

An Investigation of Psychologists' and Medical Practitioners' Responses to Overlapping Relationships in the Context of Mental Health Care

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Abstract

Aim: The aim of this research was to investigate rural, regional and metropolitan psychologists' and medical practitioners' beliefs of ethical appropriateness of overlapping relationships, especially when they are concerned with mental health issues. It was hypothesised that rural practitioners would encounter more overlapping relationships with clients/patients than their urban counterparts and that psychologists would be less accepting of overlapping relationships than medical practitioners.

Method: Psychologists (n=439) and medical practitioners (n=478) were recruited by email and mail to respond to 10 scenarios which described a range of overlapping personal/professional relationships in the context of common mental health care provision. Judgements about three scenarios that depicted incidental contact (small talk in the supermarket), a boundary crossing (accepting an invitation by a patient/client to an event) and a boundary violation (taking financial advantage of a patient/client) were measured. Group comparisons were undertaken using non-parametric analyses.

Results: Psychologists living in rural areas were less concerned about a colleague's acceptance of an invitation to a social event than their counterparts living in either a regional or large urban centre (Md=5, n=85), $Z=-2.16$, $p=0.03$, $r=0.1$). For each of the scenarios psychologists were more likely than medical practitioners to express ethical concern about the clinician behaviour. Experiencing previous overlapping relationships significantly influenced attributions of ethical concern for both psychologists and medical practitioners.

Conclusions: Overlapping relationships are inevitable for the rural, regional and at times urban psychologist and medical practitioner. Managing overlapping relationships whilst living and working in rural environments creates atypical treatment situations that can be difficult for all health clinicians. Further research is required to understand the specific experience of clinicians whilst living and working in a 'fish bowl'.

Keywords: Clinical practice; Mental health; Overlapping relationships

Introduction

"At the end of our consultation, a client/patient tells me that he's seen me playing squash at the local courts, and has asked me to partner him in the upcoming squash final as his current partner is unavailable for the game."

How would a psychologist or a medical practitioner respond to this hypothetical scenario and might they respond differently? Would the clinician's decision to accept the offer be influenced by where he or she worked: in a rural, regional or metropolitan setting? Would discipline specific professional ethics and education impact upon the psychologist's and the medical practitioner's decision making? What other influences might impact on the decision to accept or decline the invitation?

Background

For health practitioners, especially those working in small rural areas an overlapping (dual) relationship with a client/patient may be

inevitable [1]. At times a clinician may feel they have little choice than to agree to treat a colleague, an acquaintance, a friend or at times a family member, when access to health services is limited [2]. Social networks are dense, small in size and it is common place for practitioners to have more than one role within the community [3]. Social and professional boundaries may overlap as the clinician engages in local activities and supports local trade [4]. Whilst communities advocate and actively seek to keep local health care services [5], overlap between the practitioner and his or her clients/patients may occur due to the one or two degrees of separation between individuals, especially in small communities. Whilst practitioners may find it difficult to be anonymous in their community, clinicians have developed professional strategies to manage this life in a 'fish bowl' [6]. Overlapping relationships, whilst being an issue in a wide range of clinical contexts, may be seen as especially challenging for clinicians treating personally sensitive issues including mental health concerns. Clinicians when considering both the closeness of their relationship to the patient/client and the ongoing nature of the consultation, may choose not to treat those they know when a personality disorder, substance abuse or acute psychosis are present [6].

However, there are times when such exclusions cannot be readily applied, such as when an isolated practitioner finds he or she needs to treat a member of his or her family. Given this unusual situation, Crowden [7] suggests that rural practice engenders distinct rural ethics that emerge from the environment, creating ethical sensitivities developed from living and working in smaller communities. Distinct rural ethics are based on the lived experience of the practitioner and may go beyond the standard ethical understanding of the profession [7,8]. Therefore, everyday experiences sculpt the health professionals' attitudes allowing for heuristics to influence the decision making process.

Heuristic learning describes an interactive way of discovering information based on trial and error. It provides a mental short cut that allows for people to make decisions quickly and efficiently [9]. Ethics are influenced by daily interactions, where the dynamic information flows interchangeably to shape perception [7]. If a practitioner, living and working in a small community has previously experienced overlapping relationships with patients/clients, it is possible that he or she may respond differently to an invitation to play squash compared to a metropolitan clinician who has never experienced an overlapping relationship. When clinicians have never experienced an overlapping relationship they may use the code of ethics of their profession alone to inform them of the 'most appropriate' decision. By contrast, the practitioner who has experienced an overlapping relationship may use this knowledge in addition to the codes of ethics to inform his or her behaviour. Health professions have a code of ethics, statements reflecting the appropriate and expected behaviour, typically developed by relevant professional associations and supported by a regulatory body.

