The College of Physiotherapists of Ontario presents Understanding and Maintaining Professional Boundaries: Chapter 3: The Slippery Slope. This is the third of four chapters designed to heighten awareness and assist physiotherapists' understanding of professional boundaries.
This chapter will explore the concept of trust in the therapeutic relationship. Within this discussion, a distinction will be made between the intent of your professional actions and the impact perceived by your patients. The chapter will also present five scenarios for you to consider and to work through.
As a registered physiotherapist, you have a responsibility to keep your patients’ needs primary in the work that you do, as was discussed in previous chapters.

Patients trust that you will do so and that you will do only good and not cause harm. They trust that you understand and accept the power imbalance that exists. And they trust that you will use your professional power in an appropriate manner.
As a general concept, trust is implicit. In other words, trust is assumed but rarely voiced. Yet this trust is a vital element in the work that you do. While you have the responsibility to keep your patients’ needs primary, you have a secondary responsibility to maintain your patients’ trust or confidence that indeed, you are keeping their needs primary. Therefore, it becomes important to bring the concept of trust to the foreground and begin to make it explicit or evident in your thinking as you move through your day-to-day practice.

More on Exploring Trust

- Trust is implicit or assumed, yet it is a vital element
- Physiotherapists have two responsibilities:
  - maintain patients’ trust
  - keep their needs primary
- Important to make trust an explicit part of day-to-day practice
To begin, it is important to understand that trust is both dynamic and relational. In other words, trust is something that you can have and it is also something that you can lose.
Take a moment to consider a time when you said to yourself, to the patient directly or to a colleague – “but that’s not what I meant!” – in reference to an interaction with a patient.

Now reflect further. What caused the confusion that led to the intent of your actions and the impact experienced by the patient to be different?

Did the patient's trust in you as a professional change in any way? Did the therapeutic relationship change? Did it become a bit uncomfortable or strained?

On reflection, what might you have done differently in that particular circumstance?
From time-to-time, you may do, say or imply something that causes a patient’s trust in you as a physiotherapist to be shaken or in the extreme, to be withdrawn completely.

In other words, you do something that we’ll call “the act”. In turn, this act has a consequence; and in turn, this consequence has an impact on the patient. The impact is the patient’s interpretation of what you did or said.

This impact may be something very real that occurred. It may be something perceived by the patient to be real. It may be something that the patient feels may happen in the future or has the potential to occur. Regardless of whether it is real, potential or perceived, this impact may result in the patient’s trust in you being lost or compromised.

What does this look like in practice?
Take a moment to consider the following scenario;

You are in a bit of a hurry and while positioning a patient he or she lets out a small yelp of pain - “ouch!”.
The act in this case is the act of positioning a patient while in a hurry.

The consequence of positioning the patient in a hurry results in a real or perceived less than gentle “touch”.

The impact on the patient is pain.
In the absence of a sincere apology, the patient may wonder about a possible recurrence. That is – potentially, it could happen again and could lead to the patient losing trust and faith that you are there to do good (either for that particular treatment or for treatment as a whole).

**Possible Chain of Events**

In the absence of a sincere apology:

- Patient concern i.e. possible recurrence
- Loss of trust and faith that you are there to do good (either for that particular treatment or for treatment as a whole)
It is important to understand that there is a distinction between the intent of what you did, said or implied and the impact experienced by your patient, as they can be very different.

However, the impact of your actions or words becomes the patient’s reality. That is, they may or may not like it; may feel indifferent about it; may be upset about it; or perhaps may even be angry about it. And as you saw in the previous example, their perception of your actions, as it relates to them as a person, will either support their trust in you or not and will determine their subsequent actions, such as whether they return to see you.

While it is true that you can never possibly know the impact of everything that you say or do, it is important to be aware of this concept as it applies to your day-to-day practice.
Let’s explore this concept further.

From time-to-time, you may enter into what you consider to be innocent professional behaviours; in other words behaviours that you believe to be harmless. However, are they really?

