

Ethical Boundaries in the Patient-Clinician Relationship

***A Report by the National Ethics Committee
of the Veterans Health Administration***

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Founded in 1986, the National Ethics Committee (NEC) of the Veterans Health Administration (VHA) is an interdisciplinary group authorized by the Under Secretary for Health through the National Center for Ethics in Health Care. The NEC produces reports on timely topics that are of significant concern to practicing health care professionals. Each report describes an ethical issue, summarizes its historical context, discusses its relevance to VHA, reviews current controversies, and outlines practical recommendations. Previous reports have been useful to VHA professionals as resources for educational programs, guides for patient care practices, and catalysts for health policy reform. Scholarly yet practical, these reports are intended to heighten awareness of ethical issues and to improve the quality of health care, both within and beyond VHA.

Executive Summary

Health care professionals are committed to promoting the welfare and well-being of the patient over and above any personal consideration. Indeed, this fiduciary obligation is one of the defining characteristics of a “profession” as such. This concept of a profession gives rise to the notion of boundaries in client-professional relationships—that is, to the notion that there are limits of ethically appropriate professional behavior.

A boundary violation occurs when a health care professional’s behavior goes beyond appropriate professional limits. Boundary violations generally arise when a personal interest displaces the professional’s primary commitment to the patient’s welfare in ways that harm the patient or the patient-clinician relationship. Interactions between health care professionals and patients are ethically problematic when they can reasonably be expected to affect the care the individual or other patients receive or the health care professional’s relationships with colleagues—or when they give the appearance of doing so.

This report by the VHA National Ethics Committee examines the concept of professionalism in health care and the role-based obligations of health care professionals in their relationships with patients, clarifies the concept of boundaries and boundary violations, and analyzes examples of potentially problematic actions to help clinicians identify and avoid professionally inappropriate conduct. The report recommends that health care professionals:

- (1) Critically examine their own actions by asking themselves the following questions:
 - ❖ Is this activity a normal, expected part of practice for members of my profession?
 - ❖ Might engaging in this activity compromise my relationship with this patient? With other patients? With my colleagues? With my institution? With the public?
 - ❖ Could this activity cause others to question my professional objectivity?
 - ❖ Would I want my other patients, other professionals, or the public to know that I engage in such activities?

- (2) Take appropriate action if the answers to these questions indicate that an activity *may* violate professional ethical boundaries:
 - ❖ Determine if there are applicable standards.
 - ❖ Consult a trusted and objective peer for a second opinion about the activity.
 - ❖ Seek assistance from a supervisor or ethics committee.
 - ❖ Communicate his or her concern to the individual involved.
 - ❖ Transfer the patient to another clinician’s care if the professional relationship has been compromised, or if avoiding the violation will damage the relationship.

- (3) Be familiar with:
 - ❖ Relevant professional codes of ethics, standards of practice, guidelines, and position statements;
 - ❖ Applicable policies in their facilities;
 - and
 - ❖ Laws pertaining to relationships between patients and health care professionals.

Introduction

Boundaries define the limits of appropriate behavior by a professional toward his or her clients. By establishing boundaries, a health care professional creates a safe space for the therapeutic relationship to occur. Concerns about professional boundaries in the relationship between patients and health care providers—and the damage that results when boundaries are transgressed—captured public and professional attention following reports of inappropriate sexual relationships between health care professionals and patients.¹⁻⁵ Relatively little attention has been paid to the “boundary question” outside this context,^{4,8} but many other interactions raise concerns about boundaries as well. Health care professionals need guidance if they are to avoid engaging in interactions with their patients that may prove ethically problematic.

