Patients, Friends, and Relationship Boundaries

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SUMMARY

When patient and physician are close friends, both professional and personal relationships can suffer. Jointly exploring and setting explicit boundaries can help avoid conflict and maintain these valuable relationships. This is particularly important when the physician practises in a small community where such concurrent relationships are unavoidable.

RÉSUMÉ

Lorsque le patient et le médecin sont de proches amis, les relations professionnelles et personnelles peuvent en souffrir. La détermination conjointe de frontières explicites peut contribuer à éviter les conflits et à préserver ces relations. Ces limites sont particulièrement importantes lorsque le médecin exerce dans une petite communauté où de telles relations concurrentes sont inévitables.

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The natural anxiety [of a physician], the solicitude which he experiences at the sickness of a wife, a child or anyone who ... is rendered peculiarly dear to him, tends to obscure his judgment, and produce timidity and irresolution in his practice.[1]

— *American Medical Association, 1847*

An important objective for family physicians is to develop long-term, trusting, empathic relationships with their patients so that they can provide them with the best possible care. Many patients relate to their physicians as trusted professional friends within the confines of a patient-physician relationship. The relationship becomes more complicated when patient and physician are also personal friends.

These concurrent relationships can happen to any family physician. Even in large urban areas, where physicians can more easily keep separate patients and personal friends, some concurrences will occur. In rural areas, such a separation of relationships is practically impossible unless physicians have either very few personal friends or very few patients. Over the years, a physician living in a rural area will provide medical care for someone in almost every family within the community, either through his or her own practice or while covering for a colleague. Rural family physicians will thus have many patients who become personal friends and vice versa. The richness of these relationships is part of the joy of rural family practice.

Does being friends with a patient "obscure judgment, and produce timidity and irresolution" in the physician's practice?[1] The depth, complexity, and entanglement of the two types of relationship can be a serious challenge. Each physician must find a comfortable balance; medical schools and postgraduate training usually provide little guidance in this area. An exploration of the issues involved might help family physicians develop appropriate

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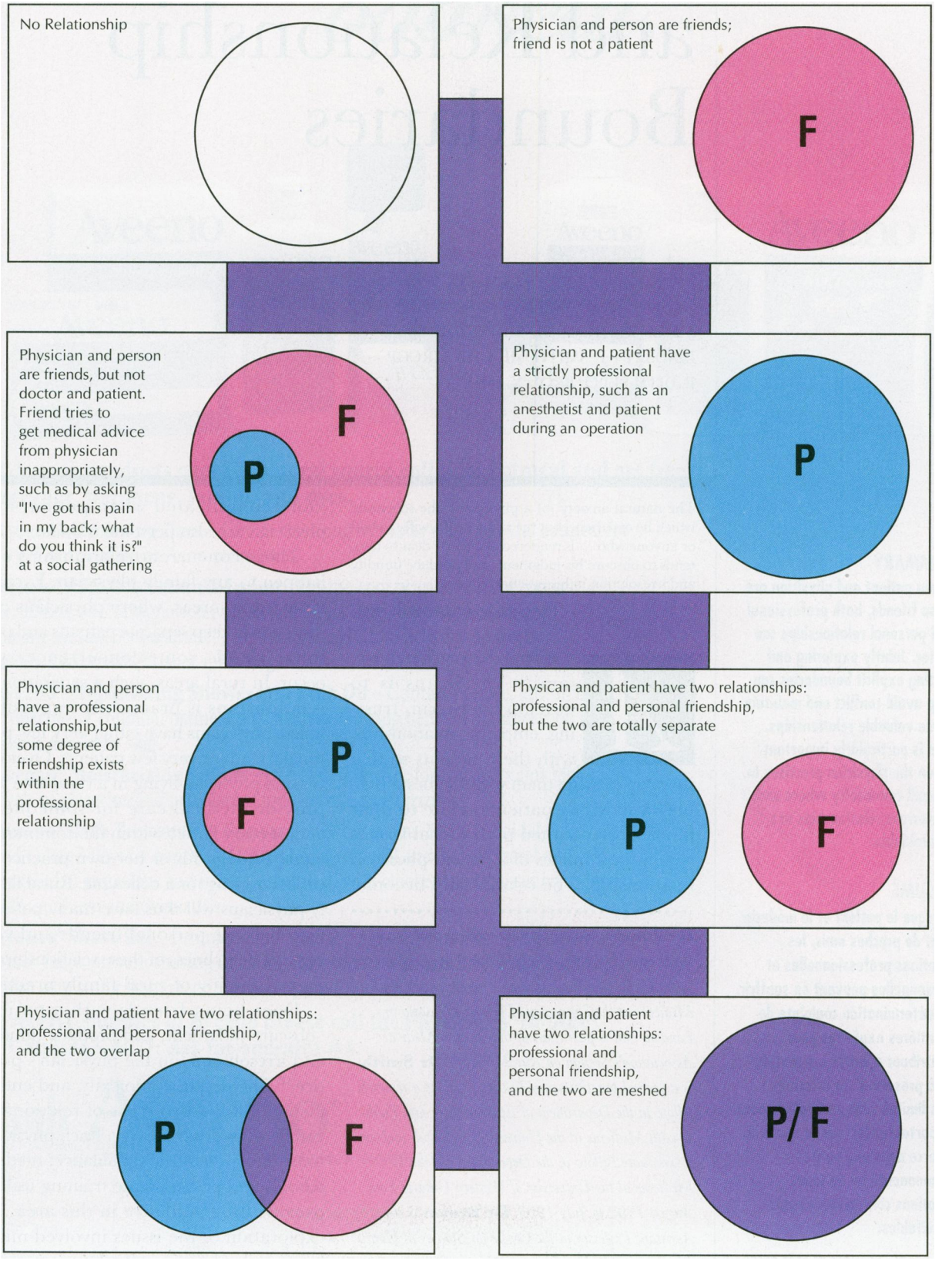
POSSIBLE COMBINATIONS OF THE PROFESSIONAL (P) AND FRIENDLY (F) RELATIONSHIPS THAT CAN EXIST BETWEEN PHYSICIANS AND PATIENT-FRIENDS.



