When Patients Are Normal People: Strategies for Managing Dual Relationships

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A significant number of generalist physicians, particularly those in rural areas, often find themselves participating in the care of patients for whom the therapeutic relationship overlaps with another relationship (e.g., social or professional). Although psychiatrists and psychologists are typically advised to avoid such "dual relationships," no such prohibition exists for generalists. Little, if any, guidance exists to aid in the management of such dual relationships for the generalist who provides treatment for psychiatric conditions for his or her patients. The author, a generalist with experience in the treatment of mood disorders, describes potential challenges faced by the generalist who chooses to provide care for "dual relationship" patients and outlines strategies for successfully meeting these challenges.

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What happens when patients are normal people? Should they ever *be* normal people? As nonsensical as these questions sound, they approach the center of what has become a quite challenging, but equally rewarding, segment of my daily work as a generalist practicing in a rural area—providing care for that subpopulation of patients who are known to me in some fashion outside the therapeutic relationship.

For some clinicians, such a subpopulation of patients does not exist. In their worldview, the universe is divided into 2 distinct camps—"patients" and "normal people"—and never the twain shall meet. In other words, these physicians, following clinical ethics originally elucidated in the field of psychiatry,[1,2] endorse an absolute prohibition on seeing patients with whom the therapeutic relationship is not the solitary relationship. Most nonpsychiatric clinicians, however, do see at least some patients with whom they have extra-therapeutic relationships, but may do so with feelings of reluctance, annoyance, or trepidation.[3]

In my practice (a university-affiliated family medicine training program in a rural county), such a neat partitioning of people into compartmentalized relationships is not feasible. In addition to the relational overlap that inherently occurs in small-town practice,[4] the reputation that the program enjoys as a center of excellence in generalist medicine has prompted many persons with whom I have a prior relationship (either professional or social) to present for care.

Such multilayered relationships offer unique opportunities for fulfillment, but present challenges that must be managed carefully if outcomes (clinical and otherwise) are to live up to that promise. Reflecting on several successful (and a few unsuccessful) multilayered therapeutic relationships, I have identified certain challenges faced when a physician treats a patient whom he or she knows outside the therapeutic relationship (Table 1). I have formulated a set of responses to these challenges, which I share with my patients at the beginning of the therapeutic portion of each multilayered relationship—what I term "the speech." These "dual relationship" patients have responded enthusiastically, and I have found that our therapeutic relationships are strengthened within this structure and that the majority of our extra-therapeutic relationships not only remain intact, but are enhanced while carried forward within this context.

POTENTIAL CHALLENGES AND MANAGEMENT STRATEGIES

Awkwardness

Many patients who know the clinician in other arenas feel quite awkward during the initial consultation and during times of increased intimacy as directed by clinical circumstances. Whether the embarrassment is rooted in revealing aspects of one's body, personal habits, or family history, many patients fear that allowing the clinician access to this knowledge will change the clinician's attitude toward the patient and thus alter the extra-therapeutic relationship(s) in a negative fashion.

Example 1. I see a woman who is a fellow member of my community of faith, who feels somewhat reluctant to reveal certain elements of her medical or social history,

Table 1. Challenges Inherent in Multilayered Therapeutic Relationships and Suggested Strategies for Managing Them

Challenge	Management Strategies
Awkwardness	Expression of gratitude, honor
Confidentiality	Invocation of trust
	Reassurance
	Judicious recording of information
Clinical sprawl	Boundary negotiation
Control	Consultation
	"Therapeutic immunity"

because to do so would indicate current or past participation in activities censored by the community of faith.

Example 2. A medical student is seen for the first time with a complaint of a thrombosed hemorrhoid. He feels quite embarrassed to disrobe, because our previous interactions have been strictly on a professional level.

To counter this potential awkwardness, I specifically emphasize 2 points at each initial encounter. First, I indicate the honor inherent in being chosen as a physician by a person who, by virtue of his or her prior relationship with me, has "insider information" regarding my personal or professional characteristics. As the proverb (attributed to Galen) says, "He heals best in whom the patient has most confidence."[5] I share with patients that I accept their mere presence in the clinic as a resounding vote of confidence and pledge to attempt to acquit myself well in light of that judgment. Second, I reassure patients that they remain in complete control of how much of themselves is revealed. They may choose to forgo certain types of examinations or revelations, but if they choose to do so, they should be forthright, so that the aspect of their care affected by their reservation of privacy may be referred to the oversight of another clinician.

Confidentiality

Multilayered therapeutic relationships offer challenges to confidentiality that not even the Herculean efforts proposed to comply with regulations of the Health Insurance Portability and Accountability Act of 1996 can adequately address. Chiefly, these challenges fall into 1 of 2 categories. The first, a problem with medical record access, arises from the fact that all items in the medical record are de facto subject to the scrutiny of clinical staff. In many cases, it is not only the treating physician who knows the patient outside the context of the therapeutic relationship, but others in the office as well. Such persons might be tempted to peruse the medical record—a case of minor celebrity leading to major breaches of a basic patient trust.

