



Professional Boundaries

Discussion and Cases

A Distance Education Module

Prepared for the College of Optometrists of Ontario

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Introduction

Boundaries are the limits that facilitate an appropriate professional relationship between the optometrist and his or her patient. These boundaries are **always** based on the patient's clinical needs.¹ A boundary violation occurs when the optometrist places his or her needs above the needs of the patient, thus, gaining at the expense of the patient.

Boundary issues within the doctor/patient relationship arise regularly in day-to-day practice, but they may not always be obvious. Boundary issues that become boundary violations usually begin innocently and are frequently thought to be harmless until something goes wrong. Though innocent in its inception, the impact on the patient is the same as if the intent were deliberate. It is **solely** the optometrist's responsibility to maintain and/or restore the boundaries **regardless** of who is pushing them – the patient or the optometrist.

To assist optometrists in better understanding professional boundaries, the following discussion provides information and tools that can be used in day-to-day practice. *Section 1* presents an overview of key principles underlying boundaries, particularly those of professional ethics and the power imbalance inherent in the doctor/patient relationship. *Section 2* offers optometrists a framework to assess whether or not they are approaching a boundary violation with a patient and if so, how to restore the boundaries. *Section 3* presents five case studies that will provide an opportunity to apply the information in the previous sections.

Section 1: Professional Boundaries: An Overview of Key Principles

The Role of Professional Ethics

Professional ethics shapes the professional relationship required between optometrists and their patients. More specifically, professional ethics seeks to ensure that the treatment provided by the optometrist passes the following five “tests”.

The treatment should:

- “Do good”;
- Not cause harm;
- Foster the patient's right to make treatment decisions for him or herself;
- Reflect the commitments that were promised to the patient; and
- Be true to the defined goals of the optometric service.

Professional ethics also defines the inappropriate behaviours to be prevented in the doctor/patient relationship. In doing so, professional ethics begins to put a face to the word “harm”, which is the first step to be considered in preventing inappropriate behaviours. In particular, professional ethics is intended to prevent the *temptation* to:

¹ Peterson, M. (1992) *At Personal Risk*, New York, W. W. Norton & Company.

- Take short cuts;
- Deceive or cheat patients;
- Manipulate patients;
- Treat patients as objects;
- Impose personal bias of what is right, good, fair or just to shape the doctor/patient relationship; and
- Seek financial, physical, emotional or social self-gain (at the expense of the patient).

At first glance, the six behaviours noted above appear to denote purposeful and deliberate actions on the part of the professional. However, as illustrated in **Table 1** below, the same negative behaviours can easily occur innocently. Although unintended, *potentially* the behaviour may cause harm to the patient.

Table 1 – No Harm Intended

With a busy practice you frequently run behind schedule. In an effort to get ahead, you shorten the time spent with patients. Although no harm is intended by doing so, you have:

- Taken a short cut by not giving the patients all the time that they may require.
- Cheated your patients of time to talk about their clinical needs and/or clinical options. That may mean that your patients do not have all the information that they need to make an informed decision and ultimately give an informed consent.
- Deceived your patients as you know that they would have had more time to discuss their clinical needs if it were not for the fact that you were running late. The patients may not be aware that they have a right to a fully informed discussion.
- Manipulated your patients by virtue of the power that you have to control the time allotted and the extent of information provided.
- Treated your patients as objects by hurrying them through the appointment.
- Acted for your own self-gain – that of getting ahead and not running even further behind.

In **Table 1**, if the question is asked, “Whose needs are coming first - yours or your patients’?” the answer becomes your needs at the expense of those of the patients. By shortening the appointment time and perhaps not performing the appropriate procedures or not giving all the information that your patients require to make an informed treatment decision, you have used your power to fulfill your own personal needs. Although your patients may feel rushed, they are vulnerable as they need your expertise and perhaps are reluctant to say anything for fear of losing it all.

This situation can occur because of the *power imbalance* that exists in the doctor/patient relationship and underscores the discipline required by optometrists to maintain the professional relationship between them and their patient.

The Power Imbalance

A power imbalance exists by virtue of the knowledge differential and the trust that a patient places in the optometrist to help him in his time of clinical need. From a preventative perspective, putting a face to the power imbalance is another critical element in helping to maintain the appropriate professional boundaries. This requires that optometrists:

- *Recognize* that the power exists;
- *Understand* the elements of the power; and
- *Accept* that these elements of power create an imbalance within the doctor/patient relationship.

