Establishing and Maintaining Ethical Professional Boundaries

I) Course Purpose

This course will discuss professional boundaries in both clinician-client relationships and colleague-colleague interactions. It will address ethics issues, the benefits of professional boundaries and common mistakes made with regard to establishing and maintaining these standards. It will also provide tips for how to sustain ethically-driven relationships with clients and colleagues. This course was written for a variety of healthcare disciplines.

II) Course Objectives

- Define professional boundaries
- Discuss ethical foundations for professional boundaries
- Examine the importance of professional boundaries in client relationships
- Examine the importance of boundaries in colleague relationships
- Discuss common lapses made when establishing professional boundaries
- Provide tips in how to maintain professional boundaries

III) Course Outline

I) Course Purpose
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   A) Introduction
   B) What are Professional Boundaries?
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A) Introduction

In our healthcare roles, we encounter numerous individuals throughout the day, week or year in various work settings. Whether we are Therapists, Nurses, Counselors, Social Workers, Activity Directors or other health professionals, it is imperative that we apply the upmost standards of conduct to all of our working relationships. One way of assuring this is by establishing and maintaining healthy professional boundaries.

Based on our particular work assignments, different interpersonal situations exist. For example, the relationship forged with a client in a hospital emergency room is far different from that developed in an individual’s home setting. In the former, the interaction between a professional and client tends to be rather short in nature, albeit likely highly intense. On the other hand, the ability to become closely involved with a client over a longer duration of time has greater probability when working with that individual in his or her own home. In other situations, a clinician may engage in a far more intimate level of relating to a client that is actively dying verses a client who is merely known on an outpatient basis. Regardless of the setting, the nature of the healthcare treatment or the length of the therapeutic relationship, the need to understand and adhere to professional boundaries is paramount. This skill involves knowing what professional boundaries are, how professional boundaries are driven by ethics, how professional boundaries affect client and colleague relationships and how professionals can go about establishing and maintaining professional boundaries. The course you are about to review will address all of these important issues.

B) What are Professional Boundaries?

The MSN Encarta dictionary defines a boundary as, “a limit; the point at which something ends or beyond which it becomes something else,” (MSN Encarta, 2009). Professional boundaries can be thought of, then, as
parameters, invisible structures or division lines around which we base our relationships with clients and colleagues. Professional boundaries create space between two or more individuals. They also help define the manner in which professionals are to relate to those with whom they work. Furthermore, professional boundaries set limits for what should not be done while also pointing to things that should occur work-related interactions. Regardless of the different words, phrases or definitions we choose to apply to the idea of a professional boundary, each of these descriptions is useful for the purposes here. Additionally, each description indicates that there are particular ethical guides, or standards, by which we can compare and gage our own professional behaviors.

Boundaries help to determine professionally-bound constraints and our responsibilities for working with others. They are meant to protect both clients and clinicians. They also set aspirations, or expectations, of how healthcare providers should respond in particular work-related situations. Having well-established professional boundaries can help assure that a practitioner is seen by clients and colleagues as upstanding, virtuous or honest. Professional boundaries can also indicate that an individual has integrity and uses good clinical judgment. Finally, practitioners that abide by sound professional boundaries are more likely to be seen by others as trustworthy and reliable.

Conversely, when practitioners’ behaviors are affected by boundary issues, this can lead to a variety of undesirable responses. Most importantly, the clinician can be seen as unprofessional by those in their care or by those with whom they work. Boundary issues can also lead to unethical decision making with regard to what may or may not be in the best interests of others. Moreover, professional boundary issues can create situations in which there is uneven therapeutic leverage, or control, between practitioners and clients. The same can be true of control in practitioner and colleague relationships that have become affected by boundary issues. Lastly, when professional boundaries are disregarded, this can result in unintended reactions from others. These responses may include favoritism, sadness, anger, stress, entitlement, inappropriateness, misunderstanding, rejection or shame.

Beyond the negative outcomes impacted onto clinician-client and colleague-colleague relationships, boundary issues can also be detrimental to our own well-beings as healthcare practitioners. Boundaries issues can cause a practitioner to lose objectiveness in his or her professional relationships. They can also cloud a healthcare worker’s judgment. When others begin to suspect or address possible boundary infractions, practitioners can become
defensive or hostile. In their worst cases, boundary issues can lead to practitioners becoming burnt out or engaging in activities that are unacceptable, illegal or otherwise incongruous with clinicians’ ethical codes of conduct.

At this point, it is likely wise to point out that the severity of boundary issues may vary. In professional practice, there are distinctions between something which occurs that is more of a lapse in conduct, or a boundary crossing, and something that occurs which actually constitutes a boundary being violated. A boundary crossing might occur when a clinician begins move away from a relationship that is strictly professional to one that has more of a personal element at its core. For example, when a clinician starts doing special favors for a particular client during his or her off time or begins sharing personal information that goes beyond that of therapeutic disclosure, these are more likely boundary crossings. Other boundary crossings might include being defensive about a relationship with a client, accepting gifts from a client or flirting with a client. A boundary violation occurs when a clinician has fully stepped outside the expected standards for his or her professional role and has participated in behaviors that are unacceptable under that person’s ethical code. If a clinician were to establish a sexual relationship with a client who is presently under his or her care, this would be a boundary violation. (Note: Certain professions allow for romantic or sexual relations between clinicians and former clients after particular time durations have elapsed. Other professions strongly suggest that the practice should be avoided altogether.) A second example of a boundary violation might occur when a clinician chooses to override a medical order for care because he or she erroneously believes to know what’s truly “best” for the client. For instance, providing extra doses of narcotic medications to a client whose physician is attempting to gradually eliminate these sorts of drugs from the individual’s pharmaceutical regimen. In this situation, the clinician’s behavior would not only constitute a boundary violation but would also be illegal.

