Boundaries, touch and the lone worker

About Julie

Julie Stone is an academic medical ethicist and lawyer with a long-standing regulatory and research interest in professional boundaries. As Deputy Director of the Council for Healthcare Regulatory Excellence, now the PSA, she led the 2008 'Clear Sexual Boundaries Project'.

Julie was a GOsC Council Member, where she chaired the Osteopathic Practice Committee, scrutinising the drafting and introduction of the OPS 2019. She contributed to the development of internationally authored guidelines on the Ethics of Touch and is currently a lay panel member for the GCC.

Author of numerous books and chapters on ethics and professionalism, she has written two GOsC Reports: Thematic Analysis of Boundaries Teaching in OEIs (2017), and Supporting Professionals, Protecting Patients: Shifting the Narrative on Professional Boundaries (2022).

She is currently working Ethics Lead and Chair of the Ethics Committee for UKCP, developing new guidelines on professional boundaries. She has most recently undertaken work with the ambulance service and contributed to Royal College of Surgeons initiatives to improve sexual safety culture.

Keeping this discussion safe: Ground rules

This is a sensitive subject. Take time out if necessary.

Talking about sexual boundaries can be triggering. Exercise self care

Treat yourselves and each other kindly and with respect

Don’t (feel under any pressure to) disclose personal or sensitive information

Non-attributability of what is said within the room (permission to record)

Boundary cases and FtP

Boundary violations by all regulated professions (statutory and non-statutory) including but not limited to sexual boundaries

Recent regulatory focus on colleagues as well as patients, with new Code requirements

As fitness to practise cases represent only the most serious complaints, volume of unboundaried practice may be significantly higher than regulators record. FtP after the event, and when harm has been done. Focus needs to be preventive

Touch-based therapy raising unique issues

Lone working/non-managed environments raise additional issues

Education and training needing to focus on boundaries as an everyday issue, and not 'othering' 'deviant' practitioners

Keeping patients safe is everyone's business. Links to Speaking Up and moral courage.

When boundaries are seriously breached

Maintaining boundaries respect patients. Harms of breached boundaries:

a. for patients, including: loss of trust, in the individual, other practitioners and potentially from seeking further help at all, triggering previous abuse, psychological harm, depression, self-blame, suicidality

b. for professionals: potentially loss of career, loss of professional identity, loss of sense of self

c. diminution of reputation in the profession: the role of the regulator extending not only to the impact of and on the individual, but the extent to which acts of misconduct diminish patients' and the public's trust and confidence in the profession as a whole

Changing context of boundaries discussions

[Hyper]sexualised society/access to pornography/sexting

Swipe right culture – inappropriate behaviours from patients

Sexual harm and exploitation of young people and sexual harassment at school and university

Appreciation of the high levels of childhood sexual abuse and systematic abuses by those in positions of power (e.g. the Church)

Negative role of influencers e.g. Andrew Tait, growth of ‘incel’ culture

Growth of online grooming

Revenge porn/cyber bullying

Shared understanding of professional boundaries

Boundaries as limits of accepted/acceptable professional practice, encoded in Codes of Ethics and Good Practice

To create a safe space in which the needs and best interests of the patient are paramount

Boundaries keep patients safe from harm and practitioners safe from allegations

Boundaries reflect relationships of trust e.g. to disclose personal information and allow themselves to be observed and/or touched for diagnosis and treatment

Boundaries acknowledge inherent power dynamics

Not just sexual - physical, emotional, financial boundaries also matter

Power dynamics and professional relationships

Serious breaches described as abuse of trust and breach of the power dynamic inherent in professional relationships. This power may be relative, e.g. students may not perceive themselves as holding power

Some patients are more vulnerable than others, even though it is always the professional's responsibility to establish, maintain and enforce boundaries

Sex in the treatment room. Do professionals know how to respond? Patient initiated advances disempowering the practitioner. Cultivating skills to manage patients testing boundaries

Despite duty to speak up, students/ newly qualified professionals may not feel empowered to challenge unethical behaviours of those who have power over their career progression

How use of touch impacts on professional boundaries

Boundary violations within osteopathy and chiropractic significant. Less so physiotherapy (operating often in managed environments). Massage therapy? Fewer, but many non-regulated

'Touchy feely' practitioners? Hands on, touch-based therapy (psychotherapy plus touch?).

