

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

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Other documents produced by the Clear Sexual Boundaries Project:

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

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

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1 Executive summary and recommendations

Background

This report was produced, following extensive consultation, by the Council for Healthcare Regulatory Excellence as part of its Clear Sexual Boundaries Project. It is one strand of a wider project which aims to ensure regulatory bodies, healthcare professionals, patients and their carers are aware of the sexual boundaries that need to be established and maintained in order to create appropriate professional relationships.

The aim of the report is to encourage those involved in the training, development and regulation of healthcare professionals to consider ways to ensure that students and healthcare professionals receive effective training on clear sexual boundaries. The report includes recommendations to higher education institutes and training providers, students, regulatory bodies, Royal Colleges and professional institutions and the Department of Health.

Summary of content

- Research shows that effective education and training is an important part of the strategy to prevent health professionals breaching sexual boundaries with patients or carers. Inquiries into such cases recommend ongoing education and training in this area.
- There is a variety of ways in which sexual boundaries issues can be taught, each with their own advantages and disadvantages. Approaches that allow students or professionals to role play relevant scenarios or discuss real or hypothetical case studies in a supportive group environment are considered to be of particular benefit. Examples of such learning approaches are given within the report.
- Training should aim to include the spectrum of inappropriate sexualised behaviour and enable students and healthcare professionals to recognise and deal with situations to avoid causing harm to patients or putting themselves at risk. It should also enable students and professionals to handle situations in which they are concerned about the behaviour of their colleagues.

- Sexual boundaries training could sit within several areas of the curriculum such as clinical skills development, ethics and law, communication skills and personal and professional development.
- There is no clear evidence regarding the most effective time to teach students about sexual boundaries within the curriculum, however those students who have contact with patients from the earliest stages of their course need to be informed at an early stage about acceptable and unacceptable behaviour and the legal and professional consequences of acting inappropriately.

Recommendations to higher education institutes and training providers

- Training on sexual boundaries should be an essential part of the healthcare curriculum. Higher education institutes have considerable autonomy in deciding what is taught where and when, but they have a responsibility to ensure that this subject is taught at appropriate levels, and is reinforced across different areas of training.
- Students should be taught about their responsibilities towards patients and carers before they go into clinical placements and when they are working in supervised training environments, such as practice clinics. Higher education institutes need to have policies in place to ensure that students know what their ethical and legal requirements are. This should link into any formal student fitness to practise mechanisms, as appropriate. In the most serious of cases, a student who has either repeatedly breached boundaries, or has been convicted of a sexual offence, should be removed from a course.
- Students are less likely to act inappropriately if they are able to discuss their concerns with an understanding personal tutor or supervisor. It is vital that supervisors and tutors who provide advice and training on boundaries issues are themselves adequately trained and non-judgemental. A policy position needs to be taken on the extent to which confidentiality can be offered to students and staff who raise boundary concerns.

- Clinical staff are also important role models for students and boundaries issues can arise at various points in a student's education, so higher education institutes and training providers should make this training available to as wide a range of staff as possible. The capacity for developing a code of guidance for clinical staff/tutors should be explored.

Recommendations to students

Students and health professionals need to take responsibility for their learning needs in this important area. They should commit to the following:

- attendance and participation in boundaries training as a student and as a professional
- developing the insight and awareness to not breach boundaries themselves
- familiarising themselves with the process of reporting unacceptable activities, whether of other students, or existing members of staff, including senior members of staff.

Recommendations to regulators

- Regulators should offer guidance to their registrants on sexual boundaries, based on CHRE's *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals* (CHRE 2008)
- Regulators should strongly encourage the inclusion of training on sexual boundaries within curriculum and validation mechanisms, and specifically question providers as a routine part of quality assurance. As inspections become harmonised with other agencies, such as Skills for Health, partnership working may be required to ensure that this area is not overlooked.
- Regulators should work with Royal Colleges and professional associations to ensure that an appropriate balance is struck between what might best be imparted at a pre-registration level, and what should be taught as part of post-registration education and training or continuing professional development.

- Regulators should make available to education and training establishments, including colleges and schools, examples of previous fitness to practise cases and relevant legal challenges, for use as part of learning about boundaries.
- Regulators should consider opportunities for synergy between the creation of materials for use in training, and the creation of materials for use within their fitness to practise processes. Training programmes could, in the future, form part of remedial/rehabilitative sanctions for healthcare professionals who have breached sexual boundaries, but who demonstrate a degree of insight, consent to remediation, and are considered to be of sufficiently low risk to be allowed to remain on the professional register. Attendance on such a programme could also be a prerequisite for re-admittance after a period of suspension.
- Regulators should work together and with CHRE to ensure that codes of conduct and other guidance about sexual boundaries emphasise the shared, core responsibilities of all regulated health professions.

Recommendations to Royal Colleges and professional associations

- The sensitive nature of teaching of sexual boundaries means that in-depth teaching of this subject (and certainly the specialty-specific dimensions) may be more usefully included as part of specialist training. Even if students have been taught about boundaries pre-registration, this will need to be reinforced once they are registered. Medical specialties which have the highest reported incidences of sexual boundary transgressions can reasonably be expected to take a lead on training provision (psychiatry, general practice and obstetrics and gynaecology). Professional bodies within other health professions should also demonstrate a commitment to training provision in this area, for example, by making boundaries training a compulsory element of continuing professional development (CPD). This would, of course, be subject to having piloted educational programmes to ensure their effectiveness.

- As identified above, effective supervision is an important part of the strategy for preventing abuse. Royal Colleges and professional associations might wish to consider formal mechanisms for widening access to supervision¹. In smaller professions, such as osteopathy and chiropractic, one suggestion might be to encourage or require more senior healthcare professionals to supervise newly-registered colleagues. This could be incentivised, if necessary, for example by training in supervision skills counting towards CPD hours.
- Royal Colleges and professional associations should ensure that they use information from data collection (of disciplinary and fitness to practise cases) to make sure that educational content is informed and up-to-date.

Recommendations to Department of Health for further research

The report reinforces the findings of national inquiries in recommending boundaries training for all health professionals. Because resources are limited, the following next steps have been identified as being most likely to promote widespread introduction of education and training:

- a survey of what, when and how higher education providers are currently teaching about boundaries
- systematic collection of teaching materials currently used by higher education institutes, together with a database of boundaries cases/vignettes drawn from regulators' fitness to practise cases, disciplinary cases, and court cases for use in pre-and post-registration training
- development of a specific, focused, training module on boundaries, including, potentially, an e-learning package as part of blended learning about boundaries
- the creation of a framework to evaluate the impact of education and training initiatives.

¹ The Kerr-Haslam Inquiry (Chapter 35) recommended specifically that the Department of Health, in association with the National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists publish guidance in relation to clinical supervision of consultant and career grade psychiatrists.

2 Introduction

This report was produced, following extensive consultation, by the Council for Healthcare Regulatory Excellence as part of its Clear Sexual Boundaries Project. It is one strand of a wider project which aims to ensure regulatory bodies, healthcare professionals and patients are aware of the sexual boundaries that need to be established and maintained in order to create effective and appropriate professional relationships.

