Watch your step: Nursing and professional boundaries

Karen V. Holder RNP, MHS, FNPC
Stephen J. Schenthal MD, MSW

Nursing Management
February 2007
Volume 38 Number 2
Pages 24 - 29

Nursing boundaries, first addressed by Florence Nightingale, are referred to in the "Nightingale Pledge" used in pinning ceremonies throughout our country. Passages such as "I will abstain from whatever is deleterious and mischievous…maintain and elevate the standard of my profession…will hold in confidence matters committed to my keeping…in the practice of my calling…and devote myself to the welfare of those committed to my care" all refer to standards or boundaries relating to our duties and responsibilities as nurses. 1

The American Nurses Association's (ANA) code of ethics states, "The nurse acts to safeguard the patient when his care and safety are affected by the incompetent, unethical, and illegal conduct of any person." In the section under professional boundaries, the ANA states, "When acting within one's role as a professional, the nurse recognizes and maintains boundaries that establish appropriate limits to relationships." 2 These statements, however, don't advise us on what to do in the many difficult situations that arise in the nursing profession.

Boundary issues, in fact, exist everywhere for nurses, regardless of the professional setting. Boundary continuum issues range from giving or receiving a gift from a patient, to picking up groceries for a homebound patient, to social contacts with former patients or their relatives—especially in the case of minors—to having a sexual relationship with a patient. This list isn't exhaustive, but definitions and interpretations of such boundary issues are expanding in state nurse practice acts, in media sources, and in courts of law.

While nurses are educated in the importance of therapeutic disclosure with patients, and in the concept of "partnering with patients," there's little training given on the concepts of inherent power differentials or on crossing the line with gifts, gestures, touch, or special attention. Though many of these areas aren't harmful within a therapeutic context, nurses and nurse managers must be increasingly aware of patterns of boundary crossings and the potential or real harm that may come to patients and to nursing staff.

Some authors go so far as to state that professional boundary crossings and violations are an occupational hazard in nursing and in the healthcare professions. 3 Certainly nurses and other health professionals are vulnerable to patient/client perceptions and other practice issues. Some common examples of vulnerabilities in hospital settings are isolated work environments, lack of direct nurse supervision, length and intensity of nurse-patient interactions, and patient vulnerabilities such as the fear and jeopardized independence brought on by surgery and illness.

Though these and other vulnerabilities inherent in nurse-patient interactions put every nurse at some degree of risk, there's a general lack of boundary theory among nurses and other healthcare providers. 4 Nurses rarely have the time or resources available to discuss ethical dilemmas that

arise with patients, colleagues, and staff members. And perhaps most consistently lacking is the area of professional boundary education in nursing curriculums and workplaces.

Professional boundaries have come under more public scrutiny in the past decade, as media report stories of victim abuse and as malpractice suits increase. All the while, legislators scurry to pass more regulatory statutes in attempts to define and protect the rights of the innocent. [5] There's a growing milieu of mistrust or, at best, wariness among clients and professionals that certainly impacts the nurse-patient relationship.

What's out there?

Unfortunately, contemporary nursing literature addressing therapeutic boundaries is scarce; few in depth inquiries and critical analyses exist. [3] In the authors' search, only two nursing surveys containing questions related to sexual boundaries in nurse-patient relationships were found. Both analyses showed evidence of boundary violations. They're dated, but considered landmark studies from 1974 and 1990. [6,7]

The National Council of State Boards of Nursing has taken a leading role in bringing the issue of boundary violations to the forefront in nursing. The organization has published several guidelines in areas of boundary violations, the most serious being sexual boundary violations. Unfortunately, even this work is almost a decade old. [8-10]

Much of the basis for findings and recommendations in the area of boundaries and boundary violations has been taken from the psychiatry/mental health world. Even the National Council of State Boards of Nursing references Gary Schoener, PhD, a psychologist, for much of its boundary theory. Some of the principles conceived and published by authors well known in the field are applicable to nursing, and many aren't.

