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

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ABBREVIATIONS USED IN THIS REPORT

CHRE	Council for Healthcare Regulatory Excellence
FtP	Fitness to Practise
GOsC	General Osteopathic Council
GOPRE	Guidance on Osteopathic Pre-Registration Education
NCOR	National Centre for Osteopathic Research
OEI	Osteopathic Education Institute
OPS	Osteopathic Practice Standards
PSA	Professional Standards Authority
QA	Quality Assurance

BACKGROUND TO ANALYSIS

According to NCOR research[1], roughly a quarter of all complaints raised about osteopaths relate to boundary and patient modesty issues[2]. Complaints mechanisms, by their very nature, report problems after they have already occurred, so whilst they highlight that there may be a problem, they do not offer a solution for how to improve osteopathic practice. From a regulatory perspective, complaints mechanisms may be thought of as looking at this problem down the wrong end of the telescope[3]. So how best do we foster high ethical standards in practitioners? Whilst individuals are ultimately responsible for acting ethically, education and training is where students learn about professionalism, and what will be expected of them as osteopaths. The aim of any regulator, in partnership and conjunction with its stakeholders, is to promote good practice and help develop professions and professionalism. Instilling a strong sense of professionalism, including an appreciation of the importance of effective boundaries, is a key plank of osteopathic education and training, which is why this analysis is looking at OEI activity in this area.

Whilst boundary violations occur in all professions, the proportion of complaints involving boundary related issues within osteopathy, combined with similarly high numbers of complaints about poor communication[4], calls into question *whether there are factors which are specific to osteopathy* which make boundary issues more of a concern in osteopathy than in other professions. Whilst not unique to osteopathy, there are certain distinguishing features which might make boundaries more problematic in osteopathy than in other professions. Potentially, these might include: the proportion of professionals working in sole, independent practice, without the support or oversight of other professional colleagues; the touch-based nature of the healing intervention in a touch-averse dominant culture, in which the individual osteopath is the hands-on healer; the nature of the consultation in which patients are usually partially undressed, and potentially vulnerable; the capacity for patients misunderstanding the nature and intent of healing touch; and the absence of a profession-wide system of formal appraisals, mentoring or supervision. Part of this analysis was intended to ascertain whether, and if so how, any these potential risk factors are dealt with by OEIs as part a holistic approach to educating about boundaries.

Another aim of this analysis was to evaluate how OEIs balance the need to emphasise boundary issues as an integral part of everyday practice, whilst ensuring mechanisms are in place when things break down. An assumption underpinning this analysis is that creating and maintaining

[1] Carnes, D. *Types of concerns raised about osteopaths and osteopathic services in 2013*. NCOR (2013).

[2] In 2013, of the 112 concerns raised which related to conduct, 11% of complaints were about sexual impropriety (12 complaints), 9% related to failure to protect a patient's dignity and modesty (10 complaints), and less than 1% related to conducting a personal relationship with a patient (5 complaints), exploiting patients (1 complaint) and failing to offer a chaperone (3 complaints).

[3] Stone, J. 'Professional regulation and its capacity to minimise professional abuse'. In Subotsky, F., Bewley, S. and Crowe, M. eds. (2010). *Abuse of the Doctor-Patient Relationship*. Royal College of Psychiatrists Publications. This highlights that although fitness to practise mechanisms are the most visible aspect of the regulatory process, the area of regulation most likely to prevent practitioners from offending is education and training.

[4] In the same year, inappropriate and ineffective communication accounted for 24% of complaints about conduct.

effective boundaries is, and should be seen as a central aspect of *good clinical practice*, an inherent part of professionalism. This will impact on where and how this topic is covered in the curriculum, and part of the function of this analysis is to see how boundaries can be taught as an element of developing professionalism and creating good therapeutic relationships more broadly.

Managing patients' (sometimes unrealistic) expectations, learning how to hold a safe emotional space for patients, keeping oneself resilient, preventing burnout, and dealing appropriately with strong feelings towards patients, both positive and negative, are also aspects of ordinary clinical practice. Attending to these elements of osteopathic work requires a high level of self-awareness, insight and emotional intelligence. Instilling these qualities is also, therefore, an important part of educating about boundaries. This requires specific teaching on practitioner and patient psychology, including a deep understanding of the psychology as well as the physiology of touch (for the practitioner and the patient), and a cultivation of sensibility towards patients and their emotional states. The aim of this teaching is first and foremost to protect patients, but also to protect students and tutors, as allegations of breaching boundaries may end their career[5].

In recognising that boundary challenges arise every day in practice, an underlying assumption in this analysis is that learning how to create and maintain good boundaries as part of effective therapeutic relationships is core learning for all. This analysis aims to get a feel for whether boundaries are indeed embedded in osteopathic education and training as a predictable and common aspect of all therapeutic relationships, along with the everyday issue of boundary challenges coming from patients, or, whether boundary violations - at the most extreme end, having sex with patients – are presented as a rare, unpredictable and unpreventable occurrence, relating to the misconduct of 'deviant' practitioners.

Boundaries education and training, within many health professions, is situated within a growing attentiveness towards cultivating professionalism – ensuring that students and registrants are not merely taught how to pass assessments, but also come to *embody* the knowledge, skills, attitudes and professional values which justify the trust placed in them as professionals. Instilling an embodied sensitivity is germane because of the touch-based nature of the therapeutic encounter, in which the osteopath is the vehicle through which healing takes place.

Learning how to use touch appropriately forms a major part of osteopathic training, and should be one of the ways in which students learn how to convey appropriate boundaries[6]. Clinical

[5] General Osteopathic Council Indicative Sanctions Guidance (2013) states that removal from the register is the likely to be the appropriate sanction for proven allegations where the behaviour is fundamentally incompatible with registration with the GOsC as an osteopath and involves, amongst other things, serious abuse of position/trust (particularly involving vulnerable patients) or serious violation of the rights of patients or convictions or cautions for sexual offences or findings of sexual misconduct.

[6] Schiff, E., Ben-Arye, E., Shilo, M., Levy, M., Schachter, L., Weitchner, N., Golan, O., Stone, J. 'Development of Ethical Rules for Boundaries of Touch in Complementary Medicine – Outcomes of a Delphi Process'. *Complementary Therapies in Clinical Practice*. 2010 Nov;16(4):194-7.

teaching about touch needs to be augmented by consideration of both ethical and legal aspects of touch, including consent to touch, including consent to touch sensitive parts of the body. Learning to touch patients in ways which conveys caring and competence in a professional manner is crucial, as touch is capable of being misconstrued. The nature and quality of the osteopath's touch conveys a lot about the practitioner, as well as the patient. Whereas in counselling and psychotherapy, a patient might be 'reading' the practitioner from the pictures hanging in the consulting room, so osteopathic patients are 'reading' the unspoken language of touch conveyed by the osteopath in a hands-on treatment, hence the need for osteopath to learn how to ensure that the way they touch is wholly professional *and is perceived as such*. Learning about safe touch needs to incorporate an understanding of the pleasurable aspects of touch and the potential for erotic transference to arise.

Whilst learning how to palpate and treat is a clinical skill, and thus likely to be taught and assessed in OEIs as a practical/clinical skill, combining this with self-awareness (what does the osteopath get out of the touching?) and emotional intelligence (is the osteopath attentive to what the patient is experiencing? is necessary to create an appropriate boundary in a physical sense. Part of this analysis aims, therefore, to see how clinical skills teaching, communication (verbal and non-verbal), and interpersonal skills are combined, as both are needed to keep patients and students safe[7].

Professionalism can be instilled in a variety of methods and at a variety of points throughout education and training. As well as explicit statements found in codes and role-modelling by more senior colleagues, it also involves an understanding of key requirements such as accountability, responsibility, and respect for patients. Some of these aspects may be taught within an ethics and law curriculum, although they may arise and be reinforced in other areas of teaching. This report will seek to show whether boundaries are taught in isolation, or as part of an integrated approach to thinking about professionalism and good practice.

This analysis has been undertaken alongside the Annual QA exercise as a means of exploring what the OEIs are currently teaching in terms of professional boundaries, with a view to i. describing what is happening ii. eliciting good practice iii. making recommendations for future development. This analysis would not have been possible without the engagement of the OEIs and the author is grateful to all OEIs for supplying information to make this preliminary analysis possible. The author acknowledges the limited nature of this work and recognises that OEIs may already be covering many of the recommendations set out in this report. Indeed, the process of completing this analysis has led several OEIs to consider changing or augmenting their policies or making boundary issues more explicit in their courses, and it will be interesting to assess the utility of this exercise moving forward.

Any errors and omissions are solely those of the author.

[7] Education must also equip practitioners to recognise patients who have poor sense of boundaries, and learn how to deflect inappropriate behaviours of patients and keep them safe. Stone, J. *'Professional regulation and its capacity to minimise professional abuse'*. Above.