The vast majority of healthcare professionals work with dedication and integrity and are committed to the best possible patient care. However, in a small minority of cases healthcare professionals have seriously breached sexual boundaries with patients or their carers, resulting in several major national inquiries and a number of investigations in recent years. These inquiries have demonstrated the serious and enduring harm caused to patients when sexual boundaries are transgressed. As well as harming patients, sexual boundary breaches damage the trust that is vital for the delivery of effective healthcare – trust between patient and healthcare professional, and between the public and healthcare professions in general.

Education and training on clear sexual boundaries has an important role to play in preventing boundary transgressions by enabling students and healthcare professionals to explore the issues, to recognise and handle situations where there is a risk of sexual boundaries being breached and to report concerns. Research has shown that education and training can prevent sexual boundary breaches and help students and healthcare professionals to deal appropriately with situations that arise during their careers. However it has also shown that many students and healthcare professionals feel they have not received adequate training in this area.

This report aims to encourage key players in the training, development and regulation of healthcare professionals to consider ways to ensure that students and healthcare professionals receive effective training on clear sexual boundaries. It contains information and recommendations on the content of training and its outcomes, effective training methods, assessment of training and where it might sit within the curriculum. It also contains some tools that can be used and adapted as part of training on clear sexual boundaries.

It is informed by the findings of relevant inquiries and other sources including an overview of literature² on sexual boundary violations and an audit of key education providers³.

Definition of terms used within this report

Patient: a person who receives care or treatment from a healthcare professional. The information in this document 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. Sexualised behaviour does not just include criminal acts such as rape or sexual assault, but includes a spectrum of behaviours, of varying seriousness, all of which can cause harm. A list of examples of sexualised behaviour can be found in section 5 of this report.

² Halter, M, Brown, H and Stone, J. *Sexual Boundary Violations by Health Employees: An Overview of the Published Empirical Literature (2007)*. Council for Healthcare Regulatory Excellence and Department of Health.

³ CHRE (2007). Postance, B. *Educational Audit: Clear Sexual Boundaries between Healthcare Professionals and Patients*. Council for Healthcare Regulatory Excellence and Department of Health.

3 Learning outcomes, teaching methods and assessing effectiveness

Background

Research has shown that good education and training is an important part of the strategy to prevent health professionals from breaching sexual boundaries with patients or their carers. The Kerr-Haslam inquiry acknowledged that education would not deter all healthcare professionals from behaving inappropriately. Nevertheless, the inquiry recognised the importance of education and training on clear sexual boundaries:

There are limitations on the impact of education and training. We doubt that it is wholly possible to train doctors to be virtuous, to train them not to abuse the patients in their care. However, there is a most valuable role for education and training. First, it may assist in focusing attention on ethical issues, and on the position of the patient, particularly the vulnerable patient. Secondly, it will assist in training future and existing doctors and other mental health service professionals on how to respond to disclosures made to them, and how to pass on their own concerns about the conduct, attitude and behaviour of colleagues.

Kerr-Haslam Inquiry (36.39)

The inquiry also pointed out that if students were not taught about boundaries as part of their pre-registration curriculum, it could not be assumed that they would receive any formal training on this subject as part of their staff induction or in-service training. The absence of such training has contributed to a culture in which sexual boundary transgressions have occasionally been tolerated, members of staff have not challenged poor practice or have been disbelieved when expressing concerns. It is important that students enter into a clinical environment with appropriate knowledge, skills and attitudes, as, far from seeing positive examples of practice, they may find themselves exposed to poor role-modelling which they will need skills and confidence to challenge.

There is also a danger that if education and training about boundaries is optional, students and healthcare

professionals with the least personal insight and who are most in need of training will avoid it.

This is a sensitive topic which must actively engage all students. This section suggests learning outcomes and describes methods that can be used to achieve them.

Learning outcomes of education and training on sexual boundaries

Responses to an audit of key stakeholders suggested that training for students and healthcare professionals on sexual boundaries should ensure the following outcomes:⁴

- instilling professional values and respect for patients and their carers
- knowing what is meant by clear sexual boundaries
- understanding the impact of breaching boundaries
- learning to differentiate between creating rapport and trust (including the appropriate use of touch in therapeutic relationships), and acting in a sexually inappropriate way
- knowing how to recognise sexual feelings arising in a healthcare setting, how to recognise early warning signs of inappropriate sexual behaviour, how to deal with such circumstances appropriately and where to seek advice
- knowing how to maintain clear communication with patients at all times
- learning appropriate techniques for intimate and other examinations and history-taking
- being familiar with protocols for intimate examinations and the use of chaperones
- developing an understanding of, and respect for, the different needs of patients, including the needs of vulnerable groups of patients for whom boundary-setting may be especially hard
- developing a recognition of how their own cultural and religious values and the cultural and religious values of patients and service users might affect boundary issues, for example around the acceptability of use of touch

⁴ CHRE (2007) Postance, B. *Educational Audit: Clear Sexual Boundaries between Health Care Professionals and Patients*. Council for Healthcare Regulatory Excellence and Department of Health.

- knowing what to do, and their duty to report, if they have concerns about other health professionals who have displayed sexualised behaviour towards patients
- knowing how to handle patient complaints and concerns, demonstrating the ability to apply key ethical, legal and psychological concepts in day-to-day practice. This includes a clear knowledge of their professional code of practice and the legal implications of any sexual boundary transgression.

How could sexual boundaries be taught?

Different learning outcomes require different educational approaches, and the approach taken by education and training organisations will vary according to their individual circumstances and resources.

Appropriate methods might include a combination of the following:

- lectures
- plenary discussion
- showing of videos followed by discussion
- vignettes (composites or based on actual fitness to practise/court cases)
- problem based learning
- small group teaching
- patients/survivors talking to students
- role play
- e-learning (as part of blended learning, with potential for a wider audience than healthcare students, for example as part of employers' induction for staff, or for training clinical tutors)
- keeping personal journals
- self-directed learning.

Some strengths and weaknesses of various teaching methods

An audit of stakeholder views on how sexual boundaries should be taught elicited the following preferred methods:⁵

- **68%** Case studies/vignettes and analysis
- **43%** Problem-based learning
- **32%** Role play
- **27%** Small groups
- **22%** Seminars
- **16%** Videos
- **8%** Lectures
- **5%** Online modules
- **3%** 1-1 supervision
- **3%** Workbooks

The following paragraphs consider the strengths and weaknesses of some of these teaching methods.

Vignettes: This is a well-used approach for teaching ethics, where students are asked to consider cases raising ethical dilemmas. Vignettes drawn from real-life examples such as fitness to practise cases can be particularly useful because they have a real-life ending. Vignettes can be given in two parts – firstly a presentation of the facts, followed by a discussion; secondly the presentation of what actually happened, followed by a further discussion of the outcome. A number of regulatory bodies publish details of all of their fitness to practise (FtP) cases on their websites. Additionally, CHRE will be working with regulators to develop a database of cases for use in training FtP panel members. These could be readily adapted for pre- and post-registration training purposes. Newspaper stories can also form the basis of vignettes. More information about vignettes, together with some examples, can be found in section 6 i.

Role play: Role play can be a very effective teaching method, and is one which is used by a number of education providers as part of their communication skills courses. Role play can involve students interchangeably taking the role of patient and professional. This can be useful given that students are also patients. This form of role play can help impress upon students that sexual attraction can be two-way, and that they will need

⁵ CHRE (2007) Postance, B. *Educational Audit: Clear Sexual Boundaries between Health Care Professionals and Patients*. Council for Healthcare Regulatory Excellence and Department of Health.

to know how to respond if they have sexual feelings towards a patient or if a patient appears to be displaying sexualised behaviour towards them.

