

The Case of Flirtatious Patient

Case Written by Isabelle Colmers, MD(cand)

Case

Isabelle Colmers

Objectives / Questions:

Dr. Tamara McColl

Expert Responses

Dr. Merrill Pauls

Dr. Kari Sampsel

Curated Community

Commentary

Dr. Tamara McColl

MEdIC Project Lead

Dr. Teresa Chan

ALiEM Editor-in-Chief

Dr. Michelle Lin

Half way through clerkship, Rachel was finally feeling like she had hit her stride. The past few weeks of her rural placement had involved periodic visits to the emergency department, which made her feel right at home. She had been doing well and her preceptor was giving her more and more independence.

So far, this particular Thursday afternoon had been uneventful. She was in the department, and was seeing a steady stream of patients. The next chart she picked up was an elbow laceration that required suturing. 'Perfect', she thought, 'I've assisted a few laceration repairs with my preceptor. I'll try to do this one on my own!'

The patient, Rory, was a friendly, athletic young man her age. From the triage note, Rachel noted that he had fallen while rock climbing and landed awkwardly, glancing his forearm on the edge of a sharp rock. Luckily, this was his only injury. "You know," said Rachel, "You need a better story... You should probably tell people you jumped out into traffic to save a puppy or something."

"Hmmm... Would that work better with the ladies you think?" asked Rory, raising a quizzical eyebrow. "You know, a lonely single guy like me can use all the help he can get..."

Rachel smiled, and excused herself to go and review the case. A few minutes later, she re-entered the room with her attending, Dr. Richards. Rachel glowed with excitement as Dr. Richards viewed the wound and fully endorsed her plan for wound management.

"I'll be around if you need me, just ask one of the nurses to get me if you want my help. I am pretty confident you should be fine on your own though," he stated, patting Rachel on the shoulder and exiting the room.

In the next few minutes, Rachel mentally walked herself through the procedure

steps and prepared supplies, Rory made several attempts to make small talk. "So, I haven't seen you around much," he stated. "Have you worked here very long?" Rachel explained a bit about her rural placement, and explained that she was hoping to become an emergency physician. Rory then proceeded to ask more questions about her life, and these questions seemed to fill the awkward silence as she cautiously set up her little surgical field, so she kept answering. To be honest, she also felt a bit indebted to the patient who was allowing her to 'practice' on him, so she continued to oblige him in polite conversation.

As she was debriding and suturing, he continued the chat. He begun asking her about where she was from, what she liked to do outside of school, the type of music she listened to. They had lots of common interests, it turned out...Rock climbing, being one of them. She was enjoying the conversation, but not until she was bandaging up, did she realize she had been so focused on the suturing, she hadn't noticed how personal the conversation had become until Rory's final question:

"Hey, so, will you be around in 7 days when I need these stitches out? Or, really, any other time between now and then? I would really like to see you again..."

Aware of how inappropriate this was, Rachel muttered nervously about needing to get Dr. Richards to look at the stitches again, and quickly jetted out of the room. Susan, the charge nurse saw the concerned look on Rachel's face as she exited the suture room.

"Hey there," she asked, "Are you okay? Are you feeling faint from the blood? You should sit."

Rachel shook her head, and then explained everything to Susan. "It sounds like the cute guy you were fixing up was flirting with you. You're single, you should go for it!"

Usage

This document is licensed for use under the creative commons selected license: Attribution-NonCommercial-NoDerivs 3.0 Unported.



Questions for Discussion

1. As a colleague or attending physician, how would you counsel Rachel about this interaction with her patient?
2. Despite the longstanding argument that the balance of power in the physician-patient relationship is skewed towards the physician, is it ever acceptable for a physician to develop a romantic relationship with a patient? Are there any differences between primary care and emergency care type relationships and does this make a difference?
3. The physician-patient relationship is the basic foundation of medical care, dating back to the times of Hippocrates. How has the physician-patient relationship evolved in modern medicine and has this improved trust, compliance and ultimately patient care?

