**Boundary Lessons**

In a column 18 months ago, I highlighted the risks of doctors entering into sexual relationships with patients.[1] I noted that complaints about doctors (and other health professionals) overstepping professional boundaries and entering into personal relationships with patients are a difficult area of HDC's work. Fortunately, such complaints make up a tiny proportion of the 1,000 or so complaints received each year. Unfortunately, they are a recurring feature and distressing for all involved.

When a doctor enters into a sexual relationship with a patient, he or she clearly oversteps appropriate boundaries. However, as highlighted in a recent case, it is not just sex with patients that can be a risky business. Boundaries can be blurred by other actions and lead to concern and complaints irrespective of whether the relationship becomes sexualised.

*Case study*
The case in question involved a small town GP, Dr B, who was consulted by Ms A in relation to a breast infection. During that consultation Ms A told Dr B about her personal circumstances and her recent marriage break-up. After a second consultation with Dr B, and some chit-chat about the fact that Dr B had recently started smoking again and could not smoke at the surgery, Ms A invited him to her house (near the surgery) for a cup of coffee and a cigarette. After a coffee and cigarette, Dr B left with a container full of home-grown tomatoes from Ms A. Accepting a one-off gift of home-grown produce may not in itself give rise to any ethical issues. However, it is generally unwise and in this case it was the start of a slippery slope.

Some days later, Ms A's request for the return of the container led to a further visit from Dr B. He claimed that Ms A professed her attraction to him. Dr B said he discussed with Ms A the inappropriateness of such comments but she broke down and told him more about her relationship problems. Feeling uncomfortable, Dr B left, but not before giving Ms A a hug "out of sympathy and concern". Ms A's recollection of events was markedly different. She described Dr B grabbing her and trying to kiss her while she endeavoured to repel his advances.

Whichever version of events one accepts, there were clear warning signs that the appropriate doctor–patient boundary was becoming blurred. It certainly seemed irresponsible for Dr B to return to Ms A's house that evening with a bottle of wine, irrespective of whose idea the bottle of wine was (which was disputed). Ms A recalled letting loose and telling Dr B how inappropriate his actions had been, in response to which he talked about his love life and said that he wanted to be her lover. He then tried to kiss her again when walking out to his car. In contrast, Dr B said that he invited himself over to talk about what had happened that afternoon, and that he was concerned about Ms A. He raised concerns about what had transpired that afternoon and emphasised that their relationship could only ever be that of doctor and patient. Ms A then tried to kiss him as he left.

[1] "Sex with patients — risky business", *NZ Doctor*, 25 August 2004 (http://www.hdc.org.nz/publications.php?publication=225)

*Complaint/investigation*
Ms A subsequently complained to the medical centre where Dr B worked, and then to my Office. HDC takes complaints about inappropriate relationships with patients very seriously, and commenced an investigation. Regardless of the differing accounts, I considered that Dr B "was naïve and foolish in going to the home of a patient in such circumstances, and it was most unwise to return that evening with a bottle of wine". The matter was brought to the attention of the Medical Council and the College.

Although the investigation was discontinued in light of the markedly different accounts and lack of corroborating evidence, it was undoubtedly distressing and stressful for Ms A and Dr B. The distress could have been avoided had Dr B maintained appropriate professional boundaries in his relationship with Ms A. Even accepting Dr B's version of events, it is not difficult to see how his actions sent mixed messages to a patient whom he knew was going through a stressful marriage break-up. Consoling hugs, home visits and bottles of wine go well beyond the scope of an appropriate doctor–patient relationship. Dr B may have been well-intentioned, but he was Ms A's doctor, not her friend.

*Zero tolerance*
The Medical Council has for some time maintained a strict "zero tolerance" position in relation to any breaches of sexual boundaries. Its publication "Sexual boundaries in the doctor–patient relationship" (March 2004) provides a thorough discussion of the issue and practical advice for doctors on dealing with awkward situations. The Council makes it very clear that it is the responsibility of the doctor, as the professional, to set and maintain the professional boundary and respond appropriately to any suggestion that the boundary is threatened. One example of a "danger sign" is giving or accepting social invitations from a patient.

Boundary issues, by their very nature, involve two people. However, the onus is on the doctor to behave in a professional manner. As the Medical Council notes, "It is not acceptable to blame the patient for your transgressions." This is not to say that doctors can have no social contact with their patients. Such a prohibition would be harsh and unrealistic — particularly in the context of a small town or rural practice. Provided that professionalism and common sense guide a doctor in his or her interactions with patients, both in and out of the surgery, there should be little room for concern.

*False accusations?*
Some doctors, particularly male doctors, worry about being the subject of spurious claims of a sexual nature. Once again, practical steps such the presence of a 'chaperone' (eg, a practice nurse), ensuring appropriate disrobing facilities and clear communication are all useful ways for maintaining safety for patients and doctors. Doctors who act professionally have little to fear from false complaints. Vexatious complaints are very rare, and the legislation empowers HDC to take no action if satisfied that the complaint is not made in good faith.

As illustrated by this recent case, maintaining professional boundaries requires more than just refraining from a sexual relationship. Blurring of boundaries and failing to respond appropriately to "danger signs" can be damaging for patients and stressful for both parties, and risks professional censure and loss of credibility for the doctor.

**Ron Paterson**
**Health and Disability Commissioner**
*NZ Doctor*, 22 March 2006