Should we play basketball with our patients? Professional boundaries and overlapping relationships in rural Australia

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"At the end of our consultation, a client (patient) tells me that he's seen me playing squash at the local courts, and has asked me to partner him in the upcoming squash final as his current partner is unavailable for the game." This experience will be familiar to many rural practitioners. This paper explores psychologists' responses to overlapping relationships.

Background and aims

We all have moral obligations in our everyday lives. Beyond everyday morality, those of us in professional roles develop distinct norms and principles to guide our well-intentioned professional conduct. We develop certain ethical sensitivities that have been learnt through engagement with the specific nature of working in our chosen professions. Through processes of acculturation good clinicians develop a kind of 'ethical sensitivity' to the distinct demands of their particular clinical practice. With experience the links between a clinician's knowledge, technical ability and ethical 'nous' firms.[1] This study seeks to explore if experienced clinicians make decisions that may call on these skills.

As practitioners have developed the practice wisdom that is so essential for expert ethical clinical practice, experienced rural practitioners develop a kind of 'interprofessional sensitivity' to the demands of rural practice. Like their metropolitan colleagues, a rural professional will act from their respective profession's distinct ethics. The rural professional will in addition develop through engagement and experience of rural practice an acculturated appreciation and an ethical sensitivity to the specific nature of rural clinical practice. Thus, it is the distinct interprofessional character of the rural practice context itself that engenders the development of a distinct ethical sensitivity to the particular demands of rural health care, beyond the requirements of both broader and professional morality. In this sense a 'distinct rural ethics' is grounded in the reality of rural professionals' lived experiences.[2] This study seeks to identify elements of this 'distinct rural ethics'.

Rural health practitioners may assume more than one role with a client or patient, such as a health practitioner and as a local social contact.[3] Treating acquaintances, work colleagues and perhaps at times friends may not be considered unusual.[4] Such overlapping roles are more likely to occur in smaller and more isolated communities than larger urban centres.[5] A number of community expectations, including that professionals participate in local activities and support local trade, and that patients/clients should be able to receive appropriate care without unreasonable travel to a larger centre, may also promote multiple relationships between health professionals and their clients/patients. Whilst many health professional codes of conduct recognise the undesirability of this situation, community expectations mean that rural health practitioners may have limited choice in avoiding overlapping relationships if reasonable community expectations are to be met.

Overlapping relationships are considered problematic by health professional regulatory bodies that determine ethical standards of practice.[6] Difficulties for the practitioner and administrators are also experienced. Overlapping relationships, although a boundary crossing, do not automatically result in a boundary violation. Boundary crossings and boundary violations differ in a number of ways. The major difference is the presence of exploitation, manipulation, deception and coercion (boundary violation) or the absence of these features (boundary crossing).[7] Boundary violations are clearly ethically unsound and must be avoided at all times. Boundary crossings however, may be experienced by the rural practitioner regularly. This paper assumes that

boundary crossings occur for rural practitioners – it reports an approach that will both explore practitioners' view of those crossings and if distinction between boundary crossings and violations are recognised and if boundary violations are seen as unacceptable.

The recently established Australian Health Practitioner Regulation Agency is responsible for registration of every psychologist in Australia. Australian Health Practitioner Regulation Agency has adopted the code of ethics from the Australian Psychological Society (APS). The APS code of ethics mentions overlapping relationships suggesting that APS psychologists must refrain from entering into overlapping relationships that may:[6]

- impair their competence, effectiveness, objectivity or ability to provide psychological service
- harm clients
- lead to the exploitation of clients

It is unlikely that any psychologist, or other health professional, would argue that exploitation and harm of clients is acceptable under any circumstances. However rural practitioners, especially smaller community isolated practitioners may have little option than to enter into therapeutic arrangements in which their objectivity may be compromised and at times effectiveness limited.[8] Helbok (2003) argues that belonging to community may place a clinician under the spot light, where personal and professional life becomes difficult to separate and role-blurring may be experienced.[9] In this instance if the practitioner's objectivity and effectiveness are to some degree compromised, this is preferable to a client in need not receiving reasonable care. To ensure access to all people, a practitioner may have to practice with compromised objectivity and treat those with whom he or she has had a prior relationship.[10] The range of treatment delivery options, including travel to an alternative centre, fly in-fly out services or electronic services may not be suitable for all. Professional code of ethics may be easier to adhere to in a metropolitan community that is rich in professional resources and where referral options are extensive, rather than in an interdependent rural environment.[8]

