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

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A Report for the General Osteopathic Council

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CONTENTS

LIST OF ABBREVIATIONS

BACP	The British Association for Counselling and Psychotherapy
CAM	Complementary and Alternative Medicine
CHRE	Council for Healthcare Regulatory Excellence
FtP	Fitness to Practise
GDC	General Dental Council
GMC	General Medical Council
GOsC	General Osteopathic Council
GOPRE	Guidance on Osteopathic Pre-Registration Education
HCPC	The Health and Care Professions Council
HEE	Health Education England
MDT	Multi-disciplinary team
MSK	Musculo-Skeletal
LTC	Long Term Condition
NCOR	National Centre for Osteopathic Research
NHS	National Health Service
NHSE/I	National Health Improvement
iO	Institute of Osteopathy
OEI	Osteopathic Education Institute
OPS	Osteopathic Practice Standards
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcome Measures
PSA	Professional Standards Authority
QA	Quality Assurance
SBV	Serious Boundary Violations
VT	Vocational Training

SUMMARY OF KEY FINDINGS

1. OEIs are the primary source of professionalism training for osteopathic students. Classroom and Clinic teaching combine to provide students with the skills to provide effective, patient-centred care. Boundaries education, as an element of professionalism training, is dispersed throughout the curriculum, and delivered by a range of lecturers, integrated and reinforced by OEIs through clinical teaching in lectures and in the Clinic.
2. OEIs could increase impact and effectiveness by linking boundaries teaching more explicitly with teaching on consent, communication, and contracting skills. Specifically, there needs to be a far greater link between the teaching of touch and the teaching of professional boundaries. Psychology modules should link to resilience and wellbeing.
3. Despite most OEIs teaching about boundaries and professionalism, boundary breaches, including sexual boundary violations, continue to account for a significant proportion of complaints against registered osteopaths (perpetrators predominantly male, aged 41-60).
4. Education and the Osteopathic Practice Standards only partially influence professional behaviour, and in the case of serious boundary violations, do not deter misconduct.
5. Discomfort talking about sex hampers effective boundaries education. Arousal in response to touch and sexual feelings towards and from patients are predictable phenomena and should be taught as such as part of pre-registration training, with boundaries training reinforced through post-registration CPD when osteopaths have had sufficiently diverse patient experiences to make this training meaningful.
6. Osteopathy urgently needs to develop and understand the concept of trauma-informed practice. This should inform boundaries teaching, both as to the impact of re-traumatisation on victims, patient-initiated boundary breaching, and also osteopathic technique.
7. The 'taboo' nature of sexual boundary violations finds sexual abuses described as '*dating*' patients (or ex-patients). This inhibits appropriate understanding of professionals' offending, characterised by *abuse of power* and *breach of trust*. Teaching and guidance should also highlight the damaging nature of serious non-sexual breaches.
8. A fundamental narrative shift is required, informed by research on professional boundary violations, away from boundary violators as 'deviant *others*' towards a more psychologically-informed approach, targeted at identification and prevention. This is not a 'soft option', but a strategy to minimise harm and achieve better public protection.
9. Boundary breaches may occur when professionals are inadequately psychologically equipped. Boundaries training should be taught in conjunction with resilience-building and attentiveness to mental health, with mechanisms to help students and practitioners identify their vulnerabilities and seek support.
10. Improved transitions are needed to ensure greater continuity from classroom to Clinic, and from Clinic into autonomous practice. OEIs are supportive of post-registration support/training, ranging from structured Associateships, mentored practice, through to a formalised Foundation Year approach.

11. Supporting the professionalism of Clinic Tutors is key, because of their significant role in shaping student professionalism in practice. Suggestions included: formal teaching qualification requirements, peer review of teaching, two-hander teaching, Faculty training days, and ensuring Tutors have an overview of the OEI's pre-registration curriculum. Rates of pay should be comparable to practice. OEIs should consider incentives for the role.
12. Students identified inter-generational, cultural, and diversity gaps between themselves and staff/Tutors. 'Me Too', and Covid have opened up helpful conversation spaces about power, sexual harassment, and patient and practitioner vulnerability.
13. OEIs' policies, pastoral offering and 'open door' culture support boundaries development by providing psychologically safe ways of raising problems and seeking support. OEIs have taken active steps to encourage 'Speaking Up' and reporting issues of concern.
14. To improve boundaries, GOsC needs to explore avenues for legislative and non-legislative reform, applying a broadly psychologically-informed lens. FtP processes, as currently constituted, are a blunt tool for dealing with cases involving sexual boundaries. Panels require specialist, forensic evidence on risk and potential for remediation, and sanctions linked to mandated education (including registrant pscyho-education).
15. Regulators are not seen as the 'go to' source of advice on sexual boundaries. Osteopathy requires a shift away from viewing boundary breaches as an *individual* problem - eliciting a punitive, regulatory response - towards being seen as a *systemic* problem within the profession, which require supportive, professionally-led solutions.
16. Specifically, professional isolation, lack of oversight, and absence of appraisal/specialist training structures create a context for post-registration 'professional drift' in which boundary breaches are more likely to occur. Clinical Supervision was widely supported as a mechanism to help osteopaths discuss difficult cases, together with peer-led, safe reflective spaces, and access to support and advice *before* problems arise.
17. Osteopathy should build on ways to replicate or benefit from system-wide mechanisms in the NHS which help support patient safety, just culture and continuous learning. OEIs supported building on inter-professional learning, exploring NHS placements, and embedding leadership training.
18. More could be done by OEIs to embed 'Patients as Educators' in osteopathic education, practice, and research, and by regulators to better understand patients' views on public protection, including exploring the patient/public appetite for restorative justice and rehabilitative approaches to dealing with sexual boundary breaches. The patient voice is key to improving public protection in ways that are meaningful *to them*.
19. Post-registration boundaries training is required at pace and at scale. It is recommended that this be a mandatory component of CPD. 'Me Too' provides an incentive for uptake, to help reduce osteopaths' concerns of being the subject of complaints.
20. Systemic change requires profession-wide conversations and consultation, including on the nature of osteopathy. Radical change requires a joined-up approach involving a wide range of stakeholders.

INTRODUCTION

In 2017, GOsC commissioned a Thematic Analysis of Boundaries Teaching in the UK's Osteopathic Education Institutions (OEIs)[1] to try to understand why a significant proportion of complaints against osteopaths involved breaches of professional and/or sexual boundaries. The rationale for focusing on osteopathic education and training and the role of OEIs, rather than FtP or complaints, is that OEIs are where students learn how to become osteopathic professionals. It is the area where professional norms and expectations, as codified in the Osteopathic Practice Standards (OPS), are mapped, through GOsC's Guidance on Osteopathic Preregistration Education (GOPRE), onto the curriculum, and, where, it is hoped, professional attitudes and behaviours are instilled.[2]

The 2017 Report asked each OEI to provide data on what OEIs were teaching about professional boundaries, and what organisational policies were in place to support students, patients and staff. It highlighted good practice and made recommendations in relation to teaching and assessment and associated OEI policies.[3] How OEIs taught varied from institution to institution. All OEIs weaved professionalism teaching throughout the curriculum. Professionalism was role-modelled by classroom, Clinic and support staff, and OEIs deployed a range of formative and summative teaching and assessment strategies. In 2017, most, but not all OEIs, taught specifically about professional boundaries. There was evidence of some limited teaching about practitioner wellbeing, albeit with little linking of professional stress or burnout as a recognised factor in breaching boundaries. Courses on psychology were taught by some schools, not necessarily in great depth, and, for the main part, concentrating on mental health diagnostic categories. The overarching impression was that the bulk of education and training was geared towards the acquisition and practice of technical skills.

In 2021, GOsC commissioned an update of the 2017 Thematic Analysis, aware that the number of osteopathic cases involving boundary breaches remains high. This is a considerable cause for concern for GOsC, as it should be for the profession as a whole. Albeit small numbers because of the size of the profession, complaints involving breaches of boundaries represent a worrying 25% of cases. Persistently high, this proportion of cases involving boundary breaches increased in 2019 according to the 2013-2019 NCOR data.[4]

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[1] Stone, J. (2017). Thematic Analysis of Boundaries Education and Training within the UK's Osteopathic Educational Institutions. London, England: GOsC https://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/thematic-analysis-of-boundaries-education-and-training/(accessed 28 December 2021)

[2] Regulatory oversight of education involves an interplay of registering qualifications, quality assurance, and guidance on pre-registration education and student fitness to practise guidance.

[3] Recommendations from the 2017 report can be found in Appendix One

[4] In 2019 there were 17 concerns and complaints about sexual impropriety compared to the previous 6 year mean of 11.5 (range 7-14), this is the most ever recorded) . NCOR 2013-2019 Available at https://www.osteopathy.org.uk/news-and-resources/document-library/publications/ncor-concerns-and-complaints-report-2013-19/ (accessed 28 December 2021)

Boundary breaches are one of the most serious types of breaches of professional standards, often causing patients serious and enduring harm.[5] An osteopath found guilty of a sexual boundary breach is likely to be suspended or erased from the osteopathic register.[6] This reflects the seriousness with which GOsC regards these cases, in terms both of harm to the individual patient, and damage to the reputation of the profession.[7] Despite osteopathy being a statutorily regulated profession, removal from the Register may not stop an osteopath continuing under a different guise.[8] This should be a major concern, given the overarching function of regulation is to protect the public. Moreover, the perceived punitive nature of Fitness to Practise (FtP) amongst registrants means that osteopaths experiencing difficulties arising out of boundary issues are unlikely to contact GOsC for advice, or possibly even their professional body or insurer, for fear of referral and/or censure (notwithstanding the duty of candour to speak up when something has gone wrong).[9]

Whilst the 'Me Too' movement has heightened osteopaths' concerns about being complained against, there is a generally lack of recognition in osteopathy as to how much courage it takes for a patient to initiate a complaint about a health professional[10], especially relating to sexual conduct[11], with many complaints going unreported.[12] The number of formal complaints resulting in FtP action is likely to substantially under-represent the number of incidences occurring. When things go wrong in osteopathy, patients are far more likely to stop seeing the osteopath, and possibly drop out of treatment altogether. At this point, there is no indication that the 'Me Too'

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[5] Symptoms include post-traumatic stress disorder, anger, a sense of betrayal and exploitation, guilt and self-blame. Halter, M., Brown, H., & Stone, J. (2007). Sexual boundary violations by health professionals: an overview of the published empirical literature. London: CHRE

[6] GOsC Sanctions Guidance, see https://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/hearings-and-sanctions-guidance/

[7] Decisions to suspend or erase are not taken by Council, but by independent Fitness to Practise panels appointed by GOsC, who operate within case law and in accordance with GOsC's Sanctions guidance, which recommends the highest levels of sanctions for serious boundary violations, particularly those of a sexual nature.

[8] As a previous Chief Executive of the Professional Standards Authority noted, because statutory regulation currently works through protection of title: "someone who has been struck off can change their title and still continue to work.". See: Dowd, A. National body is considering a single register for all health and care professionals. *BMJ* 2016;354:i3775 https://www.bmj.com/content/bmj/354/bmj.i3775.full.pdf (accessed 1 January 2022)

[9] GOsC OPS D3, and also October 2014 UK regulators' joint statement, see: https://www.osteopathy.org.uk/standards/guidance-for-osteopaths/duty-of-candour/

[10] One OEI specifically teaches about how hard it is to complain. Professional myths that many complaints are malicious or vexatious need to be challenged. Recommendations later in this report include learning from patients who have brought complaints before GOsC.

[11] Hook, J and Devereux, D. Sexual boundary violations: victims, perpetrators and risk reduction. BJPsych Advances (2018), vol. 24, 374–383 doi: 10.1192/bja.2018.27

[12] PSA cite a Healthwatch report claiming that fewer than half of patients experience poor care report it. Healthwatch England (2014) Suffering in silence [Online]. Available at: http://www. healthwatch.co.uk/sites/healthwatch.co.uk/ files/hwe-complaints-report.pdf, cited in Rethinking Regulation (2015) PSA https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf

movement has led to a spike in complaints against osteopaths about boundary breaches, although interviews suggest it has heightened osteopaths concerns about being *complained against*. What the 'Me Too' movement has highlighted is that abuse occurs within relationships where there is an imbalance of power[13], and has drawn attention to the challenges associated with speaking up and being believed. It has also revealed the huge extent to which women and girls (and some men and boys) are exposed to sexual assault, sexual harassment, 'grooming' and 'trolling', including at school and college.[14] A 2021 Ofsted report found that sexual harassment and online sexual abuse is endemic in UK schools and colleges, and that sexual harassment is so commonplace that many students don't report it.[15] As we delve into the subject of boundaries teaching within OEIs, we should bear in mind the lived experience of students entering into osteopathic education and training, and the inevitability that a proportion of students will enter osteopathic education themselves having experienced sexual trauma.

The 2017 Report sought to make clear that whilst sexual boundary violations by health professionals are rare, day-to-day boundary issues arise for *all* osteopaths and are a routine aspect of professional practice. It did so to dispel the myth at a pre-registration level that only 'bad' osteopaths breach boundaries. It suggested a need to balance teaching between positive messaging - learning how to negotiate boundaries through effective consent, communication, and patient management, with the need for rule-based compliance, in accordance with the OPS's clear and unequivocal prohibition of sexual relationships with patients. This Report suggests the dichotomy is more complex than merely 'positive' versus 'negative' teaching, and the presumption in the literature that there is a progression from minor boundary breaches to more serious boundary violations.[16] Instead, this Report explores why it is necessary to shift the narrative away from a 'positive versus negative' binary (do do versus don't do) towards more compassionate and psychologically-informed approaches, which recognise the internal and external resources needed to support osteopaths throughout a career of caring for others – in therapeutic relationships where the psychological needs of the practitioner are not met *and are not there to be met*.[17] A new approach is needed which gives osteopaths psycho-educative skills about their clients' and their own mental health and wellbeing to respond appropriately when their professionalism is challenged.

[13] One of the challenges in teaching about boundaries at a pre-registration level is that students in training may not yet experience or appreciate the extent to which they hold power in the patient/practitioner relationships.
[14] https://www.everyonesinvited.uk/ was set up as a site for victims to post their anonymous stories
[15] Ofsted (2021). Review of Sexual Abuse in Schools and Colleges. Published 10 June 2021. https://www.gov.uk/government/publications/review-of-sexual-abuse-in-schools-and-colleges/review-of-sexual-abuse-in-schools-and-colleges (accessed 26 December 2021)
[16] Whilst 'lesser' boundary crossings may lead to more serious boundary violations, this is not necessarily the case, and they may represent deliberate and justifiable attempts to create rapport with patients, and to demonstrate empathy. Osteopaths and patients interviewed saw many minor breaches, such as gift giving, as acceptable.
[17] For discussion, see Celenza, A. (2007). Sexual Boundary Violations. Therapeutic, Supervisory and Academic Contexts.

The recommendations made in 2017[18] included the need to consider whether there were factors *specific to osteopathy* which might account for the high incidences of boundary cases. In doing so, it recognised that whilst OEIs had an important role in instilling professionalism, the nature and context of osteopathic practice might hold clues as to why this remains a problem. Specifically, it wondered whether the number of cases might relate to the hands on, touch-based nature of osteopathic treatment, where professionals often worked in sole, unsupervised practice, often outside multi-disciplinary team (MDT) environments, and sometimes from their own homes, operating, in the main, outside broader systems found in the NHS designed to protect patients from harm, and provide 'cover' for clinicians. This 2022 Report considers the implications of students leaving the safety of the OEI environment, and entering into the predominantly unsupported context of osteopathic practice.

In seeking evidence-informed solutions, GOsC commissioned this review in the context of emerging research on professionalism, regulation, and touch. Specifically, this report builds on the findings of two earlier GOsC research reports: McGivern's work on osteopathic professionalism and compliance with regulation[19], and Concannon and Lidgely's research on how touch is communicated in manual therapies.[20] It also draws on the Professional Standards Authority's (PSA) research into the nature of sexual misconduct by health professionals, and research into public opinions about regulation, including sexual misconduct.

This 2022 Report is also informed by emerging evidence about health professionals who breach sexual boundaries, how individuals at risk of breaching boundaries might be identified and supported, and whether some professionals may be amenable to remediation. Whilst much of this research originates from psychotherapy, arguably, the nature of some osteopathic encounters shares many similarities to counselling and therapy relationships, *whether or not osteopaths see themselves as 'therapists*'. Whilst osteopaths might see any psychological benefit they deliver as a side benefit of touch, some patients view the osteopathic relationship more as a form of embodied psychotherapy, and bring similar expectations to osteopathy that they would bring to a therapy relationship. This has significant implications for therapeutic intimacy, and erotic transference and counter-transference issues.[21] Indeed, a key theme to explore here is the extent to which osteopathic education is sufficiently attentive to the psychological dimensions of the

[18] Set out in Appendix One at the end of this report.

[19] McGivern G, Fischer M, Palaima T, Spendlove Z, Thompson O., Waring J., (2015). Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. Report to the General Osteopathic Council, https://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/dynamics-of-effective-regulation-final-report/ (accessed 27 December 2021).

[20] Concannon, M and Lidgely, S (2019). How is touch communicated in the context of manual therapy? A literature review. A report commissioned by The General Osteopathic Council and General Chiropractic Council. Available at: https://www.osteopathy.org.uk/news-and-resources/document-library/publications/how-is-touch-communicated-in-the-context-of-manual-therapy-a/(accessed 26 December 2021)

[21] Discussed in the 2017 Report. Erotic transference occurs in psychotherapeutic relationships and is taught and addressed in training. See: Pope, K., Sonne, J., and Holroyd, J. (1993). Sexual Feelings in Psychotherapy. Explorations for Therapists and Therapists-in-Training. Washington, DC: American Psychological Association.

therapeutic relationship, and how the osteopath's 'care' and 'caring' is perceived from the patient's perspective. Increased attentiveness to psychological need might be particularly relevant during and post-Covid, when osteopaths are likely to be seeing patients who are lonely, distressed, and with high levels of psychological distress.

GOsC also wanted this review to take account of broader social trends, including the 'Me Too' movement, the need for greater recognition of equality and diversity, and the extent to which Covid has changed people's views on the importance of human touch. Course leaders, teachers and Tutors, practitioners and students were asked how they thought these broader issues had impacted on the profession. OEIs and students, in particular, were asked how these issues have had an effect on osteopathic education.

At the start of the pandemic, the Wellcome Foundation funded and reported on one of the largest global studies into the importance of touch in collaboration with BBC Radio 4.[22] This highlighted the value people place on touch - albeit the research was not looking specifically into touch in the context of touch-based healthcare/therapeutic relationships. Instinctively, most would accept that COVID has brought to the fore the unprecedented value of touch and the need for human connectedness. Restrictions on social contact have deprived people of the level of physical touch they take for granted in their lives. It has also highlighted the fragility of people's emotional health and wellbeing, including that of students and, indeed, health professionals, many of whom continue to actively support patients post Covid infection.

The 2017 Report wondered whether boundaries take on a special significance in the touch-based therapies of osteopathy and chiropractic, where touch is not only the vehicle through which technical skills are delivered, but is a primary way in which the practitioner expresses care and concern, and through which non-specific elements of healing may occur. Within osteopathy, research has revealed the afferent nature of touch, and its importance within therapeutic relationships. Touch is the mechanism through which trust in the osteopath is embodied, and, as will be explored in the next section, touch can be seen as a direct form of communication with its own particular language. Teaching about boundaries needs to be more closely linked to teaching about touch, especially thinking about how patients experience touch.

The 2017 Report sought to provide baseline data about the teaching boundaries. This 2022 Thematic Review involved a more in-depth, qualitative approach to draw out the complexity of the issues and generate theories about professionals who breach boundaries, why they do so, and how best to respond to protect the public. A desk-based mapping exercise was followed by open ended interviews and focus groups discussion with stakeholders from six groups: OEIs (Course Leaders/Tutors/Clinic Leads), student osteopaths, expert patients (osteopathic and non-osteopathic), professional regulatory and professional body leaders, osteopaths in practice, and academic/policy experts. Findings from interviews were analysed and synthesised with existing

[22] See: https://www.bbc.co.uk/mediacentre/latestnews/2020/the-touch-test-results (accessed 28 December 2021)

research policy documents and research to provide (i). an update of how boundaries are approached within the OEIs and identify opportunities for improvements (ii). an analysis of contextual factors within osteopathy and how these impact on professionalism (iii). an analysis of principles and assumptions underpinning regulation (including education and training, and fitness to practise) to consider options for reform, and (iv). analysis and recommendations for whole-system, supportive approaches for tackling and reducing boundary-related harm.

