



Crossing Boundaries Ten Cases and Ten Misconceptions

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Recently, the College had its first boundary crossing case go through the discipline process. Although exceptional for this College, sexual abuse and other forms of boundary crossings are not exceptional among some other health professions. In fact, crossing boundaries is a pervasive problem that can easily ensnare diligent and otherwise ethical practitioners. Even “minor” boundary crossings are risky and can escalate into unprofessional behaviour.

The following ten actual cases identify common misconceptions about the risk of crossing boundaries. These cases caution dietitians to be vigilant in maintaining professional boundaries.

MISCONCEPTION NO. 1: IT IS ALWAYS ABOUT SEX

Boundary crossings can be completely non-sexual. For example, in one anonymous social worker case, the allegations were that the social worker encouraged an elderly vulnerable client, who was in ill health, to sell her home and move into an apartment. The social worker (who was also a real estate agent) offered to sell the client’s home and recommended a number of unsuitable apartments for the client. It was further alleged that the social worker arranged for their own spouse to do work in the client’s new apartment. The social worker then terminated the client’s treatment abruptly, without making adequate efforts to ensure continuity of care.

After learning of the complaint to the College, the social worker sued the client for facilitating the social worker’s wrongful dismissal. The social worker’s side of the story was never heard and the allegations were not determined because the social worker resigned from the profession. However, this case illustrates that entering into a dual

relationship with a client is a form of boundary crossing that is fraught with risk to both the client and the practitioner.

MISCONCEPTION NO. 2: BOUNDARY CROSSINGS JUST HAPPEN

It is extremely rare for sexual abuse to begin suddenly. In almost every case the boundary crossings develop incrementally. For example, in *Venema vs. College of Social Workers and Social Service Workers of Ontario*, the social worker saw the client over decades. During the first course of treatment, Mr. Venema would hug the client and stroke her hair at the end of treatment sessions. There was a gap of thirteen years when they did not see each other. The client returned for treatment, and during that subsequent four-year period, the conduct escalated as follows:

- a) complimenting the client on the client’s body and appearance;
- b) stroking the client’s hair and massaging the client’s back;
- c) engaging in touching and behaviour of a sexual nature during sessions in the social worker’s office;
- d) inappropriately disclosing personal details about his private life to the client and making comments of a sexual (and non-clinical) nature;
- e) meeting with the client outside of the member’s office; and
- f) sexual touching.

This conduct case was particularly concerning because the client had come to the social worker for issues of depression, anxiety, low self-esteem, gambling, alcohol addiction and marital difficulties. This case illustrates the point made by Chuck Palahnuik, the author of the book *Fight Club*, when he said: “Because after you’ve crossed some lines, you just keep crossing them.”

MISCONCEPTION NO. 3: IT WAS DESTINY

Movies portray love as destiny. As Julia Roberts said, “I believe that two people are connected at the heart, and it doesn't matter what you do, or who you are or where you live; there are no boundaries or barriers if two people are destined to be together.” While Hollywood can make good entertainment, it can idealize bad judgment. Destiny does not include crossing boundaries with a client.

For example, in *Melunsky vs. College of Physiotherapists of Ontario*, a female physiotherapist treated a male client. Their personal and sexual relationship did start during the course of treatment. However, treatment was terminated and the couple married. In fact, at the discipline hearing the client/spouse testified that the relationship was a positive one for him and he did not feel that he had been abused. The argument was that the law was interfering with a couple that was meant to be. Despite this testimony, the Discipline Committee found that there had been sexual abuse. The panel accepted that the sexual abuse provisions were designed to protect clients and that it would be impossible for a Discipline Committee to assess, on a case by case basis, whether the relationship had truly been exploitative or abusive. In fact there was expert evidence that over time the client could change his or her understanding of the genesis of the relationship. The finding of the Discipline Committee was upheld by the courts.

