INVISIBLE BORDERS: SEXUAL MISCONDUCT IN NURSING

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Abstract

Sexual misconduct can occur when nurses practise in close physical or emotional proximity with patients. Nurses, however, have a professional responsibility to maintain professional boundaries to avoid the potential for sexual misconduct to occur. In New Zealand, there is evidence that some nurses have been involved in sexual misconduct, resulting in disciplinary proceedings against them. Despite this, there is an absence of guidelines and discussion for New Zealand nurses to prevent such occurrences. This article identifies difficulties in naming and defining sexual misconduct, and discusses sexual misconduct as an abuse of power by nurses. New Zealand and international literature about sexual misconduct by nurses and other health professionals is described, as are guidelines designed to prevent sexual misconduct. Finally, we make recommendations for actions needed to facilitate New Zealand nurses in identifying and avoiding sexual misconduct in practice.

Key Words: Sexual misconduct, sexual boundaries, professional boundaries, nursing guidelines.

Introduction

Nurses often work in close physical and emotional proximity with patients, meaning that they must be ever vigilant about maintaining professional boundaries, including those of a sexual nature. However, there is evidence from both international literature and Nursing Council of New Zealand (NCNZ) disciplinary hearings, that nurses have been involved in incidents where they cross sexual boundaries, leading to sexual misconduct. Despite this, there is a relative lack of critical discussion about sexual misconduct in the New Zealand nursing literature. The purpose of this article is therefore to analyse issues surrounding sexual misconduct in nursing and to recommend the development of guidelines to avoid such behaviours. Significantly, no suggestions are made for the content of these guidelines. Rather, we recognise that nursing practice is context specific, and therefore guidelines need to be produced that reflect sound ethical

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principles which can be applied in multiple settings.

Professional boundaries

Professional boundaries are invisible borders that protect clients from financial, social, emotional, physical and sexual exploitation and include professional guidelines related to expected work behaviour. The National Council of State Boards of Nursing of America (1996a) state that boundary violations are linked to power differentials between patients and nurses, and are related to abuses of power. Such abuses are often for the gratification of individual nurses, meaning that actions move from being helpful, to the nurse becoming overly-involved (Fox-Young, 1997) and may include the transgression of sexual boundaries, leading to sexual misconduct.

Sexual misconduct

Literature on sexual misconduct highlights the difficulty in formulating a singular definition that can apply across legislation, and social and professional contexts. The Florida Nurse Practice Act (1994, as cited in Smith, Taylor, Keys, & Gortno, 1997) states that:

> It [sexual misconduct] occurs when the provider initiates sexual interaction with a patient or responds to a patient in a sexual manner, or where a nurse induces or attempts to induce, the patient to engage or attempt to engage, in sexual activity outside the scope of practice or the generally accepted examination or treatment of the patient (p. 28).

This definition recognises that nursing interventions do, on occasions, require intimate physical contact between a nurse and a patient. The definition also identifies that sexual misconduct can occur even if there are sexual overtones from a nurse in the absence of physical contact.

The National Council of State Boards of Nursing's [NCSBN] (1996b) definition of sexual misconduct also includes behaviours that do not necessarily involve a physical act. They state that "professional sexual misconduct includes seductive behaviour or sexually demeaning behaviour" (NCSBN, 1996b, p. 2). Smith et al. (1997) agree, defining sexual misconduct as "any expression by a nurse or other health provider of erotic or romantic thoughts, feelings, or gestures that are sexual or may be reasonably construed by the patient as sexual" (p. 28). Significantly, such expressions are still considered sexual misconduct even when a patient initiates or agrees to such advances (Sheets, 2001).

Nursing, unlike other health literature, appears to favour the term "sexual boundary crossing" over "sexual misconduct". Sexual boundary crossing can be viewed as a step towards sexual misconduct; however we believe that some sexual boundary crossing is, in itself, sexual misconduct. We have therefore used the term "sexual misconduct" in this article, except where the original authors have utilised the phrase "sexual boundary crossing".

Whilst there is some agreement around definitions of sexual

misconduct, determining just who constitutes 'patient' is more problematic. Unfortunately, much of the literature does not address this. Zook (2001) does suggest that sexual contact with past, as well as current patients is inappropriate. However, just who should fall into the definition of 'past patient' is unclear.

