Advances in Health Sciences Education
https://doi.org/10.1007/s10459-023-10282-3

RESEARCH

“Juggle the different hats we wear”: enacted strategies for negotiating boundaries in overlapping relationships

Andrea Gingerich[1] · Christy Simpson[2] · Robin Roots[1,3] · Sean B. Maurice[1,4]

Received: 14 July 2022 / Accepted: 28 August 2023
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Abstract
Despite agreement that teaching on professional boundaries is needed, the design of health profession curricula is challenged by a lack of research on how boundaries are maintained and disagreement on where boundaries should be drawn. Curricula constrained by these challenges can leave graduates without formal preparation for practice conditions. Dual role or overlapping relationships are an example: they continue to be taught as boundary crossings amidst mounting evidence that they must be routinely navigated in small, interconnected communities. In this study, we examined how physicians are navigating overlapping personal (non-sexual) and professional relationships with the goal to inform teaching and curricula on professional boundaries. Following constructivist grounded theory methodology, 22 physicians who had returned to their rural, northern and/or remote hometown in British Columbia, Canada or who had lived and practised in a such a community for decades were interviewed in iterative cycles informed by analysis. We identified four strategies described by physicians for regulating multiple roles within overlapping relationships: (a) *signalling* the appropriate role for the current context; (b) *separating* roles by redirecting an interaction to an appropriate context; (c) *switching* roles by pushing the appropriate role forward into the context and pulling other roles into the background; and (d) *suspending* an interfering role by ending a relationship. Negotiating boundaries within overlapping relationships may involve monitoring role clarity and role alignment, while avoiding role conflict. The enacted role regulation strategies could be critically assessed within teaching discussions on professional boundaries and also analyzed through further ethics research.

Keywords professional boundaries · dual role relationships · overlapping relationships · rural healthcare ethics

Professional boundaries reify professionalism. And yet, as foundational as this concept is, and despite requests from medical trainees for formal curricula on professional boundaries (Lapid, 2009; AlMahmoud et al., 2020), there is little research on how to teach others to appropriately maintain both “the interpersonal limits placed on behavior within a clinical

Extended author information available on the last page of the article

Published online: 07 September 2023

relationship" (Chen et al., 2018) and the separation between their professional and personal lives (Marshal et al., 2021; Wong et al., 2021; Szumer & Arnold, 2023). This is problematic as poorly managed professional boundaries can result in patient harm (Gutheil & Gabbard, 1998) and practitioner burnout (Chipp et al., 2011; Fallowfield et al., 2014; Marshall et al., 2020; Rapp et al., 2021). There does seem to be agreement that "Boundary issues should be discussed in all clinically oriented courses, as well as ethics courses [and…] any teaching about the doctor-patient relationship" (Nadelson & Notman, 2002). However, curricula on professional boundaries can be challenging to design because boundaries are defined as "the edge of appropriate or professional behaviour" (Gutheil & Simon, 2002; Chen et al., 2018) and "as rules that establish a professional relationship" (AlMahmoud et al., 2020) but the medical profession does not agree on where and how these boundaries should be drawn (Brown & McGee, 2014; Nieva et al., 2020; Appel, 2021).

One particularly contested professional boundary is the appropriateness of having two or more relationships with the same person in the course of professional practice (Simpson & McDonald, 2017; Szumer & Arnold, 2023). Dual roles or overlapping relationships tend to be thought of as a friend becoming one's patient or a patient becoming one's attorney, but other configurations such as family or friends becoming colleagues or subordinates/superiors are common (Brooks et al., 2012; Lines et al., 2015; Goodine, 2017; Rowland & Kuper, 2018). Despite mounting evidence that overlapping relationships are unavoidable and routinely managed in various practice contexts (Crowden, 2008; Miedema et al., 2009a; Miedema et al., 2009b; Baca, 2011; Brooks et al., 2012; Brocious et al., 2013; Piché et al., 2015; Unhjem et al., 2018; Nieva et al., 2020; Brassolotto et al., 2021; Eketone, 2021; Szumer & Arnold, 2023), overlapping relationships continue to be classified as contrary to practice standards (Canadian Medical Protective Association, 2014; College of Physicians and Surgeons of British Columbia, 2021), remain unsanctioned (Crowden, 2008; Baca, 2011; Appel, 2021) and are taught as boundary crossings (Nadelson & Notman, 2002; Marshall et al., 2008; Chen et al., 2018). In fact, the notion of overlap is, in some ways, conceptually incongruent with the notion of boundaries (Austin et al., 2006; Brown & McGee, 2014). This creates paradoxes for practitioners when the obligations of their professional role seem to contradict the obligations of their personal roles within the community, as has been described for physiotherapists living and practising in rural, northern and/or remote communities (Gingerich et al., 2021). As a result, the rural reality of routinely navigating overlapping relationships can be framed and experienced as a threat to professionalism while also necessary for being a 'good' professional in these settings and an essential skill for professionals to learn and put into practice (Brooks et al., 2012; Simpson & McDonald, 2017; Fors, 2018).