Primarily, the aim of this research has been to identify what can be done to reduce risks of boundary violations occurring and to protect patients and the public. Its central thesis is that *supporting practitioners is essential to protect patients*. Some of the issues raised may be triggering to readers, and some of the conclusions in this Report will make uncomfortable reading. But the hope is that the conclusions drawn provide a constructive basis of addressing the persistent problem of sexual boundaries violations within the profession. Whilst education and training and OPS 'rules' help most students and practitioners to understand their professional responsibilities, they do not prevent a small number of osteopaths from breaching sexual boundaries.

In negotiating this difficult terrain, it is axiomatic to acknowledge that osteopaths who do breach boundaries, and particularly osteopaths who have sex with their patients, know this is wrong, and in all probability 'had the lecture', but went ahead anyway. These professionals may, until this point, have provided effective and professional care to patients. For some, the acts leading to a complaint or FtP case may be entirely 'out of character'. *Whilst in no sense diminishing the need to hold professionals to account*, it behoves us to better try to understand why some professionals don't feel that rules apply to them, or self-sabotage through high risk activities which put their patients (and their career) in jeopardy.

If the threat of removal from the Register or suspension does not act as a deterrent, attempts must be made to understand *why* osteopaths breach boundaries, and to explore whether it is possible to prevent problems before they result in patient harm. This requires an informed and responsive approach to research about professionals who sexually offend (who may be subject to criminal justice proceedings). It requires, in particular, exploring regulatory opportunities for remediation, rehabilitation, and restorative justice, together with enhanced professionally-led opportunities for supporting osteopaths in practice.

Since the influential 'Clear Sexual Boundaries' guidance was published by the Council for Healthcare Regulatory Excellence (CHRE) in 2008, regulatory research has not led to significant regulatory innovation, and there has been no substantive attempt to embed a forensic/psychologically-informed approach to offending behaviours.[23] Substantially overhauling FtP would require legislative change, courage, and public debate, but our existing approaches are seen as brutalising to professionals, and daunting and adversarial to complainants. This report will interrogate whether current assumptions and regulatory responses to boundary breaches are

[23] Whilst the PSA is to be congratulated on commissioning ground-breaking research on sexual misconduct, to date, this has not resulted in recommendations for substantive regulatory reform.

delivering optimal public protection, and in so far as they are not, will consider ways in which a narrative shift may allow for different discussions as to causes and solutions. In doing so, it recognises the constraints of the current legislative frameworks within which statutory regulation operates.

Part One will set the background and context for this report. It will consider the contested nature of osteopathy, and wider factors which have a bearing on the teaching of professional boundaries. Part Two concentrates on the current role of OEIs in educating and training students on professionalism and boundaries. Building on the 2017 recommendations, it will highlight emerging and interlinked themes, calling for an integrated approach to educating about boundaries. Part Three considers the absence of oversight of osteopaths in practice, and proposes a whole-system approach for supporting professionalism, and the need for professional ownership of structures and safeguards for improving practice. Part Four will synthesise findings, draw conclusions and Part Five will make recommendations for next steps.

PART ONE

FRAMING THE ANALYSIS

The focus of this Report, as with the 2017 Report, is on how OEIs are approaching boundaries through education and training and supportive structures. It is worth exploring in a more detail why OEIs were again chosen by GOsC to be the appropriate start for investigation. Unlike healthcare professionals working predominantly in the highly managed National Health Service (NHS), or NHS-commissioned 'High Street' healthcare professionals, such as dentistry and pharmacy, subject to overlapping regulatory regimes beyond those of their professional regulator, once osteopaths graduate from an OEI with their registered qualification, they are free to practise more or less without appraisal or oversight. Osteopaths' only other mandatory educational requirement is to comply with GOsC's three-year continuing professional development (CPD) cycle.[24]

How does this compare to other regulated professions? Medical students undertake a two-year Foundation Programme after medical school.[25] This is followed by specialty training overseen by a medical Royal College which lasts between three to eight years depending on specialty. Dentists, similarly, undertake a year-long Foundation Training in an 'Approved Practice' post-registration. Clinicians and support staff working within the NHS have to undertake annual mandatory training on a range of subjects, including safeguarding, data security, and infection prevention and control.[26] Healthcare professionals employed by the NHS are subject to routine appraisal or revalidation, and required to have Clinical Supervision, separate from line management. Supervision provides a 'safe space' for professionals. The aims are as follows:

> "[S]upervision aims to safeguard standards, develop professional expertise, and deliver quality care. It is a formal process of professional support and learning and a means of identifying solutions to problems and encouraging self-assessment and analytical and

[24] This requires 90 hours of CPD over a three-year period, a proportion of which includes learning with others. Details of CPD requirements can be found at: https://cpd.osteopathy.org.uk/. (accessed 26 December 2021). The scheme expressly "aims to address professional isolation by fostering a culture of peer support and creating collaborative learning environments."

[25] After completing the medical degree, medical students are given provisional registration with a licence to practise by the General Medical Council. Students who wish to practise medicine in the UK then go on to apply to the Foundation Programme. This is a two-year training programme for newly qualified doctors. After successful completion of its first year, the General Medical Council grants full registration with a licence to practise. This is necessary to practise as a doctor in the UK. https://www.medschools.ac.uk/studying-medicine/after-medical-school/foundation-programme (accessed 26 December 2021). Dentists are also required to undertake a one-year Foundation Year Training. Their work in practice is overseen by a dentist trainer (the 'Education Supervisor'). https://bda.org/careers/Aftergraduation/Pages/DentalFoundationTraining.aspx (accessed 26 December 2021). They may then go on to train in one of 13 dental specialties. The General Dental Council maintains both the Dental Register and the Specialist Lists, and quality assures specialty training as well as pre-registration training. https://www.gdc-uk.org/education-cpd/quality-assurance/dental-specialty-training (accessed 26 December 2021)

[26] https://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ (accessed 26 December 2021)

> reflective skills. It encourages staff to view patients/ clients as individuals and supports clinicians to explore their feelings and provides a link between research and practice"[27]

Additionally, healthcare professionals may have paid access to post-graduate training, and have multiple opportunities for intra- and inter-professional learning,[28] including, for example, attending 'Schwartz Rounds', which bring multi-disciplinary professionals and practitioners in training together to provide safe, reflective spaces.[29]

> "The underlying premise for Rounds is that compassion shown by staff can make all the difference to a patient's experience, but that *in order to provide compassionate care staff must, in turn, feel supported in their work*."[30] (my emphasis).

Most osteopaths, in comparison, are sole practitioners, working in isolation. Their practice takes place behind closed doors, and their primary source of feedback or 'appraisal' comes from their patients. Whilst osteopaths are taught to be reflective practitioners at OEIs, and are required to undertake a proportion of their CPD learning with others, osteopaths are not embedded within a 'learning profession' or complex learning organisations or networks. NHS employees, by way of contrast, work within a complex and highly regulated environment. Their work is supported by operational managers, where adverse incidents are part of a continuous cycle of patient safety, critical incident reporting, and systematised learning from things that have gone wrong. NHS healthcare practitioners work within Clinical Governance mechanisms. This is defined as:

> "[A] framework through which UK National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care".[31]

Clinical governance covers a broad range of activities including quality improvement, risk and incident management. These are orchestrated at a national, regional, and organisational level, and underpinned by commitments towards Just Culture[32] and Compassionate Leadership.[33] Individuals work as part of a regulated system, in multi-disciplinary teams, with tiers of operational and clinical oversight. Increasingly, attempts are made to learn from mistakes not to punish individuals (albeit a 'fair blame' culture does not mean 'no blame', and there is an expectation that individuals will still be held to account). Compared to this dense and interwoven web of learning

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[27] https://wessex.hee.nhs.uk/wp-content/uploads/sites/6/2021/03/2021-01-29-What-is-Clinical-Supervision.pdf (accessed 1 January 2022)

[28] See, for example: Royal College of Physicians (2021). Never too busy to learn. https://www.rcplondon.ac.uk/projects/outputs/never-too-busy-learn-pandemic-response-0 (accessed 1 January 2022)

[29] https://www.pointofcarefoundation.org.uk/our-programmes/schwartz-rounds/about-schwartz-rounds/ (accessed 26 December 2021). These provide time and space for reflection, and reduce isolation and stress.

[30] ibid

[31] https://assets.publishing.service.gov.uk/media/57a08d59ed915d622c001935/Clinical-governance-in-the-UK-NHS.pdf (accessed 26 December 2021)

[32] https://www.england.nhs.uk/patient-safety/a-just-culture-guide/(accessed 26 December 2021)

[33] https://www.england.nhs.uk/culture/what-does-compassionate-and-inclusive-leadership-mean-to-us/ (accessed 26 December 2021)

and professional support, osteopaths, by way of contrast, once they qualify from an OEI, have only their own professionalism to keep themselves and their patients safe, and when something goes wrong, it sits on their shoulders alone.

Osteopathy also lacks an embedded system of Clinical Leadership, recognised in other professions as a core function of professionalism.[34] Whilst some Schools recommend it, there is no mandated requirement that they work for a time, post-registration, within a group practice. Even those who do work as Associates under a Principal, receive no formal education. Whilst they may benefit from having colleagues on hand, and from informal mentorship, the Associate/Principal relationship is predominantly a mutually beneficial commercial arrangement (salaried or percentage of earnings based), to facilitate a new osteopath building up a practice, and extend the practice's capacity.

The quality of the osteopathic CPD market is variable, and the sector is unregulated. There is no mandatory kite-marking or quality assurance of CPD by the regulator. In recent years, GOsC has made consent and communication mandatory components of CPD, (which has seen a significant drop in numbers of complaints related to consent). Beyond that, there is no requirement for osteopaths to undertake courses related to professionalism, and no mandatory requirement for osteopaths to undertake boundaries training, even though many osteopaths who have been in practice for a number of years may never have been taught about professional boundaries, and the bulk of serious boundary violations involve osteopaths between ages 41-60.

The combined implications are that, for now, the OEIs are where substantive education and training about professionalism and boundaries takes place. This is why the inputs at the OEI level to embed understanding of boundaries, and the skills necessary to put boundaries into practice, are so important. Because realistically, they provide the *only* formalised point at which GOsC can exert any significant level of influence, via its system of registering qualifications, periodic quality assurance (QA) of OEIs, through recommended pre-registration curriculum content (GOPRE), and through the requirement for OEIs to have in place student fitness to practise (FtP) mechanisms.

Clearly other *informal* opportunities do exist for osteopaths to improve their technical and professional skills, and many osteopaths access a range of self-directed learning opportunities, in excess of their CPD requirements. But for some, their 'professionalism' learning is limited to what they learn in the classroom, what they observe in the Clinic setting, and what they absorb through the 'hidden curriculum'. This places a considerable responsibility on OEIs to deliver a professionalism curriculum which embeds critical thinking, self-reflection, and emotional intelligence, and which encourages students to seek support if they are struggling and to speak up if they have concerns. In addition to structured, classroom learning, much of the day-to-day professionalism skills training falls on Clinic Tutors, who are practising osteopaths, but not

[34] See, for example, the Royal College of Physicians' report on Advancing Professionalism: https://www.rcplondon.ac.uk/projects/outputs/advancing-medical-professionalism (accessed 28 December 2021)

necessarily professional educators. The focus of this report is not just about what each OEI currently offer, but whether what they do, *or can reasonably be expected to do*, adequately equips students with the skills they will need to support their practice, potentially for the entirety of their careers. This is clearly a complex phenomenon, and there is no right answer about how best to do this.

Within the constraints available to them, OEIs have relative freedom in how they satisfy GOPRE. They each described innovative approaches to enhancing professionalism, and greater attentiveness to diversity issues, but spoke of constraints on their ability to initiate substantial curriculum changes within QA and University regulations. All spoke of the crowded nature of the curriculum, and the expanding *breadth* of topics that need to be covered. This report considers the *depth of teaching* in certain areas which might help support student professionalism and reduce complaints, particularly the skills and self-awareness needed to foster ethically appropriate and therapeutically effective relationships.

OEIs and other interviewees were asked whether they had any idea as to why boundary violations seemed to be a particular problem in osteopathy. The range of answers that came back suggested a far broader set of concerns than what was or was not taught in schools. Some thought this was intrinsically a fitness to practise issue – a need to weed out wrongdoers, and to identify possible clues in student behaviours which might suggest later problems. Others seemed to feel boundary breaches were inevitable – and, despite the clear wording of the OPS,[35] suggested that 'you can't stop people from falling in love' (be it with their patient or their student). Some felt that, despite the clear wording, the revised 2019 OPS lack clarity about dating former-patients[36], and read the absolute prohibition against social and sexual relationships to be time-limited. Others even felt the factors listed at OPS D2 5.8 provided a legitimising 'workaround' for dating patients, as long as they are no longer in active treatment, and providing any necessary referral on is made.[37]

This Report stresses the importance of shifting dialogue away from the persistent idea that this is about osteopaths 'dating patients', towards understanding boundary violations as a fundamental breach of trust and an abuse of power. At the same time, the debate must acknowledge that whilst having sex with patients is wrong in every way, for some, it is irresistibly compelling, even if career-limiting. Moreover, that the positioning of offenders as 'other' is unhelpful, as all professionals are capable of acting unprofessionally in certain situations. That all of us are capable

[35] OPS Standard D2 specifically states "You must establish and maintain clear professional boundaries with patients and must not abuse your professional standing and the position of trust which you have as an osteopath."

[36] The guidance states at D2 5.6 clearly states "You must not take advantage of your professional standing to initiate a personal relationship with a patient. This applies even when the patient is no longer in your care, as any personal relationship may be influenced by the previous professional relationship and an imbalance of power between the parties."

[37] D2 states 'Factors which must be considered if an osteopath thinks a personal relationship with a former patient might develop include: the nature of the previous professional relationship (5.8.1); the length of time the professional relationship lasted and when it ended (5.8.2); and whether the former patient was particularly vulnerable at the time of the professional relationship (5.8.3)'. It also makes it clear that an osteopath must not end a professional relationship solely to pursue a personal relationship with a patient (5.7).

of breaching trust and serious errors of judgement, and that, on the rare occasions we do act out of line, we, like defendants in the dock, probably also seek ways to justify what we have done and to minimise our culpability, shifting blame onto others.

We aren't good at talking about sex.[38] And if we are to shift the narrative, we have to think about how to broach necessary conversations in education, including attraction to and from patients. Improving how we do this is integral to more open and informed debate. An issue which several people identified was the inter-generational gulf between students and staff, and between newly qualified osteopaths and osteopaths who had been in practice for many years. 'Me Too' has highlighted differences in attitudes and life experiences. Students and staff spoke of young people sexualised at increasingly earlier age, of endemic harassment amongst young people, of the ubiquity of porn, of Influencers, of 'new' offences such as up-skirting and drink spiking, of the impact of sexual abuse and sexual assault, and of generational differences towards sex and relationships occasioned by online dating and the 'swipe right' culture. There was clear dismay about the 'moral tone' set by those in a position of authority, and the seeming impunity of those in power acting immorally.

In terms of diversity, students spoke of gender fluidity, and the ignorance of some Tutors.[39] In some cases, students seemed to be educating Tutors rather than the other way around. If OEIs are to create safe learning spaces where sex can be talked about freely, they need to do so in ways that are inclusive, informed and sensitive to lived experience.

Given the space and time to think about these issues during interviews, respondents talked candidly about sex-related topics. They talked about relationships between students and other students, and about changes made to OEI policies in the last few years having become aware of relationships between students and staff. OEIs described positive initiatives they were putting in place, such as LGBTQI groups, of open-door policies to support students facing some of these issues. All of these broader developments collectively improve the culture in which students learn, and, critically, help create the context in which students feel supported and psychologically safe to speak up when they don't.

However, one notable gap in interviews with OEIs was how they broached sexual attraction to or from patients in formal education. It almost seemed as if the prohibition of the act closes down the possibility of meaningful discussion, beyond reference to the OPS. As the 2017 report noted, failing to talk about sexual attraction to and from patients, and maintaining silence of this 'taboo', makes it harder for students and practitioners to seek help in managing their feelings, and deprives students of the opportunity to cultivate professional attitudes and behaviours within the

[38] There is evidence that workers find all sexual issues difficult to talk about or face up to, *even in areas of medicine where this is necessary and an everyday occurrence*. Halter, M., Brown, H., & Stone, J. (2007). Sexual boundary violations by health professionals: an overview of the published empirical literature. London: CHRE

[39] As a profession, osteopathy might usefully research and produce guidance on clinical dimensions of transitioning, in addition to routinising appropriate use of pronouns as an integral aspect of patient respect and dignity

safety of a formative, educational setting. Teaching by OEIs needs to acknowledge that all professionals are capable of acting in unprofessional ways, just as all humans are all capable of acting badly. This is the challenge of effective teaching and training. Hook and Devereux stress:

> "Individual practitioners at all stages of professional development need to be aware that, under adverse circumstances, they can become vulnerable to meeting their own needs through inappropriate relationships with patients."[40]

Sexual boundary breaches by professionals in a position of power occupy a decidedly uneasy space. They may involve sex but are not just about sex. To the extent they involve an abuse of power and fundamental breach of trust, such acts have more in common with rape than they do 'dating patients'. Does calling it 'dating' suggest a collective form of minimisation and denial because it is so disturbing for us to think of trusted professionals in the same camp as potential sex offenders? Testimonies of survivors of professional abuse describe actions similar to 'coercive control'.[41] Searle discusses sexual misconduct in the context of health as 'a distinct type of wrongdoing that fundamentally challenges accepted notions of professionals' integrity and trustworthiness'.[42] If we were to characterise serious violations as sexual misconduct or coercive control, and those who perpetrate them as 'sex offenders' would the profession or the public be comfortable in considering remediation as the appropriate regulatory response?

At the core of this Report is the question: How do we balance the need to hold individuals to account with the need to ensure that we reduce the risk of offending behaviour from reoccurring? This question is a broader question for society to grapple with, given what we know of the levels of sexual harassment predominantly against girls at school and college. How are we to educate boys and men? We cannot criminalise a whole generation of young people, and so have to find better ways to establish ways of enforcing what is and is not acceptable. The same questions have to be applied to professional boundary violations.

Professionals are afforded a high degree of autonomy and professional regulation is essentially self-regulation. How best ought we respond to such fundamental breaches of self-regulation? Can we find mechanisms which simultaneously hold individuals to account, but seek to restore their capacity for internal self-regulation, if possible? There may be situations where that is not

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[40] Hook, J and Devereux, D. Sexual boundary violations: victims, perpetrators and risk reduction. BJPsych Advances (2018), vol. 24, 374–383 doi: 10.1192/bja.2018.27

[41] A crime since 2015, the offence of controlling and coercive behaviour is limited by statute to intimate partners and family members. Coercive control involves a pattern of abuse, which may involve psychological, physical, sexual, financial and emotional abuse. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf, and https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship (accessed 1 January 2022)

[42] R.H. Searle, C. Rice, A.A. McConnell, J.F. Dawson. (2019). Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/antecedents-and-processes-of-professional-misconduct-in-uk-health-and-social-care.pdf

possible. But we have to accept that if we remove 'offenders' by erasing them, we might protect osteopathic patients, but we continue to expose members of the public to risk. This might seem outside the remit of statutory regulation, and a problem for 'society' and not GOsC/regulators but if opportunities are not taken to support individuals who could remain in supervised practice, is this really achieving 'public protection'?

How, in particular, do we balance this against our need to protect and support patients, especially knowing that offending professionals tend to target vulnerable patients who have often already previously experienced abuse? Since CHRE's 2008 work on 'Clear Sexual Boundaries,[43] there has been little research involving the views of victims of professional abuse, including any appetite they may have to participate in or promote restorative justice approaches. NCOR's 2013-2019 report identifies qualitative feedback from those who make complaints as a potential new area of investigation, noting:

> "It may resonate with practitioners to understand the consequences of their behaviours and actions on their patients and give value to adopting behaviour changes in their osteopathic practice and care".

Until now, little attention has been paid to the role of restorative justice, which might also have resonance for responding to boundary cases.

> "Restorative justice brings together people harmed by crime or conflict with those responsible for the harm, to find a positive way forward. Restorative justice gives victims the chance to tell offenders the real impact of their crime, get answers to their questions and get an apology. Restorative justice holds offenders to account for what they have done. It helps them understand the real impact, take responsibility, and make amends."[44]

Could we develop mechanisms through which the narratives of people who have experienced abuse might inform training? GOsC could usefully commission research on how a restorative justice approach might enhance existing FtP processes. In considering alternative regulatory

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[43] Council for Healthcare Regulatory Excellence (2008). *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals*. CHRE https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/sexual-boundaries-responsibilities-of-healthcare-professionals-2008.pdf); Council for Healthcare Regulatory Excellence (2008). *Learning about sexual boundaries between healthcare professionals and patients: a report on education and training.* CHRE. http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/sexual-boundaries-report-on-education-and-training-2008.pdf (accessed 26 December 2021)

[44] https://www.gov.uk/government/collections/restorative-justice-action-plan(accessed 28 December 2021). Used increasingly in hospitals, and in the criminal justice system, restorative justice includes preventive and reactive approaches. See: https://restorativejustice.org.uk/what-restorative-justice

solutions, the profession might explore informal complaints and mediation processes and some of the practice-improvement oriented approaches being taken in non-statutorily regulated professions, which are able to adopt more flexible ways of responding to unprofessional practice,[45] as well as thinking about how to make use of voluntary and third-sector organisations who support victims.