Several nursing scholars have written articles describing and expanding on basic boundary theory and its application to nursing. [3,11–14] Most of these authors focus on nurse-patient relationships in mental health and counseling interactions; there are few who address nonbehavioral health boundary issues in nursing.

Regulatory structure

Every U.S. state has a nursing regulatory agency, which is most often a board of nursing. These agencies are given the responsibility of protecting the public. Board members are appointed by state governments to implement and oversee safe nursing practice. These tasks are carried out via statutes, rules, and regulations that make up state Nurse Practice Acts.

The Nurse Practice Act is the foremost legal document regulating nursing. It's credited with protecting the public, defining nursing practice, describing practice boundaries, establishing standards for nurses, and protecting the domain of nursing. Used by courts and boards in disciplinary endeavors, the Act is the basis in determining the appropriateness of nurses' actions. [15]

More states are including specific language in their Nurse Practice Acts about professional boundaries, professional misconduct, and boundary violations—especially in the areas of sexual boundary violations and dual relationships. In fact, in the 24 Nurse Practice Acts reviewed by the authors, only two had no wording specific to sexual misconduct or boundary violations.

Reporting

There's wide disparity in national reporting of professional misconduct among nurses in all categories, both geographically and demographically. 10 However, boundary issues still comprise a small percentage of overall disciplinary action taken by nursing boards. A total of 141 RNs were reported to the Health Integrity Protection Data Bank under categories of misconduct and sexual misconduct betweeen 2000 and 2006. 16

There are several difficulties inherent in interpreting data for sexual misconduct cases. Reported cases are small in number and vary widely geographically and demographically, particularly in terms of gender (males reported in higher numbers). Compiled annual data vary from year to year, and vary widely from state to state, with some states consistently reporting lower numbers and some consistently reporting higher numbers. The area of inclusion for sexual misconduct is also quite broad and can include violations pertaining to use of sexual language, harassment, romantic involvement, rape, or sexual abuse of a patient or family member.

There's little published data on nurses who've been sanctioned for boundary violations, and less in the area of sexual misconduct and exploitation. Most of the work with offenders has been in psychiatry. Richard Irons, MD, did research on offenders evaluated and treated through his program in the 1980s and 1990s. He described six archetypes that offenders commonly fit, and carried out research on their rehabilitative potential as well as therapeutic interventions that worked with each of the archetypal types. 17 Other experts have categorized offenders by describing their personality traits, or sorted offenders into major groups, classified by psychiatric deviations or traits. 18

All of this work was done primarily on male offenders, most of whom were physicians. Early data showed gender trends for violators as approximately 75% male and 25% female. 9 Although the number of violations may be small, research is certainly needed in areas of female offenders and in nurse offenders.

Due in part to the higher number of physician offenders, and certainly due to these researchers' commitments to the area of boundary violations, several physician-based treatment programs currently exist in the United States. But only one state, Florida, has an intervention program geared toward nurses and specific to boundary violations—the Intervention Project for Nurses.

