

College of  
Dietitians  
of Ontario



Boundary Guidelines  
for Professional Therapeutic RD-Client Relationships

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## 1. Purpose of the Boundary Guidelines

The *Boundary Guidelines for Professional Therapeutic RD-Client Relationships* (Boundary Guidelines) clarify the laws and principles that RDs must put into practice to maintain professional boundaries with clients. The boundary crossings discussed here are specific to therapeutic RD-client or patient relationships.<sup>1</sup> In this document, the term 'client' means 'patient'.

The Boundary Guidelines are not meant to be overly restrictive for RDs. They are intended to help RDs refine their awareness of boundary crossings and to gain a better understanding of the behaviours leading to boundary crossings that can harm clients or damage the therapeutic RD-client relationship. Although the principles in these guidelines can apply to non-therapeutic RD-Client relationships, for guidance in other areas of dietetic practice, consult the College's [\*Standards and Guidelines for Professional Practice: Conflict of Interest\*](#).



## 2. How to Use the Boundary Guidelines

When thinking about boundary issues, consider contextual factors such as the environment, your motivation and mindset or the motivation and mindset of the client. All of these have an influence on appropriate behaviours and decision-making for setting professional boundaries that best protect the therapeutic RD-client relationship.

Follow these guidelines in conjunction with any other applicable organizational guidelines or policies in your workplace. If there is discord between these guidelines and those established in your workplace, follow the higher standard of the two.

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<sup>1</sup> In matters of sexual abuse, the *Regulated Health Professions Act, 1991* specifically refers to "patients" of health professionals.

### 3. Professional RD-Client Therapeutic Relationship

The purpose of the professional RD-client therapeutic relationship is to provide safe dietetic services to people who need them. The RD-client relationship depends on clearly defined professional boundaries to maintain the mutual trust, integrity and respect essential for quality nutrition care.

In the RD-client therapeutic relationship, there is an inherent imbalance of power; RDs are empowered by the authority they have in the health care system, their professional knowledge and client dependency on the services they provide. They also have access to confidential client information and the ability to influence decisions about client care, which puts clients in a vulnerable position.

Therefore, it is always the RD's responsibility to recognize the inherent power imbalance of the therapeutic relationship and create an environment where clients feel safe. Clearly defined professional boundaries benefit both the RD and the client by ensuring that behaviours, words and actions within the RD-client relationship are always focused on what's best for the client. RDs have a legal responsibility to act in the best interest of clients at all times.

Clearly defined professional boundaries benefit both the RD and the client.

### 4. What is a Boundary Crossing

A boundary crossing is the point at which the RD-client therapeutic relationship changes from professional to personal. It is a breach of the typical limits which define the safe space of the therapeutic relationship.

Boundary crossings can be one-off or cumulative. They can be expected or unexpected, accidental or purposeful. They can be initiated by the RD, clients, both or a third party. They can have little impact on a client or result in a situation that poses a high risk of harm to them. Boundary crossings become problematic when another type of relationship or feeling towards a client interferes with the professional RD-client therapeutic relationship.

Boundary crossings are similar to conflicts of interest, except that the competing interest is a personal feeling rather than another tangible incentive (financial or otherwise). If unchecked, a seemingly insignificant intrusion into a client's personal space can eventually lead to serious boundary violations.

The boundary-crossing may:

- be harmless and not negatively impact the RD-client relationship.
- appear harmless, such as having a cup of coffee with a client, which can unintentionally or intentionally lead to a more problematic boundary crossing if unchecked.

- be purposeful behaviour meant to help a client but results in a brief, thoughtless or inadvertent excursion into a client's personal space that harms the therapeutic relationship.
- be a misuse of power where the RDs is focused on meeting personal needs rather than that of their client. The misuse of power does not have to be intentional to be considered a boundary crossing.

