Management of Professional Boundaries in Rural Practice

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Abstract

Purpose
Rural physicians wrestle with professional boundary issues routinely in everyday interactions, and their situation differs from the experience of their urban colleagues. Medical students receive limited exposure to professional boundary management in preclinical training. Increasingly, schools are implementing rural longitudinal clinical clerkships which expose students to rural boundary setting. This qualitative study explored the management of professional boundaries integral to rural practice and how this management may differ from their urban colleagues.

Method
Semistructured interviews were conducted in 2010 with 12 rural physicians across Minnesota exploring their perceptions of professionalism in rural practice. A social constructivist approach to grounded theory was used to analyze the data.

Results
Five primary themes regarding rural professionalism emerged from the data: centrality of care, rural influences on choice, individualization of boundary setting, advantages of dual relationships, and disadvantages of them. These themes served to illustrate rural boundary management.

Conclusions
This study's findings indicate that rural physicians are routinely confronted with professional boundary issues in everyday situations, and these circumstances do not always reflect those of their urban colleagues. Given the increase in longitudinal immersion clinical clerkship programs to nurture student interest in future rural practice, acknowledgment and acceptance of the nuances of dual relationships and boundary setting in different clinical learning contexts are vital to help students identify their personal needs for privacy and be better prepared to negotiate the realities of rural practice. These findings may inform future medical education initiatives on professional boundary setting as an aspect of professionalism.

All relationships have inherent expectations, rights, and obligations. In medicine, professional boundaries describe the limits of the fiduciary relationship created when a patient entrusts his or her welfare to a physician who receives a fee for the service. Rural physicians face unique challenges when managing the boundaries of their relationships with their patients. The traditional admonition against "dual relationships," where physicians engage both personally and professionally with patients, and which range from friendships through sexual relationships, does not factor in the realities of rural life. Many rural physicians find deep satisfaction in being involved in their communities; they believe that living in the community improves the trust and rapport between their patients and themselves; and they appreciate the opportunity to better understand their patients by observing and interacting with them in their broader life context. Their ability to maintain appropriate professional boundaries is affected by three features of their rural communities: size, isolation, and expectations. These factors and more add to the complexity, suggesting that approaches to managing boundaries must be individualized. It is important to acknowledge these complexities, to differentiate between boundary crossings that are acceptable and those that are not, and to articulate examples of successfully managed dual relationships.

Medical students are typically educated in large urban settings, and although the teaching allotted to professional boundary management has been limited (and, according to students, inadequately addressed), the lessons have been straightforward: Dual relationships can harm the physician–patient relationship and, therefore, violate professionalism. Dual relationships are said to raise the risk of overidentification rather than empathy, avoidance rather than objectivity, and coercion rather than collaboration. The role of supervision in teaching these issues has not been clear.

Over the past 60 years, the educational advantages of longitudinal integrated clerkships, a model pioneered by the University of Minnesota, have become clear. Medical schools are increasingly implementing rural longitudinal immersion clinical clerkships, such as the University of Minnesota Medical School’s Rural Physician Associate Program where students spend nine
months working closely with preceptors in small communities. Students enter these immersion programs having had no formal teaching on the particular challenges of boundary management for rural clinicians, arriving only with a general understanding from their preclinical didactics and early clinical clerkships that professional boundaries must be crisp, unassailable, and rigorously managed. They then are encouraged to fully immerse themselves in their adopted rural communities, both professionally and personally, to explore their interest in practicing rural medicine. This creates many possible dual relationships with patients who are neighbors and who may become friends, and with hospital and clinic staff who are both coworkers and patients. In these settings, students can watch real-life role models manage professional boundaries and compare what they are taught in urban settings with the realities of rural practice, but the dearth of literature on this topic suggests that the richness of rural experiences, including the challenges of managing dual relationships, has not yet been addressed when preparing our students for these immersion programs.

The broad acceptance of this largely rural model of clinical education enhances the opportunities to address issues of doctor–student relationships by approaching them through long-term integrated learning in context. In this qualitative study, we explored the management of professional boundaries, including dual relationships, by a group of rural family physicians. We hope that, by articulating more clearly the way rural physicians manage relationships and boundaries, we can inform future medical education initiatives on professional boundary setting as an aspect of professionalism.