Without adequate teaching on maintaining professional boundaries within overlapping relationships, graduates could enter known practice conditions in small interconnected communities within rural settings (Roberts et al., 1999; Miedema et al., 2009a; Miedema et al., 2009b; Chipp et al., 2011; Brooks et al., 2012; Piché et al., 2015) and also those within urban settings such as military medicine (King & Snowden, 2020), the Deaf community (Smith, 2019; Panzer et al., 2020), and others (Alvarez-Hernandez et al., 2021; Eketone, 2021) ill-prepared for navigating these types of challenges and considerations. Practitioners who feel unable to cope with the repeated boundary challenges inherent to these often medically underserved communities, tend to leave (Miedema et al., 2009a, b). If we were to acknowledge that there are legitimate circumstances for practitioners to treat friends, fam-

ily, colleagues and coworkers and to socialize with fellow community members who were, are, or could become one's patient, then we would be obligated to teach our trainees how to manage these relationships well. If we were to develop formal classroom and mentorship curricula that are inclusive of all practice contexts, we would need to teach how to maintain professional boundaries within overlapping relationships. Therefore, a first step in designing this component of the curricula is articulating some of the ways physicians strive to maintain professional boundaries within overlapping relationships. In this study, we examined how physicians are currently trying to navigate overlapping relationships. Our analysis aimed to identify how physicians conceptualize maintaining professional boundaries while navigating overlapping relationships. We used a social cognition lens to focus our efforts on the psychological processes physicians use within social interactions (Fiske & Taylor, 1991; Bodenhausen & Morales, 2012; Castro & Heras-Escribano, 2020). Our goal was to provide conceptually relevant language for use in the teaching of professional boundaries within our curricula.

Methods

Our research question 'how do physicians navigate overlapping relationships and maintain professional boundaries?', required the study of social interactions impacted by social rules in social contexts and invited the use of constructivist grounded theory (CGT) methodology (Charmaz, 2014). Based on previous research, we expected that physicians who lived and practiced in communities that were highly interconnected due to population size, culture, and geographical remoteness would have ample lived experience with navigating overlapping relationships. Therefore, our recruitment began with purposive sampling to maximize variation in demographic characteristics of physicians living and practising in rural (non-metropolitan), northern (in the Northern Health Authority catchment) and/or remote (isolated by distance or terrain from metropolitan centres) communities in British Columbia, Canada. Analysis of interviews 1–6 indicated that physicians who had returned to their rural, northern and/or remote (RNR) hometown to practice or had lived and practised for decades in one RNR community could describe elaborate approaches to navigating overlapping relationships. Therefore, we took care to invite these "insider" physicians, who had recently returned to their hometown, practised in their hometown for an extended period time, or had lived in a community long enough for it to become home, to participate in this research. Participants included 22 physicians who had spent 1–35 + years in RNR communities (see Table 1).

Data collection involved semi-structured interviews completed in-person, by phone or by videoconference between July 2019 and June 2021. Interviews averaged 35 min (24–54 min) in duration, were audio-recorded, professionally transcribed and de-identified. Data analysis focused on non-sexual boundary expectations, as outlined in the provincial practice standard for physicians (College of Physicians and Surgeons of British Columbia, 2021). Following CGT methodology, analysis was iterative with data collection and informed changes to the interview guide (Charmaz, 2014). See Table 2 for exemplar interview questions. The first 6 interviews focused on experiences with navigating overlapping relationships in clinical and social contexts. Analysis identified strategies used for maintaining professional boundaries, such as communicating to others which role was the appropriate

Table 1 Demographic information for 22 participants recruited through purposive and theoretical sampling