Sexual misconduct as an abuse of power by nurses

Any relationship between health care professionals and clients will be asymmetrical as the helper holds the power and the helpee, in seeking care, is potentially vulnerable (Gallop, 1993; Peternelj-Taylor, 2002; Peternelj-Taylor & Yonge, 2003). The latter also point out the power of nurses in such situations is often recognised by patients who expect nurses to use this power responsibly.

Sexual misconduct is clearly an abuse of power. Smith et al. (1997) believe that such behaviours can occur because of the very nature of nursing. Nursing is rife with situations where usual social boundaries are crossed, such as intimate physical touching during nursing assessments. The transmission of personal and confidential information by patients can also create a vulnerable position for both the patient and the nurse. Some patients misinterpret the closeness and intimacy of such situations, while nurses may feel they have to reciprocate and share their own personal information (NCSBN, 1996b). It is therefore essential that nurses ensure that they, as health professionals, be responsible for the maintenance of professional boundaries, including sexual boundaries (Gallop, 1998).

Rae, Murphy and Collins (1997) discuss sexual misconduct occurrences in the United Kingdom. Although Rae et al.'s discussion is limited to mental health services, their article reiterates the notion that the crossing of sexual boundaries is an abuse of power. Additionally, Rae et al. consider such behaviours to be a betrayal of trust of unwell and potentially vulnerable patients who, in some instances, have been abused in the past. They also suggest that some patients in psychiatric settings may misinterpret the therapeutic relationship which must be formed by the nurse. Gallop (1998) suggests that male staff (including nurses) are more likely than their female counterparts to become sexually involved with patients at such times, often through the use of coercive measures. On the other hand, female staff who violate sexual boundaries may view the sexual relationship as a "rescuing move" (Gallop, p.43) believing that this special love can save the patient. Additionally, female nurses are sometimes seen as potential victims of duplicitous male patients (Peternelj-Taylor & Yonge, 2003). There are many potential reasons as to why health care professionals are involved in sexual misconduct. Later in the discussion section we state that the potential risks of such situations need to be brought to the attention of nurses through dialogue. In addition, we also believe that all Registered Nurses, regardless of gender, are responsible for the maintenance of sexual boundaries.

Sexual misconduct and the New Zealand context

Professional misconduct is defined as conduct which can either be considered malpractice or negligence by the nurse related to the area they are registered in, or brings or is likely to bring discredit on the nursing profession (Burgess, 2002). Professional conduct is also discussed in an oblique manner within the Social Policy Statement, the Code of Ethics and the Standards for Nursing Practice (New Zealand Nurses Organisation [NZNO] 1993; 1995; 1998) but none of these documents specifically address sexual misconduct.

Sherrard (1996), the then departing convener of the NCNZ preliminary proceedings committee, states that professional sexual misconduct is more common than most nurses and midwives would like to believe. Perhaps in response to such concerns, the NCNZ's latest Code of Conduct (2001), in contrast to previous editions, cites "entering into a sexual or inappropriate intimate relationship with a client or ex-client" (p. 7) as an example of a behaviour which could be considered a basis of complaint about a nurse or midwife. We were unable to locate overt comments about sexual misconduct in other published New Zealand nursing standards and codes of practice.

While there is a lack of guidance and discussion about sexual misconduct in New Zealand nursing publications, there are cases in recent years that show that New Zealand nurses have been disciplined for such behaviours. The NCNZ is regularly called upon to make decisions regarding the professional (mis)conduct of nurses, and these decisions are published in their tri annual newsletters. A perusal of these publications would suggest that sexual misconduct is not uncommon in New Zealand. Whilst there are no published cases prior to 2000, there have been five cases between 2000 and 2004 where a nurse has been removed from the New Zealand register for entering into a sexual relationship with a patient. Another nurse was disciplined for entering into an inappropriate, but non-sexual, relationship. Two other nurses were found guilty of professional misconduct for making sexual advances to a patient (NCNZ, 2000; 2002; 2003).

The Health and Disability Commissioner (HDC) has published a number of case notes and opinions related to sexual abuse and misconduct between 1997 and 2004 (HDC, 2004). The cases cited related to a therapist, a general practitioner, two psychologists and a councillor, with none of the case notes or opinions citing nurse transgressions. It is difficult to determine whether the HDC and NCNZ citations reflect an increasing trend of sexual misconduct, or a more vigilant reporting and complaint investigation process. Either interpretation highlights the potential for sexual misconduct by health professionals to occur.

