Sexual boundaries between physiotherapists and patients are not perceived clearly: an observational study

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Question: What are the sexual boundaries between physiotherapists and their patients? and do they differ between males and females? Design: Observational study using a postal questionnaire. Participants: 2248 physiotherapists registered with the Physiotherapist's Registration Board of Western Australia. Outcome measures: Respondents were asked to state: i) their perception of the behaviour of a hypothetical physiotherapist in six vignettes highlighting professional sexual boundaries; ii) the incidence of sexual attraction between themselves and their patients, and iii) the course(s) of action they would take in a situation of alleged sexual misconduct between a physiotherapist colleague and a patient. Results: A response rate of 42% (939 responses, 706 females) was achieved. The majority of respondents (≥80%) thought the physiotherapist's behaviour to be wrong in four of the six vignettes; 65% of respondents thought it acceptable for a physiotherapist who provides physiotherapy services to a rugby team to go on a date with a team member; 74% of males and 41% females (p < 0.001) reported having felt sexually attracted to a patient; respondents were aware of a colleague who had dated a patient (33%) or ex-patient (60%). When presented with a vignette describing alleged sexual misconduct, 83% of respondents stated they would advise the patient to make a written complaint to the appropriate disciplinary body. Less than 20% stated that they would personally report their colleague to the Physiotherapists’ Registration Board (19%) or the Australian Physiotherapy Association National Professional Standards Panel (15%). Conclusion: The variation in responses to the vignettes, the reported incidence of sexual attraction and dating of patients, and apparent confusion with regard to the complaints process identifies the need for education of the physiotherapy profession in Australia.


Key words: Physiotherapy, Professional ethics, Professional-patient relationships, Sexual behaviour

Introduction

Professional boundaries are the parameters that dictate the expected behaviour between a health professional and the patient within that relationship. They are governed by a mix of international conventions and local laws, and in most instances are communicated by means of a profession-specific code of conduct that relates in part to what is considered to be appropriate touch, communication, and relationship development in the context of the therapist-patient encounter (Higgs et al 2001). By the nature of their role, physiotherapists frequently develop a close physical relationship and an emotional attachment with their patients that is often unique within the healthcare sector (Poulijis 2007). As a result of this therapeutic relationship, physiotherapists need to be aware of the limits of the professional boundaries as they may be at higher risk of boundary violations than members of other healthcare disciplines. The professional relationship is often seen as one where a patient entrusts their welfare to a health professional. This implies a contractual agreement that requires a professional service to be conducted within the accepted boundaries set by the relevant professional body (Garfinkel et al 1997). Society in general allows considerable autonomy to a profession with the assumption that members of a profession acknowledge a commitment to competence, integrity, and morality, and are governed by a code of ethics (Creuss et al 2004).

The characteristic of professional autonomy has undergone considerable change in recent years and the interaction between professional and patient has changed to being more of a partnership (Creuss et al 2002). This change, however, comes with the need to ensure self-regulation and it becomes incumbent upon any professional to make certain that the relationship remains within the boundaries set by their profession for the benefit of both the patient and the practitioner. If professional boundaries are transgressed to the point of violation then the relationship between the health professional and the patient may become damaged irrevocably (Sanbar et al 2007). If clinicians seek to serve their own needs over those of their patients, this is viewed as an abuse of their power and a breach of their fiduciary agreement (Gabbard 1999). Not only does the patient then lose trust and respect for the health professional, but society may do likewise. One specific boundary between a health professional and their patient is the sexual boundary. In many cases, violation of this boundary is not a consciously predatory action but develops from a more benign boundary crossing of a non-sexual nature; this is often referred to as the ‘slippery slope’ (Galletly 2004). Physiotherapy services occur in a wide variety of settings that include health organisations, private practices, nursing homes, schools, community settings, sports clubs, and in the workplace (Higgs et al 2001). In some instances, the trappings of a formal physiotherapist/patient relationship are not present.
which may make the boundaries of the professional relationship less clear.