Participant characteristic	Count
Gender	
female-presenting	12
male-presenting	10
Practice duration in rural, northern and/or remote community	
less than 5 years	4
5-20 years	8
more than 20 years	10
Practice location	
hometown	7
Northern Health Authority[a]	14
remote by terrain or distance, non-northern	4
rural, non-metropolitan, non-northern	4
Practice Specialty	
family practice	15
family practice with Certificate of Added Competence[b]	7

[a] seven communities with varying rurality and remoteness

[b] addiction medicine, anesthesia, emergency medicine, obstetrical surgical skills, sport and exercise medicine

Table 2 Exemplar interview questions for each of three iterative cycles of analysis informing data collection

Iterative cycle	Exemplar question
Interviews 1–6	We know that dual roles or overlapping relationships are unavoidable when you're living and practicing in a community where you know everyone and everyone knows you. Please tell us about the overlapping roles or relationships that you deal with and how you deal with them.
Interviews 7–14	How have dual roles or overlapping relationships impacted your professional boundaries (doctor-patient and personal-professional)? a. As a doctor, you carry with you privileged knowledge about others. When has that knowledge become a challenge for you? b. As a community member, you know patients as people through interactions outside of clinical settings. How has that knowledge entered into clinical encounters? How did you respond? c. As a community member, others know you as a person. In what ways do patients bring that knowledge into clinical interactions with you? How do you respond?
Interviews 15–22	Tell me about a time when you realized that you could not be a doctor for someone because of an overlapping relationship? a. What is your process for recognizing the "friend/family factor" entering into a clinical interaction and how do you "try to remove" it to "stay objective"? b. How would you describe it to a trainee?

role for the current interaction. The strategies the participants used then became the focus of subsequent questioning until no additional information was needed to understand the phenomenon (interviews 7–14). Further analysis identified role switching (Ashforth et al., 2000; Lynch, 2007; Danna-Lynch, 2010; Cornwell, 2013) as a social cognitive mechanism for maintaining boundaries. We then used role switching as a sensitizing concept (Charmaz,

2014) to revise the interview questions for interviews 15–22. The enactment of switching between professional and personal roles became the focus until we sufficiently understood the process. Data collection was stopped when constant comparison of the 22 interviews sufficiently informed our understanding of how physicians strive to regulate multiple roles while striving to maintain boundaries within overlapping relationships.

In line with the research question, analysis focused on *how* physicians navigated overlapping relationships and *how* they negotiated professional boundaries and not on cataloguing *what* overlapping relationships they navigated. Coding proceeded inductively by closely examining the data with initial codes, then interpreting the data with focused codes, and finally abstracting a cohesive understanding–that was still grounded in the data–with theoretical codes (Charmaz, 2014). The focused codes grouped together themes describing boundaries, how maintaining boundaries could require negotiation with others, and how multiple roles could be navigated. The theoretical codes constructed an overarching understanding of how physicians conceptualized maintaining boundaries within overlapping relationships by regulating multiple roles. Coding was led by AG, informed by regular debriefs with fellow interviewers and discussions with the research team, and supported by NVivo 12 (QSR International Pty Ltd). Memos collected the evolving interpretation of the data and detailed project notes served as an audit trail. This study received approval (H19-01498) from the University of British Columbia and the University of Northern British Columbia research ethics boards.

CGT methodology posits that meaning is constructed by researchers interacting with the data and participants and so it invites interpretation of the data through differing perspectives (Charmaz, 2014). As such, the research team and personnel were composed of individuals with varying rural and clinical lived experiences; varying lived experiences with rural and distributed health professions education; and varying expertise in rural health ethics. In research meetings, each team member shared their interpretation of excerpted transcribed data and contributed to the evolving codes by applying their diverse points of view. Team meetings included reflexivity on how each researcher's perspective contextualized the data and the tensions within it. For example, the team compared a multitude of examples of how physicians navigated being approached for medical inquires in retail stores. The rural clinicians raised in rural communities highlighted what was unsaid and drew from their experiences to comment on the typicality of the examples and alternate outcomes, the rural educator raised in an urban community asked what would happen if the patient was dismissed or the conversation was overheard and what would be different if it occurred in a metropolitan centre, and the bioethicist raised in a rural community identified ethical principles that were upheld as part of the navigation strategies. This invited reflections on how others who were not present, such as the College and associations and urban-raised urban physicians, might differently interpret the data. It prompted discussions on the tensions between being an autonomous professional in control of a situation and a member of a greater whole constrained within the situation and of being a good neighbour with being a good doctor who followed policy. It also prompted discussions about maintaining confidentiality with preventing embarrassment and loss of face, the implications for access to care in medically underserved communities and the need to unwind without professional obligations. Reflexivity also included review of our research methods including returning to the transcripts to ensure selected quotes reflected the participant's context, returning our focus

to *how* participants were maintaining boundaries while navigating overlapping relationships, and reminding ourselves that we could not determine the efficacy of any approach.

