Three years on:
changes in regulatory practice since

Independent review of the use of chaperones to protect patients in Australia

Commissioned by

the Australian Health Practitioner Regulation Agency (Ahpra)
and the Medical Board of Australia

Report by

Professor Ron Paterson

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Part A Overview

Purpose of review

In October 2019, the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia (MBA) commissioned this 'Three years on' review, following my 2017 report, *Independent review of the use of chaperones to protect patients in Australia* ('the chaperone review report' or 'the report'). Key conclusions in the report were that 'Patients, practitioners and the public deserve prompt, thorough, fair and consistent action in the interim period while the truth of sexual misconduct allegations is established. Interim restrictions must be workable, acceptable to patients, and adequate to protect the public.'[1] 'The use of chaperones to protect patients in the interim situation – while allegations of sexual misconduct are investigated – should be replaced by gender-based prohibitions and suspensions.'[2]

A raft of 28 recommendations ('the recommendations') were set out in the report. Ahpra and the MBA announced, in April 2017, that all the recommendations would be adopted, and in August 2017 reported 'significant progress' in implementation.

The purpose of the current review is to assess the progress over the past three years, specifically:

1) what has been achieved since the report?
2) what has been the impact of implementation of the recommendations?
3) are chaperones / practice monitors now being imposed only in exceptional cases?
4) what recommendations have been implemented partly or not at all, or too broadly?
5) have there been unintended consequences from implementation of the recommendations?
6) how are notifier and practitioner voices being reflected in regulatory processes and decisions?
7) what further changes in regulatory practice would be beneficial?

The full Terms of Reference for this 'Three years on' review are in **Appendix B**.

Reviewer

The review has been undertaken by Ron Paterson, Professor of Law at the University of Auckland and Distinguished Visiting Fellow at Melbourne Law School. He was New Zealand Health and Disability Commissioner 2000–2010 and New Zealand Parliamentary Ombudsman 2013–2016. Professor Paterson is an international expert on patients' rights, complaints, healthcare quality and the regulation of health professions.

Review process

The review process involved interviews (in person and by telephone) in November 2019 and February 2020 of Ahpra staff, the Chair and Deputy Chair of the Sexual Boundaries Notifications Committee (SBNC), the Chair of the MBA, the National Health Practitioner Ombudsman and Privacy Commissioner, and representatives of medical defence organisations. To complete the national picture of current regulatory

[1] Report p 6.
[2] Report p 10.

practice, information was obtained from the Queensland Health Ombudsman and the Health Professional Councils Authority (NSW). International practice (in handling allegations of sexual misconduct by doctors) was reviewed by obtaining information from a selection of leading medical regulators: the General Medical Council (UK), the College of Physicians and Surgeons of Ontario, the Washington Medical Commission and the Medical Council of New Zealand.

In-depth analysis of sexual boundary notifications (including review of decisions, update letters and 'no further action' letters) and Ahpra data, policies and processes has informed the review. De-identified feedback from notifiers and practitioners surveyed after closure of a sexual boundary notification was also reviewed. Attendance at a confidential SBNC weekly teleconference meeting, in November 2019, provided helpful insights into decision-making. Relevant case law from tribunals and courts since April 2017 has also been analysed, as well as recent literature about sexual misconduct and health practitioners.

Acknowledgments

I thank Martin Fletcher, Chief Executive, Matthew Hardy, National Director Notifications and numerous Ahpra staff, who provided detailed written and face-to-face briefings and access to confidential files. I am especially grateful to Sharon Gaby, Operations Manager, Boundary Violation and Sexual Misconduct, who provided prompt and helpful assistance throughout this review.

My thanks also to MBA Chair Dr Anne Tonkin and SBNC Chair Christine Gee, and members of the SBNC, for their thoughtful contributions. It was a privilege to attend a confidential SBNC meeting.

I acknowledge the assistance of National Health Practitioner Ombudsman and Privacy Commissioner Richelle McCausland. In the co-regulatory jurisdictions of New South Wales and Queensland, I thank the Director of the Health Professional Councils Authority (HPCA), Ameer Tadros and the Queensland Health Ombudsman, Andrew Brown and Elizabeth Foulger, Director of the Office of the Health Ombudsman, who provided helpful comparative information and data. I also thank the representatives from leading Medical Defence Organisations who agreed to be interviewed.

International medical regulatory bodies were also generous with their time and assistance. I thank Medical Council of New Zealand CEO Joan Simeon and Lead Legal Advisor Emma Kennedy; College of Physicians and Surgeons of Ontario Associate Registrar Sandra McCulloch; Washington Medical Commission Executive Director Melanie de Lore; and General Medical Council Assistant Director Anna Rowland.

