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Physician-Patient Boundaries: Professionalism Training Using Video Vignettes

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Abstract

Introduction: The concept of professional boundaries is often not included in medical training. Historically, the field of psychiatry has given much consideration to the topic of boundaries, partially due to the high incidence of sexual boundary violations in psychotherapy practice. And while there is a perception that more formal education is needed in psychiatry, the pressure to adjust the frame of a treatment in clinical practice is ubiquitous. We developed this presentation and discussion, using stimulus videos to depict common boundary issues that crop up in everyday outpatient medical practice. **Methods:** This 90-minute session consists of a 20-minute PowerPoint presentation introducing the concept of professional boundaries and identifies the nine boundary domains as defined by Gutheil and Gabbard. Then the class views and discusses six brief video vignettes (allowing 10 minutes per vignette) with a 10-minute break. Faculty panelists from different specialties and at different stages of training are present to discuss the video vignettes and give examples from their own practice. **Results:** This curriculum was implemented in 2009 at the University of Vermont College of Medicine and has been held annually since. Pre and post data were obtained in March 2009 from third-year medical students who participated in the seminar just prior to beginning their clinical clerkships. Statistically significant changes between pretest and posttest means were observed in five of the 10 questionnaire items, including one knowledge-based question about prescriptions to nonpatients **Discussion:** The two learner groups we targeted were medical students during their clerkship year and residents in their first year of training. However, this material could easily be extended to other disciplines in medicine such as nursing.

Keywords

Boundaries, Medical Ethics, Professional Boundaries, Physician-Patient Relationship

Appendices

A. Boundaries
B. #1A Needy Patient
C. #1B Needy Patient
D. #2 Z-pack
E. #3 Christmas Present
F. #4 Touching
G. #5A Flirting
H. #5B Flirting
I. #6 Church Street

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

At the end of this session, the learner will be able to:

1. Define the concept of physician-patient boundaries and identify nine boundary domains, as defined by Gutheil and Gabbard.
2. Describe how and why physician-patient boundaries are a challenge to negotiate throughout one's medical career.
3. List the clinical, social, and community factors that may shape how professional boundaries are defined in practice.
4. Tolerate ambiguity where boundaries are not clearly defined by legal, professional, and/or institutional standards.
5. Explain the importance of self-monitoring of professional boundaries for practice-based learning and risk management.

Introduction

A 2007 search of our medical school's curriculum on the topic of professionalism revealed a notable absence of formal teaching about the concept of professional boundaries. Little existed in the literature to fill that gap, with the exception of a 1994 article by Duckworth, Kahn, and Gutheil[1] that identified the

psychiatry clerkship as a natural time to teach about boundaries. This article outlined a set of common boundary pitfalls medical students encounter as they adjust to their new professional role and advocated educating all physicians about the distinction between boundary crossings and boundary violations, a distinction first made by Gutheil and Gabbard.[2]

Historically, the field of psychiatry has given much consideration to the topic of boundaries. There exist fairly extensive practice guidelines,[3,4] overarching principles,[5] and some published pilot curricula[6,7] to guide education on this topic. Indeed, given the high incidence of sexual boundary violations in psychotherapy practice, education on boundary vigilance and avoidance of the so-called slippery slope[8] should be mandatory in the field of mental health. However, even amongst psychiatry residents, there is a perception[9] and some data[10] that more formal and widespread education on the topic is needed. Importantly, too, this educational tradition does not extend to other medical specialties or occur early enough in medical training to reach all learners.[11] Since pressures to adjust the frame of a treatment are ubiquitous and not isolated to psychiatry, we developed the following materials for presentation and discussion, using stimulus videos to depict common boundary issues that crop up in everyday outpatient medical practice.

The two learner groups we targeted were medical students during their clerkship year and residents in their first year of training. However, this material could easily be extended to other disciplines in medicine such as nursing. Ideally, to be optimally prepared to engage with the material, learners will already have had some clinical exposure in which they have struggled with boundary issues. In our medical school, the most convenient time to deliver this content occurs during an orientation week before the clerkship year for the entire class of students (110 in our school). We have also given a shorter version (minus the panel) to PGY1 psychiatry residents every year during their Introduction to Ethics course.

This curriculum was implemented in 2009 at the University of Vermont College of Medicine and has been held annually since. This 90-minute session consists of a 20-minute PowerPoint presentation followed by the viewing and discussion of six brief video vignettes (allowing 10 minutes per vignette) with a 10-minute break. Faculty panelists from different specialties and at different stages of training are present to discuss the video vignettes and give examples from their own practice.