ACGME	CanMEDS
Professional Values (PROF1)	Professional Communicator

Intended Objectives of Case

1. Discuss and identify key components of the physician-patient relationship.
2. Describe an approach for handling Rachel's predicament.
3. List specific things that should be considered with regards to professional behaviour in this or similar scenarios.

No role for Romance in Rachel's Role

by Merrill Pauls MD, CCFP(EM), MHSc

This case is a great illustration of how quickly boundaries can be blurred in a professional relationship. This student both allowed, and even encouraged the boundary blurring and yet she has done nothing wrong. She has been invited by her patient (and encouraged by her co-worker) to enter into a different type of relationship. How can she make sense of what has just happened, and make the best choice for herself, her patient, and her profession?

What are boundaries and why are they important?

Every relationship has written and unwritten rules. There are ways we interact with those who are close to us - questions we ask, information we disclose, physical proximity or intimacy - that we would not with casual acquaintances or strangers. These rules exist on a spectrum (How close do we have to be before I give you a hug?) and depend upon both the initiator's intentions and the receiver's perceptions (Think of the last time you heard an off-color joke and how everyone around you reacted to it). Interacting with someone who does not understand or abide by these rules can lead to a range of reactions - from awkwardness and embarrassment, to feelings of harassment or violation.

Some boundaries are quite explicit. The law identifies certain types of relationships and certain activities as illegal - such as child abuse or sexual assault. Medical professionals have codes, statements and guidelines that outline how they are expected to act. The penalties for transgressing these rules can be significant - including censure and losing one's license. There are institutional or regional policies that apply to behaviour in the work place, and school policies and codes of conduct that medical students need to know.

Boundary violations occur when we step across one of these clearly established lines and are always wrong. Boundary blurring is much more common, may be more difficult to define, and may even be good or bad depending upon the context and the intentions.

Why are boundaries particularly important in medicine?

The relationship between a physician and their patient is unique in a number of ways.

- 1. There is a power imbalance.** Patients seek out physicians because they have unmet health-care needs. They require our knowledge and expertise. They answer personal and potentially embarrassing questions. They submit to intimate examinations. They do so because they expect these activities will further their own needs, and will not be used to exploit or take advantage of them. The patient must have confidence their physician is acting with their best interests in mind. This is the definition of a fiduciary relationship. "...because the balance of knowledge and information favours the physician, patients are reliant on their physicians and may be vulnerable. The patient must always be confident that the physician has put the needs of the patient first." [1] When boundary violations occur in a physician-patient relationship, the physician is no longer keeping the patient's medical needs as their primary interest, but is using the relationship, and the knowledge gained through that relationship, to meet the physician's needs and to further their own interests.
- 2. What happens in these relationships has both individual and societal implications -** Establishing appropriate boundaries is important so that an individual patient can feel comfortable in their interactions with their own doctor. It is also crucial so that any patient who is cared for by any physician knows there are clear rules governing their interactions, and that if these rules aren't followed there will be consequences. Society provides physicians with significant prestige and monetary rewards, and in return they need to know physicians



About the Expert

After completing medical school, family medicine, and emergency medicine training at the University of Manitoba, Merrill obtained a Masters of Health Sciences (Bioethics) at the University of Toronto. From 1999 until 2004 Merrill was an assistant professor in the Departments of Emergency Medicine and Bioethics at Dalhousie University. In 2004, Merrill returned to Manitoba where he is currently associate professor in the Department of Emergency Medicine, Co-Director of the Professionalism Course, and Director of the Pre-Clerkship Curriculum for the University of Manitoba College of Medicine, Faculty of Health Sciences.

Expert Response

will behave in a way that is worthy of their trust. They allow physicians to regulate themselves, and in return need to see that physicians establish rules which nurture that trust, and will hold physicians accountable if they do not keep the needs of the patient as their primary focus.

So how do I know if I am approaching a boundary line?

