Clear sexual boundaries between healthcare professionals and patients: **guidance for fitness to practise panels**

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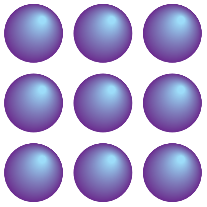

council for healthcare regulatory excellence

The Council for Healthcare Regulatory Excellence (CHRE) is the organisation that oversees the nine regulators of healthcare professionals in the UK. Our primary purpose is to promote the health, safety and wellbeing of patients and other members of the public. More information about our work can be found at www.chre.org.uk

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Other documents produced by the Clear Sexual Boundaries Project:

- *Learning about sexual boundaries between healthcare professionals and patients: a report on education and training*
- *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals*

These documents are available from the Council for Healthcare Regulatory Excellence, www.chre.org.uk

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Contents

1 Introduction

Despite a number of high profile inquiries, including Ayling, Kerr-Haslam and Peter Green[1], regulators continue to receive allegations of sexual misconduct towards patients or their carers on the part of healthcare professionals. Complainants in these cases are often young, suffer from mental health problems, have relationship problems or are otherwise vulnerable. It is important that fitness to practise (FtP) panel members are adequately informed about this subject so that they can fulfil their public protection function.

Accordingly, as part of its project on clear sexual boundaries between healthcare professional and patients, the Council for Healthcare Regulatory Excellence (CHRE) has developed this guidance to inform regulatory bodies' FtP panel members of the nature and effects of sexual boundary transgressions by healthcare professionals.

The contents of this document are intended to provide some background information about boundary breaches and to provide possible indicative content for training of FtP panel members, intended to supplement or support existing training arrangements that regulators have in place. These materials and exercises can be adapted to make them relevant for different healthcare professions.

In order to provide an evidence base for its recommendations, CHRE commissioned an overview of the sexual boundaries literature regarding healthcare professionals and patients between 1970 and 2006[2], the key findings of which are reproduced at Appendix A. Research indicates that harm resulting to patients from serious boundary transgressions can be extensive and long-lasting. Sexual boundary transgressions by healthcare professionals diminish confidence in regulated professionals.

FtP panels need to be aware of certain critical factors when adjudicating cases involving sexual boundary breaches. These include the following:

- sexual boundary breaches commonly involve vulnerable people
- healthcare professionals who breach sexual boundaries tend to abuse more than one patient, and use strategies such as minimisation, normalisation and denial when challenged about their behaviour
- contrary to stereotypes, healthcare professionals who abuse patients may be personable and charismatic, highly regarded by their colleagues and held in high esteem by other patients
- confusion about boundaries can impair clinical judgement
- patients themselves may have a poor sense of appropriate boundaries. Setting boundaries is important for the protection of the professional as well as the safety of the patient.

This document attempts to provide materials in a form that can be flexibly and easily adapted for training purposes by regulators. Further education and training materials, along with more information on this subject, can be found in *Learning about boundaries: a report on education and training*, available from the CHRE website (www.chre.org.uk).

Section 2 of this document explains the importance of healthcare professionals setting and maintaining clear sexual boundaries. Section 3 considers factors which FtP panel members need to be aware of when deciding cases involving allegations of boundary breaches. Sections 4 and 5 provide some guidance on the content of training and some sample training materials and exercises.

Definition of terms used in this document

Patient: a person who receives care or treatment from a healthcare professional. This guidance also applies to **carers** and others who are close to patients and who are part of their clinical experience, for example a parent who accompanies their child to hospital.

Sexualised behaviour: acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires. Examples of sexualised behaviour are listed at Appendix B.

[1] Committee of Inquiry: Independent Investigation into How the NHS Handled Allegations about the Conduct of Clifford Ayling, September 2005, Department of Health, Command 6298. The Kerr/Haslam Inquiry, HM Government, Command 6640, July 2005. Investigation into issues arising from the case of Loughborough GP Peter Green, Commission for Health Improvement, 2001.