Prevention

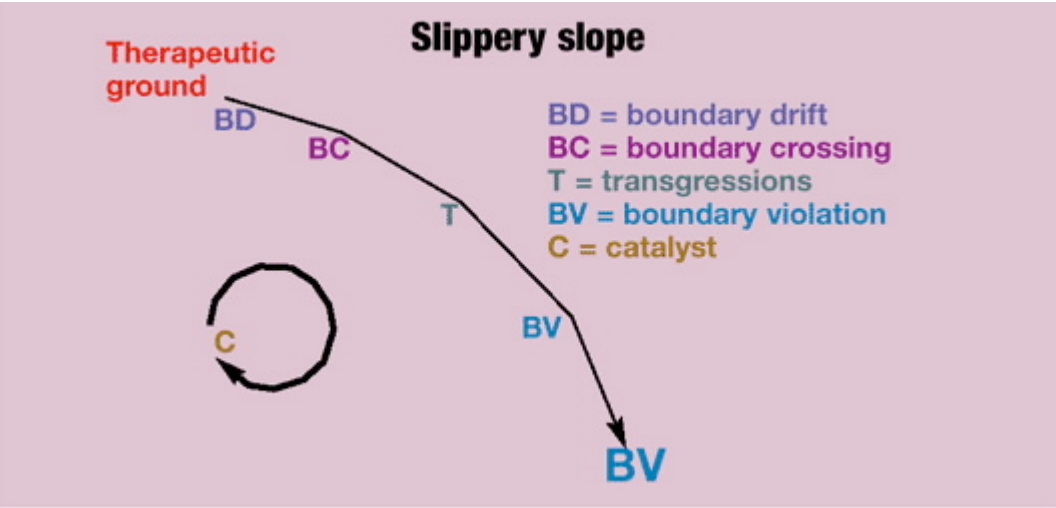
As we've described, boundary issues surface in every area of nursing. Education among nurses and managers is often lacking in the areas of boundary theory, language, appropriate management and reporting of violations, and in areas of training and prevention.

The safety of a well-trained and experienced nursing staff can be illusory when it comes to boundary violations. Many boundary transgressions have been committed by well-educated, ethical, law-abiding professionals during periods of stress, loss, and trauma. The majority are rarely the result of deliberate exploitation. Rather, they're the consequence of the well intentioned that self-deceive and rationalize crossing lines for the benefit of the ill.

In actuality, the needs of the professional supplant the needs of the patient. Authority carries a fiduciary responsibility. Boundary violations are typically preceded by boundary drifts (fantasy or thoughts), which progress to crossings and potentially to a violation that harms the patient, professional, and the treatment. The slippery slope from professional nurse to offender is defined by this progression. For prevention to be successful, it has to occur before the slide begins. (See "Slippery slope.")

As noted earlier, boundary crossings may occur in a therapeutic context, but all crossings run a risk of collapsing the distance separating the "powerful" nurse and the dependent, vulnerable patient. Once a nurse becomes involved in the patient's world, there's no return to the security of the therapeutic frame. Professional objectivity is compromised, and worse, the trust that's central to the therapeutic alliance is betrayed.

The Boundary Formula is an effective teaching tool used in boundary courses to gauge a nurse's relative violation potential (VP) and to facilitate insight into the variables affecting their boundaries. Every nurse and every healthcare provider carries a VP. VPs are dynamic and change over time in response to life events, professional risk factors (RF), and personal vulnerabilities (Vul). 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.