A boundary crossing can have serious consequences for RD-client relations:

- It can damage the trust between an RD and a client.
- It can interfere with an RD's professional judgment to the detriment of the client because the RD values an emotional or other benefit over the client's well-being, or because of fears that inappropriate conduct involving the client will be exposed.
- It can hinder a client's ability to question treatment suggestions.
- It can compromise a client's ability to provide voluntary consent.

## 5. Assess Whether a Boundary Crossing May be Occurring and Manage Accordingly

It is always the RD's responsibility to protect clients by assessing and managing boundaries with vigilance and professional integrity. Boundary crossings frequently begin with good intentions or the desire to help a client. They are not necessarily the result of predatory behaviours, although they can be. Rather, they often begin as small innocuous actions that cumulatively, over time, grow harmful and intrusive.

Typically, the opportunities for boundary crossings present themselves in an RD's area of weakness or vulnerability. For example, an RD with a tendency towards [rescue fantasies](#) may get into trouble with an isolated and depressed teenager, becoming a "friend" in order to help "save" this client.

Learn to identify the early warning signs of boundary crossings.

It is also important to keep in mind that a client can initiate a boundary crossing in good faith, without understanding the boundary or the reason why it exists. It is always the RD's responsibility to recognize the potential for a boundary crossing and to maintain firm professional boundaries with clients.

Boundary crossings can begin with small steps across a line which is hardly noticeable and eventually lead to great harm to clients. Constantly reflect on your RD-Client relationships and be aware of gradual changes that may be happening. Identify the early warning signs of boundary crossings, including:

- Inappropriate emotions: excessive feelings of love or dislike
- Daydreaming about a client
- Discussing personal issues with clients

- Engaging in behaviours that can be interpreted as flirting
- Spending more time than necessary with a particular client
- Meeting a client in a setting which is not professional (a coffee shop, restaurant or a bar)
- Deliberately scheduling early or late appointments for client sessions, when others are likely to not be present and this has not been requested by the client
- Excessive self-disclosure
- Exchanging personal or expensive gifts with a client
- Offering to help a client with something unrelated to the therapeutic treatment
- Providing preferential treatment or arrangements: cancelling appointments with others to see this client, extending credit beyond usual practice or lending money
- Doing something unethical or illegal for a client, such as, providing false receipts or checking the hospital records of the client's relative

RDs are responsible for managing the professional relationship at all times in the best interest of safe, ethical dietetic practice. If you become aware that you have engaged in any of the early warning behaviours described above, stop and reflect on your obligations as a regulated health professional. Refocus your thoughts and intentions on what's best for the RD-client therapeutic relationship. The questions listed in the box will help you assess your feelings. You may also need to seek advice from a trusted colleague or mentor.

### BOUNDARY CHECKLIST

Assessing whether a boundary crossing may be occurring, ask yourself:

- 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/partner about this?
- Am I treating the client differently?
- Is this client becoming special to me?

## 6. Common Categories of Boundary Crossing

### a. Self-Disclosure

While careful and limited disclosure of personal details by an RD can help develop rapport with clients, self-disclosure should be managed with extreme care. Sharing personal details about your private life may confuse clients. They might assume that you want to have more than a professional relationship.

Certain types of self-disclosure by the RD can suggest that the professional relationship is serving a

personal need. It can also result in the RD developing dependency upon the client, which is damaging to the RD-client therapeutic relationship. Self-disclosure by the RD may also be uncomfortable for a client and the client may not object to the self-disclosure for fear of offending the RD and compromising the care relationship.

## b. Accepting or Giving Gifts

A gift to or from a client is potentially dangerous to the professional relationship. A small token of appreciation purchased while on a vacation, given around the holidays, or at the end of treatment may be acceptable. However, gifts do have an emotional component that can change the dynamics of the therapeutic relationship. Receiving or giving gifts may indicate that a personal relationship is developing between an RD and a client. This can cause confusion in the professional relationship.