There are some rules in this area that are very black and white, but there is some grey as well. Since boundary blurring and boundary violations depend on the context, and exist on a spectrum, it may be helpful to consider some guiding principles:

- 1. The greater the vulnerability of the patient, the greater the caution one must exercise** - Patients who have long-term relationships with their physicians, who engage in specific types of relationships (such as counseling or psychotherapy) or who discuss certain areas of their lives (such as sexual dysfunction or relational counseling) have placed great trust in their doctors, and have shared a great deal of information that should only ever be used therapeutically, and never be exploited to initiate or establish an intimate relationship
- 2. The more intimate or personal the engagement, the greater the caution one must exercise** - Patients who answer personal questions or undergo intimate examinations have similarly shared something with their physician in the context of a professional relationship they would never share with an acquaintance. If either party now seeks to change the relationship from a professional one to a more personal one there are grave concerns about the level of information that has been disclosed, and the basis on which that relationship is based.
- 3. The ultimate test is whether the patient's needs are the primary consideration** - When physicians violate boundaries, they are usually seeking to meet their own needs at the expense of their patient. Good physicians may ask patients about their personal lives, or disclose some personal information, in order to strengthen the doctor-patient relationship and encourage positive change. Physicians who are troubled and likely to violate boundaries will ask personal questions, or disclose information not because they are worried about the

patient, but because they are trying to meet their own emotional needs.

- 4. It is not just about the relationship between one doctor and their patient, it is about the relationship between the profession and society** - When we set clear rules in this area, it sends an important message to all future patients that they will not be viewed as a potential date or mate by their physician. They can share personal information and submit to intimate exams and not be worried about ulterior motives or inappropriate conversations.

Shades of Grey

Given these rules, there are some situations that are clearly wrong, and others that are a little more grey. Developing an intimate (sexual) relationship with a current patient is always wrong. The longer and more involved the doctor-patient relationship is, the greater responsibility the doctor has to ensure clear boundaries. The doctor is always responsible for setting and maintaining the boundaries, regardless of the patient's expressed wishes, and the doctor-patient relationship does not end the moment the last visit has occurred.

At the other extreme, a physician may provide episodic care of a benign nature and then meet that patient in a social setting (e.g. A doctor in a small town sutures a patient in the emergency department and 3 months later meets the patient at a party). If that physician and their former patient choose to pursue a personal relationship they should take steps to ensure they will not enter into a more formal physician-patient relationship in the future, but there is much less concern about the nature of this relationship.

What if I don't want to have sex with a patient, but they offer to build my deck?

While legal and professional guidelines are clearest regarding personal and sexual relationships, there are other ways that physicians can violate boundaries. College complaints have involved physicians who enter in to financial or business relationships with their patients, who employ patients to build their houses or decks, or who blur boundaries in other ways. The same issues that come up with regards to intimate relationships also arise when these other boundaries are ignored. There are also concerns about these patients receiving (or expecting, or being perceived as having) special access to medical care because of their

Expert Response

special relationship with the physician. An additional practical concern for physicians who (unwisely) enter in to these types of dual relationships is that if the enterprise does not go well, the patient may complain to the regulatory authority. This could have significant implications for the physician and their ability to practice medicine.

Can boundary blurring ever be a good thing?

Good physicians will ask patients about their personal lives because they want to build a robust relationship that will motivate the patient to change in healthy ways. Physicians may disclose information of a personal nature in order to encourage and identify with patients. For example, they may share their own struggle with exercising regularly. This is very different than a physician who shares intimate details from their own life, or who seeks out personal information from the patient for their own gratification. The College of Physicians and Surgeons of Ontario has identified important warning signs for physicians, and a self-reflection tool that physicians can use to determine if they are at risk for boundary violations. [2]

So let's get back to Rachel:

Rachel has done nothing wrong. Her initial comments to the patient may actually have encouraged the blurring of boundaries in this case, but are likely an innocent attempt to put the patient at ease and establish rapport. The patient's response (identifying himself as a "lonely single guy") is a comment that further blurs boundaries and a more seasoned clinician may have recognized this as a warning sign. The increasingly personal nature of the conversation during the suturing is concerning and a more experienced physician should have the insight to recognize this, and the ability to redirect the conversation while still managing the task at hand. Having said that, Rachel still has done nothing unprofessional. When the patient asks if he can see her again Rachel realizes this has gone some place it should not have, and wisely steps out to compose herself and seek counsel. The nurse is very unhelpful in this regard.