In February 2002 the NZNC published a statement outlining the findings of an appeal by a nurse

previously found guilty of sexual misconduct. The nurse appealed for a lesser penalty on the grounds that the relationship happened when the patient was on leave. In response, the judge reviewing the case decreed "that a nurse's professional and ethical duties to a patient do not end at the door of the hospital or surgery, and do not terminate with a nurse/patient relationship" (NZNC, 2002, p. 10).

The newly graduated nurse also requested a lesser penalty on the grounds that she had been given no direction or guidance on sexual contact with patients. The NCNZ outlined the judge's response:

> A sexual relationship between a nurse and patient s/he is caring for is fundamentally unprofessional and inappropriate. He [the judge] said that the Nursing Council is made up of nurses with extensive experience, who know what the basic principles of nursing are and what nurses are taught. Members of all professions are judged by their peers, he said. The Nursing Council's Code of Conduct is a general guide, which does not need to specifically state that the nurse should not have sexual relationships with their patients (NCNZ, 2002, p. 10).

The appeal finding clearly indicates that nurses should not have sexual relationships with any patients. Although we agree with this principle, we nevertheless believe that New Zealand nurses would benefit from input into, discussion about, and guidance from, policy statements around such behaviours.

Unlike the NCNZ, the Medical Council of New Zealand (MCNZ) (1998) does have statements on sexual relationships with both current and former patients, a statement on sexual abuse in the doctor/patient relationship and guidelines for ending a professional relationship (MCNZ). In addition, the MCNZ has produced a policy on assessment and rehabilitation of doctors admitting or found guilty of sexual misconduct. These policy statements go some way to defining the boundaries of appropriate sexual behaviour with patients for medical practitioners. However, the HDC believes that the new codes designed by the New Zealand Medical Association (NZMA) in conjunction with the MCNZ are ambiguous in determining when a relationship with a past client might be acceptable (A new code, 2002). The HDC suggests a time line be included, with a 'stand down' time of two years to identify when a personal relationship is acceptable with an ex-patient. The NZMA, however, believe that imposing a time line may leave a loop hole for inappropriate relationships to occur even when the time line is adhered to. For instance, once the 'acceptable' time is up, relationships which are inappropriate for a number of reasons may occur (A new code).

Although the MCNZ policy statements appear problematic to the HDC, they do at least publicise issues relating to sexual misconduct and attempt to proffer a 'line in the sand' for professionals. The impact of the

introduction of the Health Practitioners Competence Assurance Act 2003 on issues of sexual misconduct is as yet unknown. The Act is designed to make for both greater consistency between health professions, and greater accountability for professional behaviour. Although sexual misconduct is not specifically mentioned, the Act does allow for the reporting of health professionals by colleagues if the former is thought to be incompetent in that role. Colleagues may well then report known sexual relationships between nurses and clients due to the impact the relationship may have on providing ethically competent care within the therapeutic and professional relationship. We therefore believe that there will be an even greater onus on nurses to understand the issues and impact of sexual misconduct than is currently the case.

Sexual misconduct by nurses

We undertook a search on the computerised data-bases Proquest, Medline and the Cumulative Index to Allied and Health Literature (CINAHL), along with a Google search on the world-wide web, using a combination of the search terms 'sex', 'sexual misconduct', 'professional boundaries' and 'nursing', in an attempt to access literature on sexual misconduct.

There is a relative dearth of research data about nursing and sexual misconduct. Only one research article (Bachmann et al., 2000) was located in our searches. These authors surveyed 279 nurses at two psychiatric hospitals in Switzerland to determine the frequency of sexual contact between nurses and patients, and to identify the characteristics and attitudes of nurses who had had sexual contact with patients. Whilst Bachmann et al. deliberately used a broad definition of sexual contact (sexual contact in which sexual arousal occurred in the nurse), the indication that 17 % of male nurses and 11% of female nurses had had sexual contact is still significant. Of these, nurses within five years of graduation as registered nurses, and male nurses who had a past history of experiencing sexual abuse were most susceptible to sexual misconduct with patients. Interestingly, although most nurses who had had sexual contact with patients thought that counselling programmes should be provided for transgressors, most would not have actively sought help themselves. Bachmann et al. therefore suggest that proactive, rather than reactive measures are needed to attend to sexual misconduct in nursing.