SUMMARY OF KEY FINDINGS

1. Boundaries are recognised as being an important part of osteopathic training.
2. Despite a fixed definition, the responses suggested familiarity with and support for understanding the term professional boundaries as it is used in CHRE's work on Clear Sexual Boundaries, and by GOsC in the OPS.
3. The emphasis, broadly, within education and training is positive, rather than negative, aimed at supporting the creation of strong boundaries for all, backed up by policies and procedures to deal with boundary breaches by students or staff.
4. Good boundaries are seen as a key element of professionalism and are widely taught as an integral part of training on professionalism.
5. Boundaries are often taught as an element of ethics, law and communication skills.
6. Some, but not all OEIs, augment boundaries teaching by providing lectures on mental health and psychological aspects of caring, including learning how to manage strong positive and negative feelings towards patients.
7. Because many osteopaths are mature students, or into osteopathy from other health professions, some OEIs might assume prior knowledge of boundaries.
8. For some OEIs training on managing boundaries is implicit rather than explicit.
9. Boundaries teaching is integrated with clinical skills training.
10. There was little evidence of boundaries training addressing issues specific to osteopathy as distinct to boundaries in other healthcare professions.
11. Multiple methods are used for teaching and assessing boundaries at multiple points throughout the curriculum.
12. OEIs have effective informal and formal mechanisms for making and resolving complaints.
13. Boundaries training is reviewed through various quality management mechanisms with some good evidence of OEIs reviewing and updating policies and teaching as necessary.
14. All OEIs provide guidance to students about appropriate conduct in clinic settings.
15. All OEIs have a policy on how students can refer a patient.
16. Clinics are supportive of patients' complaints and many encourage students to view patient feedback, positive or negative, as a helpful learning tool.
17. Most OEIs provide guidance to staff on safe boundaries with their students, and most, but not all OEIs actively discourage personal relationships between staff and students.
18. Developing professionalism is underpinned and supported by role-modelling by tutors throughout course.

INTRODUCTION

As the first analysis conducted by GOsC of its kind, a few preliminary issues emerge which need to be clarified. The first issue is that in seeking information from the OEIs, no definition was offered by GOsC as to what it understood by boundaries. Accordingly, it was up to the Schools to determine what the remit of the information supplied should be. Many of the respondents referred to the Osteopathic Practice Standards (OPS) and the Guidance for Osteopathic Pre-Registration Education (GOPRE), and to Student Fitness to Practise (FtP). Some displayed an awareness of the work carried out by the CHRE, now Professional Standards Authority on 'Clear Sexual Boundaries'. By leaving the question of what was meant by boundaries open, this facilitated a wide range of responses on issues including managing stress, managing strong emotions towards patients, dealing with complaints, friendships and commercial relationships between staff and students and students and patients, and not merely a narrow interpretation of boundaries as being about a prohibition on sexual relationships with patients.

Indeed, all of the OEIs referred heavily to the teaching of professionalism, and to this extent, there may have been an implicit understanding of creating, maintaining and reinforcing boundaries as a positive professional duty, which enhances the therapeutic relationship and keeps students/practitioners as well as patients safe. This would certainly tie in with a constructive understanding of professional education and training with an emphasis on *what to do, rather than what not to do*.

The OEIs varied significantly in the amount of data and detail they supplied. Some included specific lecture content, others pointed to where in the curriculum boundaries sat. Some provided information mapping learning outcomes to the OPS, and some provided links as to university- wide policies. Another respondent provided an in-depth narrative as to how professionalism was taught, and how their programme aimed to equip students to embody professionalism and ethics, within and beyond clinical practice. In order to capture this data in a useful way, this report presents a summary of findings, without providing in-depth information as to what is taught where. A common finding emerging from these diverse responses is that education and training about boundaries is a broad and *dispersed* activity, which straddles multiple subject areas and is further reinforced through expectations about conduct set out in policies and procedures, particularly in clinic.

Another significant preliminary observation is that it became clear from a number of the responses that the division of material sought for the purpose of this analysis into five discrete themes or topics was somewhat artificial. Respondents noted that it was sometimes hard to describe the range of activities which OEIs offer which support students' understanding of boundaries, and noted a degree of overlap in the different sections. However, as this was the framework followed by OEIs to supply the information, this will form the framework for analysis in this report. If repeated, future iterations of this work may collect data differently.

The understanding of the need to promote strong boundaries as part of effective and caring therapeutic relationships appears to underpin much of the teaching of this area, but for a number of schools, teaching and education about boundaries is *implicit rather than explicit*. For example, some of the schools offer sessions on stress, or psychology, and how to deal with patients you don't like, and most of the clinics have a specific policy about referring on patients. But only some OEIs seem to link teaching around the management of strong feelings, positive or negative, to an understanding of boundaries. Similarly, to the extent that OEIs describe lectures and guidelines on stress and keeping healthy, few schools drew out an explicit emphasis on the link between professional burn out and inattentiveness to one's own wellbeing with the increased likelihood of acting unprofessionally (including, by breaching boundaries).

As a first analysis of its kind, the report will be useful in establishing a baseline, but has not been able to answer all of the questions it might have been helpful to understand more about. Future analyses might concentrate on teaching method, aiming to ascertain, for example, how to make professional boundary and sexual boundary teaching maximally effective, at what stage of the curriculum to introduce various themes, and when and how to integrate theoretical and practical skills teaching.

With one exception, each of the OEIs offer specific teaching on boundaries, usually within the context of personal and professional development courses, and ethics, law and professionalism courses. There was little discussion in the responses about whether professionalism is different to ethics and law, or whether ethics and law provide the theoretical basis for professionalism, which is a live debate within broader clinical ethics and law teaching. Arguably, in instilling a basis in ethical theory, educators provide a basis for students and practitioners to think through how to act in a variety of situations, and how to analyse and weigh up conflicting duties and principles. But few OEIs offered much information on whether, to the extent boundaries is taught as part of ethics and law, boundaries were analysed much beyond an aspect of 'non-maleficence' and not harming patients, rather than as part of a broader discussion about respect for dignity and beneficence.

In addition to professional knowledge skills and attitudes being inculcated via taught sessions, the returns suggested that another significant strand of teaching about this subject was, additionally, 'taught/communicated' outside of the standard curriculum and noted this was hard to capture or quantify within this questionnaire. This raises an interesting point as to the extent to which boundary training involves good role modelling on the part of tutors and whether this was something which could or should be formalized. A number of the colleges described buddying and mentoring systems which might also form part of developing a sound basis of professional learning about boundaries.

Some of the OEIs have a specific boundaries policy. This may sit within the college, or be a University-wide policy. Policies cover not just sexual boundaries, but close familial, sexual, friendships and financial relationships. The issue of receiving gifts was mentioned (including use of a vignette about gift-giving). This is helpful as the giving and receiving of gifts to and from

patients is recognised in the literature as a precursor to other boundary crossings[8]. Excessive self-disclosure, another precursor, was not explicitly mentioned as a topic which is addressed. It was clear that much of the practical training on managing boundaries takes place in the clinic setting.

Interestingly, whilst all the OEIs ensure that students know how to protect a patient's modesty and dignity, there was little information offered as to whether, and if so how or why this is related to professional boundaries. This is interesting as various assumptions have been made that the breaching of a patient's modesty and dignity is a major boundaries issue in osteopathy. Moving forward this may require fresh analysis, as to link the two risks confusing a number of discrete issues. Whilst an osteopath who is reckless when it comes to respecting a patient's right to modesty and dignity may display other unprofessional behaviours, e.g. failing to offer a clean environment, it is a rather old-fashioned and unhelpful view of boundary violations to assume that the sight of exposed flesh will turn an otherwise professional osteopath into a practitioner with a sexual interest in the patient. Not only is this unlikely and unevidenced, bearing in mind that many/most patients are in a state of undress, it fails to explore the nature of boundary crossings and violations as related fundamentally to breaches of trust and an abuse of power, which is how the literature commonly understands boundary breaches.

Nonetheless, the number of complaints about this issue suggests a potential mismatch between patients' expectations and osteopathic practice, including: what level of undress will be required; whether, and if so why, an osteopath may watch a patient getting undressed (for example, to assess functional ability); and where and how a patient may be touched in the course of an osteopathic treatment. Consent, communication and clinical skills training are all areas where this could usefully be taught and assessed.

In terms of the structure of this report, for the purposes of the analysis, the themes in the questionnaire will be dealt with as separate topic areas, notwithstanding the acknowledged overlap between some of the sections, and the weighting of the material, with much of the content provided in the first section. Each heading will be broken down into a description of key findings, commentary on the findings, examples of good practice, and potential opportunities for development and recommendations.

[8] See for example, Gabbard, G. 'Patient Therapist Boundary Issues'. *Psychiatric Times*, October (2005) http://www.psychiatrictimes.com/articles/patient-therapist-boundary-issues and Stone, J. 'Respecting professional boundaries: What CAM practitioners need to know'. *Complementary Therapies in Clinical Practice* (2008) 14,2 –7. Along with the giving and receiving of gifts, other potential precursors include excessive self-disclosure, special arrangement for appointments (e.g. at unusual times or at a patient's home) and social or dual relationships.

TOPIC 1:

Findings

This topic was intended to draw out, specifically, how boundaries are taught within the various OEIs, assuming, broadly, that professional boundaries for the purpose of this analysis would cover the range of issues addressed in the OPS and earlier work undertaken by the CHRE (now PSA) in its 2008 project 'Clear Sexual Boundaries'. Notably, the responses all demonstrated an understanding of boundaries as referring to positive aspects of the osteopath/patient relationship, to do with dignity, respect, empowering patients and for osteopaths, appropriately managing stress and exercising self-care, and boundary crossings, be they of an emotional, sexual or commercially exploitative nature. Broadly, this topic elicited the why, what, where, when and how boundaries is covered both explicitly, within the formal curriculum and the clinic setting and implicitly, for example, through demonstration of good practice and role-modelling by tutors.

