



opinion & debate

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Kerr/Haslam Inquiry into sexual abuse of patients by psychiatrists

Nearly 1000 pages of the Kerr/Haslam Inquiry report published in July 2005 tell in detail how, over a period of more than two decades, according to many female patients, two male psychiatrists working from the same hospital were able to sexually abuse them. By the time police investigations and the Inquiry were complete, a total of 67 patients had declared themselves victims of William Kerr and at least 10 of Michael Haslam. Kerr was convicted in 2000 on one count of indecent assault. He was considered too ill to face trial but was convicted on trial of the facts. Haslam was convicted on four counts of indecent assault in 2003 and was given a 3-year prison sentence.

Although this North Yorkshire tragedy may have had extraordinary features, the Inquiry panel, led by Nigel Pleming QC, concluded that sexual abuse of psychiatric patients by mental health professionals is probably endemic and widespread. The 70 plus recommendations are for the entire National Health Service (NHS) and are designed to address the 'cultural, systemic, and moral failures' that allow repetition of such abuses without effective action. The recommendations have far-reaching implications for all psychiatrists.

Background

William Kerr was disciplined in the mid-1960s when a psychiatric registrar in Northern Ireland for allegedly having sexual intercourse in his car with a teenage patient whom he told needed this for her therapy. He was advised to leave the province if he wished to continue a medical career. He was able to obtain a post in York, then promotion to consultant without the disciplinary history being passed on to his new employer. There followed year-by-year (over the 1970s and 1980s) reports of repeated sexual incidents with patients. A few were alleged at the time but most not until 10–20 years later when the publicity of a police investigation gave patients courage to come forward with the knowledge that they were not alone. The alleged incidents generally occurred during domiciliary visits or out-of-hours consultations at isolated hospital sites. Patients reported that Kerr exposed himself and 'invited' sexual acts – often

masturbation or oral sex, but in some cases full sexual intercourse. Kerr's ability to make patients comply with his wishes left them feeling confused and with guilty feelings that inhibited complaints at the time.

Michael Haslam's patients described more subtle grooming which led gradually to sexual intimacy that sometimes became consensual for periods of time. Grooming included prolonged interviews, over-detailed sexual inquiry, self-disclosure, social meetings, and supposedly affectionate touching and hugging. Patients were made to feel special by being recruited for 'research' using a Kirlian camera to detect their 'hand auras'. Unorthodox 'therapies' were given which included Somlec (weak electrical application to the temples), carbon dioxide inhalation for relaxation and unchaperoned whole body massage. All these were predominantly for younger female patients and, again, were often given out of hours in isolated hospital locations or private practice rooms.

A minority of patients divulged the abuse at the time to a general practitioner (GP), a psychiatric nurse or another psychiatrist. Most professionals did no more than pass on this 'gossip' to colleagues and alter referral habits. Patients said they had expected much more decisive action. Ironically, concern was expressed about Kerr on one occasion to his wife, also a consultant psychiatrist, and on another occasion to Haslam. The very few patients who submitted formal written complaints all declined to take part in any formal disciplinary proceedings – sometimes after intimidation by the psychiatrist concerned ('No one will believe you against the word of a consultant').

Investigations were drawn to an early conclusion at hospital, district and regional levels for lack of sufficient evidence. The General Medical Council (GMC) was not contacted because of the prevailing and probably correct view at the time that no action would be taken without a complainant witness. Until very recently the burden of proof at a GMC hearing had to be 'beyond reasonable doubt' rather than as it is now 'on the balance of probabilities'. Haslam was allowed voluntarily to remove his name from the GMC register in the late 1990s to avoid a disciplinary hearing, even though several complainants were by then willing to give evidence. The reason given by



the GMC was that should proceedings against him fail he would be able to continue treating patients.

Some key issues

Many GPs, psychiatrists and nurses had heard allegations or gossip that abuse might be going on but only a few took action. The Inquiry attributed this general failure to:

- colleagues putting the interests of professionals before patients
- consultants being 'all powerful'
- a lack of clarity on what (in the sphere of sexual relations) are the boundaries that define professional misconduct or criminal behaviour
- poorly developed and understood processes for dealing with rumour, unsubstantiated or withdrawn allegations.

Managers failed to recognise that reluctant complainants needed sensitive and skilled support if they were to cope and perhaps contribute to further investigation. The making and retention of records of investigations was very poor. No systems exist in the NHS for carrying forward a continuous record of proven or unproven concerns about an individual as they change employer or organisations are restructured. Had these systems been in place it would have been evident much earlier that something was seriously amiss with the practices of both psychiatrists, even though no single allegation or rumour provided sufficient proof. Patients whose care was transferred to another consultant were disappointed that their therapy and their case notes did not include detailed coverage of the abuse and the distress it caused.

Boundaries

The Inquiry repeatedly demonstrated that mental health professionals are far less clear than they should be on what is and is not acceptable behaviour. Concepts of 'transference' and 'countertransference' may appear muddlesome and can be used as a potential smokescreen for malpractice. Unless patients, managers, GPs and all mental health staff have the clearest guidelines approved by authoritative bodies, such as Colleges, the Department of Health and employers, it is likely to be difficult for transgressions to be identified and remedied quickly. The trainee, and even the well-intentioned trained clinician, may be on a slippery slope to a harmful sexualised relationship without knowing it. The abuser deliberately using inappropriate behaviours as grooming techniques cannot be confronted. The lack of clarity has been such that Haslam, on behalf of the Society of Clinical Psychiatrists, felt able to write an open letter to the *British Medical Journal* responding to a paper by Fahy & Fisher (1992) arguing strongly against the latter's conclusion that sexual relations with patients are always harmful.

Some other countries have gone much further in defining professional boundaries than we have in Britain because it has been recognised that sexual abuse of patients by health professionals is more common than we know.