The remainder of this chapter will focus on five scenarios. Each scenario will be followed by a series of questions for you to reflect upon.
Scenario 1: You are seeing a patient who suffered multiple trauma as a result of a car accident. Formerly very physically active, he now struggles to take a few steps. One day during treatment he begins to cry and you give him a hug.
Now take a moment to consider - what would you say about the act of giving a hug to a distressed patient?

Is it okay? Not okay? Or maybe okay?

Regardless of your response, what is your rationale for your decision? In other words, how or on what basis did you decide to give your patient a hug?
Because of the Hug, Has the Boundary or the Safe Connection Between You and the Patient:

A. Changed?
B. Not changed?

Keeping in mind your response and your rationale, because of your action – the hug - do you think that the boundary or safe connection between you and the patient has changed or not changed as a result?

If you think that the boundary has not changed – think again. But does this mean that you should never enter into touch of a personal nature with a patient? We will discuss this further in a few moments.

But first, let’s talk about the way in which the boundary has changed because of the seemingly innocent hug that you gave.
But first a question – with whom do you usually enter into touch of a personal nature? While the hug is used as an example in the scenario, generally the answer is that you use personal touch to communicate with family or friends. Touch of a personal nature is not limited to hugs, but can take many forms.

What happens to the therapeutic relationship should you enter into any form of personal touch? Remember, personal touch is different from your therapeutic or work-related touch which will be addressed in a few moments.
As outlined in Chapter 1 and repeated in Chapter 2, patients come to you with a need for your specific knowledge and expertise and your respective roles are clear – that of patient and that of physiotherapist.

By introducing touch of a personal nature, you insert another element into the therapeutic relationship and the roles may no longer be as clearly defined. Whether real, potential or perceived, there is now this personal element in the middle of the therapeutic relationship.

If the roles are no longer clear, then the expectations of the relationship may not be as clear either. The therapeutic boundary has become blurred and the relationship has been “dualized” with the introduction of this third element or personal touch. Your relationship with the patient now includes the dual roles of physiotherapist as well as real, potential or perceived “friend” OR “somehow different than before” physiotherapist.
The question is - should you ever enter into touch of a personal nature with a patient?

You recall that you were asked to reflect on the scenario and determine for yourself whether entering into a hug was an okay, not okay or maybe okay professional behaviour. Unfortunately, there is no clear answer to this question. Ultimately, you will need to use your professional judgment at the time and be prepared to rationalize your choice.
Reflective Questions to Consider

- How do you know that your patient wants a hug?
- If you ask – how do you know that you will be told the truth?
- Would you hug all your patients or just this particular patient?
- Will the intent of your hug and the impact be the same?
- What harm could result?
- What would your colleagues think?
- Could this be perceived as sexual in nature?

To assist you in your decision-making, there are a few reflective questions to consider.

If you are initiating the hug or touch of a personal nature, how do you know that your patient wants the hug or is okay with that touch? If you ask whether they would like a hug or if they need a hug as in the case of a distressed patient - how can you be sure that you will be told the truth? For they may not want to hurt your feelings; or they may be worried that your therapeutic relationship with them may change if they refuse.

Would you enter into touch of a personal nature with all of your patients or just this one patient? If just this one patient - how or why are they different than your other patients? Will the intent of your actions be received as you intended? Or could the impact of your actions be perceived differently by your patient? What harm could occur as a result? What would your colleagues think if they witnessed the hug?

Could this touch be perceived as sexual in nature?
There is a difference between touch of a personal nature and the work-related touch that you do in your daily practice. Needless to say, you have direct physical contact with your patients that can be very intimate, depending upon the procedure. All direct physical contact is entered into with your patients’ consent.

Should you make a professional judgment to enter into touch of a personal nature with a patient, consider the potential impact and be careful that this does not become a pattern. Ask yourself: whose needs are coming first? Yours or the patient's?

In the world of boundaries, entering into touch of a personal nature is a key red flag or warning sign that you may be on a slippery slope in your therapeutic relationship with that patient. A reflective step back is required with appropriate measures taken to put the boundary back into place.
Now let’s consider Scenario 2. This scenario involves a long-standing patient.