For a Summary of meetings undertaken for this review, see **Appendix C**.

Part B Context

Over the past three years, there has been an unprecedented level of discussion in the print and social media about sexual abuse by individuals (predominantly male) in positions of power in the church, sports teams, the entertainment industry, workplaces and the health professions. The #MeToo movement, which began following publicity about multiple sexual abuse allegations against US film producer Harvey Weinstein in October 2017, has gained a huge social media following around the world. In the doctor-patient setting, the risk of multiple offending by a predatory doctor was highlighted in the case of gymnastic sports doctor Larry Nassar of Michigan State University. Nassar was convicted of sexual assaults on minors in 2018 and sentenced to life imprisonment after more than 250 women and girls accused him of sexually abusing them during medical examinations and purported treatments.

In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse has had a major impact. In a series of reports, the Commission highlighted the prevalence of myths about reporting of sexual abuse and weaknesses in the traditional responses of authorities and the criminal justice system to allegations of sexual abuse. As was evident in the high-profile case of Cardinal George Pell, prosecuted for sexual abuse of two choirboys in the 1990s when he was Archbishop of Melbourne, contemporary juries may be willing to believe uncorroborated but credible historic allegations about the actions of men in positions of power – although if there is credible evidence raising a reasonable possibility that the offending had not taken place, a conviction may be set aside on appeal.[3]

Sexual harassment of junior medical staff in Australia has also been exposed as a significant problem, leading to concerted educational programs from colleges (notably the *Building Respect, Improving Patient Safety* program of the Royal Australasian College of Surgeons, tackling bullying, discrimination and sexual harassment in surgery). Cases of multiple, historic alleged sexual abuse by doctors continue to gain prominent media attention in Australia.[4] There has been a surge in reports of alleged sexual misconduct to Ahpra[5], with a 48% increase in sexual boundary notifications against doctors in 2018/19 (to 209 matters) over the previous year.[6] Some tribunals are taking a tougher line in cases of proven sexual misconduct. In May 2020, the South Australian Civil and Administrative Tribunal found Dr Mario Athinodorou guilty of professional misconduct for sexual assaults on female patients over 15 years. The Tribunal cancelled his registration and imposed a ban of 13 years from applying for re-registration – one of the longest ever bans imposed on a health practitioner in Australia.[7]

The chaperone review report has prompted renewed interest in the problem of sexual abuse of patients by doctors, and the topic has featured in the program of international regulatory conferences over the past three years. The report has influenced policy and practice internationally. Many regulators are revising their processes for handling sexual boundary notifications to enhance public protection. Recent examples

[3] As occurred when the High Court of Australia allowed Cardinal Pell's appeal against conviction: *Pell v The Queen* [2020] HCA 12.
[4] See, for example, C Houston, 'Doctor accused of assaulting 50 women won't stand trial', *The Age,* 28 August 2019.
[5] M Davey, 'Surge in sex misconduct reporting', *The Age*, 5 December 2019.
[6] Briefing papers for SBNC meeting, October 2019.
[7] 'SA doctor banned from practising for 13 years', 20 May 2020, available at: https://www.ahpra.gov.au/News/2020-05-20-SA-GP-banned-for-13-years.aspx .

include an independent review for the College of Physicians and Surgeons of Nova Scotia[8] and, in the United States, a Federation of State Medical Boards Workgroup report on *Physician Sexual Misconduct*.[9]

Medical regulators in New Zealand, Canada and the United Kingdom are grappling with similar issues to those discussed in this review. The General Medical Council (UK) reports that its position on the importance of considering the risk to public confidence in serious cases, even when the doctor does not appear to pose a direct risk to patients, remains unchanged.[10] The College of Physicians and Surgeons of Ontario continues to use practice monitors as an interim condition, provided that such conditions are not gender-based. An extensive training program is in place for practice monitors, and for practices with multiple sites, including hospitals, a practice monitor 'supervisor' is also required. The New Zealand Medical Council has focused on removing barriers to notification for boundary violations, in an effort to remove or mitigate the stigma, fear and intimidation experienced by some notifiers. There has been considerable investment in specialised training for staff and Council members handling sexual boundary notifications.