Society grants optometrists the privilege to use their expert knowledge to “do good”. This privilege is enshrined in laws such as the Regulated Health Professions Act, and is supported by institutions, such as the College of Optometrists of Ontario. This privilege is a fundamental element of the optometrist’s power; however, it is not the sole element. Additional elements are highlighted in Table 2.

Table 2 – Elements that give Optometrists their Power

The power imbalance in the doctor/patient relationship is shaped by the following elements:

- The patient’s need for the optometrist’s expert knowledge.
- The optometrist’s access to required clinical resources.
- The patient’s reliance on the optometrist to provide sufficient clinical information so that the patient can make an informed decision.
- The patient’s expectations, both realistic and unrealistic, and the manner in which the optometrist manages these expectations.
- The availability and accessibility of the required optometric services.
- The patient’s personal information shared while the patient knows little, if anything about the optometrist’s personal life.
- The patient’s clinical crisis that, in turn, heightens their trust in the optometrist to do no harm, while significantly increasing the patient’s vulnerability.
- The optometrist’s professional tools of the trade, such as equipment, title, lab coats.

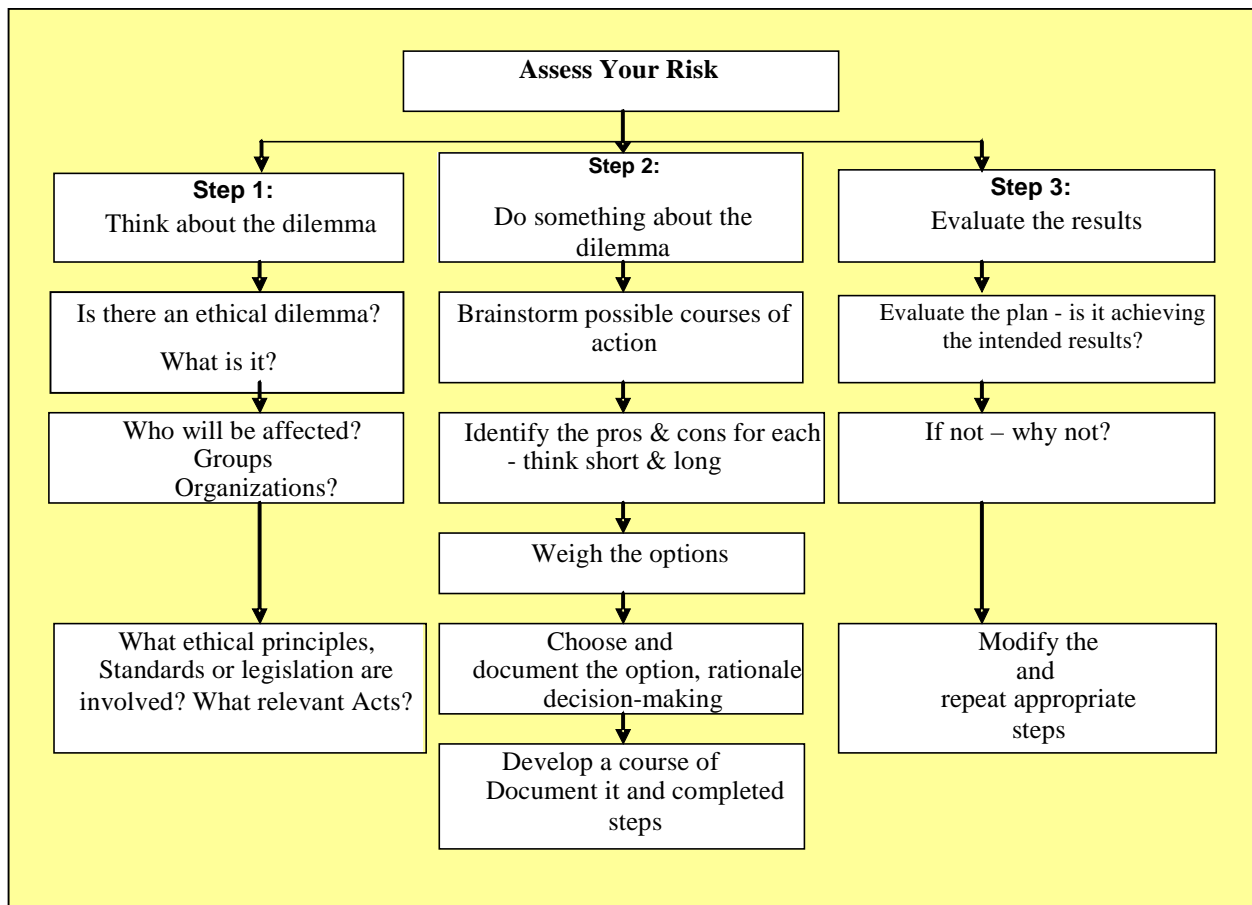
It is incumbent upon the optometrist to manage the relationship and the resulting power imbalance appropriately. To do so, in addition to understanding the dynamics of the power imbalance, optometrists must know their obligations to their College and under other statutes that define the professionals’ role and parameters of service. As an example, the *Guide to the Practice of Optometry* sets out expected professional behaviours such as the obligation to