Use your professional judgment. Asking yourself the questions in the box will help clarify the circumstance, the motives and the mindset — yours or the client's — for accepting and giving gifts. Most of the time it is best to avoid accepting or giving gifts to protect the professional RD-client therapeutic relationship. If an organization has policies regarding accepting or giving gifts to clients, it is recommended that RDs follow them.

### ACCEPTING AND GIVING GIFTS

When accepting or giving a gift, ask yourself:

- Would accepting this gift from my client create a situation or cause a cultural misunderstanding where they felt I was a friend or something more?
- Why do I want to give a gift to this client? Are my reasons client-centered?
- If I give this gift, will the client feel an obligation to give back?
- Am I giving all my clients a gift? If not, why is this one special?

## c. Dual relationships

Dual relationships can blur professional boundaries and interfere with the provision of dietetic care. They occur when an RD has both a professional relationship and a personal relationship with a client, for example, treating a friend, family member or colleague.

### i. Treating Your Relatives and Friends

Although RDs are not prohibited from treating relatives and friends, unless they are romantic partners or spouses (see [Section 7. Sexual Abuse - An Extreme Boundary Violation](#)). It is best to

refer them to another RD whenever possible. If referring them to someone else is not feasible, reflect on what's best for your relative or friend. Be clear about expectations, fees for service and about your professional obligations as an RD. Ask yourself:

1. Do you have the necessary knowledge, skills and judgement to treat this relative or friend?
2. Are you comfortable treating this relative or friend? Will they be comfortable being treated by you?
3. Will you be able to maintain objectivity?
4. Will you be able to maintain confidentiality?
5. If the family member is a child, do you have a good relationship with the child's caregivers, who may also be family members? How will you handle the potentially competing roles of health care provider to both the child and family member?
6. How will you handle disagreements with the client? Will you be able to accept the choices made by the client if you disagree with them?
7. What about the financial arrangements? Are both sides happy with those arrangements? Do you feel pressured to provide services for free or at a reduced rate? How will you deal with payment issues, should they arise?
8. Are you prepared to discontinue services if necessary?
9. Will the family member expect special treatment from you?
10. Will you be able to maintain your professional obligations, regardless of the nature of the relationship, such as complying with all record keeping requirements?

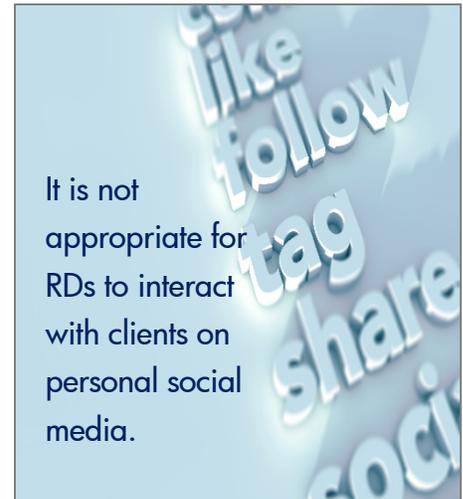
## ii. **Becoming Friends with a Client**

Avoid this dual relationship. Clients should not be placed in the position where they feel they must become a friend of their RD. It may be difficult for clients to communicate that they do not want to be friends. If you become friends with an existing client, many of the complications listed above in "Treating Your Relatives and Friends" will come into play and may negatively interfere with what was otherwise a healthy, professional RD-client therapeutic relationship.

### iii. Interacting with Clients on Email, Telephone or Social Media

Separate your professional from your personal communications via email, telephone and social media. Be mindful that even on the phone or through email, sharing too much personal information may signal the beginning of a friendship. Use the phone or email for friendly but professional communications only. Keep your personal life private.

It is not appropriate for RDs to accept clients as friends on their personal Facebook page or to interact with them on other personal social media sites. Friending, linking or interacting with clients on personal social media would be a boundary crossing and could potentially interfere with the professional RD-Client relationship.



### iv. Personal Relations with a Client's Family

For the same reasons as outlined above, refrain from developing personal relationships or forming friendships with a client's partner or any other family member (e.g. parent, sibling, son/daughter, etc.) while the client is in your care.