In the Australian setting, the regulatory body the Australian Health Practitioner Regulation Agency (AHPRA) supported by profession specific boards. Practicing psychologists and medical practitioners are registered with AHPRA and both the Psychologists Registration Board of Australia and the Medical Board of Australia have adopted the code of ethics from their respective professional associations, the Australian Psychological Society (APS) and the Australian Medical Association (AMA). Although the principles underlying the codes of ethics are similar, including the requirement to 'do no harm', the wording and subsequent interpretation of these documents may influence members of each profession differently.

An invitation to play a game of squash could be judged differently by a psychologist compared to a medical practitioner. Based on the 'APS Code of Ethics' a psychologist needs to be aware of potential boundary crossings and take steps to establish and maintain proper professional boundaries with clients [10]. Conversely, the AMA 'Good Medical Practitioner' states that treating a person with whom you have a close personal relationship is best to be avoided. If the relationship between a patient and a practitioner is not physically, emotionally, sexually or financially exploitative, based on the code of conduct, medical practitioners may use their good judgement to make the appropriate decision regarding overlapping relationships with patients [11].

Informed by these differing ethical frameworks [11,12] and the distinct rural ethics "where rural professionals develop a kind of ethical sensitivity to a rural context" [8, p. 72], this study examined psychologists' and medical practitioners' beliefs of ethical appropriateness of clinicians' behaviour using a range of hypothetical scenarios depicting incidental contact (e.g. small talk in the supermarket), boundary crossings (e.g. accepting a wedding

invitation) and boundary violations (e.g. exploitation of a client/patient) in the context of providing care for common mental health conditions. The aim of this research was to investigate rural, regional and metropolitan psychologists' and medical practitioners' beliefs of ethical appropriateness of overlapping relationships. It was hypothesised that rural practitioners would encounter more overlapping relationships with clients/patients than their urban counterparts. As health practitioners living in rural communities may consistently experience overlapping relationships and subsequently develop heuristically a distinct set of ethics [7], it was hypothesised that clinicians' practicing in small communities would be more accepting of overlapping relationships than their metropolitan equivalents. Furthermore, it was thought that psychologists would be less accepting of overlapping relationships than medical practitioners based on sensitivity of work content and variation in their respective professional codes of ethics.

Having identified potential differences between professions in terms of codes of ethics that might influence practitioner response to overlapping relationships, research was undertaken to explore the views of psychologists and medical practitioners of clinical scenarios that included overlapping personal and professional relationships.

Method

Psychologists' and medical practitioners' views of potential ethical dilemmas were investigated using a survey tool, in which participants were asked to respond to brief clinical scenarios about mental health issues that included varying degrees of professional/personal relationship overlap. The research was undertaken in Victoria, Australia during 2010/2011.

Recruitment of psychologists

Psychologists were recruited using the public register of the Psychologists Registration Board of Victoria. Of the 7,386 psychologists listed on this register, 2,000 were randomly selected from the 5,318 with a publicly listed email address. Psychologists were sent an email with a link to the online survey. A follow-up email was provided two weeks after the first request. A further 2,000 psychologists were selected randomly from the 5,318 and sent a recruitment email. Following a limited response rate (6%) a further 1,000 psychologists were randomly selected, including those who did not have a current email address. A hard copy of the documents and survey were sent by post.

Recruitment of medical practitioners

As medical practitioners' contact details were not publically available from a professional register they were identified from the Yellow Pages online database. A total of 11,339 medical practitioners with publically available contact details, were identified.

The raw data were cleaned, duplicates identified and multiple entries eliminated. For medical practitioners listed more than once, the first entry on the data base was chosen as the postal address. If both a hospital and a clinic address were available the clinic address was used. Medical clinics without an identifiable individual medical practitioner were excluded. From a clean data base of 7,384 medical practitioners, 2,000 were randomly selected and recruited by mail, as email addresses for medical practitioners were not available. This initial contact included a hard copy of the survey. A further 2,000

medical practitioners were randomly selected from the data base and recruited.

