Our white coats are not armour

Protecting physicians in the doctor-patient relationship

Allyn Walsh, MD, CCFP, FCFP

Physicians are notorious for not wanting to think of themselves as at risk when it comes to their own health and safety. In this issue, Dr Donna Manca describes the truly frightening situation of a patient harassing and stalking her physician (**page 1640**). Although the local licensing authority and the police were supportive, at that time there was little legal recourse because (fortunately) there had been no overtly violent act. A number of useful strategies for dealing with such situations are provided in the article. Dr Manca is right to note that such episodes are probably much more common than we realize; the literature she cites supports this.

Although there was no sexual component in this instance, a 1993 survey of Ontario female physicians[1] showed that more than 75% of participants reported being sexually harassed by a patient at some time in their career, most commonly by a patient in their own practice. Being a physician is not a guarantee of safety.

Training and preparation

Clearly, the case Dr Manca describes is an extreme one, reflecting the perpetrator's mental state. Nothing could have been done to prevent this situation: it was a matter of working to deal with it. In some ways, episodes like these can be seen as an occupational hazard; physicians work with individuals at risk for behaving in inappropriate or threatening ways. And, like any occupational hazard, physicians should be trained, prepared, and protected to the best degree possible.

Canadian residency programs are required by the College of Family Physicians of Canada to have resident safety policies in place,[2] which are intended to ensure, for example, that residents are not left seeing patients alone at night in obscure corners out of earshot or making housecalls alone on unfamiliar patients. Many hospitals provide security workers to accompany physicians to their cars late at night. Large strides in physician-safety programs have been made over the last few years. Nonetheless, it is often left up to physicians themselves, no matter how junior, to sense when situations or actions might not be safe.

Examining our habits

Traditionally we have believed that we can go anywhere we want and be safe and inviolate. To express fear or concern, to ask for some sort of protection, can feel like being a "wimp." We are not yet at the point where this is acceptable. But the policies required by residency programs could help all of us learn to be more cautious, and we more senior physicians might need to re-examine our habits. Take care where and when we see patients; protect our personal information (where feasible) by using unlisted phone numbers and call blocking and by getting rid of personalized licence plates. Most importantly, we need to reconsider our mantle of inviolability and to listen and reflect when our younger colleagues express concern about doing things we have done for years without worry.

Setting boundaries

Cases of patients stepping over the boundaries of what their physicians see as appropriate behaviour abound, particularly in family medicine. There, our relationships with patients are often long established, and it is very important that physicians have a well-thought-out approach to setting and tactfully negotiating boundaries. Boundaries in this context can be defined as the social, physical, and psychological distance between physicians and their patients. Many of these boundaries are discretionary and depend on the comfort level of the physician and the cultural norm of the setting—using each other's first names during consultations, for example.

Some boundaries are clearly defined by law and are not discretionary at all, such as those pertaining

to sexual relationships with patients. But others are not as easily defined and seem to be tested constantly as we go about our lives. If they are not addressed appropriately early on, they can grow into major issues. The first time a patient calls your home for medical advice, what do you say and how do you handle it? What about the first e-mail to your personal e-mail address? The consultation in the hardware store or while grocery shopping? And then there are the social occasions when those who are not patients seek medical advice. When such situations have been considered in advance, it is easier to handle them with tact and in a way that fits with long-term practice plans rather than expediency.

It might seem trivial to discuss such boundary issues in the context of serious criminal harassment, such as that described by Dr Manca. Nonetheless, without making up our minds about how to handle such things, it is easy to slide down a slippery slope and end up resenting patients who seem to be encroaching on our lives. Making decisions about our own comfort levels and then discussing them with patients is easier to do at the start of a career, which is one of the reasons medical students and residents are being taught these concepts.

Protecting patients

Boundaries protect patients as well as physicians, and much of what has been written on the topic focuses on that aspect of the problem. It is still important to consider the physician side of the equation, however, and for physicians to learn to set and negotiate boundaries that will help them to maintain comfortable ongoing relationships with their patients. Seminars in which medical students and residents have an opportunity to consider a variety of clinical situations can give them time to formulate their own boundaries and approaches to patients, as well as an opportunity to understand the rules of professional conduct that have been laid down for them.

It is particularly important to discuss these issues in a context that emphasizes the Canadian Medical Association Code of Ethics, in which the first fundamental principle is "Consider first the well-being of the patient."[3] There is a fine balance between setting limits with patients and being inconsiderate of their needs. Other important boundaries include things like gift giving, touching, and physician self-disclosure.[4] In a paper published in *Canadian Family Physician* in 1993, Rourke and colleagues provide a helpful approach for family physicians when patients are also friends or have other roles in physicians' lives.[5]

Physicians *do* need to protect themselves. They need to protect their physical safety and their emotional well-being. Most patients are wonderful people, for whom it is an honour to provide care, just as most physicians are caring human beings doing their best for their patients. But we need to make sure that our educational programs continue to do their best to educate young physicians about how to look after themselves, and that those physicians who did not receive such training stop and reflect on whether they are being as careful as they should be as they go about their professional work.

Dr Walsh *is a family physician and Assistant Dean of the Program for Faculty Development at McMaster University in Hamilton, Ont.*

***Correspondence to*: Dr Allyn Walsh,** *McMaster University, MDCL 3510, 1200 Main St W, Hamilton, ON L8N 3Z5; telephone (905) 525-9140, extension 22489; fax (905) 528-6552; e-mail* **walsha@mcmaster.ca**

References

1. Phillips SP, Schneider MS. Sexual harassment of female doctors by patients. *N Engl J Med* 1993;329(26):1936-9.
2. College of Family Physicians of Canada. *Standards for accreditation of residency training programs.* Mississauga, Ont: College of Family Physicians of Canada; 2005. Available from: **www.cfpc.ca/local/files/Education/Red_Book_Feb_05_English.pdf**. Accessed 2005 September 17.
3. Canadian Medical Association. *CMA code of ethics (update 2004).* Ottawa, Ont: Canadian Medical Association; 2004. Available from: **http://policybase.cma.ca/PolicyPDF/PD04-06.pdf**. Accessed 2005 September 17.
4. Linklater D, MacDougall S. Boundary issues. What do they mean for family physicians? *Can Fam Physician* 1993;39:2569-73.
5. Rourke JTB, Smith LFP, Brown JB. Patients, friends, and relationship boundaries. *Can Fam Physician* 1993;39:2557-64.