Some providers employ trained actors to take the role of 'difficult' patients. This approach provides an important opportunity for students to experience first-hand the range of feelings that can be provoked by patients and to learn how to respond in a constructive way. Usefully, role play allows students the opportunity to practise 'how-to' skills, especially important in learning how to respond to patients who are behaving in a sexualised way towards them. An example of a role play in current use is provided in section 6 ii.

Problem Based Learning (PBL): An advantage of this approach is that it is already successfully embedded in higher education institutions/training colleges. PBL cases can be used to incorporate ethical, legal and communication issues alongside clinical teaching and could easily include a sexual boundaries aspect. The PBL approach is helpful because it sets boundary issues in context, and will help to reinforce the fact that where sexual boundary issues arise, they interfere with the patient's clinical needs and may impair the healthcare professional's professional judgment. However there is a concern that if sexual boundaries issues are going to be taught using PBL, a wider range of tutors and facilitators need to be aware of sexual boundaries issues, and will themselves require training, so that the learning experience can be subtler and more nuanced than simply restating normative prohibitions.

Lectures: Respondents to CHRE's audit did not consider lectures an ideal way of teaching students about sexual boundaries. Although lectures are a cost-effective way of imparting knowledge to a large number of students, the sensitive nature of sexual boundaries, and the need for students to explore their own feelings, means that lectures should, if possible, be accompanied by an experiential

learning component⁶. Lectures remain, however, a widely used method for teaching ethics and law, and may be useful in imparting normative information about professional guidelines, criminal law and the consequences for healthcare professionals if they breach sexual boundaries with patients.

Though not an ideal teaching method, there are ways of making lectures about sexual boundaries more accessible and thought-provoking. These include:

- showing video clips/short films about abuse
- using newspaper stories or storylines from popular culture as a basis for discussion
- presentations to the group by patients who have experienced sexual boundary transgressions (provided this is led by a highly experienced facilitator)
- presentations from the appropriate regulatory body giving examples of fitness to practise cases.

E-learning: Advantages of e-learning are that it can be accessed at a time convenient to the learner, it allows a considerable amount of relevant data to be made available through use of links, it can combine a range of effective learning strategies (video clips, multiple choice questions, self-assessment ratings) and once developed, it would be relatively cheap to maintain and deliver.

As e-based learning is carried out in isolation, e-learning would need to be supplemented with group-based work so that students can be enriched by experiencing the real-time emotional complexities that arise from discussion about sexual boundaries. Optimally, e-learning packages could facilitate virtual learning communities, or other opportunities for learners to study with others. Access to supervision and support would remain crucial.

⁶ A course combining lectures and experiential components has been developed by the Faculty of Medicine, University of Toronto, as described in Robinson, G and Stewart, D. 'A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment Part 1: Content'. *Canadian Medical Association Journal* 1996; 154: 643-649 and Robinson, G and Stewart, D. 'A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment Part 2: Teaching Method' *Canadian Medical Association Journal* 1996; 154: 1021-1025.

www.collectionscanada.ca/eppp-archive/100/201/300/cdn_medical_association/cmaj/vol-154/0643e.htm

The learning environment

Research has shown that learning about boundaries requires a supportive and conducive environment. Because the thought of deliberately abusing patients is abhorrent to the majority of healthcare professionals, when students and professionals do experience sexual feelings towards patients, feelings of embarrassment, guilt, shame and fear may deter them from seeking the help and support they need to resolve the situation. It is imperative that students learn, in a conducive and supportive way, that most healthcare professionals, at some time or other, experience sexual or other intense feelings towards patients and that they learn to recognise and differentiate sexual feelings from displaying sexualised behaviour.

Tutors should be mindful that some students learning about boundaries may have been sexually abused themselves and may therefore find this topic hard to deal with. When teaching existing health professionals and staff about boundaries as part of CPD, tutors also need to anticipate that members of the group may already have experienced uncomfortable situations, or even have been confronted about behaviours in the past. These situations equally require highly skilled facilitation and support, and a reminder for all participants to treat each other with sensitivity and respect.

Assessment and evaluation strategies

Methods of assessing the effectiveness of training and education will depend on the method of learning used. Clinical skills aspects of sexual boundaries might be tested, for example, through objective structured clinical examinations. Where boundaries teaching is being delivered through experiential methods such as role play or discussion of vignettes, facilitators can assess participation in discussion, and demonstration of effective communication skills and ethical attitudes.

The University of Westminster's Dynamics of Clinical Practice module⁷ uses a variety of different assessment strategies to assess whether learning objectives have been met, broken down as follows:

- oral presentation and participation in group-inquiry process (25%)
- tutor assessment of group process (15%)
- self-assessment of facility with inquiry process (15%)
- reflective study (45%).

Views on assessment strategies were elicited as part of CHRE's audit of key stakeholders. The following ideas emerged:

- use case studies or vignettes – ask people to identify sexual boundary transgressions and score scenarios on a scale of 1 to 5, i.e. acceptable to completely unacceptable
- present case studies in small group discussion and observe individual responses/problem-solving
- ask a small group to role play a case scenario and observe
- use individual/group supervision to discuss actual cases and issues surrounding sexual boundaries in relation to patient care
- monitor student or qualified professional during clinical skills assessment/clinical management supervision
- written examination, short written test paper or viva question
- verbal questioning of student/healthcare professional during oral assessment
- use of reflective practice journals as part of CPD work
- regular in-service training sessions for all staff members and refresher questionnaires sent out for completion at regular intervals to maintain levels of awareness
- direct observation of students'/professionals' interaction with patients or use of video to assess professional's behaviour during consultations
- periodically observe written records of care provided by the professional
- request feedback from patients/service users on care provided.

⁷ Dynamics of Clinical Practice (3CTC 611). Details reproduced with permission from Practitioner Development Theme leader, Sylvina Tate, University of Westminster.

Standard assessment tools, such as questionnaires, can be used to assess how well students and healthcare professionals felt that the training delivered content.

However it is important to ensure that assessment methods, particularly in relation to CPD, go beyond subjective measures of whether the student/learner enjoyed the training and thought it would be useful. The harder question for assessment is whether the training actually leads to improved practice and reduced incidences of boundary violations.

To date no examples have been found of assessment and evaluation tools that are capable of determining how far training has actually prevented sexual boundary transgressions which might otherwise have occurred. Strategies need to be developed to ensure that resources are being targeted at the most effective training methods available. This would be an important area for future funded research.

In the post-registration context, supervision may form an important part of the assessment process. This may be particularly relevant in professions in which the delivery of care takes place outside managed environments. There is a need for healthcare professionals to be able to access formative, non-judgmental advice. Although limits to confidentiality would still apply – a supervisor would need to speak out if sexual boundaries had been breached – provision of appropriately trained staff should be seen as an important element of promoting patient safety, and as separate from formal assessment processes. Employers should ensure that they make supervision arrangements available so that a healthcare professional who has boundary concerns can talk to an appropriate person at an early stage.

4 Sexual boundaries training within the curriculum

Where could boundaries training sit in the curriculum?

Education and training providers need to consider the most appropriate place for sexual boundaries training within the curriculum. Some obvious places for pre-registration teaching are within:

- clinical skills development
- ethics and law
- communication skills
- personal and professional development.