respect patients’ confidentiality. *The Health Care Consent Act* lays out the components of informed consent to which optometrists must adhere.

Section 2: A Framework for Action

When treating your patients, how do you assess if you are at risk? And what do you do if you are at risk? What happens when there is that uncomfortable feeling that something is not right or the boundaries are being pushed or crossed? The following framework is offered for consideration. For discussion purposes, the framework is divided into two sections, 1) how to assess your risk and 2) the steps to take if you recognize that you are at risk.

Restoring the Boundaries: A Strategic Decision-Making Framework²



² NCA Associates, 2005

Restoring the Boundaries: Assessing Your Risk

To assess your risk, look for the red flags. A red flag alerts you to the fact that your own personal needs are beginning to shape the doctor/patient relationship, rather than the needs of your patient³. Other reflective questions can tease out your level of risk further. The red flags and reflective questions are offered in **Table 3** and **Table 4** below.

Table 3: Red Flags

To help identify your risk, ask yourself the following questions;

- Are you making the patient feel special?
- Are you entering into personal sharing?
- Are you always right?
- Are you making your own rules - that is, you don't like a rule, so you substitute your own?
- Do you have a dual relationship – e.g., being the optometrist and friend?
- Are you burnt-out and/or in high stress situations?
- Did you fail to define your professional role and the parameters of your service with the patient?
- Do you place your ideology before your patients' needs – whether it be a political, religious or other strongly held belief?
- Do you promise on-going availability to your patient, e.g. giving him your home telephone number or email address?

Answering 'yes' to one question may mean that you are on a slippery slope towards boundary violations and that professional care, caution and consultation is required. If you answer 'yes' to *two or more*, applying Steps 1 through 3 of the framework given above is strongly recommended, in addition to consultation throughout.

³ Peterson, M. (1992) *At Personal Risk*, New York, W. W. Norton & Company.

Table 4: Additional Reflections

Tease out your risk further by asking the following questions;

- Whose needs are coming first? In other words, are you gaining at the expense of your patient in any way? Emotionally? Physically? Financially? Socially?
- Did you give your patient all the information that he needs to make an autonomous informed decision?
- Did you take a short cut with your patient?
- Did you “manipulate” the doctor/patient relationship in any way?
- Would you do or say “this” in front of a colleague?
- Would you document “this” in your patient’s file?
- How will others react if “this” is published in the newspaper?
- Does “this” contravene any legislation, or professional standard?
- Are you operating within your professional strengths or professional weakness?
- Does your reason further your ethical obligation to your patient?

Restoring the Boundaries: Steps to Take

You have assessed your boundary risk and determined that further steps may be or are required. The process requires that you **think** about the dilemma, **do** something about it and then **evaluate** whether or not the steps taken are having the intended results. And if the results are not restoring the safe connection, the process recommends that you **repeat** the steps required.

Consultation from the beginning is urged, as you may be too close to the situation to see or recognize all the factors involved. Each step is outlined below.

Step 1: Think about the dilemma.

Outline what occurred and what the problem appears to be. The act of writing may help to crystallize your understanding of the dilemma. Then list only *the facts*. The facts may be slightly different than your outline as it is natural to include assumptions made in the initial writing. Listing the facts helps to clarify the issue further and identifies areas that require further information.

