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# Professional Boundaries Violations

## Case Studies From a Regulatory Perspective

**Holly R. Fischer, JD; Betsy J. Houchen, MSN, JD, RN;  
Lisa Ferguson-Ramos, JD, RN**

This article provides case studies in professional boundaries violations from a state regulatory perspective. All cases discussed are actual cases that occurred in the state of Ohio, based upon complaints investigated by the Ohio Board of Nursing. The studies set forth basic factual information related to the boundary violation, relevant law and administrative regulations, and disciplinary outcomes. One can conclude that boundaries violations that result in licensure board disciplinary sanctions typically involve gross or egregious conduct rather than subtle or transitional zone conduct. These cases tend to involve recurring patterns that may be categorized as involving 2 factors: (i) high patient vulnerability and (ii) prolonged patient contact. Often, the 2 patterns coalesce. Administrators, directors of nursing, and supervisors in these patient populations and in the settings discussed should be particularly mindful of potential boundary violation behavioral indicators.

**Key words:** *disciplinary action, nurses, professional boundaries violations, prolonged patient contact, vulnerable patients*

[AQ1]

**T**HE TOPIC of professional boundaries is perhaps among the most widely discussed in nursing practice literature, although boundaries violations comprise a very small percentage of disciplinary case. According to a recent analysis of reported state regulatory board disciplinary data compiled by the National Council of Boards of Nursing,<sup>1</sup> approximately 0.24% of reported disciplinary cases involved sexual misconduct (boundaries) and 0.23% involved theft from a client. The Ohio Board of Nursing's experience is similar in that historically, less than 1% of all disciplinary actions taken involve boundaries issues. That being said, boundaries violations continue to provoke public interest, perhaps due to the

profound affect these cases have on both the patient involved and the reputation of the nursing profession in general.

Much of the literature related to professional boundaries focuses on models developed to identify what the "boundary" is and when a healthcare provider has "crossed" a boundary. A professional boundary might be described as an invisible line that provides limits to a professional's behavior that allow for a safe relationship with a patient based on the patient's needs. The National Council of Boards of Nursing describes boundaries in terms of a "Continuum of Professional Behavior":

A zone of helpfulness is the center of the professional behavior continuum. This zone is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client is on the right side of the continuum; this includes boundary crossings, boundary violations and professional sexual misconduct. Under-involvement lies on the left side; this includes distancing, disinterest and neglect, and it

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*From the Ohio Board of Nursing, Columbus.*

*Corresponding author: Holly R. Fischer, JD, Ohio Board of Nursing Executive Director; Ohio Board of Nursing Compliance Unit Manager; Ohio Board of Nursing 17 S. High St, Suite 400 Columbus, OH 43215 (e-mail: hfischer@nursing.ohio.gov).*

can also be detrimental to the client and the nurse. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead, it is a gradual transition or melding.<sup>2</sup>

[AQ2]

Other literature has focused on the behavioral indicators or “red flags” that administrators, directors of nursing, and supervisors might utilize in identifying potential professional boundary violations. Some of these include nurse behavior in which: (i) a disproportionate amount of time is spent with a patient, (ii) the nurse is observed spending time with a patient while “off-duty,” (iii) the patient modifies his or her behavior in anticipation of the nurse’s arrival, for example, by dressing in a certain way, by staying awake to greet a night-shift nurse, (iv) the nurse “swaps” assignments to work with a particular patient, and (v) the nurse is guarded or defensive when questioned about their interactions with the patient.<sup>3</sup>