The APS developed a series of guidelines to clarify and amplify the application of these principles.[11] These guidelines specifically explore psychological practice in rural and remote settings. Although the guidelines identify most of the pitfalls and areas of concern, there is limited direct guidance to help the practitioner negotiate potentially difficult unavoidable overlapping relationships. The guidelines are to be used in conjunction with the code of ethics, which is based on non-negotiable fundamental principles.[11] The challenge for many practitioners is to apply non-negotiable fundamental principles to their specific clinical and social context.

Overall, if health care is to be provided locally, supporting ready access for all, the rural clinician often has little alternative than to practice in the context of overlapping relationships.[12] This unique challenge, although seen by many metropolitan practitioners as problematic, may be considered standard for the rural clinician.[13] These potentially conflicting roles although ethically challenging may be part of the rural practitioners' routine daily working life.[14]

Ethical decisions in relation to overlapping relationships taken by rural practitioners may be viewed negatively by their metropolitan counterparts. However, the same broad principles apply in both settings. It may be that the metropolitan practitioner has not encountered overlapping (dual) relationships and through lack of previous experience or need to consider the issues, sees the decision of their rural counterpart negatively. This may not reflect a 'true negative' consideration but one resulting from lack of familiarity. Conversely, for the rural practitioner familiarity with the ethical dilemma of overlapping relationships should not offer any opportunity to consider the issues less rigorously. The rural practitioner needs to consider the issue and find a solution; often the practitioner in a large city neither needs to consider the issue nor find a solution.

The aim of this research is to investigate rural and metropolitan practitioners' beliefs and experience of dual relationships. These findings may help in the development of Australian guidelines that are both ethically sound and applicable in routine rural practice to help clinicians manage overlapping relationships. Little empirical work has been conducted in Australia on dual relationships. Scopelliti et al recommended that Australian based guidelines that help rural practitioners manage dual relationships be developed.[5] Effective

guidelines may encourage clinicians who previously thought it professionally untenable to work in a rural setting to feel more confident to practice in smaller communities.

The current study measured metropolitan, regional and rural health practitioners' perception of overlapping (dual) relationships. It was hypothesised that metropolitan based clinicians will identify greater ethical concerns about such relationships than their rural counterparts. Conversely, rural practitioners will rate potential overlapping (dual) relationships as less problematic. The ultimate aim of the research is to develop a useable framework for rurally based treating practitioners to help them respond to dual personal and professional relationships in a manner that ensures both ethical and clinical needs of every client/patient are appropriately addressed.

Method

Psychologists were recruited to the study by email or mail contact using the public register of the Psychologists Registration Board of Victoria's website. A random selection of psychologists, with current public email addresses, was recruited to complete an online survey. Hard copies of the same questionnaire were sent to similarly randomly selected psychologists without a publicly listed email address. Participants were asked to respond to ten hypothetical scenarios encompassing a range of dual personal/professional relationships. This paper will report the results from four of these hypothetical scenarios: two boundary crossing scenarios, one boundary violation scenario and one scenario of incidental contact. Psychologists' perspective of ethical dilemmas was measured using a ten point scale with 1 representing most ethical/most appropriate and 10 least ethical/most inappropriate. The four scenarios reported were as follows:

Boundary crossing scenarios (1 and 2):

> I have seen this client a couple of times and have only just discovered that he is a member of my church. As it has a large congregation, I have opted to ignore this connection and continue with therapy
>
> Last year I treated Jan twice for a stress issue which was work related and had not seen her since. We have both recently been elected to the school committee. Jan has now invited me to her 40th birthday party. I have accepted the invitation

Boundary violation scenario (3):

> My client recently disclosed during therapy that he needed to sell his house quickly as he is in serious financial distress. I have made him an offer. This will be a mutually beneficial arrangement as I think I might get it cheaply and he will have a quick sale

Incidental contact scenario (4):

> The other day I ran into my client in the local supermarket, he stopped me, and we talked about the local football then went our separate ways

To preserve the confidentiality and anonymity of respondents living in small rural communities, participants did not report their work postcode and as such Accessibility Remote Index of Australia (ARIA) was not used for categorization of data. Participants were asked to indicate the size of town where they work using descriptors of the Rural, Remote and Metropolitan Areas (RRMA) classification.