Results

In the following, we begin by presenting how professional boundaries can be conceptualized as both set and negotiated within overlapping relationships. We then present four strategies commonly described by physicians for regulating multiple roles within overlapping relationships with the intent to maintain physician-patient and personal-professional boundaries. The strategies include *signalling* the appropriate role for the current context; *separating* roles by redirecting an interaction to the appropriate time and place; *switching* roles by pushing the appropriate role forward into the current interaction and pulling other roles into the background; and *suspending* an incongruent role that interfered with interactions by taking action to end one of the relationships.

Maintaining professional boundaries amidst overlapping relationships

When discussed in an abstract sense, boundaries were framed as a responsibility of the physician and tended to be described in terms of "rules" (MD10) that guided future decisions by marking "the edge where, for example, my licence becomes at risk—that's where my boundary needs to be" (MD13). Since boundaries were set by the physician and guided their future decisions, maintaining boundaries were typically described in terms of commitment, strength and enforcement: "I had set my boundaries quite <u>rigidly</u>" (MD15) to "draw the line and be <u>firm</u>" (MD8) because they are "<u>hard</u> boundaries that you have to maintain" (MD3). Accordingly, boundary crossings could be accompanied by self-blame: "when things haven't turned out well or people push limits it's when I haven't set up a boundary clear enough" (MD14).

In contrast, when discussed as a lived experience, professional boundaries tended to be described as mutually respectful interactions requiring co-construction, negotiation, and reciprocation. Setting boundaries within overlapping relationships was then described as "a two-way thing" (MD18) that needed to take into account the "nuances of who is that patient" (MD19). For example, it required a more formalized approach with patients who had difficulties themselves in setting and maintaining healthy boundaries. Conversely, many participants said it was easier to socialize with other professionals who respected boundaries: "you self-select with other professionals in the community" (MD1) "who understand the separation between professional and personal lives–those are the kind of people you hang out with and you'll have a glass of wine and you'll feel relaxed with" (MD12). For "the people that you would choose to be friends with, it's possible to have an open conversation about, 'here's the boundary issues: Are we violating them in any way? How can we manage it?' and just to set up some rules for coping with it" (MD19). Thus, we asked physicians to further elaborate on how they monitored outcomes and adjusted rules for boundaries in overlapping relationships.

Juggling many "hats" to maintain boundaries within overlapping relationships

Despite overlapping relationships being the norm, RNR physicians commonly described paradoxical obligations with their licensing organizations, community, practice, patients, and themselves:

> "the College has the rule, 'You don't be friends with anybody,' but in a small town that would come across as being a very strange person, for one thing, and you become a strange person, after a while, if you have absolutely no friends that you can talk to." (MD19).

Although some overlapping relationships could be avoided under certain conditions, participants made it clear that RNR communities did not allow for anonymity. Accordingly, incidental encounters with patients in the community were described as ubiquitous and required physicians to "own that role at all times essentially" (MD9). A hat metaphor was frequently used by physicians to explain how they managed multiple roles both within their social lives where they "wear many hats" (MD13) in the community and also "within the doctor-patient relationship there's multiple hats that you may have to wear" (MD9). Participants often talked about needing to "juggle the different hats we wear" (MD1) to regulate the multiple roles and maintain boundaries. The metaphor not only portrayed that the multiple roles were potentially visible at all times but also that the roles were distinct and not worn at the same time: "I learned some things about boundaries […] I realised that maybe it's better to have very clear roles when it comes to this work" (MD7).

Enacted strategies for regulating multiple roles within overlapping relationships

We were able to identify four strategies that were frequently described for regulating multiple roles within overlapping relationships. Each are detailed here and summarized in Table 3.