Little taught on the potency of touch. Anatomical and physiological training insufficiently attentive to interpersonal/psychological dimensions of working with touch

Osteopaths/chiropractors working behind closed doors (even if no longer necessarily in sole practice) – no MDT, no managed environment so falls to self-regulation and accountability

Relative lack of patient understanding of what different manual therapies do and what is appropriate (working on floor v treatment couch, loosening clothing or undoing bras etc)

Lack of structured professional and peer support, mentorship, appraisal or supervision, allowing for 'professional drift' and deviation from norm

Lone workers/independent practitioners

Likely to lack oversight inherent in working within managed environments or large multi-clinics

Protect self against professional isolation, e.g. through mentoring, buddying or peer support networks

Ensure good client facing materials making it clear expectations of professionals and patients at or before first appointments

Document any problematic encounter in your notes and notify your indemnity insurer ASAP.

‘Rupture and repair’ – understanding possibility to move on from minor boundary breaches, but refer on if not possible to maintain boundaries

Avoidance of home visits and keeping treatment spaces ‘professional’

Awareness of language/humour/clothing and how this will be perceived by patients

Commissioned research

THEMATIC ANALYSIS OF BOUNDARIES EDUCATION AND TRAINING WITHIN THE UK'S OSTEOPATHIC EDUCATION INSTITUTIONS

A Report by Julie Stone commissioned by the General Osteopathic Council

March 2017

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SUPPORTING PROFESSIONALS, PROTECTING PATIENTS: SHIFTING THE NARRATIVE ON PROFESSIONAL BOUNDARIES IN OSTEOPATHY

Julie Stone

A Report for the General Osteopathic Council

May 2022

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What did the reports find?

Osteopathic Education Institutes (OEIs) the main opportunity to teach about boundaries. Most OEIs include boundaries education, but what, where, when and by whom varies. 2022 Report provides some indicative content.

Experientially, teaching well received using role play, narrative, case analysis and small group discussion

Crowded curricula - danger of ethics and professionalism teaching seen as not core. Regulator (GOsC)-led sessions instilling fear and 'othering', especially in early years. Help needed in HOW TO not just DON'T

Discomfort in discussing sex generally, especially when taught by older tutors to younger/diverse students

Discomfort in talking about the possibility of sexual attraction to and from patients and lack of advice and what practical steps if this happens

Generally, emphasis on clinical skills training. Opportunities for tutor development limited

Education: What to teach, when to teach about boundaries

What to teach, when to teach it, how to teach it, who to teach it, how to know that this teaching is making (enough of) a difference

How do we ensure that boundaries teaching is relevant to today's students, including recent legislative changes to protect workers from harassment?

Encouraging good practice (do do this) v. understanding the consequences of unacceptable practice (don't do that)

Teaching with reference to what goes wrong via FtP cases, encourages 'othering', rather than owning our own vulnerabilities to act unethically in certain circumstances e.g. when burnt out

Small group discussions face to face to allow emotionally intelligent tutors to recognise signs of distress within the room

Pre-registration training needs to be reinforced with impactful CPD/safe reflective spaces, acknowledging many tutors were not taught about boundaries

Including sexual attraction and arousal in the curriculum

How to? Upskilling tutors to be able to talk about these issues in a sensitive and trauma-informed way, recognising they may not have been taught about these issues in their training

Talking about arousal as a normal patient response to touch

Making this subject relevant and tolerable, including bridging the generational and cultural gaps between tutors and students

Who best to deliver this material?

Potential for peer-led discussion?

Attentiveness to LGTQIA+ experience

Legal and ethical dimensions of therapeutic use of touch

Opportunities to teach boundaries through the lens of consent to touching, with opportunities to rehearse 'battery' (no consent to touch at all) or negligence (touching without having given information as to risks to a competent and voluntary patient, answering questions which they feel material to their decision as to risk).

Touch as a vehicle for healing but also having potential to harm – most well-intentioned therapists do not consider the capacity of their intervention to harm, beyond specific treatment effects. But, as with non-specific benefits, so too, non-specific harms

Touch supercharges boundary issues e.g. around practitioner self-disclosure

For osteopaths/chiropractors/physiotherapists need to learn about the potency of touch, as experienced by patients (isolation of Covid heightened need for touch and issues of client dependence)

Other relevant topics to consider within professional boundaries training

The giving or receiving gifts to or from patients, including value of any organisational policy

Making or accepting social invitations, which may include, e.g. a funeral of a patient you have worked with

Anticipating unscheduled contact in a social setting/on the street (greater prevalence working in rural settings). Potential use of contracts at the start of working with new patients

Self-disclosure, including in relation to direct questions by a patient

Security of social media and avoidance of communicating e.g. through WhatsApp. Separate personal and professional accounts.