Data regarding physiotherapist/patient sexual boundaries are scant. Cullen et al (1997a, 1997b), who surveyed all members of the New Zealand Society of Physiotherapists following the introduction of a policy on Professional Sexual Boundaries in 1995, reported that 8% of respondents had engaged in a sexual relationship with a patient, and that 42% had been sexually propositioned or harassed by a patient or their relative. De Mayo (1993), who surveyed members of the American Physical Therapy Association, reported that 86% of respondents had experienced some form of inappropriate patient sexual behaviour, and 63% reported at least one case of specific sexual harassment. McComas et al (1993), who surveyed Canadian physiotherapists and undergraduate physiotherapy students, reported that 81% of respondents had experienced inappropriate patient sexual behaviour. Surveys of other health professionals have reported an incidence of sexual boundary violation by the health professional ranging from 1% to 12%. In all of these studies, males were more likely to transgress than females (Gabbard 1999).

The absence of Australian data gave rise to this study. The Australian Physiotherapy Association (APA) has recently updated its Code of Conduct, which now states ‘Members shall not engage in any sexual activity with a person who is a current client’ (APA 2008, p. 2). However, there are no guidelines to educate and assist physiotherapists working within Australia when issues of sexual professional boundaries arise. The aims of the study were to collect data from physiotherapists registered with the Physiotherapists’ Registration Board of Western Australia and compare it with the findings of the New Zealand survey (Cullen et al 1997a, 1997b). The specific research questions were:

1. What are the sexual boundaries between physiotherapists and their patients?
2. Does this differ between males and females?

The study did not seek to determine what constitutes a sexual relationship or to make an ethical judgment about the responses received.

Method

Design

A questionnaire was used to examine how physiotherapists recognise and interpret professional sexual boundaries. The questionnaire used in this study was modified from Cullen et al (1997a). Permission to use and modify the questionnaire was obtained in November 2006. Pilot testing of the modified questionnaire and the covering letter was carried out with six physiotherapists (four females). Minor changes were made in response to their feedback.

The questionnaire consisted of 14 closed questions divided into four sections (see Appendix 1 on the eAddenda for the full questionnaire). Section 1 included six vignettes with respondents asked to choose a single response on a five-point scale ranging from ‘This is OK and I might do it if the circumstances were right’ to ‘This behaviour is so wrong that it is a current client’ (APA 2008, p. 2). However, there are no guidelines to educate and assist physiotherapists working within Australia when issues of sexual professional boundaries arise. The aims of the study were to collect data from physiotherapists registered with the Physiotherapists’ Registration Board of Western Australia and compare it with the findings of the New Zealand survey (Cullen et al 1997a, 1997b). The specific research questions were:

1. What are the sexual boundaries between physiotherapists and their patients?
2. Does this differ between males and females?

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Results

Participants

The cohort comprised the 2248 physiotherapists registered with the Physiotherapists’ Registration Board of Western Australia on 16 July 2007.

Data analysis

Analyses comprised descriptive statistics, test of single proportions, Chi-squared test and Fisher’s exact test. A probability value of $p < 0.05$ was regarded as significant.

View of professional sexual boundaries

Table 3 presents the responses to the six vignettes. The majority of respondents (≥80%) thought the physiotherapist’s behaviour to be wrong in four vignettes (A, C, D, and F). For Vignette B, set in a rural setting, 31% of respondents thought it acceptable for a physiotherapist to develop a sexual relationship with one of their patients. A higher proportion of respondents employed in an urban setting considered the behaviour to be wrong (58% urban vs 43% rural, $p = 0.02$). Additionally, a higher proportion of respondents currently employed in the public sector considered this behaviour to be wrong (62% public vs 50% private, $p = 0.04$). For Vignette E, two-thirds of respondents (65%) thought it acceptable for a physiotherapist who provides physiotherapy services to a rugby team to go on a date with a team member. Only for Vignette A, did a significantly higher proportion of
female respondents think the behaviour so wrong that the physiotherapist should be barred from practice (25% females vs 12% males, \( p = 0.003 \)).