Signalling

Since the hats were metaphorical, physicians described various communications to signal to others which role was congruent to the context. A commonly reported technique was using titles with patients in clinical settings and first names in social settings "to distinguish when I'm working, I'm known as Dr. 'Doe' and when I'm outside of work I'm 'Jane' […] for all intents and purposes [those patients have] never met 'Jane', they've met Dr. 'Doe'" (MD11). Similarly, some participants reported using titles when they, or their children, were the patient seeking care from a colleague: "when I'm working with someone, we use first names and we're not formal but when I'm at their doctor's office I call *my* doctor by their doctor names […] I think using those formal titles helps maintain boundaries when you're in those kinds of situations" (MD2). However, this signalling was not always well-received and further explanation was sometimes needed for role regulation:

> "I was criticized by a nurse for this once—I said, 'Would you call in Dr. 'X'?" and she criticized me for calling him by his proper name. I said, 'Look, when I'm in the

Table 3 Strategies used by physicians to regulate multiple roles within overlapping relationships

Enacted strategies	Examples
Signalling	Using cues to indicate which role is being portrayed now. e.g. using the "Dr." title for clinical interactions and a first name for social interactions
Separating	Redirecting a part of an interaction to a more appropriate time and/or place. e.g. asserting that medical concerns raised in a social setting can be better discussed during an appointment
Switching	Changing from one role to another during an interaction. e.g. witnessing a medical emergency while socializing and transitioning into a physician role to provide care
Suspending	Ending a relationship to eliminate interacting with that person in that role. e.g. referring a patient to another physician

> hospital I don't say to the patient, 'I'm going to ask my husband whether we need to do a section or not. That's lack of respect for the patient but it's also lack of respect for the other doctor.' And I said, 'It also helps me in that this is our role together, we are two physicians conferring on a patient's case; we are not a husband and wife dealing with their children.'" (MD20).

Another signalling technique involved exaggerating the activities of the role that was congruent to the context. For example, during incidental encounters with patients who were trying to interact with their physician role, some participants described being able to "dip into the mom role to get away from some of those boundary problems" (MD10). By focusing attention on their children's needs, these participants were able to push the parent role forward to remind others that they were not in their physician role. Signalling techniques tended to use indirect communication as hints to the other person. When more direct communication was described, it tended to be accompanied by the use of techniques that we have labelled as *separating* strategy.

Separating

Taking it a step further, the roles could be explicitly separated by redirecting the context-incongruent part of an interaction to a time and place that was better aligned with that role. This physician uses a brain metaphor, similar to the hat metaphor, to deflect medical requests made by friends and family while socializing: "'it would be better if you had my doctor brain applied to this […] why don't I call you the next time I'm in the office and I can actually pull up your chart'" (MD15). By communicating that they were not in the physician role and not in a clinical context, these physicians said that they could postpone the interaction while acknowledging the request and offering help. This separation was sometimes discussed with patients prior to anticipated social interactions: "I've found [patients who became] friends fairly good if I just have a quick conversation of 'When we're hanging out

I'm not your doctor giving you medical advice,' they tend to be pretty respectful of that" (MD16). For some, this separation of roles into contexts coincided with a clear separation in identities "like night and day—put up this psychic wall—now I'm in the office and now I'm not" (MD19). Whereas other participants separated their actions into different locations, but their identity remained consistent across contexts.

Some participants shared that one of the most difficult overlapping relationships to navigate was having colleagues or coworkers as patients because the "people that you work with are actually probably more inclined to cross boundaries in some ways then the ones you socialize with because they will often ask you questions in that worksite about their health and that's actually sometimes more tricky" (MD18). In these scenarios, the clinical context was congruent with the physician role in both the physician-patient and physician-coworker relationship. However, the content of the interaction was congruent with only one of the relationships at a time. The clinical context seems to have required more complicated efforts to separate 'I'm in *a* physician role now' from 'I'm in the role of *your* physician.'