During the course of treatment, the two of you chat about this and that. Usually, it is light chatter such as movies that you both saw or books that you both have read. But sometimes you’ll talk about more personal things, like family. Your patient is going through a tough time and you share a similar experience and tell her how it turned out in the end.
Now as you did in Scenario 1, take a moment to consider. What would you say about your action or behaviour – the sharing of personal information?

Is it okay? Not okay? Or maybe okay?

What was your rationale for sharing this information? In other words, how or on what basis did you make the decision to do so?
Keeping in mind your responses and your rationale - because of your action – the sharing of more intimate personal information - do you think that the boundary or safe connection between you and your patient has changed or not changed as a result?

If you think that the boundary has not changed – think again. As with the first scenario, this does not mean that you should never enter into personal disclosure with your patient and we will address this further in a moment.

But first, let’s talk about why the boundary has changed because of the seemingly innocent sharing of personal information.
As discussed in the previous scenario, your patient comes to you with a need for your specific knowledge and expertise. Your roles are clear – that of patient and that of physiotherapist.

By introducing your personal information into the therapeutic relationship, you create another role for yourself and “dualize” the relationship.

And as was noted in the previous scenario, if your roles are not clear then the expectations of the relationship may not be as clear either. And again, the therapeutic boundary becomes blurred.
Reflective Questions to Consider

- Does the patient feel that there is now a special bond?
  - If yes, what are the implications?
- What harm could be caused if the outcome is not the same for the patient?
- Does the patient feel that he or she needs to take care of you?

Here are some questions to consider.

Does your patient feel that there is a special bond between you that was not there before you shared this more intimate information? What are the implications should that be the case?

What is the harm caused to the patient should the resolution of his or her situation not be the same as the personal one that you shared?

Or depending upon the personal information that you share, does your patient feel now that he or she needs to take care of you, creating a role reversal?
In the world of boundaries, personal disclosure is a key red flag that you may be on a slippery slope with your patient and as a result, the therapeutic boundary or safe connection between you and your patient may be weakened.

But the question remains - should you ever share personal information with a patient? You recall that you were asked to reflect on the scenario and determine for yourself whether entering into personal disclosure was okay, not okay or maybe okay professional behaviour. As with Scenario 1, there is no clear answer to this question. You will need to use your professional judgment at the time.

However, there is a key question to help guide you and that is, - “What is your professional purpose or rationale for sharing this information?” For should you choose to enter into self disclosure, it must have a professional purpose.
You may determine that it is appropriate to enter into personal disclosure as a way to build rapport or to put your patient at ease. Should you choose to do so, here are some points to consider.

Keep your disclosure at a high level. That is, do not go into any depth.

Keep in mind that what you share is now in the public domain. That is, it may not be held in confidence by your patient.

And finally, be cautious about sharing intimate personal information that implies that you or someone close to you has experienced something similar. The caution is that this experience that you share with your patient may become your credential in their eyes. In other words, their reason for coming to seek your services changes from the need for your knowledge and expertise as a physiotherapist to a desire to share information with someone who knows what they are going through on a personal level.

Let’s explain.
Consider

Your patient is recovering post surgery. He is distressed as he does not feel that the surgery has helped and he is not recovering as quickly as he had hoped.

You share with him that one of your family members underwent similar surgery and it all turned out very well with a full recovery.

Consider the following scenario.

Your patient is recovering post surgery. He is distressed as he does not feel that the surgery has helped and he is not recovering as quickly as he had hoped. You share with him that one of your family members underwent similar surgery and it all turned out very well with a full recovery.
The fact that you have “walked in their shoes” as a family member of someone with a similar experience may shift their belief in you as a physiotherapist to a more personal level. The mere fact that you have an intimate understanding of their experience on a personal level may become a more important factor than your professional skills and expertise.

Consider what the impact may be if your patient's outcome is not as good as your family member's outcome.
Now consider Scenario 3.