An interesting aspect of this case was that the mandatory order of five years revocation was not imposed. However, subsequent court decisions (see the *Leering v. College of Chiropractors* case below) have determined that the mandatory order is defensible because of the need to deter all sexual abuse even if in some cases it is arguably not predatory in nature.

MISCONCEPTION NO. 4: IT IS OK SO LONG AS THERE IS NO POWER IMBALANCE

Some argue that in some professional relationships there is no power imbalance and that a sexual relationship is not abusive when it is consensual. These arguments were certainly made in the *Melunsky* case described above. In that case, expert evidence showed that a practitioner always has inherent power over a client because the client comes to the

practitioner with a health condition or a need and is relying on the judgment and expertise of the practitioner to help.

Discipline Committees routinely reject the argument that there is no power imbalance in some professional/client relationships. For example, in *Khan vs. College of Physicians and Surgeons of Ontario* an emergency room physician practising in Texas (but also registered in Ontario) had a brief (two month) personal and sexual relationship with a patient. The Texas board accepted his argument that he had made a mistake and was remorseful and, in effect, only ordered “probation”.

When the matter came up for discipline in Ontario, Dr. Khan argued that there was no power imbalance as the relationship was consensual and the client had two other physicians who were addressing her mental health issues. The Discipline Committee rejected these arguments. It found that a sexual relationship with a client is “intolerable under any circumstances” and that the consent of the patient did not mean that there was no power imbalance. The Discipline Committee found the fact that the client was receiving treatment for mental health issues reinforced the power imbalance and did not militate against it. Despite the approach taken in Texas, where the conduct occurred, the Discipline Committee revoked Dr. Khan’s registration.

The Ontario legislation starts with the proposition that a sexual relationship with a client is always a violation of the power imbalance.

MISCONCEPTION NO. 5: IT IS OK IF THE PERSONAL RELATIONSHIP COMES FIRST AND TREATMENT SECOND

There is a common misperception that if the personal relationship began first and the treatment relationship followed, there is no sexual abuse. This perception is most common where the practitioner and the client have an established spousal relationship. This “spousal defence” exception has been soundly rejected by Ontario’s highest court, most recently in the case of *Leering v. College of Chiropractors of Ontario*. Dr. Leering met a woman through an online dating website.

Their personal and sexual relationship progressed quickly and within four months they were living together.

About five months after they met, and about a month after they were living together, Dr. Leering began to provide his partner chiropractic services. He did not bill his partner directly; rather he submitted claims to the insurance company for the services. This was after Dr. Leering told his partner that the treatments would be “off-book”. When the money came in, the partner gave the money to Dr. Leering.

A few months later their personal relationship ended badly and Dr. Leering tried to claim the balance of the amount for his services from his former partner. She complained to the College about Dr. Leering trying to collect the money. However, the College was more interested in the fact that Dr. Leering treated her during the time that they were in a personal and sexual relationship. Dr. Leering argued the “spousal exception” defence which was, as noted above, rejected by Ontario’s Court of Appeal.

There is no spousal exception defence. One cannot treat one’s spouse. There is a proposed Bill to modify this rule. However, until the Bill is passed, one cannot treat one’s spouse. In addition, the proposed Bill does not actually permit practitioners to treat their spouses. It simply allows each individual College to make a partial (or full) exception if that College believes it will serve the public interest. Thus, even if the Bill passes, the College would still have to make rules defining in what circumstances, if any, a practitioner can treat his or her spouse (and defining spouses for that purpose – a five month relationship may not qualify).

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The Dr. Leering case illustrates just a few of the complications that arise when one treats immediate family members (or indeed, engage in any form of dual relationships). How can an insurance company be confident in the objectivity and necessity of the treatment? Also, Dr. Leering appeared to demonstrate that his personal feelings towards the client (i.e., former partner) affected his professional decisions towards her

(i.e., determining how much the client owed him for services).

