The College of Physiotherapists of Ontario presents Understanding and Maintaining Professional Boundaries: Chapter 2 - The Power Imbalance. This is the second of four chapters designed to heighten awareness and assist physiotherapists’ understanding of professional boundaries.
In this chapter you will have the opportunity to reflect on your degree of comfort with the power imbalance that exists between you and your patient. We will review why the power imbalance exists; outline the specific components that create the power imbalance; and introduce the concept of professional choice, that is choosing to use your professional power appropriately or not.
First, let’s talk about why the power imbalance exists. We will then address the specific components or elements that “give” you or make up your professional power.

At the core of the power imbalance is the simple fact that your patients have need for your expertise and the therapeutic services that you provide. They come to you expressly for that purpose. The patient’s need for your skills, knowledge and expertise creates a fundamental patient vulnerability.
Patients come to you trusting that you will apply your expertise to do good and not cause harm. They trust that you will keep their needs primary; that you will treat them with respect; and that you will accord them their autonomy or right to self-determination. They trust that you will not function from a point of personal bias and therefore gain personally at their expense. They trust that you will not treat them like an object; that you will not take short cuts; manipulate, deceive or cheat them in any way. These are behaviours that were introduced in Chapter 1 and put a face to the word “harm”.

This need for your skills, expertise and knowledge creates a power imbalance between you and your patient and as a result, the therapeutic relationship is not an equal or level playing field.
This fundamental vulnerability of patients can be better understood when you look at the numerous reasons why many patients do not complain about the service provided or the behaviour of the professional. It is important to understand that it is possible for you to do or say something that causes upset to your patient, yet they may never speak up and therefore you may never know.

Consider the following possibilities as to why this might occur. The patient may be afraid that you will discontinue their treatment; or that the next time you see them your attitude will have changed and you will not be as pleasant or as gentle in your touch; or they like you and do not want to get you into trouble or cause you offense. They may feel intimidated by you; they may feel that “this” may be their fault and if they were only nicer, more cooperative, or did their exercises faithfully you would not being doing “this”. Sometimes patients do not complain because they do not know that what you are doing is not considered to be an appropriate professional behaviour or action.
Before moving on, take a moment to consider the following:

Do you have difficulty accepting the power that you hold in your relationships with your patients?

Would you say yes or no? If you believe that you may or actually do have difficulty accepting your power, take another moment to think about why this may be so.

If you answered “no” you have no difficulty – congratulations; you may have a very good sense of your professional power and know why you have it!
However if you said yes, you are not alone. When asked the same question, professionals from all walks of life acknowledge that their professional power is difficult to “own” or accept. They give a number of reasons why this is so.

One reason offered, is the word “power” itself. For many, the word is negatively charged and conjures up such words as dominance, control and authority. The negativity associated with the word is enough to cause discomfort for many in accepting the power that that they hold in the therapeutic relationship.

Some professionals will state that they are unaware of their professional power. Usually, this comment is made when talking about boundary issues that appear to be innocent and seemingly harmless. Professionals often say that their actions are what any compassionate and caring human being would do in that particular circumstance. However by doing so, they allow a personal element to enter into the therapeutic relationship.
For others, it is the reluctance to accept the responsibility that is associated with the professional power that they have.

Take a moment to consider the following.

Your patient is on long-term disability from his employer. His continued benefits are dependent on your assessment, feedback and report. Without a doubt, that is a significant responsibility and with that responsibility comes accountability - accountability for your decisions, your actions and your behaviours. For many professionals this is the root of why they do not want to accept the professional power that they have.

Whether you do not want the responsibility; believe that your professional power does not exist in certain circumstances; or you would like simply to change the word “power” to a less emotionally charged word, the reality is that it is professional power that you have.

More Common Reasons for Not Accepting Professional Power

- The responsibility associated with one's professional power
- The corresponding accountability for one’s actions
To more fully understand why the power imbalance exists, it is important to know the elements that form or make up your professional power.

The first element and key to your professional power is your academic training or the knowledge, skills and expertise that you use in the job or position that you hold. This includes your registration with the College that permits you to practice.

