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**Professional Boundaries:**
**Discerning the Line in the Sand**
***Definitions***
Jane W. Barton, MTS, MASM

**Professional Boundaries:**
Professional boundaries are defined as limits that protect the space between the professional's power and the client's vulnerability. Maintaining appropriate boundaries safeguards both the patient/client and the nurse by controlling or limiting this power differential. This boundary setting allows for a safe connection between the nurse and the patient based on the patient's needs. (Nursing Center)

Boundaries in Patient care are "mutually understood, unspoken, physical and emotional limits of the relationship between the trusting patient and the caring physician or provider. Health Professional boundaries represent a set of culturally and professionally derived rules of how health care providers and their patients interact. (Fast Facts)

**Fiduciary Responsibility:**
Fiduciary relationship is described as "one in which a person with a particular knowledge and/or ability accepts the trust and confidence of another to act in that person's best interest." (Nursing Center)

**Therapeutic Relationship:**
Therapeutic relationships are defined by the National Council of State Boards of Nursing as a continuum of professional behavior that spans from an extreme of under involvement to a "zone of helpfulness" to an extreme of over involvement (Nursing Center)

**Boundary Crossing:**
Boundary crossings are defined as "intentional or unintentional excursions across boundaries with a return to established limits of the professional relationship." Boundary crossings imply no harmful long-term effects.4 An example might be accepting a gift from an appreciative patient. (Nursing Center)

**Boundary Violation:**
Boundary violations do imply harm to the patient. They occur when therapeutic boundaries are crossed and are characterized by role reversal, secrecy, double binds, or the nurses' needs being met rather than the patients'. Minnesota's Board of Nursing position statement includes indulgence of professional privilege as a fifth criteria.6 An example of a boundary violation might be an overtaxed nurse disclosing personal information or venting personal feelings to a patient. (Nursing Center)

**Violation Potential:**
Every nurse and every healthcare provider carries a VP. VPs are dynamic and change over time in response to life events, professional risk factors, and personal vulnerabilities. This variation explains why a nurse may have a low VP at one moment and a high VP at another. Risk factors encompass a number of external elements such as work setting, patient type, and experience. (Nursing Center)

# Professional Boundaries for Caregivers

| Type of Boundary Crossing | Staying In-bounds |
|---|---|
| **Sharing personal information**: It may be tempting to talk to your client about your personal life or problems. Doing so may cause the client to see you as a friend instead of seeing you as a health care professional. As a result, the client may take on your worries as well as their own. | • Use caution when talking to a client about your personal life<br>• Do not share information because you need to talk, or to help you feel better<br>• Remember that your relationship with your client must be therapeutic, not social |
| **Not seeing behavior as symptomatic:** Sometimes caregivers react emotionally to the actions of a client and forget those actions are caused by a disorder or disease (symptomatic). Personal emotional responses can cause a caregiver to lose sight of her role or miss important information from a client. In a worst case, it can lead to abuse or neglect of a client. | • Be aware that a client's behavior may be the result of a disease or disorder<br>• Know the client's care plan<br>• If you are about to respond emotionally or reflexively to the negative behavior of a client, step back and re-approach the client later.<br>• Note that the client may think his action is the best way to solve a problem or fill a need<br>• Ask yourself if there is a way to help the client communicate or react differently |
| **Nicknames/Endearments:** Calling a client "sweetie" or "honey" may be comforting to that client or it might suggest a more personal interest than you intend. It might also point out that you favor one client over another. Some clients may find the use of nicknames or endearments offensive. | • Avoid using terms like "sweetie" or "honey"<br>• Ask your client how they would like to be addressed. Some may allow you to use their first name. Others might prefer a more formal approach: Mr., Mrs., Ms, or Miss<br>• Remember that the way you address a client indicates your level of professionalism |
| **Touch:** Touch is a powerful tool. It can be healing and comforting or it can be confusing, hurtful, or unwelcome. Touch should be used sparingly and thoughtfully. | • Use touch only when it serves the needs of the client and not your own<br>• Ask your client if he/she is comfortable with your touch<br>• Be aware that a client may react differently to touch than you intend |
| **Unprofessional demeanor:** Demeanor includes appearance, tone and volume of voice, speech patterns, body language, etc. Your professional demeanor affects how others perceive you. Personal and professional demeanor may be different. | • Loud voices or fast talk may frighten or confuse clients<br>• Good personal hygiene is a top priority due to close proximity to clients<br>• Professional attire sends the message that you are serious about your job<br>• Off-color jokes, racial slurs, profanity are never appropriate<br>• Body language, facial expressions speak volumes to clients |