MISCONCEPTION NO. 6: SEXUAL ABUSERS ARE PREDATORS

Quite often sexual abuse flows from practitioners who want to help too much, rather than practitioners who want to take advantage of their clients. For example, in *Bennett-Rilling vs. College of Social Workers and Social Service Workers of Ontario*, social worker Bennett-Rilling provided counselling and psychotherapy services to an adolescent client for anger management issues, substance dependence and abuse, and difficulties with the client’s parents.

However, Bennett-Rilling had sessions with the client outside of her office and outside of regular office hours. For a while Bennett-Rilling allowed the client to stay at her home when the client was released into her care after a court appearance. One night Bennett-Rilling and the client consumed alcohol in Bennett-Rilling’s car while discussing counselling issues (i.e., what had happened earlier in the day between the client and her father). At some point they kissed in a sexual manner. Later that evening Bennett-Rilling failed a breathalyzer test while the client was present. There was no indication that Bennett-Rilling had preyed on her client. Rather, she allowed her desire to help the client to become woefully misguided.

MISCONCEPTION NO. 7: NO ONE IS GOING TO TELL

Where a sexual relationship is consensual and is conducted privately, a practitioner may believe that no one will find out. In *Mizzau v. College of Dental Hygienists of Ontario*, the sexual relationship began while the male client was still being treated by the dental hygienist. They married. Years passed. No one knew that their sexual relationship began during the course of their earlier professional relationship. The marriage failed and the client/spouse then made a complaint to the College. While one can question the motivation for making the complaint then, the fact remained that the practitioner was found to have engaged in sexual abuse and had her registration revoked for a minimum period of five years.

There is no “statute of limitations” on sexual abuse. Complaints and concerns can arise years afterwards and the College will investigate them.

MISCONCEPTION NO. 8: THEY CAN'T PROVE A THING

In *DiNardo vs. College of Chiropractors of Ontario*, a client made a bizarre-sounding allegation that Dr. DiNardo had put his penis on her forehead as she lay on the treatment table. No one else was present in the office. Dr. DiNardo denied the allegation and suggested that the client had misinterpreted his shirt tail as his penis. The Discipline Committee found the client credible and found Dr. DiNardo not to be credible.

A significant reason for finding Dr. DiNardo not to be credible was forensic evidence that demonstrated that Dr. DiNardo had rewritten part of his chart in an attempt to create grounds for doubting the client's story and to establish that the client was a chronic liar. The forensic evidence was established by indentations of a clinical note found on an x-ray made well after the events that matched the clinical note that was supposedly written years earlier at the time of the events.

MISCONCEPTION NO. 9: BEING COMPASSIONATE JUSTIFIES CROSSING BOUNDARIES

Many practitioners defend inappropriate conduct on the basis that they were simply showing compassion to the person. The unstated inference from this explanation is that boundaries are unreasonable rules created by uncaring rule-makers.

For example, in *College of Nurses of Ontario vs. Duval*, nurse Duval worked at a psychiatric facility. He met the client at the facility where the client was being treated for an aspirin overdose. After discharge, the nurse called the client and they became friendly. The extent of the relationship was disputed but it was established that Mr. Duval socialized with the client including attending the client's birthday party and the birthday party of the client's father. While Mr. Duval denied it, the Discipline Committee found that Mr. Duval gave the client a birthday card, attended family functions with the client; slept

with the client and engaged in a sexual romantic relationship with the client involving: kissing, hugging, and holding hands. The Discipline Committee was not prepared to conclude that sexual intercourse had occurred.

Mr. Duval testified that he was a new nurse and that his compassion did not end with his nursing activities. The Discipline Committee rejected that explanation concluding that he clearly breached known professional standards with a vulnerable client. The Discipline Committee imposed a reprimand, an eighteen month suspension and terms, conditions and limitations.