**Method**

This qualitative study, approved by the University of Minnesota institutional review board, was nested within a larger survey-based project in which we explored personal traits of rural physicians. From that broader project, we purposefully sampled 18 physicians with diverse genders, practice experiences, and political/philosophical perspectives; 17 agreed to participate. Because of time constraints, D.E. conducted only 12 semistructured interviews (10 face-to-face and 2 by telephone) in August 2010. The face-to-face interviews took place at the physicians’ practices. Each interview lasted 40 to 60 minutes, and all participants were reimbursed for their time. The semistructured interviews focused on professionalism in rural practice. They were digitally recorded, transcribed verbatim, deidentified, and then read and coded by R.P. using NVivo-9 to organize the data. At two meetings, we analyzed the data following the principles of the social constructivist version of grounded theory, identifying and organizing themes and subthemes as they emerged. Where there were uncertainties, we used NVivo-9 to explore the relationship between themes, revisit data where necessary, and further discuss how the themes and analysis were developed. After three more team meetings, we reached consensus on the validity of the themes and the representation of the data. Further, we asked three Rural Physician Associate Program faculty members to give us feedback on the accuracy of our themes. We maintained an audit trail by producing analytical memos and keeping minutes of our meetings.

The study protocol was approved by the institutional review board of the University of Minnesota and the Behavioural and Social Sciences Ethical Review Committee of the University of Queensland.

**Results**

Of the 12 physicians we were able to interview, 4 (33%) were female. The participants ranged in age from 30 to over 60 years old; 8 (67%) were over 40. The time they had been in practice ranged from 5 to over 30 years, with the majority practicing between 10 and 30 years. All 12 physicians had teaching experience, the length of which ranged from less than 5 years (for 2 of the participants) to 15 to 20 years (for 6 of the participants); some had been preceptors for students in the Rural Physician Associate Program’s nine-month longitudinal rural rotation. They practiced in areas that ranged in population from 900 to 18,000, and they served diverse communities, including farmers, workers in the tourist industry, and Native Americans.

Our analysis of the data revealed five themes as primary to professionalism in rural medical practice. Table 1 further illustrates each theme.

**Centrality to care**

The respondents strongly viewed themselves as central to patient care, reflecting a rural culture in which physicians engage in a broad scope of medicine and are an integral part of the community. They take their central role seriously, as seen in their discussions defining professionalism.

To me, professionalism’s about understanding that what I do is a vocation. It is not a job; it is not a business position. It is a vocation. It is something I chose to do as a service. If I look at that as, I have a service to provide, I am a member of my community, and as such I’ve got certain responsibilities to my patient and my community to do that. (Professional 11)

**Choice and geography**

Some of the respondents compared the life of a physician in a rural community to living in a fishbowl. The smaller the town, the less choice they had in whether or not to interact with patients in social or community settings.

The respondents noted that they were not the only professionals in their communities who had to manage dual relationships; this was also true for other professionals, including accountants and attorneys. Indeed, the roles sometimes reversed, with doctors becoming clients of their patients. These sometimes-unavoidable situations allow the community to create common expectations about such relationships.

When I go see an attorney here in town, who might be a patient of mine, he doesn’t treat me any differently because we have a doctor–patient relationship. We have an attorney–client relationship. So if you’re dealing with it on a professional level and you go in the room, you’re no longer the friend, you are the person’s physician. (Professional 11)

The limited choices that come with increased isolation raise the risk that poor practice and ethical violations will be overlooked or tolerated. In small communities with few physicians, dual relationships and investments in the practice can make patients unwilling to notice and colleagues reluctant to
Physicians in small rural communities are deeply embedded in the local culture and fundamental to health care delivery in that community. "I certainly believe the culture is different. I believe that there is, to some degree, a more natural dependency on family physicians in a rural community because that is the culture of what a rural community has grown to understand and expect." (Professional 4)

The culture, size, and isolation of each rural community influence the choices available to physicians and patients. "I see a number of people I consider friends who come and see me as a physician. I think one of the things they enjoy about it is it's somebody who knows them." (Professional 2)