C) Ethics and Professional Boundaries

All healthcare professions have ethical conduct standards which are to be upheld by the various clinicians or members practicing within these groups. Most times these organizations’ Codes of Ethics explicitly address professional relationships and the boundary confines that exist therein. These standards of conduct are routinely defined in terms of boundary statements. Boundary statements outline how professionals are to go about forging and maintaining appropriate working relationships with clients and colleagues. Boundary statements not only help to provide guidance in ethically-driven situations but may also designate certain absolutes. For
example, nearly all professional codes mentioned here contain specific clauses that prohibit professionals from engaging in certain unethical acts, such as establishing sexual relations with a client who is under the healthcare provider’s care. Other statements about boundaries, however, are more general in nature. These guidelines point to what a clinician should or shouldn’t do in a given circumstance. At times professional organizations or credentialing bodies leave the interpretation of these particular situations to the individual. An example of this might be when a clinician is presented with an opportunity of accepting someone as a client who is already known in another capacity such as a neighbor, church member or social acquaintance. In this situation, boundary statements can assist a professional in determining whether the co-existing relationship might interfere with their ability to exercise acceptable judgment and performance in the clinical realm.

Having a solid understanding of our own discipline’s interpretation of professional boundaries is important in any area of healthcare. Listed below are brief selections of boundary statements found in various organizations’ Codes of Ethics.

**Activity Professional**

The National Council for Certification of Activity Professionals (NCCAP), mentions professional boundaries in its Code of Ethics by addressing both Resident/Client Relationship Standards and Professional Relationship Standards. Of the former, NCCAP requires its certified members to guard the rights and dignity of clients while simultaneously protecting their welfares. They also forbid Activity Professionals from bringing personal issues into clinician-client relationships. In discussing Professional Relationship Standards, NCCAP urges Activity Professionals to be effective team members, to maintain high standards of conduct and to exhibit ethical behaviors at all times. In addition, certified members are responsible for assuring that other activity staff members are aware of and uphold the ethical standards and practices which are established for the profession (National Council for Certification of Activity Professionals, Code of Ethics).

**Counselor**

The American Counseling Association (ACA) has a rather lengthy, but highly specific, code for its members. According to this organization, the code is meant to clarify Counselors’ ethical responsibilities, establish principles that define ethical behavior and serve as an ethical guide for developing professional courses of action during counseling services. The ACA code suggests that respecting the dignity and promoting the welfare of clients
should be Counselors’ primary responsibilities. Counselors are also to avoid harming those in their care or others to whom they have responsibilities and are to minimize or remedy any unanticipated harm when necessary.

ACA-member Counselors are strictly forbidden from engaging in or condoning any form of sexual harassment during their professional activities or roles. This includes making offers or solicitations for sexual activity, physical advances or other actions that are sexual in nature. This also includes tolerating such behavior from or by another individual if it is unwelcome, offensive, creates a hostile workplace or learning environment or is significant enough that a reasonable person would consider these actions to be harassment in a given situation. In relation to this, Counselors are prohibited from exploiting others in their professional relationships.

Regarding other professional boundaries, ACA members are forbidden to participate in sexual or romantic relationships with current clients and these persons’ romantic partners, family members or others significantly attached to them. The organization does, however, allow for these sorts of relationships following a period of five years since the last professional contact, provided the interactions have been well-considered and, in some circumstances, documented. If there is any form of exploitation or potential to harm the client, these relationships must be avoided. Similar versions of this rule also apply to relationships with individuals that Counselors supervise, individuals who are counseling students or individuals who are serving as counseling research participants. Moreover, if establishing a social, romantic or sexual relationship with a prior student, Counselors are to openly discuss how these former roles might have an impact of the newly formed pairing.

In the case of nonprofessional interactions (e.g. social conduct) with current clients, former clients, their romantic partners, family members or others significantly attached to them, Counselors are permitted to engage in these sorts of relations only if such interactions are potentially beneficial to the current or past client. As with the scenarios above, harm cannot be expected to occur. These encounters, too, require a Counselor’s careful consideration. Additionally, they require documentation of the rationale for the relationships and how these interactions might affect the other party or parties. Later, if unforeseen or intentional harm does occur to any of these individuals, the Counselor must attempt to remedy the situation.