Professionalism in Health Care

The notion of boundaries in the health care setting is rooted in the concept of a “profession.” While this concept is understood in several different ways in the medical and sociological literature, there is consensus regarding one of the defining characteristics of professions and professionals: commitment to serve the profession’s clients.⁹ That is, professionals are expected to make a fiduciary commitment to place their clients’ interests ahead of their own. In exchange for faithfully applying their unique knowledge and skills on behalf of their clients, members of a profession are granted the freedom to practice and to regulate themselves.¹⁰⁻¹²

Thus for physicians:

*Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.*¹³ (original italics)

Patients who come to health care professionals when they are ill and vulnerable bring with them expectations about this interaction and how clinicians should behave toward them *as health care professionals*, though patients are not always able to articulate those expectations clearly. Patients should be able to trust that their interests and welfare will be placed above those of the health care professional, just as they should be confident they will be treated with respect, and be informed so that they can make their own health care decisions to the greatest extent possible.

Professionals, as such, are held to different standards of conduct from other persons. Relationships and interactions that may be ethically unproblematic among nonprofessionals may be unacceptable when one of the parties is a professional. An individual may have a personal interest that is perfectly acceptable in itself, but that conflicts with an obligation the same individual has *as a health care professional*. For example, under circumstances in which it would normally be acceptable for one person to ask another individual for a date, it may not be acceptable for a physician or other health care professional to ask a *patient* for a date, because doing so might compromise the professional’s fiduciary commitment to the patient’s welfare. The nature of professions is such that “the human needs the professions address and the human relationships peculiar to them ... are sufficiently distinct to warrant, indeed to demand, expectations of a higher morality and a greater commitment to the good of others than in most other human activities.”¹⁴

The clinical relationship is one of both great intimacy and great disparity in power and knowledge, giving rise to special obligations for health care professionals. The American College of

Physicians defines the ethics of the patient-physician relationship in just these terms:

The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians hold and the imbalance of power between physicians and patients.¹⁵

The Ethics of Professional Boundaries

Boundaries, it has been said, "define the professional relationship as fundamentally respectful and protective of the patient and as dedicated to the patient's well-being and best interests."¹⁶ A boundary violation occurs when a health care professional's behavior goes beyond appropriate professional limits. Boundary violations generally arise when the interaction between parties blurs their roles vis-à-vis one another, or creates a "double bind" situation in which a personal interest displaces the professional's primary commitment to the patient's welfare in ways that harm—or appear to harm—the patient or the patient-clinician relationship, or might reasonably be expected to do so.¹⁷⁻¹⁸

The Code of Ethics of the American Nurses Association observes:

The intimate nature of nursing care, the involvement of nurses [in] important and sometimes highly stressful life events, and the mutual dependence of colleagues working in close concert all present the potential for blurring of limits to professional relationships. ... [R]emaining within the bounds established by the purpose of the relationship can be especially difficult in prolonged or long-term relationships. In all encounters, nurses are responsible for retaining their professional boundaries.¹⁹

A variety of standards establish the limits of appropriate professional behavior, whether those limits are explicitly enumerated in standards of conduct, codes of ethics, or law, or tacitly conveyed through professional training and widespread acceptance. Individuals who seek help must rely on the professional they consult to be trustworthy—when clinicians behave in ways that call their professional judgment and objectivity into question, the trust on which the relationship depends is compromised. And when trust is compromised, the efficacy of the therapeutic relationship is adversely affected.²⁰⁻²¹

Boundary violations harm not only individual patients; they carry consequences for others when they erode trust and confidence in the profession more broadly. As the American College of Physicians *Ethics Manual* notes, physicians' obligations to society "parallel their obligations to individual patients. Physicians' conduct as professionals ... should merit the respect of the community."¹⁵ Clear—and scrupulously adhered to—boundaries thus protect health care professionals as well as patients, helping to sustain the public trust on which the freedom to practice rests.

It is important to note that personal and professional interests are not inherently in conflict with one another; in fact, they often coincide. A clinician's personal desire to be compassionate is compatible with his or her professional obligations. It is natural to want to earn money through one's professional activity. That desire becomes problematic only when the personal interest in earning a livelihood interferes with one's commitments and obligations as a health care professional.