New research has analysed the nature and consequences of publicly reported sexual violations by physicians in the United States,[11] the characteristics of notifications to health regulators alleging sexual misconduct by health practitioners in Australia[12] and types of sexual misconduct in health and social care in the United Kingdom.[13]

These developments are relevant context for consideration of the steps taken by Ahpra and the MBA to implement changes in their handling of allegations of sexual abuse[14] by a practitioner. The zeitgeist has changed, with victims more willing to speak up; recognition that sexual abuse by trusted professionals or people in positions of authority is less rare than previously assumed; intolerance of slow or ineffective responses by authorities to whom abuse is reported; increased sensitivity to the needs of victims; and growing awareness that the handling, investigation and determination of allegations of sexual abuse requires specialised skills and training.

This context has made it both timely for Ahpra and MBA to reform how allegations of sexual abuse are handled, and essential that changes adopted are fit for purpose.

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[8] *Independent Review of Sexual Misconduct Processes at the College of Physicians and Surgeons of Nova Scotia*, 2019.
[9] In May 2020, the Federation of State Medical Boards (FSMB) adopted as policy the FSMB Workgroup report, with far-reaching recommendations to address and prevent sexual misconduct by physicians. See *Physician Sexual Misconduct* (FSMB Workgroup report, 2020) available at: http://www.fsmb.org/siteassets/advocacy/policies/report-of-workgroup-on-sexual-misconduct-adopted-version.pdf .
[10] Advice from GMC Assistant Director Anna Rowland, March 2020.
[11] J DuBois et al, Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sexual Abuse* 2019, 31(5), 503-523.
[12] M Bismark, R Paterson et al, Sexual misconduct in the health professions, 2011-2016: a retrospective analysis of notifications to health regulators, *Medical Journal of Australia* 2020, available at https://onlinelibrary.wiley.com/doi/full/10.5694/mja2.50706 .
[13] R Searle, Sexual Misconduct in Health and Social Care: Understanding Types of Abuse and Perpetrators' Moral Mindsets, Professional Standards Authority, 2019.
[14] In this report, I use the terms sexual abuse and sexual boundary violation interchangeably to refer to situations of boundary violation and sexual misconduct.

Part C Key findings[15]

1 Nearly all recommendations fully implemented

Much has been achieved over the past three years. Nearly all 28 recommendations of the chaperone review report have been fully implemented, resulting in significant changes in regulatory practice. Some work is well advanced but ongoing: the development by Ahpra of highly specialised staff and investigators for handling sexual misconduct cases (rec 3); and the development of MOUs with police, to ensure good communication and information sharing between Ahpra and police (rec 8). Recommendation 20, that the National Law be amended to allow a National Board to require a practitioner to disclose the reasons for a restriction to patients and to permit chaperones / practice monitors to be fully briefed about those reasons, has been only partly implemented. Legislative change is ultimately an issue for Health Ministers and Parliaments, not Ahpra.

The detail of implementation of each recommendation is set out in **Appendix A**. I have reviewed the table of actions taken by the MBA and Ahpra, and confirm that the information is accurate and consistent with my findings.

2 Major impact from changes in regulatory practice

Government agencies are often quick to report full compliance with recommendations made by independent reviewers, when closer scrutiny suggests that little has changed. My in-depth assessment of current practice is that the changes made by Ahpra and the MBA, in response to the chaperone review report, have been wide and deep. The impact of implementing the recommendations has been profound in terms of how notifications of alleged sexual abuse are dealt with by regulators. It is too early to say whether the changes will flow on to have a positive impact on patients and the public, but there are promising signs.

As detailed below, the use of mandated chaperones has been abandoned – instead, gender-based prohibitions and suspensions are imposed more frequently. There is evidence of more consistent decision-making, more expertise in handling sexual boundary notifications, greater sensitivity to the needs of notifiers and enhanced protection of the public, in cases where an alleged sexual boundary violation by a medical practitioner is notified to Ahpra.

Chaperones abandoned in favour of gender-based prohibitions and suspensions

The most striking impact of the implementation of the recommendations has been the abandonment of the use of mandated chaperones, which have all but disappeared from the regulatory landscape of the National Scheme. Even though practice monitors have been retained as a possible interim restriction for use in exceptional cases, the MBA and other National Boards have rarely imposed them. In cases when the MBA (or other National Board) reasonably believes there is a need for immediate action to protect public health or safety, or in the public interest, a gender-based prohibition or suspension is imposed more frequently. Relevant data appears in point 3 below. These changes represent a dramatic change in regulatory practice and a recognition that a traditional regulatory tool, the chaperone condition, is no longer fit for purpose.