It was encouraging to see most OEIs approach the subject of boundaries as an integral and every day aspect of teaching and learning about professional practice. What was quite surprising was the paucity of data provided on whether and if so how OEIs teach about serious sexual boundary violations, other than through the provision of codes of conduct and student fitness to practise policies.

Why teach about boundaries?

Most of the OEIs described the need to consider boundaries as part of the much broader subject of professionalism. Accepting that each of the OEIs has a different student profile, the end result is to create practitioners able to display high levels of professionalism, to operate within the Osteopathic Practice Standards (all domains, and not just the professionalism domain), and to inculcate through education and training reflective practice skills and an appetite for lifelong learning to support osteopaths throughout their professional careers.

OEIs highlight the nature of the expectations of students enrolling onto a professional course in different ways, but a noteworthy aspect is highlighting of the additional professionalism required of students from the very start of their training, and the importance of their personal conduct outside as well as inside the School. Some OEIs require students to sign a contract before they start their course to signify that they understand and agree to the requirements expected of them as a student. These may include requirements to provide a valid enhanced disclosure under the Disclosure and Barring Service, agreement to abide by relevant professional standards and commitment to behave appropriately whilst on College premises.

What is taught?

Schools teach both the positive and negative aspects of professional boundaries, as in what to do, and what not to do. One OEI described the process of education more widely as equipping students with the necessary empathy and ethical skills to embody professional practice. The term 'emotional intelligence' and insight came up as part of what training on boundaries was aiming to instil. Responses highlighted the everyday nature of boundary issues as part of broader discussions such as managing difficult patients, or managing strong emotions, or negotiating situations where a particular client 'pressed the student's buttons'. In at least one school, these issues were covered within a specific module on psychology. Certainly, themes relating to projection, transference and counter-transference were referenced, although not necessarily in the context of the formal curriculum.

Broadly, the responses demonstrated an approach to professional boundaries which went beyond lecturing to students on having inappropriate relationships to a far deeper, nuanced understanding of the ethical foundations underpinning trust-based relationships, particularly where there may be an imbalance of power (students and patients and staff and students). Areas covered include:

- Sexual boundaries
- Emotional boundaries – one school highlighted teaching about self-care
- The nature of professional boundaries in a theoretical and practical context
- Receiving gifts from patients
- Standards of Practice, with and without specific reference to the OPS, and for some mapping learning outcomes against OPS
- Professional responsibility
- Accountability
- Ethics in practice, including establishing trust in the therapeutic environment
- Patient safety – duty of candour and Francis mentioned in this context, highlighting a need to impress on students the duty to speak out if they see inappropriate behaviours in others
- Safeguarding in practice (safeguarding seen as helping support related issue of professional boundaries)
- Risk in practice. Unclear whether this included the specific risk of allegations being made against an osteopath or student and how to mitigate against that risk. Some schools expressly teach/practice use of chaperones, auditing, consent procedures
- Whistleblowing
- Managing stress/triggering situations/coping strategies
- Managing patient expectations
- Managing 'difficult' patients
- Psychology of healing

When in the curriculum is this taught?

The key finding is that boundaries is taught and integrated throughout the entire curriculum. As such, even in the schools which teach specific boundary lectures, e.g. as part of ethics and law teaching, the subject is revisited and covered in multiple parts of the curriculum. Most of the schools situate teaching about boundaries within teaching and learning about professional practice. Some schools acknowledge that their teaching on this topic could be more explicit with discrete learning outcomes around professional boundaries.

There is a strong emphasis on teaching about professionalism in all of the OEIs and several schools have ways of impressing upon students from the start of their student journey that they have particular responsibilities training as an osteopathic professional, and that the requirements of them in terms of personal behaviours are more onerous than the requirement on university students not undertaking vocational courses. OEIs reinforced this in different ways, for example, through making students agree and sign up to an explicit learning contract, or formally sign up to a code of conduct. One OEI advises students who apply they will need an enhanced Disclosure and Barring Service (DBS) certificate as a way of impressing the professional responsibilities inherent in undertaking a professional training.

OEIs identified a number of specific junctures where students were introduced to boundary issues including:

- As part of student induction. Many schools highlight the extent to which OEI induction introduces students to the responsibilities expected of them as a student and future osteopath, stressing the need for professionalism from the outset, and highlighting that unlike students on other course, behaviours and conduct outside the classroom environment might also impact adversely on their ability to be admitted to a professional register. Other relevant induction topics mentioned as relevant include ethics and patient-centred care.
- As part of teaching about the Student Fitness to Practise (FtP) policy
- As part of the induction to working in Clinic
- As part of ethics and law curriculum
- As part of learning about risks in practice
- As part of communications skills training
- Throughout clinical skills training
- As part of learning about reflective practice, including in relation to Personal and Professional Portfolio completion
- Throughout the entirety of the course via role-modelling by tutors, within and beyond the clinical setting. This includes the ethical role-modelling of personal behaviors, in relationships with students and colleagues, as well as relationships with patients

Sources/Materials:

i. Handbooks

- Student Handbooks - as with learning contracts, students at some OEIs have to sign up to the responsibilities in their handbooks/codes of conduct as a way of formalising their responsibilities
- Module Handbooks - contain specific teaching content, learning outcomes and assessment requirements
- Staff Handbooks (either at an OEI level, or sometimes University-wide, Staff Handbooks set out various requirements germane to boundaries, which will be considered under Topic 2)
- Professional Practice Handbooks
- Clinic Handbook (guide students to consider specific elements relating to boundaries that build as they progress through the programme). NB. This raises the developmental nature of teaching about boundaries.

ii. Policies

- Student Fitness to Practise (FtP) Policies
- Staff/Student relationship Policies
- Disciplinary Policies
- Complaints and Grievance Policies
- Student Welfare Policies

iii. Lectures

- Ethics and law, including in lectures on consent (and consent to treatment involving intimate areas)
- Osteopathic Practice Standards and regulation
- Patient safety
- Stress
- Psychology

How is this taught?

- Tutorials – allowing for debate. NB. This is important to create reflective spaces, as the nature of professional boundaries is complex and the 'right thing to do' is not always straightforward. It is important to provide non-judgmental spaces where students can begin to formulate ideas and challenge others' thinking in safe environments (counselling and psychotherapy training, by way of comparison, provides opportunities for expressly considering attraction towards patients as well as dealing with irritation). One OEI described how students are taught reasoning skills based on ethical theory, legislation and the OPS. Several of the schools referred to small group teaching, which

presumably provides students with the safety to explore and develop what one school described as 'wicked' competencies.

- Lectures – whole cohort lectures used by most schools to convey various elements on boundaries, such as consent, stress, psychology
- Vignettes and case studies
- Clinical workbooks
- Reflective practice, student reflective incidents and reflective logs – OEIs cited opportunities for reflection as a place where discussions about boundaries emerged. Self-reflection was widely discussed as an ongoing way of being, with the aim of teaching and learning to instil reflection and continuous improvement as something students incorporated instinctively
- Support and observation under supervision in clinical practice setting, followed up by the opportunity to reflect with tutors, allowing tutors to observe students learning to become proficient in managing complexity in real life practice situations
- Use of learning contracts – a number of schools emphasised student self-responsibility for their own learning. Ways in which this was given effect included use of explicit learning contracts
- Role-Modelling – a number of schools highlighted the extent to which members of staff embodied and displayed the values expected of an osteopath, not only in clinic, but how they conducted themselves outside of their professional practice. One school highlighted that role-modelling formed a significant part of instilling good professional practice and there were several references to values-based recruitment
- Pastoral/Student support – a number of the schools mentioned open door policies whereby students could discuss concerns with any member of staff, and others described pastoral/student support as a mechanism for supporting students working through difficulties
- Buddying and mentoring – as with tutor role modelling, some schools have systems of buddying and mentoring in place, sometimes linking new students with more advanced students. This provides opportunities for safe spaces and potentially difficult discussions which students might prefer not to have with tutors

How is boundaries training assessed?

Because of the dispersed and sometimes implicit nature of teaching about boundaries, no single method of assessment was described. Rather, to the extent that boundaries are taught as part of broader themes around professionalism and personal development, OEIs described multi-modal formative and summative assessment methods, combining theoretical and practical aspects of training. This includes, but is not limited to: clinical assessment evaluating student competence as professionals, observation and evaluation behaviours in practice, including ability to recognise, manage and respond to boundary issues in the real world setting. Assessment methods cited include:

- Reflective clinical assessment
- Case presentation
- Case study presentation
- Practical Clinical Assessment
- Objective structured clinical exam (OSCE) which may include assessment of professional demeanour (marking criteria are notably lacking in detail about how this might be assessed and there is scope for fleshing out details, e.g. displaying effective communication)
- Written exam
- Essay
- Course work
- Critical appraisal report
- Data analysis exercise
- Literature review
- Personal and professional portfolio (including reflection, SWOT analysis, action planning)
- Presentation to peers
- Research proposal
- Research poster
- Vignettes (including those circulated in the GOsC ebulletin and discussion of past FtP cases)

Good practice example

Several OEIs use case studies and vignettes requiring students to reason around a range of moral or ethical problems including boundaries and how they might act in response to such issues. They are required to underpin their decision-making in relation to ethical theory, legislation and the OPS. This is important so that students can learn how to describe what they have done with reference to ethical principles and duties, and to that they can begin to learn how to capture and articulate any departure from established norms.