How common?

Donaldson (1994), when a regional medical officer in the north-east of England, had serious concerns about 6% of consultants in the region brought to his attention over a 5-year period. Psychiatrists were proportionately represented and in half of their cases the concern was of sexual behaviour with patients. Very long periods of between 2 and 20 years had elapsed from the concern first being felt by colleagues to action being taken at regional level to protect patients – usually early retirement. Of the 20 doctors referred to the GMC's disciplinary committee for improper sexual relations with patients between 1995 and 2003, 7 were psychiatrists. Hardly any research on prevalence has been conducted in this country, but the Inquiry noted that it is fair to assume that sexual contacts between health professionals and their patients are vastly underreported.

International studies reviewed in the Inquiry report suggest a fairly constant figure of 3–6% of doctors who have engaged in intimate sexual contact with patients, where there is no indication of assault. In so far as that estimated range can be extrapolated, the startling figure of somewhere between 6500 and 13 000 doctors registered with the GMC are having, or have had, a sexual relationship with one or more of their existing patients. Psychiatrists, GPs and gynaecologists are likely to be particularly at risk. About a third of abusive doctors may be repeat offenders. Studies confined to therapists, rather than doctors generally, raise the prevalence to around 7–9% of male therapists and 2–3% of female therapists admitting to sexual relationships with patients.

Some particular challenges

The Inquiry report recognises that not all allegations of this kind are true – some evidence obtained for the Inquiry suggests that perhaps 2% are false. It also recognises that rumour and gossip can be grossly misleading. However, when rumour, gossip and withdrawn or unsubstantiated allegations refer to the same person repeatedly, the balance of probability grows that patients are being harmed. Hence, the report challenges the absence of a clear moral and contractual obligation for all mental health professionals to report all such information, and the lack of an NHS system to maintain an accessible memory bank of all such data. Will the professions fear this as a 'big brother' scenario or welcome it as essential protection of their patients and their credibility? How would vexatious anonymous complainants be prevented from abusing such a database?

Circumscribing clinical practice by defining behaviours that will no longer be acceptable would greatly aid early detection and prevention. Self-disclosure, extensive



opinion & debate

sexual inquiry, twosome social meetings, isolated clinics, unaccompanied home visits and casework without supervision (even for consultants) could be up for discussion. Such behaviours might be moved from the 'be careful' to the 'absolutely prohibited' category. What are the limits to comforting touches? Managers and patients should not be bamboozled by the esoterics of such concepts as transference in collecting circumstantial evidence. Trainees should be clear about safe practice from the outset of their careers. However, would the profession welcome and police these limits to their clinical freedom?

The fear and reluctance of patients to pursue a complaint of sexual abuse has many powerful and complex reasons. Had there been skilled therapeutic support to help deal with the distress caused by abuse and then overcome inhibitions about bearing witness, the outcome might have been better for the patient and prevented others being abused. However, would the training of therapists for such roles be seen as producing 'agent provocateurs' trawling for trouble to frame consultants? Or, would the best psychotherapists see research and training in this aspect of care as supremely important work for the benefit of patients and to protect the reputation of the psychiatric profession?

Recommendations

Below is a brief summary of recommendations in the Inquiry report which are most relevant to the issues raised in this paper:

- Any job application should include references from three previous employers and the consultant who conducts the applicant's appraisal.
- Guidance should be published in relation to clinical supervision of consultants.
- All trusts should develop guidance to reduce the likelihood of sexualised behaviour and to be incorporated into contracts of employment.
- An expert group should develop guidance and best practice on boundary setting, boundary transgressions, sexualised behaviour and all forms of abuse of patients in mental health services. This guidance should address former as well as current patients.
- The context in which staff have a positive obligation to inform NHS management of suspicions regarding possible abuse of patients should be clarified.
- Strategic health authorities should set up telephone helplines where anonymised or identified concerns could be received, and consideration given to a national database for collection and retention of complaints, allegations or informal concerns, whether substantiated or not, that would be retained for the lifetime of a mental health professional.
- Detailed research should be carried out on the prevalence of sexualised behaviour between mental health practitioners and existing or former patients.

Some personal views and conclusions

The author was consultant psychiatrist then manager of the service in which Haslam worked during the 1980s. He was therefore a witness to the Inquiry and along with many others had to reflect hard on previous decisions and actions. With that hindsight the report is a fair analysis of collective failure. It is so thorough and all-encompassing that its two large volumes will not be widely read and understood. Worse, there is a possibility that some will be quite incredulous that an amazing and horrifying local story like this has far-reaching national implications. Therefore some priorities for action might be:

- The executive summary of the Inquiry report, or better still a précis especially written for clinicians, is made available for the early attention of all psychiatrists and trainees.
- Medical directors start to engage consultants in discussions about the local practicalities of prevention, early identification and action on any possible sexual abuse of patients by staff. This may not only be the quickest way of raising awareness of a significant risk but also help to inform and advise what action at trust and national levels would be most practical and effective.
- Recommendations in the Inquiry report that especially need to be developed with the skills and self knowledge of the profession are: (a) the production of clearer guidance on physical and sexual boundaries in professional relationships; and (b) the psychological management of patients who have made allegations of abuse.
- Academic colleagues start to devise methodologies for researching prevalences and trends in sexualised relations between staff and patients.

Unless the psychiatric profession responds strongly, positively and effectively to the contents of the Inquiry report we shall be in danger of being as compromised as some church hierarchies have been in dealing with their pederast priests. If we wait to be told what to do rather than take initiatives we could get less satisfactory guidance and be criticised for passivity on matters of such paramount importance to patients.

Declaration of interest

P.K. was consultant psychiatrist in York and general manager from 1986.

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