You have a new patient with very strong opinions on many things such as politics and religion and even last night’s hockey game. This patient is not shy about expressing her opinions and uses strong language spoken in a forceful tone when doing so. Most of the time, you are able to deal with it however today, her opinions are too close to home and you are very upset. Although she requires another couple of treatments, you consider telling her that all is good and her treatment is complete.
As you did in the previous scenarios, take a moment to consider. What would you say about your action or behavior if you followed through on your thoughts and discontinued treatment?

Is it okay? Not okay? Or maybe okay?

What would be your rationale? In other words, how or on what basis would you make this decision to stop treatment?
Do you think that the boundary or safe connection between you and your patient has changed or not changed as a result of considering terminating treatment prematurely? Keep in mind your responses and your rationale as you did in the previous section.

If you think that the boundary has not changed – think again. Let’s talk about this further.
The Confusion of Roles

- Your personal bias is shaping your professional thoughts and causing your own role confusion.

- Which is coming first,
  - your professional responsibility?
  or
  - your personal desire to end the relationship?

In this scenario you are considering terminating the treatment prematurely because of your strong reaction to your patient's views. You have not acted on your thoughts as yet, however their very existence at that moment means that your personal bias has begun to shape your professional thoughts. So at that moment, the safe connection between you and your patient weakened. In turn, this intrusion of your personal bias could determine your subsequent professional behaviours or actions (either now or in the future). In other words, you could act on your thoughts and terminate treatment. Or if you continue treatment, your thoughts, actions, or behaviours may be different than at the beginning of the treatment sessions.

As in the previous two scenarios, the patient came to see you with a specific need for your particular knowledge, skills and expertise. The roles are clear – that of patient and that of physiotherapist.

However, with the intrusion of your personal thoughts, you with your own values have introduced a new element into the therapeutic relationship and that element is intensely personal. As a result, this becomes very much your own confusion of roles. Before acting, you will want to consider which is coming first - your professional responsibilities and obligations to your patient or your own personal desire to be done with this particular patient?
From time-to-time you may have patients whose ideology is strongly in conflict with your own. Ideology can be religious or political beliefs; conflict of personal morals and values; or it could be a conflict of some other strongly held belief.

It could also be something other than ideology, meaning something that you find offensive about the patient, such as body odour as was mentioned in Chapters 1 and 2.

Does this mean that as a professional, your personal beliefs or feelings can never be voiced or taken into consideration?
The world of boundaries recognizes that professionals may experience tremendous ideological conflict with patients on rare occasions. It is important to repeat – on rare occasions. When this conflict occurs, the professional will have significant difficulty being able to place the patient's needs above their own. As a result, the potential for harm to the patient increases.

Because of the increased potential of harm to the patient, the world of boundaries will say that consideration may be given to the removal of the professional, with the final outcome being the substitution of a professional who is able keep the patient's needs primary. However again, it is important to stress that this is usually in cases of extreme ideological conflict for as a professional, you are expected to be able to put your own personal bias behind you - even though there may be an ideological conflict with your patient. This is equally true should you find something personally offensive about a patient.

If you find yourself in such a situation – consult, consult, consult. Consult the rules (that govern your professional behaviours) and the right people; those individuals who can provide objective opinions.

When developing a constructive plan of how to address whatever the particular issue may be, you will want to keep in mind that there is legislation that prohibits discrimination, such as the Ontario Human Rights Code. You have an ethical responsibility and a professional obligation not to abandon your patient and to ensure appropriate continuity of care.

**Points of Consideration**

- In cases of extreme ideological conflict (rare) it may not be possible to put the patient's needs first, creating a potential for harm. In such cases it may be best to remove the professional.
- Ensure to consult broadly and thoroughly.
- Consider legislation that prohibits discrimination (Human Rights Code).
- Develop a plan to communicate and ensure continuity of care.
One of your patients is a financial advisor. This is a keen interest of yours and you follow the markets closely. You have never actually invested but you have saved a bit of money and are considering your options. You ask for your patient’s advice.