On the surface of it, these seem like two competent young adults with common interests. This has been a single episode of care with no personal questions or intimate examination. There is no sense here that the medical student is taking advantage of this patient - in fact the patient has been the aggressor. Would it really be such a bad idea for Rachel to go out on one date?

This would be a very bad idea for Rachel, for a number of reasons. The relationship has been initiated in a health-care setting. This medical student is supposed to be here to learn and care for patients. The regulatory authority would discourage this type of relationship and her school likely has an explicit policy against this. She also places herself in a difficult position if the relationship does not work out and her ex-boyfriend (and former patient) decides to complain to the regulatory authorities or the school.

In the future Rachel may be able to avoid similar situations by recognizing the "red flags" earlier, and developing the skills to redirect conversations, and/or discourage inappropriate attention. For now she simply has to clearly let Rory know that as a student doctor it would be inappropriate to go out on a date with one of her patients, and to wish him well in his future endeavours.

References:

- 1) College of Physicians and Surgeons of Ontario website. The Practice Guide - Principles of Practice and Duties of Physicians. Available at: <http://www.cpso.on.ca/policies-publications/the-practice-guide-medical-professionalism-and-col/principles-of-practice-and-duties-of-physicians>. Accessed May 22, 2015.
- 2) College of Physicians and Surgeons of Ontario website. Maintaining Boundaries with Patients. Available at: <http://www.cpso.on.ca/CPSO/media/images/Maintaining-Boundaries.pdf>. Accessed on May 22, 2015.

Additional Resources

Medical Professionalism in the New Millennium: A Physician Charter. *Ann Intern Med.* 2002;136:243-246.

Cruess SR, Cruess RL. - Professionalism and Medicine's Social Contract with Society. *Virtual Mentor.* 2004 Apr 1;6(4). <http://virtualmentor.ama-assn.org/2004/04/msoc1-0404.html>

The Problem of When Harry Met Sally in the ED...

by Kari Sampsel MSc MD FRCPC DipForSci

As emergency physicians, we need to establish rapport with our patients quickly and, as people, we tend to be outgoing and even a tad chatty. To gain the trust of our patients and put them at ease, we often engage them in general small talk. And as generalist specialists, we will inevitably see people of our own age group and social status. And some of them may even be attractive to us...

Regulatory Body Rules:

Medical regulatory bodies usually have strictly defined boundaries with respect to physician-patient interactions. For the most part, these rules are jurisdictional, so be sure to familiarize yourselves with local guidelines. Generally speaking, social or romantic relationships with someone who a medical practitioner has seen as a patient are forbidden for 1 year from the time of termination of the physician-patient relationship. This time frame extends indefinitely for any physician-patient relationship that includes psychotherapy. The one year lock-out period for non-psychotherapy based physician-patient relationships exists to ensure that the patient has had adequate time to recover from whatever ailment caused them to seek care in the first place (so that an emotional attachment is not based in immediate gratitude) and that the patient has had adequate time to find a new medical practitioner to provide their care. This rule applies to medical students equally as it does to fully licensed attending staff physicians. The rationale behind this ruling is that a power differential exists between a medical practitioner of any level and their patient. Any personal relationship in the context of provision of medical care could be viewed as exploitative.

One only needs to look as far as the decisions against physicians by their regulatory colleges to see that this line has sometimes been crossed. Some of the decisions against these physicians started out as a seemingly consenting relationship between a patient and their medical provider. Somewhere along the line, that relationship changed and a complaint was filed, an investigation conducted and a decision made. These

decisions take time, are very stressful and are publicly disclosed. The complaint can be filed by the patient themselves or by anyone familiar with the circumstances of the relationship and can occur at any time. If another physician becomes aware of the circumstances of their relationship, they are duty-bound to disclose this to their regulatory college.