How might we apply this to the OEIs? Research suggests that it is possible to identify, and also potentially thus to support, individuals most likely to act in ways inimical to their professional training and expected codes of behaviour, acts which require individuals to overcome the prohibitions of their own internal moral compass. Whilst it may not be possible to detect traits in students which might be indicative of subsequent 'acting out', it *is* possible to increase their emotional intelligence during training, and to create conditions in which students feel safe to report any actions of peers which make them feel uncomfortable, and which encourage students who have issues to seek pastoral/professional advice and support. Involving patients in education and research might be a way of enhancing practitioner empathy and understanding vulnerability and power imbalance from the patient's perspective.

We also need to acknowledge practitioners' feelings of vulnerability (more broadly), and recognise that *students and early years osteopaths may not see themselves as holding power*.[46] Even experienced practitioners might view themselves as 'service providers' beholden to patients rather than view their professional status as imbuing them with power and status. This includes the power differential between Associates and Principals, and how realistic it is to expect osteopaths in their first employed role to challenge policies and behaviours, especially when they are under commercial pressure to retain patients for the first time.

The Report suggests the need for realistic expectations about the role and responsibility that OEIs can take in nurturing professionalism. It is unhelpful to think that OEIs, alone, can bear responsibility for educating 'unprofessionalism' out of students. More realistically, we should be

[45]See, for example, BACP's practice review hearings process: https://www.bacp.co.uk/about-us/protecting-the-public/professional-conduct/professional-conduct-procedure/practice-review-hearings/ (accessed 1 January 2002)

[46] For a rich qualitative analysis of how students grow in confidence throughout their clinical training, see Bartlett, D. et al. **'**Understanding the professional socialization of Canadian physical therapy students: a qualitative investigation**'.** Physiother Can. Winter 2009;61(1):15-25. doi: 10.3138/physio.61.1.15. Epub 2009 Feb 13. Early in training, students described conflicting emotions that included feeling awestruck, compassionate, empathetic, elated, fortunate, gratified, proud, and relieved as well as feeling angry, awful, embarrassed, frustrated, helpless, indifferent, nervous, sad, shaken up, shocked, and overwhelmed. In interviews for this report, qualified osteopaths said they did not always feel in a position of power over patients, especially at the start of professional practice.

looking at OEIs as providing the foundations for professionalism, upon which other regulatory and profession-led structures can be built. We also need to be cognisant that OEIs regard teaching osteopathic technique as their main focus, and that those teaching within OEIs are more likely to be familiar with osteopathic philosophy than moral philosophy.

As a discipline, osteopathic professionalism is still in its infancy, despite the volume of GOsC and iO activity to increase awareness of professionalism. This is not to denigrate the high standards to which most osteopaths practice. But whereas medical professionalism is a hugely researched and embedded discipline (reflecting, in part, the rebalancing away from paternalism towards therapeutic alliances), osteopathic professionalism is understood by most osteopaths as more to do with providing effective osteopathic treatment. Greater involvement of patients in education and training and research would help to better identify how patients determine what a 'good osteopath' looks like.

In seeking to explore how OEIs might improve teaching about boundaries, a key theme to emerge is that an understanding of boundaries includes a wider range of issues than may previously have been thought relevant and taught in a single lecture or series of lectures, often related to what a student osteopath would or would not do in a given scenario (vignettes being a particularly popular teaching tool). Understanding why individuals act unprofessionally or unethically in their professional life, as in personal lives, requires a greater attentiveness to areas which have not, historically, been well covered in the curriculum. Some of these areas relate to the interpersonal dynamics within osteopathy as a therapeutic relationship, mirroring issues arising in counselling and psychotherapy (notwithstanding osteopaths are not therapists). Some relate to how osteopaths keep themselves psychologically, physically, and potentially spiritually resourced for working as a healing professional. Some relate to the ways in which attentiveness to contracting with patients and managing patient expectations reduce the likelihood of complaint. These topics will be explored in more detail throughout the Report.

Whilst there is some evidence that good boundaries teaching heightens awareness and sensitivity to the issue,[47] the role of OEIs in preventing future osteopaths from acting in unprofessional ways may be more limited that has been explicitly acknowledged. This by no means underplays the function that pre-registration plays in instilling professionalism, and the opportunities it provides for staff role-modelling what good practice looks like. Through formative teaching, OEIs provide frameworks and opportunities for training osteopaths to begin to formulate their own individual

[47] Halter, M., Brown, H., & Stone, J. (2007). Sexual boundary violations by health professionals: an overview of the published empirical literature. London: CHRE. See too: 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.

professional identity - a sense of what sort of osteopath they are going to be - and to begin to embrace what becoming a healthcare professional means to them.

A key finding is that pre-registration boundaries education and training needs to be built upon and supported within a more holistic and integrated education and research-informed framework, within and beyond regulation. The next part of the report will explore how OEIs are teaching about boundaries and some of the broader issues within the osteopathic profession which impact on education. How to integrate these issues will be developed in Part Three.

PART TWO

BOUNDARIES EDUCATION AND THE OEIS

OEIs, as discussed at the start of the last section, provide the mainstay of professionalism education and training. Those who go on to work in private practice have few ways of accessing training other than post-graduate training and CPD. For the reasons highlighted, this places a significant responsibility on OEIs to instil the technical and professional skills to work as a safe beginner, but which could, theoretically, serve osteopaths for the entirety of their careers. Readiness to practice from day one post-registration means osteopaths get none of the reinforcement and systematic development over time common in other regulated professions.

Whilst OEIs are independent institutions, each with their own characteristics, osteopathic education and training sits within a prescribed regulatory framework and operates within an evolving understanding of the nature of osteopathy. Those OEIs situated within Universities have additional governing requirements, in addition to GOsC's quality assurance mechanisms. Some OEIs are situated within Schools of Health, which may facilitate inter-professional learning. Additionally, OEIs are commercial institutions which need to attract students to survive, and this means different OEIs have different approaches and selling points (as well as differential needs to recruit and retain students).

OEIs, through both classroom and Clinic teaching and learning then, are the place where student osteopaths get most of their learning about professional relationships. Reflective skills are a core component of training, where students develop the skills to think about what has gone well and what has gone less well, and how they might do better in the future. It is an activity they carry out independently, and in peer review groups, sometimes with input from Tutors. OEIs are where students gain a sense of themselves as 'healers', ideally, fostered through self-awareness and emotional intelligence. Influenced by role-modelling in the first instance, OEIs are where students grow in confidence as they cultivate their own professional style and learn how to apply appropriate interventions tailored to the patient in front of them. It is where they learn how to read patients verbal and non-verbal signs - what is said, and what is not said, what they observe through their eyes and through palpation, and what they intuit. Broadly, OEIs provide the environment where students learning not only about patients, but also *where they learn about themselves* in a safe and supportive environment.

In terms of boundaries, OEIs are where students learn what safe practice looks like and how to draw the line – between themselves and their patients, demonstrating empathy and dependability, but not allowing undue dependence to develop, between what is within their realm of competence and what is beyond it. Implicitly, and over a period of time, they learn what it is to offer safe, effective treatment. That includes an internalised understanding what they should do, and what they should not do.

One of the reasons OEIs find it hard to articulate how they teach boundaries is that teaching what is appropriate covers so many different areas and can be taught from many different perspectives. Part of boundaries training is *relational* - whether, for example, to answer patients' probing questions about their personal life, whether to accept seemingly innocuous gifts or whether to risk offending patients by refusing them, whether to give distressed patients a bit more time and attention than has been allocated - knowing this will cut into other patient's appointment time. Other elements important to boundaries relate to *technical* aspects of the therapeutic relationship and how these are communicated. These might include, for example, how to explain the clinical need for a given procedure involving considerable body-to-body contact, or how to gain consent, when, exceptionally, an osteopath might feel it necessary to observe a patient undressing for the purposes of diagnosis or treatment[48]. Or how to explain the clinical need for a given procedure involving considerable body-to-body contact.

This sort of boundaries training will be more meaningful when it is delivered in an integrated way as part of clinical skills training, although this requires all lecturers and Tutors to identify that this might be perceived problematically as a boundaries issue. Many of the FtP allegations have involved situations in which the osteopath performed an accepted clinical procedure, but did so in a way that the patient interpreted what they were doing as unduly invasive or sexually motivated. Learning to combine communication and dialogue to accompany invasive or potentially sensitive investigations is a core skill.[49]

The challenge of how to teach about boundaries is part of the bigger question of how to teach osteopaths about professionalism. This commonly involves teaching students professional rules (relating to putting patients interests first, benefitting and not harming) and underpinning values (respect, dignity, compassion, integrity etc.). Often, these are combined in the form of professional Codes of Ethics – currently the Osteopathic Practice Standards (OPS 2019). But ethics teaching should, additionally, bolster students' sense of themselves as moral agents, as the embodiment of moral sensibility and inclination towards 'being good' rather than merely following rules by rote. Noting the importance of ethical values, Tyreman observes:

> "More than most other professions, osteopaths engage with their patients in a physical and extremely intimate way. This intimacy doesn't just relate to touching 'sensitive' areas. The act of touching in relation to any part of the body can be intimate, but it may be central in the therapeutic effectiveness of osteopathic treatment, i.e., we are working at an

[48] The OPS states at A6 2.3 that express consent must be obtained and that if a patient does not wish to be observed that must be respected.

[49] None of the respondents addressed whether or how per vaginal (PV) and per rectal (PV) examinations are taught in OEIs. This may be because these techniques are not taught to undergraduates or widely used. Or it may be possible that they were not flagged up as requiring particular mention in relation to boundaries, as they are viewed merely as one more clinical tool in the toolkit, subject, like all procedures, to rules of consent, and not worthy of ethical distinction. Presuming that at some stage osteopaths learn how to use these techniques, their capacity to cause psychological harm if inexpertly performed requires some thought, and might, for example, be discussed in the context of trauma-informed education.

> emotional and psychological level at least as much as at a biomechanical level. If this is the case, just putting in regulations about gaining consent or using gowns and chaperones is a blunderbuss approach to a complex and mysterious activity that may destroy rather than nurture patient-practitioner trust."[50]

The concept of 'moral courage' should be instilled to enable students to challenge inequity and injustice, speak up when they witness wrongdoing, and critically, be prepared to challenge even where there is a risk to self-interest in doing so (for example, post-registration, as an Associate, preparedness or new graduates to challenge/report unethical working practices they may be expected to operate within).

Students can find ethics teaching challenging, especially at the pre-registration stage where they are generally idealistic and unquestioning about their personal motivations for entering into a healing profession, and keen, primarily, to learn osteopathic techniques to provide them with the technical skills of the trade. Unless they are mature students who have prior experience of working in health-related professions or other positions of trust, ethics teaching in general, and boundary teaching in particular, may feel particularly abstract to them ("I would never….").

Part of the challenge of embedding effective boundaries, as part of professionalism training, is that taught badly, or from a predominantly negative perspective, this subject has the capacity to alienate students who think that they would never seriously breach boundaries. On the other hand, unless students are exposed to precisely the sorts of behaviours and attitudes which have resulted in complaints to the regulator and the imposition of serious sanctions or erasure (for example, by looking at fitness to practise cases), it will be hard for them to have a yardstick of what is and what is not appropriate. Getting the balance right means looking at different ways to embed and cultivate constructive relationship-building skills and ways to avoid the pitfalls of inappropriate or risky ways of engaging with patients.[51]

However attractive it would be to offer a prescriptive 'off the peg' set of teaching materials, as with interpreting the OPS guidance, the essence of professionalism training is not to provide answers to what students ought to do in any and every conceivable situation. Rather, it is to provide students with the situational judgment skills to be able to do the right thing, at the right time, for the right reasons, and in a way which could be justified, if need be, after the event. The teaching of reflective skills, and the reinforcement of the role of reflection after each patient encounter, begins to provide students with the skills necessary to review their professional, as well as their technical, skills, and to begin to cultivate the emotional intelligence to consider how treating patients makes them feel, how to respond to that in moment, and how that in turn influences their ability to forge warm, empathic therapeutic relationships, even where they may

[50] Tyreman, S. 'Valuing Osteopathy. What are our professional values and how do we teach them?'. IJOM 11 (2008) 90-95

[51] GOsC have recently developed a series of vignettes for discussion which provide an excellent basis for group discussion: See https://www.osteopathy.org.uk/news-and-resources/blogs/part-six-thinking-about-professional-boundaries-what-would-you/ (accessed 28 December 2021)

be lacking in confidence, uncertain as to diagnosis or treatment, unable to judge their clinical effectiveness, or otherwise overwhelmed.

Students do not arrive at OEIs with pre-developed professional skills, albeit they should understand the enhanced responsibilities associated with being a student on a vocational training course. Several respondents thought that boundary breaches would not occur if only 'the right sort of students' were admitted to OEIs, but skills and aptitude cannot be assessed with any certainty at this developmental stage.

The 'moral education' role of OEIs in shaping boundaries is not just related to what they teach. It might include needing to talk to students about what they are wearing, about their relational style with other students and with staff. It requires conversations about privacy settings on their social media, limiting what can be found out about them online, and never divulging patient information online. It may require conversations about cultural competencies and working with difference. It may require challenging students on dealing with bias – their own, those of staff, and patients. All of these aspects of professionalism feed into a culture of safety, dignity and respect, and a culture in which students feel it is safe to speak up. How students are taught to treat each other, seeking consent at all times, with sensitivity to being undressed, with appropriate use of language are all dimensions of creating safe boundaries.[52]

Professionalism, especially in a highly individualistic profession like osteopathy, is not well described in protocols, albeit there may be a role for checklists, e.g. in relation to consent. Rather, professionalism is about instilling a nuanced sensibility which is highly responsive to the individual patient's needs and the particularity of the circumstances. Badly taught boundaries lectures may lead students to think they cannot be friendly, or must not reveal their true character to patients. This is not the case at all. Patients value authenticity, and for some patients, a less formal style may optimise the therapeutic relationship.[53] Indeed, the OPS states that osteopaths should adapt their communication approach to take account of the particular needs of the patient.[54]

Students must learn what a 'boundaried, empathic warmth' looks like, and what is needed *by this patient in this appointment*. It includes gauging how light-hearted or jovial to be – how strongly to chide a patient who has not done any of the exercises recommended, how forcefully to recommend self-care without which a patient is unlikely to experience the benefit of treatment.

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[52] Most OEIs are highly sensitised to their responsibilities, and demonstrate this in multiple ways, e.g. providing space for students to dress and undress, introducing shorts and crop top uniforms rather than vest and pants, and requiring students working on each other to role-model how they would talk to patients, e.g. seeking consent even when practising on each other.

[53] For discussion of this point, see: Trimberger, G. (2012) An Exploration of the Development of Professional Boundaries. Journal of Social Work Values and Ethics. Volume 9, Number 2 (2012) https://jswve.org/download/2012-2/pp%2068-75%20Professional%20boundaries%20JSWVE%20vol%209%20no%202%20Fall%202012.pdf (accessed 29 December 2021)

[54] OPS (2019) at A2

These are not skills that can be found in a book or are easily taught in a classroom. Many schools rely on Tutors to role-model this, more or less explicitly, rather than a tick off list of what a student needs to be able to do. This, in turn, places a big responsibility on Tutors, who themselves, need to be adequately resourced to role-model exemplary behaviours.[55]

Guidance on Osteopathic Preregistration Education (GOPRE) merely states education and training should enable osteopaths to establish and maintain clear boundaries, recognising the importance of trust within therapeutic relationships. It does not provide detailed learning outcomes. CHRE's outcomes for boundaries education, set out in the table below, provide a useful framework for what good boundaries education is seeking to achieve. OEIs are likely to be already covering most of these aspects of professionalism, without necessarily identifying them as 'boundaries' related.

Table 1: Extract from Council for Healthcare Regulatory Excellence (2008). *Learning about sexual boundaries between healthcare professionals and patients: a report on education and training*.

- instilling professional values and respect for patients and their carers
- knowing what is meant by clear sexual boundaries
- understanding the impact of breaching boundaries
- learning to differentiate between creating rapport and trust (including the appropriate use of touch in therapeutic relationships), and acting in a sexually inappropriate way
- knowing how to recognise sexual feelings arising in a healthcare setting, how to recognise early warning signs of inappropriate sexual behaviour, how to deal with such circumstances appropriately and where to seek advice
- knowing how to maintain clear communication with patients at all times
- learning appropriate techniques for intimate and other examinations and history-taking
- being familiar with protocols for intimate examinations and the use of chaperones
- developing an understanding of, and respect for, the different needs of patients, including the needs of vulnerable groups of patients for whom boundary-setting may be especially hard
- developing a recognition of how their own cultural and religious values and the cultural and religious values of patients and service users might affect boundary issues, for example around the acceptability of use of touch
- knowing what to do, and their duty to report, if they have concerns about other health professionals who have displayed sexualised behaviour towards patients
- knowing how to handle patient complaints and concerns, demonstrating the ability to apply key ethical, legal and psychological concepts in day-to-day practice. This includes a clear knowledge of their professional code of practice and the legal implications of any sexual boundary transgression

[55] Including a responsible attitude towards the nature and purpose of regulation and the regulator – instilling professionalism supportive of patient-centred therapeutic alliances, rather than what to do to keep out of trouble.

The components of personal and professional development courses vary differ from school to school. Ideally, this element of the curriculum should evolve responsively in the light of changing patient, public, and professional norms. Quality Assurance and governance approaches require formal mechanisms to make significant programme changes, but within this context, interviews with OEIs suggest they are nonetheless sufficiently agile to be free to introduce new ways of teaching and to emphasise issues which they think their students need to be aware of. Several OEIs, for example, have found ways to improve their culture and teaching around equality, equity, diversity and inclusion, both within teaching, and supported by the creation of EDI representative student groups and training for Tutors.

Given the crowded nature of the curriculum (which most OEIs interviewed referred to), rather than thinking about boundaries education as requiring *additional* teaching, it may be more helpful to reframe this as requiring *different* teaching, and specifically reviewing the way in which boundaries education is integrated across all aspects of classroom and Clinic teaching, making links more explicit than they currently are. The varied and dispersed and nature of teaching about professional boundaries means that different members of staff will be involved in it – most commonly, those staff delivering Personal and Professional Development, Ethics and Law, Communication, and Psychology components. To teach about boundaries in a truly integrated way, all staff need to be able to make linkages between different subjects, and to think about whether there are professionalism issues generally, and boundaries issues specifically, in what they are delivering.

Part of the difficulty seems to be that the very nature of boundaries is poorly understood. Whilst all have a clear vision of what osteopaths shouldn't do, it is less obvious how to teach what they should do. Taught purposively, learning how to forge effective therapeutic relationships is essentially the same as learning to create, maintain and enforce effective boundaries.

Boundaries training usually talks about lines which must not be crossed – the limits of acceptable behaviour. A different way of thinking about boundaries is *to consider a safe boundary as the circumference of a circle within which is the sphere of recognised good practice*. This shifts the focus so that the emphasis turns on what it is to deliver effective and empathic training, not what not to do.

Whilst all OEIs have different ways and different opportunities for teaching about boundaries, the areas in Table 2, building on the 2017 Thematic Analysis, represent topics it would be useful for them to cover at some point in the curriculum. This is not definitive, and may change as our understanding of psychologically-informed approaches to boundary violations deepens.