Counselors who serve as supervisors are urged to avoid nonprofessional relationships with individuals under their direction. If a Counselor shares a
multi-faceted relationship with a supervisee, as in the case of a clinical supervisor who also serves as an educational instructor, the ACA encourages the Counselor to attempt to separate the expectations and responsibilities for these differing roles. As with clients or former clients, Counselors must consider how a nonprofessional relationship with a supervisee might affect this individual. Additionally, this type of relationship must be free from exploitation and must be potentially beneficial to the supervisee. Prior to the establishment of such a relationship, a Counselor must openly discuss with the other individual how these interactions might affect the Counselor-Supervisee roles and must document the rationale for the nonprofessional contact before proceeding further. Because of the potential for conflicts in these sorts of relationships, Counselors are discouraged from accepting close relatives, romantic partners or personal friends in supervisee roles.

ACA Counselors who serve as professional educators are also to avoid forming nonprofessional relationships or participate in actions that may compromise the training experiences of his or her students. If this sort of relationship is to be established it must be time-limited and at the consent of the student. As with other Counselor relationships, any such interactions must be beneficial to the other individual. Here, too, the Counselor must openly engage in discussion with that person how the development of a nonprofessional relationship might affect the existing Educator-Student roles. The Counselor must also inform the student the rationale for these actions, the nature of these endeavors and the limitations of the new relationship. Counselor educators are not to serve as clinicians to current students unless this is a brief association that is related to the student’s training experience.

In yet another area of the code, the ACA states that nonprofessional relationships with research participants who are under the care of Counselors should be avoided. If these sorts of relations are formed, they must be at the consent of the research participant and must serve to benefit this individual. These sorts of interactions also require a Counselor’s documentation of the rationale, benefits or potential negative consequences that may occur. If unintentional harm does occur to the research participant as a result of the nonprofessional interaction, the Counselor must show evidence of an attempt to remedy this circumstance.

Finally, this code encourages Counselors to manage their various professional responsibilities and any potential dilemmas through utilization of ethical decision-making models that can bear public scrutiny. The ACA contends that it expects a high level of professional conduct from each of its
members and trusts that Counselors will hold peers to same degree of ethical standards. This organizations also advocates that Counselors resolve ethical dilemmas with direct and open communication among all parties involved and by seeking consultation with colleagues, other professionals or supervisors when necessary (American Counseling Association, Code of Ethics).

**Nurse**

The American Nursing Association (ANA) emphasizes that in all professional relationships, Nurses are to employ compassion and respect. The ANA notes that these courtesies apply to all individuals with whom Nurses interact including clients, colleagues and others. The ANA prohibits Nurses from engaging in prejudicial actions, harassment, threatening behaviors or showing disregard for their own actions. The ANA also suggests that Nurses must always act under the Code of Ethics with conduct that is grounded in moral principles. In this code, professionals’ primary responsibilities are to act in the best interests of clients. This document instructs that if conflicts of interest do arise in relationships with clients, Nurses are to examine these conflicts and attempt to resolve them in ways that preserve both the safety of clients and the integrity of the Nursing profession. Regarding professional boundaries, the Nursing code clearly states, “In all encounters Nurses are responsible for maintaining professional boundaries.” This requires the Nurse to recognize his or her own boundaries and to place appropriate limits on relationships with others. The ANA code further explains that, while Nurses often have close engagements others, professional nursing relationships differ from those that are personal and unstructured, such as friendships. When professional boundaries are jeopardized, Nurses are urged remove themselves from compromising situations or to seek to assistance from peers or supervisors (American Nursing Association, Code of Ethics).

**Occupational Therapist**

Occupational Therapy’s Code of Ethics, first and foremost, eludes to professional boundaries as it emphasizes the importance of beneficence; doing what’s in the best interest of the client. This code also addresses non-maleficence; taking measures to avoid causing harm to clients. In elaborating on this principle further, the American Occupational Therapy Association (AOTA) suggests that Occupational Therapists are to refrain from exploitive relationships (i.e.; sexually, physically, emotionally, psychologically, financially, socially or other) or relationships and activities that might affect a clinician’s ability to exercise objectivity and good judgment. Furthermore, the AOTA requires Occupational Therapists to treat
colleagues and other co-workers with respect, fairness, discretion and integrity (American Occupational Therapy Association, Code of Ethics).

**Physical Therapist**

The American Physical Therapy Association (APTA) addresses the topic of professional boundaries in its ethical principles as well. Several APTA principles describe how Physical Therapists are to go about maintaining relationships with others including: acting in a trustworthy manner towards patients and clients, exercising sound professional judgment and protecting the public and the profession from unethical, incompetent and illegal acts (American Physical Therapy Association, Code of Ethics).

**Social Worker**

Like the American Counseling Association’s edits, the Social Work Code of Ethics contains very specific language regarding professional boundaries. Also similar to the NCCAP standards for Activity Professionals, the National Association of Social Workers (NASW) divides its ethical responsibilities into both client and colleague areas.

With regard to clients, the NASW requires its members to avoid conflicts of interest that might interfere with Social Workers’ abilities to exercise discretion and use sound professional judgments. When issues arise here, Social Workers are urged to resolve the situations in manners that place clients’ needs above all; even to the extent to discontinuing professional relationships with those individuals, as necessary. Social Workers are further advised to refrain from taking advantage of professional relationships, exploiting clients or engaging in multi-faceted or dual relationships that could lead to similar outcomes (e.g.; when a client is known through more than one capacity related to professional roles, social roles, through business ventures, etc.). Social workers are also not to bring personal issues into professional relationships with clients.