| Type of Boundary Crossing | Staying In-bounds |
|---|---|
| **Gifts/Tips/Favors:** Giving or receiving gifts, or doing special favors, can blur the line between a personal relationship and a professional one. Accepting a gift from a client might be taken as fraud or theft by another person or family member. | • Follow your facility's policy on gifts<br>• Practice saying no graciously to a resident who offers a gift that is outside your facility's boundaries<br>• It's ok to tell clients you are not allowed to accept gifts, tips<br>• To protect yourself, report offers of unusual or large gifts to your supervisor |
| **Over-involvement:** Signs may include spending inappropriate amounts of time with a particular client, visiting the client when off duty, trading assignments to be with the client, thinking you are the only caregiver who can meet the client's needs. Under-involvement is the opposite of over-involvement and may include disinterest and neglect. | • Focus on the needs of those in your care, rather than personalities<br>• Don't confuse the needs of the client with your own needs<br>• Maintain a helpful relationship, treating each client with the same quality of care and attention, regardless of your emotional reaction to the client<br>• Ask yourself: Are you becoming overly involved with the client's personal life? If so, discuss your feelings with your supervisor |
| **Romantic or Sexual Relationships:** A caregiver is never permitted to have a romantic or sexual relationship with a client. In most cases, sexual contact with a client is a crime in Wisconsin. | • While it may be normal to be attracted to someone in your care, know that it is never appropriate to act on that attraction<br>• Do not tell sexually-oriented jokes or stories. It may send the wrong message to your client<br>• Discourage flirting or suggestive behavior by your client<br>• If you feel that you are becoming attracted to someone in your care, seek help from your supervisor or other trusted professional right away |
| **Secrets:** Secrets between you and a client are different than client confidentiality. Confidential information is shared with a few others members of a team providing care to a resident. Personal secrets compromise role boundaries and can result in abuse or neglect of a client. | • Do not keep personal or health-related secrets with a client<br>• Remember that your role is to accurately report any changes in your client's condition |

# Decision Tree

**Proposed Behavior**

↓ YES

**Meets a clearly identified therapeutic need of the patient, rather than a needs of the provider? For example, is it in the plan of care?**

NO → **Abstain from Behavior**

↓ YES

**Is the behavior consistent with the role of the providers in the setting?**

NO → **Abstain from Behavior**

↓ YES

**Is this a behavior you would want other people to know you had engaged in with a patient?**

NO → **Abstain from Behavior**

↓ YES

**Proceed with the behavior and document actions.**

(Adapted from Therapeutic Nurse-Client Relationship, Revised 2006, College of Nurses of Ontario)

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**Questions for Self-Reflection**

**Note:** Not all boundary issues are detrimental to the provider-patient relationship. Some clearly enhance compassionate care and serve to reinforce a trusting therapeutic relationship. However, it is important for the provider to self-reflect when boundaries are approached.

- *Am I treating this patient or family differently than I do my other patients?*
- *What emotions of my own does this patient/family trigger and are the emotions impacting my clinical decision-making?*
- *Are my actions truly therapeutic for the patient, or am I acting in a manner to meet my personal needs?*
- *Would I be comfortable if this gift/action was known to the public or my colleagues?*
- *Could this boundary issue represent a sign that I am experiencing professional burnout?*

***Fast Facts 172***

Other questions to consider from ***Professional Boundaries in Health-Care Relationships***

- Is this in my client's best interest?
- Whose needs are being served?
- Will this have an impact on the service I am delivering?
- How would this be viewed by the client's family or significant other?
- Am I treating this client differently from other patients?
- Does this client mean something special to me?
- Am I taking advantage of the client?
- Does this action benefit me rather than the client?
- Am I comfortable documenting this decision/behavior in the client file?
- Does this contravene the standards or ethical codes of my discipline?