Survey tool

Participants were provided with an electronic or hard copy survey tool. Using a 10 point scale, they were asked to respond to ten scenarios which described a range of overlapping personal/professional relationships with patient/clients, who had recently been treated for a high prevalence mental health condition. Participants were requested to report the degree of ethical concern/appropriateness of the clinician behaviour described in the scenario where 1 represented most ethical/most appropriate and 10 least ethical/most inappropriate. The term 'client' was used with psychologists and 'patient' with medical practitioners in keeping with accepted professional terminology. The scenarios included incidental contact, boundary crossing and boundary violation. One example from each of these groupings is illustrated below. The scenarios were developed by the researchers to reflect clinical events with incidental contact having the least potential and boundary violation the most potential to be associated with high levels of ethical concern.

Incidental contact scenarios (n=3)

Example: Small talk about the local football in the supermarket, running across a client in the coffee shop and belonging to the same church as a patient/client

Boundary crossing scenarios (n=4)

Example: A 40th birthday invitation from an ex-patient/client, treating a colleague's spouse, invitation to a client's/patient's wedding and playing squash with a patient/client

Boundary violation scenarios (n=3)

Example: Employing a patient/client as a cleaner, befriending a patient/client on Facebook and gaining financial advantage from a client/patient

To preserve the confidentiality and anonymity of respondents living in small communities, participants were not asked to provide their work postcode. Participants were asked to indicate the size of town where they work using descriptors from the Rural, Remote and Metropolitan Areas (RRMA) classification [13].

Statistical analysis

Quantitative analysis of data was undertaken using standard techniques. SPSS version 20.0 was used. Statistical significance was set at $p < 0.05$. Group comparisons were undertaken using non-parametric tests Mann-Whitney U for two group comparison or Kruskal-Wallis tests for three or more group comparisons. The project received ethics approval (HREC 0933028) from The University of Melbourne.

Following each scenario participants were asked if they had been in a similar situation to the presented scenario and at the end of the survey participants were asked if they had experienced overlapping relationships in their professional practice. Three representative scenarios have been selected for results presentation, one from each category: Incidental contact, boundary crossing and boundary violation.

Results

Data were available from psychologists (n=439) and medical practitioners (n=478). Response rates to email and mail recruitment of psychologists were 6% (n=238 out of 4000) and 20% (n=201 out of 1000) respectively. Recruitment response rate for medical practitioners using mail only was 14% (n=478 out of 3500). In total number of participants were 917. Overall electronic survey data was obtained from 26% (n=238 out of 917) of participants and hard copy survey data from 74% (n=679 out of 917).

Demographics

Demographic data included participant gender, highest education level, years of professional experience, size of community in which practice is located and the type of practice. Results are presented in Table 1.

	Psychologists (n=439)	Medical Practitioners (n=475)*
Gender		
male	19% (85)	68% (321)
female	82% (354)	32% (154)
Highest level of Education		
Under graduate	4% (19)	15% (73)
Graduate Diploma	30% (131)	11% (53)
Masters	43% (186)	7% (35)
Fellowship	n/a	61% (288)
Doctorate/PhD	23% (103)	6% (26)
Years of professional experience		
< 1 year	3% (12)	0
1-3 years	13% (59)	1% (2)
4-10 years	31% (136)	3% (14)
>10 years	53% (232)	96% (459)
Size of town of practice		
0 to 24,999	20% (87)	18% (85)
25,000 to 99,999	21% (94)	13% (62)
≥100,000	59% (258)	69% (323)
Type of practice		
Private Practice	41% (180)	90% (431)
Corporate Organisation	2% (9)	2% (8)
Community Organisation	7% (31)	1% (5)
Government/hospital	25% (109)	5% (23)
Institution e.g. University	5% (22)	0.5% (2)
Other	2% (8)	1% (3)

Combination of private practice and other	18% (80)	0.5% (2)
*Three medical practitioners did not provide demographic information		

Table 1: Demographics, size of town and type of practice for psychologists and medical practitioners.

The majority of responding psychologists were female whereas the majority of medical practitioners were male. The gender imbalance reflects the gender inequity within these professions [14,15]. Most respondents had a post graduate qualification and had been practicing for longer than 10 years (70 and 76% respectively). The number of medical practitioners with over 10 years of experience was greater than psychologists. A substantial number of practitioners were from populations greater than 100,000. The majority of psychologists and medical practitioners work in private practice either as a sole practitioner or as part of a multi-clinician practice.

Due to the small numbers of participants (n=18) working in communities of less than 5000 people, data on size of community in which the participant worked were collapsed into three categories: Metropolitan/ large urban center ($\geq 100,000$), regional centre (25,000 to 99,999) and rural area ($\leq 24,999$).