Ethical, Legal & Institutional Standards

Standards regarding professional boundaries can be found in a variety of sources. Directly or indirectly, professional codes of ethics, consensus statements, position papers, policies, and laws

define the boundaries of appropriate behavior for health care professionals.²² The Medical Professionalism Project of the American Board of Internal Medicine notes, for example, that medical professionals must exhibit a:

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purposes.¹³ (original italics)

These various codes, consensus statements, and position papers can assist clinicians to maintain boundaries in their professional relationships with patients. Some standards are concrete, setting specific thresholds for professional behavior, often by proscribing particular activities or relationships. For example, the Code of Ethics of the American Medical Association (AMA) expressly prohibits “sexual contact with patients that occurs concurrent with the physician-patient relationship.”²³ Similarly, the American College of Physicians forbids sexual relationships with patients and former patients, arguing that “[t]he intense trust often established between physician and patient may amplify the patient’s vulnerability in a subsequent sexual relationship.”¹⁵ Often, the standards set by professional organizations carry sanctions for professionals who violate acceptable behavior. Thus, for example, the AMA’s Council on Ethical and Judicial Affairs has authority to “censure, suspend or expel an active constituent member from the American Medical Association for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct.”²³

Other standards, however, set out only general values and principles that should guide the professional’s conduct and decision making, and rely on health care professionals to use good judgment in applying those values and principles. Thus, for example, the National Association of Social Workers’ Code of Ethics requires that social workers “not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client” and broadly defines “dual or multiple relationships,” but does not suggest criteria by which professionals should assess the nature or level of risk a particular dual relationship would pose for a client.²⁴ The message implicitly shared by all such documents, however, is that being a professional entails forgoing some interactions or relationships in which one might otherwise wish to engage in order to protect the interests and well-being of clients/patients.

In addition to professional codes of ethics, various legal and regulatory requirements address boundaries in patient-professional interactions.* As employees of the federal government, all VHA clinicians are subject to 5 CFR, Part 2635, “Standards of Ethical Conduct for Employees of the Executive Branch,” and violations can result in disciplinary action, including removal. These provisions are intended to safeguard and foster public trust through the promotion of transparent and ethical behavior. The rules cover the acceptance of gifts (2635.202(a),(d)), prohibited financial interests (2635.402,403), and the use of public office for private gain (2635.702), among other topics. Advice regarding 5 CFR, Part 2635 or the criminal conflicts of interest laws can be obtained from the designated agency ethics official (DAEO) in the Office of General Counsel or from deputy ethics officials in Regional Counsel Offices.

* Ethics and law are not the same. One way to describe the difference is that law is generally geared toward making sure that behavior conforms to a floor of appropriate conduct established by requirements imposed by case law, legislation, and/or regulation. Ethics is generally concerned with defining and promoting what is right and what should be done in relation to broader moral values and that may not be clearly defined by law.

Beyond these specific federal rules, clinicians are subject to guidelines for professional conduct in health care promulgated by state licensing boards. Several state licensing boards, as well as the Federation of State Medical Boards, have addressed specific “boundary” issues,^{5,25-28} for example, “engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual ... [or] behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient.”²⁷ Some state board guidelines offer specific guidance to help clinicians avoid inappropriate conduct, such as recommending that professionals restrict contact with patients to appropriate times and places for the therapy to be given.²⁶ Violations of these guidelines could result in probation, limitation of practice, and suspension or revocation of licensure. Clinicians should be aware, moreover, that inappropriate sexual or physical contact can result in patients suing clinicians for battery and malpractice, and in several states sexual exploitation of a patient is considered a felony.²⁹ VHA clinicians should seek guidance from Regional Counsel Offices or the Office of General Counsel regarding whether and which state laws apply in given circumstances.

Institutional policies are another source of guidance regarding the ethical boundaries of patient-professional relationships. Within VHA, for example, the Black Hills Health Care System directive “Relationships between Employees and Patients, Former Patients, and Patients Families” implemented in 1998 clarifies the conduct expected of all staff and provides specific guidance for addressing instances of inappropriate behavior.³⁰ (Available at <http://vaww.va.gov/vhaethics/download/BlackHills.doc>.)

