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Necessary Boundary Crossings in Pediatrics

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"Tammie?" I watched the attending physician lean over the bed in a darkened hospital room. A heap of blankets shifted slightly to reveal the eyes and forehead of a 16-year-old girl undergoing chemotherapy. "Did you get up today?"

"Mmm-mmm," she groaned. The blankets returned to their original position.

"You know I want you to get out of bed and get moving. Can you do that for me?"

"Mmm," groaned the blankets.

"OK, tell you what. I have five dollars, and I'm going to leave it on your table here. But to keep it you have to walk all the way down to the gift shop and buy something, and you have to show it to me when I get back later today. How does that sound?"

Silence from the blankets.

"Tammie?"

"OK."

Light bribery—whether with candy, cash, or toys—was a common occurrence on the pediatric floor. So were coloring sessions at the nurses' stations, foosball games with medical students, and piggyback rides during rounds. Residents went back to visit former patients who had been readmitted, even if they were off service. Emotions went unbridled—clinicians celebrated with their patients in good times and wept with their families in the worst times. They attended graduation parties. They attended funerals. On my pediatrics rotations, everywhere I looked I saw clinicians going above and beyond what was required for their patients' physical well-being. To treat each child as a whole person, they were involving themselves in their patients' lives in ways clinicians seldom would with adult patients. Arguably, at times they were crossing professional boundaries to do so. And they were better pediatricians for it.

Professional boundaries are meant to protect patients. Patients are vulnerable: they may be ill or injured, alone, physically exposed, at extremes of age, or just plain scared. They

are required to reveal intimate details about themselves to strangers in order to receive treatments they may or may not understand. The only way this relationship can be therapeutic is if the patient can trust the clinician not to violate his or her position of power for personal gain—in other words, to place the patient's benefit first.

Professional boundaries also protect clinicians. Sharing intense experiences with clinicians may lead patients to seek out inappropriately intimate relationships with them. Clinicians can experience personal heartbreak and burnout if they do not maintain some professional distance from their patients' suffering. And a personal relationship may damage a clinician's objectivity, causing him or her to spare a patient a painful procedure or to continue treatment beyond the hope of help. The need for professional boundaries is exemplified by the principle that clinicians should not treat family members or friends [1, 2]—the therapeutic relationship must be paramount to all others. When those boundaries are violated, that relationship is jeopardized.

Professional boundary violations are not to be confused with boundary crossings. Boundary violations refer to situations in which clinicians take advantage of their patients' vulnerability for selfish ends, thereby damaging the therapeutic relationship, and they should be universally recognized as inappropriate. They include romantic relationships, financial exploitation, the venting of personal problems, and reversal of the caregiving roles. Boundary crossings, on the other hand, are nonharmful, nonexploitative actions that briefly transgress professional boundaries in an effort to meet a particular patient need.

My belief is that boundary crossings are necessarily more frequent in pediatrics than in other specialties because establishing a therapeutic relationship with pediatric patients requires a social relationship as well. Clinicians must establish trust with pediatric patients on a deeper level than with adults. Most adults are fully autonomous, able to make their own decisions about treatment, and able to cooperate with procedures. This is not true for children. While older children have some influence over their care, treatment decisions are generally made by their parents. As a result, children may undergo necessary but painful and frightening procedures against their will. If they do not trust their clinicians, they may be less likely to cooperate, and visits to the hospital could become terrifying and traumatic. Pediatricians must gain this level of trust by making the extra effort to connect with children socially, in order to effectively care for them medically. Spending time on activities not related to medical care, giving small gifts, comforting with physical touch, providing rides home, and sharing brief personal anecdotes for encouragement may all be entirely appropriate in the course of caring for a pediatric patient.

Pediatricians must establish a good relationship with the parents as well as the patient. Due to advances in modern medicine, children are generally expected to be healthy. A

chronic illness in a child throws the entire family into crisis. Since a sick child is not autonomous, his or her family is inextricably part of care. Caring for a child with a chronic illness is thus, in a sense, caring for the family as well. This means that extra measures such as getting to know the patient's siblings, home visits, and exchanging personal cell phone numbers may be beneficial and even necessary to provide the context for proper medical care of a child.

One of the roles of a pediatric clinician is to maintain a semblance of normalcy for their patients. Children with chronic diseases spend enormous amounts of time in the hospital. It is virtually impossible, even unnatural, for clinicians not to develop friendships with children and families that they see so often. Additionally, children with chronic illnesses miss school days and many normal childhood experiences. However, they generally still want to spend time with their friends, play, and "be kids," which is necessary for their continued resilience and eventual recovery. Allowing them to lose their desire for normal childhood experiences or fall into a victim role can be devastating for them. They may refuse to eat, decline activity, and stop pursuing any goal of recovery. Thus a pediatrician must be much more than a sympathetic person in a white coat who knows a few personal details. It is impossible for a clinician to help a child in this situation without knowing how to motivate him or her and then going to extra lengths to do so.

All this does not mean that pediatricians abandon the doctor role. In fact, there are times when they must step back and clarify professional boundaries. They must never try to take over the parents' role. They must make sure that the patient has relationships and coping mechanisms with people outside the medical team. They must also avoid favoritism and be willing to make the same efforts for all of their patients. And they must recognize that the needs of their patients differ; some of them may not want or benefit from a more personal therapeutic relationship. Boundaries must only be crossed in service of the patient. The best pediatric clinicians are those who can best balance the therapeutic and social, and who can offer patients and families the therapeutic relationship they need, whether they are suffering through a vaccination day or surviving cancer.

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