician teacher to discuss the challenges of finding and keeping balance as a component of physician resilience. 'All work and no play' with no life outside medicine is unsustainable; but equally important, medicine is a calling, not a 'nine to five' job. Don't assume that your learners have a similar outlook on work-life balance, and that your challenges are theirs and your solutions are what they strive for. Observe the learner and watch for signs of rigidity or lack of boundaries, then promote self-awareness.

Jensen has identified four main aspects of physician resilience:

1. attitudes and core values including altruism and self-awareness for self-care;
2. balance and prioritisation;
3. practice management style, and
4. good communication with positive personal relationships and effective professional relationships (22).

Here are some reflections on finding and keeping balance (23).

- Finding and keeping balance doesn't just happen. It takes awareness, communication and conscious planning, often with the help of colleagues, staff and family.
- On the other hand, don't plan everything. Seize the moment. Occasionally opportunities appear unexpectedly that require energy and courage to deviate from the anticipated path; but in the end can be worth it.
- Try to keep things in perspective. Don't sweat the small stuff. Delegate non-essential duties. Do stop to smell the roses.
- Life is a continuum, but is also constantly changing. The right balance at one stage of life isn't necessarily right at another. Unexpected personal or family illness can result in short- or long-term changes in balance. As the saying goes: 'Life happens'.
- There are many occasions to reflect on and adjust one's balance in life. It's never too late - the opportunities will keep arising.
- In this age of social media and handheld devices, where the speed of expected replies to messages keeps increasing, make opportunities to unplug and have protected time.
- Moderation and flexibility is a useful motto. The three types of parenting that Barbara Coloroso describes in her book 'Kids are Worth It' (24), also apply to developing work- life balance. The 'brick wall' approach is black and white with no exceptions, but may result in dissatisfied doctors and patients. The 'jellyfish' approach lacks structure with the danger, in the demanding medical profession, of burnout. The 'backbone' approach has structure, with room to bend when appropriate. As physicians we must recognise that there are times when the help we offer our patients will inconvenience ourselves.
- Sharing work and on-call responsibilities with colleagues can be the key to finding balance. Freely help your colleagues and they, in turn, will help you.
- And as in most aspects in life, a healthy sense of humour helps!

## Case studies to discuss with learners

### **#1 *Ready and waiting***

It is Sunday morning and you, your spouse and children are all packed and about to leave for a day at the beach. Everyone has been looking forward to this all week. You are not on call. The telephone rings. It is a good friend who is also your patient. She says that she has severe abdominal pain, and asks if you can come to see her.

### **#2 *Will you 'friend' me?***

1. One of your patients sends you a 'friend request' on Facebook.
2. One of your friends asks you for medical advice on Facebook.

### **#3a *How can I help?***

Your dear friend and patient is dying of cancer at home, and is under your care. Increasing doses of morphine are needed for pain control. Because of your feelings of grief, you have difficulty coping with your patient's needs for care and comfort.

### **#3b *Your spouse: Can't you do something?***

Your very dear friend is dying of cancer. Your spouse is your friend's doctor. You cannot bear to see your friend in pain, and wonder why your spouse (patient's physician) cannot totally control your friend's pain.

### **#4 *Your family: family planning***

You are the 16-year old daughter of a physician. You and your 18-year old boyfriend are having unprotected sex. You are afraid to go to your doctor for contraceptives in case your parents find out because your doctor and your parent are colleagues and close friends.

### **#5 *Conflicting loyalties***

You notice that your physician colleague seems stressed and is making some mistakes in medical practice. You are unsure if he considers you to be his personal physician, but you are not aware of him having another physician, and you have written him prescriptions for pain medication for his intermittent chronic back pain.

**#6 *The slippery slope***

You are a resident who would like to date a nurse who works at the hospital. You are doing internal medicine clinics and see his/her name on a list of patients that you and your preceptor will be seeing that day.

**#7 *Friend or foe?***

You are a medical student. You see that one of your classmates has posted on Facebook information about a recent case they have seen.

- i) The posting includes identifiable patient information. OR
- ii) The posting contains unprofessional language about a nurse who was also involved in the case.

***Summary of key points***

- As in many aspects of life, the ‘backbone’ approach of structure with flexibility works better in developing personal and professional boundaries than do either the ‘brick wall’ or the ‘jellyfish’ approaches (24).
- It is important for the doctor to have an explicit discussion with the patient at the beginning of any multi-faceted doctor-patient relationship or when circumstances in either the professional or the personal relationship change.
- In rural practice there are many opportunities to show learners examples of personal and professional boundary and balance issues, as rural physicians ‘live’ these issues daily.
- Some of the learners least interested in this topic may be the ones that need it the most - e.g. regarding attitude, boundary violations, etc.

**Broader applicability and implementation**

Although personal-professional boundary issues are obvious in rural areas, multi-faceted doctor-patient relationships can occur in any community and in all branches of medicine. Socially interconnected communities exist regardless of population size: for example through neighbourhood friendships, shared leisure or family activities, or faith groups. Sub-specialists who treat all the cases from the region will inevitably have patients who are friends and colleagues. Teachers can help learners gain awareness, understanding and insights into boundary and balance issues by initiating discussion, modelling reflection, and mentoring learners.

## **Conclusion**

- Personal-professional relationship and boundary issues occur for all physicians, are an enriching aspect of medicine, but can have pitfalls and result in stress.
- Awareness, reflection, and a proactive approach can help establish appropriate flexible functional boundaries and balance.
- Listen to your 'gut' (inner sense); watch out for that 'oh-oh' feeling.
- Be aware of your own health and get advice when in doubt.
- Help your learners gain confidence and competence in boundary and balance issues in order to promote their resilience as physicians.

## **Acknowledgements**

We would like to thank Dr Len Kelly for his insights on the topic of relationships and boundaries and, in particular, as editor of 'Community-based medical education: A teacher's handbook', for his assistance to us as authors of Chapter 23 'Relationships and Boundaries'.

We would also like to acknowledge Drs Sheila Dunn and Risa Freeman for their conceptual development of the issues pertaining to doctor-patient balance of power, professionalism, and boundary violations which have been adapted into Tables 1 and 2 and Figure 1.

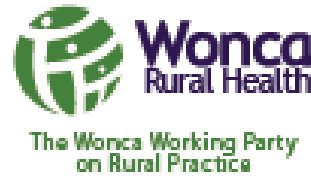
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This article is a chapter from the **WONCA Rural Medical Education Guidebook**.  
It is available from [www.globalfamilydoctor.com](http://www.globalfamilydoctor.com).

Published by:  
WONCA Working Party on Rural Practice  
World Organization of Family Doctors (WONCA)  
12A-05 Chartered Square Building  
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**Suggested citation:** Rourke L, Rourke J. Boundaries and balance: Managing relationships in rural practice. In Chater AB, Rourke J, Couper ID, Strasser RP, Reid S (eds.) *WONCA Rural Medical Education Guidebook*. World Organization of Family Doctors (WONCA): WONCA Working Party on Rural Practice, 2014. [www.globalfamilydoctor.com](http://www.globalfamilydoctor.com) (accessed [date]).