Discussion

Boundaries education is found in diverse places, with OEIs referring to explicit but also implicit teaching around professionalism generally, and boundaries more specifically. There is no single correct way of teaching about professional boundaries, although certainly, OEIs highlighted the need to pick this up throughout the curriculum, and reinforce theoretical lectures with clinical skills training, working towards *phronesis* or 'practical wisdom'

OEIs demonstrated variable levels of appreciation of the need to cultivate self-awareness, empathy and emotional intelligence as key to training students about boundaries. There was recognition that these are not straightforward competencies to cultivate, or to assess (the term 'wicked' competencies used by one OEI).

What was clear from the responses was that boundaries issues are considered and taught in a holistic way, and that OEIs see their role as creating a teaching and learning environment where a professional approach to boundaries can flourish. To this end, rather than describing specific sessions on boundaries, OEIs highlighted, for example, creating spaces for students to explore various aspects key to effective boundaries, such as: exploring patient expectations; identifying and responding to patients' needs; and establishing trust within the therapeutic environment.

The dispersed nature of activities listed by OEIs was reflected in methods for monitoring and enhancing practice. This included, but were not limited to: mapping of courses against benchmarking statements, GOPRE and OPS, monitoring and analysis of complaints, monitoring and analysis of student fitness to practise hearings, reviewing course and unit content through periodic review and other quality management processes, and feeding findings from complaints back into policy and practice.

Several OEIs described the extent to which practising on each other as students allowed students to gain a deep insight into how it feels to be a patient. This was often described in relation to cultivation of empathy, and to gain a better awareness of patient expectations, the development of communication as well as clinical skills, and also, evocatively described by one OEI, as a means of new students experiencing, when they undress to practise on each other, 'the uncomfortableness of being a patient' (see below). Some OEIs were attentive to the potential for that sensitivity to be lost so in practical teaching sessions require the 'treating' student to maintain professional dress when working on a student colleague, mirroring the professional working relationship.

The developmental nature of teaching about boundaries was raised, but not explored in great detail in the OEI responses. What is clear is that professionalism, more broadly, is taught and built on throughout the curriculum, and assessed in ways which may capture various elements linked to boundaries, such as effective communication, but it was not obvious whether this explicitly includes developmental learning and assessment specifically on how to manage boundaries effectively. This might be part of wider discussions within OEIs as to what attitudes and behaviours might trigger student FtP processes, differentiating, perhaps, the developmental approach towards inculcating professionalism of which boundaries training is a part, with a zero tolerance, for example, towards sexual assaults.

The responses lacked granularity as to what is taught about boundaries, when and why. Building on professionalism teaching, it would be helpful to develop knowledge about what

teaching approaches about boundaries work most successfully at what stages. Is there an optimum time to teach students about different elements of boundaries? Specifically, in relation to boundaries, what needs to be taught before students practise on each other, practise for the first time in clinic, and work towards practising under less supervision?

Psychological aspects of training vary significantly across the OEIs and might potentially be developed as part of a concerted approach to reducing boundary incidences through normalising student understanding of the strength of feelings, positive and negative they may experience towards patients, along with topics commonly taught within counselling courses, such as projection, transference and counter transference, as well as exploration of the student's own vulnerabilities. In terms of sexual boundaries, more open teaching and discussion of erotic transference and the erotic/emotional content of touch might be useful. This is potentially an area which could be developed with other manual/hands on professions, but particular attention needs to be paid to the additional 'risk factors' present in the often unsupervised, sole practitioner forms of delivery of osteopathic care.

Recommendations

- Useful to collate a database of vignettes based around or including a boundaries dimension
- Useful to collate potential learning outcomes associated with creating and maintaining appropriate boundaries
- Further research on effectiveness of what should be taught when and whether and if so how theoretical boundaries training at the OEI can best be reinforced in clinic settings
- Whilst some schools teach modules on psychology and counselling, little information was supplied about the extent to which insight, self-awareness and self-care relates to boundary issues
- Whilst several OEIs talked about boundaries teaching as part of clinical skills training, there was little information about the specific boundary issues raised by touch. It may be that is such a core part of the curriculum as not to have been highlighted, or it may be that this topic needs further development
- Helpful to consider specific communication skills in relating to boundaries, and the use of creative methods, such as role-play to enhance skills. Potentially covered in sessions various described as managing patients' expectations, and managing difficulties, no OEIs described dedicated communication sessions where students might learn how to respond to specific boundary challenges coming from patients. Learning how to respond sensitively and appropriately to inappropriate or unboundaried behaviours from patients could serve to protect students and practitioners from allegations and complaints

TOPIC 2

Boundaries between tutors and students. Relevant school policies and how these are made known to tutors and students e.g. as part of a staff and/or student induction

Findings

Each of the OEIs has policies and procedures in place to ensure appropriate boundaries are maintained by staff and students. Situated within employment codes of conduct, staff and student handbooks, bullying and harassment policies and disciplinary codes, some of these are situated within School's policies, and some are university-wide policies. An obvious first point is that the responses highlighted that OEIs highlight this issues in policies and codes both for staff *and* for students, highlighting the responsibilities of each, and reinforcing these responsibilities in different ways.

Why look at boundaries between tutors and students?

In addition to the promotion of strong supportive professional relationships between staff and students, prohibitive codes expressly circumscribe inappropriate behavior on the part of staff towards students. Implicitly or explicitly OEIs recognise and articulate the power imbalance between tutors and students. Strong professional boundaries between tutors and students mirror the boundaries needed between practitioners and patients, and are often described, similarly, in terms of relationships of trust. Schools recognise and highlight the need to provide a safe learning environment, and the associated issues of bullying and harassment. Whilst students also have responsibilities to act professionally and appropriately, the onus on setting, maintaining and enforcing appropriate boundaries sits with staff and tutors. Codes and rules prohibiting staff/student relationships also protect the reputation of the school, as allegations made against members of staff have an adverse impact on the School and university, with reputational and commercial implications.

OEIs highlight the dangers of boundaries between tutors and students being blurred/breached as including:

- Damaging the learning potential for the individual student
- Damaging the learning environment for other students
- Boundary breaches impair teaching (in the same way as pursuing a relationship with patients shifts the focus away from their therapeutic needs towards towards gratifying the needs of the practitioner, so blurred boundaries in the teaching environment damage the focus on the learning needs of the individual student, and students more widely, if a member of staff is fixated or distracted)

- Opening the OEI to allegations of unfairness and actual or perceived bias (some schools operate a policy where members of staff who have ties to a particular student are expressly prohibited from being involved in their assessment)
- Demonstrating poor role-modelling, an abuse of power and an abrogation of professional responsibility

What is covered?

All OEIs have a range of specific policies which set out very clearly rules and regulations, at a School and university level of the expectations of staff and students. Tutor responsibilities may form part of wider codes of conduct for employers which may or may not explicitly mention or prohibit relationships or abuses of power with students, other staff members or clients (interestingly one OEI's Employee's Handbook extensively lists various behaviours which would be considered as gross misconduct, including 'obscene behaviour' and 'behaviour likely to bring employer into disrepute' but does not explicitly refer to abuses of power or breaches of boundaries).

Some schools also have policies prohibiting the treatment of friends and families. Some OEIs highlights the need for members of staff to refrain from entering into financial or commercial relationships with students. Most but not all OEIs expressly prohibit emotional/sexual relationships between staff and students. Where tutor/student relationships are tolerated, they nonetheless require any relationship to be disclosed to the institution so that steps can be put in place, for example, to ensure that a tutor does not mark assessments. Interestingly, one of the OEIs extends its requirements on professional boundaries between students and staff, preferably, to relationships between students and their peers.

Where is this information to be found?

Sources include:

- Student handbook
- Staff induction
- Staff Disciplinary policy
- Clinic Tutor Handbook
- School Code of Conduct
- Harassment policies
- Raising concerns policies
- Pastoral/Student Welfare and support services provide guidance to students

The bulk of the guidance is directed towards close personal and sexual relationships, but one OEI also stresses the need for staff and students to avoid business relationships as well as

personal relationships. This is interesting in that it captures the wider implications of how relationships of trust can be abused. Whereas prohibitions tend to concentrate effort on the sexual end of boundary violations, relationships of trust are capable of being exploited in various ways, so attention more fully should ensure that students, like patients, are protected from financial, emotional and psychological, physical as well as sexual abuse and exploitation from those in a position of relative power over them.

When is this topic addressed?

Appropriate relationships between staff and students in many OEIs are included as part of staff inductions, as part of ongoing staff training, and as part of clinic tutor training. Reciprocal responsibilities on the part of students are highlighted in student inductions, student codes of conducts and clinic introductions and reinforced in clinic codes of conduct.

OEIs offer multiple channels of support to students, describing various ways in which students who have concerns can raise issues. Some of these will be covered more extensively in the section on complaints (and indeed, for the purpose of this analysis, it might, on reflection have been more logical to capture complaints mechanisms for students against staff within this section). Most OEIs offer a range of *formal and informal mechanisms* for dealing with concerns. Some schools offer a personal tutor system, whereas others describe 'open door' policies, where students can report concerns to any member of staff, as well as pursuing more formal channels.