Patient's come to you expressly for the application of your knowledge, skills and expertise to their specific physical need.
In addition to your unique professional knowledge, skills and expertise is the professional information that you acquire by virtue of the position that you hold.

First, let’s talk about how you apply this unique knowledge. Then let’s discuss what you do with the information you acquire in your professional role.
Following your assessment of a patient, you develop a course of action or treatment plan. In other words, you create a professional road map so that you know where you are going, what you will do and how you will get there.

Your patients trust that you will apply your knowledge, skills and expertise to create this roadmap. That is why they have to come to you in the first place.

Of course, you also share and discuss this road map with your patients.

It is important to recognize that your patients may not fully understand all aspects of the treatment plan and effective communication is critical. For as discussed in Chapter 1, the message sent by you is not always the same as the message received by your patient. Repetition may be required.
As noted a moment ago, during the course of your work and your career as a physiotherapist, you will acquire information by virtue of the position that you hold.

This includes the personal information obtained about the patients themselves. For example, you know your patients’ physical issues; you know how it impacts their life both the personal and social aspects, as well as their work or career.

You may have the authority to influence the timing of their return to work or even whether they will return to work. You may also have the authority to influence the types of benefits they may receive.

So how you manage or use information is part of the power that you have. This power can demonstrated verbally (in the way that you speak) as well as in the words (and reports) that you write.

And finally, your patients may share personal information with you that has nothing to do with why they are seeing you. They trust that you will keep this unrelated information as confidential as you do their specific physical issue.
In addition, you have other professionally acquired knowledge and information, such as an understanding of the functioning and processes of the organization or practice setting or knowledge of community resources and referral processes. Even if you don’t retain this information, you do have access to it. This is information that your patients may not have.

Not only do your patients trust that you will use your professional knowledge to assist them, they trust that you will use your professionally acquired information to support and help them navigate “the system” and to refer them to the appropriate resources.
Applying Your Knowledge and Acquired Information

Having access to information can mean that you:

- Start in the “middle of the story”
- Leave out information that your patient should be aware of

This can be innocent, unintentional or purposeful.

Having access to additional information means that there may be times where you start in the “middle of the story” and as a result, you leave out information of which your patients should be aware. This may be an innocent or unintentional omission on your part.

For example, while explaining a treatment option to a patient you make an assumption that the patient knows certain facts or is aware of certain community resources. Caution is required to ensure that you do not make assumptions about what the patient knows or should know and that you start at the beginning of the story, ensuring that all information is communicated.

How you apply or use your professional knowledge and professionally acquired information is part of the professional power that you have.
Another element of your professional power involves your patients’ expectations. When your patients come to you for therapeutic services, they may have expectations of what that therapeutic service involves.

These expectations could be about the treatment procedure itself; the duration or length of time that treatment will be provided; the cost of the individual session or the course of treatment; and the parameters of your role as their physiotherapist. These expectations may be expressed to you or may be a vision of the treatment that they have in their mind and do not share.

These expectations may be formed from having undergone physiotherapy treatments before; from speaking with someone else who has used physiotherapy services, such as a family member, friend, or colleague; or from what they have read in the newspaper, searched on the internet or seen on television.
As you know, not all expectations are realistic. Some expectations may fall outside your knowledge, skills and expertise or the role and the job description that you hold. Some expectations may fall outside the mandate or policies of the organization or agency with whom you work. Some may fall outside the standards of the College or your scope of practice.

Take a moment to reflect. Can you think of a time in which a patient expressed expectations that did not reflect your ability to provide the service? What did you do?

Did you feel comfortable in addressing the unrealistic nature of the expectation? If not, what was the cause of your discomfort? Were you afraid of causing offence? Was it difficult to find the right words? Did you feel in awe of, or even somewhat intimidated by this particular patient?
In essence, patients who come with expectations that cannot be met, may push the boundary or that safe connection between you, the professional, and them. However, as discussed in Chapter 1, you are solely accountable for maintaining the boundary.

Another key element of the professional power that you have is how you manage your patients’ expectations. Are you able to address the expectations and put the boundary back into place? Or do you avoid doing so for your own personal reasons, such as feeling uncomfortable or not being able to find the “right” words?