With regards to the case in question, there are several areas of conflict here and Rachel is in a difficult situation. She started out this clinical interaction with the intent of putting her patient at ease and was enjoying a casual conversation. Because she was focused on her work, she didn't realize until the end that this was crossing over the friendly line into flirtation. She is a junior learner in a department away from her primary medical school institution, so she likely doesn't have or may not be aware of resources to help her deal with this situation and may not feel comfortable pursuing these with her current physician preceptors. Additionally, her ED staff member is encouraging her to "go for it", which may certainly add to her unease about this situation.

Implications for a Medical Student or Learner:

Rachel, while a junior learner in her department, still has some responsibility for this patient's medical care and thus a power differential exists. Therefore she is bound by the medical regulatory body in her practice region and cannot enter a social or romantic relationship with her patient for one year from the termination of their physician-patient relationship (which will likely occur when he is discharged from her ED). To violate those terms may result in a formal complaint to her regulatory body, which will have practice implications for her as immediate as getting an Emergency Medicine residency spot, as complaints such as these must mandatorily be disclosed on any residency application. Nothing says "do not invite for interview/do not match" as much as a college complaint for boundary issues to any residency program! These complaints remain on the physician's file for the duration of their career and are

Expert Response

shared between medical licensing authorities and must be disclosed to any potential employer.

So what should Rachel do?

When she goes back into the room to give discharge advice to the patient, she should politely thank him for his offer of coffee but state that her medical regulatory body doesn't allow her to see any patient socially and that this rule applies for one year from the termination of their physician-patient relationship. If they happen to meet up in a year, no further physician-patient relationship exists and they are mutually interested, then she is free to "go for it".

References:

- 1) College of Physicians and Surgeons of Ontario website. Maintaining Boundaries with Patients. Accessed at: <http://www.cpso.on.ca/Policies-Publications/Policy/Maintaining-Appropriate-Boundaries-and-Preventing>. Accessed on May 22, 2015.
- 2) Dialogue publication - Summaries of Decisions Against Physicians; College of Physicians and Surgeons of Ontario. Accessed at: http://www.cpso.on.ca/cpso/media/uploadedfiles/policies/policies/policyitems/mandatory_reports_sept07_dialogue.pdf. Accessed on May 22, 2015.



About the Expert

Dr. Sampsel (@KariSampsel) started her medical clinical career at Queen's University and chose to pursue her Royal College of Physicians and Surgeons of Canada specialty training in Emergency Medicine at Queen's University. During residency, she undertook fellowship training in Clinical Forensic Medicine at the Victorian Institute of Forensic Medicine in Melbourne, Australia. Dr. Sampsel completed the 2 year Diploma program in 10 months and is currently the only Canadian physician to hold this designation. She has been active in the fields of forensic medicine and medical education, with multiple international conference presentations, publications and committee work.

Curated Community Commentary

By Tamara McColl MD, FRCPC (candidate), MHPE(candidate)

In his exploration of the power and limits of modern medicine, Atul Gawande describes the art of medicine as being “dominated by a single imperative—the quest for machine-like perfection in the delivery of care”(1). Throughout the evolution of the practice of medicine, society has persistently held physicians in the highest regard with an unspoken expectation that we will behave with the utmost professionalism with ethical prowess in all spheres of our clinical, academic and personal lives. The reality, however, is that medicine is a fundamentally imperfect discipline and physicians are also humans; flawed in the same respects as our fellow neighbors, regardless of educational accomplishment and social standing. This month’s MEDIC case stimulated interesting online conversation surrounding the ethical and legal implications of blurring and possibly crossing the line of the physician-patient relationship. Is it ever acceptable for a physician to befriend or date a patient? Is there a difference if you’re an attending physician, resident or medical student? As Matthew Zuckerman points out, “many friendships and romances develop from chance encounters at the workplace”. Why is medicine so different?