Regarding sexual relations, the NASW forbids Social Workers from engaging in these sorts of relationships with clients. It also discourages Social Workers from engaging sexually with clients’ relatives or anyone closely tied to the client as this behavior could be potentially exploitive or harmful to the client. This is also true for former clients. Furthermore, Social Workers are advised not to provide services to individuals with whom they have had sexual relations in the past, even if this relationship had concluded prior to the need for care. Moreover, the NASW suggests that its members are not to engage in physical contact with clients if this behavior has the possibility to cause harm. Lastly, Social Workers are not to make any sexually harassing
gestures towards clients including making advances, solicitations and sexual favor requests or engaging in other conduct of a sexual nature with these individuals.

With regard to their relationships with colleagues, Social Workers are charged to cooperate with colleagues and to exhibit ethical behaviors at all times. They are also instructed to refrain from sexual relations with those whom they supervise, educate, train or have professional authority over. Per the NASW, sexual relationships with other colleagues are to be avoided as well if this activity might lead to potential conflicts of interest. As with clients, the professional organization advises that Social Workers are prohibited from directing sexually harassing gestures towards colleagues (National Association of Social Workers, Code of Ethics).

**Speech Therapist**

For Speech Language Pathologists, guidelines for professional boundaries are contained in the American Speech-Language-Hearing Association (ASHA) Code of Ethics. This code specifically implies, “Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of allied professions. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships and accept the profession’s self-imposed standards.” Speech Language Pathologists (SLP’s) aim to meet these requirements by: refraining from conduct that can be viewed as dishonest, fraudulent, deceitful or that is misrepresentative of the profession. SLP’s are also admonished to refrain from engaging in any interactions that involve sexual harassment. Additionally, the ASHA prohibits its members from engaging in sexual activities with clients or students over whom they have professional authority (American Speech-Language-Hearing Association, Code of Ethics).

**D) Professional Boundaries in Client Relationships**

Beyond maintaining compliance with one’s own professional standards, there are multiple benefits and advantages for sustaining healthy boundaries with clients. As mentioned earlier, the presence of these constraints can assure that clinicians are seen by clients with positive regards. These limits are also advantageous to clients in a number of other ways, a few of which are described below.

Shared Therapeutic Leverage – Sound professional boundaries assure that shared therapeutic leverage is present in clinician-client relationships. Therapeutic leverage involves control being managed collectively between
each party involved in the professional interactions. Although a clinician might ultimately possess an unequal share of this control based on his or her clinical knowledge and the inherent vulnerability of a client needing care, the intention of the clinician should never be to monopolize the client’s ability to exercise autonomy and self-determination. When the clinician and the client share control in a professional relationship, the potential for positive outcomes is optimized for both parties.

Maximized Trust and Confidentiality – When trust and confidentiality are present in professionally-bound relationships, a client’s ability to express his or her concerns without fear of breach is maximized. These traits assure with certainty that items discussed between the clinician and the client will be kept between these individuals during and after the course of the professional relationship. There are, however, times during professional relationships in which a client divulges information that must be disclosed to legal or other authorities; such as the mandatory reporting of particular illegal activities. In these circumstances, the obligation to report this information outweighs the importance of keeping certain knowledge concealed between the clinician and the client.

Sense of Safety – Professional boundaries give clients a sense that they will not will not be exploited, taken for granted or subjected to harm during the course of the relationship with the clinician. These limits confirm that all related interactions will be undertaken for the benefit of the client and that the client’s safety, health, or well-being are the driving factors in the professional relationship.

The benefits listed here are just a few of the many reasons to establish and maintain ethical professional boundaries with clients. As we move on, this educational session will address potential and real boundary infractions that can involve those within our care.

E) Boundary Lapses with Clients

When professional relationships serve to benefit the clinician instead of the client, boundaries have been lapsed. Boundary lapses can occur in many areas, often without willful attempts on the part of a professional. Several such situations are mentioned here. Most of these situations are relatively benign in nature and constitute more of a boundary miss-step or crossing than of an actual boundary violation. True violations do occur, however, and are also mentioned on the next page.
The following descriptions, in red, were adapted from a document for nurses titled, “Professional Boundaries: a nurse’s guide to the importance of appropriate professional boundaries,” (National Council of State Boards of Nursing). While originally written for a particular profession, the points listed here can be applied to experiences that occur in a variety of healthcare roles. After each description, in bulleted points, are examples are actual boundary situations that the author has witnessed in the last fifteen years in healthcare. As you review these areas, attempt to determine whether the scenario involved describes either a boundary crossing or a boundary violation. Keep in mind that various factors can impact whether a behavior is merely inappropriate or wholly unacceptable. These may include things such as whether the response should have been avoided or simply managed differently. These factors also might include whether the response was illegal, prohibited by one’s professional Code of Ethics, exploitative or otherwise harmful to any of the individuals involved.