The chaperone review report has been cited to tribunals in numerous proceedings over the past three years. In *Gerstman*, the Victoria Civil and Administrative Tribunal (VCAT) stated 'while chaperone conditions might have been considered in the past, their use has been limited followed the 2017 report…'.[16] In *Al-*

[15] The key findings mirror the Terms of Reference set out in Appendix B.

[16] *Gerstman v Medical Board of Australia* [2019] VCAT 830 at 66.

Naser, the ACT Civil and Administrative Tribunal upheld a gender-based prohibition imposed by the MBA on a medical practitioner as an immediate action, in response to notifications alleging multiple boundary violations with a vulnerable patient. The tribunal cited the report in support of the limited effectiveness of chaperones in protecting patients.[17]

Nonetheless, in some cases, tribunals continue to countenance use of a chaperone condition as an immediate action, seeing it as an effective risk mitigation strategy to minimise the risk of harm to patients. Notable examples are the *Colagrande* and *Phillips* decisions. In *Colagrande*, a Queensland tribunal permitted a cosmetic surgeon, who had been found guilty of sexually assaulting a patient during a follow-up consultation after a breast augmentation procedure, to see female patients in the presence of a chaperone: 'It was not a case where … the practitioner is a sexual predator or has shown a tendency towards that type of conduct.'[18] In *Phillips*, a New South Wales tribunal overturned a gender-based restriction and permitted an osteopath facing serious criminal charges of aggravated indecent assault and aggravated sexual assault – and with history of prior allegations of sexual misconduct – on the basis that a mandated chaperone was adequate to protect female patients.[19]

Two VCAT decisions are also of note in relation to limits on practice. In *Espedido*, VCAT ordered a stay of a gender-based restriction (no female patients) imposed by the Physiotherapy Board of Australia as an immediate action, following an alleged sexual assault; instead, an unusual order was substituted that he not 'treat the pelvic region of female patients'.[20] The tribunal emphasised that leaving the gender-based restriction in place would have severe financial consequences on Espedido and render any final hearing nugatory.

In *Gerstman*,[21] VCAT ordered a stay of a gender-based prohibition (no female patients) imposed by the MBA on an endocrinologist after multiple notifications of inappropriate breast examinations. The tribunal was satisfied that there was no element of sexual predation but rather issues of information, understanding and consent. It substituted a condition that Gerstman not undertake breast examinations on female patients.

As noted in the chaperone review report, '[i]t is not appropriate for a regulator to limit the ability of a practitioner to provide clinically appropriate care, absent concerns about the quality of care'.[22] It seems equally dubious for a tribunal to carve out areas of clinical practice in relation to patients a practitioner is permitted to treat.

Tribunals have also on occasion substituted a gender-based restriction for a suspension. In *Milky,* a GP had been suspended as an immediate action by the MBA, following notifications from 12 female patients, over many years, alleging serious boundary violations. VCAT granted a stay and substituted a gender-based and place of practice restriction (no female patients, three specified practice locations), based on 'the absence of demonstrated risk at this point to non-female patients, or to public confidence in the profession'.[23]

These decisions suggest that the thinking of tribunals about alleged sexual misconduct by health practitioners is still evolving and may not yet reflect changing community expectations. Judicial officers may

[17] *Al-Naser v Medical Board of Australia* [2019] ACAT 110 at 63.
[18] *Colagrande v Health Ombudsman* [2017] QCAT 107 at [46].
[19] *Phillips v Osteopathy Council of New South Wales* [2017] NSWCATOD 50.
[20] *Espedido v Physiotherapy Board of Australia* [2017] VCAT 1401.
[21] *Gerstman v Medical Board of Australia* [2019] VCAT 830.
[22] Report, p 79.
[23] *Milky v Medical Board of Australia* [2019] VCAT 1780 at 92.

not yet have grasped what an Ontario Court of Appeal judge has referred to as 'the shift that has taken place in society's understanding of the consequences of physician sexual abuse and its tolerance for such behaviour'.[24]

More consistent decision-making

In 2016 the approach of state and territory Board committees of the MBA, in handling allegations of sexual boundaries notifications, was not consistent – a reflection of 'changing membership of Board committees and differing advice from [Ahpra] staff in local offices…'.[25] The establishment, in July 2017, of a single delegate committee of the MBA to handle these cases – the Sexual Boundaries Notifications Committee (SBNC) – has, as anticipated, led to far more consistent decision-making.