### v. Entering into Business Relationships with Clients

Avoid engaging in business-related activities with clients due to the power imbalance that exists between an RD and their client. It would be inappropriate for RDs to take advantage of a client's vulnerability for their own personal benefit. For example, RDs should avoid entering into business-related activities or financial transactions with existing clients (e.g. asking a client for money). Also, be cautious about entering into such relationships with former clients as power imbalances can exist even after the RD-client therapeutic relationship has been discontinued.

Power imbalances can exist even after the RD-client therapeutic relationship has been discontinued.

### vi. Treating Your Romantic Partner or Spouse

It is never permitted to treat a romantic partner, including your spouse. This is considered sexual abuse and is strictly prohibited by law. See [Section 7: Sexual Abuse – An Extreme Boundary Violation](#) for more information.

### vii. Treating Your Boss, Colleague or Employee

Treating a boss, colleague or employee creates a dual relationship that can interfere with both the RD-client therapeutic relationship and the work relationship. An RD may consciously (or unconsciously) provide preferential treatment to such a client and/or their professional judgment may be compromised. As with other dual relationships, such as family or friends, colleagues or employees may not feel comfortable questioning proposed treatments and may not be able to provide informed consent. Although treating your boss, colleague or an employee is not prohibited, it is best to avoid these dual relationships and refer them to another RD or clinic for treatment.

### d. Rescue Fantasies

Most RDs like to help people. A rescue fantasy occurs when an RD's desire to help goes too far. The help goes beyond the RD-client therapeutic relationship, intruding into the client's private life. This boundary crossing is harmful to the client. It fosters dependence on the RD, who may not have the skills or the means necessary to help the client. RDs should always work within their scope of practice and cultivate the autonomy of clients. If a client needs support not related to their nutrition treatment, refer them to an appropriate source for help.

### e. Touching a Client

#### i. Client-initiated touch

In some cases, a client may initiate touch through a hand shake, a pat on the back, or a friendly hug as a thank-you at the conclusion of the RD-client therapeutic relationship. Use caution in such interactions to maintain boundaries in a manner that doesn't embarrass the client or damage rapport.



#### ii. RD-initiated touch

Always ask for consent prior to touching a client. Explain the purpose of the touch in relation to the nutrition assessment/treatment. Consider that the client may view touching differently.

Depending on their culture or past experiences, they may feel touching is an act of encouragement or is necessary for the purpose of delivering nutrition care. Conversely, clients may feel touching is an invasion of their personal space or interpret it as a sexual gesture. Be sensitive to how your touch affects clients.

### iii. Principles for respectful and professional physical encounters with clients

1. Be sensitive to various cultures and their attitudes about touching.
2. Obtain the client's consent before touching, if it is necessary to touch a client while providing care.
3. Acknowledge that the client has the right to change their mind about consenting to procedures, including those that involve touching.
4. Use proper draping techniques, if applicable.
5. Respect the client's personal sense of space.
6. Use firm and gentle pressure when touching the client to give reassurance and produce a relaxed response.
7. Use deliberate and efficient movements which inspire confidence.
8. Understand when to use gloves for reasons relating to infection control and to decrease intimacy.
9. Provide reassurance and explanations throughout the procedure.
10. Constantly check with the client for level of understanding and consent.

### f. Ignoring Established Social, Cultural and Economic Conventions

Dietetic services should always occur in a professional environment appropriate for the services being delivered. Having treatment sessions over a meal at a restaurant or drinks in a bar is a professionally risky activity as it blurs the lines between the professional relationship and friendship.



### g. Starting a Romantic Relationship with a Client

The most extreme boundary crossing is having a romantic or sexual relationship with a client. It is never permitted to have a romantic or sexual relationship with a client. This is considered sexual abuse and is strictly prohibited by law.