boundaries and foster therapeutic professional relationships and rewarding personal friendships.

Obligations

When a patient is also a physician's personal friend, the physician has obligations within both of these relationships. If these obligations conflict, then the physician will experience stress. The conflict and consequent stress could compromise the physician's obligations in one or other of the two relationships.

The obligations that we have to our friends are at two levels: those that we owe to all human beings and those particular to personal friends. We should respect the autonomy of others, not harm them, and be just in our dealings with them.[2] These are personal social obligations that are independent of voluntary commitments. In a more general sense, we also have an obligation to help those less well off, both directly and by restructuring society to benefit them.[3] Over and above these general obligations, we have additional obligations to our personal friends: to do them good, to trust them, and to be loyal to them.[4]

We have slightly different obligations to our patients within the patient-physician professional relationship. To them we should offer medical beneficence[2]; and for them we should acquire and use expertise appropriately (implies an obligation to be competent[5] and to be up-to-date), maintain the standards of the profession and practise accordingly,[3] practise for their benefit (fiduciary relationship),[6] be compassionate,[5] and also, perhaps, be just in distributing health care.[3]

What about the patient's obligations? They have social obligations and those of friendship as do physicians. In addition, as patients, Benjamin[7] argues that they must recognize that health care resources are limited, honour their commitments, and disclose all relevant information. He argues that they might also have obligations to be research participants and to be teaching subjects. Patients, then, might also find that the obligations of one relationship could compromise the obligations of the other.

Definitions

We have adopted Aristotle's definition of friendship: personal friendship evolves due to time spent together sharing some type of activity or interest, and is based on goodness rather than utility, is permanent, and finally is fiduciary.[8] But our definition of personal friendship excludes the fiduciary friendship, which some suggest is necessary within the patient-physician relationship,[4,9] because it is based on utility and ceases when the patient-physician relationship ends.

Various models of the patient-physician relationship have been suggested,[10] most notably the engineering, priestly, collegial, and contractual or covenant models. The "traditional model" is the priestly one: the physician makes paternalistic decisions for the benefit of the patient in keeping with the Hippocratic Oath to do good and not to do harm. All models vary in the relative importance that they place on the obligations that physician and patient have to each other within the relationship. Whichever model a physician adopts, conflict between obligations is always a possibility.

Case studies

The degree of overlap or meshing that exists between a personal friendship and a professional relationship might well affect the ability of a physician or a friend to discharge their obligations in either relationship. The degree of overlap is determined by the boundaries of the two relationships (*Figure 1*). These boundaries could be set by the physician, by the patient, by them both, or by neither. We describe four cases, each illustrating one of these four situations. We discuss the implications of boundaries and we explore whether they need to be explicitly agreed between physicians and patient-friends.

Case 1. Sue Green, a 32-year-old labour coach, preferred naturopathy, herbal remedies, and home birth, and declined the usual immunizations for her child. She mistrusted orthodox medicine and felt uncomfortable with traditional physicians, but nevertheless had several medical problems that needed ongoing care. Her personal friend, Dr Jane Jones, a family physician, accepted her proclivities and agreed to see Sue as a patient. At first this worked satisfactorily, but later Sue began to discuss her medical problems more and

more outside the office during Jane's personal time.