Methods

To engage our audience in a stimulating classroom discussion, we used educational grant money (2007-2008 Frymoyer Scholarship Grant from the University of Vermont College of Medicine) to film stimulus video segments to illustrate boundary dilemmas that commonly occur in clinical practice. In developing the scripts, we drew from our own clinical experiences. Each scripted vignette depicts one to four boundary domains so that learners have the opportunity to recognize and name them. Our standardized patient actors played the roles of both patients and physicians, with the exception of the Christmas present vignette in which we made cameo appearances out of necessity.

We piloted this material during the psychiatry clerkship lecture series but discovered small audiences (e.g., six to eight students) with only one faculty member present limited the depth of the discussion. In addition, we thought that input from faculty in other specialties would enrich the discussion, especially since our vignettes depict scenarios in a general practice setting. We were fortunate to find time in the general orientation bridge week before the clerkship year, as described above. The 90-minute format we developed is lengthy, but the discussion is rich and the material relevant and entertaining, so the time goes quickly. Faculty panelists enjoy the experience and return every year to participate. The advantage of covering all the material in a single session is the preservation of faculty time; however, this material could easily be broken up into two 45-minute sessions (see Format section, below) and can be presented without modification to smaller learner groups.

Description of Materials

1. Boundaries PowerPoint presentation (Appendix A). You will need to customize this slide set to include your own state medical board and/or institutional policy on prescription limitations (slides

3, 22) and institutional gift policy (slide 24). The note sections of the PowerPoint contain educational points for the lecturer (time allowing) and for students who review the material on their own.

2. Six video vignettes and two optional vignettes (Appendices B-I; see Table 1). The optional vignettes (#1B and #5B) are scenarios that were filmed a second time to illustrate a more professional outcome. These video files can be imbedded in the PowerPoint for ease of presentation.

Table 1. Boundary Vignettes

Vignette Title	Description	Boundary Domains
#1A Needy Patient	Anxious/needy patient repetitively phones the practice	Time
#1B Needy Patient (optional)	Above scenario with appropriate boundaries set	Time
#2 Z-pack	Prescription request by a nonpatient	Role
#3 Christmas Present	Gift giving by a grateful patient	Gifts
#4 Touching	Touching a patient	Physical contact
#5A Flirting	Flirtatious patient and responsive physician	Role; attire; self-disclosure; place and space
#5B Flirting (optional)	Above scenario with maintenance of boundaries	Role
#6 Church Street	Encountering a patient in public	Self-disclosure; language; role

Faculty and Resources Needed

1. One presenter to give the PowerPoint lecture and then moderate the discussion of each scenario.
2. A panel of faculty and trainees in different specialties. We invite four panelists: a general internist, a surgeon, a family practice resident, and a psychiatrist.
3. One panelist also serves as a timekeeper, to keep the scenarios moving.
4. A computer/LCD projector for the PowerPoint presentation. The computer must have the capacity to play film (Windows Media Player, QuickTime, or other).
5. A lectern with a microphone for the presenter.
6. Portable microphones for the panelists.
7. Chairs for the panelists at the front of the auditorium, facing the students.

Format

We designed our learning exercise for medical students to last 90 minutes with one 10-minute break at the 45-minute mark. To begin, one faculty member presents the first 18 slides of the PowerPoint (Appendix A) in a lecture format timed to last 20 minutes. During the lecture, the teacher gives one or two clinical examples of each boundary domain to bring the material to life before moving on to the next slide. After the teacher briefly fields questions about the material presented, the first two patient scenarios are played and discussed, followed by a 10-minute break. Then, the remaining four scenarios are viewed and discussed. The panelist who is the timekeeper helps the moderator keep the group moving through the vignettes (approximately 10 minutes per vignette).

After each vignette is played, the presenter asks students to identify which boundary domains are being illustrated in the vignette. The presenter asks for student reactions and thoughts about the scenario as depicted. Then, each panel member (or a subset if comments get lengthy) comments on the scenario, including what he/she would do in this situation and whether he/she has encountered this in clinical practice. Often, panelists and students will share their own case examples that resonate with the material viewed. Students are encouraged to ask questions and to respond to the ambiguity of the scenarios by weighing in with their own thoughts.

Notes on Vignettes

#1A Needy Patient (Appendix B): This scenario is common and recognizable but is sometimes perceived as over the top by students when the patient starts to spell out the names of her medications. However, this vignette was modeled on an actual patient in practice. Given the less-than-professional response of

the physician in this vignette, we filmed an alternative scenario (Version #1B; Appendix C) to illustrate how one might set effective boundary limits with a needy patient over time. Discussion of high-maintenance, anxious patients in a busy clinical practice is a lively one, and the anger and abruptness of this physician are understood by most panelists and some students.