While Chapter 4 will address preventative tips and tools that you can apply to day-to-day practice, managing your patients expectations appropriately is very important. Providing clarity up front is one proactive method of managing both the stated and unstated expectations of patients. In other words, in the beginning, outline the parameters of the service that you will provide; articulate the expected length of time or duration of treatment; and define your role in this therapeutic relationship. Again, when in doubt about what to do, seeking consultation is highly recommended.

Your Patient’s Expectations cont’d

- When expectations cannot be met or push the boundary or safe connection, how you manage these expectations is very important.
- Outline the parameters of the service.
- Define your role.
- Seek consultation.
Moving on to another element of your professional power, consider the following:

In a time of patient crisis does your professional power increase or decrease?
If you answered “increase” you are correct. Your patient's vulnerability rises substantially in a time of crisis.

In other words, patients’ faith and trust that you will do good and not cause harm is magnified as their need for your knowledge, skills and expertise intensifies. Therefore, how you conduct yourself professionally in a time of patient crisis becomes another element of the professional power that you have.

The assessment of whether you maintained that safe connection between you and your patient may be higher as a direct result of their heightened vulnerability. In other words, your professional actions and behaviours may be examined more closely at this time.

Can you think of other situations where your professional actions or behaviours may be examined more closely due to increased patient vulnerability?
Another element of the professional power that you have is the words that you use. This can be either the spoken or written word and includes words that you use in team meetings, in consultation with or referral to community agencies or other care providers and in your charting or documentation. It could also be acronyms, or medical jargon or the use of descriptive phrases such as, “the knee in room 4”.

The words that you use help to foster or form mental impressions of your patient that may be lasting. In other words, the words may become a label.
Consider This Statement

Mrs. J. is manipulative.

Let’s consider a statement uttered by a colleague while transferring a patient file to you. “Mrs. J. is manipulative”.

What is your initial reaction to this statement? What picture of Mrs. J. do you have in your mind now?
Does being told that Mrs. J. is manipulative....

A. Affect your impression of Mrs. J.
B. Will not affect your impression of Mrs. J.
C. Will maybe affect your impression of Mrs. J.
D. Don’t know if it will affect your impression of Mrs. J.

This is not a test of right or wrong, but rather a point of personal reflection. Please answer honestly, your response will be known only to you.
Now think about the following questions.

What does the word manipulative mean to you? Does it mean the same thing to you as it does to your colleague? In other words, are you filtering the label through your own personal interpretation or bias? Is your colleague filtering the label through their own interpretation or personal bias?

Having been told that she is manipulative, what mental picture are you creating of Mrs. J.? When you meet her for the first time, will you be open to information that is opposite or contrary to this label?

As the statements in the quiz imply, will it negatively colour or cloud your thinking while working with her? If it does, what is the potential impact of harm to Mrs. J. as a result?
Without a doubt, the word “manipulative” can be a strong, negatively charged adjective that in the context of the previous scenario, may become a lasting label attached to Mrs. J..

Understanding and using the professional power inherent in your words makes it important to articulate the specific behaviours or actions that you consider to be an issue. In other words, describe what you may have observed rather than use an adjective as a stand alone descriptor. This shifts your communication from the subjective to the objective.
This discussion has focused on the spoken and written aspects of communication. However, a larger part of communication is non-verbal, meaning body language. It becomes important to pay attention to your own body language, in addition to the words that you use, as all aspects of communication are a part of the professional power that you have.

Your sensitivity to, and respect of cultural differences, as well as age and gender differences, will be reflected in your communication with your patients. Should you sense that something is not right, either by something that your patients say or indicate through their body language, it is important to address the issue. Frequently it is miscommunication that is at the core of misunderstandings. Chapter 3, The Slippery Slope will address this further when discussing the difference between the intent and impact of both actions and words.
It is important to be aware that you also have symbols of your professional power, being careful not to underestimate their impact.