## 7. Sexual Abuse – An Extreme Boundary Violation

### a. RHPA Definition of Sexual Abuse

Sexual abuse is an extreme form of boundary violation. In the prohibition against “sexual abuse” found in the *Regulated Health Professions Act, 1991* (RHPA), sexual abuse means any sexual words, gestures or touching between a registered health professional and a client. Under this definition:

1. Sexual abuse involves frank sexual acts, such as sexual intercourse with a client and also includes sexualized banter or other non-touching activities.
2. Consent is irrelevant. Even if the client initiates or willingly participates in the sexual activity, it is still prohibited.
3. Evidence of exploitation is not required. Even when both parties think that they are genuinely in love, sexual relations with a client are never permitted.

The RHPA definition of sexual abuse is very broad including all frank sexual acts, inappropriate touching, gestures, or sexual innuendo of any kind, photos or calendars, jokes or any remark of a sexual nature.

This strict approach is taken to prevent the abuse of the power that health practitioners often have over their clients in a clinical context.

Sexual abuse includes not only sexual intercourse or other forms of physical sexual relations with a client, but any touching, behaviour or remarks of a sexual nature. This definition of sexual abuse prohibits the telling of a joke with sexual undertones or innuendos to or around a client. The definition also includes showing a sexually provocative photo, such as posting a calendar.

## b. Exercise Vigilance

Exercise vigilance to prevent sexual abuse of clients in your practice. Complacency in this area is dangerous for a number of reasons:

### i. Sexual abuse can appear to be "consensual"

The notion of a practitioner physically assaulting a client is only one aspect of sexual abuse in the health professions. Health care providers who "fall in love" with their clients, and who believe that their clients return the feeling and "consent" to the personal relationship, are engaging in sexual abuse. Indeed, client consent is no defence, even if the client vigorously initiates the relationship. Such "consent" is not valid.

Most clients come to an RD because they need their expertise for professional nutrition counselling. This and other circumstances, such as the social status accorded to health professionals, create an imbalance of power between the RD and the client which nullifies any apparent consent from the client to sexual activity.

### ii. The Development of the Sexual Relationship Can Be Incremental

A common pattern of sexual abuse is that the crossing of professional boundaries begins with small steps, such as personal disclosures, and progresses incrementally over time. Typically, the relationship meets an unmet personal need of the health care provider, such as being idealized or loved by another. Afterwards, the practitioner may be as surprised as anyone about what has occurred. Be sensitive to the early warning signs of boundary crossings and be vigilant in preventing them.

## c. No Exceptions for Spouses

There have been several major court challenges to the RHPA regarding sexual abuse asserting that the provisions were "over-sweeping" in nature. In each case, the Ontario Court of Appeal affirmed the validity (including constitutional validity) and societal importance of the provisions.

In [\*Leering v. the College of Chiropractors of Ontario \(2010\)\*](#), for example, the complaint was initiated by the chiropractor's sexual partner after the romantic relationship ended badly. There was no

The determining factor in the ruling was whether there was an ongoing clinical relationship or not. In the Leering case, the chiropractor had clearly provided clinical care and billed for it as treatment. The court held that the definition of "sexual abuse" in the RHPA was clear; there is no spousal exemption.

dispute that the client consented to the sexual activity. In fact, the person first became a sexual partner and developed an established personal relationship with the chiropractor before receiving any treatment.

The Court suggested that incidental care (e.g. the usual domestic support of a spouse undergoing a headache, fever or cold) would likely not make the family member a client. RDs who give the usual sorts of guidance about food and lifestyle choices would not be making their spouse a client simply because the RD was more knowledgeable about those issues.

However, where more than a casual assessment is involved, or where the support becomes ongoing or systematic, then a spouse could well become a client. This would be the case where the RD is replacing what would generally be done by another RD in a clinical setting. For example, if the spouse had diabetes and would ordinarily be seeing a RD for counselling and dietary planning, the family member would become a client if the RD took over that role. However, there likely would not be an RD-client therapeutic relationship where an RD supported a spouse in implementing the treatment plan of the treating RD. RDs should not conclude from the Leering case that as long as one does not create a chart or submit a bill, that the person is not a client. The issue is whether a clinical relationship has developed.