From a regulatory perspective, most cases involving boundaries violations, on which disciplinary action is taken, do not involve subtleties or shades of gray. From a regulatory standpoint, not only are boundaries violations infrequently reported but also those that are reported and on which action is taken tend to be egregious cases involving rather gross or obvious incidences of misconduct. These cases tend to involve recurring patterns that may be categorized as involving 2 factors: (1) high patient vulnerability, and (2) prolonged patient contact. Often, the 2 patterns coalesce. The violations typically involve either financial or other personal gain at the expense of the patient or sexual misconduct. “High Patient Vulnerability” may be associated with the elderly patient for example, or with any patient who is vulnerable due to other life circumstances that create isolation and dependency (eg, the unwed obstetric patient). “Prolonged patient contact” cases involve settings in which, due to patient care needs, the same nurse is assigned to the same patient over a prolonged period of time, for example, in rehabilitation, renal care, or state correctional institution care settings. The disciplinary out-

come is typically tailored to address the nature of the violation. For example, permanent practice restrictions may be imposed removing the nurse from a particular patient population and/or care setting. The *goal* of this article is to provide an overview, from a state regulatory standpoint, of the major types of boundaries cases observed and concurring disciplinary outcomes. All of the cases reviewed are actual cases that occurred in the State of Ohio and are based on complaints investigated by the Ohio Board of Nursing. The cases are categorized to highlight the 2 primary factors described above.

[AQ3]

### **CASE PATTERN 1: HOME CARE, THE ELDERLY PATIENT AND FINANCIAL OPPORTUNISM**

#### **Nurse A**

From 1997 to 1998, nurse A, RN, was employed by a hospital to work as a home health-care nurse. During the course of her employment, nurse A was responsible for providing care to the patient, an elderly patient who had been diagnosed with congestive heart failure, chronic ulcer disease, hypertension, and diabetes mellitus. During the time that nurse A was providing care for the patient, she disclosed issues regarding her personal life and problems that she was experiencing in her personal life. Nurse A also led patient 1 to believe that she was not only patient 1’s caregiver she was his friend. In addition, nurse A went shopping and out for dinner with the patient and received many items from him, including money, furniture, a television, a cellular phone, and clothing. The value of the items that she received from the patient was in excess of \$4500.00.

*Disciplinary outcome:* The Board found that nurse A violated § 4723.28 (B) (13), Ohio Revised Code (ORC), which authorizes the Board to discipline a nurse who has obtained or attempted to obtain money or anything of value by intentional misrepresentation or material deception in the course of practice and § 4723.28 (B) (19), ORC, for failure to

practice in accordance with acceptable and prevailing standards of safe nursing care.\* Nurse A received probation for a minimum period of 7 years. As a condition of probation, nurse A was required to make restitution to the patient within a 6-month period, participate in individual counseling, complete continuing nursing education (CNE) on professional boundaries, and submit employment reports to the Board. Furthermore, nurse A was *permanently restricted* from practicing in any home healthcare, agency, or private care setting.

#### **Nurse B**

Nurse B, RN, owned and operated a home care agency. In June 2002, nurse B visited an alert and oriented 84-year-old patient for purposes of conducting a posthospitalization assessment. Patient 2 was single, childless, and lived alone. Within 2 weeks of conducting the

assessment, nurse B had obtained power of attorney over patient 2's assets. In July 2002, the patient suffered a stroke. Shortly thereafter, nurse B gained control over some \$150,000 in patient 2's cash and real estate. Patient 2 died. Criminal charges were filed against nurse B. Nurse B testified that before patient 2's death, the patient's wish was that nurse B convert the patient's property into a nursing home facility and that nurse B took patient 2's cash assets so that his niece could not get the cash. In the criminal case, she pled guilty under an "Alford plea," a plea enabling the defendant to stipulate that sufficient evidence for a conviction exists, while maintaining a position of innocence. The court found nurse B guilty of theft from an elderly person, a third degree felony.

*Disciplinary outcome:* The Board found that nurse B violated § 4723.28 (B) (4), ORC, which authorizes the Board to discipline a licensee who has been found guilty of any felony offense. The Board did not find credible nurse B's assertions that the patient had asked her to become involved in the patient's financial affairs. Even had the Board believed this testimony, under Rule 4723-4-06 (L), Ohio Administrative Code, for purposes of reviewing a potential boundaries violation, "the client is always presumed incapable of giving free, full, or informed consent to the behaviors by the nurse." The Board *permanently revoked* Nurse B's license.