Table 2: *Indicative core boundaries content*

- Understanding what it means to be a professional – and what the ethical basis of professional practice is, with reference to individual moral values, as well professional values, and rules and expectations as set out in the OPS and associated guidance. Inclusion of 'moral courage'
- Exploring the 'fiduciary'/trust-based nature of healthcare relationships, and why trust is a fundamental pre-requisite and defining aspect of therapeutic relationships
- Understanding from the patient's perspective what it feels like to invest sufficient trust in someone else to disclose personal medical history, to undress, and to allow someone to perform invasive and potentially risky procedures on them when they are in pain
- Exploring and critiquing notion of patient vulnerability
- Developing a sense of what makes therapeutic encounters safe for patients (ideally based on patient voices).
- Appreciating what experiencing osteopathy touch feels like from the patient perspective, and particularly how certain techniques might be perceived as odd or unduly invasive from the patient's perspective
- Understanding of 'healing touch' and about the difference of specific and non-specific effects of the clinical encounter, the potency to patients of the offer to heal, and the capacity for patient dependency
- Cultivating understanding what the relationship is there to achieve, and how it is achieved i.e. the sphere of good practice, the better to understand what the limits and boundaries are
- Individualising treatment and care. Finessing relationship skills to assess what is right for that patient. Learning what is and is not appropriate to say
- Thinking about what it might feel like from a patient's perspective when professional trust is breached, including impact statements from people who have been subject to professional abuse
- Studying what sorts of cases have given rise to complaints in the past (formal and informal) and how to learn from those examples
- Learning about what it feels like from an osteopath's perspective to be complained against
- Understanding the concept of defensive practice
- Exploring the nature of professional power or *relative power* that osteopaths hold power by dint of their professional position, *whether or not they experience themselves as holding power* (particularly whilst they are in training, or early years practitioners). Specifically, recognising and discussing the imbalance of power between the practitioner and the patient including: expectations that the patient will disclose personal information, expert knowledge on the part of the osteopath, the potential to relieve pain and suffering, the potential to cause significant harm, the fact that the

patient is generally undressed and supine for some or all of the session, and the extent to which, for some patients, this is highly uncomfortable and potentially triggering

- Considering the aspects of practice which might be experienced as demeaning and disempowering – e.g. osteopath as 'service provider', and how to counter the feelings this might engender
- Learning about the physical and psychological sequalae of trauma and understanding what offering trauma-informed care requires, in terms of treatment and practice environment
- Cultivating ways to demonstrate and respect patient dignity during appointments, including taking a history whilst the patient is still dressed, signposting how much clothing needs to be removed, and whether considering whether undressing is necessary at all, explaining the purpose if observing dressing or undressing, providing disposable paper underwear if needed
- Forging an ability to maintain a dialogue throughout consultations linking what the osteopath is doing/about to do and why as part (boundaries as an aspect of consent – including the right to say 'No' or 'Stop' at any point
- Communicating in patient-centred ways, and catering to language, comprehension, and cultural barriers
- Understanding cultural differences and how these impact on practitioner and patient expectations of boundaries
- Managing patient expectations, and being clear about what the osteopath's obligations and responsibilities are and what the patients are
- Understanding the importance of verbal and non-verbal language, and consideration of 'the language of touch'. Cultivating self-awareness and emotional intelligence as to what non-verbal signs are telling the patient about the osteopath
- Learning about the affective and arousal aspects of human touch as well as touch in the context of clinical technique.
- Learning how to deal with (common) signs of sexual arousal without embarrassment and in ways which normalise the experience for the patient
- Learning how to keep oneself safe from allegations (e.g. where to place the patients' hands in such a way as to minimise inadvertent contact with the practitioner's genital area)
- Thinking about the risks or otherwise of 'social touch' including hand-shaking, hugs, beginning and endings of sessions (including patient-initiated touch)
- Learning how to cultivate and demonstrate boundaried warmth and empathy towards patient suffering without becoming swamped, engulfed or burnt out
- Building resilience and understanding how lack of resilience and burnout are closely associated with breaches of boundaries
- Exploring and critiquing the notion of 'wounded healer'
- Learning how to deal appropriately with sexual attraction to and from patients
- Learning about so-called 'slippery slope issues' including social relationships, invitations on social media, and the giving and receiving of gifts, and considering how lesser boundaries may erode professionalism and clear messages to the patient

- Discussing dual relationships and how to manage circumstances where these are unavoidable
- Understanding issues in treating friends and family members
- Understand the challenges of maintaining boundaries when involved in dual relationships with patients or members of a patient's family
- Knowing where and how to escalate concerns about patients
- Knowing where to seek support about boundaries
- Understanding why patients complain, and how to respond effectively to complaints dealing with them as close to the point of complaint and as locally as possible
- Understanding the impact of Covid on psychological health and physical health - being aware of possible increased acuity of patients with mental health issues and morbidity of patients with MSK/LTC issues

Role and oversight of Clinic Tutors

OEI respondents identified the role of Tutors as being highly instrumental in helping forge students' sense of their professional identity – to find, as one Course Leader put it: 'their inner osteopath'. Professional identity formation is a highly complex phenomenon. Afshar et al (2021) describe professional socialisation as:

> "a non-linear, continuous, interactive, personal and psychosocial process that is formed through the internalization of the specific culture of the professional community and its main outcome is the formation of professional identity".[56]

Personal identity underpins professional identity, which means that students adapt to a professional role at a different pace, and with different maturity, responding differentially to the same educational experiences. They note:

> "[P]rofessional identity formation is a complex and multi-layered process that requires the internalization of a wide range of values, behaviors, and perceptions that are often implicit, and formed through authentic work experiences sub-consciously"[57]

The role-modelling and demonstration of professionalism by Tutors in 'live' Clinic situations provides a basis for students to learn how to respond to clinical situations as they emerge, what language to use, how to combine technical and interpersonal skills, and how to deal with uncertainty. Clinic Tutors 'hold' reflective spaces where students can analyse and discuss what they have seen and learn how to manage complexity and discomfort. They act as a guide, ideally,

[56] Afshar, L., Yazdani, S. and Avval, HS. Professional identity of medical students: Proposing a Meta Static Structural Model. J Adv Med Educ Prof. 2021 Oct; 9(4): 211–220. doi: 10.30476/JAMP.2021.89121.1364
[57] Ibid.

providing the safe space in which students, individually and collectively, can self-reflect and acquire practical wisdom.

Depending on the OEI, Tutors also have a responsibility for continuously assessing professionalism and providing formative feedback in Clinic (continuous assessment is felt by many OEIs to overcome the problem of students modelling ethical behaviour for the purposes of passing a practical assessment). Tutors do not assess specific competencies, mapped against the OPS. As students are overseen by different Tutors, one suggestion was that it might make sense for students to hold a 'log book' so that different Tutors could make comments/provide formative assessment. This would provide a centralised record which the student could reflect on. The assessing of professionalism, meantime, is an imprecise science, and there is scope for further research on appropriate assessment methods, including making greater use of patients within student assessments.

The effectiveness of Tutors relies on a number of factors, including how well they are embedded into the wider OEI teaching faculty, and also, on their own training and professional development. Increasingly, OEIs are requiring Clinic Tutors to have formal teaching qualifications. But, as respondents noted, despite the offer of Induction Days and Training days, a potential problem is that Clinic teaching is more or less unsupervised, so quality control over Tutor inputs is challenging. Some schools have introduced peer observation of Tutors by other Tutors as part of their upskilling endeavours. Others have Tutors working in pairs, so that students can also see how practising osteopaths may arrive at a different diagnosis or treatment formulation.

The role of the School is to ensure effective continuity between what is taught in the classroom, and how that is demonstrated and role-modelled in the Clinic. By dint of Tutors often being part-time, working on a sessional basis, and many years since they studied, it may be hard to ensure that the Clinic Tutor fully appreciates what is being taught on the course, or how. Making sure that Clinic Tutors are fully briefed on the totality of the OEI's curriculum may help to ensure that students don't receive mixed messages, and so that the Clinic environment builds on, rather than contradicts what they have learned in the classroom.

Several respondents felt that Tutors could sometimes exert a 'rogue influence' on students, contradicting how student osteopaths have been shown how to do something in the classroom, and demonstrating instead how they themselves would do it in practice. What messaging Tutors send out about GOsC and regulation also forms part of the hidden curriculum, and may influence impressionable students. It is worth considering that most of the Tutor's professional career as an osteopath will have been unsupervised.

Compared to frameworks to support and enhance medical education in pre- and post-registration settings, professional support for osteopathic Tutors is underdeveloped. Whereas medical educators sit within a comprehensive framework of post-graduate education and training, overseen by post-graduate deaneries, again, no such parallels exist within osteopathy. GOsC and

PSA might want to consider some standardisation of requirements for all professionals acting in education roles, and recommendations for professionalising Clinics as learning environments.

One of the ways that OEIs reduce tutor isolation is to have Tutors not only supervising in the Clinics, but to also embed them in classroom teaching. This may help them feel like they are more of a part of the Faculty, rather than sessional practitioners. Some OEIs have now instituted this approach to bridge the divide.

Compared to private practice, the rates of pay for Clinical Tutors is set at a relatively low, academic hourly rate. OEIs need to ensure that the number of hours includes protected time for Tutors to facilitate individual or group reflection, ideally after all Clinic sessions. This time, without seeing patients, provides an important debrief opportunity, and allows structured time to ensure that reflection on the patients that the students have seen takes place close to the point of the therapeutic encounter.

Boundaries as pre-or post-registration training?

The teaching of professional boundaries needs to occur at different stages of the osteopath's journey. Pre-registration about boundaries, and particularly the sexual aspects of boundaries, needs to take account of students' age and possible lack of life experience[58]. It also requires skill and sensitivity towards cultural and EDI dimensions, as well as an appreciation that the subject matter may be triggering to students, and especially to students with a history of sexual trauma. For these reasons, teaching about the sexual dimensions of professional boundaries might best be taught within the psychology component of pre-registration teaching, with the more 'rule-based' elements taught within ethics and law or personal and professional development. However, the variety of professional development courses is such that OEIs need to determine where the issues raised in this part of the report best sit within their curriculum. Teaching sessions on sexual boundary violations should offer signposting to students on sources of support, and OEIs might consider the need for a trigger warning.

Ultimately, given the many points at which boundary related questions and teaching opportunities might arise, all members of staff – Faculty *and* support staff – need to be skilled in being able to talk about these issues. A trauma-informed, organisational approach would provide the necessary safeguards to protect students, staff, and ultimately, patients.[59]

CHRE's 2008 guidance on boundaries education and training suggests a role for both pre-and post-registration training, recommending Higher Education Institutions (HEIs) work with professional associations to strike the appropriate balance. [60] That report notes:

[58] One mature student commented that younger peers found it acutely difficult talking about sex-related issues in class

[59] The Scottish government developed useful materials with different levels of training for a whole system approach: https://www.gov.scot/publications/trauma-informed-practice-toolkit-scotland/

[60] CHRE (2008). Learning about sexual boundaries between healthcare professionals and patients: a report on education and training

> "The sensitive nature of teaching of sexual boundaries means that in-depth teaching of this subject (and certainly the specialty-specific dimensions) may be more usefully included as part of specialist training. Even if students have been taught about boundaries pre-registration, this will need to be reinforced once they are registered."

The report went on to recommend that post-registration training in this subject could usefully be made a mandatory element of CPD. The reason for making this a mandatory post-registration CPD requirement is that if it is not, *those most in need of upskilling may be those with the least insight that they would benefit from this training*. One of the challenges of teaching this subject at a pre-registration level is that students may have no prior healthcare experience, and possibly enter into OEIs with little or no life experience, or sexual experiences to draw on. Those who teach professional boundaries observed that students often find it extremely hard to relate to sexual boundary violations (or, indeed, any serious wrongdoing which would harm patients), and cannot imagine that *they* would ever find themselves in that position or acting in that way.

In contrast, practising osteopaths, responding to this research, spoke of direct experience of patients having acted inappropriately, and said that undergraduate training, including role-playing, (which some OEIs use) might better have equipped them know what to do in difficult situations. At a post-registration stage, osteopaths have experienced a wider range of relationships with patients, and may be more comfortable acknowledging, for example, that they like some patients and loathe others, but know how to foster a benign, therapeutic warmth to all patients regardless.[61] Research is needed to determine what sort of education and training is most impactful at different stages of the osteopathic career. Seasoned osteopaths require a more sophisticated teaching approach than the Year One pre-registration lecture.

In other words, many of the boundary issues which osteopaths need to know how to deal often only feel relevant or become obvious once they are in practice, and are responsible for managing and retaining patients. Whilst the pre-registration and Clinic setting can prepare students for these issues, post-registration is when this 'goes live', and when the full impact of managing a caseload of neediness can, for unsupported osteopaths, lead to a sense of overwhelm and unboundaried responses. This is more likely to be the case when osteopaths are not in a psychologically robust position themselves.

Acting in an unboundaried ways is rarely sexual in nature. Far more commonly, osteopaths may work when they are physically or mentally unwell, they may take on or see more patients than they should, because they need the money, and for the same reason, potentially, keep patients in treatment longer than is necessary, and they may work beyond the limits of their competence. It is unusual for any of these things to result in a fitness to practise referral, or even necessarily in a patient complaint, yet they are all examples which relate to professional boundaries, and which should be acknowledged in teaching.

[61] The 2017 Analysis explored the impact of transference and countertransference, concepts drawn from psychotherapy, and their relevance to therapeutic relationships.

As NCOR figures show that most boundary breaches involve osteopaths in the 41-60 year old age brackets, the profession needs to dramatically improve access to safe, reflective spaces where osteopaths in practice can seek advice and take appropriate action *before issues escalate*. Osteopathy also needs system-wide, supportive mechanisms for colleagues to feel confident to challenge and educate practitioners demonstrating inappropriate behaviours. Pre-registration 'bystander' training imprints the moral responsibility not to ignore inappropriate behaviours and upskills individuals to know how to speak out. Ideas emerging from OEI/practitioner interviews included structured buddying, mentoring programmes and Clinical Supervision (of the sort psychotherapists are required to undertake). These are systems which recognise the emotional toll of being a healthcare professional, and allow opportunities not only to discuss dilemmas and challenges arising in practice and how to manage them, but also, how these make professionals feel.

> "Supervision is a space where individuals can consolidate learning, explore the effects of our work and make sense of the feelings our work evokes. It provides the opportunity to replenish reserves and bolster our resilience by considering new strategies. It also enables us to consolidate learning and celebrate our achievements."[62]

The format of such systems, and who might pay for them, requires consultation within the profession. Professional bodies, interviewees suggested, may be better able to support these initiatives than the regulator.

Interviewees spoke of the toll of professional practice on mental health and the need to look after their own wellbeing to sustain their professionalism. Psychology and psycho-education is offered by some OEIs to help students better understand their own mental health and wellbeing needs, as well as those of their patients, and looking at ways in which professionals can avoid burnout.

<u>Sex and Boundaries: a psychological approach to understanding sexual attraction to and from patients</u>

So much did the 2017 report focus on the ubiquity of boundary issues affecting all osteopaths practice that it directed less attention as to how OEIs should teach about attraction to and from patients. This key topic needs to be taught, as well as how to manage more everyday aspects of boundaries, with arousal in response to touch and attraction expressly included. In their literature review 'How Touch is Communicated in Manual Therapies', Concannon and Lidgely[63] note:

> "There is evidence that feelings of sexual attraction arise from both sides of the HCP-patient boundary, confirming that this is a complex subject area and that sexual attraction exists, generally, within healthcare settings (McNulty et al., 2013). One study showed that 74% of male and 41% of female physiotherapists in Australia reported being sexually

[62] https://wessex.hee.nhs.uk/wp-content/uploads/sites/6/2021/03/2021-01-29-What-is-Clinical-Supervision.pdf (accessed 1 January 2022)
[63] Concannon, above.

attracted to a patient during their clinical practice (Cooper et al., 2008). Also, 90% of qualified physiotherapists experience patient-initiated sexual behaviour (Soundy et al., 2013; Cooper et al., 2008; Cooper & Jenkins, 2008).

Respondents to this Report expressed a naïve, but worryingly persistent view in the profession, despite unequivocal OPS guidance, that when osteopaths breach sexual boundaries with their patients, this is because of sexual attraction on the part of one or other or both parties, rather than an abuse of professional power. Two important points need clarifying: first, whilst sexual attraction may be a feature of some boundary violations, this does not imply 'sexual motivation' is uppermost, secondly, that patients may both be sexually attracted to health professionals and initiate sexual contact or even sexual assault does not lessen the responsibility of the professional, *always*, to create and maintain boundaries. As Halter et al[64] state:

> "Discussions of sexual boundaries are often confounded by reference to abuse of professionals by clients as well as of patients by professionals, as if these were equivalent risks that cancel each other out."

Views expressed in interviews included: 'that these things happen', 'that you can't legislate who people fall in love with', and 'that osteopaths don't get to meet potential partners in the course of their work'. Not only is this the wrong message for students to be exposed to but it demonstrates a simplistic understanding of why boundary violations occur, and that they represent an abuse of power and an abuse of trust.

As discussed in Part One, thinking about sexual boundary violations is hampered by our difficulties in talking about sex. And OEIs have a difficult balance to strike. First and foremost, they need to instil the professional standards as encoded in the OPS, and to do so emphatically. As far as having sex with patients, it is understandable why, in a heavily crowded curriculum, OEIs may choose not to go further than a strong, condemnatory approach, drawing on examples from FtP as to the likely consequences of breaching this cardinal professional prohibition. But they also need to convey that in a manual, touch-based therapy, where deep, therapeutic connections are forged, and patients are semi-undressed, sexual feelings will, on occasion, enter into the treatment space. OEIs need to discuss these as an integral aspect of teaching about forging empathic, caring relationships, avoiding practitioner overwhelm, managing patient dependency, managing therapeutic endings, as well as more 'contractual' aspects of managing patients' expectations.

Patients push at boundaries for a number of reasons, including simply not realising that it is inappropriate for professionals to develop social relationships with their patients, yet this is rarely taught or discussed in boundaries education. For some patients, the asymmetry of power they experience in the 'patient role' is deeply uncomfortable and heightens their sense of vulnerability. What might this look like in practice? When health professionals visit osteopaths, they may attempt to assert some control by 'talking shop' or using medicalised terminology to describe

[64] Halter, M., Brown, H., & Stone, J. (2007). Sexual boundary violations by health professionals: an overview of the published empirical literature. London: CHRE

their ailments. Patients who have been bereaved might ask their osteopath if they've been through a similar experience to understand what they're going through. Patients with a sports injury might ask if their osteopath has ever had a similar injury, or whether the osteopath does sports, to see if they have any common interest. In these non-sexualised examples, osteopaths will often share information about themselves. Implicitly, they recognise there is a line not to cross in disclosing too much information about themselves, but make a calculated 'boundary crossing' to demonstrate empathy and build good therapeutic relationships.[65]

What about more personal questions, such as whether the osteopath has a partner? Sometimes, this will feel like an innocuous question which the osteopath will feel happy to answer, but at other times, this may feel more like the patient is sexually interested in them, and is fishing for information. Patients may 'up the ante' subtly, asking a series of increasingly personal questions over a period of weeks, or less subtly, for example, attributing their injury to an athletic sex position, in a manner clearly attempted to sexualise the dynamic in the treatment room.

Osteopaths should recognise these sorts of situations as a warning sign. Patients may genuinely think there is no harm in 'trying it on' with an osteopath they find sexually attractive, whereas, in practice, osteopaths who are sexually harassed in practice find this both a traumatising and fearful experience (including concerns that rebuffing a patient may lead to them being inappropriately complained against).

Some patients act provocatively as a conditioned response[66]. Practitioners interviewed spoke of stepping out of the room having advised patients to take their outer layers of clothing off, to return to find they had stripped completely. An osteopathic researcher noted patients may wax or shave, or wear 'fancy' or small underwear when they know they have to undress. Male, female, trans, non-binary alike – the very act of removing clothes is highly sexualised in our culture. Patients noted that whilst it may feel normal to the osteopath, being undressed in front of someone else is not an everyday experience for patients, who may find this exposing and embarrassing. Patients then lie down, in their underwear, and receive caring touch for an extended period of time. Whether patients are young or old, psychologically robust or psychologically vulnerable, sexually interested or not, physical contact elicits a strong, primal response. It may also, not uncommonly, produce an arousal response. [67] Osteopaths should be alert to the non-verbal sounds patients are making, the way they position their bodies, the way they move into the osteopath's touch rather than away from it, as well as displaying more obvious

[65] The OPS guidance to D2 recognises that not all crossing of professional boundaries will necessarily be an abuse of professional standing, recognising that personal disclosures may support empathy and trust.
[66] Sexual trauma may result in avoidant or seductive behaviours – both are recognised phenomena.
[67] See, for example: Cutler, N (2005). A Common Male Physiological Response to Massage. https://www.integrativehealthcare.org/mt/erection-during-massage/. Arousal is a common response to touch which activates the parasympathetic nervous system. This may result in men getting an erection or women displaying less overt signs of arousal which do not necessarily indicate the presence of emotional or sexual desire.

signs of sexual arousal. For some patients this is embarrassing, and for others, it is arousing and pleasurable.