Quantitative analysis of data was undertaken using standard techniques. SPPS version 17.0 was used. Statistical significance was set at $p<0.05$. Group comparisons was undertaken using Analysis of Variance (ANOVA) and Chi Square test for independence.

Results

Invitations to complete an online survey or hard copy questionnaire were sent to 4000 psychologists and 1000 psychologists respectively. Response rates to the email and mail versions of the survey were 6% and 16% respectively. Preliminary data from 410 psychologists who responded have been analysed.

Demographics

Four hundred and ten psychologists responded to the survey; on-line 239 (58%) and by post 171 (42%). Eighty per cent of respondents were female with 266 (65%) having completed a master's degree and beyond. Two hundred and thirteen participants (52%) had ten or more years of experience in practice, with 69 (17%) reporting less than three years experience. Two hundred and forty two respondents (59%) were from cities with population exceeding 100,000, 85 (21%) from regional centre (population size between 25,000 and 99,999), 36 (9%) from small rural centre (10,000 to 24,999), 37 (9%) from a rural area (5,000 to 9,999) and 10 (2%) from remote rural area (less than 5,000). Most participants, 295 (72%), had more than four years practicing in their current location. Psychologists working in private practice made up the majority of respondents 243 (59%), with those practicing in hospitals 100 (24%) being the second largest group.

There were no demographic differences between email and hard copy respondents except for the length of time in professional practice and the number of years practicing in the nominated size of town. Participants who had been practicing for longer than 10 years accounted for 60% (102/171) of the hard copy survey results compared to 46% (111/239) of the email results. Similarly those who had been practicing for longer than 10 years in the size of town nominated accounted for 29% (70/239) of email and 48% (82/171) of post surveys. These demographic differences may have resulted from changes in the registration requirements, requesting current email addresses from new registrants.

Responses to scenarios

Data have been collapsed into three groups because of smaller numbers in small rural centre, rural areas and remote rural areas. There were only 10 respondents in the remote rural group. Therefore, in the presented data the term 'rural area' represents populations ≤ 24,999.

Many psychologists reported experiencing dual/overlapping relationships in the course of their professional practice, see Table 1.

Table1 Percentage of psychologists who experienced dual/overlapping relationships in their professional practice

		Experienced dual/overlapping relationships	
Population of town/area	**n**	**Yes**	**No**
Metro urban (≥100,000)	241	54.4%	45.6%
Regional centre (25,000 to 99,999)	85	75.3%	24.7%
Rural area (<25,000)	82	87.8%	12.2%

The proportion of psychologists reporting experience of dual/overlapping relationships is greater in rural areas. It is worth noting however that more than half of the psychologists from large cities reported that they had experienced dual relationships in the course of their professional practice.

Scenario 1:

> I have seen this client a couple of times and have only just discovered that he is a member of my church. As it has a large congregation, I have opted to ignore this connection and continue with therapy

Participants' responses on the 10 point scale to the abovementioned scenario, Means and standard deviations, are reported in Table 2. Greater degree of ethical concern about the scenario is represented by a larger number. A one-way ANOVA was conducted to compare respondents' beliefs surrounding the ethical behaviour of a psychologist who continues to see a client/patient after he/she discovers that the client/patient is part of his/her church congregation.

Table 2 Means and standard deviations of participant responses to scenario 1

	Number	Mean	SD
Metro urban (≥100,000)	242	5.12	2.69
Regional centre (25,000 to 99,999)	85	4.25	2.80
Rural area (<25,000)	83	3.69	2.73

A significant difference was found between psychologists' beliefs from metro urban, regional centre and rural area $F(2, 407) = 9.67$, $p=0.0001$. A Tukey post hoc comparison indicated that the psychologists who continued to see his/her client once discovering that the client was a member of the church was considered more unethical by metro urban respondents than from either respondents from regional centre or a rural area.

Scenario 2:

> Last year I treated Jan twice for a stress issue which was work related and had not seen her since. We have both recently been elected to the school committee. Jan has now invited me to her 40th birthday party. I have accepted the invitation

Data for this second boundary crossing scenario was analysed and is presented in the same manner as the previous scenario, refer Table 3.

