A PIECE OF MY MIND

Crossing Boundaries—Violation or Obligation?

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It is 5 PM on Friday afternoon. After 2 hours on the telephone trying (and failing) to get her insurance plan to pay for her medication refill, I reached into my pocket and handed the patient $30 so she could fill the prescription. It seemed both kinder and more honest than sending her away saying, "I'm sorry I can't help you." While I hardly expected a commendation for such a simple act of kindness, I was completely surprised to find myself being reprimanded for my "unprofessional boundary-crossing behavior" after the resident I was supervising shared this incident with the clinic directors. This allegation of an ethics violation was not only personally painful; it also raised important, controversial, and timely questions about appropriate professional roles.

After more than three decades as a general internist at a Midwest public hospital, I joined the staff of an academic medical center in Boston. While the public hospitals' patients were predominantly poor and uninsured, the academic center had both a different patient-mix and, to my surprise, a different culture and different norms related to "professional-patient boundaries." Actions my public hospital colleagues and I regularly took to help needy patients were questioned as inappropriate and unprofessional. Indeed, informal polls I've recently conducted at conferences in several hospitals comparing views and practices showed that there were dramatic differences in physicians' views on the acceptability of, for example, helping patients pay for medications, assisting unemployed patients in finding jobs, or, in a situation where there were no better alternatives, giving a patient a ride home. Some physicians (in all settings) considered these acts acceptable and had done so themselves, although these views and behaviors were much more common in public hospital settings. Other physicians felt these acts represented a violation of proper and needed professional boundaries.

Physicians must indeed respect certain boundaries. A growing literature and guidelines have admonished physicians and other health professionals to strictly respect boundaries to avoid improper expectations, dependency, legal liabilities, and confusion of personal and professional relationships. Most concerning were data documenting sexual relationships between physicians (often psychiatrists) and their patients.[1] In reaction to such abuses, medical societies and regulatory bodies established codes that strictly—and appropriately—proscribe sexual or other relationships that may exploit patients' vulnerability and trust.

However, some interpretations of these restrictions risk constructing a misguided model—one that discourages physicians from humanly caring for and about their patients. This new paradigm risks encouraging detached, arms-length, uncaring relationships. When do "boundaries" become barriers to meaningful caring relationships?[2] And will such bounded thinking serve to rationalize abdication of our professional and personal responsibilities to humanely respond to patient suffering and underlying injustices?

While I had rarely paid for a patient's medication as I did on that Friday afternoon (medications had been free at the public hospital clinic), in this situation it seemed reasonable and appropriate. Various ethics and conflict of interest rules prohibiting physicians from having "financial relationships" with patients may be appropriate when it comes to physicians *taking* or *soliciting* money from patients. But what about the propriety of *giving* money to a needy patient in this particular situation? While other alternatives such as using a special fund might be preferable, when I found that no such fund existed at my hospital (and the drug insurance plan denied coverage due to a technical glitch in the patient's enrollment), was it wrong to personally help a patient in such a moment of need?

Everything we do in medicine has risks. Whether prescribing a medication or performing surgery, we, in consultation with the patient and family, must weigh potential benefits and risks. When considering reaching out to help patients in need, possible adverse effects should be weighed against the benefits in that particular context and situation. Potential risks include, for example, the possibility that patients would divert money to instead buy street drugs or alcohol; that patients might come to expect, or depend on, or demand such help in the future; liability risks if one had a car crash when driving a patient home; diverting time and attention from other patients; that acts of kindness would be misinterpreted by patients as requiring reciprocal favors. In addition, time and energies required for professionals to carry out and sustain these extended-caring acts can further stress already overburdened physicians and other professionals.

In weighing such risks, however, we need to be clear *whose risks* we are considering. Many of these risks are actually more risks to physicians, rather than to patients. Thus, those insisting on stricter boundaries need to rethink what they mean by "limits." Who are those limits designed to protect? Are "limits" protecting the patient, or are they protecting us—protecting our time or even protecting our consciences, allowing us to avoid painful questions of inequality or taking needed moral action? While there is nothing inherently wrong with protecting caregivers against overwhelming time demands or burnout, let's not pretend we are imposing limits for patients rather than our own best interests.

The American Medical Association's Code of Medical Ethics states: "The practice of medicine … is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. … The

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relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest … and to advocate for their patients' welfare."[3] The type of caring relationships embodied in this statement, and the kindness I believe most patients and physicians yearn for, has been pejoratively dubbed "nostalgic professionalism." This outmoded model of professionalism, it is argued, needs to be replaced by a more dispassionate business-like model where limitations and boundaries are more circumscribed and it is clear that we are not our patients' friends, neighbors, or personal advocates for issues beyond their medical problems. Short of avoiding caring for poor patients entirely or not being part of the community in which our patients live and work (both unfortunately not rare), personal engagement with patients as people, not just as "clients" or "consumers," is inevitable, and even desirable.[4] For many of us (particularly primary care physicians), more than any P4P (pay-for-performance) financial incentives, our most fulfilling rewards and professional satisfactions come from having meaningful relationships with our patients, as well as our ability to broadly ameliorate their problems and suffering.[5] Of course we have to make daily compromises with reality, especially the realities of suffering and hardships poor and underserved patients face—problems we obviously can't personally cure. Nonetheless, we should try within the limitations of our time, resources, and abilities to help where we can.

The real danger of personal engagement is not that we further complicate already complicated relationships with our patients by doing too much. Rather it is that of tokenism—of doing too little and feeling satisfied and excused from addressing the social and economic injustices that underlie poor patients' suffering. It is here we have to be mindful of the fundamental distinction between charity and solidarity.[6] Yes, we need to be charitable in every way possible, but we also need to stand alongside our patients in striving for a fairer, more caring world. If physicians want to stand aloof, addressing only the biomedical problems, ignoring and seemingly indifferent to the social circumstances of our patients, then patient/relation-centered medical homes are likely to feel more like gated communities than places where people live and work together. Fortunately, the two strands of genuine "caring DNA" are closely intertwined. Collective advocacy for societal change and personal advocacy and helping of individual patients cross-fertilize and nourish each other. Minimizing barriers for professionals and patients working together for this shared agenda represents true patient-centered medical care.

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