UNPROFESSIONAL RESPONSES WITH CLIENTS

**Excessive Self-Disclosure – The professional discusses personal problems, feelings of sexual attraction or aspects of his or her intimate life with the client.**

Self-disclosure involves communicating personal information that may or may not pertain to a clinician’s professional role. Some self-disclosure may be indicated for the particular situation. For example, if working with a family that is deciding whether or not to implement hospice services for a loved one, it may be appropriate to share a positive experience that the healthcare worker experienced while making the same decision. Self-disclosure is not, however, indicated for clinical situations if it provides an inordinate amount of personal details about the professional or does not serve to benefit the client in any way. Here are a few examples of excessive or unbeneﬁcial self-disclosure:

- After experiencing a few turbulent months at home, a Nurse shared with her clients that she was separating from her husband.

- A Nurse directed a large amount of special attention to a young woman who had diagnoses of Bipolar Disorder and Borderline Personality Disorder. On one particularly difficult day, the Nurse shared with the woman, “I understand...I’m Bipolar too.” This information was soon known by all the other clients with whom the Nurse worked.
● A Therapist became tearful when a news story chronically an automobile crash appeared on a client’s television. The Therapist told the client that one of her friends had been killed in the accident. The client then became tearful in response.

● A Counselor shared his personal religious and political beliefs as part of his client’s individual treatment sessions.

● A Nursing Assistant told a client about his plans to go to a club and get drunk the following evening.

**Secretive Behavior – The professional keeps secrets with the client and/or becomes guarded or defensive when someone questions their interaction.**

● A Nurse whose client would not have a necessary prescription delivered by the time his next dose was due, gave the man two pills from her own personal supply. She asked him not to mention this event to the next Nursing shift.

● A Nurse told a client about another client’s personal problems after he promised not to share the information further.

**“Superman/Superwoman” Behavior – The professional believes that he or she is immune from fostering a non-therapeutic relationship and that only he or she understands and can meet the client’s needs.**

● Having worked with the same group of clients for some time, a Nurse referred to them as her “family” and allowed them to call her “Mom.”

● A Social Worker provided a client’s family member with her cell and home phone numbers so they could call her at non-work hours.

● A Nurse gave a client her medications outside the accepted administration parameters as she feared other shifts would neglect the individual’s needs.

**Singled-Out Client Treatment or Attention to the Professional – The professional spends inappropriate amounts of time with a particular client, visits the client when off-duty or trades assignments to be with the client. This form of treatment may also be reversed, with the client paying special attention to the professional (e.g., giving gifts to a nurse or other caregiver).**
● An Activity Director consistently covered outing expenses for one of her favorite clients and allowed this individual to have first choice of attending all such events.

● Each Saturday on her day off, a Nurse came to her workplace and brought lunch to a group of four particular residents.

● At Christmastime, a Nurse took a client to her home to share a holiday meal with her family.

● A Nurse periodically allowed a certain resident to join her on smoke breaks. She also shared her own cigarettes with him. In response, the client told the nurse she was his “favorite” staff member.

● An Activity Assistant routinely remained at her workplace after her shift in order to visit with a terminally ill client. During each visit the two individuals expressed love for each other.

● A Nursing Assistant allowed a client to loan her his credit card after she made a sincere promise to pay back any amount charged.

Selective Communication – The professional fails to explain actions and aspects of care, reports only some aspects of the client’s behavior or gives “double messages.” In the reverse, the client returns repeatedly to the professional because other staff members are “too busy.”

● A Nurse failed to report a client’s possession of a prohibited item as she feared this would result in a loss of his privileges. She told the client if he used the item appropriately that the matter could remain just between them.

Flirtations – The professional communicates in a flirtatious manner, perhaps employing sexual innuendo, off-color jokes or offensive language.

● A Nurse allowed a client to write love letters to her and thanked him when they were received.

● An Activity Assistant sat on the lap of a male resident and gave him a big hug.

● A Nursing Assistant joked, cursed and shared stories with clients as if they were family members or friends.
• A Nurse responded back to a flirtatious male resident with the comment, “You couldn’t handle all this!”

• An Activity Assistant kissed a confused male resident on the lips, laughed at his sexual innuendos and referred to him as her “sweetie pie.”

“You and Me Against the World” Behavior – The professional views the client in a protective manner, tends not to accept the client as merely a client or sides with the client’s position regardless of the situation.

• A Nurse allowed a client to move into her home upon discharge from a stay at her place of work.

• Knowing that several out-of-state family members with limited funds wanted to visit a client at her workplace, an Activity Assistant contacted the family and offered to provide free lodging for them. Later, the Activity Assistant picked the family up at the airport and transported them to and from the facility during the entire length of their stay.

Failure to Protect the Client – The professional fails to recognize feelings of sexual attraction to the client, consult with supervisor or colleague, or transfer care of the client when needed to support boundaries.

• A Nurse began dating a client while he lived at her workplace. She established a live-in relationship with the individual after he was discharged.

• A Nursing Assistant accepted money from a resident in exchange for performing a sexual act on him.

OTHER UNPROFESSIONAL RESPONSES

• A Therapist began dating the son of a client that was currently on her caseload.

• A Nurse told a non-compliant client, “You hurt my feelings. I can’t believe you would act that way after all the nice things I’ve done for you.”