[2] Halter, M, Brown, H, Stone, J (2007) *Sexual boundary violations by health professionals – an overview of the published empirical literature*. CHRE. Available from www.chre.org.uk

2 The importance of setting and maintaining clear sexual boundaries

Healthcare professionals must not display sexualised behaviour towards patients or their carers. This is because the healthcare professional/patient relationship depends on confidence and trust. A healthcare professional who displays sexualised behaviour towards a patient or carer breaches that trust, acts unprofessionally, and may, additionally, be committing a criminal act. The abuse of patients is also highly damaging in terms of confidence in healthcare professionals generally and leads to a diminution in trust between patients, their families and healthcare professionals.

The effects on patients and carers of breaches of sexual boundaries by healthcare professionals

Research literature demonstrates a widespread acknowledgment that sexual boundary transgressions are damaging to patients and carers. A number of qualitative[3] studies have been carried out to explore the impact of such transgressions. These show that patients can experience considerable and long-lived harm.

The negative impact can be exacerbated by young age and a previous history of sexual abuse in the patient. The harms caused can include:

- post traumatic stress disorder and distress
- major depressive disorder
- suicidal tendencies and emotional distrust
- high levels of dependency on the offending professional, confusion and dissociation
- failure to access health services when needed
- relationship problems
- disruption to employment and earnings
- use and misuse of prescription (and other) drugs and alcohol.

[3] A summary of key research findings can be found at Appendix A. For further information see Halter, M, Brown, H, Stone, J, (2007) *Sexual Boundary Violations by Health Professionals – an overview of the published empirical literature*. Council for Healthcare Regulatory Excellence, London – available from www.chre.org.uk

3 Factors for fitness to practise panel members to consider

Research findings

Panel members should be aware of relevant research findings[4] which show:

- significant evidence of under-reporting of sexual boundary transgressions. The absence of further complaints does not necessarily mean the absence of offending behaviour
- that abusers commonly have a pattern of acting abusively. Healthcare professionals who display sexualised behaviour towards patients may also be the subject of complaints by members of staff towards whom they have acted inappropriately
- common tactics deployed by healthcare professionals who are accused of abuse include minimisation, normalisation, blaming the patient and rationalisation. This may take the form of justifications including: "the patient came on to me", "she started it", "I fell in love with the patient", "I was going through a hard time and the patient really understood me"
- that most abusers are male and most victims are female, although there are reported examples of females abusing males and of same sex abuse.

How the experience of abuse can affect the ability of a witness to give evidence

For most complainants, bringing a complaint requires courage and fortitude. Panel members need to appreciate that all witnesses giving evidence will be nervous. Giving evidence in a quasi-judicial setting can be highly intimidating for any witness and requires courage and support. Patients or carers who have been abused may find giving evidence particularly difficult. Being cross-examined and accused of lying can be especially traumatising for people who have been previously abused and have had experience of being disbelieved.

For this reason regulators must take particular care to ensure that vulnerable witnesses are adequately supported and that proceedings are conducted in a way that will elicit the best evidence possible from vulnerable witnesses. Most regulators have statutory provisions in place to facilitate the giving of evidence by vulnerable witnesses. These provisions should be made available to panel members. Some regulators are exploring the use of victim impact statements as a way of allowing complainants, who may not be able or willing to give evidence, an opportunity to be heard. These should be seen as one of a number of ways of making complainants feel that they have a meaningful role in the process. Complainants should be kept informed of what is happening in the case. Particular care should be taken in the language used to communicate with complainants who may be particularly vulnerable.

Advocates for the defence will wish to promote their client's case as strongly as possible. This may include cross-examining vulnerable witnesses in a way that they will find distressing. Panel chairs need to halt a line or style of questioning which they feel is inappropriate or improper.

When an allegation of sexual misconduct is made, it will often be a case of the patient's word against the healthcare professional's. The absence of corroboration may make it harder to establish that abuse has taken place. The Kerr-Haslam inquiry identified the difficulties that patients suffering with mental health problems can have in being believed[5].