Switching

We identified the strategy of switching roles as distinct from separating roles as switches were a dynamic transition from one role to another within an interaction: "you have to just switch hats" (MD10). In social contexts, signalling the switch could include subtle communication cues such as "go[ing] into your doctor demeanor" (MD 10) to relay a quick clinical update and then going back into a casual demeanor for social conversation. An unexpected situation, such as discovering an accident scene, often preceded the decision to switch: "if you're in your off-time, you don't want to be the doctor; sometimes, you have to step into that role" (MD20). In clinical contexts, explicit explanation was often reported as being used to communicate the switch, for example, when a friend needed care in hospital:

> "as soon as we get in here–because I have to put my doctor hat on and have to stop thinking of them as a friend–I think of them as a person and story and as a patient and I have to really think about it and I tell them, 'I'm now Dr. 'Doe', I have to think about it and treat you the way I would any other patient, which is giving the best quality care'". (MD11)

Many participants described compartmentalizing the social relationship to create clinical distance and allow objectivity in the clinical interaction: "Being a good doctor for friends is hard. It's hard to stay objective, but you must. I try to remove the friendship factor and just focus on the medical issue when seeing friends in the ER[emergency room]" (MD22). The preamble of "'this is a time where I need to be very objective and so I'm going to turn off the little bit of a friend person right here and we're really going to get into this and I'm going to ask you some hard questions that might be really super uncomfortable, are you OK with that?'" (MD7) could be used to prepare the patient for the switch and to help themselves push the friend role into the background. The switching strategy was often described as being readily employed for simple, common, or algorithmic treatment: "this [clinical task] is so rote for me—this is just a part of my day-to-day that it [the patient also being a friend] doesn't affect my decision-making in that situation" (MD16).

The above examples featured conscious decisions to switch roles within an interaction. Roles could also be involuntarily pulled forward by the context and force the physician to decide if they were going to stay and interact in the switched role. Witnessing a medical incident within the community was the most common example because, in the small communities, participants emphasized how they would be recognized as a physician and expected to act in that role: “a person would collapse in the [sporting event] and you could just see 2000 people were staring at me like – and I just, I want to just be there with my kids and I couldn’t—well, I could have, but I would choose to go and help” (MD7). Unfortunately, being repeatedly and involuntarily displaced from the context-congruent parent and spectator roles and into the physician role could lead to a solution to discontinue being in the dual role situation by *suspending* one of the roles, as in this case: “And so my poor kids, I don’t think they ever sat with me through a [sporting event] to the point where I actually, eventually, I stopped going” (MD7).

Suspending

The *suspending* strategy refers to the actions taken to end a relationship when one of the roles was interfering with the other roles, in order to maintain boundaries. Shared examples where relationships could no longer be overlapped included when a friend role could not be set aside from a clinical context and it was interfering with the doctor role or when the physician role could not be turned off and it was interfering with the friend role in a social context: “I do have some friends and they’re also my patients. There’s a certain threshold beyond which I would ask them to stop being my *patient* or stop being my *friend”* (MD9). The threshold in clinical contexts was the inability to put feelings aside: “‘I can’t provide that therapeutic relationship with you because I’m there too emotionally and as a friend, I can’t be there as a doctor as well’” (MD11). A commonly shared example was ending their physician role through referral to a colleague when a patient-friend developed chronic, debilitating disease or when palliative care was needed:

> “ended up asking another colleague—and friend—to step in and take over because I just didn’t feel that I could still be objective in her care […] I was feeling like my emotions were clouding my judgment in whether or not the decisions being made were being made because I knew her as opposed to being the appropriate choice. […and then one night it got really bad and it looked like she was going to need an invasive procedure so] it was quite high emotion and I knew that I couldn’t do the [procedure] if I needed to”. (MD2)

As alluded to in the above quote, suspending a role by ending a physician-patient relationship and referring the friend-patient to another physician often meant referring them into another overlapping relationship. However, there seemed to be an expectation that the referral physician was better positioned to regulate the dual roles.

In summary, setting and maintaining professional boundaries in overlapping relationships can be conceptualized as implementing rules and negotiating mutually respectful ways of interacting while enacting strategies to regulate multiple roles. Many of the stories shared by physicians described fiduciary responsibilities, patient priorities, and personal sacrifice. When given the opportunity to discuss their experiences with overlapping relationships, it

was not unusual for participants to express resentment at the regulatory college guidelines for being "a bit insulting" (MD16) and a "square peg in the round hole" (MD8) that represented the College's "shortsighted[ness] when it comes to isolated positions" (MD17). Some even spoke of an ideal future where the needs of physicians, as humans, were balanced with the needs of patients, as people, to receive safe care:

> "I would love for our College to become more contemporary. I understand where they're coming from. I think the intentions are good. The intentions are to protect patients and to protect you but they're not human and realistic: they're inhuman. And I think as long as we continue to expect physicians and physio[therapist]s and other key providers to be inhuman, it's going to add to their stress and their discontent and their burnout and everything. And I think we have to stop pretending that this doesn't happen and be honest and open about it and say, 'OK, well, what can we realistically expect from humans? Yeah they're going to form friendships with patients. So OK that's fine. How can we help educate them and support them so that they're able to manage that?'" (MD7).