#### **Nurse C**

From 1998 to 2000, nurse C, RN, provided care to a diabetic, elderly man who lived alone in a rural area (patient 3). Nurse C met patient 3 after providing home care nursing services to his daughter, who was deceased. Nurse C obtained a power of attorney with respect to patient 3, under which nurse C was to take care of the patient's medical needs, including making decisions regarding nursing home placement. Nurse C adamantly denied that she was patient 3's "nurse" but rather stated that she was merely his power of attorney. However, in an administrative hearing,

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\*At the time of this disciplinary case, the Ohio Board of Nursing did not have administrative regulations in place specifically addressing professional boundary violations. Current regulations, adopted in 1999, are set forth under § 4723-4-06(D), (K), and (L) of the Ohio Administrative Code (OAC). The § 4723-4-06(D) OAC, states that a nurse shall delineate, establish, and maintain professional boundaries with each client. The § 4723-4-06 (K) OAC, states that a nurse shall not engage in behavior that causes or may cause or may reasonably be interpreted as physical, verbal, mental, or emotional abuse to a client. The § 4723-4-06(L) OAC, states that a nurse shall not misappropriate a client's property or engage in behavior to seek or obtain personal gain at the client's expense, engage in behavior that may reasonably be interpreted as behavior to seek or obtain personal gain at the client's expense, engage in behavior that constitutes inappropriate involvement in the client's personal relationships, and engage in behavior that may reasonably be interpreted as inappropriate involvement in the client's personal relationships. Furthermore, the client is always presumed incapable of giving free, full, or informed consent to the nurse's behavior.

nurse C testified that she bought patient 3 food, medication, and medical supplies and checked to make sure he was taking his medication. Nurse C eventually acquired real estate that had belonged to patient 3 and opened bank accounts in her name jointly with him, from which she withdrew cash. Concerned over his well-being, his brothers repeatedly sought assistance from law enforcement. In 2000, deputies arrived at his home to find him frail, extremely thin, without food or medicine, and surrounded by animal feces and filth. Nurse C was convicted, in her fiduciary capacity, of a criminal misdemeanor for failure to provide a functionally impaired person with treatment, care, goods, or services necessary to maintain health or safety.

*Disciplinary outcome:* Without determining that nurse C was actually acting in a professional capacity as a “nurse” to patient 3, the Board found that her criminal misdemeanor conviction involved a crime of “gross immorality or moral turpitude” on the basis of the circumstances of the case. Nurse C violated § 4723.28 (B) (4), ORC, which authorizes the Board to take disciplinary action in any case involving a crime of gross immorality or moral turpitude. The Board *permanently revoked* nurse C’s license.

## **CASE PATTERN 2: THE VULNERABLE PATIENT AND PERSONAL GAIN**

### **Nurse D**

In 2006, Nurse D, RN, had been employed as an obstetrical nurse at a hospital for approximately 16 years. Patient 4 was admitted to Nurse D’s unit when she delivered an infant. Patient 4 was a rape victim and had selected a potential family to adopt her infant. After meeting the potential adoptive family, patient 4 advised nurse D that she did not want to give her infant to the family because of their age and the poor health status of the potential father. Patient 4 and nurse D engaged in a conversation regarding the agency nurse D had used when she adopted her own children and she disclosed the name of the agency to

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patient 4. During the conversation, patient 4 asked her whether she would adopt her baby. Thereafter, nurse D gave the contact information for her adoption agency to a resident physician to give to patient 4. There was a delay in the resident relaying the information so nurse D gave the information to patient 4 directly. Patient 4 was transferred to another unit and nurse D visited her after the nurse had clocked out for the day. Patient 4 had already contacted nurse D’s adoption agency. Patient 4 was discharged the following day. Prior to her discharge, social services staff did not have an opportunity to meet with patient 4, which was contrary to hospital policy.