#### **d. Registration Will Be Revoked For At Least Five (5) Years for Frank Acts of Sexual Abuse**

The zero-tolerance provisions for sexual abuse in the RHPA are clear:

1. RDs cannot have sex with a client.
2. RDs cannot treat a sexual partner.

An RD found guilty of sexual activity which involves frank sexual acts with a client, like sexual intercourse, will have their registration revoked for at least five (5) years.

#### **e. Avoid Conduct That Could Be Perceived as Sexual**

1. Not engaging in any sexual behaviour including revealing intimate sexual information, flirting, making sexual-related comments or jokes;
2. Politely but firmly stop clients when they flirt, reveal intimate sexual details, tell sexual jokes, or initiate any sexual or sexual-related behaviour or comments;
3. Document any intimate talk, touch or exposure that is repeatedly initiated by a client or that you otherwise feel should be documented, and record any corrective actions taken;
4. You may have to refer a client who continually flirts or persists making sexual comments despite asking them to stop. Documenting the behaviour (as outlined above) would help

- explain why you are referring that client to someone else;
5. Do not comment on a client's body or sex life;
  6. Never date a client;
  7. Avoid self-disclosure; and
  8. Detect and deflect clients who attach themselves emotionally.

## 8. Having a Romantic Relationship with a Former Client

RDs are not permitted to have a romantic relationship with a former client for a minimum of one (1) year from the date the RD-client therapeutic relationship ended. This period of one year is the minimum requirement, not a maximum.

Following the minimum one year from the date the RD-client therapeutic relationship ended, if thinking about entering into a romantic relationship with a former client, it is advisable to proceed with caution. Consider the following:

1. **The duration of the therapeutic relationship:** A romantic relationship with a former client is more likely to be inappropriate where an RD treated the client over a number of years than a romantic relationship with a client with whom there had been only one consultation.
2. **The client's vulnerability:** The more vulnerable a client is, the more likely it is that having a romantic relationship with them at any point after the end of the one-year period would be an abuse of the power of the RD.
3. **Continuing care for other members of the former client's family:** If an RD continues to care for other members of a client's family, then, the combination of personal and professional relationships may be inappropriate.

Upon reflection, an RD may decide that it would never be appropriate to form a romantic relationship with a former client. A regulated health professional could still be found guilty of disgraceful, dishonourable and unprofessional conduct towards a former client, if that client was abused in any way.

## 9. Boundary Crossing Scenarios

### Hiring a Client

You work for a community agency that serves new immigrant women. You have spent some time assisting Felicia, and she has shared with you some of the terrible things that have happened in her life. You know she has virtually no money. Felicia asks if she could clean your house. In fact, you are looking for a house cleaning service and would be very pleased to pay her. Is there a problem?

There are a number of complications arising from dual relationships and some are illustrated in this scenario. You are being asked to enter into a dual relationship with the client, to be both her RD and her customer. Consider how the following difficulties can occur:

- To a degree, the client would be financially dependent on you. She might feel compelled to follow your treatment recommendations without question for fear of losing the house cleaning income.
- If the client failed to meet your house cleaning expectations, you might have to confront her and perhaps even terminate her services. Such actions could easily have an impact on the dietetic services: the frustration with Felicia might spill over into the therapeutic RD-client relationship and Felicia may not wish to face you as a nutrition client once you discontinue her house cleaning services.
- The client would learn much about your private life and this could interfere with the RD-client therapeutic relationship. The healthy dialogue, the give-and-take of the professional relationship could be affected. Felicia's view of you as a person may change, negatively or positively, and this could distort how she responds to your therapeutic recommendations.