Once the facts are outlined, determine if there, indeed, is a boundary dilemma. If there is, the next step in the process is to determine who is impacted. Think about individuals, groups and organizations. Then identify the practice standards involved. This may require a review of the *Guide to the Practice of Optometry*, other College documents and/or consultation with the

College. In addition, you need to determine if you have obligations under any other legislation, such as the *Highway Traffic Act* or the *Health Care Consent Act*.

Step 2: Do something about the dilemma

After identifying the boundary issue and determining the facts, it is time to do something about it.

Begin the process by brainstorming possible courses of action. Then identify ‘pros’ and ‘cons’ for each option, thinking about short and long-term consequences. Weigh the options using the questions listed in **Table 5** below. Ultimately, you need to choose one of the options. When you do so, document the option and include the rationale for choosing it and the decision-making process you used. Then, develop a course of action to implement your option. Document it and be sure to document the completed steps.

Table 5: Weighing the Options

Weigh each option by asking the following questions;

- Does this option present any risk of harm to my patient?
- Is this option consistent with successful decisions that I’ve taken with similar situations in the past?
- What is my professional purpose for choosing this option?
- If the roles were reversed, how would I feel with this option?
- Are my own values entering into this decision?
- Does this option adhere to the profession’s code of ethics, standards of practice and other relevant documents?
- Does this option conform to applicable legislation?
- Can I explain **why** I took this course of action to my patient, the College, the media and the courts?
- Am I comfortable with this decision?

Step 3: Evaluate the results

The last step is to evaluate your plan. In other words, is it achieving the results that you intended? If it isn’t, repeat the steps of the framework required and modify your course of action appropriately.

Each ethical dilemma may have more than one sound option. Ultimately, you need to determine a course of action. By being clear about what the dilemma is; by developing options and weighing those options carefully, you are being thoughtful and proactive in your practice.

And most importantly, you are placing the patient's clinical needs and rights firmly in the centre of the doctor/patient relationship.

Section 3: Case Studies Sample

Following are five case studies. Read the cases and respond to the questions that go along with each case. A definitive right or wrong answer may not be readily apparent. This underscores the complexity of boundary issues.

To assist you with each question, think of the relationship that exists and the power imbalance. Ask yourself if any harmful or negative professional behaviours are present within the relationship. For example, taking a short cut in the course of treatment at the expense of your patient. Assess the risk in each case study by applying both the red flags and the additional reflective questions provided in the framework for action.

If you choose to participate in this home study continuing education program, complete the answer sheet and return it to the College of Optometrists of Ontario along with your cheque for \$101.70 (\$90 + HST). For out of province participants, the cost is \$113.00 (\$100 + HST). Upon receipt at the College, you will be provided with additional analysis of the cases and comments about the answer options. The College will issue a continuing education certificate for 6 hours for your participation in the program.

Case #1:

A young mother brings in her infant telling you that the baby has teary eyes and that the eyes appear to be larger than normal. The mother appears to be quite distraught, repeatedly saying how worried she is about her baby. You conduct an examination and, as a result, are concerned that the infant may have congenital glaucoma. However, given the fretfulness of the infant, you feel that the only way to obtain a definitive diagnosis is to refer the infant to a facility where the baby could be examined under anaesthesia.

You inform the mother about the congenital glaucoma concern and that the only way to obtain the diagnosis is an assessment under anaesthesia. The mother becomes quite upset as she does not want to put her baby through the ordeal. You spend quite a bit of time talking with her about the procedure and why it is necessary. Reluctantly, she agrees to a referral.

You consider the options of referring the infant to a new general ophthalmologist with only a little experience with children, or to a paediatric ophthalmologist. You want what is best for the baby. So, you choose the option of the paediatric ophthalmologist even though the wait time will be longer. You contact him to discuss your findings and concerns. He agrees to see the baby in six-months.

You provide the mother with the information about the up-coming appointment.

Four months later, the mother calls hysterically. She feels that her daughter's

eyes have deteriorated markedly. She found out from a neighbour that another ophthalmologist in the city could have seen her baby a lot sooner. She demands to know why you didn't tell her about this option.

Questions:

For all questions, choose one answer only.

Question 1: Which one of the following do you think would have the most influence on the mother's consent to refer the baby to an ophthalmologist?

- a) The desire to get the best care for her baby.
- b) Your professional opinion and the reasons for it.
- c) That she had sufficient information to make an informed decision.
- d) That only she can make such an important decision for her baby.

Question 2: What is the purpose of consent?