Nurse D reported that after she made arrangements to adopt patient 4’s infant, she was questioned by hospital administration. Nurse D advised that she would not adopt the infant if she would lose her job. Nurse D was not instructed to stop the adoption process. Nurse D’s employer gave her a written corrective action plan to attend a mandatory in-service, to specifically follow the hospital adoption policy, and to contact her manager if unusual situations occur on the unit. During the investigation, information was provided to the Board indicating that nurse D had engaged in similar conduct at the same hospital when she adopted her other children. However, there was no record that nurse D was disciplined and/or advised that this conduct was inappropriate or a violation of hospital policy.

*Disciplinary outcome:* In a settlement agreement, nurse D admitted to the Board that she understood that her conduct was a violation of nurse/patient boundaries. Nurse D’s conduct would have violated professional boundaries whether she made the adoption arrangements independently or through another party. Specifically nurse D violated § 4723.28 (B) (31), ORC, for failure to establish and maintain professional boundaries with a patient and Rule 4723-4-06 (L), Ohio Administrative Code (see footnote).

Nurse D’s license was suspended and subsequently reinstated subject to probationary conditions including permanent practice restrictions on her employment: Nurse D

agreed never to practice in unsupervised settings, including agency work or home care or in obstetrical employment, other than in her position with her current employer.

#### **Nurse E**

In 2005, Nurse E, RN, worked in an obstetrical unit at a local hospital. Patient 5, a young, unwed mother, gave birth in Nurse E's Unit. Nurse E learned that the patient was interested in placing the baby for adoption. Rather than following the hospital's adoption policy (entitled *Avoiding Conflicts of Interest in Adoption*), Nurse E contacted a personal acquaintance and told her of an opportunity to adopt the baby. Within 12 hours of birth, Nurse E's friend met with patient 5 at the hospital, and 2 weeks later, her baby was discharged from the hospital with Nurse E's friend.

*Disciplinary outcome:* In a settlement agreement, Nurse E admitted to the Board that she understood that her conduct was a violation of nurse/patient boundaries. Nurse E was placed on probation for a period of 2 years, agreed to CNE in Professional Boundaries and Ethics/Professionalism, employer reporting, and permanent practice restrictions: Nurse E agreed never to practice in unsupervised settings, including agency work or home care, unless the position was approved in advance by the Board.

#### **Nurse F**

Nurse F, LPN, worked as a home care agency nurse. Patient 6, an infant, was born prematurely with multiple medical problems in 2003, including short bowel syndrome and hydrocephalus. Patient 6's mother was young and single (the father was incarcerated) and the mother also had a toddler in the home to care for. Nurse F was assigned to provide home nursing care to patient 6, who required Broviac care and IV antibiotic administration. Despite the care needs of patient 6, nurse F took on the case without disclosing to patient 6's mother that she was not certified in IV care. In addition to providing nursing care,

in an administrative hearing, nurse F testified that she began to babysit both patient 6 and his sibling as a "free and personal service" to patient 6's mother. Nurse F testified that at times, she took patient 6 into her personal residence to baby sit him as respite care for the mother, whom nurse F described as being overwhelmed. Nurse F submitted bills for providing 24-hour nursing care to patient 6. In 2004, when patient 6 was hospitalized, nurse F stated on hospital medical forms that she was the patient's "Guardian." Nurse F verbally advised hospital staff that she was patient 6's foster parent. In 2005, county children's services ordered that patient 6 be placed in foster care and ordered nurse F not to be present in any home of patient 6 or in his presence.

*Disciplinary outcome:* Nurse F's license to practice was permanently revoked.

### **Case Pattern 3: Vulnerable Patient, Prolonged Contact, and Sexual Misconduct**

#### **Nurse G (Part 1)**

In 2000, nurse G, RN, worked as a nurse in a psychiatric unit of a state correctional institution. In this setting, nurse G had prolonged contact with inmates and engaged them in recreational activities (eg, playing cards). Nurse G was investigated by the correctional facility for developing a sexual relationship with an inmate. The relationship allegedly involved nurse G exchanging sexual fantasies with the inmate, an incidence of touching, and mutual discussion of sexual experiences.

*Disciplinary Outcome:* Nurse G voluntarily underwent a professional evaluation and in 2004, entered into a settlement agreement with the Board in which she agreed to a 3-year probation and work restriction including not working with psychiatric patients or in correctional settings.

