RACGP's GP boundaries, containment and burnout webinar: 9 December 2020

Establishing effective boundaries and containment can improve the doctor/patient relationship

Relationship and rapport underpins the likelihood of positive behavior change and is essential. Patients that use AOD often feel shame, stigma and judgement and have a well-developed intuition of detecting insincerity or reluctance. Although it can be taxing when patients display problematic behaviors (eg associated with drug seeking), it can help to review patients as being in "survival" mode, and to remain hopeful, keep the "door open".

- I want to help you. But I can't help you the way you want today. I have to act safely and responsibly.
- I can see you are genuinely uncomfortable right now. I can prescribe you a dose for today. Can you come to see me tomorrow?
- I can see you are quite upset. I do want to help you. Please come see me when you feel a little better and able to chat.

Patients benefit from hearing that you're invested in helping them. Display comfort (body language / facial expression) with what patient shares. In building relationship, avoid being enmeshed (result in GP burnout) or rigid/detached (affect rapport). Phrases that can help establish positive two-way boundaries:

- I have no moral concerns with your AOD use. You are an adult free to make your own choices. As your GP, my primary concern is your health and overall wellbeing.
- As with all my patients, I will expect that you turn up to our appointments on time, be respectful to the staff and myself. In turn as your GP, I aim to run on-time, and treat you with honesty and respect.
- As your GP I will support you and your goals, but I must also be objective, so at times my advice might be challenging to you. Please know that I have your health and wellbeing foremost in mind.
- If you work in a rural / remote region, or live close to your practice, be explicit that if the patient sees you in town, that you are happy to chat, but not about work (ie their health etc).

A patient centered, whole person care approach to manage boundary setting

Take a socio – psycho – bio approach. Social: What are the relationships like? Is there dysfunction? Is disconnect causing stress? Psychological: Any anxiety? Financial stress? What are the coping behaviors? Biological: Hungry? Physical health issues? During consults be mindful of how these domains are affecting you. Are you hungry? Are you stressed by something at home? For example, a demanding patient with chronic pain may make you want to see them less, when they probably should see you more.

So acknowledge this response (your own triggers or beliefs/values that influenced your initial reaction) then make a plan. Flag with your patient what you want to talk about in smaller more frequently consults and that your colleagues will also help. This will reduce their anxiety and help your consults run more smoothly. This lets the patient know three things:

- That you're prepared to help them.
- That they're on a journey that will take time
- That others in the practice will help them as well.

Approximately 20% AOD workers experience vicarious trauma. GPs who work in AOD can be more vulnerable to boundary crossings or difficulty setting boundaries. Humans are social beings and empathy is hard-wired. Transference goes both ways, and is contagious. Emotional literacy is important for yourself and for your patients. Feeling pessimistic is contagious, as is feeling hopeful. The media portrays a sense of hopelessness, blame and shame. The way we conduct ourselves as GPs conveys hope (you are important, your health is important, I am here to help, things can get better).

Family members may share observations with you with or without the 'index patient'. If index patient not present, acknowledge the family member said something, however do not engage in discussing further. Use as an opportunity to offer family-oriented support as family may feel alone, ashamed and in need of connection with others. Encourage to find "their community" shared experience, and if those recommended doesn't work, then find another.(Resources al-anon, family drug support, Peer support works; AA, NA, SMART recovery)

If the patient is aware that information was shared with you, be mindful the patient may feel shame or guilt. Use therapeutic techniques "Your family member seemed concerned and I'm here for you", reflect back on their concern and normalise feelings. Family member involvement can aid recovery. If family member present, explain that usual practice is to consult only with the patient (this allows the patient indicate their comfort with the family member remaining in the room).

Use a range of strategies to recognize and prevent vicarious trauma and burnout and manage your wellbeing

- Try to avoid defining success as supporting a patient to abstinence. Pre-contemplative patients will continue to use, and efforts to minimise harm / brief interventions are important. You might not see the fruits of your labor immediately, but let those seeds grow. Lapse and relapse is to be expected, like diabetes or asthma. So keep in mind that you are responsible to your patient, not for them
- A moment of self-reflection at the end of every consultation can be an effective strategy. If feeling uneasy, park it for the end of the day and talk with a colleague. Incorporate into your daily routine. ('what's moving within me', 'why am I feeling this way?') Reflection can also help identify skills strengths and gaps and where to access support/ help.
- Are you more inner or outer compass? Outer compass make decisions based on feelings of others, try to help or please. In doing so they can find collective harmony at the cost of inner disharmony. Inner compass make decisions based on clear sense of self, their values, and less swayed by feelings of others. Downside is may be more isolated, less able to adapt and may impact rapport.
- Acceptance and Commitment Therapy: embrace thoughts and feelings rather than fighting or feeling guilt over feelings. 'Fusion' is to understand the problem, the ability to buy in to the story (watching the movie as if it is a real, emotional experience). Too much fusion results in burnout. 'Defusion' is the ability to experience with distance, consider objectively to problem solve, (watching the movie, knowing it's a movie and have fun). 'Detachment' e.g. not connected to the experience, such as a judge/surgeon, (not interested in watching the movie)
- Part-time workers might want a GP buddy. Seek someone with an opposite perspective for balance (if you're outer compass have an inner compass buddy). Share patients, check results, consistent care for the patient on days you're absent.
- 'Self-sacrifice schema'. To fulfil your own needs feels selfish. Instead of viewing it as all or nothing, aim for 60% of energy going towards others, and always keeping 40% for yourself, for overall balance.

- If you or a colleague become cynical and disillusioned, then burnout may be likely. Consider formal support through:
    - 1:1 mentoring
    - Group sessions with a hired expert facilitator
    - In-practice group meetings or meetings with likeminded GPs
    - Consider joining an established Balint group (useful to defuse from patient rather than fuse)
    - Lifeline: 13 11 14
    - CRANAplus for rural and remote practitioners: 1800 805 391
    - DRS4DRS state based counselling: ACT-0294376552, NSW-0294376552, NT-0883660250, QLD-0738334352, SA-0883660250, Tas-1800991997, Vic-0392808712, WA-0893213098
    - Burnout questionnaire

Resources:

Watch Addicted Australian for patient (and clinician) perspective on AOD care in Australia:
AFP article on Acceptance and Commitment Therapy
Many free resources on the ACT mindfully website
Mental health for healthcare workers during the pandemic self care and mental health and self care podcast
Excellent RACGP self-care resource
RACGP resource on GP self-care, a little older but still relevant
Every Doctor book and website with articles on managing stress, self-discovery, mental health, and work relations for doctors. Authors Michael Kidd and Leanne Rowe
Hand-n-hand peer support:
Balint groups
Burnout and compassion fatigue
Balint groups and decision making
Challenges in the dr-pt relationship within Balint groups, 12 tips
The 'heart sink patient'
Excellent resource on Borderline Personality Disorder as well as setting therapeutic boundaries, with Project Air a great resource referenced in this BPD Tempo
AFP article on professional boundaries (general article)