Keywords: Professional boundaries/ Objectivity/Sharing experiences/ Narrative
●**This article has been double-blind peer reviewed**

Professional boundaries between nurses and their patients and relatives can be blurred. Narratives can help us reflect on where these boundaries lie in practice

PATIENT NARRATIVES: PART 6 OF 7

Defining patient-nurse boundaries

In this article...

- Defining professional boundaries
- How nurse narratives can be used to explore these boundaries
- Why boundaries may differ depending on circumstances

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Abstract Barrow R et al (2016) Patient narratives 6: Defining patient–nurse boundaries. *Nursing Times;* 112: 16, 18-19. This series exploring how narratives can be used to reflect on practice has focused on patient narratives. This sixth article uses nurse narratives to explore professional boundaries between patients and nurses. These can be difficult to negotiate and can depend on individual circumstances: what may be appropriate in one situation may be unacceptable in another.

Professional boundaries between patients and nurses can often be difficult to set. One nurse's story is used here to explore where we set boundaries with our patients. It illustrates how our professional reflection on care can be very different to our patients' perceptions.

The story is set in a hospice and involves the care of a patient at the end of her life. Her family was happy with the care they received and found it supportive and compassionate. However, the nurse's reflection raises interesting questions about where we fix professional boundaries in our relationships with those in our care. It is evident from the story that it is important to consider the patient's voice but also the nurse's experience when reflecting on care.

Read the nurse's narrative in Box 1 and consider the following reflection points.

Reflection points

In this narrative the nurse decided to share an experience of grief with a patient's daughter in the last hours of life. This included physical touch such as holding hands, hugging and shedding tears. Think of a time when you have become personally engaged with a patient and shared an experience. Can you explain why you did this?

The Code (Nursing and Midwifery Council, 2015) makes four statements that could be seen to support this nurse's actions:

- You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure their dignity is preserved and their needs are recognised, assessed and responded to;
- Treat people with kindness, respect and compassion;
- Recognise when people are anxious or in distress and respond compassionately and politely;
- Recognise and respond compassionately to the needs of those who are in the last few days and hours of life.

On the other hand, another statement in the Code challenges the nurse's actions:

- Stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.

Where do you stand on this apparent dilemma? Do you believe sharing grief is meeting the need of a patient/relative, or is it crossing a line of objectivity and professionalism? Think of a time when your own

Talking points

1. **Should nurses engage emotionally with patients?**
2. **Is it possible for a caring nurse to be totally objective?**
3. **How much physical contact should nurses have with patients?**
4. **Should nurses ever share information about themselves with patients?**
5. **Is it ever appropriate to cry with a patient or relative?**

Should nurses use or avoid physical contact when comforting patients?

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BOX 1. THE NURSE'S NARRATIVE

Grace Booth* was admitted to the hospice so her pain and nausea could be controlled. She talked about herself and how, until a few weeks previously, she had been a volunteer in a healthcare setting where I had previously worked. I acknowledged that I was aware of her contribution as a volunteer and, over the following days, we spent time reminiscing about people we both knew and how, over the course of her involvement in the NHS and my 20-year career, nursing and the NHS had changed.

Mrs Booth talked about her husband to her daughter. He had previously been cared for and died at the hospice and she stated that the hospice was her preferred place of care at the end of her life. I was able to talk about Mr Booth as I had known him. In hospice care we often get to know the family personally as we see them over a long period of time. I knew this family quite well and they knew about my family and other personal details.

Mrs Booth's condition rapidly deteriorated and early on a Saturday morning at the start of my shift, I had to call her daughter, Jenny*, to tell her that this was the case. Understandably she was very distressed and arrived at the hospice alone as other family members, who lived some distance away, had returned home a few days before.

I met her at the entrance to the unit and escorted her to the family room to explain the events of that morning and reassured her that I and another member of staff had been with Mrs Booth throughout. She was extremely anxious and frightened, and unsure about seeing her mother. I said I would go in with her if she wanted, but made clear that it was entirely her decision. She said that would help and we entered the room. Over the next couple of hours, she recalled memories and stories of their life and their mother–daughter relationship.

As is often the case when people are by the side of a relative approaching the end of life, this is done with tears and smiles. I hugged Jenny and held her hand. I felt I was there as a "replacement" for family as she was alone. Throughout this time, I took care not to intrude on Jenny's time with her mother and took cues from her body language. I asked her, at intervals, whether she would like to be alone but she said she wanted me to stay with her. Mrs Booth died peacefully with her daughter by her side, holding her hand.

*The patient's and relative's names have been changed.

actions might be seen to cross this line. Do you think those actions can be justified?

Patient fear and grief are common experiences in the working lives of nurses. How should we respond to these experiences?

It is useful to read the personal stories in the Francis (2013) report, which include many examples of good practice. These are used by the storytellers as points of comparison for the stories of abuse and neglect; many include acts of emotional connection. These could be interpreted as "unprofessional" and yet these actions are sometimes the things patients remember. For example, patients often remember the nurse who held their hand when they were afraid or in pain, who chatted about family after visiting times or appeared to be concerned about them (Francis, 2013).

Think about the last patient with whom you worked. What do you think they might remember about your nursing care? Would they conclude that you are a caring nurse?

Think about each of the following actions and reflect on whether or not you consider them to be appropriate behaviours when nurses are interacting with a patient:

- Holding hands;
- Sharing personal family details. This might include showing pictures of your own children if patients show you pictures of their family. It might be talking about your holiday if that is what a patient wishes to talk about;
- Hugging a patient;
- Being tearful if a patient is upset.

Examples from other fields of nursing

The theme discussed in this article applies to all fields of nursing. Below are some examples that make similar points:

- A community mental health nurse was doing a home visit with a client who had severe depression. The client's son had recently got married and she was showing the nurse photographs of the wedding. The nurse's son had also got married within the last year and she had a photo of the wedding in her diary. She shared it with client and told her a bit about her son's job, family and house. Have you ever done something similar? Do you feel this is appropriate?
- Grace Chandler* was admitted to the ward following a diagnosis of an aggressive cerebral tumour. As her husband visited every day, the nurses got to know him. He had very little support from his family so he valued the care from the ward staff. When Mrs Chandler died her husband thanked the staff for their support and kindness. In the following weeks he visited every day and brought gifts to say thank you. Initially the staff would offer him a coffee and some time to chat. However, his visits continued for the next month and staff began to feel compromised. While they felt it was appropriate (and indeed a privilege) to care for both Mrs Chandler and her husband, the continued support of her husband appeared to cross over the professional boundaries and responsibilities of staff. They discussed whether they should ask him to stop visiting but felt uneasy about this. How could they bring it to an end knowing that he would be both distressed and saddened?

Conclusion

Nurses are often required to be close to patients and their families in very emotionally charged situations. Patients and relatives may be experiencing grief, fear, pain and confusion. The nurse may be the closest support available to them. The nurse's professional requirements are for objectivity and clear boundaries while the human requirements are for empathy and sympathy. As professionals, we should ensure we are conscious of our own personal boundaries; we should be able to give fully considered reasons for all of our behaviour and actions. **NT**

- *The patients' names have been changed

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