Research[6] shows that people who have been seriously abused respond in a number of ways that may have a bearing on how they appear as witnesses before FtP panels. Dissociative identity disorder (DID) is a common symptom of having been sexually abused. This may result in complainants becoming frozen or withdrawn under stress, and appearing to lose concentration whilst giving evidence. Victims of abuse may also demonstrate passive compliance or learned helplessness, or blame themselves for what has happened. In short, witnesses may not present as strongly as panel members might expect, given

[4] See footnote 3

[5] Kerr-Haslam Inquiry, 36.14, 36.71, 37.16

[6] See footnote 3

the nature of their allegations. Abused patients may, alternatively, present as hostile and angry with a disdain for authority and misgivings as to whether they will get a fair hearing. Panel members need to bear this in mind when evaluating a witness's demeanour and the reliability of their evidence.

Panel members need to appreciate that a complaint may not have been lodged immediately. It may be several years before the complainant came forward. This is entirely consistent with a post-traumatic shock disorder diagnosis, and may be exacerbated if the patient has previous experience of abuse. It may take many years for a patient to be able to pin-point the source of their problems, or to appreciate that what they experienced constituted abuse. This needs to be borne in mind if a professional raises in mitigation that no other complaints have been raised in the years since the alleged events.

Aggravating and mitigating factors relevant to sanction

The following sections outline some common factors to emerge in cases involving sexual boundary transgressions which FtP panel members may wish to consider in determining sanctions. Common aggravating and mitigating factors to emerge are:

Aggravating factors

- whether the abuse took the form of a serious criminal offence, such as rape or indecent assault for which the healthcare professional was prosecuted, and if so, whether they were convicted. Failure to secure a conviction does not mean misconduct requiring action on registration did not take place
- the vulnerability of the patient. Research shows that abusers often target vulnerable groups of patients, including those seeking help for mental health or emotional problems, physically disabled young people and adults in institutionalised settings, people with learning disabilities, young females and males, people with life-threatening illnesses and previous victims of abuse. Panel members should take into account the additional responsibilities of healthcare professionals to act in the best interests of patients whose decision-making capacity is impaired
- whether the healthcare professional took deliberate steps to facilitate abuse, for example scheduling the appointment as the last of the day, working without a chaperone being present, making inappropriate house calls, dissuading the patient from seeking a second opinion
- whether the healthcare professional provided inappropriate prescription drugs, for example as an inducement to secure sexual favours
- whether there was any grooming of the patient, ie did the healthcare professional deliberately cultivate an empathetic relationship with the patient over a period of time?
- whether the healthcare professional used confidential information obtained in the course of treatment to their advantage, for example by encouraging the patient to discuss marital problems whilst providing 'a shoulder to cry on'
- whether the abusive behaviour happened on one occasion or on several occasions and whether the abuse involved one patient or several patients.

Arguments which might be put forward in mitigation

The following are arguments commonly put forward in mitigation. Panel members must decide if any weight should be given to these factors. Panel members must bear in mind the principles set out in this guidance, principally that any sexualised behaviour towards a patient or carer can cause enduring harm.

- the healthcare professional was depressed and/or had relationship/other personal difficulties at the time of the alleged relationship
- a relationship with the patient appeared to have started consensually, or even at the patient's request. This may be combined with the argument that the allegation of inappropriateness was only made when the practitioner broke the relationship off

- the fact that several years have passed since the alleged behaviour and that there had been no complaints in the intervening period
- the fact that the healthcare professional is held in high esteem by professional colleagues and was able to adduce a number of testimonials.

Determining sanction

In determining sanction, panel members should consider issues including:

- whether the healthcare professional has demonstrated any insight
- whether the healthcare professional works with or has access to vulnerable groups of patients or carers
- whether there is a risk of the healthcare professional re-offending if allowed to continue in unrestricted practice.

What do the professional guidelines say?

Panel members should consider whether the healthcare professional demonstrated an awareness of, and acted in accordance with, relevant provisions from the regulatory body.