Sarkar[68] highlights the need for practitioners to anticipate flirtation and seductive behaviours coming from vulnerable patients. Osteopaths should have sufficient understanding of psychology to recognise this generally arises pathologically, rather than out of sexual attraction. This is why CHRE's 2008 guidelines highlight that it is *always* the responsibility of the practitioner to maintain boundaries, even when it is the patient pushing at boundaries.[69] Speaking in relation to psychotherapy, Celenza points out that to acknowledge and recognise this is in no sense to blame patients:

> "If a particular woman who has been a victim of sexual misconduct can be appropriately described as seductive, it is wise to remember that she came to treatment for help with, not to be exploited by, these very qualities."[70]

Osteopaths, whose therapeutic relationships elicit many of the same issues as therapy, need this firmly impressed upon them in training along with the firm understanding that, in the words of Freud (1915):

> "[The analyst] must recognize that the patient's falling in love is induced by the analytic situation and is not to be attributed to the charms of his person; so that he has no grounds whatever for being proud of such a "conquest" as it would be called outside of analysis."[71]

In terms of patient arousal, osteopaths should view this as normal, anticipated, and respond with consummate professionalism, albeit their training also needs to provide a safe space to acknowledge *their own* response to touching others in an 'intimate', but (hopefully) not sexual way. The discomfort of knowing what to say, as well as what to do, can be reduced by talking about these things in a group setting, or via role-play.

Again, it is not the patient's responsibility to establish an appropriate boundary, *it is always the professional's*. Osteopaths in such situations should be clear in setting out to patients what is and is not appropriate, and knowing how, where it is possible, to bringing the situation 'back into line' by explaining, politely, and firmly, the therapeutic basis of the relationship, and the extent to which their aim is to provide effective care. It is not to consider terminating the relationship and considering how long before they might consider responding to sexual advances.

It is hard to know how often osteopaths find themselves in this situation, although anecdotally, most practitioners spoke of patients pushing boundaries at some point in their career. At best, osteopaths may discuss these situations with trusted colleagues, but may feel that even this is too

[68] Sarkar, S. (2004). Boundary violation and sexual exploitation in psychiatry and psychotherapy: a review. Advances in Psychiatric Treatment. Vol. 10, 312–320
[69] CHRE (2008). Clear Sexual Boundaries and OPS (2019) D2 5.4 and 5.5
[70] Celenza, A. (2007). Sexual Boundary Violations. Therapeutic, Supervisory and Academic Contexts. Aronson
[71] Ibid.

dangerous, lest it attract censure or regulatory interest. This is why osteopaths need structures such as Clinical Supervision, where they can talk about troublesome cases, or access to 'safe spaces' where groups of professionals can openly discuss concerns and techniques for managing awkward situations. Better training is paramount, because if osteopaths haven't been taught how deal with these issues in their training, they find themselves floundering when this happens in practice.

The pushing at boundaries by patients is marked in those who have previously been sexually abused, as is the re-victimisation by professional abusers of those who have previously been sexually abused[72]. The phenomenon is well understood from a trauma-informed perspective, in which a vulnerable person might test the boundaries, consciously or unconsciously, to recreate previous experiences of having been exploited, or to assess whether this is a situation in which they are safe. And for people with a history of having their personal and sexual space invaded, safety might be characterised by their ability to 'control' the situation by sexualising it before someone else does. Such situations provide opportunities for skilled practitioners to show patients who have been damaged by prior abuse what a boundaried 'holding the line' looks like, and what it can feel like for patients to feel safe, and to allow themselves to trust and receive care and support. For some trauma survivors, this experience can be life-transforming. Conversely, when a professional breaches their trust again and perpetrates further abuse, this rips open seams of past trauma, and has hugely damaging repercussions.

One of the most powerful things 'Me Too' has done has been to open up conversations about abuse, power, and the reason that women (usually, but not exclusively) don't speak up. It has been an opportunity to appreciate how high the levels of sexual abuse and sexual assault are, and the extent of other adverse childhood experiences. Society is still struggling to appreciate how this impacts on trust and a person's sexual identity. OEIs have to make these issues safe to discuss. The spectrum of behaviours and responses, of patients and practitioners, are poorly understood, but desperate for analysis, and further research. Respondents to this report already acknowledged that 'Me Too' is making them practise defensively, to not use certain techniques they might previously have done, and to avoid certain diagnostic procedures, including per vaginal (PV) and per rectal (PR) procedures completely. And at a time when osteopaths are more likely than ever to be seeing NHS overspill patients, including patients with higher mental health acuity than ever before, these discussions must be considered a priority.

Whilst a proportion of boundary breaches may relate to sexual attraction, (on the part of the patient, the osteopath, or both parties), the reasons why any responsible practitioner would risk their entire career to engage in self-sabotaging as well as patient-harming behaviour is likely to have more complex psychological reasons than mere sexual attraction. Increasingly, regulation has to ask why some people break rules, and in particular, why professionals breach sexual boundaries. A psychologically-informed approach acknowledges the seductive power of being

[72] Halter, M., Brown, H., & Stone, J. (2007), above

put on a pedestal, or of a patient professing love or attraction. It recognises that practitioners who are not in a good place in their own lives, or who may themselves have experienced rejection, abuse or faulty attachments might latch on to these pleas for affection. As Sarkar states."[73]

> "Idealisation can be hard to resist. In the face of personal problems, the therapist may look to a patient for narcissistic repair or love. However, a therapist's attraction to the patient is a toxic or malignant type of 'love', which does not have the other's welfare at heart. The therapist needs therefore to be prepared for this type of occupational hazard; to be constantly alert for seductiveness and neediness and the risk of boundary violations, in both their patients and themselves."

The pushing at boundaries by patients requires further research in itself, and is an area where regulators might do well to involve patient groups for a patient-informed perspective, and if possible, the voices of patients with lived experience to inform their thinking. Whilst theoretical instruction to students, or role play between students, provide some opportunities to practise, for example, the language they would use to bring a situation back into line, or the way in which they might re-drape a towel on a patient who has removed it, such simulacra are unlikely to capture the embarrassment, shame, or fear practitioners may experience in practice. These are exactly the sorts of cases it would be useful to discuss in Supervision.

It is hard to estimate with any accuracy how many health professionals have sex with their patients. A 2003 study[74] found 2% of professionals self-reported boundary violations, but this is likely to be an underestimation, because of the risk of censure. FtP figures provide a proxy estimate of complaints, but do not reflect the incidences with any accuracy. Whatever the precise figures, we know that this is a problem. This extreme form of 'patient harm' requires better understanding of why professionals abuse their patients, and how this can be prevented.

Whilst different theories have been espoused, two of probably the world's leading experts on sexual boundaries by professionals, Glen Gabbard and Andrea Celenza, have come closest to presenting a unified theory as to causes. McNulty[75] summarises their theory as follows:

> "Working with Gabbard, Celenza (2003) has made the only identified attempt to link several factors into a comprehensive, multi-factorial theory that included both aetiological characteristics and the immediate offence chain. Their account included a role for situational factors (life crises such as divorce or bankruptcy), intrapsychic factors (unconscious guilt, a grandiose defensive structure, intolerance of aggression) and interpersonal factors (the replication of childhood traumas in the therapy, a rescue fantasy

[73] Sarkar (2004), above

[74] Lamb, Catanzaro, & Moorman (2003) cited in Halter, et al. (2007)

[75] McNulty, N., Ogden, J., & Warren, F. (2013). 'Neutralizing the patient': Therapists' accounts of sexual boundary violations: Neutralizing the patient. Clinical Psychology & Psychotherapy, 20(3), 189-198. doi:10.1002/cpp.799

with an abused patient, or the mismanagement of aggression or suicidality) (Celenza & Gabbard, 2003[76]).

Resilience and ego-debilitation

Professional resilience supports health professionals to 'show up' for their patients, day in, day out, and to deliver care based on the primacy of the patient's best interests. Keeping physically and mentally well keeps patients safe, and is, for that reason, an ethical responsibility.[77] Lack of resilience and professional burnout are known precursors to boundary violations. Yet, the current regulatory approach to boundary violations is to blame individuals for wilful misconduct. This thinking impacts on OEI education and training. Merely teaching students ethical principles of respect for autonomy, duties of beneficence and non-maleficence will not deter malevolent or dysregulated individuals from 'behaving badly'. Codes and education exert some positive influence, but will not deter all predatory behaviour. Tailored boundaries education needs to be informed by research on what leads people to breach sexual boundaries violations and why.

Searle's evidence-based review on sexual misconduct, which reviews FtP decisions from several regulated professions, provides useful insights. The idea of negative/fear-based teaching (don't do) versus positive teaching (do do) is insufficiently sophisticated to convey why professionals act badly and would put their careers and reputations on the line. Understanding and adopting Searle's differentiation between 'a bad apples' theory and an 'ego depletion' approach[78] might be most apposite for osteopathic training.

This provides a good basis for linking boundaries into teaching about resilience, as it is based on an approach that misconduct is:

> [T]he culmination of exhaustion and the toll of accumulated stresses and strains in eroding individuals' self-regulatory resources and ability to maintain their otherwise good behaviour (Baumeister et al., 1998). Studies show how actively trying to inhibit one's negative responses draws on a limited and exhaustible reservoir of resources (Baumeister et al., 2006). Extant research indicates that this is a dynamic degradation, which can comprise continuous efforts at self-control, such as in the vigilance required to control temptations (Muraven and Baumeister, 2000); or efforts to respond to high levels of stress (Fox et al., 2001, Fina et al, 2015); or to manage negative emotions (Kiefer and Barclay, 2012)]

[76] Celenza, A. & Gabbard, G. (2003). Analysts who commit sexual boundary violations: A lost cause? Journal of the American Psychoanalytic Association, 51(2), 617-636.

[77] D11 of the 2019 OPS requires osteopaths to ensure that any problems with their health do not affect patients. This applies to physical and mental health:https://standards.osteopathy.org.uk/themes/professionalism/

[78] Searle, R see above.

This approach usefully shifts the narrative and provides alternatives to assuming all those who perpetrate abuses are 'bad' ('Machiavellian') or 'mad' (psychopathic). Rather, they may simply be psychologically immature, naïve, and psychologically/emotionally depleted.[79]

Osteopaths who find themselves before FtP panels may be competent and professional practitioners, well-liked by patients, and otherwise capable of forging effective therapeutic relationships with their patients. The extent to which all professionals may breach boundaries to gratify their own needs is a core part of this Analysis. This needs to be an essential part of training, and the subject of conversations which need to be had within the profession. Koocher and Keith-Spiegel make a compelling argument, potentially as relevant to the 'private and intimate settings' osteopath as to psychotherapy:

> "[E]ven those with excellent training and high levels of competence may relate unacceptably with those with whom they work because their own boundaries are not firm, or they feel a need for adoration, power, or social connection."[80]

Regulation, and FtP in particular, needs to be responsive to the causes of the particular reason behind the allegations, with a range of responses, including remediation and rehabilitation if this is appropriate.

When professionals do breach boundaries, they find various ways of distancing themselves from their actions:

> [S]tudies show how accumulated emotional exhaustion creates depersonalisation and disidentification (Bolton et al., 2012), and moral disengagement (Fida, et al, 2015) in which individuals can actually excuse their wrongdoing… external environments can have an insidious and accumulative influence in overwhelming and eroding the good intentions of individuals… such outcomes are not universal: they emerge as a by-product of diminished abilities to self-manage."

Currently, self-stigma prevents many students (and osteopaths) from acknowledging that they are struggling. This means that they keep their problems hidden, and do not seek support when they need it. In the absence of profession-wide structures, OEIs should support students and staff to recognise and seek help if they are not coping. Learning how to do so will be an important skill for students to take forward into practice.[81] Covid has provided OEIs with an opportunity to review the level of support OEIs offer, and to put in place additional mechanisms to support students

[79] Whether the specific individual is, to use crude shorthand, 'bad' or 'burnt out', will be a matter to be determined in specific FtP cases informed by forensic evidence.

[80] Koocher, K and Keith-Seigel, P. (2008). Ethics in Psychology and the Mental Health Professions. Oxford University Press. 3rd Edition. p266

[81] Attention needs to be given to the fact that osteopaths work as self-employed practitioners. Without access to statutory sick pay, practitioners may be less willing or likely to acknowledge that they have psychological issues incompatible with being in practice for any given time. This may not be because they lack insight but because they cannot afford not to work.

who have experienced isolation, poor mental health, and financial struggles as a result of the pandemic. It is hoped that a positive impact of Covid will be to raise the profile of mental health amongst students and across a profession customarily more at ease talking about biomechanical issues than biopsychosocial.[82]

Better Linking in of Boundaries Training with Touch, Consent and Communication

Some of the overwhelm in terms of teaching and learning about boundaries could be reduced by realising that most of what counts as creating good boundaries is already being taught within different subjects, and in particular, in consent, communications, and contracting with patients. For most schools, their boundaries training would be substantially enhanced simply by linking what they are already teaching in these areas, and showing more explicitly how this relates to boundaries. Three particular areas require better linkage into boundaries education:

1. The use of touch
2. Consent
3. Communication and contracting with patients

Use of Touch

We have already considered the extent to which touch may elicit feelings of sexual arousal. In this section, we need to consider the broader issues surrounding how touch is taught, and the different meanings osteopaths and patients attach to touch. For osteopaths, touch is predominantly their tool for diagnosis and the vehicle through which osteopathic techniques are delivered. For patients, touch takes on the form of a language. As Consedine puts it:

> "[T]ouch may not be merely a by-product of examination and technique but is the foundation in which care and attention as well as professional attitudes and competence are communicated to the patient".[83]

OEIs need to be as proficient in teaching students about the patient experience of touch as an integral part of demonstrating professionalism as they are teaching touch in the context of osteopathic techniques. Osteopathic training needs to incorporate sensitivity to patients' non-verbal responses, as well learning how to use the non-verbal 'dialogue of touch' to foster effective therapeutic relationships. How the osteopath communicates through touch, if done well, has the capacity to benefit, and if done poorly, has the capacity to harm. Fluency in 'the language of touch' is thus a core aspect of creating safe boundaries. Consedine makes the point clear:

[82] An interesting response was that in mental health terms, osteopaths and patients have been on a par. As one of the first professions to return to practice at the start of the pandemic, a different dynamic arose whereby patients have potentially become a risk (of contagion) to osteopaths.

[83] Consedine, S, et. al. (2015). Knowing hands converse with an expressive body. An experience of osteopathic touch. IJOM, Volume 19, 3-12

> "As many complaints about health professionals can be traced back to the quality of communication, practitioners need to be thinking about the role of touch within their own practise"

Using touch effectively helps engender trust in the therapeutic relationship[84] and can increase patient satisfaction and influence outcomes.[85] Specifically, in relation to boundaries:

> "The relative contributions of verbal and non-verbal communication in a healthcare setting are also relevant in generating trust. Research suggests that if verbal and non-verbal cues are contradictory then the non-verbal message will predominate."

Consedine notes:

> "[touch] usually communicates directly an attitude which expresses the toucher's (often subconscious) genuine sentiments"

This has profound implications for boundaries. One of the known areas where practitioners need to exercise caution is around appropriate levels of self-disclosure. Healthcare relationships, unlike friendships, are characterised by an asymmetry of personal information. Patients disclose personal health information about themselves trusting that healthcare practitioners need to know that information and use it for the benefit of the patient. A feature of unboundaried relationships is professionals volunteering too much information about themselves, or patients asking unduly personal questions, and professionals talking about themselves. Excessive self-disclosure is often thought to be a precursor to other, more serious breaches of boundaries, as it takes the focus of attention away from the patient and towards the practitioner. Information asymmetry has a particular relevance to sexual boundaries. Osteopaths know more about their patients so that they can treat them effectively. Patients do not need to know about their practitioner. Therapists who have sexually breached relationships often seek to justify these breaches of trust as being a 'relationship of equals'.[86] This is a way of minimising the abuse of power inherent in boundary breaches.

Self-disclosure thus takes on an interesting dimension when it relates to how osteopaths use touch. Osteopaths need to understand that patients 'read' their osteopath through how the osteopath touches them. The quality and nature of the osteopath's touch conveys a huge amount of information bypassing spoken dialogue – whether the osteopath is at ease or not, whether the osteopath feels rushed, or frustrated, whether the osteopath is giving touch with an open heart, or carelessly. Osteopaths need to cultivate a high degree of sensitivity as to how what they are

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[84] Lee-Treweek, G. Trust in complementary medicine: the case of cranial osteopathy. *Social Rev.* 2002; 50: 48-68

[85] Consedine, above

[86] See, for example, McNulty, N., Ogden, J., & Warren, F. (2013). 'Neutralizing the patient': Therapists' accounts of sexual boundary violations: Neutralizing the patient. Clinical Psychology & Psychotherapy, 20(3), 189-198. doi:10.1002/cpp.799

doing is being 'felt' by the patient. Ostensibly, this would be part of an osteopathic technique discussion. But it also needs to be explicitly linked with discussion of safe boundaries. When osteopaths get this right, the combination of dialogue plus touch produces a powerful synergy. Conversely, poor verbal communication plus ambiguous use of touch leads to sub-optimal outcomes and possible complaint. Concannon's research finds:[87]

> "The potentially enhanced communication skills will necessarily seek to improve the positive experience of clinical encounters for patients and thereby reduce the potential negative consequences of poor communication"

Touch also plays a role in establishing appropriate distance in the clinical relationship. The importance of boundaries emerged in a qualitative study of patients' experience of physiotherapy.[22] Participants identified the vulnerability of physiotherapy patients and how this needed to be respected by practitioners. Touch is a mechanism for conveying safety and appropriateness. Osteopaths need to be skilled enough to use the language of touch to convey that their touch is wholly professional and not the basis of an emotional/sexual relationship.

Concannon's research confirms that historically, researchers have focussed on the procedural, diagnostic or examinatory 'component of touch, that is palpation, and how best to teach it (Browning, 2013; 14), whereas touch has a far wider range of 'meanings':

> "There is a distinction between 'procedural' and 'expressive' (communicative, affective, caring or healing) touch, with frequently acknowledged significant behavioural and psychological benefits of expressive touch, such as increased rapport, and improved perception of patients self-esteem, well-being, self-actualisation, belief in responsibility and social processes: factors contributing to an overall improvement in the patient's perception of their quality of life (Morris et al., 2014; Roberts & Bucksey, 2007). Physical contact with the human body holds a high potential for the conveying of spiritual meaning. More philosophical attention and research ought to consider the psychological, phenomenological and spiritual significance of touch, such as theories of embodiment (Morris et al., 2014; Williams, 2007)."[88]

Concannon highlights that the multi-faceted nature of touch makes it a complex phenomenon to research, but that it is encumbent on osteopathy to find ways to understand the different meanings of touch to provide best practice.

<u>Consent</u>

Consent is the legal device through which an otherwise unwanted touching becomes lawful. Consent plus communication minimises the likelihood of mismatched expectations, especially

[87] Concannon, above.

involving touch, as to what the osteopath views as an element of ordinary clinical practice, and what a treatment naïve patient may experience as threatening, invasive, or sexually motivated.

Consent is not just relevant in terms of physical contact with a patient, and its relevance to boundaries is not merely limited to consent to allow an osteopath to touch a patient. Another important limb of consent to consider here is ensuring that the patient understands the risks and benefits of treatment, and the alternatives to treatment, including other modalities, referral to another osteopath better skilled to treat that patient, and, importantly, the alternative of no treatment at all[89].

Whilst sexual boundary breaches attract the bulk of attention, financial breaches are also important breaches of trust, and can arise when an osteopath recommends treatment, keeps a patient in treatment longer than is necessarily required, or even, more broadly, fosters a dependence on spinal manipulation when other patient activities, e.g. exercises would secure as good or better a potential outcome. As one dually qualified osteopath and doctor describes:

> [I]t would be unusual for an osteopath or chiropractor to tell patients that their back is strong, and they have a simple sprain that will probably improve on its own if they keep mobile, and that hands-on manual treatment is not needed. Most of these professions work in the private sector, and the pressures are different from those in the NHS.[90]

Communication and contracting with patients

In many of the FtP boundary cases, poor communication has been at the heart of why patients complained. Whilst osteopaths might be clear why they are doing something to the patient, unless they explain it well, a patient might, not unreasonably, question why something happened the way it did, and may infer sexual motivation where there genuinely was none. Sarkar,[91] citing the Royal College of Psychiatrists' publication *Vulnerable Patients, Vulnerable Doctors*,[92] points out:

> "it is the meaning of a behaviour to the patient, and not the intentions of the doctor, that determines harm." [93]

A core element of understanding boundary issues involves understanding what patients regard as injurious, and what situations would cause them sufficient concern to initiate a complaint.

[89] Albeit, anecdotally, few osteopaths in private practice tell patients that doing nothing is the best alternative, or make referrals to other professionals. Similarly, few osteopaths explore the potential for harm arising out of poor therapeutic relationships as a risk to disclose in therapy.

[90] Snelling, N. *BMJ* 2011; 342 doi: https://doi.org/10.1136/bmj.d3683 (Published 20 June 2011)

[91] Sarkar, S. (2004). Boundary violation and sexual exploitation in psychiatry and psychotherapy: a review. Advances in Psychiatric Treatment. Vol. 10, 312–320

[92] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr180.pdf?sfvrsn=b9cde0a5_2 (accessed 28 December 2021)

Whilst gross breaches of professional conduct, such as a serious sexual boundary violations, are an obvious example, albeit there are reasons why patients may not complain, including the highly adversarial nature of the process, better communication as to what the osteopath is doing and why would minimise the risk of being complained against.