DEMOGRAPHICS

Several commenters discussed whether the type of medical practice holds different levels of accountability and social standard. Take for example a primary care clinic where the family physician is expected to provide on-going care and treat all aspects of the patient’s health vs an emergency department where the interaction is short-lived and the physician is unlikely to be involved in any further care. Furthermore, Sameed Shaikh asks the question of whether certain interactions should even be perceived as a “relationship”. Does gluing a small brow laceration or refilling an NSAID prescription qualify as a professional relationship? Although this may be ethically debatable, medical regulatory authorities (although variable from region to region) clearly outline that all physicians must maintain professional boundaries with their patients to avoid exploiting them due to a significant power imbalance (2,3,4). This is not variable based on the type of interaction. Loice Swisher encourages us to consider a scenario where a simple elbow laceration leads to a debilitating infection from

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Blog:

Nikita Joshi
Tamara McColl
Eve Purdy
Loice Swisher
Sameed Shaikh
Matthew Zuckerman

Twitter:

Ali Alhajahmed
Gustavo E. Flores
Ali R. Jalali
Heather Murray
Eve Purdy

a retained foreign body. The complexity of both a personal and professional relationship with the patient could create a significant quandary. Commenters also noted that perhaps in the Emergency setting, due to the necessity of establishing a rapid rapport, interactions may seem more comfortable and casual, a style that emergency trainees pick up early in their training to help put their patients at ease. This can occasionally blur the lines of professionalism when the interaction becomes more conversational and personal information is divulged.

ACCOUNTABILITY - STUDENT VS STAFF

Commenters also debated the liability of the medical student when compared to the staff physician. Are medical students held to the same standards both professionally and ethically? Loice Swisher again brings up the question of whether medical students are truly involved in the doctor-patient relationship? They review their cases and do not make any independent medical decisions. Although this question provides even greyer areas for discussion, as Nikita Joshi points out, the general consensus within the medical community is that medical students and residents are required to uphold the same level of professionalism and ethical conduct.

Another interesting point that was brought up in discussion was that learners have very little formal training on ethical relationships with their patients beyond a general overview of professional and ethical

Curated Community Commentary

conduct in the form of a single lecture or handout. With really serious consequences and ethical considerations surrounding crossing boundaries in medicine, it would be reasonable to dedicate more focused discussion and training in this area.

TIPS FOR RACHEL

Rachel has entered a profession in which the primary goal is to care for and protect vulnerable members of society. Our patients entrust us with their lives and as a result, society disapproves of any behavior that could potentially call into question our ethical and moral conduct. Rachel has to develop some tools to help her deal with questionable situations in the future. Commenters suggested the benefits of having scripted responses, whether humorous or simply succinct, to help steer the conversation away from any personal conversation surrounding age, relationships, likes/dislikes etc, and maintain the interaction as professional as possible, given the situation.

Additionally, having a good understanding of professional boundaries and accessing her regional ethical and legal guidelines would help outline what behavior is acceptable in a medical setting. The College of Physician and Surgeons of Ontario, for example, highlight several situations that may be considered to be crossing professional boundaries and provide options as to the appropriate approach to various patient interactions (3).

About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

Did you use this MEdIC resource?

We would love to hear how you did. Please email MEdIC@aliem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

References

1. Gawande A. *Complications: A Surgeon's Notes on an Imperfect Science*. New York: Picador; 2003: 37.
2. Professional Standards and Guidelines: Sexual boundaries in the patient-physician relationship. Available at: <https://www.cpsbc.ca/files/pdf/PSG-Sexual-Boundaries-in-the-Patient-Physician-Relationship.pdf>. Accessed on June 3, 2015.
3. Maintaining boundaries with patients. Available at: <http://www.cpso.on.ca/CPSO/media/images/Maintaining-Boundaries.pdf>. Accessed on June 3, 2015.
4. Maintaining appropriate boundaries. Available at: https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/professionalism/Respecting_boundaries/maintaining_appropriate_boundaries-e.html. Accessed on June 3, 2015.

Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

Usage

This document is licensed for use under the creative commons selected license:
Attribution-NonCommercial-NoDerivs 3.0 Unported.

