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## **BOUNDARY ISSUES**

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As a lawyer, it has always struck me that one of the most difficult tasks especially that psychiatrists must undertake relates to the appropriate management of boundaries within the doctor-patient relationship. From my perspective as counsel, the boundaries often appear to be elastic and involve a consideration of many diverse issues. The concept of boundary management is itself elusive, tied to psychodynamic or “analytic” approach to psychiatry - an approach which may not be relevant to the clinical setting in which the practitioner actually practises medicine.

Boundary crossings can, as I understand it, in some circumstances, be a very effective tool in the doctor-patient relationship. Boundary violations, on the other hand, are deemed inappropriate. In some circumstances, a boundary crossing may become a boundary violation. Sorting these issues out, from a legal perspective, can be very difficult.

A somewhat cursory review of published literature did not identify any thorough statements on appropriate boundary management in the child psychiatrist-patient relationship. I was, however, able to obtain a copy of the American Academy of Pediatrics policy statement on boundary management in the pediatrician family-patient relationship. I attach a copy for review and consideration.

Again, from a non-medical perspective, it strikes me that one of the most problematic areas in this field relates to the fact that children have a very different understanding of boundaries than adults. Their sense of physical and personal space is very different and their desire to be attached/comforted can also be quite different than the adult expectation. Controls may also have to physical, e.g., restraining the hyperactive child. Further, play as a form of therapy may involve a degree of physical closeness that would otherwise be improper. Again, and from a legal perspective, the test of appropriate boundary management would likely be viewed very differently in the context of a complaint from a child than when it is from an adult.

I've attached some other policy statements/guidelines on the issue of patient-physician relationships and the sexual abuse of patients. They are as follows:

1. CMA policy entitled “The Physician-Patient Relationship and the Sexual Abuse of Patients”;
2. Manitoba College statement entitled “Sexuality and the Doctor-Patient Relationship”;  
and

3. article authored by Epstein and Simon entitled “The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy”.

Not attached but also of interest is the article by Gabbard and Nadelson entitled “Professional Boundaries in the Physician-Patient Relationship”: JAMA, 1995, vol. 273 at p. 1445.

In past cases/complaints, a number of allegations have been made which appear to have been the focus of the patient’s anger/hostility/underpinning of the allegation. In many cases, the physician’s conduct was innocent and in no way improper, at least from an ethical point of view. Behaviours which have been the focus of complaint (short of clear boundary violations) include the following:

- limited self-disclosure (giving rise to an inference of personal interest);
- insufficient attention to physical boundaries (pat to the shoulder);
- questions arguably of a personal but non-therapeutic nature (have you had lunch, what did you have for lunch, are you going for lunch);
- overly informal use of language (expletives, slang); and
- inattention (“He was gazing at my breasts”).

When a series of such allegations are strung together, over a number of appointments, it can become very difficult to defend the psychiatrist against an allegation of serious boundary violation. The minor boundary crossing, when combined with an allegation of a boundary violation, add up to an almost insurmountable inference of guilt in the eyes of the College.

From a legal defence perspective, what are the essential ways of protecting oneself against these allegations. In my view, they are as follows.

1. The maintenance of good records. If there are minor “boundary slips”, then these should be documented in the chart.
2. Unusual or surprising comments made by the patient should be clearly documented.
3. The psychiatrist should develop a standard/invariable approach to dealing with certain issues which might arise in the course of the doctor-patient relationship. If the psychiatrist departs from this practice, then the departure should be documented, along with the reason for the departure.
4. The psychiatrist should also have a good understanding of the literature in this area and be able to articulate how and why his practice departs from the standard approach. The psychiatrist should also be familiar with the practice of other people who practise in the same field.

It is also important to observe that the College, in assessing the credibility of the defence, will often look for those boundary crossings which might appear to be outside of the clinical norm.

By way of example, a psychiatrist may meet a patient in the parking lot, either before or after an appointment. The adolescent patient may invite the psychiatrist into his or her automobile. On its face, the psychiatrist's decision to enter the motor vehicle may be innocent enough. In the context of an allegation of sexual impropriety, however, the psychiatrist's acceptance of the invitation would almost certainly lead to an inference of impropriety and thus, a finding of guilt. Certainly, if the psychiatrist were to accept such an invitation, then clear documentation of the event must be inserted into the chart. A failure to document such an encounter would, once again, reinforce the inference of guilt.

In summary on this point, therefore, it is important that psychiatrists are mindful of boundaries at all times. If they are dealing with an inappropriate or sexually aggressive patient, then the psychiatrist needs to document the patient's behaviour and how the behaviour was managed. While an abrupt termination of the psychiatrist-patient relationship may not be clinically indicated, it is also important for the psychiatrist to ensure that his or her own professional interests are not violated and manipulated by the borderline patient. Termination must be considered when the physician's interests are potentially jeopardized. Of course, when this occurred, supervision by another experienced psychiatrist would clearly be helpful in establishing a defence, should an allegation be made.