The 2017 report discussed ethical practice as being not just about the set of technical skills the osteopath possesses, but also the professional empathy and capacity for relationship-building. Osteopaths need to be able to forge good relationships with all patients, approaching each clinical encounter with a professional interest and curiosity in the patient as a person and not just in their condition. We know from research that therapeutic benefit occurs both through the physical manipulation, but also through the therapeutic relationship. So too, harm can be occasioned through getting this aspect of treatment wrong.

Although it may be hard to bring an action in law relating to poor relationships, these are often what lead to complaints.[94] Table 3 sets out what osteopaths can do to minimise complaints arising out of poor relationships. Whilst this may seem indirect to patient boundaries, and even a little legalistic, for the osteopath working in private practice, it provides an opportunity for creating a professional relationship, where other system wide assurances are not present.

Table 3: *Practice Leaflet/Advance contracting with patients*

Counsellors and psychotherapists expressly 'contract' with their patients at the outset of treatment. This concept could provide a useful framework for thinking about how to manage patients' expectations.

Osteopaths should consider the ways in which a patient, and especially, a treatment naïve patient, can be informed about what to expect from them. This might be done through a verbal conversation before seeing someone, or through using a practice leaflet. It may be formalised into a document which the patient is sent and asked to complete and sign in advance of treatment.

This allows the osteopath to set out:

- what will happen in a treatment session – and that the consultation involves examination, assessment, diagnosis and a treatment plan being formulated
- what the osteopath's style of treatment is
- that the patient is likely to be asked to remove clothing
- that the patient is able to bring a chaperone to their appointment if this makes them feel more comfortable
- how the patient may feel afterwards
- what will happen to the patient's information, and how it will be stored, and any circumstances in which it might be shared

[94] Stone, J and Matthew, S (1996). Complementary Medicine and the Law. Oxford University Press.

- the osteopath's expectations of the patient relating to payment, cancellations and missed sessions
- the osteopath's ability to refuse to treat a patient who is intoxicated or acting abusively
- the osteopath's right to withdraw treatment if unable to treat the patient (for example, because what the patient is presenting with is outside their limit of competence, and the osteopath feels that a referral to another practitioner is more appropriate).

Recognising the impact of the hidden curriculum

Students do not just learn from the formal, taught curriculum. They absorb much of the culture of the profession from what is known as the hidden curriculum - the unwritten, unregulated norms and cultures which shape, in particular, professional attitudes and behaviours. This phenomenon is much described within medical education, and clearly has an impact within osteopathic education as well. The hidden curriculum impacts on what students pick up about how to get through and do well on their course. A study of medical students described it as:

> "The set of influences that function at the level of organisational structure and culture, including, for example, implicit rules to survive the institution such as customs, rituals and taken for granted aspects." [95]

The hidden curriculum is the way in which students form opinions of who it is worth listening to, who the best Tutors are, who they would most like to oversee their work in practice, who they regard as good teachers and who they regard as poor teachers (whilst 'known' by students, and discussed amongst themselves, this is unlikely to be fed back to the School).

The hidden curriculum also impacts on transition into practice and is largely absorbed through role-modelling. It involves learning what shortcuts practitioners take, and how to survive within the profession. It's what students absorb from those who have gone before them about what it's really like in practice, not what they are taught in the classroom. Nunes-Mulder, a blogger on the medical hidden curriculum, suggests it may involve adaptive and maladaptive strategies:

> "It can teach us unsafe shortcuts, poor ways to deal with stress or uncertainty, and harmful cultural practices. But it can also be a force for good. After all, we learn essential skills and coping mechanisms from talking to people who have gone ahead of us." [96]

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[95] Lempp, H and Seale, C. The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *BMJ* 2004; 329:770

[96] Nunes-Mulder, L. Sharp Scratch: shining a light on the hidden medical curriculum. https://www.bmj.com/content/bmj/365/bmj.l2223.full.pdf (accessed 1 January 2022)

To the extent the hidden curriculum informs and shapes professional identity and provides tips for resilience, it is important to thinking about how OEIs instil boundaries. Ways of bringing these currently hidden dimensions of the student experience to the fore would go a long way to understanding how better to foster a more open dialogue, in which students feel able to discuss *all* elements of their learning experience. Examples suggested by OEIs include structured mentoring of students from higher to lower years, or creative use of Year Groups.

PART THREE

A WHOLE-SYSTEM APPROACH TO TACKLING BOUNDARY BREACHES

The clearest message to emerge from interviews is that whilst the OEIs are an important part of the jigsaw, preventing and responding to boundary breaches requires a holistic approach, which recognises the need to reinforce professionalism through formal and informal structures and systems. Part Three of the Report will highlight the themes identified as relevant to creating a whole-system approach to thinking about boundaries in osteopathy.

1. Osteopathic context and the contested nature of osteopathic identity

Professional identity is only partially shaped by education, and by regulation[97]. How osteopathy views itself and how it is viewed by others shapes professional identity. Many respondents described osteopathy as a profession which is in a state of flux, and that this has a bearing not just on boundaries education, but on the whole curriculum. Some felt osteopathy is a profession which is unsure of itself - a profession committed to honouring its heritage and the underlying philosophy of A.T. Still[98] on the one hand, whilst wanting to be seen as an evidence-informed primary care profession on the other. To be respected as health professionals, but distinctive. In his research on the impact of regulation on regulated osteopaths, McGivern observes:

> "Many interviewees commented on the limited evidence of the risks and benefits of osteopathy, which was a source of professional insecurity. Yet osteopaths were also concerned that evidence should be developed in terms appropriate to osteopathy, rather than using a biomedical approach."[99]

Patient safety and patient boundaries are associated with osteopaths' sense of self, and how and where they fit into the larger healthcare arena. Interviewees variously described osteopathy as an MSK specialism, a whole system mind-body-spirit approach, a set of biomechanical techniques, and an energetic therapeutic touch form of healing. Several people used the phrase 'Osteopathy is what osteopaths do.'

Such a broad definition or set of definitions provides a challenging basis for professional regulation, and a confused backdrop for determining how to teach osteopathic professionalism. Previous attempts to define and codify an osteopathic Scope of Practice have proven elusive. The

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[97] For wider discussion, see the PSA's (2018) research: The Regulator's Role in Professional Identity: Validator, not Creator. https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/professional-identity-and-the-role-of-the-regulator-overview.pdf?sfvrsn=dc8c7220_4 (accessed 31/12/21)

[98] For a short history, see: https://www.iosteopathy.org/the-io/history-of-osteopathy/ (accessed 21 December 2021)

[99] McGivern G, Fischer M, Palaima T, Spendlove Z, Thompson O., Waring J., (2015). Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. Report to the General Osteopathic Council, https://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/dynamics-of-effective-regulation-final-report/ (accessed 27 December 2021).

OEIs have seemingly quite marked differences in terms of philosophy or approach, albeit, larger schools may espouse multiple schools of thought. Given that OEIs operate as commercial enterprises, one would expect different OEIs to have different USPs, appealing to different sorts of students.

Whilst professionalism training is a core element of GOPRE, different understandings of what osteopathy is will impact on how professionalism is taught and what is emphasised. An OEI which adopts a predominantly holistic, mind-body-spirit approach to osteopathy might include more in its curriculum on psycho-spiritual determinants of health. Clinic Tutors who are predominantly biomechanical in focus may be less interested in the meaning that patients ascribe to their pain, and more interested in teaching students what exercises to recommend to patients to make them better. Tutors who use a lot of cranial techniques may be less concerned to present an evidence base but draw on experiential knowledge and encourage student to seek patient satisfaction as the primary evidence that their techniques 'work'.

Relative to other health professions, osteopathy has only recently been regulated by statute, and is still perceived by many osteopaths and patients as a form of complementary and alternative medicine (CAM). For osteopaths, working outside NHS allows them work with patients in highly individualised ways. Many, but not all, osteopaths espouse a holistic view of health, and some incorporate other CAM approaches, such as acupuncture and nutritional therapy into their work. They may work in less formal environments, including working from home, with or without administrative staff. What are the implications for professional boundaries? If we understand boundaries as the limits which circumscribe what is safe and appropriate for the individual patient, the level of mismatch, in expectations and in actuality, between what a patient thinks the osteopath is there to do, and what the osteopath thinks they are there to do, can be a significant risk factor and may generate complaints.

Specifically, in relation to boundaries, not knowing what to expect from an osteopathic consultation makes it harder for a patient to know what is or isn't appropriate behaviour. This might include whether it is commonplace for an osteopath to recommend working on a mat on the floor rather than on a couch, whether it is usual to work skin-to-skin, or through clothing, whether it is necessary or appropriate routinely to undo a bra, when it might necessary or appropriate to adjust the patients pants, when internal procedures are necessary or appropriate and how they should be carried out, whether it is or isn't appropriate for osteopaths using acupuncture to burn moxa, whether lifestyle advice is part of their treatment or merely the osteopath's point of view, and whether the osteopath's views about the causes of their ill-health are backed up by evidence, or merely representative of the individual osteopath's world view.

What this highlights is the need in all circumstances for *effective communication*, so that there is congruence between what the patient expects and what the osteopath offers. One suggestion might be for osteopath to consider offering new patients a free or reduced price 'taster session' so that they can get a sense of how the osteopath works and whether they feel that they are happy to be seen by this practitioner. As described in the last section, osteopaths should ensure

that new patients understand what form the treatment will take and how to raise any concerns. Osteopaths also need to become skilled in acknowledging what sits beyond their sphere of competence and being comfortable to explain to a patient why they are not the best practitioner for them to consult. This is rendered harder in a profession which has no specialist structure, and where, theoretically, every osteopath can treat every patient.

2. A Personality-Led Profession

A far less tangible professional identity issue, but one which enough respondents remarked upon as to be noteworthy, is the extent to which osteopathy in the UK remains a profession dominated by a few 'celebrity osteopaths', who dominated osteopathic thinking and 'cornered' the CPD market. Some respondents described them as powerful 'influencers' within the profession who exert a disproportionate say over the profession's agenda. Several respondents attributed this to the lingering effects of the charismatic origins of osteopathy, and wondered if the profession still seeks out modern day 'gurus'.

Others spoke of a somewhat inward-looking profession, characterised, simultaneously, by a superiority complex in relation to physiotherapists, and an inferiority complex in relation to doctors. Some referred to osteopaths' 'arrogance', or 'osteopathic ego', linked to a self-referential narrative that osteopaths possess 'magic hands'. To the extent this phenomenon exists, people linked it to the fact that many patients come to osteopathy having exhausted all other therapeutic options. This, said some, creates a 'God Complex' and hyperinflated sense of self, which may be a risk in terms of professional boundaries, to the extent these practitioners may see themselves as inspired mavericks, innovators, and above the rules.

Whether this perception is accurate or inaccurate, it was raised often enough to merit reflection. Three issues might be worth reflecting on: (i) the extent to which 'charismatic'/opinionated Tutors may influence student osteopaths in Clinic, supplanting what students have been taught in the classroom with their own ideas and philosophies (ii) flagging up a profession-wide need to teach about power differentials between osteopaths and their patients, and seeking ways to increase patient empowerment and choice through the sharing of information, consent, education, and a focus on patient narrative (iii) a need to increase leadership skills training throughout the profession, to encourage a diversity of views and opinions to come to the fore.

3. Isolated professionals in an isolated profession

Professionalism reflects the shared values and norms of an occupational group. Entrance to a profession involves agreeing to be bound by the expectations of the profession. In terms of ethical behaviour, individuals agree to act within the confines of that profession, with rules and principles underpinning the purpose, nature and limits of relationships with patients. It is not down to individuals to determine which rules seem appropriate to them. All rules apply to all osteopaths. As described elsewhere in this Report, most healthcare professionals are subject to a raft of overlapping regulatory frameworks.

Although statutorily regulated by the Osteopaths Act in 1993, osteopathy in some regards is still at an early stage of professional maturation. This is no criticism of individual osteopaths, but is a feature of osteopathy's isolation from mainstream health professions. Whereas nursing, medicine, physiotherapy and other NHS professions are embedded within wider systems aimed at ensuring patient safety, most of these structural safeguards are absent within osteopathy. Osteopathic practices are not regulated by the Care Quality Commission, and risk management and patient safety mechanism are not systematically required or overseen. The work of NCOR, however valuable, is not formally embedded into post-registration education and training.

The relative isolation of osteopathy and osteopaths mean that the OPS is the main vehicle for setting out what is acceptable practice. Its role is declaratory to the extent it sets out what is expected of practitioners, and lets patients know what they can expect of their osteopath. However, the Codes of Ethics, as discussed, provide only a broad approach to guide professional behaviour and are not designed as a protocol for practice.[100]

Within the NHS, patient safety operates within local, system wide, and national frameworks. These provide levels of assurance aimed at preventing adverse incidents, responding to them compassionately when they occur, and making sure that system-wide learning is rolled out when something does go wrong. In recent years, there is greater understanding of the role of 'human factors' and *system-wide* causation when things go wrong.[101] These are slowly beginning to inform regulatory responses away from merely castigating the individual for what has gone wrong.[102] Clearly, even when present, these mechanisms are not a panacea, but they provide structures for learning from things going wrong. Within osteopathy, isolated professionals may have few mechanisms for learning from the mistakes of others, and little in place to identify if their professionalism is going 'off tilt'. It is necessary to consider ways in which osteopathy might either piggyback on existing mechanisms, or replicate some of these principles to provide a better context for promoting professionalism of which professional boundaries are a part.

Once many osteopaths have qualified, they practise as sole, autonomous practitioners. What they do, and how they do it operates behind closed doors, and unless the osteopath seeks Supervision

[100] See, for example, 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.*

[101] See, for example HEE (2019), Human Factors and Healthcare Evidencing the impact of Human Factors training to support improvements in patient safety and to contribute to cultural change. https://www.hee.nhs.uk/sites/default/files/documents/Health%20Education%20England%20and%20CIEHF%20-%20Human%20Factors%20and%20Healthcare%20Report.pdf (accessed 28 December 2021)

[102] The GMC decision in the case of Bawa-Gaba highlighted the mismatch between an FtP system designed to hold an individual to account in a case where there were multiple systemic failures. See Dyer, C. Bawa-Garba is free to practise again without restrictions after tribunal ruling. https://www.bmj.com/content/374/bmj.n1690 (accessed 26 December 21)

or peer review, their technique, their relationship style and their skills may not be seen by colleagues from the point they qualify until the day they retire. Of course, many professionals do seek out collaboration, retain affiliations with their training institutions, and look for collaborative social and educational opportunities via regional groups and online communities, or forge working relationships through research, conference attendance and presentations, and shared CPD activities. But in the absence of managed environments and multi-disciplinary teams, many osteopaths still work largely on their own.

Professional isolation has enormous implications for boundaries with patients. Short of a patient instituting a formal complaint about an osteopath's practice, the only way osteopaths might appreciate a patient is dissatisfied with treatment is if they don't come back. Despite the need, now, for osteopaths to include an objective activity in their three-year CPD cycle[103] (which can include patient feedback or patient related outcomes measures collection (PROMs)), the collection of PROMS is not yet routinised or well-embedded throughout osteopathic practice, nor are patient experience or patient satisfaction data regularly collected (though clearly some osteopaths to routinely audit their practice). Even where third-party payers foot the bill, the insurer only needs to know that the consultation has taken place, not what its outcomes are.

This means that for the greater part, osteopaths 'mark their own homework', in conjunction with any feedback that patients give them. This potentially allows 'drift' and establishing idiosyncratic methods out of step with best practice. Again, of course, this does not characterise the majority of osteopaths, who are educated to become lifelong learners, hopefully apply their reflective training skills throughout their practice, and who may collaborate in research and education on an ongoing basis. But the point is, apart from CPD learning with others requirements - minimal in comparison to opportunities offered to other health professionals working within the NHS where MDT working is the norm - osteopaths may work alone for much/most of their time.

This has professional and personal implications. Professionally, it means that osteopaths may miss out on the formal or informal opportunities to learn with and learn from other osteopaths and other healthcare professionals. This is unfortunate, as different professionals have different ways of treating the same conditions, and there may be multiple opportunities for cross-fertilisation of ideas and skills development which osteopaths are missing out on. This is increasingly recognised by some of the OEIs who seek opportunities to embed some interprofessional learning into the curriculum. For OEIs based in universities and Schools of Health, there may be further opportunities to forge these collaborations.

Moving forward, GOsC and OEIs might look to work with Health Education England (HEE) and the NHS Improvement (NHSE/I) moving forward) to embed, for example, a system of student placements within the NHS, so that osteopaths, as regulated primary health physicians, might be exposed to other professional norms and skills, and, vice versa - other health professions might

[103] See GOsC: https://cpd.osteopathy.org.uk/getting-started/objective-activity/

learn about the scope and potential of osteopathy. [104] As integrated care systems[105] come into place, and the focus shifts from acute intervention to health maintenance and prevention, osteopathy has the potential to reposition itself as a credible and cost-effective primary care option. How is this relevant to professional boundaries? Because at least some breaches of professionalism would be less likely to occur within structured systems which provide support and oversight.

At an interpersonal level, professional isolation may find osteopaths investing more into their relationships with patients than is professionally appropriate. For the otherwise socially isolated practitioner, this may mean that their patients are their main form of social contact. This level of isolation is a key risk factor. It may lead to osteopaths being more inclined to consider professional relationships as a source of social comfort and self-gratification. Maintaining social ties and nourishing relationships are certainly a factor that should be considered in terms of keeping oneself resourced and resilient.

4. Patient safety and Learning Cultures

Within the broader healthcare arena, several significant cultural changes have come to the fore in the last fifteen years, many as a result of the Francis Report into failings at Mid-Staffordshire hospital.[106] One of those improvement journeys has been embedding structures in which patient safety is everybody in the organisation's concern, and where everyone is confident and empowered to 'speak up' when they observe anything which might put patients at risk of harm. Aligned to this, is the concept of 'Just Culture'.[107] This is a system-wide shift to acknowledging that there is much to learn whenever something goes wrong, but that people are often inhibited from speaking up or acknowledging anything that they have done wrong if they perceive they are going to be blamed for this. Whilst Just Culture is sometime wrongly described as a 'no-blame' culture, which might suggest a want of accountability, it is more accurately a system-wide attempt to embed organisational learning, with 'fair blame' and ownership of mistakes, when they have been made.

How does this apply to boundary related issues? As discussed elsewhere, many osteopaths work in relative isolation, and whist some may work in private groups settings, there are still relatively few practitioners working within the NHS. This means that when something goes wrong, there is

[104] A new infrastructure for clinical placements within the NHS is under development, as part of an attempt to 'grow the workforce'. Professional debates might usefully explore opportunities for osteopaths to be included in any national thinking. For developments in this area, see: https://www.hee.nhs.uk/news-blogs-events/news/expansion-clinical-placements-gets-%C2%A315m-boost-hee (accessed 1 January 2021)

[105] https://www.england.nhs.uk/integratedcare/ (accessed 30 December 21)

[106] See:https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 28 December 2021).

[107] See: https://www.england.nhs.uk/patient-safety/a-just-culture-guide/(accessed 28 December 2021).

no requirement, or necessarily incentive to report it, and critically, there are fewer opportunities to learn from it. Whilst an adverse incident may give rise to individual reflective practice, unless an osteopath actively seeks support from colleagues, any wider learning, or opportunities to think about how best to resolve or remediate, are lost. Although the OPS imposes a duty on osteopaths to speak up when something has gone wrong (the 'duty of candour'), in most cases, a patient may not know that their treatment has been sub-optimal unless the osteopath speaks of it as being so.

Whilst this is an obvious concern in relation to a treatment-related adverse outcome, it also has relevance to 'adverse reactions' arising out of the therapeutic relationship, where a sub-optimal outcome has been achieved because of poor relationships. Whereas counselling and psychotherapy is beginning to acknowledge that therapeutic relationships have not only the capacity to heal, but also the capacity to harm, very few osteopaths, and very little teaching acknowledges that misjudging or mishandling 'non-technique' aspects of the osteopathic encounter can also cause harm. And once more, unlike in the NHS, unless an osteopath makes it clear in an initial contract that complaints are welcomed, and details of how to contact GOsC, patients may again, simply not return. Moving forward, GOsC and iO might want to think about how to stimulate and replicate opportunities for learning which exist in the NHS, but are less well developed, and certainly not mandated, within osteopathy.