- a) To give you permission to act in the best interest of the infant.
- b) To "get" consent so that you can document that you did.
- c) To give information so that the mother can make a decision.
- d) To get on with your proposed plan of action, the referral.

Question 3: In choosing the option of the paediatric ophthalmologist, you...

- a) Acted in the best interest of the baby.
- b) Held a "secret" from the mother.
- c) Acted in the best interest of the baby and the mother.
- d) Manipulated the situation to get the referral.

Case # 2:

While attending a fundraising event Dr. X is introduced to another patron, John. It is evident after some pleasant conversation that there is a mutual attraction. Shortly after the fundraiser, John invites Dr. X for dinner and a movie.

A few months later, John's contact lens lodges under his upper eyelid. He contacts his regular optometrist only to be informed that he is out of town. John is given the option of seeing another optometrist whose office is in the same building. He agrees and much to his surprise and delight, the optometrist is the same person whom he met at the fundraising event, Dr. X. Throughout the assessment, John and Dr. X chat amicably and again, it is evident that there is a mutual attraction. In fact, at one point Dr. X teases John about his apparent good physical condition noting that he must work out on a regular basis. Dr. X removes the contact lens and refers John back to his regular optometrist.

A few months later, they go out again for dinner. One day, Dr. X is surprised that the next patient through the door is John. He tells her that he had his records transferred so that she can provide his continuing care.

Questions:

For all questions, choose one answer only.

Question 4: When John presents with the lodged contact lens, Dr. X needs to consider...

- a) Her feelings of attraction to John.
- b) The fact that a dual relationship now exists.
- c) Her responsibility to define the boundary.
- d) John's feeling of attraction to her.

Question 5: Does Dr. X's conduct contravene the *Regulated Health Profession's Act* (RHPA) and the *Health Professions Procedural Code* (the Code) because ...

- a) She dated him before she removed the contact lens?
- b) She saw him as a patient for the removal of the contact lens?
- c) She teases him about his good physique?
- d) She dated him after she saw him for the contact lens?

Question 6: When John appears in her office as her new patient, Dr. X should...

- a) Discharge him so that she can continue to see him?
- b) Accept him as a patient and stop seeing him?
- c) Seek consultation from a respected colleague?
- d) Accept him as a patient and continue to see him?

Case # 3:

You are part of a busy practice with three other optometrists and this morning the waiting room is full, as always. As you are retrieving a patient file from the receptionist's counter, one of your colleagues stops to ask your opinion about a patient, Mrs. Elder. You have treated Mrs. Elder before. Referring to her by name he says that she has an incipient cataract in her left eye and a substantial myopic shift in the other. Already running behind, you hurriedly provide consultation.

Then you call your own patient, Marie. Marie is a new patient and as part of your assessment, you need to obtain a health history. You quickly begin to ask her questions on her general health, previous and present visual concerns, medications and any applicable family history. You move on to the eye examination. In the middle of the exam, you realize that you forgot to ask whether she is taking any birth control pills. When you ask the question, Marie bristles and curtly says no. From that point on, she appears to be visibly annoyed.

You finish your assessment and tell Marie that she is near-sighted and her vision does not meet the requirements for driving without eyeglasses. In an effort to re-establish some form of interpersonal connection and trust, you tell Marie that as long as she obtains the correction that you will prescribe, you will not report her level of vision to the Ministry of Transportation.

Questions:

For all questions, choose one answer only.

Question 7: Did you breach confidentiality when speaking with your colleague about Mrs. Elder?

- a) No, because your colleague needed immediate consultation.
- b) Maybe, but patients always hear this type of thing in waiting rooms.
- c) Yes, because the consultation takes place in the waiting area and was overheard by other patients.
- d) No, because this type of thing happens all the time.

Question 8: Why might Marie have been upset about the question of birth control pills?

- a) She feels that you are prying into her personal life.
- b) She doesn't know whom you will tell.
- c) She doesn't understand why you are asking the question.
- d) She is embarrassed by such a personal question.

Question 9: In telling Marie that you would NOT report her vision if she filled the prescription with you, you ...

- a) Were trying to re-establish rapport and trust with Marie.
- b) Assumed that there will not be any repercussions.
- c) Helped Marie by not having her driver's licence restricted.
- d) Tried to influence Marie.

Case #4:

Actively involved in your community, you sit on a number of community boards, sponsor and coach your children's hockey and soccer teams. A few months ago, you coordinated the food drive, which was the most successful ever. Frequently you get gifts of appreciation from parents of children on the teams or agencies that feel that they have benefited from your community efforts.