Previous decisions and applicable case law

Panel members may wish to access relevant past FtP cases. Panel members should be aware that such cases do not serve as precedents in deciding future cases, however they will provide information about the approach taken in cases of a similar nature and the courts will be likely to take account of them in any appeal.

4 Training for fitness to practise panel members

The training environment

Because of the emotive and sensitive nature of this training, and the need for panel members to engage with their own feelings and values around sexual boundaries, it is recommended that this training is provided in small groups, as far as is possible.

Members attending training should be reminded at the outset that some people in the group may find these issues particularly sensitive and may, themselves, have experienced abuse in the past. Those members attending such training sessions should be reminded to treat each other with sensitivity and respect.

Training content

Panel members should be made aware of the different forms of abuse, such as psychological, physical, financial as well as sexual. Ideally, training should acknowledge all possible forms of abusive behaviour, however these suggested training materials concentrate on sexual boundary transgressions.

In order to arrive at a consistent approach to decision-making in this area, it is necessary to reach a shared understanding and acceptance of what is meant by inappropriate sexualised behaviour. The following definition of sexualised behaviour is suggested:

> Acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires.

Examples of sexualised behaviour can be found at Appendix B.

CHRE's research review points out that clinical and therapeutic interventions inevitably render individual patients and their carers vulnerable. Trust relies on providing a safe space with clear boundaries in which healthcare can be provided without compromising a patient's dignity and bodily integrity. Sexual boundary transgressions occur wherever a professional relationship is turned into a sexual or sexualised encounter. It is always the responsibility of the healthcare professional to manage and maintain these boundaries. FtP panel members may hear evidence that a patient seduced a healthcare professional, or was in some way to blame for sexual activity taking place. Panel members should be aware that part of any healthcare professional's role is to know how to manage a situation where a patient, for whatever reason, has a poor personal sense of boundaries, and to do so in a way which does not compromise that patient's care.

Healthcare relationships depend on patients and carers being able to trust that healthcare professionals are acting in the patient's interests and not for their own gratification. This is especially important given the power imbalance which is often a feature of the healthcare professional/patient relationships and the powerlessness, especially of vulnerable patients or their carers, to complain for fear of retribution or reprisal. The following provides a helpful definition of what is meant by boundaries in this context:

> 'Boundaries are key to establishing therapeutic relationships. They recognise the separateness of clients and therapists, validate their uniqueness, and foster the safety necessary for client disclosure. Since clients assume a position of vulnerability in therapy by disclosing intimate information and see therapists as experts… boundaries determine the context for power, authority, trust, and dependence. Ideally, the boundaries make it possible for the client to express anything, including feelings toward the therapist, knowing the therapist will not act on these. Boundaries are derived from social, cultural, political, philosophical, clinical, ethical, legal and theoretical considerations, as well as the therapist's personal limitations and choices. They vary depending on the therapist, client, relationship, setting and time.'
>
> **Harper & Steadman 2003**[7]

[7] Harper, K., & Steadman, J. (2003b). Therapeutic boundary issues in working with childhood sexual-abuse survivors. *American Journal of Psychotherapy*, 57(1), 64-79.

Some commentators differentiate between serious boundary transgressions and boundary crossings, which may or may not be acceptable in the circumstances.

> 'A boundary is the edge of appropriate professional behaviour, a structure influenced by therapeutic ideology, contract, consent, and, most of all, context…. Boundary violations differ from boundary crossings, which are harmless deviations from traditional clinical practice, behaviour, or demeanour. Neither harm nor exploitation is involved. Boundary violations, in contrast, are typically harmful and are usually exploitative of patients' needs – erotic, affiliative, financial, dependency, or authority. Examples include having sex or sexualised relations with patients…'
>
> **Norris, Gutheil, & Strasburger 2003**[8]

Arguably, the question is simply whether the healthcare professional's behaviour was appropriate or inappropriate in light of all of the facts. This is something for panel members to decide on a case-by-case basis. Each profession will have certain professionally specific activities which may influence FtP panel decisions regarding whether or not a given activity was appropriate. For example, osteopaths may legitimately need to examine patients in their underwear to view their structural alignment. Divergent custom and practice across different professions will also influence decisions as to whether something should be construed as appropriate or inappropriate professional behaviour. For example, nurses receiving a box of chocolates when a relative comes out of hospital may be perfectly acceptable, whereas a GP who does not stop a patient bringing him regular gifts may have shown a failure to prevent the emergence of an inappropriate relationship. These subtleties should be discussed in training.