An audit of key stakeholders⁸ suggested that the following areas were appropriate for teaching sexual boundaries issues:

- **59%** said it should be part of ethics and law teaching
- **57%** said it should be part of clinical skills assessment courses
- **46%** felt there are other ways that this subject could be taught.

Ideally, sexual boundaries training should be an integral part of clinical skills training, during which students learn how to develop clinical skills in a warm and empathetic manner and learn about the therapeutic and appropriate uses of touch. They should also learn how to conduct intimate and other examinations in ways which do not cause patients harm or offence while overcoming any personal embarrassment they may have, which may manifest, for example, in inappropriate humour or comments, or insufficiently thorough examinations.

Within medicine, there is additional scope for boundaries training to be continued and reinforced as part of specialty training delivered through the medical Royal Colleges. Specialties where sexual boundary violations appear to be a particular problem include psychiatry, general practice and obstetrics and gynaecology, and we would expect these Colleges to take a lead on developing post-registration training courses.

It is recommended that personal and professional development courses explore sexual boundary issues in relation to students'/healthcare professionals' attitudes towards patients and their professional values. The following might be covered in such training:

- what it means to work in a helping profession
- why they have chosen a helping profession
- the vulnerability of patients and carers and the power imbalance in the therapeutic relationship, appreciating the value of effective communication skills
- the sub-conscious forces which operate in therapeutic relationships, including the psychotherapeutic notion of transference (whereby a patient's feelings about significant relationships are transferred onto the patient's feelings and may be acted out towards the therapist/healthcare professional) and counter-transference (where the therapist's feelings about significant relationships are triggered by, and may be acted out in, the relationship with the patient)
- the impact of the professional's demeanour and behaviour (including non-verbal cues) on the therapeutic relationship
- their gender and cultural values and beliefs (generally, as well as in relation to sexual relationships), and the role of women and men in society.

In all professions, post-registration could take the form of induction training and mandatory CPD (including as part of revalidation). There is considerable potential for teaching about sexual boundaries as an inter-professional area, as this may increase the confidence of any member of staff in challenging poor practice. Inter-professional learning could also stress the importance of the multi-disciplinary team as a resource within which individual members of staff can share their concerns about patients.

⁸ CHRE (2007). Postance, B. *Educational Audit: Clear Sexual Boundaries between Health Care Professionals and Patients*. Council for Healthcare Regulatory Excellence and Department of Health.

Reinforcing boundaries teaching across different subject areas

Boundaries training should not be made the responsibility of one isolated individual and must be reinforced across a number of teaching areas. For example, clinical skills teaching can be reinforced in ethics teaching and vice versa.

Recognition of the importance of healthcare relationships and the role of the professional in taking responsibility for establishing and maintaining appropriate relationships with patients and carers should be reinforced throughout pre-and post-registration training. Learning about sexual boundaries should be seen within this broader context and not regarded as a one-off module to be slotted in where there is a gap in the curriculum.

When could healthcare professionals learn about boundaries?

There is no research evidence available to show at what stage students and healthcare professionals should learn about sexual boundaries. However, stakeholders responded as follows when questioned on this issue as part of the education audit:

- **48%** agreed on pre-registration (year 1 of training)
- **6%** agreed on pre-registration (year 2 of training)
- **57%** agreed on pre-registration (years 3/+ of training)
- **35%** agreed on post-registration (on entering employment)
- **32%** agreed on post-registration (as part of employers' ongoing staff training)
- **38%** agreed on post-registration (as part of formal continuing professional development).

Any student who has contact with patients and carers needs to have received some form of education on sexual boundaries. Students need to be informed about what behaviour is and is not acceptable, and of the need to act in a professional and courteous way. Discussion of sexual boundaries should be included in any early discussions of this nature. Students should be made aware of the legal and professional consequences of acting in a sexually inappropriate manner. Normative rules (ie this is wrong and this is what will happen if you do it) should be reinforced

with an explanation of the ethical reasons why breaching boundaries is unacceptable.

Students increasingly come into contact with patients from the earliest stages of their courses (in some cases, as early as semester 1/Year 1). There is a danger that sexual boundaries training will be introduced to some students before they have the maturity to appreciate how it will affect their role as a student or their future role as a health professional. Discussing sexual issues with young students requires extreme sensitivity, but it is necessary to discuss boundaries issues at an early stage to ensure that students act appropriately with patients, do not become desensitised or experience poor role-modelling from senior clinicians or tutors.

Many of the learning objectives for sexual boundaries will be taught at various stages of their training, in various subject areas. Respondents to the education audit supported the inclusion of sexual boundaries within the ethics and law curriculum, and within communications and personal and professional development training. However, the placing of these subject areas varies across higher education institutions, so the stage at which students learn about them will vary.

In the absence of research evidence, it is difficult to make firm recommendations regarding when students and healthcare professionals should be taught about sexual boundaries. Further research is needed to determine when teaching on this subject is most likely to influence subsequent practice.

Training the trainers

To ensure that sexual boundaries education is appropriately reinforced throughout the curriculum, providers should consider providing specific training for clinical tutors and facilitators. This is also important since issues of sexual attraction are known to occur between students and trainees, supervisors and facilitators. Trainers and supervisors need to have done sufficient work on their own learning, understanding and ability to work with these issues. It is also recommended that providers identify mentors, supervisors and personal tutors with whom students can discuss sexual boundary issues in confidence (unless criminal/unprofessional acts have already taken place, in which case they will have a duty to report).

5 Content of sexual boundaries training

This part of the report contains more information about what students and healthcare professionals need to know about boundaries and is informed by the findings of the Ayling and Kerr-Haslam inquiries. Although these inquiries involved doctors, the lessons learned apply equally to all health professionals.

We would expect and hope that medical school graduates will be examined on and have had a sound knowledge and understanding of medico-legal and ethical issues, including (relevant to our Inquiry) topics such as:

- patient confidentiality, its purpose and its limitations;
- boundaries between a doctor and his/her patient – what they are and why they must be maintained;
- indicators of boundary transgressions – the ‘slippery slope’
- sexualised behaviour (in all its forms as discussed in this Report) with existing and former patients.

This will involve, for example, training in and a clear understanding of:

- handling concerns about boundary transgressions by colleagues;
- self-reporting;
- reporting concerns – when, how and to whom;
- recording concerns;
- complaints handling – procedures and patient/colleague support.

What is required is not merely awareness of these and similar ethical issues but why they need to be addressed (that boundary transgressions almost always cause harm), how they operate in practice, and what to do if there is a suspicion that they have been breached – by the doctor, or by a colleague.

Kerr-Haslam Inquiry 36.56-36.58

An audit of educators and key stakeholders prioritised similar learning requirements, as shown by the learning outcomes listed in section 3.

This section presents some indicative content for use in education and training. It does not include specific guidance on clinical skills teaching, but it is recognised that this is an important element of instilling good professional practice.

Materials to support elements of sexual boundaries training described in this section can be found in section 6⁹. The materials are not intended to be prescriptive, and can be used alongside other materials which providers might already offer, for example as part of training in ethics and law, communication skills, and personal and professional development.

What are professional boundaries?

It is important for students to understand what boundaries are in their broader sense before focussing on sexual boundaries. Various methods can be used to explore what boundaries mean. Two exercises can be found in section 6 iii, which enable students to explore the difference between social or personal and professional relationships.