The second challenge to confidentiality is subtler and therefore more apt to be problematic. Most physicians share stories from their practices. In most cases, little, if any, personally identifying information is transmitted, and the persons hearing the stories have little, if any, contact with the patients being discussed. Therefore, such storytelling is typically harmless, because the hearers cannot identify the individuals signified. For the patient and physician who share an extra-therapeutic relationship, however, such a practice can be disastrous, because the likelihood that the hearer will be able to surmise the identity of the patient being discussed is much higher.

An analogous problem arises when the physician is discussing his or her patient by name in casual conversation with another person, in a social or professional setting, without revealing that the person is a patient. It is sometimes quite difficult to avoid revealing information or opinions regarding the patient that are based on clinical interludes.

Example 1. A hospital administrator is seen in the residency clinic by a faculty member. A resident, working at the nurses' station, recognizes the name on the outside of the chart and picks it up to peruse the record, out of curiosity.

Example 2. I am at a dinner party with friends and colleagues when the conversation turns to the marital problems of a couple well known to most of the group. The husband in question is one of my patients and has seen me for a reactive mood disorder related to his difficulty adjusting to estrangement from his wife. A colleague asks me if I have spoken to the man lately and if I know how he is doing.

Although casual prurience has no place in a perfect medical world, physicians must be prepared to circumvent it in this, our imperfect one. Clinic directors should encourage a policy that explicitly states that only those persons with a direct clinical interest in a patient should view the chart's contents, unless conducting standard business such as billing, quality assessment, or research. As an additional precaution, I make judicious entries regarding particularly sensitive information, a practice for which I have previously argued as a means of protecting patients from unwarranted inquiries by third parties.[6]

Physicians are not automatons, and many find that sharing experiences from their professional lives with their colleagues, family, and friends provides a necessary outlet, sounding board, and means of humanizing what can be an incredibly stressful and isolating enterprise. However, utmost caution should be enjoined when sharing such experiences, so that the patients cannot be identified. This necessity is all the more urgent when dual relationship patients are the topic of such discussions. As a general rule, I discuss such patients with others only in a manner that circumscribes what I know about them from our relationship outside of the clinical context (our extra-therapeutic relationship). When in doubt, one would do well to remember the advice of Osler: "Look wise, say nothing, and grunt. Speech was given to conceal thought."[5]

Clinical Sprawl

Patients are often excited about the prospect of seeing a physician whom they know in another context, in that it

gives them an advantage in becoming comfortable in their therapeutic relationship. Although this is often patients' reward for entering a dual relationship, it is potentially purchased at the price of having their "private space" or "professional space" invaded by issues regarding their medical treatment—what I have termed "clinical sprawl."

Example 1. The personal assistant to the dean of our College of Medicine presents for treatment of hypercholesterolemia. He is prescribed an HMG-CoA inhibitor and instructed to return in a month for a follow-up appointment. Two weeks later, I call him to make an appointment to see the dean. Too late, I catch myself asking him if he has experienced any adverse effects from the medication, such as night cramps.

Example 2. My personal physician and I serve on the same hospital committee, which is consulting with an architectural firm regarding the renovation of the obstetric ward. At my last appointment, I shared with him how that after a long period of treatment for infertility, my wife and I were expecting a baby, but that we were quite nervous and had not shared the news. At the committee meeting the following month, my physician slaps me on the back and announces loudly to the room, "We'd better hurry and get some more of this stuff done—Bill here knows a lady who's going to need this facility pretty soon!"

Without exception, I have made a 2-fold pledge to every dual relationship patient that helps to curb clinical sprawl, while at the same time acknowledges the natural human tendency to superimpose (or even integrate) relationships. I tell dual relationship patients that, unless specifically notified by me that the timing is inconvenient or inappropriate, they should feel free to introduce medical topics during our extra-therapeutic interactions. Conversely, however, I promise not to initiate such conversations, so that the patient can expect to remain a person, without concerns that every interaction after entering a therapeutic relationship will involve medical discourse. In other words, patients can choose to construct the clinic in nonclinical space, but I will not bring it to them unsolicited. After laying down these ground rules, I have yet to treat a patient who has taken advantage of the arrangement in the form of repeated or annoying "curbside consultations." Although I do not specify this caveat verbally, it goes without saying that, even if requested by a patient, I would conduct only cursory physical examinations in nonclinical space. I would specifically prohibit evaluations of erogenous regions of the body of patients of either gender, as such interchanges in nonclinical space have often been associated with a progression to sexual misconduct between physicians and patients.[7]

Control

A final source of potential discomfort on the part of the patient lies in the arena of control. Traditionally, although patients occupy a position of reduced power in the fiduciary relationship, they do hold a trump card—they can choose to terminate the relationship if it no longer meets their needs, or request a referral for a second opinion if they mistrust the advice or doubt the competency of their physician. For patients who have overlapping relationships with the physician, however, such actions may be taken with reluctance, for fear that to terminate the relationship would adversely affect the extra-therapeutic relationship(s).