A lot of work has gone into orientation and ongoing training of committee members and information sharing through detailed monthly newsletter updates (with a Chair's report and summaries of relevant case law and media reports), regular Zoom meetings and six-monthly face-to-face meetings. The SBNC Chair, Christine Gee, has continued the work begun by inaugural SBNC Chair, Anne Tonkin, to develop a professional and consistent approach to decision-making. The membership of SBNC six-person notifications committees, with three members carrying over from one weekly meeting to the next, helps ensure some continuity between Part 1 and Part 2 deliberations under the 'show cause' process required by section 157 of the National Law.

The SBNC is greatly assisted in taking a consistent approach by internal changes at Ahpra, which mean that its relevant support functions are truly national, rather than local. Two national Operations Managers, Boundary Violation and Sexual Misconduct, who work closely with the SBNC Chair and relevant Ahpra staff, and attend SBNC meetings, have played a key role in improving regulatory practice. In 2017, Ahpra established a national Immediate Action team to manage all immediate actions involving medical practitioners, including notifications identifying allegations of sexual misconduct or sexual boundary violations.[26] Other critical changes have been the creation of single national Notifications, Legal and Compliance teams within Ahpra. Staff receive a monthly newsletter with updates from the SBNC and summaries of new tribunal and court decisions.

These developments reflect the maturing of the National Scheme after nearly a decade, rather than implementation of the chaperone review report, but they have enabled the handling of notifications of alleged sexual boundary breaches by medical practitioners to become an exemplar of rigorous and consistent decision-making under the National Law. Although the national teams comprise staff in different state and territory offices, the managers within each team meet regularly and seek to ensure a consistent, national approach to their various functions. While it is essential that the SBNC, like all National Board committees, assesses the evidence and exercises its own discretion in making decisions, it is interesting to note that immediate action was not taken after being proposed in only 11% of cases in 2018/19, compared with 43% of cases in 2017/18.[27] An audit of SBNC decisions over the past six months shows that in making Part 2 immediate action decisions, the committee accepted the recommendations (in papers prepared by Ahpra staff) in 15 out of 23 cases.

[24] *College of Physicians and Surgeons of Ontario v Peirovy* [2018] ONCA 420 at [153] per Benotto J, dissenting.
[25] Report p 77.
[26] The national Immediate Action (IA) team now manages notifications in which IA is being considered, for all registered health practitioners.
[27] Briefing papers for SBNC meeting, October 2019.

More expertise in handling sexual boundary notifications

My interviews with Ahpra staff and the SBNC Chair and Deputy Chair confirmed that there is much more understanding about the complexities of handling sexual boundary notifications and growing confidence and expertise in doing so.

Ahpra's investment in specialist training and skills, with well planned and executed education of staff and National Board members, has been impressive. A three-day 'Sexual Boundaries Investigations Training' course is offered to Ahpra staff every six months and has been attended by many Notifications and Immediate Action staff handling sexual boundary cases. It includes workshops led by experts (including Annitia Rynhart, Ahpra's first Operations Manager, Boundary Violation and Sexual Misconduct, and Narelle Fraser, ex Victoria Police). Staff receive training in planning and managing sexual boundary investigations, managing an initial phone call related to a sexual boundary notification and planning for interviews of patients, notifiers and witnesses.

New SBNC members are inducted into the committee's work and, like Ahpra staff working on sexual boundary cases, have access to several expert Webinar presentations (e.g. one from Mark Barnett, also ex Victoria Police, on 'Challenging misconceptions about sexual offending – empirical evidence'). At the six-monthly face-to-face meetings of SBNC, members have presentations on topics such as:

- contemporary understanding of offender and victim behaviour in the sexual assault / abuse field
- consistency in decision-making using case studies and scenarios
- sexual conduct via social media
- natural justice issues in decision-making
- considerations of bias and how it can influence decision-making.

There has been a sustained effort to educate Ahpra staff and SBNC members about misconceptions and myths in relation to sexual boundary cases. Ahpra has drawn on the excellent resources available from Victoria Police[28] and on the website of the Royal Commission into Institutional Responses to Child Sexual Abuse.[29] Staff and SNBC members spoke very positively about the training and resource materials available to them. A presentation by Gail Furness SC, Counsel Assisting the Royal Commission into Institutional Responses to Child Sexual Abuse, at the NRAS (National Registration and Accreditation Scheme) annual conference in 2019, was reported to have been powerful and educational.