**Scenario 4**

One of your patients is a financial advisor. You have saved a bit of money and are considering options for investment. You ask for your patient's advice.
As you did in the previous scenarios, take a moment to consider. What would you say about your actions or behavior – asking your patient for advice?

Is it okay? Not okay? Or maybe okay?

What was your rationale? How or on what basis did you decide to ask your patient for financial advice?
Has the Boundary or the Safe Connection Between You and Your Patient:

A. Changed?
B. Not changed?

- Because of your request for financial advice

Again, keeping in mind your responses and your rationale; because of your action, that of asking your patient for financial advice, do you think that the boundary or safe connection between you and your patient has changed or not changed as a result?

If you think that the boundary has not changed – think again.

Let’s talk about this further.
In this scenario you ask your patient for financial advice. In other words, you draw on your patient’s particular expertise. It becomes important to ask – “What are the implications of doing so?”.

Simply speaking, you created a confusion of roles. You introduced a personal element into the therapeutic relationship – that of your request for personal financial advice - and most importantly, you changed the role of your patient. For now you are asking them to be both patient and financial advisor. With this request, you created a role reversal for yourself by asking your patient to take care of you personally.
Let’s examine this situation further, from your patient’s perspective.

By creating a role reversal, you may place your patient between a rock and a hard place – meaning that no matter what he chooses to do, he will feel uncomfortable.

Consider that you have not hired him to provide you with financial advice, meaning that you have no formal arrangement, and yet you may rely on his advice. He does have a formal arrangement with you and has hired you for your knowledge skills and expertise. That is the sole reason that he is seeing you.

Your patient may be wondering what might happen to his treatment if he does not give you some advice. Will you be paying as close attention to him and his treatment or will you be more focused on listening to the advice? What will happen if his advice to you does not yield the results that you thought that it would or should? Will this have any implications to his current or future treatments with you?
Reflective Questions
As the physiotherapist

- Why are you asking for your patient’s advice?
- Are you using your professional power appropriately?
- Whose needs are coming first?

Some reflective questions for you as the physiotherapist include - are you pushing your patient’s professional boundaries? Is the only reason that you are asking this patient for financial advice because he came seeking treatment? In other words, the only way that you know about his professional background is because he is your patient? Would you go to him for this advice if he were not your patient?

Have you manipulated the situation in any way? Are you using your professional power appropriately? Whose needs are coming first? Yours or your patient’s?
From a boundary perspective, as soon as you asked your patient the question, you asked him to do you a favour. That is to provide you with free financial advice.

In doing so, you stepped outside your role. Your personal need or desire came to the forefront and your professional role receded to the background. Therefore, your personal need began to shape the nature of the therapeutic relationship.

In the world of boundaries, both asking for favours and stepping outside your role are key red flags that you may be on a slippery slope. A reflective step back is required.
And now consider this 5th and final scenario.

You find yourself drawn to one of your patients and you look forward to each treatment session. You start scheduling appointments at the end of the day so you can spend more time together. Eventually you suggest that the two of you go out for coffee. This occurs a few times and you have really enjoyed this person’s company. So you suggest dinner and a movie. The patient accepts this invitation.
As you did in the previous scenarios, take a moment to consider.

Is your behavior – asking a patient out on a date - Okay? Not okay? Or maybe okay?

How or on what basis did you decide to step outside your professional role?
Once again - keeping in mind your response and your rationale; because of your action, that of asking your patient out on a date, do you think that the boundary or safe connection between you and your patient has changed or not changed as a result?

If you think that the boundary has not changed – think again. Let’s talk about this further.
In this scenario you ask your current patient out for coffee. Then you move the relationship even further along by asking for a date. So the question becomes simply – what is your role?

You are now the physiotherapist and personally involved. Your patient has taken another role as well – that of the patient and personally involved. You have created a dual relationship with this current patient in that you are no longer simply physiotherapist and patient.