Training could usefully include consideration of previous FtP cases. Some regulators will have a ready source of past cases, which they already use as part of their FtP training. Regulators might like to consider aggregating a pool of such cases for shared use.

Panel members should be aware that previous FtP cases do not serve as precedents in deciding future cases. However they can be greatly informed by understanding the approach that has been taken to cases of this nature in the past. A discussion of changing sexual values and attitudes might also emerge from this section of training. It is important to stress in training that the prohibition against displaying sexualised behaviour towards patients is based on the documented lasting and enduring harm that breaching boundaries can cause, and its effect on public confidence.

Panel members may also find it useful to have access to relevant case law, including registrant and CHRE appeals to the High Court. Training should provide an opportunity for panel members to consider the ways in which their role as FtP panel members differs from being a member of a jury in a criminal trial, for example the extent to which their focus includes confidence in the reputation of the profession as a whole, and the fact that FtP is not concerned with punishing a healthcare professional, but protecting the public.

Section 5 of this document provides some indicative training content for panel members. It is not intended to be definitive, and regulators may wish to engage the support of expert training providers to deliver appropriate training.

Developing an understanding of boundaries and appropriate behaviours is a key part of training in this area. The following exercises can be used to begin to engage panel members in thinking about this and to explore some of the complexities involved.

[8] Norris, D. M., Gutheil, T. G., & Strasburger, L. H. (2003). This couldn't happen to me: Boundary problems and sexual misconduct in the psychotherapy relationship. *Psychiatric Services*, 54(4), 517-522.

5 Sample training exercises

Exercise 1: Friendships versus professional relationships

A significant issue that arises when determining what is and is not appropriate professional behaviour is that good healthcare relationships require warmth and empathy on the part of the professional. Examinations and treatments may legitimately involve intimate touching or observation. Healthcare professionals who have been appropriately trained should be able to apply clinical and interpersonal skills in a way which makes it clear to the patient that an examination or treatment is based on the patient's clinical needs, and leave no doubt in the patient's mind as to whether the examination or treatment was appropriate.

A useful starting exercise to begin to help define professional relationships is to ask panel members to consider some of the differences between friendships and professional relationships. The exercise involves drawing two columns on a piece of paper, one entitled 'friendships' and the other entitled 'professional relationships'. Members should spend five to ten minutes, working singly, in pairs, or in small groups (depending on the size of the group) listing as many features of the two different relationships as they can. Members should be asked to use the exercise to think about what professional relationships involve, what their limits are, and how professional relationships differ from friendships.

An example is provided over the page.

What ought to emerge from this exercise is that friendships and professional healthcare relationships do share a number of similar hallmarks, but that there are a number of important differences. Students need to explore the differences between caring for patients in a warm, empathetic and supportive way, and acting in ways which are, or could be perceived by patients to be, sexually inappropriate. This will include sensitivity to, and respect for, patients' cultural values and expectations. Good professional behaviour should leave no room for confusion as to whether a healthcare professional has or hasn't acted appropriately.

Points for more in-depth discussion could include the blurring of social and professional roles in isolated and rural communities and the complexities of maintaining boundaries in long-term institutional settings where the nature of the professional relationship may evolve over a period of time.