Responses to scenarios

Many clinicians reported experiencing overlapping relationships in the course of their professional practice, with this experience being most common in smaller centres; see Table 2.

Population of town/area	Experienced overlapping relationships	
	Psychologists	Medical Practitioners
Metro Urban	54% (138/257)	76% (238/314)
$\geq 100,000$		
Regional centre	75% (70/94)	92% (57/62)
25,000 to 99,999		
Rural area	87% (75/86)	95% (79/83)
$\leq 24,999$		

Table 2: Psychologists and medical practitioners experience of overlapping relationships in their professional practice.

The proportion of psychologists and medical practitioners reporting experience of overlapping relationships is higher in the lower populated centres, with this difference being statistically significant for both professional groups ($p=0.001$) χ^2 (2, n=437)=36.66, $p=0.001$, $\phi=0.29$ and χ^2 (2, n=459)=21.54, $p=0.001$, $\phi=0.22$, respectively. It is worth noting however that more than half of the psychologists and over three quarters of the medical practitioners working in large urban centres reported that in their professional practice they had experienced overlapping relationships, similar to those described in the scenarios.

Psychologists and medical practitioners were asked to evaluate the degree of appropriateness of behaviour of clinicians who experienced a range of overlapping relationships. The judgements surrounding the three scenarios depicting incidental contact, a boundary crossing and a

boundary violation were measured using a 10 point rating scale, with a higher number corresponding with greater ethical concern about the clinician's behaviour. Responses to each scenario were analysed within and between professions, using non-parametric analyses due to the categorical data collected.

Scenario 1 – Incidental contact

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

Scenario 2 – Boundary crossing

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

Scenario 3 – Boundary violation

A client/patient of mine is desperate for money and revealed during therapy that she used to be a house cleaner – I need a cleaner, so I have employed her to clean my house

Psychologists responses

Using either the Mann Whitney U for comparison of two groups or the Kruskal-Wallis for comparisons of three or more groups, psychologists, across years of experience and type of practice had similar ethical concern about the behaviour of the clinician who ran into a client in the supermarket, accepted the invitation to the 40th birthday party and employed the client/patient as a cleaner. However, those psychologists with a Graduate Diploma (Md=1, n=131) reported less concerned about the clinician's behaviour who ran into the client in the supermarket than those practitioners who have an undergraduate degree (Md=2, n=19), Masters (Md=2, n=186) or a doctorate/PhD degree (Md=2, n=103), χ^2 (3, n=439)=13.28, $p=0.004$. Post hoc tests, Kruskal-Wallis, confirmed that psychologists with a postgraduate degree were significantly less concerned than either those with a Master's degree or doctorate/PhD degree.

For boundary crossing scenario there was a statistical significant difference between the level of ethical concern for the clinician's behaviour across size of town (urban metro Md=6, n=258, regional centres Md=7, n=94 and rural areas Md=5, n=87), χ^2 (2, n=439)=17.52, $p=0.0005$. Psychologists living in a rural area reported significantly lower median scores than either their metro urban or regional centre counterparts as found by post hoc comparisons. Female psychologists (Md=6, n=354) considered the behaviour of the clinician as less appropriate than their male colleagues (Md=5, n=85), $Z=-2.16$, $p=0.03$, $r=0.1$). There was no significant difference in judgements amongst psychologists across level of education.

Psychologists' ethical concern about the clinician employing a client was similar across gender, level of education and size of town.

Medical practitioners responses

Medical practitioners reported similar levels of concern about the behaviour described in all three scenarios across gender, level of education, years of experience and type of practice.

In contrast medical practitioners living and working in a regional centre were significantly more accepting of employing a patient as a house cleaner than either their urban metro or rural colleagues (urban metro Md=7, n=321, regional centres Md=6, n=61 and rural areas Md=7, n=85), χ^2 (2, n=467)=7.95, p=0.19. Although the difference was significant before post hoc analysis was applied, the difference was not significant when the alpha level was adjusted according to Bonferroni of p=0.017.

Psychologists and medical practitioners responses

Psychologists' and medical practitioners' responses were compared using a Mann-Whitney U test of significance. Psychologists' and medical practitioners' recorded similar levels of ethical concern for the behaviour of the clinician who came across a client/patient in the supermarket as reflected by a similar median, (Md=1,439) and (Md=1,475) respectively.