Example 1. A neighbor who twisted her knee mowing the lawn presents to the office for a musculoskeletal examination. I diagnose her with a grade 2 strain and prescribe rest and anti-inflammatory medication. One week later, the patient is little improved, but feels that I might be offended if she were to request evaluation by an orthopedist.

Example 2. A spouse of a faculty member presents for a routine health examination. As he is 50 years old, I recommend a screening endoscopic examination of the colon and offer to perform it in the office within the month. The patient would feel more comfortable having the examination performed by a well-respected gastroenterologist known to both of us, but is loath to mention this preference because he has heard me speak often to his spouse about the importance of training generalists in performing such procedures for their patients.

Essentially, I grant all patients with whom I have extra-therapeutic ties "therapeutic immunity": they are free to truncate (or even terminate) our therapeutic relationship without fearing negative consequences within our mutual relationship(s) outside the clinical arena. I tell them that they hold the "ejector button," which they can use at any time to exit any part (or the whole) of our therapeutic relationship and subsequently present this part (or all) of their health care to any other clinician for management. When specifically reminded that they hold this power to exit part or all of the therapeutic relationship if it ceases to meet their needs, I find that most patients do not exercise it. Instead, they respond by communicating more effectively regarding their needs while remaining in the therapeutic relationship, thereby enriching its context and increasing its effectiveness.

LIMITS TO THE "NORMALIZATION" OF PATIENTS

I do make 3 exceptions to this broad "normalization" of my patient population. The first involves viewing patients as "normal persons" with respect to sexuality. Because of the imbalance of power inherent in the fiduciary relationship, and the risk of great harm to the patient if such a relationship is sexualized, I fully endorse the profession's traditional prohibition against sexual contact between physicians and patients (C. Gurule, M.D.; W.C.J., manuscript in progress). A further argument for

such a stance is rooted not in the concept of power or consent, but in the concept of familiarity—the family. Just as sexual conduct is prohibited among family members, so it should be among physicians and our patients (in this model, an extension of a clinician's "family," by virtue of a bond of increased intimacy, trust, and responsibility). This view is consistent with reports that most patients categorize their primary care physician as a "family friend" or similar to a "distant relative."[8] It may also explain why many victims of physician sexual misconduct describe the encounter in psychodynamic and interpersonal terms very similar to those of incest[4] and may exhibit psychiatric morbidity identical to that incurred in incest victims.[9]

The second exception involves viewing the clinician's own family members as "normal persons" with respect to treatment. In most cases, I endorse the traditional prohibition against seeing family members, primarily for psychological reasons. Medical practice, so often as it is performed by, for, and upon humans, is fraught with human error, most of which passes without incident, owing to the astounding reparative and compensatory capacities of our species. Occasionally, however, errors of omission and commission in the course of practice do result in suboptimal outcomes, which may breed resentment on the part of the patient and remorse on the part of the clinician. Knowing these risks, I treat only those conditions in family members that are acute and, prima facie, self-limiting (e.g., a skinned knee, an acutely sore throat, etc.).

A final caveat should be noted. The literature is replete with theoretical and practical considerations of the dangers of dual relationships between patients and clinicians practicing psychotherapy. Because of the centrality of absolutely uncensored communication from the patient to the physician in many schools of psychotherapy, such a therapeutic relationship often involves strong undertones of transference and countertransference that are difficult, if not impossible, to normalize in an extra-therapeutic setting. I do not practice psychotherapy, but, as a generalist, I do treat many patients with psychiatric disorders. Because the information required to properly diagnose and monitor such illnesses is often considered intensely personal, I attempt to approach any such patients with dual relationships with increased diligence to managing the aforementioned challenges.

CONCLUSION

Ostensibly, those physicians who refuse to see as patients those whom they know as friends or colleagues do so because they are acting in the best interest of the patient. For them, this may be true. But I suspect that at some level, the motivations underlying this stance are rooted in paternalism. Perhaps their therapeutic relationships are styled in such a way that to introduce a friend or colleague—in essence, an "equal" or at least a "normal person"—into this context would seem awkward. If so, such physicians are not protecting patients, but rather themselves.

For many generalists, the division of one's world into 2 camps, "normal persons" and "patients," is a mental construct that is perhaps psychologically useful, but pragmatically unsustainable.[10] The dissolution of this false dichotomy occurs particularly frequently for generalists practicing in rural areas and for physicians who agree to see those patients who are drawn to them (from social and professional networks) by a positive personal or clinical reputation. Although fraught with the potential for difficulties, the multilayered complexity of dual relationships offers opportunities for interacting with our fellow humans in astoundingly meaningful ways. To do so successfully, however, practitioners should consider carefully the concomitant challenges and adopt strategies for managing them that are both effective and gracious.

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