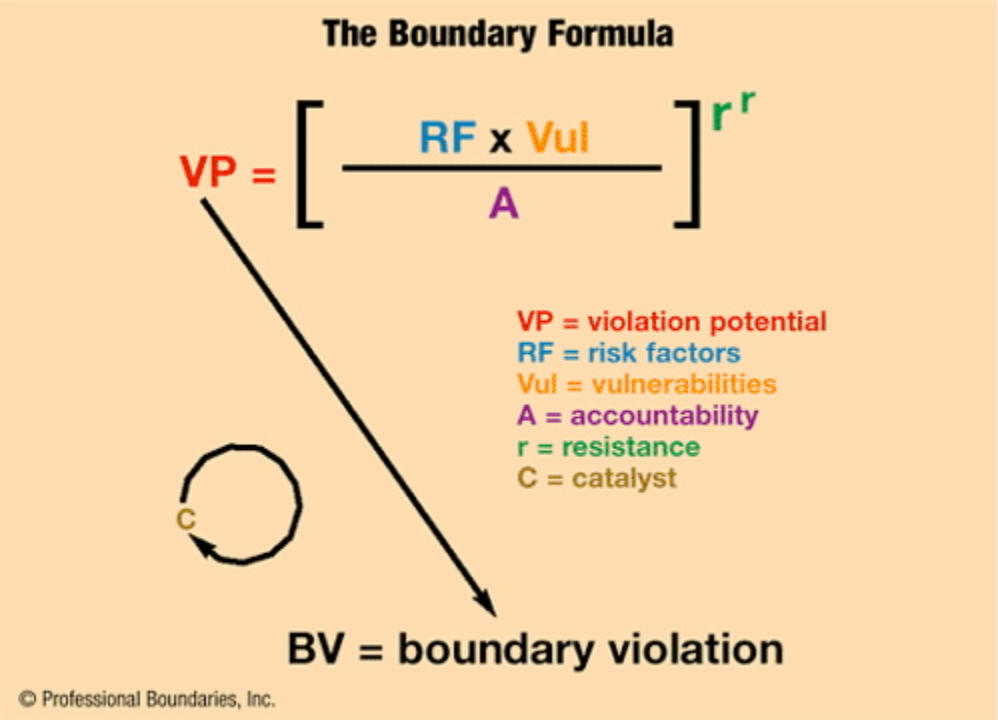


Figure. No caption available.

Vulnerabilities represent psychosocial elements that influence our boundary interactions. These elements could include unresolved childhood trauma or shame-based injuries, just to name a few. A nurse may be resistant (r) to look at risk factor or vulnerabilities. This mindset magnifies the potential for a violation because it represents a blind spot. As risk factors and/or vulnerabilities increase, the violation potential shifts from a low VP to a high VP. Concurrently, if an unexpected "catalyst" (divorce, death, career change, provocative patient, etc.) encounters a high VP, it may propel a nurse across the thin line that separates ethical from unethical. Accountability (A) is reciprocal. Increased accountability (nurse-nurse, nurse-supervisor, EAP, boundary consultations, etc.) equals decreased VP. (See "The Boundary Formula.")

Protection

Education and accountability at all levels—administration, management, and clinical—are essential components for boundary protection. Regular use of "accountability groups" is an effective way to monitor the application of boundary knowledge and boundary maintenance.

In-service boundary training should include:

* differentiation of boundary crossings and violations
* assessment of VP
* exercises for determining risk factors and vulnerabilities
* techniques and resources for managing VP
* identification of potential catalysts

* encouraged use of pre-established accountability systems
* training on how to spot early warning signs for violations.

Maintaining appropriate professional boundaries is everyone's responsibility.

Key terms

Professional boundaries are defined as limits that protect the space between the professional's power and the client's vulnerability. 1 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.

Power differentials are the inequalities that exist between professionals and clients. Differentials exist in any professional situation in which the service provider has knowledge, experience, and authority that the client seeks and needs from the professional. In nursing, often the "client" is exceptionally vulnerable by the nature of the illness or emergency for which he or she seeks services.

A 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." 2

Therapeutic interventions are conscious actions taken by a professional to promote a healthier outcome. An example of a therapeutic intervention might be a nurse taking a depressed paraplegic patient for a wheelchair stroll outdoors on a warm sunny day.

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. 3

Context is often referred to in nursing boundary literature as a reference to the nurse's intention and the patient's perception of the intervention or event. Something as simple as having a cup of tea with a homebound client can be a therapeutic intervention, a boundary crossing, or a boundary violation depending on the context and perceptions. 4 Nurses and nurse managers must ask themselves "Whose needs are truly being met in this intervention? Is the event something I can chart clearly? Is it something I can openly and honestly discuss with a coworker or supervisor? How does this 'look' to others and to the patient?"

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.

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'. 5 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.

Sexual misconduct and exploitation are extreme boundary violations and are now punishable as criminal offenses in 24 states. 7 Though the obvious example of sexual misconduct is sexual contact with a patient against his or her will, many cases involve situations of two "consenting" adults, and in some instances even nurses who have subsequently married their patients. Nonsexual boundary violations usually relate to issues surrounding touch, dual roles, and self-disclosure.