Ahpra's initiatives are consistent with a recommendation of the recent FSMB Workgroup report on *Physician Sexual Misconduct*, that all state medical board members involved in sexual misconduct cases and staff who work with complainants in cases involving sexual misconduct, should undergo training in the areas of sexual misconduct, victim trauma and implicit bias.[30]

Greater sensitivity to needs of notifiers

The training and in-house initiatives taken by Ahpra have also increased the sensitivity of staff to the needs of notifiers in sexual boundary cases. In the time available during this review, I have not been able to speak to individual notifiers about their experience of the process. However, I have reviewed anonymous feedback from notifiers surveyed after their file had been closed, as well as a random sample of update letters and NFA ('no further action') sent to notifiers. Given that the majority of notifications conclude with

[28] For example, the Victoria Police Fact sheet: Challenging misconceptions about sexual offending, available at: https://www.police.vic.gov.au/sites/default/files/2019-01/FINAL-factsheet-for-web-Challenging-Misconceptions.pdf .
[29] Available at https://www.childabuseroyalcommission.gov.au .
[30] *Physician Sexual Misconduct*, FSMB Workgroup (2020), recommendation 21.

an NFA decision, it can be difficult to tease out dissatisfaction with the process from dissatisfaction with the outcome.

Analysis of survey feedback indicates that more can be done to improve communication during and at the end of the process.[31] In a recent quarterly survey, one third of notifiers across the full range of notifications reported not knowing who to contact at Ahpra about their file; less than half reported receiving a regular update.[32] This issue is discussed further under point 7 below.

The following is one recent example of due sensitivity to the needs of a notifier. Ahpra received a referral of a notification of an alleged sexual boundary violation and noted delays in the initial assessment by another health regulator. Following an initial risk assessment, staff contacted the notifier, acknowledged that her matter had been delayed, and committed to assessing and managing her concerns as quickly as possible. The notifier was requested, if she was comfortable, to take the staff member through the events that led her to make a notification. Following this initial contact, the notifier advised that she was grateful someone had acknowledged the delay prior to her raising it as an issue and that an Ahpra officer had taken the time to listen to her concerns.[33]

Changes to the National Law mean that notifiers can now be lawfully informed by a National Board of a decision to take immediate action and the reasons for that decision, and of decisions and reasons at the end of an investigation.[34] These changes have been reflected in operational practice at Ahpra by the adoption of a common protocol, which is understandably generic in its guidance: for example, reasons for a decision should be 'limited to responding to the concerns raised by the notifier' and 'written in plain English so that they can be easily understood'.[35] Ahpra's Legal team has worked with staff and National Boards to simplify the language used to explain reasons in letters to parties.

In my view, there is scope to provide slightly more informative and empathetic letters to notifiers, in accordance with the National Law and without breaching the Australian Privacy Principles. This issue is discussed further under point 7.

Enhanced protection of the public

It is not possible to state definitively that the community is safer in 2020 because of the changes implemented by Ahpra and the MBA in response to the chaperone review report. However, the new ways of handling sexual abuse allegations against medical practitioners are designed to ensure more effective protection of the public in such cases, and have led to the MBA taking immediate action more often in sexual boundary matters (31 times in 2018/19 compared with 20 times in 2017/18),[36] and to increased use of gender-based restrictions[37] and suspensions rather than chaperones as interim restrictions.

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[31] Better communication with notifiers and practitioners is identified as a key area for improvement in S Biggar, L Lobigs, M Fletcher, How can we make health regulation more humane? A quality improvement approach to understanding complainant and practitioner experiences. *Journal of Medical Regulation* 2020, 106(1), 7-15.

[32] Notifier and practitioner engagement dashboard Q2: October to December 2019. Under the National Law, s 161(3), National Board must give written notice of the progress of an investigation at least every three months, to the notifier and the practitioner.

[33] Cited in Notifier and practitioner engagement dashboard Q4: April to June 2019.

[34] National Law, ss 159A, 167A.

[35] Common protocol for informing notifiers about reasons for decisions, August 2018.

[36] SBNC Chair presentation to Tasmanian Board of MBA, October 2019.

[37] I use the term gender-based restriction interchangeably with gender-based prohibition; both mean that the practitioner is prohibited from seeing patients of the specified gender. A restriction requiring a practitioner to see

Fairness for practitioners remains essential. I have not seen evidence that the increase in the number and level of immediate actions has been achieved at a cost of fairness for practitioners. They continue to be appropriately represented by medical defence lawyers, and tribunals and courts seek to ensure procedural and substantive justice in the cases brought before them, as discussed below.

Ahpra takes a risk-based approach to regulation across all professions.[38] Its risk assessment work is leading edge and highly regarded by other international health practitioner regulators.[39] A regulatory risk assessment tool has been developed, which takes into account the characteristics of the notification, the practice, the practitioner and the practice setting as a guide to assigning a risk rating. Only after assessing the level of risk are any risk controls in place considered (e.g. steps taken by the practitioner or their employing organisation since the notification).