Such exercises should help to inform some preliminary definitions of what is meant by boundaries, through looking at the features that denote a professional relationship. Common definitions include: limits to the relationship which mark healthcare relationships apart from social relationships; boundaries as creating a safe space in which therapy can take place; rules which set out what professionals should and shouldn't do. Boundaries in this context should be broadly defined.

Definitions in the literature often define boundaries in relation to the power imbalance between healthcare professionals and patients or carers and the consequent need for limits to protect both

⁹ Other core materials which can be used to inform education and training include:

- CHRE (2007). *Educational Audit: Clear Sexual Boundaries between Healthcare Professionals and Patients*
- CHRE (2008). *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

patient/carer and professional. Some commentators differentiate between serious boundary violations and lesser boundary crossings, including actions which may or may not be acceptable in the circumstances, for example putting an arm around a patient who is distressed. The important messages to stress in training are that to display sexualised behaviour towards patients or carers is never appropriate, and that it is always the professional's responsibility to set and maintain clear boundaries.

What constitutes a breach of sexual boundaries?

Students need clear advice on what actions are and are not acceptable. A breach of sexual boundaries occurs when a healthcare professional displays sexualised behaviour towards a patient or carer. Sexualised behaviour is defined as acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires. Students should be made aware that breaches of sexual boundaries do not just include criminal acts such as rape or sexual assault, but cover a spectrum of behaviours, of varying seriousness, all of which can cause harm.

The following list groups the main types of sexual boundary transgressions in descending order of seriousness:

- criminal sexual acts
- sexual relationships
- other sexually motivated actions towards patients such as sexual humour or inappropriate comments.

Not all sexually inappropriate acts constitute serious professional misconduct requiring action on the part of higher education institutes, or by regulators if the healthcare professional is already on the register. Students and professionals must familiarise themselves with their own regulator's guidelines.

The list on the next page, extracted from CHRE's document *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals* highlights the range of sexualised behaviours, and can form the basis of group discussion and reflection.

Facilitators should remember that certain activities may be necessary and appropriate in a given clinical situation. For example, watching a patient undress may be necessary and appropriate for a mental health professional observing a patient on suicide watch or an osteopath observing functional mobility with the patient's consent, or for a care assistant helping an institutionalised patient with activities of daily living. With the exception of criminal activities, which should be considered at the most serious end of the spectrum, there is scope for debate as to how seriously different activities should be ranked. Clearly, in any legal or quasi-legal situation, each case would be considered on its merits, taking into account all relevant circumstances. It is equally important to note that individual patients may construe even activities identified as less serious as wholly abusive. The list below can be used as a basis for discussion boundary crossings and boundary violations, thinking about when it may or may not be justifiable to act in certain ways.

Although most sexual boundary transgressions involve male healthcare professionals and female patients, there are also examples of females displaying sexualised behaviour towards male patients and same sex abuse. Educators should vary examples to draw out students' beliefs/stereotypes around gender and sexuality.

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.

Why boundaries are important

Breaches of sexual boundaries by health professionals are unacceptable, unprofessional, and potentially unlawful. Education and training needs to highlight the following substantive reasons why sexual boundary transgressions by healthcare professionals towards patients and their carers are not acceptable:

- they can cause significant and enduring harm to patients/carers
- they damage trust – the patient's trust in the healthcare professional and the public trust in healthcare professionals in general
- they impair professional judgement. Sexual or inappropriate involvement with a patient may influence a healthcare professional's decisions about care and treatment to the detriment of the patient.

Further discussion of these areas can reinforce and build on any previous teaching in ethics, communications or personal and professional development, as applicable.

Harm to patients and carers: Research evidence¹⁰ shows that health professionals displaying sexualised behaviour towards patients or their carers can cause significant and enduring harm. The negative impact of sexual boundary transgressions by professionals can be exacerbated if the patient is young and has a previous history of sexual abuse. The harms caused by a breach of sexual boundaries 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 drugs and/or alcohol.

¹⁰ Halter, M, Brown, H and Stone, J. *Sexual Boundary Violations by Health Employees: An Overview of the Published Empirical Literature* (2007). Council for Healthcare Regulatory Excellence and Department of Health. Available from www.chre.org.uk

Breach of professional trust: A patient must be able to trust that their healthcare professional will provide the best possible care and act in their best interests. They must feel confident and safe so that they can be treated effectively and participate effectively in their care. A breach of sexual boundaries can seriously damage this trust, and can result in a patient no longer accessing effective healthcare or receiving appropriate care or treatment.

Unequal power relationships: An imbalance of power is often a feature in the healthcare professional/patient relationship, although this may not be explicit. Patients are often vulnerable when they require healthcare, and healthcare professionals are in a position of power because they have access to resources and knowledge that the patient or their carer needs. A power imbalance may also arise because:

- in order to be diagnosed or treated a patient may have to share personal information
- a healthcare professional influences the level of intimacy and/or physical contact during the diagnostic and therapeutic process
- a healthcare professional knows what constitutes appropriate professional practice whereas a patient is in an unfamiliar situation and may not know what is appropriate.

It is the responsibility of healthcare professionals to be aware of the potential for an imbalance of power and to maintain professional boundaries to protect themselves and their patients.

Impaired professional judgement: Sexual activity with a patient or their carer may impair a healthcare professional's judgement about the patient's treatment. Sexual involvement may also detrimentally affect the ability of a patient to feel confident and safe in discussing private, confidential and personal information and in allowing physical examinations.

Part of the concern about relationships with former patients is that a decision to terminate treatment may have more to do with a healthcare professional's desire to commence a sexual relationship than an appropriate professional assessment that the patient's healthcare needs have been met.

Damage to the reputation of health services and professions: Breaches of sexual boundaries damage the reputation of healthcare professions and health services. Regulators, the public, the wider community, other healthcare professionals and employees expect high levels of personal integrity and the maintenance of clear sexual boundaries so that no patient will be at risk of harm. Displaying sexualised behaviour towards patients or their carers is damaging first and foremost to the individual patient, but it also reduces trust and confidence in the health professions.

Sexual activity with former patients or their carers

Sexual relationships with any former patient, or the carer of a former patient, will often be inappropriate, however long ago the professional relationship ended. This is because the sexual relationship may be influenced by the previous professional relationship, which will often have involved an imbalance of power as described above.

The possibility of a sexual relationship with a former patient may arise, for example through social contact. If a healthcare professional thinks that a relationship with a former patient might develop, he or she must seriously consider the possible future harm to the patient and the potential impact on their own professional status. They must use their professional judgment and give careful consideration to the nature and circumstances of the relationship, taking the following into account:

- when the professional relationship ended and how long it lasted
- the nature of the previous professional relationship and whether it involved a significant imbalance of power
- whether the patient was particularly vulnerable at the time of the professional relationship, and whether they might still be considered vulnerable
- how the sexual relationship began
- whether they would be exploiting any power imbalance, knowledge or influence obtained while they were the patient's healthcare professional to develop or progress the relationship

- whether they will be caring for other members of the patient's family.

If a healthcare professional is not sure whether they are – or could be seen to be – abusing their professional position, they should seek advice from an appropriate professional body.

Students and professionals should be made aware that however consensual a relationship appears to be, if a complaint is made the onus will always be on the healthcare professional to show that they have acted professionally by giving serious consideration to the points above in relation to the circumstances in question, and by seeking appropriate advice.