### Incidence of sexual attraction between physiotherapists and patients

Significantly more male respondents reported having felt sexually attracted to a patient (74% males vs 41% females, \( p < 0.001 \)). Although a higher proportion of males than females reported they had dated a current patient (7% vs 4%, \( p = 0.18 \) or ex-patient (21% vs 16%, \( p = 0.24 \), this was not significant. However, 33% of respondents stated they were aware of a colleague who had dated a current patient, and 60% were aware of a colleague who had dated an ex-patient. Some 41% of male respondents reported they had been sexually harassed by a patient or his/her relative, compared with 51% of female respondents (\( p = 0.17 \)). Significantly (\( p < 0.001 \)) more males (5%) than females (1%) reported that they had been told their touching or treatment was sexually inappropriate.

### Course of action in alleged sexual misconduct

The course of action chosen by 782 (83%) respondents was to advise the hypothetical patient in the vignette that she could make a complaint by writing to the appropriate disciplinary body. Respondents currently employed in the public sector were more likely to recommend this course of action than physiotherapists employed in the private sector (88% public vs 80% private, \( p = 0.03 \)). The second most frequent course of action, chosen by 286 (30%) respondents, was to offer to talk to their colleague and then get back to the patient. 174 (19%) respondents reported that they would report their colleague to the Physiotherapists’ Registration Board and 142 (15%) to the APA National Professional Standards Panel. Young physiotherapists (ie, the 20–29 year-old cohort) were more likely to report their colleague to the Physiotherapists’ Registration Board than their older peers (25% young vs 17% older, \( p = 0.006 \)) or to the APA National Professional Standards Panel (22% young vs 13% older, \( p = 0.004 \)).

There were no other significant differences in responses to any of the questions when responses were analysed by age or gender of respondent, years of practising physiotherapy,

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**Table 1. Response rate by age and gender expressed as a proportion of the physiotherapists registered with the Physiotherapists’ Registration Board of Western Australia.**

<table>
<thead>
<tr>
<th>Age (yr)</th>
<th>All n = 939/2248</th>
<th>Males n = 233/596</th>
<th>Females n = 706/1652</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–29</td>
<td>215/637 (34)</td>
<td>64/183 (35)</td>
<td>151/454 (33)</td>
</tr>
<tr>
<td>30–39</td>
<td>315/715 (44)</td>
<td>79/214 (37)</td>
<td>236/501 (47)</td>
</tr>
<tr>
<td>40–49</td>
<td>240/510 (47)</td>
<td>55/118 (47)</td>
<td>185/392 (47)</td>
</tr>
<tr>
<td>50–59</td>
<td>126/284 (44)</td>
<td>24/54 (44)</td>
<td>102/230 (44)</td>
</tr>
<tr>
<td>60 and older</td>
<td>43/102 (42)</td>
<td>11/27 (41)</td>
<td>32/75 (43)</td>
</tr>
</tbody>
</table>

**Table 2. Number (%) of respondents for each characteristic by gender.**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All n=939</th>
<th>Males n=233</th>
<th>Females n=706</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–29</td>
<td>215 (23)</td>
<td>64 (27)</td>
<td>151 (21)</td>
</tr>
<tr>
<td>30–39</td>
<td>315 (34)</td>
<td>79 (34)</td>
<td>236 (33)</td>
</tr>
<tr>
<td>40–49</td>
<td>240 (26)</td>
<td>55 (24)</td>
<td>185 (26)</td>
</tr>
<tr>
<td>50–59</td>
<td>126 (13)</td>
<td>24 (10)</td>
<td>102 (14)</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>43 (5)</td>
<td>11 (5)</td>
<td>32 (5)</td>
</tr>
<tr>
<td>Current employment location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>780 (83)</td>
<td>199 (86)</td>
<td>581 (83)</td>
</tr>
<tr>
<td>Rural</td>
<td>147 (16)</td>
<td>33 (14)</td>
<td>114 (16)</td>
</tr>
<tr>
<td>Both</td>
<td>6 (1)</td>
<td>0 (0)</td>
<td>6 (1)</td>
</tr>
<tr>
<td>Current employment sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>418 (45)</td>
<td>60 (26)</td>
<td>358 (51)</td>
</tr>
<tr>
<td>Private</td>
<td>487 (52)</td>
<td>169 (74)</td>
<td>318 (46)</td>
</tr>
<tr>
<td>Both</td>
<td>24 (3)</td>
<td>1 (0)</td>
<td>23 (3)</td>
</tr>
<tr>
<td>Years of practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 5</td>
<td>188 (20)</td>
<td>53 (23)</td>
<td>135 (19)</td>
</tr>
<tr>
<td>6–10</td>
<td>165 (18)</td>
<td>50 (22)</td>
<td>115 (16)</td>
</tr>
<tr>
<td>11–20</td>
<td>277 (30)</td>
<td>77 (33)</td>
<td>200 (28)</td>
</tr>
<tr>
<td>21–30</td>
<td>218 (23)</td>
<td>36 (16)</td>
<td>182 (26)</td>
</tr>
<tr>
<td>&gt; 30</td>
<td>89 (10)</td>
<td>16 (7)</td>
<td>73 (10)</td>
</tr>
</tbody>
</table>
current employment sector or location.