#2 Z-pack (Appendix D): This is fairly straightforward: a busy covering physician, a supposedly helpful (but with an undertone of threat) assistant, and the precedent of a prior physician who had prescribed for this nonpatient. Discussion usually includes how often residents and physicians are asked for prescriptions by nonpatients, the practical pressures under which this request occurs, and the binds it produces for the physician. Students are glad to be informed of the legal and institutional policies about this and often have had their own experiences with it. The facilitator could ask how this scenario would differ if it was a request for an opiate prescription or if it the office assistant had requested a prescription for herself.

#3 Christmas Present (Appendix E): This vignette was purposely filmed to illustrate the downside of adherence to a strict "no gift" office policy—a solution that, at first, seems the easy solution to this domain dilemma. Students wince for the patient, and in the background, the display of holiday cards sent to the office is meant to show that some gifts are, in fact, accepted. The gift is wrapped, illustrating how difficult it is to know the value of a gift before accepting or rejecting it. Students often have lively examples from their own experience to bring to bear. Faculty panelists provide their practical solutions to this ubiquitous challenge. Concepts such as the slippery slope (ever-increasing gifts), how to set a monetary limit for practices with wealthy patients, the burden of precedents, and other dilemmas are discussed.

#4 Touching (Appendix F): The difficulty in anticipating how a reassuring touch will be perceived by a patient is illustrated in this vignette. The patient is gay, and the touch is on the thigh—two details that may have contributed to the patient's frozen, anxious response and the abruptness with which she leaves the office. The physician is truly perplexed, as her intentions were to comfort and the patient gave little indication of her reaction until she abruptly left. Discussion usually covers the use of touch as a nonverbal soothing mechanism, the fact that some patients with histories of abuse/trauma can react differently to touch, and the fact that touch also can have a sexual dimension. Faculty should comment on possible actions this physician could take after the visit to repair the rupture to the alliance.

#5A Flirting (Appendix G): This scenario elicits the most embarrassed laughter; students think it is over the top and not a realistic scenario. However, this physician's dress is not atypical for today's acceptable female fashion (so much so that the students might not even recognize it as a depicted domain), and the questions/attitudes of the flirtatious patient are not so far-fetched. We made the injury orthopedic to illustrate the potential dynamic of a male heterosexual patient narcissistically compensating for his injury by flirting with his female surgeon in order to maintain (or resurrect) a macho identity. Scenario #5B (Appendix H) is available if you have time to show how different attire (i.e., the projection of a different professional message) and an alternative management of questions could have led to a more professional outcome. Discussion often goes to the question of romantic relationships developing between physician and patient, teacher and student. If this comes up, it is helpful to quote ethical standards of the American Medical Association[12] and/or other subspecialty organizations.

#6 Church Street (Appendix I): This was filmed on Church Street, the main shopping mall in Burlington, Vermont. It depicts an unexpected encounter between a patient and her physician outside the office. The awkwardness is evident, especially in the physician, who has been with caught off-guard (and out of role) in a nonoffice setting. The tension between being socially polite and forthcoming versus maintaining a professional role with limited self-disclosure[13] is illustrated here. The domains listed on the next slide are purposefully posed with question marks due to the ambiguity illustrated: role (is he still and only her physician when they meet on the street?), self-disclosure (isn't this entirely appropriate in this setting?), and language (how do they address each other in this context—doctor? First name? Using a name at all?). Panelists often have many humorous stories about awkward encounters with patients outside the office. Issues of working in a small community, differences between specialties, how to take cues from the patient, and introducing others you are with frequently come up in the discussion.

Results

Pre and post data were obtained in March 2009 from third-year medical students who participated in the seminar just prior to beginning their clinical clerkships. Students were asked to complete a 10-item questionnaire in advance of the seminar and then to complete the same questionnaire several days after they had participated in the seminar (see Table 2). The on-line questionnaire included eight attitude-based items (1-4 and 7-10 in Table 2) and two knowledge-based items (5 and 6 in Table 2), and responses were in 5-point Likert-scale format (1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Neutral/Uncertain*, 4 = *Agree*, 5 = *Strongly Agree*).

Table 2. Questionnaire Items

Item #	Item Text
1	I know what is meant by the term "physician-patient boundary."
2	When I encounter a professional boundary issue in my medical career, the correct course of action will usually be clear.
3	Aside from preserving patients' confidentiality, I will not need to think about professional boundaries outside of work.
4	I would decline a gift of baked goods from an appreciative patient.
5	University of Vermont Medical Center has a policy which expressly prohibits physicians accepting any gifts from patients.
6	In the state of Vermont, it would be illegal for me to prescribe myself or an immediate family member any medication other than an antibiotic.
7	It is helpful for patients if I tell them about my own experiences that are similar to the problems they bring to the office.
8	It makes no difference whether a patient addresses me as "Doctor," or by my first name.
9	If a patient cannot afford to pay my fees, it is reasonable to accept items of comparable value in lieu of money.
10	I would decline a hug from an appreciative patient.