Regarding oversight by the Care Quality Commission specifically, osteopathic practices, unlike GP practices are not regulated, even though osteopaths, like GPs are independent practitioners and therapeutic encounters happens behind closed doors. Whilst osteopaths would be unlikely to welcome the intensity of scrutiny CQC inspections involve, their principles of CQC's inspection regime and the domains covered, provide useful comparators which might have applicability to osteopathy.[108]

5. Capturing the 'risk' of boundary violations

If we consider the harms occasioned by boundary breaches as a 'high risk' in terms of patient safety and professional reputation, it is also worth thinking about the absence of formalised risk management structures in osteopathy. In the NHS, clinical governance, involving oversight of practice by Managers and Clinical Leads, provides a framework for ensuring that the right rules and procedures are in place which ensure that risks are identified and mitigations are put in place. Risk frameworks acknowledge that healthcare is an inherently risky business. Comprehensive clinical governance systems minimise the risk of harm, litigation and complaints, and ensure systems are in place for accountability and oversight.

Osteopathy, as discussed, operates outside *mandatory* profession-wide systems for identifying and managing risk, albeit NCOR provides some guidance. But beyond the retrospective role of

[108] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance (accessed 27 December 2021)

the regulator via conduct mechanisms (and, to a limited extent, through osteopathic CPD[109] and the duty of candour, which requires professionals and their colleagues to raise concerns),[110] there are few structures in place to identify and manage risk. There is an important distinction between inherent risks of osteopathic practice, and the extremely high level of risk, to the individual, and to the reputation of the profession, occasioned by a professional breaching sexual boundaries. It is a feature of many FtP cases that individual practitioners seem unaware or indifferent to the risks they face, and, in particular, the risks they are exposing themselves to in terms of potential patient complaints. Much work has been done in the profession to learn how to communicate risks in osteopathy, and how to convey these as part of gaining consent. Moving forward, similar discussions need to be had to capture and identify boundary-related risks, and how to ameliorate these in practice.

The PSA, through its commitment to 'Right Touch Regulation',[111] acknowledges that statutory regulation is an expensive way of protecting the public against risk of harm. Fitness to practise processes, especially, are a hugely burdensome and expensive approach to the alleged wrongdoings of a tiny proportion of regulated professionals. Accordingly, the PSA seeks to link the level of required regulation with the level of risk posed by professional groups. The difficulty with sexual boundary violations is that they are not an inherent risk of osteopathy in the way that stroke is a known, if tiny risk of a high velocity thrust. Yet both become a risk in the hands of an incompetent practitioner. In the case of a clinical breach, it is because they are technically 'deficient'. In the case of a boundary breach, it is because their professionalism is 'deficient'. It is a known and knowable risk to the extent that all therapeutic relationships with the capacity to heal also have the capacity to harm.[112] In the case of sexual boundary violations, they have the capacity to cause extreme harm, and attendant loss of confidence in the individual practitioner and loss of confidence in the profession.

Key to this Analysis is how the risks of boundary breaches can best be managed. Currently, serious boundary breaches are likely to be treated as FtP issues. This response is consistent with viewing offenders as a 'bad apples' who need removing from the barrel lest they rot others around them.[113] Whether certain cases could be 'diverted' at an earlier stage will need to be part of any discussions emerging from this Report, along with the adoption of new, accelerated processes for dealing with sexual boundary cases.

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[109] The new CPD scheme includes a peer discussion review with another osteopath or health professional which the osteopath must complete towards the end of the three year CPD cycle: https://cpd.osteopathy.org.uk/peer-discussion-review/

[110] GOsC OPS D3, and also October 2014 UK regulators' joint statement, see: https://www.osteopathy.org.uk/standards/guidance-for-osteopaths/duty-of-candour/

[111] https://www.professionalstandards.org.uk/publications/right-touch-regulation (accessed 27 December 2021)

[112] See Stone, J. (2002) An Ethical Framework for Complementary and Alternative Therapists. Routledge

[113] Searle, R see above at p8. A 'bad apple' approach attributes wrongdoing to functional traits, which, in relation to serious examples of misconduct, including sexual misconduct, might include 'Machiavellianism; Narcissism; and Psychopathy'.

Searle's research shows that there are *different reasons why professionals breach boundaries*, and moving forward, attempts need to be made to determine which professionals might be amenable to remediation and education. Public confidence is an important factor, but it should not be assumed that the public seeks a retributive, rather than a rehabilitative response (to borrow concepts more commonly discussed within criminal justice). The function of professional regulation is expressly *not* to be punitive (albeit sanctions may have a punitive effect), but to protect the public. Consultation is required with both the profession and with patients and the public as to how to balance the need to hold individuals to account, the need to protect patients, and the need to maintain trust and confidence in the profession.

If we are concerned about preventive, supportive approaches to identifying practitioners at risk and reducing the likelihood of offending or reoffending, then regulatory approaches will need to develop a broader range of educative and reparative responses, and, to create professionally-led approaches to support struggling practitioners.[114] As the PSA puts it in its seminal 2017 analysis: Right Touch Reform:

> "[H]ow and to what extent can regulators shrink the amount of harm, both through their own interventions and those which are achieved through collaboration?"

Fitness to Practise proceedings (FtP), albeit aiming to achieve fair and proportionate outcomes, are necessarily retrospective, rather than proactive (save to the extent that the publication of adverse findings may have a deterrent effect). Within the Osteopaths Act 1993, the test applied is whether there *has been* unacceptable professional conduct (UPC). A different test is applied by other regulators, where FtP looks at whether fitness to practise is impaired, which looks to the present and future.

For a preventive approach, ideally, FTP should be appropriate only in cases which cannot be managed in any other way, and across the healthcare sector, regulators should have a more informed range of options than currently utilised. This is likely to require legislative change and is a broader issue than osteopathic regulation alone. Suggestions for reform will be addressed in the final section.

6. <u>The need to develop and embed Trauma-informed osteopathy</u>

As of yet, the concept of trauma-informed osteopathy is not well understood, even though individual practitioners may have direct express or intuitive ways of working in a trauma-informed ways. Whilst many osteopaths are familiar with the idea that 'the issues are in the tissues', the physical and psychological sequelae of sexual trauma are only just beginning to be discussed in

[114] As the PSA puts it in its seminal 2017 analysis: Right Touch Reform, "[H]ow and to what extent can regulators shrink the amount of harm, both through their own interventions and those which are achieved through collaboration?" See: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7 (accessed 27 December 2021)

the profession, with a few OEIs referring to student research and PhDs being undertaken in this area. Understanding the impact of trauma is relevant because of the need to avoid practices, techniques and behaviours which may re-traumatise patients. The need of osteopathy to develop trauma-informed practice is rendered more pressing given the number of patients attending osteopaths whose mental health needs are more acute as a result of the pandemic, and difficulties in accessing statutory services.

Trauma-informed approaches require more than simply asking for consent to touch patients. In triggering situations, such as hands on therapy whilst in a state of undress, patients may be psychologically frozen or dissociate. Numbed acquiescence or silence may be mistaken for implied consent. The principle of trauma-informed practice are beyond the scope of this paper, but are highlighted here to the extent that failing to understand how a traumatised patient is experiencing treatment may result in patient harm or complaints that osteopaths have acted inappropriately. Those who have previously experienced sexual trauma may be acutely anticipatory of threat, and uniquely sensitive to what they experience as inappropriate use of language, tone or touch. In the Report for the Royal College of Psychiatrists: 'Vulnerable Patients, Safe Doctors', the authors point out:

> "Patients who have been subject to physical, emotional or sexual abuse may distort the meaning of the doctor's behaviour if aspects of the therapeutic encounter unwittingly echo the patient's previous traumatic experiences. Doctors must consider possible interpretations of their behaviour from the patient's point of view and be aware that their therapeutic intentions may be misinterpreted. It is the duty of all psychiatrists to respect vulnerability in patients and to refrain from exploiting any power differential."[115]

For a previously traumatised patient to place themselves in the hands of an osteopath demonstrates a huge level of trust that the touch will be professional and that their (the patient's) interests will be paramount. Sexualised breaches of those who have previously been traumatised have particularly devastating consequences. As noted previously, this is relevant because evidence from Inquiries shows that people who have already been victims of trauma are more likely to be revictimised.[116] Professionals who abuse their patients invariably exploit vulnerable patients who are most likely to have been conditioned to be compliant and maintain silence, and whose psychological states mean their version of events is less likely to be believed if events come to a trial or hearing.

[115] Royal College of Psychiatrists (2013). https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr180.pdf?sfvrsn=b9cde0a5_2
(accessed 28 December 2021)

[116] Persons who were abused as children are also at an increased risk for victimization in therapy (Koocher & Keith-Spiegel, 2008), cited in Michael R. Capawana (2016) Intimate attractions and sexual misconduct in the therapeutic relationship: Implications for socially just practice, Cogent Psychology, 3:1

Again, as discussed, previous victims of trauma who have poor experiences of boundaries historically are also more likely to challenge professional's boundaries. Koocher and Keith-Spiegel, discussing what they call 'Risky Clients' caution that:

> "Clients who have experienced victimization through violent attacks or abuse because of difficulties with trust or ambivalence surrounding their caretakers also benefit from clear boundary setting despite their frequent testing of such boundaries."[117]

What has not been adequately researched and discussed is that a proportion of professionals are themselves abuse and trauma survivors, and that the endemic levels of childhood sexual abuse will include practitioners as well as patients. Learning about trauma and sexualised behaviours generally needs to be sensitive to this fact, as both osteopath and patient may be vulnerable to sexualizing the encounter. Whilst it remains, absolutely, the professional's responsibility to set and maintain boundaries, the impact of trauma needs to be taken into account in any regulatory reform.

Trauma-informed osteopathy is an important area for professional development and, in due course, curriculum development. Given its relevance to creating safe boundaries, commissioning research in this area should be a priority together with a rollout of training for trainers.

7. <u>The case for reforming regulation</u>

Sexual boundary violations occur in all regulated health professions, and are clearly amongst the most serious acts of professional misconduct. Since the production of CHRE's Clear Sexual Boundaries guidance in 2008, there has been some follow up research, including, notably, Rosalind Searle's categorisation of types of sexual misconduct,[118] and Simon Christmas's research on relationships between health professionals.[119] But it is psychotherapy which leads the way in research into sexual boundary violations, and Celenza's work in particular, discussed in earlier sections, which provides us with tools which might better inform our understanding and approach, and with objective outcome measures for identifying which professionals are most at risk of breaching boundaries and strategies for prevention.

Yet, despite evidence being available, this has failed to influence, to any substantial degree, how the GOsC and other regulators deal with boundary violations. An obvious reason for this might be a perceived need not to be seen as soft on serious offenders, and a perception that the public expect sexual offenders to be dealt with severely – hence indicative sanctions pointing, ordinarily,

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[118] Searle, R see above.

[119] Christmas, S. (2018). Sexual behaviour between colleagues. Where does the boundary lie? A report for the Professional Standards Authority https://www.professionalstandards.org.uk/docs/default-source/publications/sexual-behaviours-between-health-and-care-practitioners---where-does-the-boundary-lie.pdf?sfvrsn=bae87220_0
(accessed 29 December 2021)

to suspension or erasure. Yet, as research emerges as to a greater understanding of the capacity and the need for remediation, fitness to practise mechanisms stay stuck in outmoded responses. Similarly, education and training fails to tackle the complexity of the issue by not training in sufficient depth on the subject, or providing inadequate support or a culture in which students can admit and discuss sexualised feelings. This is so even though feelings of sexual attraction are common, and not always ethically contentious of themselves and not invariably a threat to the public interest as regards the maintenance of patient safety, professional standards or the reputation of the profession.

PSA has a vital role in encouraging regulators to adopt evidence-based and proportionate regulatory responses. Having commissioned research which shows the need for more nuanced regulatory responses, any updates to the original 2008 guidance, and in particular, education and training guidance and fitness to practise guidance, should be based on up-to-date analysis of patient, public and professional views, and allow for a range or interventions.

Whilst statutory regulation involves a range of functions, it is the fitness to practise jurisdiction which most influences the attitude of the profession towards its regulator, invariably producing fear-based compliance. McGivern's research of the profession found:

> "[M]ore osteopaths said they complied with OPS 'to avoid getting into trouble with the GOsC' (49%) or 'being sued by a patient' (54%) than because OPS 'reflect what it means to be a good osteopath' (28% agreed)."[120]

Given the absence of other forms of professional oversight, this is somewhat dispiriting, if unsurprising. FtP processes, and the quasi-legal regulations which underpin them, need to be reformed in a joined-up approach to thinking how best to ensure public protection and to reduce harm to patients.

In relation to sexual and other serious boundary violations, FtP processes are a blunt tool for improving practice. Whilst the broad elements of cases might be useful for informing students what sorts of behaviours are likely to land them in trouble, judgments and findings are less easily shared, to the extent cases may be determined by arcane legal arguments, and the extent to which cases are determined on their specific facts mean it can be hard to extract generic learning. Additionally, to the extent 'emotional depletion' cases are dealt with as a Health Committee issue, the facts of cases which might be highly relevant to education and training around resilience and self-care, are not in the public domain.

In many sexual boundary cases, the crux of the case turns on whether it can be established that there was sexual motivation. Looking from the outside at FtP cases, it might be assumed that the boundary violations which involve sex acts are deemed the most serious types of boundary

[120] McGivern, above.

violations. This may not reflect the lived experience of survivors of sexual abuse, where acts of grooming and gaslighting may be more pernicious and triggering than a sexual act itself.

Where allegations are found proven, sanctions are invariably linked to the acts themselves. As Hook and Devereux explain, sanctions and outcomes:

> [A]re determined from the fact of the violation and are not based on a detailed psychological and psychiatric assessment of the professional. [R]isk appears to be measured through the fitness to practise or complaints process by an 'informal' assessment of expression of remorse, acknowledgement of what is often simplistically regarded as sexual motivation and empathy for the victim. Although these factors will form part of an assessment of risk and rehabilitation, they are of limited value on their own.[121]

Similarly, in reaching sanction, panel members are tasked with determining insight and remorse, with no reference to forensic expertise on either issue. Again, the 'lay' view of what does or does not constitute sexual motivation, or, specifically, a risk of re-offending means that arbitrary, inappropriate conditions may be imposed, such as refraining to work with female patients for a determined period.

Although regulators, including GOsC, provide victim support, the actual or perceived adversarial and near courtroom-like nature of the processes may put patients off initiating a complaint, who fear they may be be cross-examined with the intensity applied to discrediting rape victims in criminal trials. For osteopaths, the process is brutalising, drawn out, and rarely fails to take account that the harrowing nature of being subject to FtP itself makes it unlikely conduct will ever be repeated. Current FtP approaches may serve as a deterrent to some, but fail to provide opportunities for rehabilitation in some of the cases where a more evidence-based approach might mean this is feasible, and lead to a view, within the profession, that GOsC is unnecessarily heavy-handed.[122] A rehabilitative approach is not the same as being 'light' on offending behaviour, albeit, it needs to be balanced with ensuring public confidence. Moving forward, it is worth considering doing whatever is necessary to make a difference and reduce the likelihood of practitioners offending/re-offending.

The nature of rehabilitation may take a variety of forms, the nature of which will depend on a psychologically informed/forensic understanding of the registrant. Whilst serious sexual boundary violations are clearly inimical to professional practice, even these may, depending on the circumstances, be amenable to a rehabilitative programme and/or supervised practice.

[121] Ibid

[122] FtP decisions also reflect the need to uphold confidence in the profession by sending out a strong message, meaning a sanction may be serious to reflect gravitas, whether or not there has been remediation or capacity for remediation.

Elements of a psycho-educative, rehabilitation and remediation approach, which might be linked to conditions of practice orders or suspension may include:[123]

- undertaking personal therapy
- victim empathy training
- a requirement to undertaking Clinical Supervision
- creation of a personal development plan
- undertaking specific boundaries training
- reparative actions, where appropriate

These should be the subject of further research, along with further research to determine the public's attitude to appropriate responses to acts of sexual misconduct. 'Me Too' has provided an opportunity for fresh conversations about how sexual harassment and sexual violence is dealt with. It has also created a context to discuss consent, which includes the extent to which patients can ever be thought of as consenting to sexual relationships or sexual acts where there is an imbalance of power.

In terms of relationships with the profession as well as the public, regulators, including GOsC need to think about what messaging they are sending out about boundaries and boundary violations. How they respond will determine whether they are seen as supportive of registrants or impervious to the reasons they find themselves in difficulties. Trust in the regulator by the profession sets the scene for whether registrants are prepared to come forward to discuss difficulties, or whether they will keep issues secret. Until conduct procedures are reformed in this way, it is likely that some osteopaths will continue to view GOsC with mistrust.

Whilst legislative reform may not be within GOsC's immediate gift, in commissioning this Report, what it can do is shift the narrative and work more closely with the iO and other partners to ensure that osteopaths have access to safe reflective spaces and other structures, so that there are avenues for discussing problems in a safe, and peer-led environment.[124] Covid has shown that virtual learning spaces can be as effective as face-to-face. Because capacity and cost are likely to be issues when developing these resources within osteopathy, the profession may wish to consult on online options for delivery, used to good effect in other professions.[125]

[123] Celenza, A. (2007). Sexual Boundary Violations. Therapeutic, Supervisory and Academic Contexts. Aronson.
[124] McGivern G, Fischer M, Palaima T, Spendlove Z, Thompson O., Waring J., (2015). Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. Report to the General Osteopathic Council, https://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/dynamics-of-effective-regulation-final-report/ (accessed 27 December 2021).
[125]See, for example, research commissioned by the HCPC: Rothwell, et. al. (2019). The characteristics of effective clinical and peer supervision in the workplace: a rapid evidence review, pp 32-33 https://www.hcpc-uk.org/globalassets/resources/reports/research/effective-clinical-and-peer-supervision-report.pdf (accessed 1 January 2022)

PART FOUR

SYNTHESIS AND CONCLUSIONS

This Report was commissioned because of the concerning proportion of complaints involving boundaries. Even though all OEIs provide extensive and integrated professionalism training, and teach about professional boundaries specifically, boundary-related complaints remain a problem. This report suggests this is both an individual and a systemic problem in osteopathy.

Understanding and responding to boundary violations requires us to look beyond codes of practice, beyond indicative teaching content, and beyond existing professional rules and processes to enforce them. Boundary violations in which professionals deviate from their own, ordinarily intact, moral compass, and in particular, sexual boundary violations, expose human frailty and fallibility. They reveal how vulnerability can threaten professionals' ability to regulate their behaviours. 'Othering' of offenders is unhelpful and collective ownership of this problem requires us to acknowledge that in certain situations, and under certain pressures or constraints, we are all capable of acts which fall outside accepted norms. Without in any sense diminishing the need for professionals to accept accountability for their acts, and the duty of GOsC/regulators to enforce accountability, a blame-based approach is failing to serve the ultimate goal of regulation, which is to protect the public.

To seek to understand why people commit (sexual) boundary violators and to respond with supportive mechanisms is not 'a soft option'. It is anything but. Distancing and disowning such acts and those who perpetrate them is the easier option. But erasing professionals from registers neither addresses that individual's behaviours, nor plugs the system-wide gaps which permit poor behaviours to persist unchecked. To move from this unsatisfactory status quo requires a radical rethink which links patient wellbeing with practitioner wellbeing.

Every major NHS scandal in which patients have been harmed, sexually assaulted, or even killed through intent or neglect has highlighted multiple *systemic failures,* at all levels. They reveal missed opportunities to have measured, detected, spoken up or to have addressed unsafe attitudes and behaviours before they resulted in harm. They result in initiatives to try to reduce opportunities for harm. As noted, the Mid-Staffs Inquiry, in particular, highlighted emphatically that 'Patient Safety is Everybody's Business'. The problem is, in osteopathy, patient safety is no-one's concern apart from the individual osteopath. To the extent osteopaths are private practitioners working, to some extent, in competition for business, there is a tendency to keep one's patients to oneself. There are no structural mechanisms for specialist practice either, so no system-wide gatekeeping function for an osteopath to refer onwards, or upwards within the profession itself.

Osteopathy has a decision to make about its role moving forward. Osteopaths and patients may benefit from closer links with the NHS. This isolated way osteopaths work and compete for patients is anomalous, given how overstretched the NHS is, particular in relation to patients with

MSK issues, medically unexplained symptoms and long-term conditions. New ways of working, including contracts with Primary Care Networks, mean that osteopaths could, if the profession wanted to move into this space, easily be increasing osteopathic reach, whilst simultaneously benefiting from forms of managerial support and oversight which would enhance their practice and patient safety. But if nothing changes, osteopaths will remain professionally isolated, with limited political voice, especially if a current government review of regulation decides there is no place for small, single-profession regulatory bodies to exist.

Currently, in place of the machinery of nationally embedded initiatives, osteopathy, has, instead a smattering of cut and pasted decontextualised rules inserted into its updated guidance, but none of the infrastructure to give them context or force. Thus, for example, the revised 2019 OPS now includes a duty of candour, in line with the Francis recommendations, but does not have strong systems in place to ensure compliance. Within the NHS, the 'Speaking Up' agenda has both national and organisational processes for reporting concerns and 'whistleblowing'. In a profession where many osteopaths comply with regulation out of fear, how likely is it that concerns about colleagues will be passed on to the regulator? And if not the regulator, to whom do osteopaths 'Speak Up'? If we accept that system-wide lack of support for osteopaths at the very least contributes to why some osteopaths feel they can get away with acting unprofessionally, including breaching boundaries, then we have to look to creating system-wide solutions.