Recently you spearheaded a fundraising initiative to build a new community sports centre. The committee worked tirelessly to raise sufficient funds and you would like to see their hard work recognized. So, you contact a patient who is a reporter at the local paper, *Active Community*, and the mayor to tell them about the committee's achievements and to invite them to the up-coming celebration dinner. Both agree to attend.

During the dinner, one of the committee members praises your dedication to the community and your work as a health care professional. The mayor surprises you by giving you the key to the community in a show of appreciation for your exemplary demonstration of true community spirit. Honoured, you accept the gift on behalf of the committee. The newspaper interviews you and takes your picture. The next morning you open the paper to see your picture and the headline, "Community's #1 Optometrist Receives Key to the Community".

Questions:

For all questions, choose one answer only.

Question 10: Are there potential consequences to accepting gifts in your volunteer roles?

- a) No, because it is clear that I am in my non-professional role.
- b) Maybe, because the community may need my professional services at some point.
- c) No, because the community wants to express their gratitude and that's their right.
- d) Yes, because it is a conflict between my professional and non-professional roles.

Question 11: Do you ever stop being the optometrist and simply become a member of the community?

- a) Yes, as soon as I step in to my other roles.
- b) No, because people know me in both roles.
- c) Yes, since I have a right to be just a member of the community.
- d) No, because I am an optometrist first and a member of the community second.

Question 12: What could you have done to prevent the "# 1 Optometrist" headline appearing in the paper?

- a) Not give the interview in the first place.
- b) Be very clear that I am accepting this on behalf of the committee.
- c) Not contacted the paper and the mayor in the first place.
- d) Sought consultation before I contacted the mayor and the paper..

Case # 5:

Jane accompanies her 82-year-old mother, Mrs. Y to visit you for a routine assessment. You know the family well as you have been the family optometrist for a number of years. Jane informs you that her mother was recently diagnosed with Alzheimer's Disease and, at this point is still cognitively aware of her diagnosis. Jane tells her mother that she will wait for her in the waiting room.

In your examination room, you ask Mrs. Y if there have been any problems since her last visit. In a coherent manner, she tells you that she thinks that she bought new glasses and says that she doesn't recall having any problems. Prior to continuing with the assessment, you are called out to take an urgent phone call. Upon your return, you notice that Mrs. Y is having difficulties putting sentences together and is rambling in response to your questions. Always pleasant, today she tells you curtly that your office is untidy and that she doesn't like your shirt.

Despite all of this, you are able to complete your assessment, which reveals cataracts and 20/40 acuity. You tell her that a slight change in her prescription will help a bit. You tell her that the cataracts will likely progress, but that you can't be certain how quickly. Finally, you mention that the condition is borderline and that she could be referred now or that the referral could be delayed. In either event, she would be on a waiting list for some time. Mrs. Y looks at you and says, "Well doctor, what do you think I should do?"

Questions: For all questions, choose one answer only.

Question 13: You would consider a patient capable of giving consent if they...

- a) Say that they want the treatment.
- b) Understand the information relevant to making the decision.
- c) Imply they want the treatment.
- d) Understand the information and the consequences of making the decision or not.

Question 14: If the patient was capable, but you had *some* concerns about their capacity, and you wanted to involve a family member you would...

- a) Simply speak with the family member.
- b) Seek consultation from a colleague.
- c) Not speak with the family member.
- d) Explain to your patient why you would like permission to speak to the family member.

Question 15: When asked the question, "What do you think I should do", you would say...

- a) "I think that you should do..."
- b) "I gave you the options, think about it and make your decision."
- c) "I can't tell you what to do, but if faced with this, I would..."
- d) "That's not my decision to make, so let's talk some more."

Professional Boundaries

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Name: _____

Address: _____

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|-------------|---------|--------------|---------|
| Question 1. | A B C D | Question 9. | A B C D |
| Question 2. | A B C D | Question 10. | A B C D |
| Question 3. | A B C D | Question 11. | A B C D |
| Question 4. | A B C D | Question 12. | A B C D |
| Question 5. | A B C D | Question 13. | A B C D |
| Question 6. | A B C D | Question 14. | A B C D |
| Question 7. | A B C D | Question 15. | A B C D |
| Question 8. | A B C D | | |