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The Slippery Slope of Boundary Crossings, Part 1

Laura Christensen, MA, LAc, MAc

Every acupuncturist and every health care provider, for that matter, knows it is wrong to have a romantic or sexual relationship with their patients or clients. Our ethics training is clear on this point, and the reasons for this barrier should be obvious to everyone. However, there are many other kinds of boundary dilemmas that occur in our relationships with patients. These dilemmas can roughly be placed on a continuum of "dangerousness to patients," which has been called the slippery slope by some authors.

The Imbalance of Power

In our relationships with patients, we are always an authority figure. We hold the power in the relationship, no matter what we say to ourselves about it. Our patients see us as a person who will hopefully help them, and we have information they do not have. We are seen as holding mysterious abilities that are out of range of what is accessible to the average consumer on their own. Often our patients are desperately ill and have been failed by the health care system many times before; therefore, they place a great deal of expectation on us.

Oftentimes, we have much more education than they do, and because we take money for our service, we are acknowledged as the more powerful one in the relationship. In addition, because we usually use needles to treat clients, we are inherently threatening and thus powerful. Even if patients are not afraid of needles, our treatment is invasive and therefore threatening at a very primal level. Patients make themselves vulnerable to us in many ways: by revealing private health concerns, answering questions about personal things like bowel habits, showing their tongues, lying on a table, disrobing (at least to some degree) and having something done to them - namely, having their bodies pierced or potentially burned or shocked.

Relationship Models

As acupuncturists, we have a different style of relationship with our patients than a medical doctor or a chiropractor would with their patients because we tend to spend more time with the patient at a session. We may be with the patient anywhere from 10 minutes to an hour or more. Obviously, educating, performing moxibustion, setting up electrical stimulators, using auriculotherapy instruments or lasers, or doing bleeding, cupping and massage all take longer than simple needling. This gives more opportunity for building a relationship with the patient through talking and sharing. It also provides more opportunities to get into ethical trouble.

As acupuncturists, we may have a more open relationship with our patient than a psychotherapist, in which every remark made by the clinician and patient is given careful consideration. The psychotherapist, in the most conservative boundary model (such as psychoanalysis), never divulges any personal information. In a more open-boundary model, they may share bits of personal information

to build rapport and socially connect with the patient, or to give an example from their own life that might be useful to the patient in understanding their own challenges.

The therapist must evaluate things such as the ego strength of the patient or the type of transference involved, and attempt to predict the outcome of sharing bits of personal material. In this scenario, an unacceptable boundary violation in the more conservative model may be considered an acceptable, if not positive, boundary crossing in the more open model.

Our relationship with our patients might be more similar to a massage therapist's relationship with a client, in which some dialogue often occurs between therapist and client during a session. There are some acupuncturists who tend to speak very little or not at all during sessions. There are those who only speak to ask questions or educate the patient. Of course, there are those who do not speak the same language as the patient, so chatting is minimal. Then there are those who may have a more social type of relationship with the patient. Some sort of discussion may go on during the placement of needles or while doing other treatments within the session. These conversations may span a great variety of topics, from health concerns and Asian medicine to the personal life and issues of the patient, or even perhaps to the personal life of the acupuncturist.

Additionally, over the course of years and years of treating the same patient, we tend to develop a significant relationship with them, which might develop in many different ways. It might even develop into a friendship. But it is not exactly a friendship like those we have with people who are not our patients. It is still characterized by some of the power dynamics I noted earlier.

I wish to encourage examination of our communication and relationship with patients by giving some scenarios that likely occur during many acupuncture treatments. I believe these types of interaction may lead to ethical challenges that can be a slippery slope if not carefully considered. When relationships with patients become friendships, they have become dual relationships, and this presents special challenges for us. In the scenarios below, the acupuncturist crosses the boundary and shares personally with the patient to varying degrees.

Scenario 1: At a second session of acupuncture, while needles are being placed, a new patient asks if you get acupuncture treatment yourself. Your immediate response is probably to say yes if you do so. You have quickly surmised that your answer may help the new patient understand your profession and your standards of self-care. This boundary crossing has been made with quick consideration of the risks and benefits to the patient. You have not revealed information with which you were uncomfortable. Your patient is probably pleased with your answer. This question may lead to another regarding whom you see for treatment. Another judgment is quickly made, and so on. You might then choose to talk about some of the different approaches to acupuncture among the practitioners you know, as a way of diverting attention from your own health process to an education about acupuncture. You have managed the interaction to share personal information in a way that ultimately has an educational benefit to the patient without going past your area of comfort with personal sharing.

Scenario 2: The patient may ask if you were drawn to the profession because it helped improve your own health. Of course, they will be wondering what your health problems are and possibly whether they bear any similarity to their own. In this case, you might feel a little more uncomfortable with the inquiry, and you must then take a moment to consider the benefit to the patient versus the risk to them of knowing more about your personal health history. You will make a judgment call about the

patient's mental health, the way in which they might use your information, your own comfort with self-disclosure and the potential for harm to the patient from such disclosure.

If you choose to share your personal health history, you will make a consideration about how much information to share. You will be aware that by revealing personal health information, you place yourself more on the same level as the patient, giving up some of your power. They will see you less as an authority figure and more as a normal person with health challenges. You also may have health issues you do not care to have people know about, and this also will color your choice of answer. Many quick assessments will happen as you move toward answering your patient.

In my next article, I'll present a few more tricky scenarios and review the work of Richard Martinez, MD, a forensic psychiatrist who has written extensively on assessing the slippery slope of boundary crossings for health care professionals.

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