***The College of Psychologists of Ontario***

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**Case Studies**

## Case 1: (Mrs. Foster and the Social Worker)

Mrs. Foster is an 85 year old lady with bone cancer. You are a hospice social worker who has been working in the field for the past 15 years. You and your hospice team have been working with Mrs. Foster for 5 months, and you have grown very fond of her. Her children and grandchildren all live out of state, and her husband pre-deceased her. She seems so incredibly alone, so you always plan for some extra time with Mrs. Foster when you see her. In fact the last time you were in her home, she served you hot tea and homemade scones. The experience reminded you so much of the times you used to chat with your mother in her kitchen…before she too died of cancer.

Today, Saturday, you received a call from the nurse covering the weekend shift. There has been a significant change in the pain experienced by Mrs. Foster, and the recommendation is to change pain medications to achieve the desired relief. Mrs. Foster is hesitant to agree to the change and refuses to take the medication until she talks to YOU. She will agree to take the meds if you tell her it is the best thing to do. The weekend nurse seems somewhat irritated by the situation, which is surprising to you. But then you remember, this nurse is ALWAYS irritated when she calls you on the weekends for similar types of requests. She obviously doesn't know how to relate to her patients as well as you do. It doesn't matter. You will take care of things like you always do.

***Questions for Consideration:***

1. What are the professional boundary issues in this case?
2. Have boundaries been crossed or violated?
3. What are the warning signs?
4. What are the implications for care?
5. What are the VP risk factors for this social worker in regard to Mrs. Foster?
6. Is there evidence of a pattern of behavior?
7. Whose needs are being served in this situation?
8. How should this case be addressed by the team? The organization? By the weekend nurse?

**Case 2: (Katherine, RN)**

You are a 35 year old hospice nurse who is feeling overwhelmed and exhausted. For the first time in 2 years, you are taking some time off to be with your family for the holidays. Always before, you volunteered to cover the holiday shifts for other members of your team. But this year, THIS year, you decided to do something for yourself (although you are feeling a bit guilty!). It was been a brutal year for you, and you need some time with your parents, siblings, and cousins. Your family was there for you throughout the nasty divorce proceedings of the past year, and they are now encouraging you to come home.

Putting yourself first is NOT your natural mode of operation. However, as you drive to your parents' home in Texas, your sense of relief and freedom grows with each mile. Relief that is until your personal cell phone starts ringing! You have only been off duty for 24 hours, and already 3 patients have called. Can't people just leave you alone??? Don't they know you have your OWN life???

**Questions for Consideration:**

1. What are the professional boundary issues in this case?
2. Have boundaries been crossed or violated?
3. What are the warning signs?
4. What are the implications for care?
5. What are the implications for the nurse?
6. What are the VP risk factors for Katherine? Is there a catalyst?
7. Is there evidence of a pattern of behavior?
8. Whose needs are being served in this situation?
9. What approaches might help Katherine in establishing more appropriate professional boundaries?

**Case 3: (Arthur Davis and Family)**

Arthur Davis is a 65 year old gentleman with pancreatic cancer. You are the chaplain on the hospice team that serves Arthur and his family. Over the past 3 months, you have met most of Arthur's immediate family and feel as if you have a good rapport with all of them. So, you are very surprised to hear that the family contacted your supervisor and filed a complaint about YOU!

Evidently, the family is very distraught over Arthur's decision to decline artificial nutrition and hydration at the end of life. Previously, based on conversations you had with Arthur, he was firm in his conviction that he must fight until the very end…do everything possible to extend his life. However, over the past few months you have noticed a change in his approach to life and death. He is no longer as concerned with hanging on to this life as in preparing for the next step. This is very difficult for his family to accept as they are NOT ready for Arthur to leave this world.

Over the course of your conversations with Arthur, you shared the story of your father's death ten years ago. Your father's perspective regarding end of life treatment options radically changed as his health declined…and rightly so in your opinion! You shared the story with Arthur to highlight the fact that MANY people change their minds at the end of life; transformation is part of the process. However, the family evidently believes you overly influenced Arthur's decision. They are furious and demand that you be removed from the team and reprimanded.

**Questions for Consideration:**

1. What are the professional boundary issues in this case?
2. Have boundaries been crossed or violated?
3. What are the warning signs?
4. What are the implications for care?
5. What are the implications for the chaplain?
6. What are the VP risk factors for the chaplain?
7. Are the family's demands reasonable? How should the organization respond?
8. What would be beneficial for the family?
9. Was the chaplain's interaction with Arthur appropriate?

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# *Questions?*

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