"We're the only clinic in town. The nearest one is probably a 25- to 30-minute drive. There are a few patients who just want to go out of town. Most of them, what we've found, is that they're just satisfied somehow here. They go out of town, but most of them end up coming back." (Professional 6)

The ways in which physicians set boundaries are very individual, often require negotiation, and can depend on personality type. "I always felt that when I was dealing with someone who I knew, I would right away talk to them about that and kind of get that sort of you know uncomfortableness right out upfront, and just make sure that—say you know we've had this other relationship but now we're dealing with this sort of problem. Are you uncomfortable with this? Do you want me to get another provider?" (Professional 12)

Some rural physicians find that dual relationships enhance their personal and professional lives and, therefore, value their membership in their small communities. "I think that as time goes, relationships deepen; as relationships deepen I think that the ability to understand and care for people is much easier because you know them intimately; therefore, you can handle many things better than somebody who's trying to cover for you and would take a half-hour of discussion to understand the intimacy of their care when you can handle that same problem in maybe 5 minutes." (Professional 4)

Rural physicians who manage dual relationships inevitably face some degree of social isolation and lack of privacy. "I mean there are patients … who come in here and I think, oh if I was not their doctor and they lived in my neighborhood we'd be friends, but I'm not going to be any different with them than I am with the rest of the patients." (Professional 5)

discipline. This highlights the need to find respectful, constructive ways to address poor practice in rural areas.

As far as discipline, pure discipline is always difficult. It’s really hard here, because if we do try to discipline a physician or try to get rid of them, we’re just increasing our work load dramatically. (Professional 6)

The respondents recognized that limited choice impacted both their patients and themselves. When seeking a practice or physician that offers the care they want or need, patients must choose between important factors such as distance, time, personalities, and quality. And professionals may have few options to refer the patient to a colleague when they either cannot or do not wish to provide care themselves.

The respondents’ responses to questions about setting boundaries varied, perhaps reflecting variations in their communities’ size and remoteness, perhaps reflecting their personality types. One respondent set clear limits: “Clearly you cannot be friends with your patients” (Professional 10). This physician followed the mainstream tenets of avoiding dual relationships entirely. Several respondents, although not voicing such rigid rules, chose to live in towns outside their practice areas, thus creating privacy by separating their social and family lives from their professional lives. The respondents who did live in their practice community talked about compartmentalizing, to varying degrees, the different parts of their lives and about negotiating the terms of the relationships by, for instance, clarifying with patients who were also friends what was and was not comfortable in a medical context. In some cases, this meant referring their patients/friends to other professionals for some aspects of their care.

The respondents also discussed setting boundaries outside the medical office and hospital. One physician described:

I get people in Walmart who walk up to me, who aren’t friends, but they start talking to me about their health care problems…. I suggest it might be a good idea if you just stop by the office and we’ll talk about it there. That’s one of the harder parts in being rural. You can’t go anywhere without seeing somebody who you’ve seen professionally.

(Professional 11)

The respondents also varied in their attitudes to receiving gifts. Most had been offered gifts by patients, typically food to be shared with the practice team. They generally refused larger gifts. Some felt that gifts were part of the culture of rural family practice, perhaps born out of the older pattern of exchanging resources for medical care. Gifts given by patients with whom the doctor has a dual relationship sometimes reflect the other connections in their lives.

I snuggled up with a blanket last night—one of those fleece blankets that one of my patients made for me after I delivered her baby. You know, I think of her every time. It gives me good feelings. For me to have turned that down…. She’s a teacher who’s taught my kids. I mean, I just don’t think that would have gone over very well. I think I would have hurt her feelings.

(Professional 7)
Advantages of dual relationships
By knowing their patients in both professional and personal/community contexts, physicians can place their patients’ health within the context of their broader lives. This can, at times, make medical care more efficient. The respondents felt that such knowledge improved their ability to support their patients through challenging times. Knowledge of and by the community was valuable for the physicians because they were understood to have community responsibilities beyond work in their clinic.

The respondents also valued the opportunity to provide medical care to friends in particular circumstances, such as supporting friends through tough times or sharing good news.