#### **Nurse G (Part II)**

In 2005, nurse G, while on probation with the Board, worked at a rehabilitation facility.

Nurse G allegedly developed a sexual relationship with a male residential patient. The patient, who was being treated for chemical dependency, alleged that nurse G had taken him to her home, had sex with him, and used drugs with him.

*Disciplinary outcome:* Nurse G was ordered by the Board to a professional evaluation. In 2006, based on the outcome of the evaluation, nurse G entered into a settlement agreement with the Board placing her on an additional 3-year probation, continuing psychotherapy, and a 5-year *practice restriction*, during which time she is prohibited from working in any correctional setting or in any setting where there are adult male patients under the age of 65 years. Nurse G was later suspended for violation of the terms and conditions of the settlement agreement.

#### **Nurse H**

In 2006, the Board issued a notice of opportunity for hearing to nurse H, RN. The notice alleged that in 2003, while working as a nurse in a correctional institution, nurse H accepted approximately 80 telephone calls from an inmate at her personal residence, engaged in sexual conversation with the inmate, and assisted the inmate in researching his criminal case. This case has not been finally adjudicated by the Board.

#### **Nurse I**

From 1996 to 1997, nurse I, RN, was employed at a renal treatment center and provided dialysis care over a period of time to a patient. Nurse I admitted violating professional boundaries on the basis of her relationship with the patient.

*Disciplinary outcome:* Nurse I entered into a settlement agreement with the Board in which her license was *reprimanded*; she agreed to obtain professional counseling and provide treatment reports to the Board, take CNE in professional boundaries/ethics, and provide employer work reports for a period of 1 year.

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#### **Nurse J**

In 2002, Nurse J, LPN, while working in a nursing home was observed engaging in sexual conduct/inappropriate touching with patient 7, who was housed in a locked psychiatric unit and diagnosed with schizophrenia.

*Disciplinary outcome:* Nurse J's license was permanently revoked.

#### **Nurse K**

In 2000, Nurse K, LPN, while working in residential chemical dependency treatment facility, engaged in seductive conversations with patient 8 and requested that the patient call him at a personal telephone number. At one point nurse K conducted a bed check and became sexually aroused in her presence. Patient 8 at first described herself as being flattered by the attention but developed increased anxiety due to nurse K's behavior.

*Disciplinary Outcome:* Nurse K's license was *suspended indefinitely* by a 2003 settlement agreement, under which Nurse K also agreed to *permanent practice restrictions*, prohibiting him from working in settings with psychiatric or chemically dependent clients. In 2005, Nurse K's license was reinstated, with additional permanent practice restrictions including no agency work or home care and a 3-year *probation*.

### **CONCLUSIONS**

The Ohio Board of Nursing licenses more than 200,000 nurses and investigates approximately 4000 complaints annually, making it one of the largest nursing regulatory boards in the United States. In this context, professional boundaries cases represent less than 1% of all complaints filed with the Board of Nursing. The majority of boundaries cases adjudicated by the Board do not represent situations in which a nurse may be uncertain whether the conduct involved is located in a transitional or uncertain zone between under or

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over involvement. Rather, as depicted in the case summaries provided, most of the boundaries violations that result in Board sanctions can fairly be described as egregious in nature with commensurate disciplinary outcomes. Although exceptions exist, the cases typically involve patterns in which the patient is particularly vulnerable and/or the care setting involves prolonged nurse contact with the patient.

Administrators, directors of nursing, and supervisors who work in the settings and with the populations discussed might be particularly mindful of behavioral indicators or red flags that occur when patient vulnerability and prolonged patient contact converge, for example, in geriatric or pediatric home care, obstetric units, correctional institutions, renal care centers rehabilitation, and psychiatric treatment centers.

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[AQ4]

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[AQ5]

**Title:** Professional Boundaries Violations: Case Studies From a Regulatory Perspective

**Authors:** Holly R. Fischer, Betsy J. Houchen, and Lisa Ferguson-Ramos

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