Examples & Guidance

Many kinds of interaction potentially interfere with the primary clinical relationship between practitioner and patient and pose concerns about acceptable conduct for health care professionals. Becoming socially involved or entering into a business relationship with a patient, for example, can impair, or appear to impair, the professional’s objectivity. Accepting a gift is sometimes an appropriate way to allow a patient to express his or her gratitude, and at other times is problematic. Showing favoritism—by giving a particular patient extra attention, time, or priority in scheduling appointments, for example—can cross the boundary between action that is appropriate advocacy on behalf of a particular patient and action that is unfair to others.^{4,5,16} Such interactions or activities are ethically problematic when they can reasonably be expected to affect the care received by the individual or by other patients or the practitioner’s relationships with his or her colleagues, or when they give the appearance of doing so.³⁰ Yet not all behavior that might be considered inappropriate necessarily violates professional obligations. Although it is frequently difficult to draw bright lines, the examples below help focus the considerations at stake.

Health care professionals should be alert to situations in which they may be likely to be motivated to behave in ways that violate accepted ethical standards. Ambiguous interactions and relationships, for example, have the potential both to impair the professional’s objectivity and compromise his or her judgment,^{5,29,30} and to give rise to conflicting expectations on the patient’s part, which can contaminate the therapeutic relationship and potentially undermine the patient’s trust. Consider the following situation:

- Mr. C works in the billing department of a large medical practice and not long ago began seeing Dr. S, one of the practice physicians and a member of the Resource Committee, as his primary care provider. While seeing Dr. S for a complaint of stress symptoms, Mr. C asks how the review of his application for a new position in his department is going.

An individual who is both employed by a medical practice and is a practice patient might, like Mr. C, fail to distinguish when he is interacting with his physician and when he is interacting with his employer. Moreover, the patient will be expected to share sensitive information with his or her physician that could adversely affect the patient's status as an employee (e.g., problems with alcohol or drugs). The individual may be tempted to withhold potentially clinically important information as a patient in order to protect his or her interests as an employee. The health care professional, meanwhile, faces the difficult task of not allowing information shared in confidence in the clinical relationship to intrude on his or her judgment as an employer trying to run an efficient, profitable office.

Multiple or ambiguous relationships raise other concerns as well. Consider the case of Mr. D and Dr. H:

- Mr. D, an independent contractor, has been Dr. H's patient for three years. During a visit, he overhears Dr. H talking to a colleague about some remodeling for Dr. H's home. Later in the visit he hands Dr. H his business card and tells Dr. H that he will do the remodeling for a great price because he appreciates the care he has received from Dr. H.

The patient's offer of discounted service may contain an implicit *quid pro quo*⁵—Mr. D may now expect Dr. H to provide special services or reduce his fees, for example. An implied *quid pro quo* changes the patient's expectations of the patient-clinician relationship, and puts the clinician's objectivity in question. The patient may perceive that the physician's personal interests can be appealed to for care that is outside accepted professional norms.

The American College of Physicians' *Ethics Manual* recommends that health care professionals who find themselves in dual relationships with their patients should transfer care to another provider.¹⁵ It is not clear that this is always ethically required, however. Nor is it always feasible for a health care professional to bracket his or her interactions with a patient from other interactions he or she may have with the same individual outside the health care setting. While any practitioner may face the challenge of navigating multiple, overlapping, or ambiguous relationships, the problem may be particularly acute for practitioners in small communities, many of whose patients are also the tradespeople, shopkeepers, bankers, or others with whom they must do business regularly.¹⁶ But that does not obviate the professional's responsibility to be sensitive to the ethical concerns at stake and take appropriate action to withdraw from or manage social or other relationships in ways that minimize the possibility of harming patients, interfering with the care of others, or disrupting relationships with colleagues.

Defining what counts as a violation of professional boundaries simply by referring to "dual relationships" or to the *kinds* of relationships between patients and health care professionals (e.g., business or social) may cast the net too widely. Determining whether any given interaction is or is not appropriate behavior for a health care professional calls for careful, critical reflection on the particular circumstances. Consider the following scenario, for example:

- While Dr. T was on rotation in the family medicine clinic, he noticed Ms. L in the waiting room when she came to see his colleague, Dr. M. A couple of weeks later, Dr. T bumped into Ms. L at the grocery store near his home. He'd like to see her again and is thinking of asking her out.