It should also be made clear in training that it is never appropriate to terminate a therapeutic relationship with the intention of pursuing a social or sexual relationship. Reference should be made in training to current professional guidelines and codes of practice, including why relationships with vulnerable former patients may still be harmful and should be avoided. Students and professionals should be challenged on the view that boundary transgressions are more serious when perpetrated by some groups of professionals than others (typically, a belief that boundary abuses by doctors constitute the most serious breaches of trust). These discussions could form a useful element of interprofessional learning.

Some scenarios to generate discussion around the issue of sexual activity with former patients can be found in section 6 iv.

Training for all health professionals about mental health and the vulnerability of patients who have been abused

Evidence suggests that patients with mental health problems (in particular, women, and former victims of abuse) are especially vulnerable in relation to sexual boundary transgressions, and the Kerr-Haslam inquiry recommended training in this area for health professionals¹¹.

Training must provide students and healthcare professionals with the necessary skills to be able to treat patients – both male and female – who have been sexually or physically abused. It is all the more important that healthcare professionals learn how to demonstrate safe boundaries with such patients, who may have had repeated experiences of being exploited by adults and authority figures, and may present as hostile, child-like or seductive. Setting patients a positive example in this regard can help them to begin to develop a sense of their own boundaries and begin to give them a sense of control over their bodies, possibly for the first time in their lives.

Healthcare professionals should also learn how to manage boundaries with other potentially vulnerable groups, including patients with learning disabilities, older people, children, and people in institutionalised settings. Healthcare professionals should be aware of cultural sensitivities, recognising that certain patients may regard certain types of questions or procedures more distressing or intrusive than others.

What do the professional guidelines say?

Students and healthcare professionals should be made aware of their particular profession's guidance and advice on setting and maintaining boundaries. They should also be aware of their organisation's policy and procedures concerning abuse and violence.

It is clear that simply knowing what guidelines say does not always act as a deterrent to behaving inappropriately. Nonetheless, it is important that the content of professional guidance is made widely known for the following reasons:

- to send out clear, unequivocal messages as to what is and what is not tolerated
- to act as a deterrent to students/healthcare professionals who are deliberately naive about what is and is not appropriate
- to serve as a guideline for assessing allegations of misconduct/impaired fitness to practise

¹¹ Kerr-Haslam Inquiry, 36.76, 36.80

- to ensure that students/healthcare professionals do not have the opportunity to argue in mitigation that they didn't know what the professional standards were
- to serve as a guideline for the courts in assessing criminal or civil cases as to appropriate professional standards.

Acknowledging signs of sexual attraction

It is important to make sure that all students and healthcare professionals are taught to develop self-awareness and recognise behaviours which, while not necessarily constituting a breach of sexual boundaries, may be precursors to displaying sexualised behaviour towards patients.

These behaviours include:

- revealing intimate details to a patient during a professional consultation
- giving or accepting social invitations
- visiting a patient's home unannounced and without a prior appointment
- seeing patients outside of normal practice, for example when other staff are not there, appointments at unusual hours, not following normal patient appointment booking procedures or preferring a certain patient to have the last appointment of the day other than for clinical reasons
- clinically unnecessary communications.

Students must be taught that there is nothing unusual or abnormal about having sexualised feelings towards certain patients, but that failing to identify these feelings and acting on them is and likely to result in serious consequences for their patients and themselves.

A self-assessment questionnaire that can be used by students and professionals to identify when they are at risk of breaching sexual boundaries can be found at section 6 v.

A further potential resource for trainers or students/healthcare professionals is WITNESS's 2005 report for CHRE¹², which identifies situations in which a health professional's behaviour may be interpreted by the patient as inappropriate, or where the behaviour may be a precursor to sexual boundary transgressions.

When a healthcare professional is attracted to a patient

Students and healthcare professionals should be made aware that while it is not unusual to find patients or their carers sexually attractive, it is the healthcare professional's duty never to act on these feelings and to ensure appropriate action is taken to avoid a breach of sexual boundaries.

The following guidance is taken from CHRE's *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals*.

When sexual feelings towards a patient become a cause for concern

If a healthcare professional is sexually attracted to a patient and is concerned that it may affect their professional relationship with them, they should ask for help and advice from a colleague or appropriate body in order to decide on the most professional course of action to take.

If, having sought advice, the healthcare professional does not believe they can remain objective and professional, they must:

- find alternative care for the patient
- ensure a proper handover to another healthcare professional takes place
- hand over care in a way that does not make the patient feel that they have done anything wrong.

When a patient or carer displays sexualised behaviour towards a healthcare professional

All health professionals are likely, in the course of their career, to encounter patients or carers who are unable or unwilling to recognise the limits of sexual boundaries essential for an effective professional relationship. When this happens, the patient may misconstrue professional care and compassion, for something else. This may result in patients projecting feelings of love or sexual

¹² Prevention of Professional Abuse Network (2005). *A Comparison of UK Health Regulators' Guidance on Professional Boundaries*. Council for Healthcare Regulatory Excellence. Available from www.chre.org.uk

attraction onto their healthcare professional. Some psychotherapists interpret this behaviour as a patient substituting, in their mind, the healthcare professional or therapist for parents or other previous authority figures in their life. This is an unconscious process, known as transference. Students and professionals should not interpret a patient's attraction as a manifestation of their physical attractiveness, or an opportunity to begin a sexual relationship.

Students and healthcare professionals need to learn to recognise and manage such situations. Signs might include a patient who keeps finding reasons for repeat visits, or whose language or style of dress has become sexually provocative.

These situations can provoke strong feelings particularly in a young healthcare professional. Common reactions might include fear, embarrassment, anger or arousal. Some psychotherapists attribute these feelings to the healthcare professional's reciprocal feelings towards the patient. This is known as counter-transference. Students and professionals need sufficient capacity and maturity to develop personal insight in order to recognise their own feelings, and the extent to which their actions and behaviour may be influencing their relationship with a particular patient.

Students and healthcare professionals need to appreciate that there are a variety of reasons why patients might find them sexually attractive. Patients might be flattered or overwhelmed by the attention they are receiving, and the fact that someone is listening to them and being warm towards them. They may be attracted to what they perceive to be the professional's power and influence.

Patients who display sexualised behaviour towards healthcare professionals may have suffered sexual abuse in the past. This response towards people in a position of authority may stem from a history of repeated exploitation, characterised by an inability to protect themselves physically or emotionally from people behaving inappropriately towards them. When someone does act in this way, this may be a trigger for enquiring sensitively about previous abuse.

Where a patient appears to be displaying sexualised behaviour towards a student or healthcare professional, it is the responsibility of the student or professional to take appropriate action to avoid a breach of sexual boundaries.

The following guidance on how to act if a patient is sexually attracted towards a professional is taken from CHRE's *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals*. The key point is that dealing with this situation is always the healthcare professional's responsibility.

When a patient or carer is sexually attracted to a healthcare professional

Sometimes patients or their carers are attracted to their healthcare professional. If a patient displays sexualised behaviour towards a healthcare professional, preventative measures must be taken to avoid sexual boundaries being breached.

An appropriate course of action might be to discuss the patient's feelings and attraction in a constructive manner and try to reestablish a professional relationship. If this is not possible, the healthcare professional should transfer the care of the patient to a colleague.