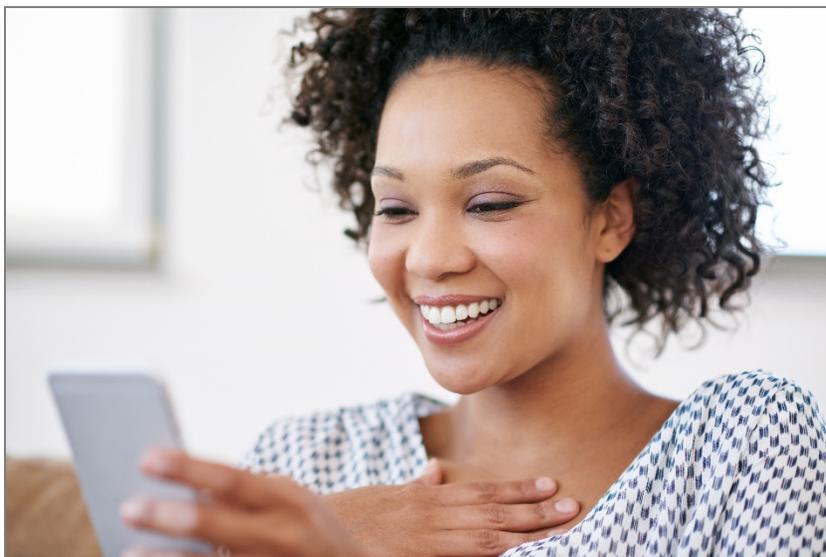


- You could become dependent on Felicia's excellent service and be prone to let it interfere with your professional judgment concerning her clinical care. For example, you may keep her on as a client beyond what is indicated in order to maintain the house cleaning relationship. Or, you may give undue weight to her requests for special or even inappropriate assistance.
- Other clients who find out about the house cleaning arrangement might feel that you are treating Felicia as "special". They might ask for similar consideration and be upset if you say no.

## Social Networking

You have been helping Jennifer through her difficult prenatal period. She was a pleasure to work with. After the birth of her baby, Jennifer updates her Facebook page and sends an invitation to your personal Facebook profile to become her friend. You will be involved for some time still on her postnatal dietetic needs. How should you respond?

Accepting the invitation to be her friend on Facebook from your personal Facebook page would involve you in Jennifer's private life and may characterize your relationship as social as well as professional. The best approach would be to send a polite response of decline or to discuss personally with Jennifer at her next visit, if it is soon, why you cannot accept her "friend" request.



## Treating Family & Friends

You work as the sole RD in a diabetes education program in a rural community. Your uncle has recently been referred to the program. Are you able to treat your uncle to help manage his diabetes?

Providing nutritional counselling for diabetes management to family and friends goes beyond answering their 'simple' questions. When counselling family or friends, a dual relationship is established. Where possible, it's best to avoid this boundary crossing and refer the client to alternate services. This can include telephone/video counselling services, as applicable, when convenient in-person options are unavailable.



Where alternate dietetic services are limited, you may have to determine whether the dual relationship would, in fact, interfere with the type of dietetic services you are being asked to provide to your uncle. You can proceed by putting in some safeguards:

1. Be open, honest and transparent. Have a discussion to acknowledge the dual relationship and explain how dual relationships have the potential to compromise an RD's professional judgment and the ability of clients to question treatment decisions and subsequently provide voluntary consent. Discuss issues where familiarity could compromise the therapeutic relationship. The following issues should be clearly settled before treatments begin:
  - a. How will you handle disagreements if they arise?
  - b. What about the financial arrangements? Are both sides happy with the arrangements? Does your uncle expect the services for free or at a reduced rate? Are you willing to offer the services for free or at a reduced rate? If not, will this create any resentment?
  - c. How will you deal with payment issues, should they arise?