It probably *wouldn't* be a violation of professional boundaries if Dr. T approached Ms. L for a

date. Ms. L is not actually his patient; she was seen by one of his colleagues (albeit at a time when Dr. T himself was seeing patients in the same clinic). There's no reason to think that seeing Dr. T socially would affect the care Ms. L receives in the clinic in the future. And as it happens, she is his neighbor and he might first have met her casually in the market, not the clinic waiting room. The location of their first contact should not determine whether any further relationship would violate Dr. T's obligations to respect professional boundaries.

In other situations, it may be more challenging to decide whether behavior may violate ethical professional boundaries. For example:

- Eighty-five-year-old Mr. W has been a resident of the nursing home for the past seven years and has now been diagnosed with early stage Alzheimer's. Mr. W has no living family. Recognizing that before too much longer he will not be able to manage his own affairs, Mr. W proposes to give Ms. I, a staff nurse who has cared for him for some time, durable power of attorney for health care (DPAHC) and power of attorney over his assets.

The proposed relationship between Mr. W and Ms. I is complicated and seems more likely to be problematic. It could be argued that as Mr. W's long-time caregiver, Ms. I will understand his values and preferences regarding care better than other possible proxies. If she does not, the facility might address the concerns raised by her lack of knowledge by requiring that she and Mr. W explicitly discuss his treatment preferences, in the presence of a witness, before the facility will recognize Ms. I as her patient's DPAHC. Such an arrangement might safeguard Mr. W's interests while at the same time allowing him to give decision-making authority to his preferred proxy. Nonetheless, it would be important to know more about the caregiving relationship Ms. I currently has with her patient, and about Mr. W's capacity to appreciate what it means to assign someone authority to make decisions for him, before one could be confident that this particular proxy relationship did not violate professional boundaries.

Giving Ms. I broader power of attorney would be problematic, however. Although health professionals are not explicitly legally prohibited from holding power of attorney for their patients, doing so can often be inappropriate, or give the appearance of impropriety. Any such proposal should be carefully evaluated in light of its specific circumstances. Most professional standards (e.g., the ANA¹⁹), would prohibit Ms. I from accepting control over her patient's financial matters.

Gift giving between patients and health care professionals* may similarly be inappropriate in some, but not all, circumstances. Scenarios such as the following are not likely to raise ethical concerns:

- Mrs. O's children have been Dr. K's patients for many years. The Os have a cottage several hours from the city where they spend the summers, and where Mrs. O is an avid gardener. At the end of every season when the children come for their "back to school" visits, Mrs. O makes sure to bring flowers and home-grown tomatoes for both Dr. K and the office staff.

Gifts from patients may be problematic if they carry with them an expectation of return favors, or might influence a physician's clinical judgment even when there is no expectation of return. But like

* Here we address only gifts between health care professionals and *patients*. The National Ethics Committee examines gifts to physicians from pharmaceutical companies in a separate report now in preparation.

Mrs. O, many patients wish to express gratitude to their clinicians, and allowing them to do so accords them a measure of empowerment and mutuality in the patient-clinician relationship and can foster greater trust and a stronger clinical bond.

In other situations, however, gifts *are* ethically problematic. For example:

- Dr. M sits on the board of a nonprofit community group that serves inner city adolescents through after school and summer activity programs. Mr. G, a local businessman, has been his patient for some time. When Mr. G comes for a routine visit during the group's annual fund-raising drive, Dr. M asks him for a contribution.

Soliciting a gift in this way takes advantage of Mr. G, who may feel uncomfortable declining a request from his physician, or worry that he won't receive the same attention from Dr. M if he doesn't contribute to the community group. Conversely, clinician gifts to patients may create confusion about roles or engender a sense of obligation on the part of the patient that adversely affects his or her openness in the therapeutic encounter.