Good practice example

Tutor/student boundary policy

One OEI reviewed and changed its policy on tutor student boundaries after a complaint. Systems and policies were enhanced and included as part of a strengthened student and staff induction programme. Areas of good practice now include staff are not issuing personal home or mobile numbers or personal email addresses to students, or engaging with students via personal social media sites e.g. Facebook. Students can only contact staff using College email and telephone numbers. Staff cannot provide treatment to students at their personal business premises. Treatment can only occur in College at student clinics using normal clinic booking procedures.

Discussion

All OEIs demonstrate a strong awareness of the need for appropriate boundaries between teaching staff and students, as well as appropriate behavior between members of staff. Schools highlighted a combination of University-wide policies, and other specific policies relating to

boundaries between staff and students, and staff and other staff members. The issue extends in several OEIs to the question of treating friends and families, which again, many schools prohibit or strongly caution against. Most of the discussion about staff responsibilities, however, was situated within a framework of employment/contractual responsibilities, and couched in negative terms relating to misconduct, rather in the context of role-modelling by staff, recognised by some OEIs as an important mechanism for instilling the values inherent in osteopathy and healthcare professionalism.

What did not come out clearly in the responses was an attentiveness to any distinct boundary issues inherent in being an osteopathic tutor, as distinct from an osteopathic student. As a developmental issues, it may be useful to recognise the similarities between boundaries issues between tutors and students and healthcare professionals (tutors and students) and patients. but also to explore some of the differences. Whilst much is written on duties of health professionals towards patients, there is less guidance on boundary issues for tutors and trainers.

An example of some key areas is set out in the following guidance produced by the Elementary Teachers' Federation of Ontario.

Unacceptable Behaviours

In general, activities which take a teacher beyond the expectations of the employer could easily qualify as boundary violations. These include:

- becoming too personally involved with students - friend, confident, surrogate parent;
- seeing students in private or non-school settings;
- writing or exchanging notes, letters or emails;
- serving as a confidant with regard to a student's decision about his/her personal issues;
- giving gifts or money to students;
- inviting students to one's home;
- having students stay overnight in one's home;
- driving individual students to or from school;
- giving one student undue attention;
- being alone with a student with the exception of an emergency situation;
- sharing your personal problems with students;
- sharing personal information about a student with a third party; and
- initiating physical contact.

http://www.etfo.ca/AdviceForMembers/PRSMattersBulletins/Pages/Professional%20Boundaries.aspx

OEIs might consider a more explicit set of requirements for tutors expressly relating to boundaries, such as the advice above. Any such guidance would need to acknowledge a significant aspect unique to manual therapy tutors, which is the extent of necessary physical contact likely between tutors and students as tutors demonstrate osteopathic techniques on students. The potency of touch is an element to explore here, especially where the student perceives the tutors touch as expert, and/or may feel themselves to be 'special' if the tutor chooses them from amongst a group to demonstrate on. Tutors often work with groups of students, so any excessive controlling or boundary crossing issues may be kept in check through the power of group observation and the likelihood of a student/s reporting if a tutor were to act inappropriately, so long as students feel confident to speak out and articulate any concerns. This could be emphasised as part of professional whistle-blowing responsibilities, but there may be considerable resistance to reporting poor practice by a tutor. Students may be particularly disinclined not to report a problem if they fear this will impact on their ability to progress through their course, as they are enrolled in a long-term commitment with the OEI and invested in their professional training.

The relationship between personal tutors and individual students may mirror practitioner/patient boundary issues, and there is a growing literature on abuses by coaches and mentors which might be relevant to consider. Presumably, some of this thinking underpins the negatively couched codes which either prohibit relationships between staff and students, which highlight the need for staff/student relationships not to impinge on the student's learning.

Unlike practitioner/patient boundaries, an interesting point to emerge was around friendships and relationships to the extent these involved mutually consenting adults. That this was raised in more than one response is significant. Essentially, this arises by nature of the fact that many osteopathic students are mature students, the implication being that relationships between staff and students more equal and less problematic. This is a very important issue. This suggestion mirrors arguments advanced by registrants in fitness to practise cases and criminal investigations about consent. But the imbalance here is not about age of the respective parties, but power, and the relative imbalance of power between staff/tutors and all students irrespective of age or status. Students attend an OEI to receive a professional education and training, and they have rights to be educated in a non-threatening, non-sexualised, non-abusive learning environment.

In a similar vein, assumptions should not be made that osteopathic students coming from another healthcare background understand about boundaries in an osteopathic context. Assuming that boundaries are identical across all health professions overlooks the specific context of osteopathy, and failure to cover these distinct features, particularly issues relating to touch, may account for higher rates of complaints and concerns in osteopathy than elsewhere.

Several OEIs noted that the impact of a member of staff breaching professional boundaries has implications not just for the individual member of staff and student but wider ripple effects on

the learning environment for others, and the reputation of the school and university as a whole. OEIs rightly adopt a robust view on the range of reasons for why such relationships are inappropriate, described above.

As with allegations by patients against osteopaths/students, part of a culture of professionalism including the maintenance of strong boundaries is to protect the practitioner, and in this case, the member of staff from allegations of inappropriate behavior. For all the reasons that patients with a diminished sense of personal boundaries may push at the limits of what is acceptable or appropriateness closeness, so too, students may similarly provoke, antagonize, flirt and be seductive with staff members. Mirroring the responsibilities of the osteopathic professional towards patients, it is the professional duty of the individual in the position of trust and in a position of relative power to cultivate, maintain, and reinforce safe boundaries. As tutors, doing so not only keeps the student safe, but can serve as a mechanism to role-model, through positive action, what safe boundaries look and feel like. This requires the same level of self-awareness and insight on the part of the tutor that education and training needs to instil in students. Staff training and values-based appointments were mentioned by several OEIs in this regard.

To the extent schools have raised whether different issues arise because osteopathic students tend to be mature students, a thorough grounding in boundaries between staff and students is a necessary part of staff training. As with training of professional boundaries for students, this needs to be more nuanced than simply prohibitive statements of what staff must not do. Whilst it is important that behaviours are reinforced through disciplinary codes and enforced as necessary, a similar attentiveness to boundaries needs to be cultivated in staff training which acknowledges the challenges to staff which might lead to poor impulse and boundary control. This might include, for example, consideration of:

- Managing strong feelings towards students, positive and negative
- Managing erotic transference AND sexual attraction towards students
- Exploring the tutor's own issues around healing, wounded healer, needing to be needed, power
- Ensuring staff have good support systems to ensure that they remain in robust (or good enough) physical and psychological health
- Ensuring that staff have support mechanisms to protect them from unfounded allegations, and from advances made by students who themselves need support and guidance in the maintenance of boundaries

Recommendations

- OEIs keep policies and procedures under review, enhancing them as need be, and constantly improving processes in the light of feedback and experience, learning from problems when these arise
- OEIs consider how to enhance staff and tutor sensitivities towards their own potential to breach boundaries as an everyday issue and not as an aberrant deviant issue
- OEIs provide full support to clinic staff, ensuring that they are training in emerging developments on ethics, law and professionalism, recognising that they may have trained at a time when there was less of an emphasis on these aspects of the curriculum

TOPIC 3

Boundaries between students and patients. Including (but not limited to) how students are taught to manage strong feelings (positive and negative) towards patients and/or tutors, and any policies for students referring patients on to another person

Findings

Responses from OEIs highlighted a significant overlap between this question and responses previously discussed in the first topic, namely, what is understood by boundaries, and how these are taught. Building on previous information given, this section provided an opportunity where OEIs could demonstrate in more detail how some of their theoretical teaching students receive is reinforced through being integrated with clinical teaching and clinical practice. It also allowed OEIs opportunity to discuss of how students begin to apply their knowledge about boundaries in the clinic situation, under close supervision from tutors at first, diminishing as they progress through their course. Within this section, OEIs described in more depth how students are taught to recognise and manage emotional aspects of the therapeutic relationship, and specifically, how to manage strong feelings between themselves and patients.

The reason for exploring this is because the boundaries literature identifies the extent to which strong emotions both positive and negative can flow from patient to practitioner and vice versa as a common part of therapeutic relationships. Working with appropriate boundaries does not mean that an osteopath should not display warmth towards clients. Indeed the skill is in cultivating a therapeutic healing touch, which conveys the osteopath's caring intent. The importance for understanding boundary issues is that positive feelings from and towards a patient, can, at times be erotically charged. Counsellors and psychotherapists are used to working with these issues of transference, counter-transference and projection and learn how to manage it, an integral part of the training of counsellors and psychotherapists[9]. Some respondents identify how they specifically address this in their courses through the provision of counselling training or psychology or mental health sessions.

Specifically, this section highlighted how schools manage relationship aspects of training and instil some of the 'people skills' elements of professional training needed to forge strong therapeutic relationships, including communication skills, establishing empathy and trust, and providing safe and boundaried care. There was also discussion of the need to help develop

[9] Ladson, D and Welton, R. 'Recognizing and Managing Erotic and Eroticized Transferences'. Psychiatry (Edgmont). 2007 Apr; 4(4): 47–50 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921238/

insight and emotional intelligence in students. Some OEIs talked about how they try to cultivate self-awareness amongst students, teaching them how to recognise their own feelings, values, insecurities, and needs. As many boundary violations occur when professionals are experiencing a personal crisis, issues of self-care and emotional resilience are also very important to protecting professionals and patients.

