



Minnesota Board of
Physical Therapy

NEWSLETTER

January 2006 - supplement

Professional Boundaries in the Physical Therapist-Patient Relationship

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Misconduct complaints to the Board of Physical Therapy have been relatively few in numbers. Yet when a complaint is filed, the emotional, professional, and economic impact on a licensee can be substantial. Furthermore, many patients who felt offended or harmed by their therapists do not file formal complaints, but simply drop out of treatment. It is not only ethical, but also in the therapist's own interest, to be cognizant of one's interpersonal and practice style that can give rise to problems and complaints. This article is an attempt to discuss these issues within the framework of interpersonal boundaries.

Boundaries are present in many aspects of our daily lives. Speed limits, office hours, dress codes, joke-telling, and eye contact are all examples of boundaries. In interpersonal relationships, boundaries serve to maintain one's identity, protect one's personal space, and allow for harmonious interactions with others. In a professional relationship such as between a patient and his or her P.T., boundaries are rules and limits that are necessary because of the **power differential** that is inherently present in the relationship.

Professional boundaries are essential to protect the patient's comfort level and sense of safety, and to ensure that the patient's best interests always remain the overriding consideration. When professional boundaries are violated, patients may experience confusion, shame, self-doubt, anger, sadness, or mistrust. These patient reactions may vary in intensity, and may harm their ability to effectively participate in other relationships, both professional and personal.

The following are some of the more common boundaries around which problems can occur in the P.T.-patient relationship:

Role. Social roles (e.g., being a parent, a neighbor, a spouse, an employee, a friend, a P.T.) are usually defined by societal expectations regarding how the individual occupying that role would behave. These expectations constitute boundaries. Problems can arise when the P.T.'s definition of his or her role is different from that of the patient or society. For example, some P.T.'s feel that their role encompasses a strong advocacy or counseling component. While their intention may be noble, this expanded role definition can sometimes undermine the effectiveness of their primary P.T. functions.

A dual role relationship is created when the P.T. takes on an additional and significantly different role with the patient. This second role could be social (e.g., friendship), financial (e.g., collaborating on investment

ventures), or business (e.g., employer-employee, or client-attorney). The two roles could be concurrent or sequential. Professional boundaries are at great risk for being violated in a dual role situation because the boundaries for the second role are usually different from those for the professional role. This creates the potential for conflicts of interest. Violations of role boundaries can compromise professional judgment by impairing the objectivity of the P.T. They can also undermine patient welfare by increasing the likelihood of exploitation.

Even in a dual role situation in which the P.T. has taken careful measures to maintain their own objectivity and to avoid exploitation, there is still the risk of public perception of impropriety, which can harm the profession of physical therapy. Recognizing these considerations, the prudent P.T. may elect to avoid socializing with their patients, even though it may not be explicitly prohibited by existing rules. Role boundary violations may be difficult to avoid in some situations, such as when one is the only P.T. in a small community. In such situations, it is the P.T.'s responsibility to establish boundaries and safeguards that help maintain their objectivity and protect the patient from exploitation, and that avoids even the appearance of impropriety.

Physical contact and space. The very nature of physical therapy makes extensive physical contact and intrusion of the patient's physical space unavoidable. While most P.T.s are respectful in how they approach physical contact with a patient, sometimes the P.T. makes the unwarranted assumption that their patient fully understands and consents to the physical contact. "For heaven's sake, they are here for physical therapy. Of course I am going to touch them. What do they expect?" Yet, it is possible that a patient may come in for physical therapy with the expectation that it involves hands-on treatment and physical touching of their body, but still not be comfortable (psychologically) with certain aspects of the physical contact. For example, the location of the body area being handled, the manner in which the physical touch is conducted, and the proximity of the P.T.'s body to the patient, are all variables that can lead some patients to question the appropriateness of the P.T.'s actions. Misperception of the P.T.'s motives can subsequently result. Such misunderstandings can be minimized when the P.T. makes a point of explaining to the patient the how and what of their actions, and taking care to avoid extraneous behaviors (e.g., incidental contact with other parts of the body, questions about the patient's personal life) during the physical contact. In some instances, the strategic placement of a pillow can significantly reduce a patient's emotional discomfort level about their physical space being violated by the close proximity of the P.T.'s body.

Some P.T.s believe that because they are in direct physical contact with intimate parts of their patient's body during an examination, it is not problematic to touch a less intimate area of their patient's body at other times. This reflects a lack of awareness that physical contact is a boundary that changes with the situation and with the purpose of the interaction. Some P.T.s hug their patients indiscriminately, believing that such a show of affection is always good for the patient. This fails to recognize that there are vast individual differences in the level of physical contact with which patients are comfortable. It also makes the unwarranted assumption that all patients will perceive the intent of the hug in the same way. Where physical contact is not part of the examination or treatment but is intended for emotional support (e.g., a gentle pat on the hand or shoulder), the P.T. should weigh the likelihood of therapeutic benefit against potential harm or misunderstanding.