• A Social Worker told a verbally aggressive client that he would have to apologize for calling her names.
A note to the reader: In your varied professional roles, you may have witnessed similar boundary situations as those described. Some readers may have even had past experiences that are somewhat similar to one or two of the scenarios mentioned. The following exercise can help determine whether you may have allowed your professional boundaries to lapse at times in the past. It can also assist in determining whether you tend to become too involved with particular clients. Consider times in clinical practice when your professional boundaries may have become lax, obscured or were questioned by others. In reflecting on these situations, ask yourself the questions listed here. If you answer “yes” to many or most of the statements below, you may need to further examine and adapt your practice of professional boundaries. Tips for doing this will be provided later in the course. If you answer “no” to many or most of statements here, you have likely found ways to preserve and protect your boundaries with clients.

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<thead>
<tr>
<th>QUESTIONS TO ASK:</th>
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<tr>
<td><strong>Do you share personal problems or aspects of your intimate life with clients?</strong></td>
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<tr>
<td><strong>Have you ever traded assignments to care for a specific client?</strong></td>
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<td><strong>Have you ever spent off-duty time with a client?</strong></td>
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<td><strong>Do you keep secrets with clients?</strong></td>
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<td><strong>Do you become defensive when someone questions your interaction with a client?</strong></td>
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<td><strong>Have you ever given gifts to or received them from a client?</strong></td>
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<td><strong>Have you felt possessive of a patient, thinking that only you could provide the client’s needs?</strong></td>
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<tr>
<td><strong>Have you ever flirted with a client?</strong></td>
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<td><strong>Have you chosen sides with a client against his or her family and other staff?</strong></td>
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(Adapted from National Council of State Boards of Nursing Inc., 1998)

As the course moves on to the next section, the importance of establishing and maintaining professional boundaries in colleague-colleague relationships will be discussed.

**F) Professional Boundaries in Colleague Relationships**

Similar to clinician-client relationships, professional boundaries in colleague-colleague relationships serve certain purposes and provide benefits to both parties involved in the clinical encounters. The presences of
sound professional boundaries in colleague-colleague relationships help assure that the clinician is seen by work-place peers as competent and in a positive light. A few of the other benefits of sustained professional boundaries are outlined here.

Shared Control – In colleague-colleague relationships, sound professional boundaries assure that shared control is present in these individuals’ workplace interactions. In co-worker relationships, collective control leads to effective teamwork, senses of ownership and shared professional responsibilities. Although there may be situations in which individuals are stratified by the structure of an organization or the nature of different work positions (e.g.; in the case of a manager and a supervisee) the ultimate goal of the relationship should be to give each participating clinician efficacious potential over his or her work role. Colleagues should not seek to exert undue power or influence over their peers regardless of whether these individuals are supervisees, employees-in-training, students or are otherwise at the direction of the professional. When colleagues share control in professional relationships, the ability to elicit positive client and colleague outcomes is optimized.

Maximized Trust and Courtesy – Maximized trust and courtesy in colleague-colleague relationships suggests to co-workers that they respect each other as professionals despite having possible differences of opinion or using divergent clinical strategies at times. This allows colleagues to appropriately express themselves in work-related situations without fear of being rebuked, ridiculed, scorned or retaliated against. These traits also assure to colleagues that professional issues which are disclosed in confidence will not be shared further unless there are legal or ethical reasons to do so.

Sense of Safety – Professional boundaries in relationships between colleagues give these individuals senses that they are safe and will not be threatened, exploited, taken for granted or subjected to harm while in the workplace. They confirm that the ultimate purpose of work-related relationships is for the benefit of clients, not clinicians, and that all such interactions should be guided by ethical principles.

G) Boundary Lapses with Colleagues

As mentioned in the section addressing boundary lapses with clients, the ultimate purpose of professional healthcare relationships are to benefit the needs of the individuals for whom clinicians serve. While the nature of some colleague-colleague interactions may have an end result of a benefit to the clinician, such as in a situation when a platonic friendships or romantic relationships id formed, clinicians should never ever allow these personal
interactions to interfere with their professional obligations. Clinicians also cannot veer away from their professional ethical practice standards in the process or for the purpose of forging a personal relationship with a colleague. When colleague-colleague interactions move beyond seeing to the needs of clients or move more towards meeting the needs of the involved clinicians over others in the workplace, professional boundaries have been lapsed. Like boundary lapses with clients, these declines of professional conduct can occur in the form of less substantial boundary crossings or more significant boundary violations. The bulleted points below illustrate examples peer-related boundary situations that the author has witnessed in the last fifteen years in healthcare. As with the prior examples, readers are encouraged to decipher whether the scenario described involves either a boundary crossing or a boundary violation.

**UNPROFESSIONAL RESPONSES WITH COLLEAGUES**

- A Therapist periodically approached colleagues at their work stations and gave them neck, back and shoulder rubs.
- A Nurse began dating a Nursing Assistant who she supervised on her team.
- A Therapist established a sexual relationship with a current student.
- An Activity Assistant gave a client her co-worker’s cell phone number as a joke.
- Two Nurses that were dating were witnessed hugging and kissing at their shared workplace.
- A Therapist phoned a Social Worker at another facility to inquire about the details of another co-worker’s termination.
- A Counselor who traveled between several care facilities frequently flirted with staff and asked Nurses at these places for dates.
- A Nurse threatened to have a Nursing Assistant fired after it was discovered they were both dating the same colleague.
- A Therapist allowed a colleague and personal friend to disregard the department’s attendance policy because she knew the individual had been out late the night before.
- A Nurse refrained from telling her supervisor that a colleague often arrived to work intoxicated and periodically drank alcohol while on duty.