For unrelated reasons, Jane moved to another town and recommended to Sue that she find another physician. Sue had difficulty finding another physician with whom she felt comfortable and increasingly called Jane for medical care over the telephone. Often these calls were at inconvenient times and required lengthy discussions or prescriptions for ongoing medical problems. Jane believed that these would be more appropriately managed by a regular family physician and advised Sue accordingly.

Despite this advice, Sue continued to call. Jane resented the intrusion of medical care into their friendship, but felt somewhat obliged to try to help her friend and put her at ease. She wondered how she should deal with this without losing their personal friendship. In time, Jane was able to help her friend establish a professional relationship with a new family physician. This helped reduce, though did not eliminate, Sue's calls for medical advice. Ultimately it lessened Jane's internal conflict and enabled her to maintain her personal friendship with Sue.

Comment on case 1. The patient kept overstepping the boundaries that the physician tried unilaterally to establish between their professional and personal relationships. The physician experienced a conflict between feeling obliged to help her personal friend as a patient and feeling that this was interfering with their personal friendship. The situation was not in the patient's best interests, and it could have jeopardized the physician's professional standards.

These negative developments could have been lessened or avoided by addressing relationship boundaries and potential difficulties when the friendship began to include the professional relationship. Expectations, obligations, and practical matters, such as when, where, and how to deal with elective and emergency medical concerns, are best discussed explicitly early in the relationship.

Case 2. The Aman family, comprised of Melissa, 38; Mark, 39; and their two children, Robert, 2, and Linda, 4, were all patients of Dr Rupert Stewart, a family physician. The family lived in the same village as Rupert and were good friends with him and his wife, Penelope. They met regularly for various social events, and Melissa provided occasional child care for the Stewarts.

Melissa had initially come to Rupert with borderline hypertension after prolonged use of the combined oral contraceptive pill. The problem abated when she was switched to the progesterone-only pill. Unfortunately, it caused irregular menstrual bleeding that was unacceptable to the couple (who did not believe that the available barrier methods were reliable enough). After discussion, Melissa and Rupert agreed that she should have an intrauterine contraceptive device. The physician offered to fit the device but Melissa declined, indicating that she would arrange an appointment at the local family planning clinic. She would continue to see Rupert for her other health care needs.

The oldest child, Linda, suffered a head injury after slipping on a wet floor in a store. She had to stay overnight in hospital. She was left with slightly unequal pupils but no other morbidity. Melissa and Mark claimed compensation from the store and litigation ensued. Rupert submitted what he believed to be a fair report, indicating that the fall had not caused significant long-term morbidity. The parents disagreed with this interpretation. Subsequent examinations and correspondence about the head injury were dealt with by Rupert's partner. Interestingly, Linda was still brought to see Rupert for all other medical problems.

Comment on case 2. This case shows how a patient can set boundaries to a physician's obligations, presumably to preserve their friendship and their professional (but now limited) relationship. This solution was possible because another physician was available within the practice and patients could choose which physician they would consult for a particular problem. The physician initially felt hurt that his friend had rejected his care, but on reflection realized that she had decided to limit their professional relationship so that their personal friendship could continue.

Case 3. A family physician, Dr Timothy Hyde, cared for Margaret, 28, her husband David, 29, and their two children, Steven, 4, and Edward, 6 months. Margaret and David had been friends of Timothy and his wife, Sarah, for 4 years and met regularly for dinner and other social activities.

Margaret suffered from hypothyroidism and took regular medication. Her son, Steven, was mildly asthmatic. David was frequently away from home on business and there was no local family support.

Margaret was diagnosed with postpartum depression 3 months after Edward's premature birth at 32 weeks. He had many problems and was not discharged home until he was 10 weeks old. Margaret blamed herself for the premature birth because she had not been taking her medication regularly. Timothy had provided all obstetric care before delivery and had provided emergency care for the premature labour until Margaret was transferred to a tertiary care centre. Timothy visited her after the birth when Edward and she were still in hospital.

Timothy continued to provide medical care and emotional support after discharge. Initially he saw Margaret weekly, both at the office and at her home when required. She appeared to relate better to Timothy than to her husband, David, who could not understand her depression now that Edward was home. David perceived that the crisis was over because there were no obvious continuing medical problems. Timothy's wife was pregnant throughout the family's experience, which was known to both Margaret and David.

Managing Margaret's postpartum depression was difficult because of her reluctance to accept the diagnosis, her insistence that Timothy was competent to treat her, and Timothy's inability to view her problem dispassionately.