Verbal behavior. The way that a patient is addressed, the language used when interacting with a patient, and how the P.T. discusses a patient's health problems or refers to their physical characteristics, are all examples of boundaries that affect the patient's comfort level and sense of dignity. Even with patients whom the P.T. knows well, it is important to use language that is professional, and for the P.T. to avoid use of slang or other "colorful" language. This can sometimes be challenging when the patient has a limited educational background and limited vocabulary, and in those instances the professional should attempt to use language that is less technical and more likely to be understood by the patient, without resorting to slang.

A good sense of humor can go a long way towards establishing rapport and making the therapy visit more enjoyable for both patient and P.T. However, the P.T. should also be thoughtful about the risks inherent in the use of humor. Many a patient have been offended by a flippant remark or an attempt at humor (perceived by the patient to be at their expense, or as insensitive) by the P.T. Such misunderstandings or inadvertent offenses can be avoided if the P.T. is sensitive and does not make unwarranted presumptions about the patient. When it comes to joking, an useful rule of thumb is: "When in doubt, don't."

A common dilemma faced by P.T.s involves verbal interactions with patients about topics that are unrelated to their health. Given the length of the P.T. visit, it is not unusual for a patient to bring up and discuss aspects of their personal life during their visit. Most P.T.'s have experienced patients who talk on and on about dissatisfaction with their job, money problems, or intimate aspects of their relationship with a significant other. In those situations, most P.T.s listen politely, sometimes with feigned interest. However, the professional boundary is crossed when the P.T. is pulled into an in-depth discussion of their patient's personal life. It is important for the P.T. to resist the temptation to give advice or to judge, or to reciprocate by sharing personal information. In some instances where the patient's excessive talking is actually interfering with the therapy, it is appropriate for the P.T. to set limits, e.g., "this next part of the therapy requires concentration on my part, so I need to ask you to not talk."

Another way that a boundary can be violated is when the P.T. engages in inappropriate self-disclosure about their private life or personal problems. Even when the intention of the P.T. is to promote rapport, such self-disclosure is inconsistent with the professional role of the P.T. It can result in patient discomfort, undermine the P.T.'s credibility or effectiveness, or create confusion for the patient about the kind of relationship they have with their P.T. In addition to monitoring the patient's emotional comfort level in response to one's behavior, one helpful way to maintain this professional boundary is by keeping in mind two questions: "Am I doing this for my patient, or am I doing this for me?" and "What is this (self-disclosure) accomplishing, and is there another way to accomplish it?"

ETHICS AND BOUNDARIES:

An essential resource for any practitioner is the code of ethics for their own profession. For P.T.s, this is listed in the Minnesota Physical Therapy Rules, section 5601.3200 (Code of Ethical Practice) and required by Minnesota Statutes, section 148.66(7). The code of ethics for P.T. is similar to that for most health care professionals, which emphasizes the following principles of modern medical ethics: beneficence, non-malevolence, autonomy, justice, confidentiality, and

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veracity. The reader is encouraged to review the official publication of the Physical Therapy Statutes and Rules for a discussion of these explicit boundaries.

It is important to keep in mind that professional boundaries involve more than explicit rules, laws, and codes of conduct. There are also implicit professional boundaries that reflect our beliefs and assumptions about the nature of healing, professionalism, patient rights and responsibilities, ethical decision making, and the role of risk management. Thus, whereas "engag(ing) in any sexual relationship or activity with any patient, or engage(ing) in any conduct that may reasonably be interpreted by the patient to be sexual, or whether consensual or nonconsensual, while a physical therapist-patient relationship exists" is explicitly prohibited under the Minnesota Physical Therapist Rules (Chapter 5601.3200 Subpart 2.C.), the rules do not directly address the appropriateness of sexual involvement with a "former" patient by a P.T., or social involvement with a current patient. These and many other grey areas require that P.T.s have a clear **internal** sense of proper professional boundaries, since external regulations and codes can rarely be comprehensive enough to clearly proscribe how one should behave in all situations. However, by understanding the spirit and reasoning behind the principles embodied in the code of ethics of one's profession, the professional is better equipped to recognize potentially problematic situations involving patients, as well as to identify the most appropriate course of action to take when presented with ethical dilemmas.

CONCLUDING REMARKS:

Problems can arise when interpersonal boundaries are too loose or permeable, but overly rigid boundaries can be equally problematic by creating unnecessary barriers that harm the relationship. The purpose of professional boundaries is not to create a relationship that is cold, distant, and calculated. That can occur if one applies boundaries rigidly and blindly, without consideration of the context of the relationship or the reason for the boundary in the first place. Some of the key ingredients of a healthy physical therapist-patient relationship include trust, mutual respect, genuine caring, and a large dose of compassion. These are entirely congruent with professional boundaries which serve to protect the comfort level, dignity, and best interests of patients, in a relationship in which they can feel safe from exploitation in any form. You can be friendly towards a patient without expecting them to be your friend. P.T.s can have a "professional" relationship with their patients and at the same time be warm, caring, and compassionate.

A copy of the Minnesota Physical Therapy Practice Act may be printed from the Board website at www.physicaltherapy.state.mn.us by selecting "Legislation" and then opening the PDF file of the "Minnesota Physical Therapy Practice Act."