References

1. Peterson MR. At Personal Risk: Boundary Violations in Professional-Client Relationships. New York, NY: WW Norton & Company; 1992:182. [Context Link] 2. Penfold PS. Sexual Abuse by Health Professionals. Toronto: University of Toronto Press; 1998. [Context Link] 3. National Council of State Boards of Nursing. Professional Boundaries: A Nurse's Guide to the Importance of Appropriate Professional Boundaries. Chicago, Ill: NCSBN; 1996. [Context Link] 4. National Council of State Boards of Nursing. Crossing the Line: When Professional Boundaries Are Violated. Chicago, Ill: NCSBN; 1998. [Context Link] 5. Sheets VR. Teach nurses how to maintain professional boundaries, recognize problems, and make better patient care decisions. Nurs Manage. 2000;31(8):28–33. [Context Link] 6. Minnesota Board of Nursing. Professional Boundaries in Nursing. 1995;11(2), fall newsletter. [Context Link] 7. Schoener GR. Relationships with former patients. Wisconsin; fall 2006. Unpublished handout/personal communication. [Context Link]

References

1. Gretter LE, Committee for the Farrand Training School for Nurses. The Florence Nightingale Pledge. Available at: http://www.nursingworld.org/about/pledge.htm . Accessed December 15, 2006. [Context Link]

2. American Nurses Association. Code of Ethics for Nurses with Interpretive Statements. Silver Spring, Md: American Nurses Association; 2001. [Context Link]

3. Peternelj-Taylor CA, Yonge O. Exploring boundaries in the nurse-client relationship: professional roles and responsibilities. Perspect Psychiatr Care. 2003;39(2):55–66. [Context Link]

4. Peternelj-Taylor CA. Professional boundaries: a matter of therapeutic integrity. J Psychosoc Nurs Ment Health Serv. 2002;40(4):22–29. [Context Link]

5. Peterson MR. At Personal Risk: Boundary Violations in Professional-Client Relationships. New York, NY: WW Norton & Company; 1992:182. [Context Link]

6. Nursing ethics: the admirable professional standards of nurses. A survey report. Nursing. 1974;4(9):34–44. [Context Link]

7. Munsat EM, Riordan JJ. Under wraps: prevalence of staff-patient sexual interactions on patient units. J Psychosoc Nurs Ment Health Serv. 1990;28(9):23–26. [Context Link]

8. National Council of State Boards of Nursing. Disciplinary Guidelines for Managing Sexual Misconduct Cases. Chicago, Ill: NCSBN; 1996. [Context Link]

9. National Council of State Boards of Nursing. Crossing the Line: When Professional Boundaries Are Violated. Chicago, Ill: NCSBN; 1998. [Context Link]

10. National Council of State Boards of Nursing. Professional Boundaries: A Nurse's Guide to the Importance of Appropriate Professional Boundaries. Chicago, Ill.; NCSBN; 1996. [Context Link]

11. Gallop R. Abuse of power in the nurse-client relationship. Nurs Stand. 1998;12(37):43–47. [Context Link]

12. Love C. Staff-patient erotic boundary violations. On the Edge. 2001;7(3). [Context Link]

13. Penfold PS. Sexual Abuse by Health Professionals. Toronto: University of Toronto Press; 1998. [Context Link]

14. Sheets VR. Teach nurses how to maintain professional boundaries, recognize problems, and make better patient care decisions. Nurs Manage. 2000;31(8):28–34. [Context Link]

15. Burkhardt MA, Nathaniel AK. Ethics & Issues in Contemporary Nursing. Albany, NY: International Thomson Publishing Services; 1998. [Context Link]

16. Health Integrity Protection Data Bank, Practitioner Data Bank Branch, HRSA, Rockville, Md. 2006. Available at: http://www.npdb-hipdb.com . Accessed December 15, 2006. [Context Link]

17. Irons R, Schneider JP. The Wounded Healer: Addiction-Sensitive Approach to the Sexually Exploitative Professional. Northvale, NJ: Jason Aronson; 1999. [Context Link]

18. Gabbard GO. Psychodynamic Approaches to Physician Sexual Misconduct. Washington, DC; 1999. [Context Link]