Results were analyzed via two-sample *t* test (two-tailed, unequal variance). Statistically significant changes between pretest and posttest means were observed in five of the 10 questionnaire items, including one knowledge-based question about prescriptions to nonpatients (see Table 3). In addition, the students gave anonymous narrative feedback about the seminar. The narrative comments reflected a range of opinions about the content and format of this educational exercise. Positive commentary included statements such as "The videos were very effective teaching tools that demonstrated the key points" and "I thought this was the best panel so far because the videos guided the discussion." Negative comments primarily focused on the length of the educational session, suggesting that it could be shorter. There was also a handful of negative comments such as "should be obvious information," "unnecessary," and other similar sentiments.

Table 3. Comparison of Pretest and Posttest Means

Item#	Pretest *M*	Posttest *M*	Pre-to-Post Change in *M*	*p*[a]
1	3.95	4.57	0.62	.0000[b]
2	3.25	3.40	0.15	.3207
3	2.03	1.86	–0.17	.3744
4	3.33	2.02	–1.31	.0000[c]
5	3.60	3.47	–0.13	.5079
6	2.24	1.71	–0.53	.0001
7	2.70	2.40	–0.30	.0837
8	3.01	2.48	–0.53	.0023
9	2.34	2.90	0.56	.0022
10	1.80	1.91	0.11	.3832

[a]Independent two-sample *t* test, two-tailed, equal variance.
[b]$p = 7.3 \times 10^{-8}$.
[c]$p = 1.6 \times 10^{-11}$.

Over subsequent years of implementation, informal feedback from faculty has been uniformly positive. Faculty found that this material fit an untaught need in the medical school curriculum and was illustrative of real-world professional dilemmas that face all physicians. The vignettes were considered both entertaining and effective stimuli for discussion. Annual ratings on didactic evaluation forms from both medical students and psychiatry residents have been positive and comments laudatory. In 2014, ratings

from a randomly selected group of 18 students averaged 4.4 on a 5-point scale (i.e., between very good and excellent), with comments describing the session as “engaging,” “clear and concise,” and providing “very strong examples.” Suggestions included wanting more examples, and one student said the session was too long.

Discussion

We started out by piloting the material in small groups during the psychiatry clerkship; however, we found that having a diverse faculty panel greatly enriched the discussion as students heard how experienced clinicians across specialties and at all training levels struggled with boundaries. If a faculty panel is not feasible, we recommend that students have had some clinical exposure prior to viewing this material so that they know firsthand the challenges involved in negotiating professional boundaries. In residency training, the material can be given without faculty panelists since residents have ample clinical experience on which to reflect. For shorter time frames, the PowerPoint (with the explanatory notes section) could be assigned before the seminar since the concepts can be clarified and reinforced during discussion of the vignettes.

Most of the scenarios elicited frank laughter from the students—probably out of nervousness but also out of a perception that the scenarios seemed unlikely or contrived. This is the downside of using scripted vignettes. However, the faculty panel offsets this perception because faculty can easily relate to these scenarios and frequently have equally extreme examples to share from their own careers.

Of utmost importance is that faculty and moderator emphasize that there are no correct answers to the scenarios. All the scenarios depict gray zones designed to portray ethical dilemmas in the care of patients. The classroom atmosphere should not be punitive or self-righteous. Even the scenario of a nonpatient requesting a prescription resonates with physicians who have had family members, nurses, or other house staff request prescriptions out of convenience. This material elicits a fear of reprisal in some students (as in “Is it wrong to accept a holiday gift?”), an incredulity in others (as in “You mean, I can never date an ex-patient, even if I practice in a rural setting?”), and denial or self-righteousness in others (as in “I would *never* do that”). Students should be encouraged to self-reflect when they are poised to cross—or have already crossed—their usual professional boundaries. Faculty should emphasize the importance of examining one’s motives for the boundary crossing and estimating the likelihood that it will further therapeutic aims. It should be emphasized that if it does not go well, one can reflect, make amends and corrections, and ultimately repair the treatment alliance. These scenarios depict boundary crossings, not boundary violations, an important educational distinction.

Not surprisingly, the length of this panel appealed to some students and not to others, as reflected in our evaluation comments (see above). The discussion was often lively such that most students and all panelists felt invigorated by the exercise. Ninety minutes was enough time to cover all the scenarios if we kept an eye on the clock, but more time is needed if the alternative scenarios are shown.

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Prior Presentations

Lewis J, Allan S. Teaching about the concept of professional boundaries using standardized patient vignettes: a subset of professionalism education. Plenary presentation at: 35th Annual American Directors of Medical Student Education in Psychiatry (ADMSEP) Meeting; June 19, 2009; Portsmouth, NH.

Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

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