- d. Will your uncle expect special treatment from you?
  - e. Will you be able to maintain your professional obligations, regardless of the nature of the relationship, such as complying with all record-keeping requirements and not practicing beyond your scope of practice?
2. Reassure your uncle that he is free to ask questions to ensure he understands all the information and is comfortable with the treatment plan that is being proposed. Your uncle needs to provide true informed consent and know that he has the right to refuse or withdraw treatment at any time.
  3. Respect confidentiality. Ensure that your uncle understands that all the information collected during the counselling session will be kept private and confidential. Do not divulge that your uncle is seeing you for diabetes management to any other family members.
  4. Maintain professionalism. Conduct yourself in a professional manner during the counselling session. Do not bring up non-relevant information from your uncle's personal life into the therapeutic counselling session. Do not judge your uncle for not following the treatment plan at family gatherings.

In the end, your uncle would have to agree to proceed with the treatment knowing the potential risks of the boundary crossing. You should clearly document the safeguards and discussions that have ensued with your uncle to demonstrate effective management of the dual relationship.

This scenario can apply to any family member or friend asking for your services. Remember that RDs are not permitted to treat their spouse. There is no spousal exception; treating a spouse is considered sexual abuse.

## Conclusion

Boundary crossings can be seen as being on a continuum. Boundary crossings are not always harmful depending on the circumstances, the mindset and the motivations of the parties involved. Often boundary crossings can interfere with the RD-client professional relationship and may have serious consequences (e.g. extreme violations such as sexual abuse).

Identifying boundary crossings and how, in some instances, they may become detrimental to the RD-client therapeutic relationship is essential for RDs to ensure safe and effective client-centred care. RDs have the responsibility to identify when they or their clients are crossing boundaries and take the necessary corrective actions to preserve their professional relationships. Appropriate professional boundaries are important because they provide structure to the therapeutic relationship and ensure that clients can always trust their dietitian.

## Contact the Practice Advisory Service

If you have questions or need any clarifications related to these Boundary Guidelines for RDs, please contact the College's Practice Advisory Service at:

College of Dietitians of Ontario  
5775 Yonge Street, Suite 1810, Box 30, Toronto ON, M2M 4J1  
416-598-1725 / 1-800-668-4990, ext. 397

Or email at: [practiceadvisor@collegeofdietitians.org](mailto:practiceadvisor@collegeofdietitians.org)

## Resources

View these resources at: [www.collegeofdietitians.org](http://www.collegeofdietitians.org). Enter topic or title in the search box.

- "[Managing Professional Relationships, Part 1](#)", Fall 2004, p.1-4.
- "[Managing Professional Relationships, Part 2](#)", Winter 2005, p. 1-4.
- "[Zero Tolerance for Sexual Abuse](#)", Fall 2010, p. 5-8.
- "[Crossing Boundaries Ten Cases and Ten Misconceptions](#)", Fall 2013, p. 8-12.
- "[Boundary Issues](#)", Chapter 10, *Jurisprudence Handbook for Dietitians in Ontario*, 2015.
- "[Professional Communications Online and on Social Media](#)", Winter/Spring 2016, p. 4-7.
- "[Managing the RD-Client Relationship and Professional Boundaries](#)", Fall 2016/Winter 2017, p. 8.

## ADDITIONAL PUBLICATIONS

Health Professions Regulatory Advisory Council. (2008). *A Report to the Minister of Health and Long-Term Care on the Health Profession Regulatory Colleges' Patient Relations Programs*. At: [http://www.hprac.org/en/reports/resources/hprac-patientrelationsreportmay\\_08englishpdf.pdf](http://www.hprac.org/en/reports/resources/hprac-patientrelationsreportmay_08englishpdf.pdf)

McPhedran, M., et al. (2016). *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991*. At: [http://www.health.gov.on.ca/en/common/ministry/publications/reports/sexual\\_health/taskforce\\_prevention\\_of\\_sexual\\_abuse\\_independent\\_report.pdf](http://www.health.gov.on.ca/en/common/ministry/publications/reports/sexual_health/taskforce_prevention_of_sexual_abuse_independent_report.pdf)

Steinecke, R. *A Complete Guide to the Regulated Health Professions Act*. Aurora: Canada Law Book, updated annually. See sections on sexual abuse.