Table 3 Means and standard deviations of participant responses to scenario 2

	Number	Mean	SD
Metro urban (≥100,000)	242	6.12	2.39
Regional centre (25,000 to 99,999)	85	6.56	2.66
Rural area (<25,000)	83	5.00	2.80

There was a significant difference found between the groups $F(2, 407) = 8.82$, $p=0.0001$. The post hoc Tukey test indicated that the psychologist who attended the 40th birthday party was considered more unethical by both metro urban and regional centre respondents than those respondents practicing in a rural area.

Scenario 3:

> My client recently disclosed during therapy that he needed to sell his house quickly as he is in serious financial distress. I have made him an offer. This will be a mutually beneficial arrangement as I think I might get it cheaply and he will have a quick sale

Participant responses for the above boundary violation scenario was analysed and is presented similarly to the previous scenarios. See Table 4.

Table 4 Means and standard deviations of participant responses to scenario 3

	Number	Mean	SD
Metro urban (≥100,000)	242	9.63	1.19
Regional centre (25,000 to 99,999)	85	9.86	0.47
Rural area (<25,000)	83	9.69	1.10

All respondents, metro urban, regional centre and rural area were united in their belief that the psychologist's behaviour was unethical and inappropriate.

Scenario 4:

> The other day I ran into my client in the local supermarket, he stopped me, and we talked about the local football then went our separate ways

This incidental meeting scenario was associated with minimal differences between the groups. Refer Table 5.

Table 5 Means and standard deviations of participant responses to scenario 4

	Number	Mean	SD
Metro urban (≥100,000)	242	2.28	1.87
Regional centre (25,000 to 99,999)	85	2.4	1.90
Rural area (<25,000)	83	1.91	1.65

Once again a one way ANOVA indicated no significant difference between metro urban, regional centre and rural area. All respondents believed the actions of the psychologist to be ethical and appropriate.

Discussion

This study has explored the experience and response of psychologists, working in settings ranging from large cities to small rural communities, to the issues posed by overlapping (dual) relationships. Data were obtained from approximately 5% of all registered psychologists in Victoria. This research suggests most psychologists (65%) identify overlapping or dual personal/professional relationships with clients. Those working in large cities are not immune to this experience and the difficulties it may bring, with more than half reporting dual relationships in their practice. However, with increasing rurality such relationships are experienced by a greater proportion of psychologists. This is illustrated by all of the practitioners in the study working in communities of less than 5000 residents (N=10) reporting experiencing dual relationships in their practice. Awareness of the issue of overlapping relationships may occur regardless of location but the need to develop constructive responses may be predominantly a rural issue. For those in large centres when a dual relationship emerges there are generally a number of available alternatives to ensure good care for the client/patient. For the rural practitioner there are the parallel problems of a greater likelihood of experiencing such a relationship whilst at the same time having less access to alternative care options for their client/patient than metro urban counterparts.

This research does not support concern that rural practitioners, familiar with issue of overlapping relationships, may become blasé about potential boundary violations. Rural practitioners' responses to a boundary crossing scenario that is clearly exploitative were the same as practitioners from larger urban situations. Similarly, responses to the most benign practitioner/client scenario showed no urban/rural difference. However, scenarios that might be regarded as indicating potential boundary crossing, such as having a client in the same church congregation or accepting an invitation to a client's 40th birthday party, were regarded with less ethical concern by rural practitioners than their large city counterparts. It is suggested by the authors that this may have resulted not from a disregard of the importance of potential boundary crossings but from careful consideration of the issue. In the rural setting psychologists may feel it is essential to appropriately deal with the circumstances, without putting it in the 'too hard basket' and avoid the situation as their large city counterparts may with their increased range of treatment options. This suggests rural practitioners may have developed constructive approaches to the virtual inevitability of overlapping relationships. It is proposed in future work to explore these approaches as a contributor to future guidelines on overlapping relationships in rural practice.

Conclusions

This study suggests that responses to boundary crossings as distinct from boundary violations by rural psychologists may differ from those of large city. The study findings are consistent with the existing literature and support further work to understand in greater detail the approaches rural practitioners employ to address overlapping relationships.

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