This section provided an opportunity to discuss how clinics deal with the situations where, occasionally, there will be a need to refer a patient to another student, a tutor, or another health professional. For the purposes of this analysis, the interest is less on how OEIs teach technical clinical skills in knowing when to refer, but on how they help students to identify situations where the therapeutic relationship, including communication and personal issues, necessitate a referral. This may be due to boundary reasons, and can include issues of transference identified above, which, as described, may lead to strong attraction between therapist and client, but may also explain hostility if the therapist, or indeed client is triggered by the relationship.[10]

Some OEIs described duties of confidentiality in this section, including a duty to speak out if a student has concerns. Several OEIs mentioned changes they have introduced in relation to duty of candour and others highlighted safeguarding in this section.

Where is this instilled?

Sources of guidance include:

- Student induction
- Student Codes of Conduct
- Student Clinic Handbooks, setting out obligations to patients and how this should inform behavior and action
- Student Fitness to Practise policy, provides specific guidance about relationships with patients
- Professional Behaviour Policy
- Referral form and patient delisting procedures
- Student guidance on gaining consent for examination and treatment

[10] A qualitative study carried out for BACP which interviewed 13 counsellors identified not only the ubiquity of sexual feelings, but also the presence of other strong feelings to be negotiated: "First, whilst our particular focus in this study was management of risk of sexual boundary violations, many of our participants, although acknowledging the significance and ubiquity of sexuality and the erotic in their work, made the point that sexual feelings are not the only emotions that may be 'stirred up' between therapist and client. Other emotional responses can be evoked that have the potential for destructive and constructive impact on clients – anger, irritation, fear and dislike, for example – and the therapist is required to manage these reactions for client benefit." It's arguable that the focus on sexual boundaries has eclipsed drawing attention to what might be more obvious and everyday relationship issues, such as managing dislike towards a patient.
http://www.bacp.co.uk/docs/pdf/15296_june%20tt%202010.pdf

- OPS

How is this topic addressed?

As above, multiple ways in which students are taught and learn to manage boundaries with patients set out under Topic 1. Significantly, this element drew out the significant role of clinic tutors as role-models, as supervisors and as sources of advice and counsel.

Some OEIs talked about the importance of values, and values-based recruitment, applying to staff and students and relevant throughout the course, but highlighted in this context. The shift towards values-based practice and values-based ethics ties in with other responses which talked about the need for college and clinical staff to role model and educate on the embodiment of professionalism, not merely donning the mantle of professionalism for the duration of the professional encounter. As such OEIs described their role as a deeply moral enterprise, teaching students to be reflective, self-developing practitioners whose ethics permeate their professional and personal spheres.

Good practice examples

One OEI describes how students are given guidance if there is a need to refer a patient to another student or practitioner external to the school. A patient referral form used for in house referral which has guidance notes to help students. Patients are also supported to raise concerns or complaints should they feel that the professional boundaries between them and their student practitioner are inappropriate.

One OEI described how it uses reflective incident logs to provide an opportunity for students to reflect and discuss issues of this nature. An example was given of a student whose patient had a fascist symbol tattooed on his body. Having weighed up the appropriateness of challenging the patient, and feeling unable to offer care to this patient, the student called the clinician to take over. The reflection provided space to recognise the student's own values and boundaries as a moral agent, and provided an opportunity to reflect on situations where it may not be possible or practicable to treat a patient towards one whom has strong negative feelings.

Use of patient feedback is good practice, utilised by many schools as part of the learning experience. Good practice is shown by several schools in supporting patients to complain, and indeed to encourage informal complaints as a vital feedback tool.

Discussion

This topic highlights the need, recognised by OEIs to balance their activity between prohibition of inappropriate behaviour, for example, through the dissemination of student FtP codes, and broader activities designed to foster a strong and positive sense of professionalism in students, in which ethical practice is automatic. This is not to say that OEIs don't need the former, and each describes a fitness to practise machinery to deal with extreme examples of misconduct. But even in the context of fitness to practise, OEIs describe a developmental journey in which behaviours and attitudes which would be unacceptable in a student close to finishing studying an about to enter independent practice, might be understandable and the subject of further training and support in a student at the start of their education.

There was some debate as to whether 'being ethical' can be taught (to the extent that many of the schools cite ethics and law and professionalism teaching as the locus for boundary activity) one presumes most OEIs think this is possible. Other OEIs referred to the use of values-based practice and recruitment, of students as well as staff. This appears to be one way of selecting onto professional courses students who are able to articulate a values-driven approach to caring, although the task of the OEIs is to translate being able to describe having values, or an ethical orientation, towards embodied ethical action.

To the extent that a proportion of complaints and FtP concerns do involve sexual boundary violations, it was surprising that the responses didn't suggest much/any teaching in some OEIs on erotic transference, both from patients to students but also students to patients (unless this is raised within discussions on 'difficult' patients). Appreciating that strong erotic feelings can and do arise in treatment is an issue which needs to be openly discussed and worked through, not least of all so that students don't feel embarrassed or ashamed to acknowledge and discuss these feelings, recognised in psychotherapy training as being ubiquitous, and included as a core aspect of psychotherapists' training[11]. Critically, training conveys that these feelings are normal and can provide useful insights into unspoken dynamics in the therapeutic relationship. Without this training, practitioners and students are more likely to react unhelpfully when they experience these feelings, may isolate themselves, fail to seek support, and possibly act inappropriately (not necessarily sexually, but possibly with hostility towards the patient). Moreover, failure to deal explicitly with this issue places students, tutors and Schools at risk from

[11] Pope, K., Sonne, J., and Holroyd, J. (1993). *Sexual Feelings in Psychotherapy. Explorations for Therapists and Therapists-in-Training*. Washington, DC: American Psychological Association.

allegations made by patients, and leaves students without a practised skill set to draw on in the event of patients acting in an unboundaried or provocative way.

Recommendations

- Creating clear feedback loops so that learning from specific boundary cases can be fed back into teaching. Mechanisms, for example for sharing reflection to the extent confidentiality could be maintained, and students and patients kept safe.
- Ensuring that patients have continuity of care if it becomes necessary to refer that patient on due to a boundary concern between patient and student
- OEIs to continue to ensure regular and full training for clinical staff members, many/most of whom are working practitioners with competing demands, and who may themselves have been educated at a time when expectations about boundaries were less explicit than they are now.
- Contributing to developing the literature on what personal factors may lead individuals to breach boundaries, including burn out, poor management of personal problems, lack of emotional intelligence and insight. Exploring educational mechanisms for conveying these 'wicked' competences, and appropriate mechanisms for assessing them.
- Several OEIs felt that they needed to make their training on boundaries more explicit. Whilst some OEIs teach students how to manage 'difficult patients' this might be augmented by specifically relating to self-awareness, and an attentiveness by students to what they are feeling and experiencing, holistically, when they encounter 'difficult' situations, and to recognise what might be behind feelings of discomfort, bodily and emotionally, triggering challenging communication.

TOPIC 4

Patient modesty – the approach to teaching and learning how to protect and promote patient dignity, and also the approach taken to maintaining dignity and modesty when students learn and practise techniques on each other.

Findings

The question of patient modesty has long been linked to discussions about boundaries in osteopathy. Whilst the importance of protecting a patient's modesty is taken to be self-evident, the responses do not discuss explicitly why, and to what extent, this single aspect of the therapeutic encounter is considered as a core boundary issue, rather than reflective of a broader need to respect a patient's dignity. This is not to say that the issue may not be discussed in greater detail in the course of teaching sessions, but why there is such interest in patient modesty is not made explicit.

The question of whether, and if so, why, a patient's state of undress is a key boundary issue was not brought out in any of the responses. Specifically, there was little linkage to show how respecting modesty was linked to more fundamental issues of ensuring safe boundaries to do with relationships of trust, unequal power relationships or benefitting and not harming patients. Perhaps this point is so obvious as not to have been raised, but the underlying assumption that partial undress might tempt otherwise boundaried students and tutors into acts of sexual inappropriateness was not mentioned. This is noteworthy, as the state of undress of a patient, for example, within physiotherapy, is not treated as a major boundary related topic, albeit, physiotherapists would be expected to treat patients with dignity. This begs unanswered questions of whether, for example, the concern is the combination of a patient being undressed and the osteopath being largely unsupervised which elevates this subject to a cause for concern. For the main part, OEIs restricted their responses to modesty in the context of broader requirements to respect patients' dignity managing patients' expectations.

The question also probed, specifically, the practising of osteopathic techniques by students on each other, not least of all, as this involves at least one of the students being undressed when they are being treated. Again, without necessarily spelling out whether this is a dignity and comfort issue rather than a boundary issue, the OEIs highlighted various attempts to ensure that students practising on each other did so safely and ethically. The level of concern about this topic can be inferred from its inclusion in GOsC's consultation on student fitness to practise, and the response from the PSA. GOsC asked whether more detail was required in the guidance on the issue of boundaries in relation to students working with each other, and in the context of relationships between educational staff and students. PSA responded:

'We would agree that it would be useful to include more detail on this issue, in particular with reference to students' practising techniques on each other as this is a fairly unusual situation occurring due to the nature of the practice of osteopathy. It may be useful to more clearly highlight the potential consequences of inappropriate behaviour in relation to a student's ability to remain on the course and ultimately being awarded a recognised qualification enabling them to practise as a registrant.' [12]

Looking at this topic more broadly, OEIs used this session to describe how students are trained to touch, a key element of the therapeutic encounter, and one which is intrinsically linked to boundaries. The importance of boundaried touch, again, is probably so obvious and central, that it few OEIs highlighted this explicitly in terms of how this relates to keeping patients safe from inappropriate touching and students and practitioners safe from inappropriate allegations of inappropriate touch. However, looking at what is taught, and how it is taught, it may be that the centrality of safety is assumed, and indeed, a core element of teaching.

