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Not just a patient: the dangers of dual relationships

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Dual relationships occur when a doctor and patient have significant interactions outside the office. These relationships are particularly difficult to avoid for rural physicians and increase the risk of boundary violations. When boundaries are not respected, the doctor?patient relationship can be damaged, the level of care can be compromised and exploitation can occur. Every physician must carefully assess and reassess her or his personal interactions with patients to ensure that the doctor?patient relationship is not compromised.

Il y a double relation lorsqu'un médecin et un patient entretiennent des contacts importants en dehors du bureau. Ces échanges sont particulièrement difficiles à éviter pour les médecins ruraux, ce qui augmente le risque de transgression des limites devant normalement exister entre le patient et son médecin. Une telle transgression peut nuire à la relation médecin?patient, compromettre les soins, voire donner lieu à une situation d'exploitation. Chaque médecin doit évaluer et réévaluer attentivement ses contacts personnels avec des patients afin de s'assurer que la relation médecin?patient ne soit pas compromise.

Dual relationships:a rural reality

Removing the tree stump was a community project. Each night for a week a few neighbours would gather around the offending remnant of a poplar tree and discuss its extraction. In the end, a chainsaw belonging to one of the neighbourly consultants completed the job. Observing from the kitchen window of the rural elective apartment, I was struck by how much stronger the sense of community was here than at home in the "big city." The closeness of this community was also evident at the physician's office where I was placed.

Patient encounters during clinical skills teaching sessions always began with a minute or two of one-sided "small talk" as the physician enquired about the patient's children, job, farm, etc. But in the rural doctor's office the exchange was mutual. The patient was just as interested in the doctor's life as the doctor in the patient's. I found this familiarity was vaguely uncomfortable, but discussions with several physicians revealed it was usual in rural practice.

Physicians who practise in rural areas are confronted with the challenge of treating patients who are, at the very least, acquaintances.[1] They may be neighbours, members of the same faith community, or sit across the table at board meetings. The rural physician may have as a patient her mechanic, or child's teacher. With these patients the physician has a dual relationship. Fellow citizens of a small community may be both patient and friend. The physician may be both doctor and customer. This reality presents special challenges for the rural physician. She has an ethical obligation to provide care

to underserviced patients. To fail to do so may leave the potential patient without a physician. On a practical level, refusing to treat any person with whom the physician has non-clinical contact may eliminate most of the potential patient population, especially if the town is remote and the physician lives where she practises. Despite this reality of rural practice it has long been recognized that dual relationships pose a threat to appropriate medical care by causing boundary violations and interfering with patient autonomy.

The dangers of dual relationships

Professional boundaries are "parameters that describe the limits of a fiduciary relationship in which one person entrusts his or her welfare to another, to whom a fee is paid for the provision of a service."[2] They ensure that nothing external to the fiduciary relationship compromises the level of care. More important, boundaries prevent the physician from abusing the patient's trust.

Resentments, dependencies and affective or financial bonds arising from the non-clinical relationship can threaten the physician's ability to be objective, empathic, sensitive and selfless, to confront noncompliance, and to communicate unpleasant medical information.[2,3] This risk, in the context of family relationships, is addressed by Article 11 of the CMA Code of Ethics, which limits treatment of close relations.[4] The same dangers confronted when treating family are present when treating others whose emotional attachment approaches that of family.

If all patients receive the "best standard of care" then all can expect similar treatment. Boundaries dictate that, in return, the physician may only expect appropriate financial reward. A dual relationship may lead either party to expect or receive "special treatment." This expectation may never be verbalized. Equally possible is that one person may perceive that special consideration is expected, or is being offered, even when that is not the case. At the office this may be demonstrated by offers of, or demands for, unusual flexibility in time, place and length of appointments[5] or waiving fees for non-insured services. Outside of the office the physician may receive, or expect to receive, favours such as products or services at a reduced price.[5] If expectations beyond those normally arising in a doctor?patient interaction exist and are not met, then clinical and non-clinical relationships can both be damaged. If the physician meets the special expectations of one patient, relationships with other patients may be damaged.

Requiring patients to meet expectations other than reasonable financial compensation for services rendered is exploitation. The doctor?patient relationship can be seen as a contract based on a spoken or unspoken agreement that treatment will be rendered in return for monetary compensation. "Changing this contract, whether by subterfuge or consent, amounts to a 'bait-and-switch' tactic."[6] The most publicized examples of this occur when a patient, attempting to ensure that the clinical relationship will continue, agrees to become the doctor's lover. But the exploitation may be more subtle. The patient may feel that it is necessary to offer the physician discounts, invitations to social events, free childcare, or any number of favours. It may even be that the patient feels the other relationship must be formed or maintained in order to continue as a patient.

Exploitation in dual relationships raises the issue of patient autonomy. The patient may not desire a relationship outside of the clinical situation but accept it as necessary.[7] If the physician knows the patient from another setting, she may assume she knows more about the patient's wishes and the patient's knowledge level than she actually does. While it may appear that one has familiarity with "how a person processes important information" and their values, it must be kept in mind that the physician "is as susceptible as anyone else to error and self-deception about the perceptions of someone who is close."[3]

The doctor may also have strong desires regarding which treatment options a patient will choose. Emotional bonds or financial links may mean the physician stands to gain or lose, depending on a patient's choices.

When to accept, when to refuse

Every social relationship exists along a continuum. The casual acquaintance is at one end. Occurring due to random factors such as geography or common social involvements, this relationship involves very little emotional investment. Expectations are minimal. Rural physicians may have many patients who fall into this category, and their experience demonstrates that one can certainly avoid serious boundary violations and respect patient autonomy. At the other end of the spectrum lies spouse, partner, close family and emotionally intimate friendships. Emotional investment is large, and expectations are many. Few would argue that any physician should provide medical

care to these people except in emergency situations.[3,8]

Between these two extremes lie many relationships. A given relationship may shift along the continuum over time. The line that divides those relationships that are casual enough to permit a safe and beneficial doctor?patient relationship and those relationships that threaten it is not clear. By asking herself these questions the physician may be able to better evaluate potential patients and re-evaluate patients with whom the non-clinical relationship may have changed.

- Would I have any difficulty sacrificing the non-clinical relationship in order to provide the best medical care possible?
- Do I desire to gain, or am I gaining, anything from the clinical relationship other than appropriate financial compensation and the satisfaction that arises from being involved in an interesting and helpful profession?[6]
- Am I too close to probe this person's intimate history and physical being, to objectively present information and treatment choices, and to cope with bearing bad news?[3]
- Does this person expect, or is this person receiving, any special consideration regarding appointment times, duration of visits, billing for non-insured services, or other clinic rules?[2,5,6,9]

If the physician cannot answer all these questions with an unequivocal "No" then she must consider carefully initiating or continuing the doctor?patient relationship. The slippery slope from minor boundary crossings (an inevitability in rural practice) to major boundary violations is greased by rationalizations. Thoughts such as "this circumstance doesn't qualify as a role conflict because... ? or "this person is special because..." should be a bright red flag warning of future difficulties.[10]

As soon as the physician concedes even the possibility that a dual relationship may interfere with care, then the situation needs to be addressed. This may mean a frank discussion with the patient or potential patient about roles and expectations. Discussing the situation with an impartial colleague may expose one's rationalizations and clarify the appropriate course of action.[11] It may be necessary to refuse or terminate one relationship for the sake of the other. It would be far better to walk away with a friendship or healthy clinical relationship than to destroy both by trying to juggle two roles.

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