Not all gifts are the same (and a gift is not always valued in the same way by giver and recipient), and some can actually benefit the patient-clinician relationship. Thus whether a gift or gift relationship violates ethical professional boundaries should be evaluated on a case-by-case basis. Small gifts of food may be acceptable because they are unlikely to affect a clinician's objectivity or judgment, while larger gifts may do so. It is always the clinician's responsibility to safeguard professional objectivity by being cautious when accepting or giving gifts. For federal employees, accepting even modest gifts may violate standards for ethical conduct. Health care professionals in VHA should be familiar with the gift limits found in 5 CFR, Part 2635, "Standards of Ethical Conduct for Employees of the Executive Branch" and seek specific guidance from their Regional Counsel Offices or the Office of General Counsel as appropriate.

Finally, seeming to "play favorites" by accommodating individual patients in special ways can also raise concerns about ethical professional boundaries. Health care professionals commit themselves to treating all patients fairly. Patients often need more than just clinical care, and it is not necessarily inappropriate for professionals to provide help in other ways. But their actions on behalf of a particular patient must not adversely affect the clinical relationship with that patient or compromise the care available to other patients, or appear to others to do so. Just what activities might constitute a violation of professional boundaries depends very much on the specific context in which such actions take place and their foreseeable likely consequences for others. For example:

- Mr. J is ready to be discharged after hip replacement surgery. His daughter is flying in to help him while he recuperates at home. She's just called to say that her flight has been cancelled and she won't arrive until tomorrow morning. Mr. J's neighbor could stay with him until his daughter arrives, but has no transportation. Mr. K, the social worker, hasn't been able to arrange other transportation. Staffing in the unit is tight tonight, but Mr. K is thinking about driving the patient home himself.

Giving Mr. J a ride home would certainly be a compassionate act, but if it would place additional burdens on other staff, or mean that Mr. K is not available to other patients, it might nonetheless be inappropriate. If Mr. K were regularly to extend the kindness of a ride home to certain of his clients he would be compromising his professional commitment to be fair to *all* of his clients. And even if he behaved identically with each of his individual clients, his conduct might create resentment among patients of Mr. K's colleagues and/or his colleagues themselves and potentially impede the

efficient functioning of the clinic.

Recommendations

Health care professionals should beware of interacting with any patient in ways that could reasonably be expected to create awkward situations for either party, compromise the professional's primary commitment to patient welfare, or call the professional's objectivity into question. While not every business or social interaction or relationship between a health care professional and a patient *necessarily* violates ethical professional boundaries, professionals should critically examine their own actions by considering the following:

- ❖ Is this activity a normal, expected part of practice for members of my profession?
- ❖ Might engaging in this activity compromise my relationship with this patient? With other patients? With my colleagues? With my institution? With the public?
- ❖ Could this activity cause others to question my professional objectivity?
- ❖ Would I want my other patients, other professionals, or the public to know that I engage in such activities?

If the answers to these questions indicate that an activity *may* violate professional ethical boundaries, the health care professional should:

- ❖ Determine if there are applicable standards.
- ❖ Consult a trusted and objective peer for a second opinion about the activity.
- ❖ Seek assistance from a supervisor or ethics committee.
- ❖ Communicate his or her concern to the individual involved.
- ❖ Transfer the patient to another clinician's care if the professional relationship has been compromised, or if avoiding the violation will damage the relationship.

As well, it is imperative that health care professionals be familiar with:

- ❖ Relevant professional codes of ethics, standards of practice, guidelines, and position statements;
- ❖ Applicable policies in their facilities;
- and
- ❖ Laws pertaining to relationships between patients and health care professionals.



Drawing bright lines is possible only with regard to the most egregious transgressions of professional ethical boundaries, and health care professionals must always exercise judgment in their relationships with patients. We have focused on obligations that flow from the notion of "profession," but the analysis offered here seems to us equally relevant to all caregivers, whether they are licensed clinicians or other staff. We trust that the guidance offered here clarifies the values and questions at stake and thus will enable all those who interact with patients to make ethically sound assessments about those interactions in different contexts. Understanding and respecting professional boundaries is part of professional competence. Maintaining those boundaries is an essential part of compassionate, effective, and ethical health care practice.

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