- Two Nursing Assistants who preferred to take dine together left a unit of clients unsupervised so they could take their lunch breaks at the same time.

A note to the reader: Here again, you may have previously witnessed or even experienced similar boundary situations in your work role. Like the earlier version, the following exercise can help you determine whether you may have allowed boundaries lapses to impact your professional relationships with colleagues in the past. One more time, ask yourself the questions listed here. If you answer “yes” to many or most of the statements below, you may need to further examine and adapt your practice of professional boundaries with colleagues. If you answer “no” to many or most of statements here, you have likely found ways to preserve and protect your boundaries with others at your workplace.

<table>
<thead>
<tr>
<th>QUESTIONS TO ASK:</th>
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<tbody>
<tr>
<td>Do you share personal problems or aspects of your intimate life with colleagues?</td>
</tr>
<tr>
<td>Have you ever traded assignments to work with a specific colleague?</td>
</tr>
<tr>
<td>Have you ever spent off-duty time with a specific colleague?</td>
</tr>
<tr>
<td>Do you keep secrets with a specific colleague?</td>
</tr>
<tr>
<td>Do you become defensive when someone questions your interaction with a specific colleague?</td>
</tr>
<tr>
<td>Have you ever given gifts to or received them from a specific colleague?</td>
</tr>
<tr>
<td>Have you felt protective, given special benefits or adapted responsibilities for a specific colleague?</td>
</tr>
<tr>
<td>Have you ever flirted with a specific colleague?</td>
</tr>
<tr>
<td>Have you chosen sides with a specific colleague against co-workers or other staff?</td>
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</table>

(Adapted from National Council of State Boards of Nursing Inc., 1998)

For readers who identified themselves as needing to further examine and adapt their boundary practices with clients or colleagues, the final instructional portion of this course will discuss tips for developing more desirable responses in these professional interactions.
H) Professional Boundary Tips

One way of cultivating desirable responses in professional relationships is by using moral decision-making approaches. This can be done by utilizing multi-step processes to analyze boundary situations or dilemmas. One method for attempting this is outlined just below (MacDonald, 2002).

1) Recognizing the moral dimensions of the situation – This step involves determining whether a particular situation involves an ethical dilemma or conflicts between two or more standards of conduct; also referred to as values or ideals. This might lead a clinician to pose the question, “Are aspects of this situation incompatible with my profession’s Code of Ethics?”

2) Identifying who the interested parties are and the relationships they have with each other – At this point the professional determines who is involved and what impact their shared relationship might have on ethical factors in the situation. For example, a clinician that accepts a friend or distant family member as a client or colleague may wish to consider, “Can I be truly effective with this individual knowing that a personal relationship already exists between us?”

3) Determining the values that are involved – In this area clinicians must consider whether acting on the situation will be in the best interest of the client or the colleague. Using the example above a clinician might ask a question such as, “Can I be impartial, nonjudgmental and honest with this individual during the course of our interactions?”

4) Weighing the benefits and burdens of the situation – This step involves establishing who serves to benefit from the situation and if there are any unnecessary consequences that that may arise as a result of the situation. At this stage a clinician might consider, “Am I doing this because it is good for me or am I doing this because it is good for the other individual?” Other considerations may be, “Will this situation cause harm to the other person or people involved?” and “Will this situation lead to conflicts of interest for another individual or for me?”

5) Looking for similar situations – This requires an examination of past situations to determine if parallels, positive outcomes or other desirable results were reached. It also requires examining times in which similar situations may have led to harmful or undesirable results. Final questions in this process might include, “What did I do the last time this situation arose?” and “Did that situation have a positive or negative outcome?”
6) Discussing with relevant others – At this stage the clinician might benefit from sharing the situation or dilemma with a trusted peer or supervisor. The professional might also openly discuss the matter with other parties that have a stake in the outcome. A related question might be, “How would you suggest I manage this situation?”

7) Assessing whether the decision complies with legal or organizational rules – As licensed or certified professionals we are bound to uphold certain rules, laws and standards. This part of the decision-making process involves looking to see whether there are certain components of the situation that are against the law or are unacceptable based on other statutes or policies. Here the clinician might ask, “Would this response go against my profession’s Code of Ethics?” or “Would my participation in this situation be illegal?”

8) Determining whether you are comfortable with the decision – The last step in this process involves an individual examining his or her comfort level with the concluding decision. Questions to be asked here might include, “Is this something that I would recommend another person to do?” and “Would I be comfortable telling my peers or family members about my actions?”