I think it enhances the relationship if anything. You feel closer to that patient…. I had one close friend of mine who had an ovarian mass and I found out it was benign and I was almost crying when I found out and trying to keep that in check and still be the doctor. It’s okay that she saw I had some tears in my eyes when I’m giving her good news but, I guess, that’s one instance that I remember that really stood out where it was the boundaries of being her doctor and giving her good news and, thank goodness, it was good news and yet still being her friend. (Professional 3)

Disadvantages of dual relationships
The respondents discussed the inevitable social isolation that occurs because of the boundaries drawn even when they are open to managing dual relationships. They discussed the difficulties of being approached for medical advice outside of medical settings. Sometimes they learned more than they wanted to about a friend. Personal relationships with patients made it especially challenging to face issues such as sudden illnesses or suicide. The respondents seemed to make a distinction between existing and new friendships. Most felt comfortable with having friends come to them as patients but found it more complicated to have patient become friends. This led some respondents to limit their friendships, making it difficult for the physicians who were new to their small communities.

Discussion
Rural physicians routinely wrestle with professional boundaries in situations that differ from the urban contexts in which medical ethical standards have developed. The respondents in our study noted the profound advantages, both personally and professionally, of actively engaging in the life of their rural communities and providing medical care to the citizens. They embraced the complexity of this dual role, saw their choice of rural practice as a vocation, and chose rural practice precisely because of the opportunity to serve their communities in multiple roles. This choice, which requires them to manage dual relationships and boundary setting, necessitates the development of specific skills, including negotiating boundaries, compartmentalizing when appropriate, and using background knowledge and relationships to deliver better care.

The respondents also articulated the disadvantages of rural practice when setting professional boundaries. Two of their main themes—“centrality of care” and “choice and geography”—interact to make professionalism more complex. The significance of these complexities depends in part on the personality and social dependency of the individual physician. Although all of the respondents accept their lots professionally and socially, they highlighted the importance of figuring out how to negotiate their roles in their communities. Some thrive on expectations of community involvement and lack of anonymity; others seek socially and professionally acceptable ways to escape. This third theme, “individualization of boundary setting,” is an example of an aspect of professionalism that rural preceptors are in a better position than their urban counterparts to teach students. The isolation, limited resources, climate extremes, poorer health, and greater needs that mark rural locations around the world make professional choice integral to recruiting and retaining doctors and health providers.16,17

 Needless to say, those physicians who choose to practice in a rural area are best suited to give their community the best possible care.

Limitations of this study include the small number of interviews of physicians from one state. A larger sample would allow for more stratification by size, location, and personality style—data that could help clarify the impacts of those factors on strategies for managing professional boundaries. Data from other states and countries might disclose cultural differences impacting on boundary management. And, although asking rural clinical preceptors to articulate how they teach about boundaries is important, as research progresses it will also become essential to understand the perspectives of students rotating in longitudinal rural programs. This is our next planned step.

Conclusion
As medical students increasingly immerse themselves in rural longitudinal clinical clerkships to explore their interest in rural practice and further their identity formation, they experience firsthand the possibilities and challenges of being integral members of their communities while caring for their neighbors as patients. Yet medical schools continue to advise complete avoidance of dual relationships, a disservice to students considering rural practice. As articulated by the respondents in our study, professional boundaries come in many shades of gray. Better education about these nuances would help students take measure of their own attitudes toward privacy and community involvement, thus better preparing them to negotiate the realities of rural practice. It would address boundary management in context, factoring in cultural norms while adhering to the imperative to act in the patient’s best interest. Instruction could be designed to include role-plays with standardized patients in preclinical settings and in longitudinal integrated clerkship orientations, as well as reflective exercises during clinical rotations. Professional boundary setting is an area in need of further analysis and curricular development and modification; we offer this study as an opportunity to advance the dialogue.

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Previous presentations: The results of this study were presented at the Society of Teachers of Family Medicine 2011 Spring Conference, New Orleans, Louisiana, and at the Consortium of Longitudinal Integrated Clerkships Fall 2011 Conference, Yankton, South Dakota.
References