Rural and Remote
Division of Family Practice
A GPSC initiative

To: Kelly Newton, BC College of Physicians and Surgeons

cc: Leanne Morgan, Executive Director

From: Dr. Amber Bacenas, Regional Physician Lead Northern and Vancouver Coastal, Dr. John Soles, Board Member & Regional Physician Lead Interior, Dr. Tracey Thorne, Regional Physician Lead Vancouver Island and Dr. Dave Whittaker, Board Chair.

Date: July 31st, 2020.

Re: **Non-Sexual Boundary Violations Practice Standard**

Dear Ms. Newton,

The Rural and Remote Division of Family Practice supports over 150 physicians who work in 12 communities across 4 geographic health authorities. Our members received the call for input regarding the revised Non-Sexual Boundary Violations Practice Standard recently circulated by the College. While we agree that physicians must maintain appropriate boundaries with patients, this guideline creates a disproportionate burden on rural doctors. We fear that this guideline, as written, would make it very difficult for physicians living and practicing in rural communities to live, shop, raise children, enjoy recreation and socialize in their communities.

The expectations listed have many significant consequences for rural doctors. Prohibiting social or business relationships with anyone closely associated with patients would, for all intents and purposes, prohibit social or business relationships of any kind for the physicians in rural parts of our province. Many of our members are longtime residents of their community - they shop locally, enroll their children in local schools, daycares and recreational activities. Rural physicians volunteer, join community groups, get their hair cut, hire childcare and need repairs done to their homes, properties and cars. In many small communities the Non-Sexual Boundary Violation Practice Standard would require physicians to abandon all of these interactions and leave their own community for almost all required services and interactions. When a small number of physicians practice in a rural community with a small population and limited services there is no way to avoid social or business interactions with patients. This puts all of our rural doctors at risk of violating this practice standard on a daily basis.

When physicians integrate themselves and their families into the fabric of the community, there are positive impacts including increased job satisfaction and higher retention within community. This leads to increased strength of longitudinal care relationships for patients and better health outcomes for the community. Should this practice standard be implemented, it may have the unintended negative consequence of deterring physicians from setting up their primary residence in rural and remote communities for fear of social isolation for themselves and their family.

This standard will unfairly impact physicians with children. This standard would make it difficult to enroll a child in school, preschool or daycare, as in many small towns the teachers, EAs, and principals are patients of the local physician. Since the standard also disallows the termination of the patient-physician relationship based on social connection, the only option is to remove the child from the classroom, which may be the only classroom option for that child. This is an unreasonable burden to place on physicians with young families.

This standard will also unfairly impact female rural physicians. Many rural communities have only one female physician. It is often the case that she will do the majority of women's health in a community - pap smears, pre-natal care, management of menopause. This standard would significantly limit her ability to interact socially with most other women in her community, even if she has only had participated in episodic care of many of these patients and was not their primary physician. This potentially puts female rural physicians at a greater risk than their male colleagues of running afoul of this practice standard, which is inherently inequitable.

Rural physicians also provide urgent and emergency care within their communities. No one can control who needs care in an emergency situation. Often there is only one physician available to provide that care. Rural physicians regularly care for their friends, neighbours and services providers out of necessity and urgency. This practice standard does not account for that aspect of care and will force physicians to knowingly contravene the practice standard.

There are many nuances related to the dynamics of rural and remote communities which we realize may not be universally understood by the authors of this standard and require additional consideration. To that end, our Division would be pleased to meet with representation from the College to describe the realities of practicing in rural communities and discuss how this this standard can be modified to be inclusive of the lived experience of rural physicians while still protecting the public.

We thank you in advance for your consideration and if you would like to meet with us, please connect with our Executive Director, Leanne Morgan at lmorgan@divisionsbc.ca and she can set up a meeting.

Respectfully yours,

Dr. Amber Bacenas, Regional Physician Lead Northern and Vancouver Coastal,

Dr. John Soles, Board Member & Regional Physician Lead Interior,

Dr. Tracey Thorne, Regional Physician Lead Vancouver Island

Dr. Dave Whittaker, Board Chair.