Consider the stethoscope around your neck or the chart under your arm. How do these symbols set you apart from your patients? Consider the modalities or machines that you use and the pain relief that your patients are seeking. Consider your name tag or keys or access codes to places denied to your patients. Consider the white coat that may cover your clothes. Consider the waiting room where your patients are waiting "patiently" to be called in for treatment. These are all visible signs of the power that you have.

Can you think of other symbols of professional power that you may have?
In addition to symbols of power, in the course of your work you will have current patients and you will have patients whose treatment has ended. While stating the obvious, these patients become your former patients.

Consider the following statement.

Upon discharge from treatment, your professional power with your patient ends. Is this true or false from your perspective?

If you answered false, in the purest boundary sense you are correct. In other words, your professional “hat” never really comes off. This will be addressed more fully in Chapter 3, The Slippery Slope. For now though, consider the following scenario.
 Scenario

It is the weekend. As you leave the local coffee shop someone calls your name. You stop, but do not recognize the person. The person tells you how happy she is to see you and goes on to say that the treatments that you provided 10 years earlier gave her back her life.

All you can think about at that moment is your children in the car and that you are already running late getting them to their hockey practice.

What you would do in this situation? What factors would you take into consideration?
The reality is that over the course of your career, you will see many people and the human memory being what it is, you will remember some and not others. However for certain patients, something that you did which could be the treatment itself or something that you said, may be etched in their minds forever, such as with the person described in this scenario.

Now consider how your professional power comes into play as you determine what you will do. If you said something to the effect of, “Glad to hear it, I have to go” and then you left, what might be the immediate impact on your former patient?

Although people will vary in their response to your brush off, one potential immediate impact could be that the person feels let down; she may feel that she didn’t mean anything to you other than being an “object” to be treated; or a “pay cheque” to be collected; and she may feel that her trust in you to do good and not cause harm is broken or lost.

A potential long term impact could range from not going back to see you specifically should a need arise, to being wary of seeking physiotherapist services at all, to not trusting that health care providers are there to do good and not cause harm. In other words, there is the potential that others will be painted with the same brush.
For this particular patient outside the coffee shop, regardless of the passage of time, in her mind, you are still her physiotherapist, she is still your patient and she trusts that you will treat her with the same respect and the same professionalism as you did 10 years before. In other words, the power imbalance did not weaken; your professional “hat” is still firmly in place and the relationship has not changed.

You may think to yourself, “It is the weekend and I do have other responsibilities”. What should you do?

Confidentiality issues notwithstanding as you stand outside a coffee shop, this fictitious patient wants simply to thank you for the treatment that you provided and to be acknowledged both as a person and for what she has accomplished. This does not take a lot of words or a lot of time to do.
There is one final over-arching element to the professional power that you have and that simply is you.

Do you accept that the power imbalance exists in your relationship with your patients?

Do you understand the elements that make up your professional power?

Do you know and accept the “rules” that govern your professional behaviour?
Having integrated the acceptance and knowledge of your professional power, do you apply and use your professional power appropriately in your day-to-day practice?

The question implies that there is an element of choice; and it’s true, you can make a decision to use your professional power appropriately or not. However, it is vitally important that you understand the consequences of making that decision. This is an important concept in the world of boundaries. Think of this as where “rules” and human behaviour meet.

In Chapter 1, a professional boundary was defined as the limits of the safe connection between you, the physiotherapist and your patient. In addition, this safe connection was further defined as always being based on your patients’ needs – not your own. So in the circumstances where you choose not to use your professional power appropriately, you may weaken or compromise the professional boundary. This choice may be innocent; it may be due to your inability or lack of confidence in putting the boundary “back into place”; and from time-to-time, it may even be a purposeful or conscious decision.

Consider the following examples.
In Chapter 1, you were encouraged to reflect upon a number of professional behaviours and whether you entered into any of these behaviours. To better understand the concept of choice in the use of your professional power, let’s take a look at three questions from the self-assessment exercise.

The first behaviour - do you do favours for certain patients such as scheduling appointments outside of regular hours or driving a patient home?