Friendships	Professional relationships
Friendships are for the benefit of both parties. Involve mutuality.	Ethical basis is the benefit/best interests of the patient. Not two-way, even if patient and therapist like each other and recognise that they might have been friends if they had they met socially.
You choose your friends.	You don't choose your patients (although patients may choose professionals because they are attracted to them).
Friendships are based on trust.	Healthcare relationships are based on trust.
Sharing confidential information – telling friends about yourself and them telling you things about them.	The patient discloses personal information but the healthcare professional doesn't/shouldn't reciprocate.
Friends may expect something they tell a friend in confidence will not be discussed further, but may recognise that some friends gossip and are less good at keeping secrets than others.	Professionals have explicit ethical and legal duties to keep information about patients confidential unless, for example, the professional feels that the patient may pose a risk to other people.
Friends are people you can call on day or night.	Professional healthcare relationships (with the exception of urgent or emergency unscheduled care) mostly occur within scheduled appointments within set hours.
Good friends can tell each other that something the other has done has made them feel hurt or angry.	Professionals don't/shouldn't take patients' actions personally and shouldn't tell them that they feel hurt by the patient's actions (subject to not tolerating physical or verbal abuse from a patient).
Friendships may involve hugs, kisses and other displays of physical affection.	Professional healthcare relationships may be warm and caring, but do not/should not involve hugs and kisses.
Sometimes, friends have sex with each other.	It is never acceptable to have sex with a patient, and it is up to the professional to make sure this doesn't happen, even if the patient is flirting or behaving in a sexually provocative manner.
Friends love each other.	Professionals may have positive, empathetic regard for patients, but shouldn't love them.
Friends treat each other and give each other presents.	Professionals do not/should not give their patients presents, even though sometimes, grateful patients want to give health professionals a token of their appreciation. Regular or excessive present-giving by a patient should be perceived as a warning sign by a professional.

Exercise 2: The right thing to do

This exercise, which was developed by WITNESS, uses a number of short scenarios to elicit what professionals ought to do in certain circumstances. As with exercise 1, each scenario can be used as the basis of a discussion about what counts as appropriate behaviour and where appropriate boundaries lie between healthcare professionals and patients in different circumstances.

Trainers can use the following examples/vignettes to devise their own profession-specific version, or use the following scenarios.

- **A healthcare professional bumps into a patient in the supermarket. Is the appropriate thing to do to stop and say hello, to nod politely, or to ignore the person? What should they do if the patient tries to engage them in discussion about their health problems?** Discussion of the importance of treatment context, and the implications of providing care in ad hoc situations. Appreciation of appropriate interpersonal skills and the extent to which intentional or unintentional self-disclosure (what the professional has in their shopping basket) can influence professional relationships. Extent to which healthcare professionals, as well as patients have a private life.
- **A healthcare professional is taking a history from a patient who suddenly bursts into tears. Should they hold out a box of tissues, or put a reassuring arm around their shoulder? Would it make any difference if the healthcare professional had known the patient for a long time? What other factors might be relevant?** Discussion of the ethical and appropriate use of touch. Importance of cultural values and expectations of patient and practitioner. Relevance of long-standing healthcare relationships, if any. Discussion of situations where physical contact might be appropriate and where it might be misconstrued. Differential societal expectations for different professions, for example might be deemed acceptable for a nurse to offer a reassuring hug, but not a medical consultant.
- **A healthcare professional bumps into a former patient in the pub. The patient offers to buy the healthcare professional a drink. Should the healthcare professional accept, decline, or make excuses and leave the pub?** Right of healthcare professionals to a private life. Importance of not blurring line between friendships and professional relationships. Extent to which rules should or shouldn't be relaxed in case of former patients, including nature of professional relationship. Are particular patients/professional relationships particularly complex in this regard, for example psychiatric nurse and former long term patient?
- **A patient wants to invite their healthcare professional to their 30th/40th/50th birthday party. It would mean a lot to them if the healthcare professional would attend. What are the implications?** Opportunity to discuss situations in which patients may blur the boundary between professional relationships and friendships. Opportunity to review healthcare professionals' need for effective communication and interpersonal skills (why do you want me to come to the party, why you matter to me as a patient and it isn't appropriate for me to accept your invitation, but I'm really touched you asked….). Situations where it might be possible to accept an invitation without it being inappropriate.
- **A healthcare professional has recently moved to a remote Scottish island. There are few opportunities for socialising. The professional is attracted to one of the practice patients. There is only one health centre on the island. The healthcare professional thinks that the geographical remoteness of their employment and lack of ordinary opportunities provides a justifiable reason to enter into a romantic liaison. What are the implications?** A useful case to highlight issue of dual relationships, especially in rural/remote communities. Whether this makes any difference. Whether it makes a difference if the healthcare professional is a GP, a practice nurse or a physiotherapist. Discussion about the appropriateness in other situations of terminating a therapeutic relationship with the sole intent of embarking on a romantic/sexual liaison.