Whilst we were unable to locate any further research specific to nursing, Taylor (1998) believes that sexual misconduct and sexual violations against patients have increased in Australia. Although such transgressions have a negative impact on patients, Taylor believes that a lack of awareness and dialogue about the potential for sexual misconduct may make nurses vulnerable to accidentally crossing sexual boundaries with patients. Nurses therefore need to be aware of their vulnerability in dealing with patients.

Discussion and professional debate will facilitate emergence of such awareness.

Professional guidelines on sexual misconduct

International nursing literature on sexual misconduct illustrates an inconsistency in standards between nursing associations, including the absence of overt statements in most instances. The American Nurses Association forbids intimate or sexual relationships, but with current clients only (Sherrard, 1996). The New South Wales Principles of Practice Guidelines state optimum care is not possible when nurses have a dual relationship (a relationship that includes a social, financial or sexual relationship as well as a professional one with a patient), but they do not expressly state that they prohibit them (Fox-Young, 1997). The most explicit statements we located were authored by the College of Nurses of Ontario. They specifically highlight and describe sexually inappropriate behaviour under the headings, 'Abusive conduct', 'Disgraceful, dishonourable and unprofessional conduct', and 'Sexual Abuse', in their Standards of Code document (College of Nurses of Ontario, 2002).

We also undertook a search of medical and allied health professional groups' codes of ethics using the same search strategies as previously outlined. We were able to locate only one professional association (The American Psychological Association, 1998) that expressly prohibited sexual contact with current *and* past patients. Other professional associations appear to be less directive in approach. The American Medical Association (AMA) (1995) deems any sexual relationship that occurs concurrently within the physician-patient relationship to be sexual misconduct. The AMA, however, does not expressly prohibit sexual contact with past patients, instead offering guidelines that state that a professional relationship must be clearly terminated, with no possibility of further care, before a sexual or romantic relationship can occur.

In contrast, The American Academy of Orthopedic Surgeons (AAOS) (1995) does not differentiate between past and current patients, but rather suggests that any sexual contact between patient and physician is unethical. The AAOS also concurs with Gartrell , Herman, Olarte, Feldstein and Localio's (1986) study of physician/patient sexual relationships, which concluded that such instances are probably under reported due to self reporting of data, the stigma associated with it, and the potential professional repercussions to the physician (AAOS, 1995).

The American College of Obstetricians and Gynaecologists (ACOG, 1998) clearly determines that sexual misconduct with current patients is an abuse of professional power and a violation of patient trust. However, like the AAOS, the ACOG does not comment on physician relationships with past patients. Similarly, The Canadian Mental Health Association (1995, p.1) gives no time limits, although they do state that "Sexual exploitation and abuse by mental

health service providers are unacceptable and unethical." Conversely, the Ontario College of Physicians and Surgeons recommends a life time ban on relationships with present and former patients (Gallop, 1993).

Recommendations

Nursing, like other health professions, appears to have a growing but limited recognition of sexual misconduct by nurses. Peternelj-Taylor and Yonge (2003) suggest that there is, in part, a 'conspiracy of silence' about sexual misconduct in nursing, brought about by a reluctance to 'whistle blow' on colleagues. Our own discussions with some colleagues in practice lead us to suspect that some deny that professional nurses are capable of such actions.

Codes of Practice/guidelines

It is apparent from New Zealand disciplinary proceedings that nurses are currently being judged against standards of acceptable behaviours around sexual contact with patients. The diverse nature of nursing in New Zealand means that it is difficult to imagine any clear overarching policy statement that shows nurses what is or is not acceptable in a given situation. Nevertheless, we believe that it is imperative that all codes of practice have, at a minimum, explicit statements that sexual contact with patients is deemed unacceptable behaviour. Additionally, we consider it important that New Zealand nurses have input into the creation of guidelines for practice that allow nurses to proactively consider the numerous sexual misconduct situations that, potentially, may occur in the myriad of settings in which nurses practice. Peternelj-Taylor and Yonge (2003) suggest that such guidelines take into account the nature of patients, the competence of nurses involved, and the variety of practice settings. Whilst it would be overly optimistic to expect such guidelines to deter all inappropriate sexual misconduct we, like the above authors, believe that guidelines which consider the specificities of practice contexts will stimulate exploration and consequently may change the conscious and unconscious behaviours of some.

Education

Rae et al. (1997) consider that health institutions offer little encouragement for nurses to share concerns about the complexities of sexual misconduct issues. They suggest, therefore, that education programmes for nurses need to be developed to allow opportunities to discuss boundaries and provide checklists for recognising and dealing with sexually inappropriate behaviour by colleagues and patients. Whilst the behaviours of the latter group cannot necessarily be controlled by nurses, we believe that the recognition of ways of mitigating these, and recognising the need to maintain professional boundaries even in the presence of such behaviour, will help lessen the possibility of sexual misconduct occurring.