You may answer, “yes, you do enter into these behaviours from time-to-time”. You often schedule your patients’ treatment time with their availability and this may be outside regular working hours on occasion. When you do so, it may seem that you are keeping your patients’ needs primary. Or if it is raining who would not drive a patient home? You may conclude that this demonstrates respect for your patients as well as being a basic human kindness.

However, the questions “do you do favours for your patients?” has a key word that highlights a real, potential or perceived shift in your professional relationship with your patient which begins to blur or confuse the professional boundary.

Can you identify the key word?
If you identified the word “favour”, you are correct. For by doing a favour you step outside your professional role and introduce a personal element into the therapeutic relationship. In essence, the addition of this personal element innocently “dualizes” the relationship, meaning that there are now both personal and therapeutic aspects to the relationship.

This additional personal element can be real (in other words, there really is a personal element to the relationship that you have with the patient), or it can be potential (meaning that although there isn’t truly a personal element, there is the potential for one to develop if appropriate steps are not taken), or it can be perceived (meaning the patient perceives that there is now a personal element – whether or not this is what you intended). The distinction between impact and intent will be addressed further in Chapter 3.
More on the Innocent Choice

Harm can be very broad, i.e. personal, financial, emotional, social

There are a few reflective questions to consider regarding the innocent choice or the decision to step outside your professional role by entering into behaviours that may appear innocent and harmless at the time. It is important to “think outside the box”, as harm can be very broad. For example, harm can be personal, financial, emotional or social.
Reflective Questions

- Would you do “this” for all patients?
- Is there anything special about this particular patient?
- What harm could occur to your patient?
- Will there be a ripple effect on your colleagues?
- What is your professional purpose?
- Whose needs are coming first?

Some of the reflective questions for consideration include:

- Would you do “this” for all your patients? If not, why not?
- Is there something special about this particular patient? What is it? Why is it?
- What harm may occur to your patient as a result of your actions?
- Will there be an impact or ripple effect on your colleagues because of the favour that you did? What would that look like?
- What is your professional purpose for stepping outside your role?
- Whose needs are coming first? Yours or your patient's?
In the world of boundaries, stepping outside your role is a key indication that you may be moving towards the blurring of boundaries and that the safe connection between you and your patient may be weakened as a result. So while you may step outside your role purposefully by entering into what you believe to be an innocent act, by doing so you make a choice of how you are using your professional power.

Or, you may step outside your role, unaware that this may blur the professional boundary and although unintentional, it is a choice as well. As discussed in Chapter 1, you, as the professional, are solely accountable for maintaining the safe connection between you and your patient. This means that you need to know the “rules” that govern your professional behaviour, for should harm occur or be perceived as harm by your patient, you will be asked to explain why you took the course of action that you did.
The second reflective question is, do you extend the number of treatments because your patient insists that he or she needs more therapy and you don’t know how to say “no” without causing offence?

This question provides an example of how you may choose not to use your professional power appropriately because of your inability to address the issue. So while purposeful on one hand, the underlying reason is not.
There may be situations that arise from time-to-time that cause you discomfort. You know that you should “put the boundary back into place” but you don’t know how, or you don’t know what to say. Therefore you agree, give in, or just let the issue slide. Having occurred once, it may occur again and you may feel increasingly uncomfortable. You may feel embarrassed to seek assistance, either from your supervisor or through consultation with colleagues.
Can you think of a situation in which you did not know what to say or what to do?

How did you feel at the time?

Did you seek consultation? If not, what prevented you from doing so or what caused you hesitation?

What was the outcome?

Was any harm caused to your patient?

And finally, whose needs were coming first? Yours or your patients?