As a result, by inserting this personal element into the therapeutic relationship, there is a confusion of roles. This leads to the boundary being confused and because the boundary is not clear, it will become increasingly difficult for you to maintain that safe connection between you and your patient. It could even be considered to be sexual abuse.

**Confusion of Roles**

- Dual relationship – for both you and the patient
- The boundary is not clear
- Difficult to maintain safe connection – it could even be considered to be sexual abuse under the Regulated Health Professions Act (RHPA)
You may think – “why would it be much more difficult to maintain this safe connection?”.

Take a moment and consider the following reflective questions.

Do you spend more time thinking about the relationship than the treatment that you are there to provide? What is the impact of harm to your patient should this be the case? Have the expectations of your patient changed with regard to the treatment – for example, do they expect more or better treatment? Do they expect different rates? Do you provide treatment outside of regular business hours or at your place or theirs? What is the potential for harm to the patient?
As you can see, having a social or personal relationship with a current patient is filled with issues related to the power imbalance and the need to protect patients from harm. The College prohibits social and personal relationships with current patients for exactly these reasons – as do health colleges generally.

But what about former patients, or patients whose treatment has been discontinued? Is it possible to have a close personal or social relationship with a former patient? This raises the question of whether the power imbalance weakens over time. The answer is sometimes.

There are times where the power imbalance is so great that the professional's power is considered to be intact forever. For example, in situations where the treatment or therapeutic relationship was of a long duration, included a great deal of physical or emotional closeness and/or patient disclosure of personal information was such that the patient will remain emotionally dependent or vulnerable forever.

On the other hand, if after the therapeutic relationship has ended and careful consideration has been given to the nature and duration of treatment as well as the degree of dependency or vulnerability of the patient, it may be appropriate to consider commencing a social relationship with a former patient. In this circumstance, it is often appropriate to wait a reasonable length of time before doing so. A reasonable length of time will vary based on these same factors. That is the length of the therapeutic relationship, the amount of intimate disclosure and degree of vulnerability of the patient.

While some television dramas may imply that it is okay to have relationships with current and former patients, you should consult the College Standards (such as the Standard on Establishing and Maintaining Therapeutic Relationships with Patients) as well as consult with colleagues and supervisors to better understand not only what is expected of you, but how to ensure the best interests of the patient.
As you can see the world of professional boundaries is not always black and white but rather quite grey. In other words, you will need to exercise your professional judgment to determine whether or not you will enter into certain behaviours or actions with your patients. Sometimes it may be OK and other times it will not be OK.

To assist you in exercising your professional judgment keep the following in mind:

1. One of your professional responsibilities is to maintain your patient’s trust that you will do only good and not cause harm.
2. Consider that there may be a difference between the intent of your actions and the impact perceived by your patients. This impact, whether real, potential or perceived becomes your patient’s reality.
3. The integrity of the safe connection between you and your patient can be weakened through role confusion, thereby blurring the professional boundary.
4. When in doubt, you should consult appropriately.

In closing, this chapter presented some red flags or warning signs that you may be on a slippery slope in the therapeutic relationship should you enter into certain actions or behaviours. Chapter 4 contains additional red flags and preventative tools that can be used in your day-to-day practice.
Select References and Resources

College of Physiotherapists of Ontario:

Standards for Professional Practice:

1. Establishing and Maintaining Therapeutic Relationships with Patients + Guide
2. Managing Challenging Interpersonal Situations When Providing Patient Care + Guide
   * Professional Misconduct Regulation
   * Mandatory Reporting
   * Sexual Abuse Prevention Resources

Congratulations on completing Chapter 3 of the Understanding and Maintaining Professional Boundaries Learning Module.

Establishing and Maintaining Therapeutic Relationships with Patients + Guide

Managing Challenging Interpersonal Situations When Providing Patient Care + Guide

Professional Misconduct Regulation

Mandatory Reporting

Sexual Abuse Prevention Resources

A complete list of references and resources is available on 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=QOKINmb7v7bHOWps5m2xQg_3d_3d to complete a short survey.

Thank you.