Comment on case 3. This case illustrates the difficulty of providing care and discharging one's obligations as a physician when the boundaries between personal friendship and professional relationship are not explicitly discussed at any stage. Male-female interaction contributed to the enmeshment, as did the transference that occurred for both the physician (the patient and his wife were pregnant concurrently) and the patient (her husband was not understanding nor supportive). Finally, the physician found that it was difficult to maintain both relationships and had to choose between terminating one or the other. Failure mutually to set boundaries early contributed to the loss of one of the relationships.

Important life events, such as marriage, loss of a loved one, or in this case, birth of a child, change and often threaten the patient-friend-physician relationship. Physicians in particular need to be aware of possible transference and countertransference issues activated by life cycle changes. Physicians should explore the effect of these life events on the patient-friend-physician relationship and set mutually agreeable boundaries with the patient. In situations where a physician becomes so entangled in the process, support or consultation with a colleague might be necessary in order to gain a clear perspective on the relationship.

Case 4. John Wilson, a 55-year-old hospital department head, was a competent professional. The stresses and strains of his responsible position aggravated a burning retrosternal discomfort. His family physician, Dr Sam Johnson, arranged for investigation. An exercise stress test showed normal results, but gastroscopy revealed reflux esophagitis.

Sam cares for four generations of John's family, including his 80-year-old mother. He had cared for his father, who died recently. John and his wife, Beth, have three children: two sons who have serious medical problems and a married daughter. Sam delivered John's daughter's two children.

Sam and John are involved in other ways as well. They meet several times a month on various hospital committees where they often have divergent and conflicting points of view. Outside of work and other professional relationships, they enjoy each other's company while playing on the same sports team.

They limit their patient-physician discussions to the physician's office and hospital clinic. Hospital business is limited to the hospital and its official functions. Their social and recreational activities are

just that. This arrangement has suited them both and has enabled them to have a deep and meaningful relationship on several levels.

Comment on case 4. Physician and friend-patient have explicitly developed over 8 years a complex, multilevel association that includes both a patient-physician relationship and a personal friendship. This has allowed them to explore the patient's illnesses and those of his family in a deep and meaningful way. They have developed and continue a mutually satisfactory business relationship and an enjoyable personal friendship centred on their recreational activities. By mutually negotiating and setting boundaries for each type of contact, they have been able to shift levels appropriately and maintain all their relationships.

In this example, the physician's friendship with his patient has increased his knowledge and understanding of his patient's family. This has contributed to more effective care for other family members. Sometimes, however, a physician's friendship with a parent can interfere with medical care for family members. For example, teenagers might be reluctant to seek contraceptive advice or discuss AIDS with a family doctor who is also their parent's good friend.

Practical implications for physicians

La Puma and Priest[11] suggest that physicians should ask of themselves seven questions before they care for members of their own families. We suggest that three of these should be asked when a physician agrees to care for a personal friend, or when a patient becomes a personal friend.

First, "Am I too close to probe my friend's intimate history and physical being and to cope with bearing bad news if need be?" (eg, take a psychiatric history, perform vaginal or rectal examinations, care for a terminal illness). Thomson[12] suggests that having friends as patients might compromise a physician's ability to manage social problems.

Second, "Can I be objective enough to not give too much, too little, or inappropriate care?" (eg, overinvestigate due to inappropriate anxiety). Peteet et al[13] are also concerned that clinicians might lose their clinical objectivity because of the need to insulate their feelings somewhat from patients. This would be more difficult if the patient were also a friend.

Third, "Will my friend comply with my medical care as well as he or she would with the care of a physician who was not a friend?" (eg, familiarity might lead to noncompliance).

A family physician has a special role in developing long-term, trusting, and empathic relationships with patients. Greater knowledge and understanding of a patient through an intimate patient-physician relationship can be beneficial unless the intimacy threatens the physician's independence of action.[14] This is most likely to happen when the patient is a colleague or close friend (as in case 3). When the boundary is crossed, the patient-physician relationship becomes enmeshed and dysfunctional. Awareness of this could prompt the physician to corrective action, which might simply entail discussing the matter with the patient to clarify boundaries. In some cases, however, both patient and physician might be served best by transfer of care.

As family physicians, we should always try to offer personal care, individually tailored to a patient's needs. Compassionate care for a friend often involves additional time, availability, and effort. When a physician, however, begins catering to a friend beyond what would be normal practice for other patients, it might be a sign that enmeshment has compromised the physician's independent actions. This boundary is crossed in relationships that lead to sexual abuse.[15]

On the other hand, physicians and patients sometimes avoid clinical areas of importance because of their personal friendship. The level of avoidance will vary considerably depending upon patient's and physician's comfort level for the particular topic. Such avoidance is most likely to be a problem when the patient is a close friend or colleague and the issues involve sexuality or psychosocial conflicts. In some cases, transfer of care (or part of care) could be in the patient's best interest (case 2). Other case reports[16-19] from the literature support our observations.