Pennington, Gafner, Schilit and Bechtel (1993) identify a need to introduce educational programmes which discuss how "faulty relationships arise and how they can

be avoided" (p. 28). They consider that such programmes should avoid apportioning blame, but rather focus on understanding how and why the breakdown of boundaries occurs. Pennington et al. also discuss the relevance and value of boundaries workshops in the United States. The intent of these workshops is to raise awareness of potentially unsafe situations for nurses and patients, and include the 'how' and 'why' of sexual contact and other inappropriate behaviour, the consequences of stepping outside the professional role, and how to avoid compromising situations. Smith et al. (1997) agree with the need for such programmes, and suggest the necessity of regular awareness training, clear workplace policies and professional supervision for all nurses. We consider these appear to be appropriate interventions to support nurses to deal with sexual misconduct issues.

The NZNO has made available Boundaries Workshops. 'Boundaries Crossings/Violations', the handout accompanying the workshops, specifically states, "a sexual intimate personal relationship is unacceptable between a nurse and a client within the context of the provision of care" (NZNO, 2003). The workshops focused on professional boundaries generally; however sexual boundaries were briefly discussed within that framework, with differences between medical and nursing perceptions of sexual misconduct highlighted, along with suggestions for ways of taking action when sexual misconduct by nurses occurs.

We suggest that Boundaries Workshops are made available to all nurses, rather than being at the request of some employees as is currently the case. Additionally, we consider there is a need for specific sexual misconduct workshops at both an undergraduate and post graduate level.

Research

While there are some empirical studies related to nursing professional boundaries in general (Doyal, 1998; Leurquin-Hallet, 1999; Lillibridge, Axford & Rowley, 2000; Poe & Duke, 2000), there is a dearth of research information about sexual misconduct. We suggest the need for New Zealand based nursing research that explores the frequency, context and effects of sexual misconduct on nurses and patients alike. The lack of research specifically accessing the opinions, beliefs and attitudes of nurses and patients is an issue which needs rectifying. We have also suggested the implementation of education about sexual misconduct in New Zealand health education institutions. Research will be needed to explore the effectiveness of such education in helping nurses to examine sexual boundary issues before they become a problem.

Conclusion

The nature of health care means that some nurses are susceptible to sexual misconduct with patients. Although it is unclear whether sexual misconduct is on the increase, disciplinary actions have occurred against nurses who have transgressed sexual boundaries. In New Zealand

there are few clear professional guidelines to direct nurses with regard to determining whether practice does or does not constitute sexual misconduct. Although practice is situated within specific contexts, we have suggested that dialogue and clear policy statements about sexual misconduct need to be made so that nurses have clarity and guidance in knowing what is and is not acceptable practice. A review of the conceptual nursing literature on sexual misconduct suggests that education, awareness raising and honest discussion are also vital in operationalising guidelines. We therefore suggest that education, coupled with nurse led research is imperative, as there is a strong likelihood that sexual misconduct does occur. There are some encouraging signs that discussion of sexual misconduct is occurring in some places; however it is apparent that nurses need explicit guidance and support in this area.

References

American Academy of Orthopaedic Surgeons. (1995). *Opinion on ethics*. Retrieved March 30, 2003, from http://www.aaos.org

American College of Obstetricians and Gynaecologists. (1998). *Code of professional ethics*. Retrieved March 30, 2003, from http://www.acog.org

American Medical Association. (1995). *Current opinion of the council on ethics*. Retrieved March 30, 2004, from http://www.acog.org

American Psychological Association. (1998). *Code of ethics*. Retrieved March 27, 2003, from http://www.apa.org

A new code of ethics for medical practitioners. (2002, April 4). *The Press*, p. 4.

Bachmann, K., Bossi, J., Moggi, F., Stirnemann-Lewis, F., Sommer, R., & Brenner, H. (2000). Nurse-patient sexual contact in psychiatric hospitals. *Archives of Sexual Behaviour, 29*(4), 335-347.

Burgess, M. E. (2002). *A guide to the law for nurses and midwives* (2nd ed.). Auckland: Pearson Education New Zealand.