Psychologists (Md=6, n=439) rated the clinician accepting the invitation to the 40th birthday party as more ethically concerning than medical practitioners (Md=4, n=471), U=64474.5, z=-9.88, p=0.0005, r=0.33. Similarly, psychologists (Md=10, n=439) differed significantly on their ethical concern for the clinician's behaviour where a client/patient was employed as a house cleaner compared to medical practitioners (Md=7, n=474), z=-18.42, p=0.0005, r=0.61, a large effect size.

Experience of overlapping relationships

Following each scenario, psychologists and medical practitioners were asked if they had experienced a similar situation. Answers were analysed using a Mann Whitney U test of significance for each individual scenario, details provided in Table 3.

	Similar experience		No similar experience		Test of significance
	Md	n	Md	n	Mann Whitney U
Scenario 1	1	781	2	129	U=36707, z=-5.66, p<0.001, r=0.19.
Scenario 2	4	346	5	559	U=82065.5, z=-3.85, p<0.001, r=0.13.
Scenario 2	8	248	9	657	U=60628.5, z=-6.81, p<0.001, r=0.21

Table 3: Psychologists' and medical practitioners' experience of overlapping relationships in relation to individual scenarios.

These data indicate that practitioners who had experienced a similar situation to each of the individual scenarios believed the behaviour of the clinician to be more appropriate than the practitioner who had not experienced a similar overlapping relationship.

Summary

Psychologists living in a rural area were less concerned about acceptance of an invitation to a 40th birthday party than their counterparts living in either a regional or urban centre. Medical practitioners' responses to the scenarios did not definitively show a difference based on the size of town where they practiced. For the boundary crossing and violation scenarios, psychologists were more constrained than medical practitioners reporting greater ethical concern about the behaviour than medical practitioners. Experiencing previous overlapping relationships significantly influenced attributions of ethical concern for both psychologists and medical practitioners.

Discussion

This paper aimed to explore psychologists' and medical practitioners' views of scenario described responses to overlapping relationships. Their views, from an ethical perspective and self-reported of similar experiences were investigated. Participants worked in rural, regional and large urban centres. The findings support the hypothesis that rural health practitioners encounter more overlapping relationships with clients/patients than their urban counterparts. With increasing rurality the number of practitioners reporting overlapping relationships also increased. Surprisingly, however, a large number of metropolitan clinicians reported experiencing overlapping relationships (76% of medical practitioners and 54% of psychologists).

Given the extensive experience of overlapping relationships for many practitioners [1], it could be argued that treating acquaintances, family and friends although more common beyond metropolitan centres may not exclusively be a rural issue.

It was anticipated that health practitioners living in a rural area, where overlapping relationships are often inevitable [1], would be more accepting of these relationships than either their urban or regional counterparts reflected in lower levels of ethical concern. The findings partially support this hypothesis as rural psychologists believed the clinician who accepted the invitation to the 40th birthday party to have behaved more appropriately than did either urban or regional psychologists. By contrast, medical practitioners attributed similar levels of appropriateness to the clinician who accepted a 40th birthday party invitation irrespective of location. However, health practitioners attributed similar levels of ethical concern for both the incidental contact and for the boundary violation scenarios, regardless of location. The supermarket scenario presented minimal concern for practitioners; by contrast most clinicians believed it to be ethically inappropriate to employ a client/patient as a cleaner. Variation in opinion existed in the boundary crossing scenario (40th birthday invitation), reflecting views about an optional, non-exploitative contact. This variability in health professionals' attributions of ethical appropriateness may be a reflection of rurality, where clinicians may need to provide services to those they know within their community and develop a distinct rural ethical response.

The third hypothesis, that psychologists would be less accepting of the hypothetical clinicians' behaviour than medical practitioners was supported by this research. Whilst this may reflect psychologists encountering sensitive issues more often than medical practitioners, it may also be explained at least in part by the variation in the psychologists' and medical practitioners' respective codes of conduct.

This is an area that requires further investigation. Psychologists rated the behaviour of the hypothetical clinician as less appropriate than the ratings given by medical practitioners for both boundary crossing and violation scenarios. These differences may reflect the varied code of ethics and expected norms of each profession which in turn acculturate an ethical understanding that imbues professional practice. Prescriptive ethics statements that are declared throughout the code of ethics are reflected in comments by Allan [16] who suggests that psychologists prefer ethical standards that are concrete and which provide specific guidance. Abstract guidelines, although easier to apply by regulators, may cause psychologists discomfort [16]. For example, the APS states psychologists should not treat family or close friends due to impaired professional judgement and that psychologists (should) refrain from engaging in multiple relationships. This guideline is very clear leaving psychologists little flexibility to contextually interpret the professional expectation. Explicit policy guidelines that dictate appropriateness of behaviour may make the application of the guidelines easier for the psychologist, but may not be helpful for the practitioner working in a small community. This research confirms that overlapping relationships are common in clinical practice. Guidelines that are inflexible may discourage discussion about incidental boundary crossings and promote the development of a silent consensus which contributes to the 'naughtiness' of engaging in these relationships [17]. This may further isolate those who have little alternative than to treat acquaintances [17].