Boundary breaches, whilst exhibiting distinct features, are reflective of other forms of poor professional misconduct, which go unchecked for want of profession-wide structures of leadership and support, in which osteopaths work as part of a collective profession, than as isolated individuals. Whilst professional regulatory oversight, and FtP sanctions, are geared towards the reputation of the profession as a whole, few mechanisms exist to build a sense of collegiate pride and responsibility. Clinical leadership skills should be embedded in pre-registration training, and a clinical leadership programme developed. The issue of specialist training and specialist lists should also be revisited. Not only would this provide opportunities for career progression, but it would mean that a culture of research, teaching and learning would underpin and shape professional practice. Clinical teaching skills should also be thought of as an important plank of professionalism and included, more visibly, in the OEI curriculum.

What then, might a system-based, joined up approach to minimising boundaries look like in osteopathy? What is proposed is recognition of shared responsibility to create a climate of psychological safety, in which 'problematic' practitioners can be supported, or managed out of patient-facing activity and the opportunity to cause harm. The paradigm shift from boundary breaches as an individual blameworthy act to a collective failure to nurture professionals has implications within and beyond osteopathy. This approach touches on the feasibility of osteopathy remaining a standalone profession, and the willingness of the profession to pay for structures which better support professionalism and reduce incidences of harm.

This Report has made the case that despite OEI inputs, risks emerge when osteopaths enter into practice. Having been 'held' in a supportive, formative environment, practitioners 'fall off the cliff' into isolated practice within in a largely isolated profession. Analysing the NCOR data, the bulk of 'offenders' are not recent graduates, with complaints highest in the 41-50 and 51-60 age brackets albeit some FtP cases do involve recent graduates. The extent to which boundary breaches do not occur amongst the recently qualified professionals is testament to the quality of the OEI inputs (and may make the case for 'reverse mentoring'). But without support individuals may begin to exhibit 'professional drift' away from ideal professional norms, with little by way of external of oversight or surveillance.

This section asks what might be put in place to mirror some of the support structures which exist by dint of organisation and management structures for other health professions, including within the NHS? Suggestions for the immediate post-registration phase might include:

- a requirement that students spend the first one or two years of practice working in a group setting. At a less formal end, this could provide opportunities for collegiality, and space for the cultivating of a more or less developed Principal/Associate relationship.
- A profession-wide system for mentoring, including reverse/reciprocal mentoring between recent graduates and more experienced practitioners
- A structured Foundation Year in an Approved Practice, which has the benefit of upskilling significant numbers of osteopaths themselves to become educators.

Each of these comes at a cost, and in a small profession, that cost is born largely, through its registration fees. Alternative approaches might be to attempt to piggyback onto existing NHS procedures. This requires political manoeuvring by the iO, amongst others, and would have pros and cons, and would likely be resisted by those who fear osteopathy becoming more standardised and less individualised were it to be incorporated more closely into the NHS.

Coming back to the role of the OEIs, can they do more to deter poor practice further down the line? The solutions at this stage are intuitive rather than researched, but point to a far greater attentiveness to the psychological wellbeing and development of the student osteopath, as well as the cultivation of their technical skills. More time should be allocated to developing student sensibilities, raising patient empathy, and helping students to better understand their own psychological motivations and internal sense of self. These are not soft skills. In a relationship where outcomes are determined through non-specific effects as well as specific effects, they should be considered as core osteopathic teaching. Loosely called 'emotional intelligence', professional practice, in service of patients, requires a lifelong attentiveness to recognising one's own emotional state, recognising the patients, learning how to sublimate one's own emotional needs within the context of treating others, yet ensuring they are met outside the therapeutic relationship. These are the features of embodied professionalism – the backbone of what it is to be a morally orientated individual.

If that sounds like a tall order for OEIs, it is. But reassuringly, it is already at the heart of OEIs, as demonstrated through open-door policies, pastoral services, Tutors who regularly and frequently routinely check with students, who support them in a non-punitive way when they are struggling, and who take formative opportunities taken to show students how to improve their skills, rather than moving swiftly to punish them when they are acting unacceptably. Many of the OEIs are already highly attentive to these ways of thinking. But the links into subsequent practice, and the importance of student support as a preventive strategy needs to be more fully articulated.

The most important recommendation from this report for OEIs is that they embed from the start of the student journey that airing uncertainty, and *asking for help is a sign of strength not a sign of weakness*. For all the steps being taken to embed EDI, owning up to mental health challenges amongst health professionals remain stigmatised. The role of OEIs is to send out a very strong signal throughout studies that it is okay not to be okay, and that it a measure of strength, and not weakness, to seek help. Whilst a duty to seek help appears within GOsC's student FtP guidance,[126] the culture of the OEI needs to be such that students feel that they can safely seek help without being judged, whether about boundary-related issues or health related issues.

Occasionally, hopefully rarely, there will be some students who are not suited to osteopathy. To the extent they have not been weeded out from entering into an osteopathic training course, there should be student-centred and supportive ways of managing them off a course. But the harder challenge is for schools having sufficient time and ability to discern those students who are not so obviously ill-suited as to not be able to remain on a course, whose actions fall short of requiring student fitness to practise interventions, but who, for whatever reason, are displaying attitudinal issues which should ring alarm bells. Be they over-confident or under-confident, overly friendly, or jocular, most Tutors might recognise characteristics which might if left unaddressed develop into problems once that individual is working in an unsupervised manner. To both recognise and know how to support these individuals requires all OEI staff to have a psychologically-informed skillset, allowing for a nuanced and individualised response. This too may require a cultural shift and some upskilling - with some staff and Tutors better able to provide this support, quite possibly where they have themselves struggled with and overcome personal difficulties.

Hopefully these recommendations will be received in the spirit in which they are written - challenging yet achievable, and firmly focused on improving public protection. It is recognised that several of the recommendations would require legislative change, the pace of which is not entirely within GOsC's gift, and which may be superseded by regulatory reforms within the wider health and social care sector. The OEIs have a significant role to play, broader, certainly, than the delivery of a targeted 'boundaries' curriculum, and one which, more roundly, sets the student off on a lifelong journey of personal and professional self-inquiry. In order to do this, they require

[126] Para 32: It is also important for you to confide in the appropriate person at your osteopathic educational institution if you have concerns about your own fitness to practise. This will help the osteopathic educational institution provide you with the right support and guidance to help you qualify as an osteopath.

the support of GOsC, who in turn, require the support of the PSA, as many of these issues apply to all health professionals and not just to osteopaths.

In moving from where we are now, one set of voices remain noticeably absent. Patients and the public could have a far greater role in contributing to education and training. Routes include providing first-hand narratives to increase osteopaths' empathy, to inform meaningful PROMS and PREMS, and to feedback what it is patients value and consider to be 'good osteopathy'

Specifically, in relation to sexual boundaries, both OEIs and the profession as a whole need to take the opportunities 'Me Too' has provided to discuss how better to protect individuals from unacceptable levels of harassment, and also how to change how we educate boys (and girls) not to be perpetrators of sexual violence. Broader societal questions about how best to tackle sex-offending and coercive control in relationships should also inform these debates, whilst recognising the uniquely privileged positions of power occupied by health professions, and the corresponding need to bolster individual professionalism within a context of external forms of oversight.

The recommendations in this report have far-reaching consequences. They require some challenging conversations, and doubtless, some of the conclusions will be unpalatable. Regulatory change is slow, but our current system is in desperate need of an overhaul if it is properly to protect the public. Each regulatory limb needs to be evidence-informed, and critically, the still, largely fear-based compliance with regulation will only change when fitness to practise is replaced with a less adversarial, inquisitorial system, embedded within system-wide learning structures.

The psychologically-informed model advocated in this Report does not remove the role of holding people to account, but seeks to do so in a way which understands why things have gone wrong for this particular osteopath and aims to minimise the risk of future occurrences. These ideas are not new. And several opportunities to reform regulation have been missed. It will take courage to dismantle the legalistic FtP machinery we currently have in place and replace it with models that are fit for purpose, and extensive consultation will need to ensure that the public agree and inform what they believe to be in the public interest.

The whole-system approach recommended here needs to carry the support of the profession. The prize is that what is recommended protects and safeguard professionals as much as it does patients. Within osteopathy, strong professional leadership is required to ensure a consistent and coherent scope of osteopathic practice emerges, which is evidence-informed, and whilst respectful of osteopathy's origins, replaces dogma with evidence. This is likely to arise out of, and be informed by, OEIs. If achieving statutory regulation was the ambition of the last century, creating an evidence-base to underpin and inform osteopathic practice must be the more mature professional ambition this century.

These changes are medium to long-term, and will require investment of time and money. In the shorter terms, a change of mindset could allow for several of these recommendations to begin to

emerge organically. A mindset which places the ethical rigour of a vocational career centre stage. Which nurtures and supports the challenges experienced by those whose professional role is to support others, and which recognises the sustained psychological impact of operating as a health professional in health-injurious times. Supporting osteopaths to support others requires compassion, leadership and a generosity of mind and spirit. Systems which allow osteopaths to flourish and feel safe to seek support when they need it is not only our best preventive strategy, but it is also an approach which is congruent with osteopathy's underlying mind, body, spirit philosophy. It is also an approach which accepts that the wellbeing of each one of us impacts upon the wellbeing of us all.

PART FIVE

RECOMMENDATIONS

Registration

- Commission research on a meaningful alternative to 'good character' requirements of initial registration and re-registration
- Require boundaries training as a mandatory component of the CPD cycle
- Introduce a mandatory Supervision scheme linked to ongoing registration
- Consider a 'provisional license' year post OEI, linked to mandatory Foundation Year of working in an Approved Practice
- FtP erasures, suspension and conditions of practice sanctions should cross-link with international registers and with PSA-accredited registers, including massage therapy
- Reconsider creation and maintenance, by GOsC of specialist registers

Education and Training

- Core ethics teaching for all students to instil and bolster their moral capacity, build moral character and embed moral courage
- Provide specific, tailored training for lecturers and Clinic Tutors on teaching boundaries
- Include sexual attraction to and from patients as part of pre-registration training, drawing on training methods and concepts used in therapy training
- Commission research on trauma-informed osteopathy. Specifically, adopt a trauma-informed approach to educating about sexual boundaries
- Create web-based links from published FtP findings for use in education, training and CPD
- Explore training opportunity for FtP panel members to inform OEI staff and influence boundaries teaching
- Involve (willing) registrants who have been subject of FtP allegations to inform teaching
- Substantially increase patient involvement in education and training, including voices of patients with lived experience of sexual and or other boundary breaches
- Create buddying systems between higher and lower years to expose hidden curriculum
- Roll out practice-based placements for final year students to expose them to real world practice
- Encourage recent graduates and early years practitioners to work as Clinic Tutors. to retain links with OEIs
- Research and implement a development programme for Osteopathic Clinical Supervision
- Embed Clinical Leadership training and Clinical Teaching skills as elements of professionalism training
- Review post-registration specialist training options and research effective strategies and best practice for teaching about boundaries at different stages of the osteopathic career

Practice Standards

- Produce guidance notes on safely managing sexual feelings towards patients, building on current GOsC materials. Signpost where to get support.
- Improve student fitness to practise guidance, linking boundaries with a responsibility to keep oneself resourced and seek help when struggling
- Reconsider guidance in light of profession-wide narrative around 'dating patients/ex-patients. Ensure guidance not seen as providing a legitimate 'workaround'
- Include serious non-sexual boundary breaches in the OPS and practice guidance, to highlight boundary breaches as breaches of trust and abuse of power (and not just about sex)
- Develop guidance on serious, but non-sexual, boundary violations, including psychological, emotional and financial exploitation to decouple the linkage between serious boundary violations and sex
- Develop guidance on Clinical Leadership in osteopathy
- Use data more smartly to link sections of the OPS to standards guidance and FtP findings

Fitness to Practise Improvement

- Adopt a trauma-informed approach to FtP practices, policies, and training, including training for panel members and Chairs
- Commission research into public and professional appetite for remediation and rehabilitation
- Replace attempts to establish 'insight' or 'remorse' with forensically-informed evidence as to psychopathology and risk analysis
- Better link allegations and sanctions to the psychological impact of the boundary violation on victims and not the 'acts' committed, with particular emphasis on 'grooming'
- Ensure evidence-informed boundaries training to FtP panel members and Chairs, including, if possible, lived experience of victims of professional abuse, and registrants charged with sexual allegations
- Consider use of 'expert panels' to determine serious boundary violation cases
- Couple suspension and conditions of practice with individualised pscyho-educational upskilling requirements, to include victim empathy training
- Consider expanded role for Health Committee in dealing with boundary violations which arise predominantly due to the professional's psychiatric/psychological factors
- Continue work with professional association and insurers to establish informal complaints and resolution mechanisms sitting outside FtP processes
- Undertake research on restorative justice approaches and potential application in boundary violation cases
- Consideration of need for culture-specific education and training on sexual boundaries and continue to provide EDI training for panel members
- Continue mature communications with the osteopathic profession about FtP

Managing Transitions into Practice

- Introducing mentorship for early years
- Pending consultation on statutorily required Foundation Year, provide tools to professionalise Associateships. Institute an accreditation scheme for Approved Practices and provide incentives
- Recruit recently-graduated osteopaths as Clinic Tutors (tie in the Clinical Teaching as a core professional skill)

Embedding Practice-based Support Structures

- Require mandatory Clinical Supervision
- Reverse mentoring programmes, whereby new graduates mentor more senior colleagues
- Profession wide systems of Clinical leadership should be introduced and a post-registration Clinical Leadership Programme developed
- Discuss alternatives to CQC oversight, based, e.g. on Pharmacy Superintendent model
- Utilise online learning platforms to organise virtual 'Schwartz Rounds'

Support for 'struggling' osteopaths

- Ensure that EDI improvements within OEI are supportive of students with mental health and neurodiversity issues
- Creation of dedicated support service for osteopaths struggling with mental health issues, along the lines of the Doctors' Support Network (https://www.dsn.org.uk/)
- Consider insurance/benevolence options to ensure that osteopaths who need to take time out of practice due to ill-health can afford to do so

Promoting a Learning Culture

- Providing resources to mainstream patient feedback, patient related outcome measures and patient related experience measures
- Supporting and expanding research and development roles of NCOR and iO
- Undertake and disseminate regulatory research into:
  a. Understanding why osteopathic patients make complaints
  b. Trauma-informed osteopathy
  c. Restorative justice

Utilising Political Leverage

- Explore ways of building on links with osteopaths working within the NHS
- Build on political capital of osteopaths availability during Covid, and use to broker education/support, e.g. access to NHS e-learning opportunities
- Position osteopathy within NHS recovery plans, including managing of MSK waiting lists
- Work with HEE to develop reciprocal placements to encourage inter-professional learning
- Explore opportunities for osteopathy within the Integrated Care System architecture

ADDITIONAL READING

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APPENDIX ONE

THEMES AND QUESTIONS FOR OEIS TO CONSIDER

1. Has how you teach about professional boundaries changed in the light of the 2017 report? https://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/thematic-analysis-of-boundaries-education-and-training/
2. Has how you teach about boundaries changed in the light of broader social trends, including the 'Me Too' movement, and concerns re student safety/harassment?
3. Do you teach students how to keep themselves safe from allegations and complaints? Are you concerned potential 'defensive teaching' and 'defensive practice/s'
4. How do you assess character of applicants to your OEI and do you think this has a bearing? Could more be done to 'weed out' unsuitable applicants to the profession at admissions stage?
5. Where in the curriculum do you teach about boundaries? Do you separate off the teaching of ethics, law, professionalism and communication skills or are these integrated with clinical practice?
6. How do you assess the skills of Clinic Tutors to teach about boundaries?
7. To what extent is your teaching biopsychosocial – how much/how and when do you teach students about psychological health/somatising illness, medically unexplained symptoms etc.
8. Specifically, to what extent is the subject of 'trauma informed care' understood, described and taught within osteopathic education?
9. How much/how well do you teach mental health/wellbeing/resilience/self-care of practitioners (given the known links between burnout and crossing of boundaries)
10. The 2017 Thematic Analysis highlighted 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.

In addition to a list of questions supplied to OEIs in advance, two more general questions were asked during interviews:

- Could they think why the rates of boundary violations by osteopaths represented such a significant proportion of all complaints

- When they learned that a former student had been the subject of fitness to practise allegations, were they surprised? Was there anything about that person's behaviours or attitudes as a student which might have given cause for concern, or suggested that they would have problems further on in their career?

APPENDIX TWO

Recommendations from 2017 Thematic Analysis:

The nature of professional boundaries – including (but not limited to) sexual boundaries. When, where and how this is taught in the curriculum. Including (but not limited to) the interface between ethics/law/professionalism teaching about boundaries and clinical skills teaching and training

- 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

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

- 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

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

- 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.

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.

- 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.

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

- 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

APPENDIX THREE

Extract from GOsC's Osteopathic Practice Standards 2019

D2. You must establish and maintain clear professional boundaries with patients, and must not abuse your professional standing and the position of trust which you have as an osteopath.

1. Abuse of your professional standing can take many forms. The most serious abuse of your professional standing is likely to be the failure to establish and maintain appropriate boundaries, whether sexual or otherwise.
2. Appropriate professional boundaries are essential for trust and an effective therapeutic relationship between osteopath and patient. Professional boundaries may include physical boundaries, emotional boundaries and sexual boundaries. Failure to establish and maintain sexual boundaries may, in particular, have a profoundly damaging effect on the patient, is likely to bring the profession into disrepute and could lead to your removal from the GOsC Register.
3. Not all crossing of professional boundaries will necessarily be an abuse of your professional standing. For example, sometimes it may support empathy and trust with a patient to disclose personal information or to treat a patient as an emergency outside your usual hours. However, there is a spectrum, and osteopaths must ensure that patients who may be vulnerable are protected at the time and throughout the duration of the professional relationship.
4. You should be aware of the risks to patients and to yourself of engaging in or developing social or commercial relationships with patients, and the challenges which this might present for the therapeutic relationship and to the expectations of both patient and professional. You should also be aware of the risk of patients developing an inappropriate dependency upon you, and be able to manage these situations appropriately, seeking advice from a colleague or professional body as necessary.
5. When establishing and maintaining sexual boundaries, you should bear in mind the following:
    1. words and behaviour, as well as more overt acts, may be sexualised, or regarded as such by the patient. Examples might include:
        1. sharing inappropriate intimate details about yourself
        2. visiting a patient's home without an appointment
        3. making inappropriate sexual remarks to or about patients
        4. unnecessary physical contact.
    2. You should avoid any behaviour which may be construed by a patient as inviting a sexual relationship or response.
    3. Physical contact for which valid consent has not been given can amount to an assault, leading to criminal liability.
    4. It is your responsibility not to act on feelings of sexual attraction to or from patients.

5. If you are sexually attracted to a patient or if a patient displays sexualised behaviour towards you, you should seek advice from, for example, a colleague or professional body on the most appropriate course of action. If you believe that you cannot remain objective and professional or that it is not possible to re-establish a professional relationship, you should refer your patient to another healthcare practitioner. If referring a patient because of your own sexual feelings towards them, you should endeavour to do so in a way that does not make the patient feel that they have done anything wrong.
6. You must not take advantage of your professional standing to initiate a personal relationship with a patient. This applies even when the patient is no longer in your care, as any personal relationship may be influenced by the previous professional relationship and an imbalance of power between the parties.
7. You must not end a professional relationship with a patient solely to pursue a personal relationship with them.
8. If you think that a personal relationship with a former patient might develop, you must consider whether this is appropriate. Factors that might impact on this include:
    1. the nature of the previous professional relationship
    2. the length of time the professional relationship lasted, and when it ended
    3. whether the former patient was particularly vulnerable at the time of the professional relationship, and whether they might still be vulnerable.
9. 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. The same level of care should be given to all patients, whether you know them in a social or other capacity, or not.

APPENDIX FOUR

Extract from GOsC's Student Fitness to Practise guidance

24. 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. A patient must be able to feel confident and safe with a healthcare professional and trust that they are acting in the patient's best interests, and providing the best possible care. A breach of sexual boundaries can seriously damage this trust. 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.

25. 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. This would relate to personal friendships, as well as to any sexual relationships.

26. 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 practice 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.

27. The maintenance of clear professional boundaries with patients, colleagues and staff from the educational institution is therefore a fundamental aspect of developing professional behaviours as a student of osteopathy. A breach of such professional boundaries can lead to a student's fitness to practise being called into question, which might affect their ability to remain on the course.