It is strongly recommended that the healthcare professional seeks advice from a colleague or an appropriate professional body.

It is vital that students and healthcare professionals learn how to respond appropriately to a patient who is displaying sexualised behaviour. This could be a useful opportunity for role play, followed by group discussion. Language and non-verbal behaviour is extremely important. Professionals need to be aware that they may be sending out unconscious verbal and non-verbal cues to which the patient is responding.

Two examples demonstrating appropriate and inappropriate ways to handle such situations can be found at section 6 vi.

6 Sample training materials

This section contains materials that can be used to support elements of sexual boundaries training as described in section 5. The materials are not intended to be prescriptive, and can be used alongside other materials which providers might already offer, for example as part of training in ethics and law, communication skills, and personal and professional development.

i) Use of vignettes

Extract from Robinson, G and Stewart, D. 'A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment Part 2: Teaching Method' *Canadian Medical Association Journal* 1996; 154: 1021-1025.

Vignettes

Simple vignettes about situations involving patients or learners are presented to emphasize particular dilemmas. The vignettes may be very general or tailored to fit the clinical experience of the particular specialty group being trained. The vignettes address touching, appropriate meeting places, use of language, personal disclosure, whether a patient or learner can consent to sexual contact with a physician or educator, post-termination relationships, uncomfortable atmospheres for students and staff, dating of trainees, and sex-role socialization and power differentials. The participant is asked to categorize a particular behaviour as 'never okay', 'always okay' or 'sometimes okay'. If the behaviour is deemed 'sometimes okay', the participant is asked to consider under which circumstances the behaviour would be acceptable. This use of clinical vignettes allows participants to discuss the issue and their practices and to exchange opinions. In our experience, a group of 12 to 15 participants allows maximum participation.

To discuss touching, for example, the participant is told: "You have just told your 25-year-old patient some bad news. When she bursts into tears, you move to her side and put your arm around her." Discussion of this scenario would raise issues such as the following. Is touching ever appropriate? Are certain types of touches

(e.g., a pat on the hand or shoulder) more appropriate than others? Why would a physician put his arm around a patient? Are different types of touches suitable for different patients or situations? How may the patient feel or react to this touch? How would you know whether the patient was uncomfortable (i.e. could you count on her telling you)? What other methods can be used to comfort and show concern? What if the patient asks for a hug or kiss? What if the patient attempts to hug or kiss you without asking permission? The participant has an opportunity to think about his or her own motivation and the effect on the patient as well as to rehearse different ways of handling emotional situations with patients.

Another vignette concerns dating a student. "One of your students is very bright, attractive and witty. You ask the student out to a movie." Discussion of this scenario would likely raise the following issues. Is it permissible to date a student you are teaching and evaluating? Would a student truly feel free to refuse such a request? How could dating a student affect the teaching atmosphere for the student in question and for other students? How could it affect patient care? How would either participant feel if he or she wishes to terminate the relationship? What influence or perceived influence could this relationship have on grades, letters of reference or future training? Can sexual involvement between a teacher and a student be truly consensual? How could attraction between a teacher and a student be managed to create a positive learning environment? The participant is offered an opportunity to think about and discuss his or her motivation and behaviour and its potential positive or negative effect on the educational environment. Lively discussions about sexual tensions in teaching, supervision and evaluation often ensue.

The facilitator encourages thoughtful discussion rather than passing judgement. On the basis of his or her personal experience, the facilitator can guide the participants toward more sensitive and careful ways of dealing with patients and learners. Input from other group members helps

participants to become aware of any inaccurate assumptions they may be making. The facilitator can promote discussion about whether a physician's behaviour would change depending on the sex of the physician and of the patient. This may include discussion of homosexual fantasies or fears, and of physicians' and patients' different cultural beliefs and expectations. Many participants spontaneously offer their personal experiences and dilemmas with patients or learners for discussion.

ii) Role play scenario: chest pain

Medical student instructions:

You are seeing Mrs/Mr Joan/John Stanley who has been referred to out-patient clinic with a query diagnosis of angina. The doctor's referral letter says she is a very garrulous (talkative) patient. You are going to see her for just 10 minutes before she sees the consultant. Your task is to elicit a history of her main complaint which you will then present to the consultant.

Patient: Mrs/Mr Joan/John Stanley, aged 40ish years.

You have been referred by your GP to the hospital with a diagnosis of possible angina. You are extremely anxious. You are a very talkative person anyway but tend to get more so when worried. You have had a tight constricting pain across your chest, which came on a week ago whilst you were running for a bus to meet your sister from the station. The pain spread down your left arm. You were pretty sweaty and out of breath.

Your doctor gave you some tablets to put under your tongue. These relieved the pain but gave you headaches, flushing and your heart was thumping away (palpitations). You complain of a variety of other problems, pain in your back and abdomen, anxiety feelings (panic sensations, palpitations and breathlessness). You have great difficulty in sticking to the point. You confuse your different symptoms and when they happen. You easily go off at a tangent.

You work as a dental receptionist manager, always busy looking after the practice and staff and always on the go.

You will also demonstrate some flirtatious behaviour.

Tutor's note: the communication challenge

How to listen carefully, try to manage a patient's anxiety and their own, and how to provide some structure, organisation and guidance in the interview which helps the patient give her history within a time limit. At the same time to avoid interrogative questioning but using focused and closed questions and summarising selectively.

How to manage professional boundaries in response to flirtatious behaviour.

Some students find themselves spending a long time with patients 'for a chat' and not getting an accurate and comprehensive history.

Developed as part of CETL Clinical and Communication Skills by Annie Cushing, Ph.D. FDSRCS, BDS, Reader in Clinical Communication Skills and Head of Clinical, Communication and Learning Skills Unit at Barts and the London, Queen Mary's School of Medicine & Dentistry, University of London.

iii) Defining professional boundaries

This exercise, which students can do singly, in pairs or in small groups, draws out the distinction between friendships and other social relationships on the one hand, and professional healthcare relationships on the other.

Exercise 1: Friendships versus Professional Relationships.

Divide a piece of paper into two columns. Head one column: 'Friendships' and the other column: 'Professional Relationships'.

Under each heading, 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 each as you can.

Use the exercise to consider what professional relationships are about, what their limits are, and how professional relationships differ from friendships. A model draft is shown over the page.

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/service user).
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.

What ought to emerge from this exercise is that friendships and professional therapeutic relationships do share a number of similar hallmarks, but that there are a number of important differences. Critically, 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, as sexually inappropriate. Good professional behaviour should leave no room for confusion as to whether the 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 relationship evolves over a period of time.

Exercise 2: The right thing to do¹³

This exercise uses a number of short scenarios to elicit what professionals ought to do in certain circumstances. As with the above exercise, each mini-scenario can be used as the basis of a discussion about what counts as appropriate behaviour and where appropriate boundaries lie between professionals and patients in different circumstances. This exercise might be particularly helpful as part of post-registration/CPD, where students may be slightly more worldly, and are likely to have already experienced several of the situations under discussion. The exercise can be adapted using relevant examples/vignettes from past cases.