A notification of an alleged boundary violation or sexual assault is presumed to be a high-risk concern and assigned a 'red flag' in the Notifications record in Ahpra's internal electronic file system, Pivotal. 'Red flag' notifications are escalated to a team leader as soon as practicable for further review and consideration of referral to the Immediate Action team.

Improved data collection and internal reporting on sexual boundary notifications helps Ahpra managers maintain an overview of these cases. In early 2018, Ahpra introduced a 'case flag' field to its database, to enable all notifications involving a sexual boundary issue to be more readily searchable.

Case conferencing has been introduced to plan complex investigations and find strategies to progress files that are stalled. Interviews of practitioners are used to clarify evidence. This can help reduce the length of an investigation, especially if practitioners make admissions about the alleged conduct during the interview. This may, in turn, shorten any subsequent tribunal proceedings, if agreement can be reached on the facts, outcome and proposed penalty at mediation, rather than in a contested hearing. Earlier resolution is less stressful for the parties and less costly.

In the past, a decision by police not to lay criminal charges, or unsuccessful criminal proceedings, may have led a National Board to discontinue an investigation or decide not to lay disciplinary charges before a tribunal, even though the criminal standard of 'beyond reasonable doubt' does not apply in civil proceedings. A tougher, more public protective stance is now evident in some National Board decisions, for example filing Tribunal proceedings notwithstanding the dismissal of a police prosecution.[40]

In 2018, the Notifications and Legal teams agreed on a new process for referring notifications/practitioners to a relevant tribunal. Investigators are required to seek legal review before any notification is referred to a decision-maker with a recommendation to refer the practitioner to a tribunal. This process helps ensure

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patients of a specified gender only in the presence of a practice monitor, is classified in this report as a practice monitor condition.

[38] See 'Regulatory principles for the National Scheme', available at https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx .

[39] Personal observation based on conversations with other regulators at International Association of Medical Regulators biennial conference, Dubai, October 2018 and participation in teleconference meetings of Ahpra's International Regulatory Expert Advisor Group, 2019.

[40] An example is the *Gupta* case. Notwithstanding the dismissal of charges of indecent assault by the Magistrates Court of South Australia, the MBA filed Tribunal proceedings in relation to the allegations (inappropriate breast examination and sexualised comments with a single patient on multiple occasions). The Health Practitioners Tribunal of South Australia found Dr Gupta guilty of professional misconduct: *Medical Board of Australia v Gupta* [2019] SAHPT 20.

that all relevant information meets the evidential standards required for a tribunal hearing and provides additional oversight of matters relating to sexual boundaries.

These risk assessment and file management strategies should over time result in more responsive and effective regulatory action.

In response to recommendation 6, the MBA completed an audit of all open notifications that related to alleged sexual misconduct and/or sexual boundary violations. The first phase of the audit reviewed all sexual boundary notifications when immediate action was proposed or taken, to determine if further or other regulatory action was required. The second phase of the audit considered all remaining open notifications to determine if further action was required to ensure public safety.

A total of 101 notifications related to 59 medical practitioners were audited. There were 40 practitioners with one notification and 19 practitioners with multiple notifications, ranging from two to five notifications per practitioner. Immediate action was considered on four occasions during the audit:

- in phase one of the audit, immediate action was considered in relation to three practitioners and taken once, and
- in phase two of the audit, immediate action was considered and taken in relation to one practitioner.

The audit results indicate that the need for immediate action is being considered by Ahpra and SBNC with appropriate sensitivity and specificity.

Under the national Compliance team, Ahpra has reviewed and enhanced its monitoring of conditions.[41] Where an interim restriction has been imposed as a result of alleged sexual misconduct, or a condition on practice has been imposed after a finding of professional misconduct, a tighter and more rigorous compliance monitoring program is now in place under Ahpra's national Compliance team. Comprehensive restrictions and monitoring policies have been adopted.

Following the chaperone review report, a new Gender-based restrictions protocol was adopted, supported by relevant declarations to be made.[42] Compliance is evaluated in accordance with an Ahpra policy and guidelines, and explained in an information sheet.[43] Careful monitoring is undertaken, both initially and while the restriction remains in place, of practitioner compliance with a monitoring plan relating specifically to the practitioner and the relevant restriction. Checks of the patients seen by restricted practitioners are undertaken against Medicare data, PBS (Pharmaceutical Benefits Schemes) scripts and billing and appointment data provided by practitioners.[44] If monitoring detects a 'critical compliance event',[45] the matter is followed up with the practitioner and must be brought to the attention of the National Board (for medical practitioners, the SBNC), for consideration of the need for further regulatory action, based on assessment of the ongoing risk.

