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Management of Professional Boundaries in Rural Primary Care

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“Doctors have dual roles as social and professional beings. If the roles are kept separate, conflict is minimized, the effectiveness of the medical consultation is increased and the potential for harm in the physician-patient relationship is reduced.”

White G. Medical students’ learning needs about setting and maintaining social and sexual boundaries. Medical Education Vol 37. Issue 11, November 2003
“If physicians in rural…communities are to become active, involved members and exercise broader social responsibilities, they will undoubtedly encounter patients in other settings.”

Three features of rural communities impacting clinician’s ability to maintain clear professional boundaries

- Size of community
- Isolation of community
- Community expectations

Dual relationships – a necessary evil in rural family medicine, or a challenge with potential benefits? Themes from literature:

- Dual relationships on basis of living in community improves trust and rapport
- Allows view of patient functioning in broader settings than medical
- Gives context to patient’s story
• Insufficient teaching time allotted to boundaries
• Risks on clinical clerkships
• Role of supervision in teaching
Longitudinal Clerkships and Boundaries – The literature

- Workplace learning model
- Opportunity to develop sense of responsibility to patients and families
- Challenges to develop appropriate boundaries
The Research Questions

• How do rural family physicians describe their experience of and management of dual relationships?
• What do they role model to medical students on rural rotations?
Methods

• Convenience sample – 18 practicing rural physicians. 15 agreed to participate, 12 were interviewed.
• IRB approval
• Face to face semi-structured interviews with 10, phone with 2 on rural practice and professionalism in rural setting.
• NVivo-9, social constructivist approach to grounded theory used to perform thematic analysis.
Results
Results

• Participating physicians:
  – 33% female
  – Age range 30 to over 60
  – Majority practicing between 10 and 30 years
  – Communities ranged in size from 900 – 18000.
  – All physicians had experience teaching medical students, some were preceptors in RPAP LIC
5 themes

- Centrality to care
- Rural influences on choice
- Individualization of boundary-setting
- Advantages of dual relationships
- Disadvantages of dual relationships
Centrality to Care

- Importance of fitting in with rural life, knowing community culture
- Physician more a part of community
- Absence of broader range of providers
Rural Influences on choice

- More isolated the geography, less choice for both physicians and patients
- More likely dual relationships
- Not unique to physicians – accountants, lawyers
- Concerns re: poor practice
Individualization of boundaries set in practice.

• Clearly can’t be friends
• Enjoy being friends
• Friends as patients, patients becoming friends – the timing.
• Gifts
Advantages of dual relationships

- More knowledge, ability to support
- More efficiency
- Boundary crosser – knowledge of community
Disadvantages of dual relationships

• Social isolation
• Challenging to deal with difficult sudden issues
• Learning more than they wanted to about a friend
Coping Strategies

• Negotiation with patients
• Compartmentalization/boundary setting
• Recognition of parallel issues with other professional peers in community
Summary

• Dual relationships are a reality in rural primary care practices
• They impact both patients and physicians
• Size of community and geographic isolation important factors
• Advantage of physician as boundary crosser knowledgeable on community and healthcare
• Multiple strategies employed
Discussion

- Medical students in rural immersion longitudinal programs
  - Workplace learning
  - Role modeling
  - Different situation than typical urban educational settings and curricula
  - Opportunities and challenges
Future research

• What do students in rural longitudinal programs learn about professional boundaries and dual relationships?
• How is their learning different on this topic than their peers?
• How can we develop more explicit curricula such as reflective practices to deepen their experiential learning?
Minnesota RPAP Students