When asked, participants frequently attributed learning how to set boundaries within overlapping relationships through informal exchanges with mentors, first-hand experiences in RNR communities, or extracurricular opportunities. They lamented that "no one really teaches you how to do boundaries," (MD3) "nobody trains you on that stuff" (MD11). Some even pointed out a connection between boundary issues and retention issues: "you can recruit with incentives and bring people to the rural areas but a big reason why professionals aren't retained is because there's often some sort of boundary crossing that's occurred" (MD9). Accordingly, many participants advocated for formal curricular teaching.

Discussion

The juxtaposition of professional boundaries with regulating multiple roles in overlapping relationships invites contemplation. The expectation for professional relationships to be kept separate from personal relationships fits best with the notion of boundaries that divide and distance (Speight, 2012; Combs & Freedman, 2020) to protect the patient (Gabbard & Nadelson, 1995; Nadelson & Notman, 2002; Glass, 2003; Marshall et al., 2008). However, avoiding overlapping professional and personal relationships in some contexts would adversely impact access to care or physician well-being (Bourke et al., 2004; Brooks et al., 2012; Simpson & McDonald, 2017; Konkin et al., 2020; Szumer & Arnold, 2023). Moreover, all physicians–as humans–have multiple social roles and identities that can be invoked during clinical work (Cruess et al., 2015), in addition to the multiple professional roles that are inherent to collaborating in the workplace. Therefore, regulating multiple roles is relevant to more than just the graduates who will enter practice in small, interconnected, and isolated communities. Since physicians can experience role conflict, an important contributor to burnout, when overlapping relationships are not managed well or managed while risking ethical practice standards (Miedema et al., 2009a, b; Fallowfield et al., 2014; Marshall et al., 2020; Rapp et al., 2021), formal curricula on regulating multiple roles are critical.

The notion of regulating roles within a physician-patient interaction has been invoked previously to explain boundary crossings, such as when self-disclosure "reverses the roles in the dyad" (Gutheil & Gabbard, 1998) or with "the therapist stepping out of the clinical role" (Gutheil & Simon, 2002). Our analysis identifies that boundary negotiation within overlapping relationships can be conceptualized as strategically moving between roles. The identified strategies of signalling, separating, switching, and suspending echo those described for navigating overlapping relationships in previous research (Crowden, 2008; Brooks et al., 2012; Brocious et al., 2013; Goodine, 2017; Brassolotto et al., 2021; Eketone, 2021; Szumer & Arnold, 2023). The notion of regulating roles also invites us to draw on previous role transition and role switching research to guide our teaching and research. Role transition literature describes how routines, scripts, or rituals can take advantage of planned transition points, such as the commute to and from work, to exit from one role and enter into a different role (Ashforth et al., 2000; Cornwell, 2013). This literature also describes abrupt and unexpected role transitions as "shifting gears" or "wearing different hats" (Ashforth et al., 2000; Brocious et al., 2013; Tempelaar & Rosenkranz, 2019) and explains how microtransitions can become routine when multiple roles must be repeatedly enacted in the same context (Ashforth et al., 2000; Tempelaar & Rosenkranz, 2019). For example, managers must adapt to frequently transitioning between a subordinate role with their boss and a supervisor role with their subordinates (Ashforth et al., 2000). Similar to microtransitions, research on role switching provides additional language and techniques for dynamically and strategically changing roles (Lynch, 2007; Danna-Lynch, 2010; Cornwell, 2013). For example, the term *relocation* has been used to describe being involuntarily thrust into a role due to the expectations of the context and this research recommends selectively focusing attention on a role-aligned cue (e.g. patient chart as a cue for the physician role) to help with switching or staying in a role (Danna-Lynch, 2010). It may be worth investigating such techniques for helping learners to embody the succession of increasingly autonomous roles throughout their medical training.