- You bump into one of your patients in the supermarket. Do you stop and say hello or do you nod politely? Do you talk to them if they talk to you? What do you do if they try to engage you in discussion about their health problems?
- You are taking a history from a patient who suddenly bursts into tears. Do you hold out a box of tissues, or put a reassuring arm around their shoulder? Would it make any difference if you had known this patient for a long time? What other factors might affect your answer?
- You are a community psychiatric nurse and bump into a former patient in the pub. They offer to buy you a drink. Do you accept, decline, or make excuses and leave the pub?
- You are a GP and you bump into a patient and his partner at a gay nightclub in a nearby town. You live in a small village and have limited opportunities for socialising with gay people generally and would welcome the opportunity to make a new friend. The following week the patient comes to see you and gives you his mobile number. What do you do?
- You are a psychotherapist. Your patient has been coming to see you for three years. They want to invite you to their 30th/40th/50th birthday party. It would mean a lot to them if you go. What do you do?
- You are the new practice nurse on a remote Scottish island. There are few opportunities for socialising and you find yourself attracted to one of the practice patients. There is only one practice on the island. You think that the geographical remoteness of your employment and lack of ordinary opportunities is a justifiable reason to enter into a romantic liaison. Discuss. Would you feel differently if this case involved a GP in a similar position?

¹³ This exercise was developed by WITNESS, a dedicated charity supporting patients who have been abused by health or social care professionals. www.witnessagainstabuse.org.uk

iv) Sexual activity with former patients

The following scenarios can be used to enable students/healthcare professionals to consider issues regarding sexual activity with former patients:

- a. You are a physiotherapist who treated an attractive young man/woman on three occasions for a sports injury. You meet them six months later at a friend's party and find them very attractive. Do you ignore the fact that you once treated this person as a patient and ask them for their telephone number?
- b. You are an optician in a small town and have provided optical services to all members of a family. You have been friendly with the family's eldest daughter for several years and last year, fitted her for contact lenses. She asks you out and you are keen to accept.

v) Acknowledging signs of sexual attraction

The self-assessment questionnaire (right) may help students and professionals to identify when they are at risk of breaching boundaries¹⁴.

Boundary transgressions

Self-assessment questionnaire

1. Have you felt that you were responsible for the patient's behaviours and that his or her misconduct was a reflection of your professional competence?
2. Have you arrived early or stayed late to be with your client for a longer period of time?
3. Have you felt that other staff members were too critical of 'your' client?
4. Have you felt that you were the only one who understood the client?
5. Have you had difficulties setting limits with your clients?
6. Have you found yourself relating to a client as you might a family member?
7. Have you received any feedback about your behaviour being overly friendly or involved with clients and/or their families?
8. Have you experienced sexual feelings towards a client?
9. Have you derived great satisfaction from a client's praise, appreciation or affection?
10. Have you kept secrets or felt that there were things about a client that cannot be shared with other staff?
11. Have you felt that other staff members were jealous of your relationship with a client?
12. Have you tried to 'match-make' a client with one of your friends?
13. Have you found it difficult to handle clients' unreasonable requests for assistance, verbal abuse, or sexual language?
14. Does this client or situation remind you of a similar person or situation? If so, is there anything you feel you need to resolve about the person or situation before you can work with this client?
15. Do you feel uncomfortable in approaching your supervisor or colleagues to discuss your feelings about a certain client?

¹⁴ Doyle, M (2002). Boundary Violations Self-Assessment Questionnaire, Based on the work of Stephen Wong & Audrey Gordon (1999) Regional Psychiatric Centre (Prairies), Canada.

vi) Handling difficult situations

Example 1 demonstrates an appropriate choice of words, followed by an inappropriate choice of words, that could help a healthcare professional deal with a situation where he/she says that they are sexually attracted to them.

Example 2 (overleaf) demonstrates an appropriate choice of words, followed by an inappropriate choice of words, to help a healthcare professional deal with a situation in which a patient thinks a healthcare professional is sexually attracted towards them.

Note however, that effective communication requires a highly individualised approach and sensitivity to what is required in the particular circumstances. This may require a professional to use firm and forceful language.

Example 1

Appropriate response	What the patient will hear
“I’m pleased you brought this up”	Helps the patient not to feel embarrassed or ashamed at having articulated difficult emotions/feelings
“Sometimes patients develop strong feelings for people treating them and you’ve done the right thing letting me know how you’re feeling”	Validates the patient’s feelings – and provides reassurance that what the patient is feeling is not uncommon.
“Your treatment and wellbeing are very important to me as your doctor/nurse/physiotherapist”	Emphasises the professional basis of the relationship between you and your ethical commitment to acting in the patient’s best interests
“It would probably be better for you if I recommend someone else who can treat you”	Displays appropriate professional responsibility. If you don’t feel you can carry on treating, make sure that you make appropriate handover provisions so that there is continuity of care for the patient’s clinical needs. Do so in such a way that the patient does not feel abandoned, or that they are being punished.

Example 2

Inappropriate response	What the patient will hear
“I don’t know what you’re talking about/that’s absolutely ridiculous”	Invalidates the patient. Denies the patient’s reality and makes them doubt their own judgement, particularly if there is a sexual energy in the relationship.
“I’m really shocked/angry you’ve said that”	Makes the patient feel scared and embarrassed. Highlights professional’s own lack of knowledge and skills, and fails to acknowledge any sexual energy that may be emanating from the professional.
“Besides, I’m happily married/engaged/with someone else”	Conveys the impression that the healthcare professional would consider a relationship if they weren’t otherwise attached.
“I’d never go out with someone like you/no-one would go out with someone as messed up as you”	Compounds any feelings of low self-esteem/worthlessness/lack of confidence the patient may have, especially if s/he is a victim of previous abuse.
“But now that you’ve said that, of course I can’t treat you any more”	Makes the patient feel bad for having honestly acknowledged their feelings.
“You’ll have to find someone else to treat you”	Makes it the patient’s responsibility to make sure their ongoing clinical needs are provided for, when it is always the professional’s responsibility to do this.
“I suggest you look for a man/woman (opposite sex therapist)”	Highlights healthcare professional’s own stereotypes about gender, sexuality and sexual abuse, and the fact that transference in professional relationships will be directed at professionals of either sex.

A Appendix

Summary of research on sexual boundaries

A review of research literature¹⁵ between 1970 and 2006 found that healthcare professionals did not feel they were adequately trained or educated on sexual boundary issues with patients and that the professional guidelines lacked clarity. In addition the research review found:

- clear sexual boundaries are crucial to the safety of patients
- sexual boundary transgressions by healthcare professionals commonly result in significant and enduring harm to patients
- the majority of reported sexual boundary transgressions involve male professionals and female patients
- between 38 and 52 per cent of healthcare professionals report knowing of colleagues who have been sexually involved with patients, but self-reporting rates by healthcare professionals are considerably lower
- patient vulnerability is associated with higher prevalence rates
- a greater awareness of guidelines and sanctions, and targeted educational and training programmes, reduce prevalence rates.

Key Findings

1. 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 healthcare 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 patient's perceptions, use of chaperones, and avoidance of sexual humour
- positive training environments promote healthier coping responses.

2. Reported prevalence and incidence

- the majority of reported boundary transgressions involve male healthcare professionals and female patients
- 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.

3. 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 transgression by healthcare professionals.

¹⁵ Halter, M, Brown, H and Stone, J. *Sexual Boundary Violations by Health Employees: An Overview of the Published Empirical Literature* (2007). Council for Healthcare Regulatory Excellence and Department of Health.

4. 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 potential boundary issues
- a higher proportion of 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 have suffered previous abuse.

B Appendix

Further reading

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Notes

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