Evaluating the effectiveness of boundary training

A bigger question for ethics and professionalism generally is what is the impact of ethics training?

Can we extrapolate from what limited evidence there is, what it is that students and practitioners need to know?

Changing patterns of abuse, e.g. against colleagues and length of time to review and change curricula

What makes this teaching 'effective' and reduces the likelihood of people refraining from breaching boundaries?

Are we still at the point of wanting to encourage more complaints or should we be beginning to see a reduction in incidences of harm?

Pre-registration and/or CPD and/or ‘safe, reflective spaces’

Early years students find it hard to imagine they would act badly

Awareness of professional boundaries become more of an issue when practitioners leave relative safety of education (e.g. needing to attract and retain a client base, and/or facing challenges as salaried practitioner in practices where boundaries/ethics wanting)

Creating safe spaces for practitioners necessary to reflect on uncomfortable situations (including erotic transference/patient sexualisation of space). Peer group discussion and peer supervision can be helpful, as professionals may fear discussing this with their membership organisation or with their insurers

Acknowledging that abuse of power not necessarily experienced as such by young/newly qualified practitioners who themselves feel vulnerable, and may be more likely to look to clients for social relationships

Separating out who is responsible for what

Regulatory reach limited *albeit extends to ‘Friday night selves’,* and interventions should be upstream

Professional bodies/membership organisations

Role of insurers/indemnity organisations

Educators (including school, as sexualisation/assault endemic within education)

In the context of employed practitioners, role of line managers, and in the NHS, FTSU guardians and Boards (boundary violations as a ‘red risk)

New workers’ protection legislation to protect from harassment

If FtP, ensure allegations, regulators should consider sexual harassment allegations rather than ‘sexual motivated’ behaviour, and ensure trauma-informed proceedings to support giving of best evidence

Eliminating serious boundary breaches

For a few professionals, 'Don't have sex with patients' isn't working. Codes have only limited impact on professional behaviour. Professionals are not unaware that boundary violations are a breach of their professional duties and

Fitness to practise a blunt and retrospective tool. Prevention is key. Undergraduate education primary opportunity but crowded curriculum, and tutors don't always role model good boundaries

Multi-faceted preventive approach required of regulators, educators, employers, police and CPS – recognising broader societal context of sexual harms including in school and college education

Professionalism, ethics, law, clinical skills and training in allyship/speaking up

Part of the much bigger question of how do we reduce sexual offending and sexual harassment in our culture?

Can we weed out sexual harassment and assault?

Early identification and robust responses e.g. to unacceptable student behaviour. How do we take account of the formative nature of professional education? How do we identify students at risk earlier in their studies or their careers?

Offender management v removal from register (removed practitioners do not cease to be a sexual risk, they just become a risk *elsewhere*)

Robust use of erasure where appropriate, and rigorous application of employment policies - not being swayed by testimonials or perceived need to retain clinicians in practice

Automatic striking off or remediation?

Within FtP, consideration of psychological approaches for ‘lesser’ offenders – a supportive, practitioner-oriented approach – with early intervention, e.g. as part of rehabilitative conditions

What do people offended against want to happen? Holding to account and prevention of repetition

Do you think there are situations where remediation might be possible?

What do you think members of the public would think about this?

Need for research in this area

Resilience as one answer but not ‘the’ answer

Research suggests that those suffering burnout or overwhelm are more likely to act unprofessionally and seriously breach boundaries

Individual resilience is essential to support professionals throughout their career

Role for employers and individuals in ensuring wellbeing. Oxygen mask analogy

How do we instil resilience skills for students, tutors and professionals?

Suggested next steps

Education – pre-reg and mandatory CPD, plus upskilling tutors and far greater involvement of patients in education

Boundaried and trauma-informed training environments

Within regulation, training and upskilling of FtP panel members, Chairs. Also ensuring quality of 'prosecution' matches that of defence Counsel

Drafting better allegations re sexual harassment not sexual motivation: raping not dating

Revise PSA Sexual Boundaries Guidance, and ensure consistency of Codes and sanctions guidance across regulated and accredited professions

Thank you for your participation.

Feedback and suggestions welcomed
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