A Appendix

Key findings: *Sexual boundary violations by health professionals – an overview of the published literature (2007)*. Halter M, Brown H and Stone J

Boundaries

Discomfort, attitudes and lack of clarity regarding boundary crossing

- the majority of respondents view sexual contact as inappropriate and harmful
- discussing a sexual attraction with a supervisor increased professionals' understanding
- education or training on sexual ethics is widely perceived as inadequate
- a lack of consensus exists regarding the definition of an 'ex patient'
- confusion was expressed about responsibility for maintaining boundaries
- knowledge about how to handle such situations was scant and many would not report colleagues.

Ways in which to decrease sexual boundary transgressions

- those who have received education on the topic are less likely to transgress sexual boundaries
- factors to consider in training include communication skills, manner, explanations, sensitivity to patients' perceptions, use of chaperones, and avoidance of sexual humour
- positive training environments promote healthier coping responses.

Reported prevalence and incidence

- the majority of reported boundary transgressions involve male practitioners and female victims
- between 38 and 52% of healthcare professionals report knowing of colleagues who have been sexually involved with patients, although several professionals may be citing the same case. Self-reporting rates are considerably lower
- self-reporting acknowledges high levels of patient attraction
- between 22 and 26% of patients report having been sexually involved with a previous healthcare professional to another professional
- greater awareness of guidelines and sanctions reduces prevalence.

Impact of boundary transgressions

- the impact on survivors shows the harm caused by sexual boundary transgressions is considerable and enduring
- symptoms include post traumatic stress disorder, anger, a sense of betrayal and exploitation, guilt and self-blame
- high levels of dependency on the offending healthcare professional, confusion and dissociation are found
- youth and a previous history of sexual abuse in the patient can exacerbate the negative impact of sexual boundary transgressions by professionals.

Factors associated with boundary transgression

- difficulties in researching the subject, together with an understanding of systemic and organisational factors, leads to reluctance to rely on a predictive profile of transgressors
- rather than a simple 'bad apple' model, an alternative view is that all healthcare professionals should be aware of their 'trouble spots' around boundary issues
- a higher proportion of boundary transgressors are male, older than 'average' sex offenders, and suffer from a variety of psychopathologies
- healthcare professionals who themselves had been severely sexually abused are more likely to have engaged sexually with patients
- women are the main victims of sexual boundary transgressions
- a significant proportion of abused patients are previous victims of abuse.

B Appendix

Examples of sexualised behaviour by healthcare professionals towards patients or their carers

- asking for or accepting a date
- sexual humour during consultations or examinations
- inappropriate sexual or demeaning comments, or asking clinically irrelevant questions, for example about their body or underwear, sexual performance or sexual orientation
- requesting details of sexual orientation, history or preferences that are not necessary or relevant
- internal examination without gloves
- asking for, or accepting an offer of, sex
- watching a patient undress (unless a justified part of an examination)
- unnecessary exposure of the patient's body
- accessing a patient's or family member's records to find out personal information not clinically required for their treatment
- unplanned home visits with sexual intent
- taking or keeping photographs of the patient or their family that are not clinically necessary
- telling patients about their own sexual problems, preferences or fantasies, or disclosing other intimate personal details.
- clinically unjustified physical examinations
- intimate examinations carried out without the patient's explicit consent
- continuing with examination or treatment when consent has been refused or withdrawn
- any sexual act induced by the healthcare professional for their own sexual gratification
- the exchange of drugs or services for sexual favours
- exposure of parts of the healthcare professional's body to the patient
- sexual assault.

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