Conversely the 'Good Medical Practice' code of conduct states medical practitioners should avoid treating close friends and family but it states that at times it may be unavoidable. Although it is articulated that a medical practitioner should proceed with caution, the statement appears to encapsulate the complexity of practitioners' roles in communities where access to a clinician may be limited. Furthermore, the 'Good Medical Practice' code of conduct does not explore the multiple relationships experienced by clinicians who treat people with whom they have a prior relationship. The differences in these codes of ethics may reflect professional expectation but this interpretation will require further research to ascertain the nuances behind professional behaviour as it is reflected in clinicians' responses to overlapping relationships.

Although, the number of psychologists and medical practitioners who reported overlapping relationships became greater with increasing rurality, more than half of urban practitioners (76% (238) medical practitioners and 54% (138) psychologists) reported engaging in overlapping relationships with their clients/patients. Clinicians reporting past experience of overlapping relationships, irrespective of practice location, were more accepting of the hypothetical practitioner's behaviour than those who did not report experience of an overlapping relationship. Professional experience allows for heuristic learning which appears to moderate practitioners' degree of ethical concern about engaging in overlapping relationships. As over half the psychologists and three quarters of the medical practitioners who practice in the urban centres experience overlapping relationships it is perhaps appropriate to include metropolitan based clinicians in ethics education centred on managing overlapping relationships, rather than see this as a specific rural issue.

The potential pitfalls of rural practice and the possibility of overlapping relationships may cause a level of anxiety for practitioners. This anxiety may not be wholly negative but promote heightened awareness that can be used creatively as a reminder of the

need for ethical practice in an atypical professional engagement. The experience of anxiety associated with such consultations may reduce the likelihood of a blasé approach and reduce the risk of the practitioner making poor professional and/or personal decisions.

Conversely, those practitioners who are too anxious and remove themselves from rural life and social connectedness may not be suited to practice in smaller communities. Perhaps there is an in-between experience where practitioners, aware of the pitfalls and the issues of treating those they know, still manage to practice ethically, recognizing that clinical encounters that include a degree of relationship overlap are atypical and require additional awareness. This encourages the practitioner to openly discuss with peers and carefully negotiate the therapeutic benefit versus personal cost thereby supporting the therapeutic alliance between practitioner and client/patient.

Limitations

The recruitment approach for medical practitioners using Yellow Pages online is likely to have reduced the number of early career participants with many junior practitioners not being identifiable as an individual clinician and more likely to be listed within a practice. This is reflected in the demographics with more than 95% of medical practitioners having more than 10 years professional experience (compared to 53% for psychologists). Furthermore, a limited response rate (6%) following the initial recruitment of psychologists via emails may have been in part due to the researchers not providing a pre-notice email for potential participants. Dillman [18] states that a four contact email strategy has a comparable response rate to postal surveys. In the current study only two emails were sent, the initial request for participation and a follow-up email two weeks later. It is possible that the lack of email contact contributed to psychologists' low response rate.

Conclusions

This paper supports the view that overlapping relationships with clients/patients are common for many practitioners not just for those working in small rural settings. Existing codes of conduct may reinforce the belief that overlapping relationships are to be avoided by professionals. Psychologists are less accepting of overlapping relationships than medical practitioners. For the rural psychologist and indeed the medical practitioner, a more flexible approach while still reflecting professional ethical principles may be required for practitioners to sustainably live and work in rural communities.

This research suggests that a psychologist and a medical practitioner would most likely respond differently to an invitation to play squash with a client/patient. The psychologist would be less likely to accept the invitation than the medical practitioner. Furthermore, rural clinicians may be more accepting of playing squash with their client/patient than their urban counterparts, consistent with the concept of distinct rural ethics. Finally, those who have personally experienced an overlapping professional relationship are more accepting of decisions by their colleagues to engage in multiple relationships than those practitioners who have never encountered overlapping relationships in their practice. Further research is required to fully understand the experience of clinicians as they respond to overlapping relationships and their impact on professional practice whilst living and working in a 'fish bowl'.

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