Relationship boundaries

It appears that boundaries are required. How do we delineate them? We suggest that it is usually best for physician and patient to negotiate jointly and agree explicitly where these boundaries are to be set.

Boundaries can be set in physical terms or in personal terms. One of the easiest and most appropriate boundaries to set is that of dealing with patient problems only within the appropriate setting, ie, only at the office or hospital. If the physician makes a housecall, it is best to deal only with professional matters at that visit. Both physician and patient-friend have to learn not to practise medicine at a party or grocery store, except in emergencies. Establishing this boundary frees both to develop their personal relationships as friends, teammates, business associates, or coworkers. This approach is based on the concept of multilevel relationships. The ability to shift levels appropriately allows the greatest scope at each level of the complex but potentially rewarding patient-friend-physician relationship (case 4).

It is often difficult to decide where interpersonal boundaries should be set. Setting them toward the personal end of the scale (ie, with a large overlap between personal friendship and the patient-physician relationship) risks enmeshing the two and could lead to both physician and patient-friend not discharging some of their obligations. The physician might lose clinical objectivity or suffer excessive emotional trauma if there is an adverse outcome; the patient-friend might fail to disclose relevant information or not comply with management advice. Conflicting overt and covert communication is common. If a particularly difficult emotional or personal problem occurs (eg, mental illness, sexually transmitted disease), doctor and patient might lose their friendship completely if one or the other of them cannot separate their professional relationship from their personal friendship.

If the boundaries are set too close to the impersonal end of the spectrum (little overlap of the two relationships), there are implications for both parties. The physician might not be able to empathize adequately with the patient-friend; the patient-friend might feel unable to communicate with the physician. In either case, the personal friendship might suffer because one of them believes that the boundaries that they have set have prevented them from communicating adequately within the professional relationship.

A possible solution is illustrated by case 2. Patient and physician decide that they will maintain both their personal friendship and their patient-physician relationship, but that "sensitive" parts of that relationship will be excluded and dealt with by a different doctor. This solution is not always possible, especially in some rural settings.

Other important boundaries in practice delineate physicians' free time, their family time, and intimate social relationships. The need for uninterrupted free time is one of the most difficult challenges of rural practice.[20] The problem can arise as much from the physician's need for omnipresence as the patient's need for continuity of care. Again, conflicting overt and covert communication is common. Physicians should temporarily transfer the responsibility for care of patients to trusted colleagues to get protected free time for themselves. Patient education and negotiation need to address both the acceptance of care from an alternate physician and an understanding of the physician's need for free time. This is particularly important when personal friends are patients because they are likely to have access to physicians that other patients do not (eg, unlisted telephone numbers), as illustrated by case 1.

Physicians and their families are well known, particularly in small communities. This adds to the friendliness of, and involvement in, the community, but can make privacy more difficult to obtain. This is a serious problem if a physician has a strong need for privacy or is uncomfortable with certain aspects of his or her lifestyle. In a small community, unattached male and female physicians often find the pool of potentially eligible partners is already small and is further reduced by patient-physician encounters that prohibit future sexual relationships, according to the recommendations of the Task Force on Sexual Abuse of Patients.[15]

Conclusion

Physicians and patients can maintain both personal friendships and professional relationships and discharge their obligations to one another within these relationships. However, they must jointly explore and set explicit boundaries to both relationship types. The obligations due to each relationship might be less satisfactorily discharged because the relationships are concurrent.

Such concurrence of personal friendship and professional relationship is more likely to occur in small, rural communities. The alternative of transferring some or all of a patient's care to another physician might not be a practical option for those wishing to sacrifice part or all of a professional relationship in order to maintain a personal friendship. Thus, explicit discussion and boundary setting is more likely to be required in rural communities, and the resulting altered relationships could be less than ideal. This, however, is a small price to pay for the continued existence of these valuable relationships. Indeed, by bringing potential conflict into the open and discussing relationship boundaries, misconceptions and misunderstandings might be uncovered, improving both relationships.

Having personal friends as patients might obscure judgement and produce timidity and irresolution in the physician's practice. If physicians and their patient-friends discuss and define their concurrent relationships, such obcuration, timidity, and irresolution will be lessened, if not eliminated. Improved patient care and continued rewarding professional relationships and personal friendships would result. ■

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