Another method for achieving desirable outcomes in professional relationships is by determining where the clinician’s particular responses to others fall within a continuum of helpfulness. In the diagram below, clinicians’ ethical behaviors can be viewed in ranges between being distant and under-involved in relation to the needs of other people to being too engaged, or over-involved, with these individuals. In the middle of the two extremes is a, “Zone of Helpfulness,” in which a balance is achieved for meeting other individuals’ needs while maintaining adherence to appropriate standards of ethical conduct, including professional boundaries (National Council of State Boards of Nursing, 1995).

As we have mentioned, boundary parameters and limits may not always be clear cut or specifically outlined in an organization’s Code of Ethics. In ethical situations, clinicians are encouraged to use a variety of methods to determine how to best manage or adapt their personal approaches to professional boundaries. The following table provides additional questions...
that can be considered when determining how to assess whether boundary issues exist in particular clinician-client or colleague-colleague relationships.

**QUESTIONS TO ASK ABOUT CLIENTS:**

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Is this in my client’s best interest?</td>
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<tr>
<td>Whose needs are being served?</td>
</tr>
<tr>
<td>Will this have an impact on the service I am delivering?</td>
</tr>
<tr>
<td>Should I make a note of my concerns or consult with a colleague?</td>
</tr>
<tr>
<td>How would this be viewed by the client’s family or significant other?</td>
</tr>
<tr>
<td>How would I feel telling a colleague about this?</td>
</tr>
<tr>
<td>Am I treating this client differently (e.g., appointment length, time of appointments, extent of personal disclosures) from other clients?</td>
</tr>
<tr>
<td>Does this client mean something “special” to me?</td>
</tr>
<tr>
<td>Am I taking advantage of the client?</td>
</tr>
<tr>
<td>Does this action benefit me rather than the client?</td>
</tr>
<tr>
<td>Am I comfortable in documenting this decision/behavior in the client’s medical file?</td>
</tr>
<tr>
<td>Does this conflict with my professional code of conduct?</td>
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</table>

**QUESTIONS TO ASK ABOUT COLLEAGUES:**

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Is this in my colleague’s best interest?</td>
</tr>
<tr>
<td>Whose needs are being served?</td>
</tr>
<tr>
<td>Will this have an impact on my working relationships?</td>
</tr>
<tr>
<td>Should I make a note of my concerns or consult with a supervisor?</td>
</tr>
<tr>
<td>How would this be viewed by other colleagues?</td>
</tr>
<tr>
<td>How would I feel telling a supervisor about this?</td>
</tr>
<tr>
<td>Am I treating this colleague differently (e.g., special benefits, adapted responsibilities, subjective treatment) from other colleagues?</td>
</tr>
<tr>
<td>Does this colleague mean something “special” to me?</td>
</tr>
<tr>
<td>Am I taking advantage of the colleague?</td>
</tr>
<tr>
<td>Does this action benefit me rather than the colleague?</td>
</tr>
<tr>
<td>Am I comfortable in documenting this decision/behavior in the colleague’s employee file?</td>
</tr>
<tr>
<td>Does this conflict with my professional code of conduct?</td>
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</tbody>
</table>

(Adapted from College of Psychologists of Ontario, 1998)
H) Professional Boundary Tips

The suggestions below may also help clinicians further promote ethical and healthy professional boundaries in their working relationships with others. Regardless of your various work roles, all clinicians are encouraged to aspire to the goals mentioned here:

- Remain aware of your profession’s Code of Ethics and attempt to uphold it at all times.
- Treat all individuals in your care or persons with whom you come into contact with dignity and respect.
- Seek to act in the best interests of your clients, former clients or individuals with whom they share significant relationships.
- Seek to act in the best interests of your colleagues including students, trainees, supervisees or co-workers.
- Perform periodic “reality checks” when sensing that your own professional boundaries may have become blurred or been overstepped.
- Avoid entering into work situations that might lead to boundary crossings or violations.
- Understand that many professionals are faced with potential boundary dilemmas at times.
- Promote workplaces in which you and your colleagues can freely discuss concerns that arise regarding professional boundaries.
- Conduct or participate in ethics training sessions which address professional boundary scenarios.
- Establish, support or utilize employee assistance programs that assist in providing professional guidance regarding boundary issues.

I) Conclusion

In all professional roles, healthcare clinicians are bound to uphold certain standards of conduct in relation to their interactions with others. Professional boundaries allow for shared control in interactions between clinicians, clients and colleagues and benefit all parties involved in these relationships in numerous other ways. Through review of this course, participating clinicians have likely developed a better understanding of what professional
boundaries are, how professional boundaries are driven by ethics, how professional boundaries affect client and colleague relationships and how, as professionals, they can go about establishing and maintaining these important aspects of their relationships with others.

This completes the educational component of the course, “Establishing and Maintaining Ethical Professional Boundaries.” We thank you for your time and attention. It is the hope of Ohio CEUS that clinicians who have read this course have gained useful information will be able to utilize the strategies provided in their unique practice settings. Please be sure to check back with Ohio CEUS regularly for other courses that may be well-suited to your interests or work responsibilities.

After reviewing the Works Cited section, please continue to the Post Test.

V) Works Cited


Meadows, Bethany. “Healthy Patient-Provider Boundaries,” Advance for Occupational Therapy Professionals, 1/21/08, p. 23.


END OF COURSE