Though you may not know what to do or say from time-to-time, your responsibility to maintain the safe connection between you and your patient does not change. So, should such a situation arise, seeking consultation is a sensible and wise course of action.
In this third question from the initial self-assessment exercise in Chapter 1, “Do you discontinue service because you find something about the patient offensive, such as body odour?”, there is a purposeful and conscious decision to discontinue treatment because the patient’s body odour is so offensive to you. Unstated but implied, is that your patient requires further treatment.
Take a Moment

Is discontinuing a patient’s treatment because I find something offensive:

A. Okay
B. Not okay
C. Maybe okay
D. Don’t know

Before responding, let’s ask another question:

Is discontinuing treatment because you find something about the patient offensive:

A. Okay
B. Not okay
C. Maybe okay
D. Don’t know

Take a moment and reflect on the response that “fits” for you.
Take a Moment

When I discontinue a patient’s treatment because I find something offensive I:

A. Treat my patient like an object
B. Take a short cut
C. Manipulate the situation
D. All of the above

Rather than provide you with the answer, let’s ask one more question: When you discontinue a patient’s treatment because you find something about the patient offensive do you:

A. Treat your patient like an object
B. Take a short cut
C. Manipulate the situation, or
D. All of the above

If you chose “A”, “You treat your patient like an object”, you are correct. In this scenario, you made a conscious decision to terminate treatment despite the fact that your patient continues to require treatment. In doing so, you let your personal bias of what you feel to be right, fair and just to shape the therapeutic relationship. Your patient is no longer a person but an object to be moved through.

If you thought “B”, “You take a short cut”, you are also correct. By prematurely discontinuing treatment, you have taken a short cut. In addition, you have not addressed the issue of how the patient contributes to their care.

Answer “C” is also correct “You are manipulating the situation”. Your patient comes to you with a need for your particular knowledge and expertise. You control the amount of time for each treatment, the frequency and its ultimate duration. In this scenario, you manipulated the situation to your advantage because you could.

So obviously answer “D”, “All of the above” is the most correct response.
As discussed in Chapter 1, the over-arching face of harm relates to the concept of the professional letting their own personal bias enter into the therapeutic relationship and by doing so, the professional gains personally at the patient’s expense.

This is what occurred in this scenario when our hypothetical physiotherapist made a conscious and purposeful decision not to use their professional power appropriately at the time. In other words, the physiotherapist chose not to address the issue of body odour with the patient and to discontinue treatment instead. The offensive body odour became the dominant issue rather than the patient’s need for treatment. The physiotherapist acted to serve their own needs and not the patient’s.

Having said that, you may feel that there are situations that arise from time-to-time that cause you intense personal difficulty or discomfort. Does this mean that your intense and strongly held feelings, beliefs or values must be ignored? While we will address this further in Chapter 3, The Slippery Slope, let’s consider what could be done differently.

Should a situation arise that makes you feel so strongly that you would like to discontinue a patient’s treatment consider the following actions:

1. Ensure to initiate constructive communication or dialogue with your patient about the issue.
2. Seek consultation of the rules and the right people to understand your professional obligations.
3. Develop a plan to address the issue and communicate it to those involved.
4. Ensure continuity of care rather than abandoning your patient.

The College’s Standard for Professional Practice: Managing Challenging Interpersonal Situations When Providing Patient Care, provides additional guidance and is available in the Registrars’ Guide on the College website.
Before closing this chapter, it is important to link the power imbalance to other non-clinical roles that you may have, such as being a researcher, consultant or academic. The power imbalance exists for these roles as well.

You will want to be cautious and aware of the power that you hold when practicing:

• As a researcher who uses patients as participants in studies
• As a consultant who evaluates patients and writes reports
• As an academic who may use patients as models for teaching purposes
In closing this second chapter, remember; your knowledge of the power imbalance is critical to your work with patients and this knowledge is also applicable to other roles that you may hold.

By accepting that the power imbalance exists, knowing the elements that make up your professional power and understanding that you make a choice to use this power appropriately when you are faced with a boundary issue, your decision-making will start from a solid foundation and lead to more reliable results.
Congratulations on completing Chapter 2 of the Understanding and Maintaining Professional Boundaries E-Learning Module.

Establishing and Maintaining Therapeutic Relationships with Patients + Guide

Managing Challenging Interpersonal Situations When Providing Patient Care + Guide

A complete list of references and resources is available upon request by contacting the College.

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We are very interested in hearing your feedback on this chapter of the Professional Boundaries E-Learning Module.

Please visit http://www.surveymonkey.com/s.aspx?sm=QOKINm7v7bHOWps5m2xQg_3d_3d to complete a short survey.

Thank you.