Canadian Mental Health Association, Ontario (1995). Canadian Mental Health Association Policy Statement. Retrieved September 10, 2003, from http://www.icomm.ca/cmhacan/english/policy

College of Nurses of Ontario. (2002) *Practice standards: Professional standards*. (Rev.). Retrieved October 2, 2004, from http://www.cno.org/docs/prac

Doyal, L. (1998). Crossing professional boundaries. *Nursing Management, 5*(4), 8-10.

Fox-Young, S. (1997). Professional boundaries. *Queensland Nursing Forum, 9*(4), 28-30.

Gallop, R. (1993). Sexual contact between nurses and patients. *The Canadian Nurse, 89*(2), 28-30.

Gallop, R. (1998). Abuse of power in the nurse-client relationship. *Nursing Standard, 12*(37), 43-47.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, J. (1986). Psychiatrist-patient sexual contact: Results of a national survey. *American Journal of Psychiatry, 143*, 1126-1131.

Health and Disability Commissioner. (2004). Health and Disability Commissioner case notes. Retrieved February 10, 2005, from http://hdc.org.nz

Health Practitioners Competency Assurance Act 2003, No 48 (18 September, 2003). Retrieved February 10, 2005, from http://www.knowledge-basket.co.nz

Leurquin – Hallet, L. (1999). Professional issues. Professional boundaries in nephrology nursing practice. *American Nephrology Nurses Association Journal, 26*(1), 80-82.

Lillibridge, J., Axford, R., & Rowley, G. (2000). The contribution of nurses' perceptions and actions in defining scope and stabilising professional boundaries of nursing practice. *Collegian, 7*(4), 35-9.

Medical Council of New Zealand. (1998). Sexual boundaries in the doctor-patient relationship. Retrieved March, 2004, from http://www.mcnz.org.nz

National Council of State Boards of Nursing Inc. (1996a). *Raising awareness of professional boundaries and sexual misconduct, 17*(2), Chicago. Retrieved September 9, 2003 from http://www.ncsbn.org/public/resources

National Council of State Boards of Nursing Inc. (1996b). *Professional boundaries: A nurse's guide to the importance of appropriate professional boundaries* [Brochure]. Chicago: Author.

New Zealand Nurses Organisation. (1993). *Social policy statement*. Wellington: Author.

New Zealand Nurses Organisation. (1995). *Code of ethics*. Wellington: Author.

New Zealand Nurses Organisation. (1998). *Standards for nursing practice*. Wellington: Author.

New Zealand Nurses Organisation. (2003). *Indicators of boundary crossings/violation* [Brochure]. Wellington: Author.

Nursing Council of New Zealand. (2000, February). *News update*. Wellington: Author.

Nursing Council of New Zealand. (2001). *Code of conduct* . Wellington: Author.

Nursing Council of New Zealand. (2002, February). *News update*. Wellington: Author.

Nursing Council of New Zealand. (2003, September). *News update*. Wellington: Author.

Pennington, S., Gafner, G., Schilit, R., & Bechtel, B. (1993). Addressing ethical boundaries among nurses. *Nursing Management, 24*(6), 36.

Peternelj-Taylor, C. (2002). Professional boundaries: A matter of therapeutic integrity. *Journal of Psychosocial Nursing and Mental Health Services, 40*(4), 22-43.

Peternelj-Taylor, C., & Yonge, O. (2003). Exploring boundaries in the nurse-client relationship. *Perspectives in Psychiatric Care, 39*(2), 55-66.

Poe, L., & Duke, L. (2000). Beware of boundary crossings: Keeping the professional relationship professional. *Utah Nurse, 9*(3), 4.

Rae, M., Murphy, M., & Collins, C. (1997). Breaking the chains. *Nursing Times, 93*(6), 26-28.

Sherrard, I. (1996). Abusing patient trust. *Kai Tiaki Nursing New Zealand, 2*(4), 26-27.

Sheets, V. (2001). Professional boundaries. Staying in the lines. *Dimensions of Critical Care Nursing, 20*(5), 36-40.

Smith, L., Taylor, B., Keys, A., & Gornto, S. (1997). Nurse patient boundaries: Crossing the line. *American Journal of Nursing, 97*(12), 26-31.

Taylor, K. (1998). Legal issues for nurses' sexual misconduct. *Lamp, 55*(3), 22-23.

Zook, R. (2001). Sexual misconduct by health care providers. *Journal of Psychosocial Nursing and Mental Health Services, 39*(6),40-49.