MISCONCEPTION NO. 10: CONCEALING YOUR PROFESSIONAL STATUS REMOVES THE POWER IMBALANCE

A key component of sexual abuse is the misuse of professional status. Professional status gives a health practitioner the power that makes the crossing of the professional boundaries so harmful. However, downplaying or even concealing that professional status will not avoid accountability.

College of Nurses of Ontario v. Lapierre is one of the more bizarre boundary crossing cases on record. Nurse Lapierre treated a psychiatric client for only one shift. The client had been admitted as a result of a suicide attempt by drug overdose. Nine days later, after the client had been discharged, Mr. Lapierre called the client stating that he had met her at a music festival and the client had given him her number. The client agreed to meet with Mr. Lapierre and thought he looked familiar but did not realize, at the time, that he had been her nurse for one shift during her recent admission. Mr. Lapierre told the client that they had been high at the concert, had been attracted to each other and had been kissing. He said that if they had been alone they would have made love. Mr. Lapierre put his hand on hers and asked to kiss her. The client expressed discomfort and asked Mr. Lapierre to leave.

While Mr. Lapierre never identified himself as a nurse, the client later realized who he was. The Discipline Committee found that the conduct was unprofessional even though Mr. Lapierre was not using his professional status (and, indeed, actively concealed it) at the time he approached the client.

Assessing Whether a Boundary Crossing May be Occurring

- ☐ Is this in my client's best interest?
- ☐ Whose needs are being served?
- ☐ Could this action affect my services to the client?
- ☐ Could I tell a colleague about this?
- ☐ Could I tell my spouse about this?
- ☐ Am I treating the client differently?
- ☐ Is this client becoming special to me?

R. Steinecke and CDO, *The Jurisprudence Handbook for Dietitians in Ontario*, (Online Edition 2012) Checklist 10-1, p. 114.

The fact that the professional relationship was transitory and may not even be remembered by the client does not mean that no boundary crossing can occur.

AVOIDING MISCONCEPTIONS ABOUT BOUNDARY CROSSINGS IS A VALUABLE TOOL

These cases illustrate that crossing boundaries, particularly the boundary defined as sexual abuse, often catches diligent,

caring and otherwise professional practitioners by surprise.

Anyone can slip into a pattern of behaviour that can cause harm to clients, others and themselves. Often the circumstances appear in an area of personal vulnerability such as during the breakdown of another relationship, reversals of fortune or arise from a character trait that is otherwise a strength (e.g., a caring nature; a willingness to overlook bureaucratic restrictions for the benefit of clients).

When in doubt, the checklist above, will help dietitians assess whether they are inadvertently crossing a boundary. This checklist is taken from the *Jurisprudence Handbook for Dietitians in Ontario*, Chapter 10, "Boundary Issues" It would be useful to review this entire chapter in light of the above ten cases.

You may also want to think about these quotes:

Boundaries are to protect life, not to limit pleasures.
Edwin Louis Cole

Earth has its boundaries, but human [foolishness] is limitless. Gustave Flaubert

Avoiding misconceptions about boundary crossings is a valuable tool to help dietitians maintain excellence in their focus on client-centred care and to avoid harm.

Communicating a Diagnosis

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The first court decision interpreting the controlled act of communicating a diagnosis has been released. While rendered in the context of massage therapy, it provides some valuable guidance to dietitians.

REVIEWING THE HISTORY

For two decades now, one of the most challenging controlled acts to understand, by both regulators and practitioners, is the first one prohibiting the communication of diagnosis. The precise wording of the provision is:

"Communicating to the individual or his or her personal representative a diagnosis identifying a disease or

disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis." (*Regulated Health Professions Act*, 2 (1)).

There are three components to this prohibition. All three of these components must be present for the conduct to be prohibited:

1. **Communication.** It only covers communications with a client. It does not prohibit a dietitian from forming an impression leading to a diagnosis. It only prevents the dietitian from telling the client of a new or existing diagnosis for which the client is unaware.