Communication training was also highlighted, as this is an area which is related closely to managing patients' expectations, and generates a high proportion of FtP allegations. OEIs discussed the importance of the boundary aspects of clinical skills teaching, and again, perhaps it is so obvious as not to have been singled out, but there is a large link in the wider FtP case law of patients misinterpreting touch as inappropriate, so teaching students how to touch in ways which are not only technically correct but also cannot possibly be misconstrued is very important to keeping them and patients safe.

Some schools referred to respecting students own religious and cultural backgrounds in this section, talking of reasonable adjustments. Together with preferences for same sex student/patient dyads, this area provided an opportunity to describes training and practice in equality and respect for diversity.

What

OEIs describe teaching and learning in this area to include:

- Handling sensitive body areas
- Managing patient expectations
- Use of chaperoning
- Provision of towels and gowns
- Obtaining consent, including obtaining specific consent for touch of sensitive areas

[12] http://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2016/professional-standards-authority-consultation-response---gosc-students-ftp-guidance.pdf

When

- As part of clinic induction
- In clinical technique classes which includes care in patient handling, development of empathy, training on care of self and care of the patient

Where/sources

- Osteopathic Practice Standards
- Patient information and clinic information – OEIs describe clinic Information to patients about their appointments, including that they might be required to undress, what to wear and the provision of gowns for modesty

How

- Ongoing feedback from tutors throughout clinical training including promotion and maintenance of dignity and modesty
- Patient handling, promotion and maintenance of patient dignity and modesty monitored during practical and clinical teaching sessions
- One OEI offers female patients the option of seeing female student when they book. This is an interesting question, as there is a balance to be struck between respecting individual patient preferences, including cultural preference for a same sex therapist, and the need for osteopathic students to become familiar with male and female anatomy in a training environment

Good practice example

One OEI explicitly teaches student how to approach the subject of undressing patients and covering them up to protect modesty. This is assessed in practical exams assessing 'Professional Demeanour' and 'Care and Safety Model'.

Another OEI described how it uses the early encounters of students working with one another to begin to experience what how a treatment naïve patient will experience osteopathic care. Highly experiential learning encourages new students to focus on the uncomfortableness of being partially undressed in front of a relative stranger and to experience hands-on touch.

Good practice guidelines when students learn to work on each other and rules about one student remaining in professional mode, rather than both students being partially undressed.

Discussing same sex student/patient requests, cultural preferences and diversity of patients as

part of wider equality and diversity discussions and the need to understand patient preferences

Recommendations

- Develop learning aims associated with patient modesty and analyse more fully the link between patient modesty and boundaries more generally
- There is useful discussion to be had about same sex student practitioners/patient dyads and what this does or doesn't have to do with respecting professional boundaries. Whilst there is a need to respect client wishes, heterosexist assumptions need to be challenged
- There is clearly a need for all students to work in culturally sensitive ways, and in ways which demonstrate respect for diversity. Students need to become familiar with working sensitively with patients with diverse gender identity
- Linking clinical skills teaching more explicitly to fitness to practise - presumably, clinical skills teaching in this area will demonstrate a familiarity with previous fitness to practise cases which will inform, for example, what techniques to carry out, in what way, and where the student's body should be positioned in relation to the patients. Whilst all of this is almost certainly covered, it would be helpful to make this teaching explicitly linked to boundaries and to previous allegations made or found against osteopaths.

TOPIC 5

Complaints handling, including policies for handling complaints about boundaries made by students against tutors and policies for handling complaints by patients against students

Several OEIs found that they had already provided the bulk of data in response to this topic in previous sections. Future analyses might better interrogate where and how complaints handling is dealt with as part of the discussion on breaches of boundaries, either between staff and students or students and patients. Nonetheless, this final section gave OEIs to describe in more detail specific complaints policies, as well as broader aspects of staff and student support, the encouragement of patient feedback to students, and student feedback to tutors. This section also highlighted broader issues in relation to duties of candour and safeguarding responsibilities. Other OEIs took this section as an opportunity to describe staff/student approaches more broadly, and highlighted less formal and well as more formal channels.

Complaints by Students

Many of the sources of dealing with complaints had been raised in other sections. Formal written policies exist within most OEIs. As well as School policies, reference was drawn to relevant university Policies.

Sources include:

- Student complaints policy
- Public Interest Disclosure (Whistleblowing) policy
- Dignity at Work policy

Good practice examples

One OEI describes a Student Charter and Code of Conduct outlining explicitly what students should expect from staff behaviours and conduct

An OEI describes an 'open door' policy whereby students can talk to any member of staff about a concern that they have

Routinised feedback opportunities for students to comment on tutor performance in clinic – this is important as it gives students a sense of the responsibility to both give and receive feedback in a constructive manner and to help develop standards within the profession

Complaints by patients

OEIs describe different arrangements for the handling and resolution of complaints, including informal mechanisms and formal mechanisms. Students are taught by many OEIs how to resolve problems at a local level and how to avoid escalation.

Patients informed about complaints mechanisms in a number of ways, for example posters in treatment rooms, leaflets in clinic receptions and on School's websites.

Sources

- Patient complaints policy
- Information leaflets for patients
- Student handbook

Complaints against students

Broadly, students appear well supported when complaints are made against them and most of the OEIs describe provisions for handling over the care of patients in clinic where it is not possible to maintain a therapeutic relationship. Central to good practice in this area is ensuring that patient care is not compromised and that there are smooth handovers.

Good practice examples

The routine collection of patient feedback and the facilitating of patient complaints is an important opportunity for learning.

OEIs flag up the potential for complaints and termination of the relationship due to abuse, on occasion by patients. Students need to be prepared for dealing, constructively and professionally with unboundaried behavior by patients towards them and, more generally, ensuring that complaints are dealt with expeditiously.

OEIs make provision for continuity of patient care when the student/patient relationship has broken down

Recommendations

- All OEIs should consider formal feedback loops whereby learning from complaints can be fed back into teaching and learning
- Complaints should be facilitated, and where necessary, patients, signposted and supported in bringing a complaint
- Students should be supported in giving and receiving constructive feedback and should learn how to routinely elicit information from patients on what went well for them and what could have gone better, and to add this to existing mechanisms for reflection of what the student thought went well or could go better

CONCLUDING OBSERVATIONS

This short analysis has been an interesting opportunity to form some baseline impressions of how OEIs are teaching about professional boundaries. This will form a useful starting point for more targeted analysis of which elements of the formal and informal curriculum support the creation of strong and effective boundaries, and the appropriate balance between enhancing good professional practice and using disciplinary, FtP and other complaints mechanisms to deter misconduct.

1. Optimal ways of teaching and learning professional knowledge, skills and attitudes in relation to boundary issues

GosC's draft student FtP guidance states:

> Professional behaviour means demonstrating appropriate values, behaviours and relationships using appropriate knowledge, skills and attitudes. It manifests itself as doing the right thing and behaving appropriately, even when no one is checking. Regulation begins with personal responsibility. As part of your education and training as a healthcare professional, you will continue to learn about professional behaviour and personal responsibility.

Clearly, this statement is highly applicable to creating and maintaining appropriate boundaries, hence its inclusion, for example, by one OEI in its Student Handbook. What is less clear, educationally, is *how to* instil values, appropriate behaviours and relationship competencies, and to teach and learn the range of knowledge, skills and attitudes expected of a professional, more broadly, and in relation to boundaries, more specifically. Whilst OEIs use a variety of methods to encourage teaching and learning about boundaries, there is not much evidence as to what approaches to teaching and assessing boundaries create the most 'boundaried' practitioners[13]. Similarly, as the numbers of cases are so small, there is no overt link between adverse FtP findings and having graduated from a particular school, which is reassuring. All OEIs could usefully work together to explore, potentially with other professions and PSA, the most constructive ways of instilling good boundaries.

2. Optimising student and staff psychological health to minimise boundary crossings

OEIs have distinct styles and approach teaching and learning about the psychological aspects of being an osteopath in different ways. OEIs might consider what and how they teach students about the psychological aspects of being a carer, in addition to providing good student support. Robust psychological health is highly relevant to boundary issues, as

[13] Useful sources might include Sue Roff's 'Professionalism in Osteopathy' work. See Association for Medical Education in Europe, Lyon, 28 August 2012. *Development of professionalism learning tools in osteopathy*'. Browne, F., Currie, A., Walker, T. and Roff, S. General Osteopathic Council (GOsC)

the literature suggests an association between boundary violations, and burn out, and breaching boundaries.