Discussion

From responses to a series of vignettes presented in a questionnaire, West Australian physiotherapists are not consistent in their judgement of what is acceptable when sexual professional boundaries are crossed. It is apparent that sexual attraction between a physiotherapist and their patient may be experienced by one or both parties at some stage and on occasions may lead to the physiotherapist dating a current or ex-patient. The majority of the current State Registration Boards have specific policies that relate to sexual professional boundaries, however these have been developed primarily to protect the public. Unprofessional behaviour by members of the physiotherapy profession has been the subject of media reporting in recent years. This does little for the image that the profession has worked hard to create. A framework to prevent the slippery slide from boundary crossing to that of violation needs to be put in place so that society can be sure that the physiotherapy profession can be trusted with self-regulation.

The main limitation of this study was its response rate (42%) which was lower than in the New Zealand study (91%, Cullen et al 1997a). It represents a realistic response for a mail out questionnaire that includes questions of a sensitive nature (Edwards et al 2007, Portney and Watkins 2000) where there is a perceived risk of disclosing information that could be professionally damaging (Gabbard 1999). The New Zealand study identified respondents but not their responses, thus allowing non-responders to be targeted multiple times. However, the age and gender characteristics of our respondents, with the exception of a slightly lower response rate from physiotherapists aged 20–29 years, are consistent with data from the Physiotherapists’ Registration Board of Western Australia (see Table 1) and with census data (Schofield and Fletcher 2007). Another limitation was the closed nature of questions relating to the vignettes, which limited discussion that may have accompanied responses.

Western Australian physiotherapists responded similarly to their New Zealand peers when faced with vignettes describing relationships between a physiotherapist and a patient. We found discrepancies in opinion with regard to a sexual relationship developing within a sporting team and within a rural private practice setting. This implies some variation in the definition of what constitutes a professional relationship. However, physiotherapists work in a wide variety of settings and the definition of a professional relationship should not differ according to the setting in which the relationship occurs.

Table 3. Number (%) of respondents for each category in response to the six vignettes presented in the questionnaire.