Although role transitions and role switching are considered "common facets of everyday social life" (Lynch, 2007), the physician role comes with a fiduciary responsibility to patients that necessitates careful interactions (Roberts et al., 1999, 2005; Gutheil & Simon, 2002; Nadelson & Notman, 2002; Crowden, 2008; Appel, 2021). Our chosen methodology does not allow us to determine the ethical soundness of using any of the strategies or indicate what should ideally be done to negotiate boundaries within overlapping relationships. However, our research suggests that there is more complexity and nuance in determining what strateg(ies) may be ethically appropriate than a traditional focus or reliance on formal rules typically captures. The identified strategies offer simple language that begins to clarify that which has been tacit and that can be discussed within teaching sessions and modified through further research. For example, the label of "switching" succinctly summarizes one possible course of action. Now that it has been labelled, "switching" roles within a given interaction could be critically assessed during discussions of how to respond to coworkers' requests for informal healthcare and studied for its ethical implications. As we consider how role regulation could be included in teaching about boundaries, it seems that the concepts of *role alignment* and *role clarity* would be key. However, further research is needed to determine if monitoring role regulation during an interaction within an overlapping relationship might involve (a) noting the alignment of the roles in terms of their *coherence*, as in, how well the roles match the content and context of a given interaction and (b) tracking the clar-

ity of the roles in terms of their *concordance* (Appel, 2021), as in, how likely is it that the other person is interacting with the role that is being portrayed rather than one of the other roles that is incongruent with the interaction.

As we continue to ponder the implications of our findings, there are relevant limitations to consider. Our analysis focused on non-sexual overlapping relationships as experienced by family physicians within the oversight of specific regulatory bodies. A study of overlapping professional and intimate relationships may invite identification of other strategies that could also be studied for their ethical implications. Although our participants represent a broad range of practice contexts within rural, northern and remote communities, we expect that practitioners in different contexts navigate other overlapping relationships and may describe both similar and unique experiences with negotiating boundaries. Our focus on the experience of the physician excludes the lived experience of the patient and future research is needed to understand their contributions and perspectives in negotiating boundaries along with how they are impacted by overlapping relationships.

In conclusion, our study offers initial empirical evidence that physicians can conceptualize regulating multiple roles when negotiating boundaries within overlapping relationships. We offer language that makes explicit the strategies that are currently used within such interactions. The identified strategies can now be critiqued within teaching discussions and analyzed in terms of healthcare ethics. Those developing and updating professional boundary curricula might consider drawing on role switching and role transition research to shape discussions on role clarity, role alignment, and role conflict when teaching about physician-patient boundaries, work-life balance, and managing multiple professional and social identities within multiple professional and social roles.

Acknowledgements The authors wish to thank Kevala Van Volkenburg for her assistance as research manager, Talise Lindenbach for her involvement with interviews, and all participants for sharing their experiences with us.

Authors' contributions All authors contributed to the study design. A.G. and S.M led participant recruitment. A.G. led data collection, analysis, and manuscript preparation in consultation with S.M. and with regular contributions from all other authors. All authors edited and reviewed the manuscript.

Funding/Support This study was funded by a University of British Columbia Distributed Medical Education grant awarded through the Centre for Health Education Scholarship in 2019.

Declarations

Ethical approval This study received approval (H19-01498) from the University of British Columbia and the University of Northern British Columbia in 2019.

Competing Interests Christy Simpson receives royalties from the sale of her and F. McDonald's book, Rethinking Rural Health Ethics.

Other disclosures Christy Simpson receives royalties from the sale of her and F. McDonald's book, *Rethinking Rural Health Ethics*.

Disclaimers None.

Previous presentations BC Rural Health Research Exchange conference on November 23, 2021; Northern BC Research and Quality Conference on December 9, 2021; Canadian Conference on Medical Education,

April 2022, Calgary, Alberta, Canada; Association for Medical Education Europe conference August 2022, Lyon, France.

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Authors and Affiliations

Andrea Gingerich[1] · Christy Simpson[2] · Robin Roots[1,3] · Sean B. Maurice[1,4]

✉ Andrea Gingerich
andrea.gingerich@unbc.ca

1 Division of Medical Sciences, University of Northern British Columbia, Prince George, British Columbia, Canada

2 Department of Bioethics, Dalhousie University, Halifax, Nova Scotia, Canada

3 Department of Physical Therapy, University of British Columbia, Halifax, Nova Scotia, Canada

4 Cellular and Physiological Sciences, Faculty of Medicine, University of British Columbia, Vancouver, British Columbia, Canada