OEIs could also help contribute to understanding why professionals break rules, as part of understanding why osteopaths breach boundaries. OEIs are well placed to contribute to discussions about why some student osteopaths disregard rules and how to address this issue, because students who are exhibiting conduct-related FtP concerns may be more likely to develop into problematic osteopaths. In addition to values-based recruiting of students, OEIs might also look to how they can better identify and support students exhibiting characteristics such as narcissism, grandiosity, and other personality traits which might be precursors to serious boundary violations[14].

The same issue applies in relation to staff, particularly clinical staff who have their own osteopathic practices and roles outside their teaching role, and who may themselves be experiencing levels of emotional burnout which may make them more of a risk in terms of breaching staff/student boundaries, or, indeed, poor role modelling in general.

3. Exploring boundary factors specific to osteopathy

Whilst the responses from the OEIs demonstrated a clear commitment to teaching about professional boundaries, little information was given to help understand why boundary crossings account for such a high proportion of complaints in osteopathy. Further research could usefully explore what it is about touch-based therapies, including osteopathy, which may account for higher levels of boundary crossings than in non-manual therapies.

[14] See, for example, Garfinkel PE, Bagby RM, Waring EM, and Dorian B. 'Boundary violations and personality traits among psychiatrists'. *Can J Psychiatry*. 1997 Sep; 42(7):758-63 https://www.ncbi.nlm.nih.gov/pubmed/9307837

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Appendix One

Examples of GOsC's work with OEIs on boundaries

Osteopathic Practice Committee paper March 2015

Current activity – osteopathic education

23. We are undertaking the following activity to highlight awareness of boundaries issues to OEIs (please note that all materials are available on request from Fiona Browne – fbrowne@osteopathy.org.uk):

a. Ongoing collection (and dissemination) of data about views about lapses in professionalism from students, faculty and patients and dissemination to OEIs to promote discussion. (Professionalism in Osteopathy research with Sue Roff).

b. Presentation to students at OEIs incorporating teaching about boundaries. (drawing on both the Professionalism in Osteopathy research and the CHRE report).

c. Presentation to faculty members at OEIs incorporating teaching about boundaries. (drawing on both the Professionalism in Osteopathy research and the CHRE report).

d. Presentation to OEI principals highlighting impact and awareness of breaches of boundaries (drawing on both the Professionalism in Osteopathy research and the CHRE report).

e. Seminars facilitated by OEIs about lessons learned from cases of breaches of boundaries.

f. Seminar with Isabelle Bell, a psychodynamic counsellor and course lead for the counselling course at the North East Surrey College of Technology for 9 9 OEI principals to explore how issues about boundaries are taught, supported and managed in undergraduate counselling education.

g. In addition the work of the undergraduate professionalism group is now underway, with the first meeting of the group taking place on 11 March 2015. One of the areas of Guidance that this group will be looking at is Guidance about Student and Tutor Boundaries which is referred to in the Guidance for Osteopath

Appendix Two

Extract from GOsC Draft Student FtP Guidance April 2016

Boundaries

31. You will be introduced to the concept of professional boundaries, and what this means for you as a student of osteopathy. It is important that any healthcare practitioner maintains appropriate professional boundaries with patients. Even as a student, there is likely to be a power difference between the 'authority' figure of the practitioner and that of a vulnerable patient, and any breaching of this professional boundary may give rise to concern as indicated in the table 1 above. It is not just in relation to patients that boundary issues might arise. Personal relationships with teaching staff, for example, may lead to difficulties. Each osteopathic educational institution will have their own policy on this, and on how any such relationships should be managed, if they are permitted at all. Generally, it would be necessary to disclose any personal relationship with a member of staff at the educational institution, so that appropriate steps can be taken to ensure that the integrity of assessments is not compromised.

32. Similarly, you should consider boundaries in relation to other students. There is a degree of intimacy generated by the physical nature of an osteopathy programme which is unusual within higher education. Students are usually keen to practise techniques on each other, and sometimes this may take place away from the educational institution, perhaps in the student's own accommodation. This is an environment where boundaries are easily crossed, and which may lead to concerns and complaints. Again, your educational institution will have policies and guidance regarding the practice of techniques, and you should comply with these.

Appendix Three

Extract from GOsC Draft Guidance to OEIs on Student FtP

Boundaries

23. It is important that students are aware of the importance of maintaining appropriate boundaries with patients. They should be taught, at the earliest opportunity, about the dynamics of the therapeutic relationship, and the vulnerability of patients.

24. Similarly, guidance should be given to osteopathic educational institution staff and students regarding the appropriateness of personal relationships with students, and the potential issues that this may raise. Each educational institution will have their own processes and policies in this respect, though the issues of relationships based on the power difference between an authority figure such as an educator, and what may be a vulnerable student, will be largely consistent for each.

25. Students should also be aware of the importance of maintaining boundaries with their colleagues during their training. The familiarity which develops in a course where there is often intimate contact with fellow students, can lead to, sometimes inadvertent, boundary transgressions. Guidance should be provided to students regarding this, and on practising osteopathic techniques and examination routines when away from the educational institution's premises, where potential boundary issues can be even more evident.

26. Providing confidential support, guidance and teaching to students at an early stage may help students to develop individual insight about the impact of their behaviour on others and responsibility for fitness to practise. It may also assist in avoiding more serious problems later during the educational course, or later still when the individual is a practising osteopath. Particular examples of situations and methods to support students' understanding of fitness to practise could include the following: a. engagement with GOsC presentations about the requirements of the Osteopathic Practice Standards offered to all osteopathic educational institutions b. using examples of social networking to demonstrate fitness to practise or professionalism issues, for example placing inappropriate postings or photographs on social media c. utilising examples of fitness to practise cases and working through the issues involved d. reference to possible ethical, conduct or communication issues as an integral part of the teaching and learning process.

http://www.osteopathy.org.uk/news-and-resources/document-library/consultations/student-ftp-draft-guidance-for-osteopathic-educational-insts/

Appendix Four

Extracts from QAA Benchmark Statement on Osteopathy (2015)

On successful completion of their studies, students will have developed the following core knowledge, understanding and skills:

C Therapeutic and professional relationships

i Justifiable and acceptable management strategies to cope with ethical issues likely to confront a practitioner.

ii Deal with uncertainty effectively and efficiently without loss of professional self-confidence and the ability to manage the case.

iii A range of integrated skills and self-awareness to manage clinical challenges effectively in unfamiliar circumstances or situations.

iv Maintain high standards of care in situations of personal incompatibility with a patient.

v Maintain patient confidentiality and act only with the informed consent of the patient.

vi Adopt appropriate strategies for physical and psychological self-care during interactions with patients to maintain a high standard of professional effectiveness.

K Personal and professional skills development with a self-reflective framework

vii Self-care sufficient to consistently maintain an acceptable standard of care for a patient.

viii The attitudes and skills necessary to comply fully with any continuing fitness to practise standard requirements in order to maintain registered status.

L Professional identity, accountability, ethics and responsibilities

i Understand the concept and significance of statutory regulation authorised by Parliament.

ii Abide by the professional standards outlined in the Osteopathic Practice Standards and other guidance from time to time issued by the General Osteopathic Council and other appropriate bodies.

iii Practise osteopathy safely, competently and effectively in accordance with the law. This includes, for example, compliance data protection and health and safety legislation. 16

iv Act quickly to prevent harm. Appropriate action may include managing the situation by oneself, discussing with a colleague, or reporting to another appropriate authority or body. Taking action in all circumstances where patient safety may be at risk will include, for example: - disclosing and apologising to patients and discussing and agreeing how to make things better - being aware of and complying with the legislative framework and principles in relation to safeguarding vulnerable adults and children - taking action in circumstances where colleagues actions may be putting patients at risk - taking appropriate action where practitioner health may impact on the ability to practise safely - reporting relevant and appropriate information about conduct or competence to the regulator

v Respect and uphold patient dignity, autonomy and confidentiality.

vi Disclose and justify actions to others when appropriate.

vii Take responsibility for maintaining professional boundaries.

viii Uphold high standards of personal and professional conduct, maintaining the integrity of the profession and not bringing it into disrepute.

Appendix Five

GOsC Supplementary guidance to OPS on Boundaries

Osteopathic Practice Standards (D17) provides: 'Do not abuse your professional standing.'

The associated guidance provides that:

1. Abuse of your professional standing can take many forms. The most serious is likely to be the failure to establish and maintain appropriate boundaries, whether sexual or otherwise.

2. The failure to establish and maintain sexual boundaries may, in particular, have a profoundly damaging effect on patients, could lead to your removal from the GOsC Register and is likely to bring the profession into disrepute.

3. When establishing and maintaining sexual boundaries, you should bear in mind the following:

3.1. Words and behaviour, as well as more overt acts, may be sexualised, or taken as such by patients.

3.2. You should avoid any behaviour which may be construed by a patient as inviting a sexual relationship.

3.3. Physical contact for which valid consent has not been given can amount to an assault leading to criminal liability.

3.4. It is your responsibility not to act on feelings of sexual attraction to or from patients.

3.5. If you are sexually attracted to a patient, you should seek advice on the most suitable course of action from, for example, a colleague. If you believe that you cannot remain objective and professional, you should refer your patient to another healthcare practitioner.

3.6. You should not take advantage of your professional standing to initiate a relationship with a patient. This applies even when they are no longer in your care.

4. Osteopaths who practise in small communities may find themselves treating friends or family. In such cases, establishing and maintaining clear professional boundaries will help you ensure that your clinical judgement is objective and that you can provide the treatment your patients need.