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. After receiving therapeutic massage, a patient says he/she is feeling</td>
<td>1</td>
</tr>
<tr>
<td>much better. The physiotherapist replies that he/she is too and it would</td>
<td>2</td>
</tr>
<tr>
<td>be the patient’s turn to give the massage to the physiotherapist next</td>
<td>3</td>
</tr>
<tr>
<td>time.</td>
<td>4</td>
</tr>
<tr>
<td>B. A single physiotherapist in partnership in a rural area meets one of</td>
<td>125 (13)</td>
</tr>
<tr>
<td>his/her patients socially on a number of occasions and they develop a</td>
<td>167 (18)</td>
</tr>
<tr>
<td>sexual relationship. He/she continues to provide him/her with on-going</td>
<td>127 (14)</td>
</tr>
<tr>
<td>care for a chronic condition.</td>
<td>412 (44)</td>
</tr>
<tr>
<td>C. A physiotherapist has a sexual relationship with a patient while</td>
<td>3 (0)</td>
</tr>
<tr>
<td>continuing to act as his/her physiotherapist and as physiotherapist</td>
<td>14 (2)</td>
</tr>
<tr>
<td>to his/her children, and on occasions to his/her spouse. The</td>
<td>10 (1)</td>
</tr>
<tr>
<td>physiotherapist has made the acquaintance of the family through his/her</td>
<td>387 (41)</td>
</tr>
<tr>
<td>position as a physiotherapist.</td>
<td>523 (56)</td>
</tr>
<tr>
<td>D. A physiotherapist invites a patient to meet him/her at a bar after</td>
<td>22 (2)</td>
</tr>
<tr>
<td>work for a drink. A sexual relationship develops and the physiotherapist</td>
<td>89 (10)</td>
</tr>
<tr>
<td>continues to provide professional services.</td>
<td>66 (7)</td>
</tr>
<tr>
<td>E. A female physiotherapist is invited by her brother to be the</td>
<td>337 (36)</td>
</tr>
<tr>
<td>physiotherapist for his rugby team. She agrees and a few weeks later</td>
<td>277 (30)</td>
</tr>
<tr>
<td>accepts an invitation to go on a date with one of the team members.</td>
<td>148 (16)</td>
</tr>
<tr>
<td>F. A physiotherapist supervising a final year physiotherapy student</td>
<td>12 (1)</td>
</tr>
<tr>
<td>offers to assist them out of normal working hours with their studies.</td>
<td>49 (5)</td>
</tr>
<tr>
<td>A sexual relationship develops whilst the student remains</td>
<td>32 (3)</td>
</tr>
<tr>
<td>under the direct supervision of that physiotherapist.</td>
<td>494 (53)</td>
</tr>
<tr>
<td></td>
<td>352 (38)</td>
</tr>
</tbody>
</table>

1 = This is OK and I might do it if the circumstances were right, 2 = I wouldn’t do this, but I wouldn’t criticise anybody who did, 3 = I don’t know if this is right or wrong, 4 = This behaviour is wrong, 5 = This behaviour is so wrong that the physiotherapist involved should be barred from practice.
attraction towards their patients, were more likely to go on a
date with their patients, and were more likely to be told that
their contact was inappropriate should act as a particular
warning to male physiotherapists. Strategies such as using
chaperones, providing printed explanations of intervention,
or obtaining written consent prior to commencing physical
contact may be useful. Similar to their New Zealand peers,
only a minority of respondents reported that they had dated a
current patient, however the incidence increased when
asked whether they had dated an ex-patient. The definition
of when a patient ceases to become a patient needs to be
established clearly.

Sixty-six respondents (7%) included written comments
on their questionnaires indicating they were unsure of the
process for making a complaint about a colleague to the
appropriate disciplinary body. The finding that younger
physiotherapists (20–29 years) were more likely to make a
direct complaint on behalf of their patient when compared
to their older peers may reflect the introduction of education
on the subject of professional ethics in recent years. The
APA provides written advice to patients on how to complain
about a physiotherapist (APA 2007), but there are no clear
guidelines for professionals. The finding that females were
more likely than males to respond that a physiotherapist
should be barred from practice in situations where the
physiotherapist/patient sexual boundaries were violated
suggest that physiotherapists of both genders should be
included in the development of any policies or guidelines
relating to the physiotherapist-patient boundary.

The results of this study highlight a number of issues that
require consideration by the physiotherapy profession in
Australia. If replicated nationally, the findings could assist
both the APA and the proposed National Registration
Body for Physiotherapists when developing policies and
guidelines. These bodies are urged to develop a framework
that provides details of the boundaries expected in a
professional relationship to protect both physiotherapists and
their patients from actions that may become personally and
professionally damaging. To elucidate sexual professional
relationships, the APA, as the only body that develops
appropriately within the confines of a professional relationship.
This study also highlights the necessity for clear guidelines
from both the professional association and the relevant state
regulatory authorities regarding the complaints process.

eAddenda: Appendix 1 available at AJP.physiotherapy.asn.
au

Ethics: The study was approved by the Human Research
Ethics Committee of Curtin University of Technology. Return of
questionnaires was taken as consent to participate.

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