[41] Monitoring conditions is a function of National Boards, under the National Law, s 35(1)(j).
[42] See forms GBR1-BGR-4: Practitioner acknowledgment, Nomination of practice locations, Details of booking staff, Acknowlegment of booking staff.
[43] See Operational Policy: Monitoring gender-based restrictions (June 2017); Guidelines: Monitoring gender-based restrictions (July 2018); How is compliance evaluated? Information sheet (July 2018).
[44] See Instructions for generating billing and appointment data: Information for practitioners (May 2018).
[45] See Operational Policy: Responding to critical compliance events (July 2018) and Guideline: Managing critical compliance events (October 2019).

Six-monthly reviews of all interim restrictions and suspensions (in compliance with recommendation 9) and reviews of the need for immediate action or of the appropriateness of a restriction already in place, in light of new information (e.g. confirmed non-compliance with a current restriction, police decision to lay criminal charges, receipt of any new notification re the practitioner), mean that risk to patients and the public is appropriately reassessed.[46] If a practitioner subject to a restriction is acquitted of criminal charges, the appropriateness of continued restriction will be considered by SBNC, often with submissions from the practitioner arguing for removal. Case files I reviewed indicate that the SBNC will continue the restriction if it believes this is necessary to protect the public.[47]

As noted earlier, there has been a surge in reporting of alleged sexual misconduct by medical practitioners to Ahpra. This is probably attributable to greater awareness of doctor-patient sexual abuse issues within the medical profession leading to increased mandatory notifications (also likely spurred by publicity during consultation on and release of the new MBA *Guidelines: Sexual Boundaries in the Doctor-Patient* in December 2018), matched by increased willingness of patients (emboldened by the #MeToo movement and media publicity about cases of doctors accused of abusing multiple patients) to make voluntary notifications. The result is that suspected misconduct is more likely to be brought to the regulator's attention.

Finally, a change to the National Law to introduce a public interest ground as an alternative basis for immediate action – when a National Board 'reasonably believes the action is otherwise in the public interest'[48] – recognises the need for immediate action in cases when public confidence in a health profession or its regulatory body may be damaged if the allegations turn out to be true, and the practitioner has been permitted to continue in unrestricted practice in the meantime. This approach was supported in the chaperone review report.[49]

The SBNC has been grappling with the application of the new 'public interest' ground. Jurisprudence is still emerging as tribunals and courts hear appeals from practitioners challenging the taking of immediate action on this basis. The decision of the Victorian Civil and Administrative Tribunal (VCAT) in *Farschi*, in upholding the taking of immediate action, sets out clear principles for the application of section 156(1)(e).[50] Dr Farschi was facing serious criminal charges of slavery or forced labour involving a vulnerable refugee. The Tribunal noted that 'fundamental to good practice is the development and maintenance of trust between any treating practitioner and his/her patients/clients'.[51] 'The new public interest test allows us to look beyond questions of *risk* to persons and the need to protect public health and safety, to broader considerations, such as public confidence in the various health professions.'[52] 'Where there are serious allegations that a health practitioner may be prepared to … be exploitative and/or misuse a power imbalance or exercise seriously impoverished judgement or enter into a dual and improper therapeutic relationship, regulatory authorities have a responsibility to act in the public interest.'[53] These are helpful statements to guide National Boards (and Ahpra staff) in the exercise of immediate action powers.

[46] See Operational Policy: Review of immediate action restrictions arising from allegations of sexual boundary violations (September 2017). To date, no six-monthly review has led to further action.
[47] See, eg, the suspension in place for Dr D, registration no MED000126025, despite acquittal of criminal charges.
[48] National Law, s 156(1)(e).
[49] Report pp 80-81.
[50] *Farschi v Chinese Medical Board of Australia* [2017] VCAT 1617.
[51] Para 97.
[52] Para 79.
[53] Para 101.

Reliance on the public interest ground to suspend a medical practitioner facing criminal charges of rape or sexual assault due to alleged 'stealthing' behaviour[54] was considered by the Supreme Court of Victoria in *Liang Joo Leow.*[55] On the facts, the Court was not satisfied that VCAT had erred in holding that suspension in the public interest was not justified.[56]

However, several statements from the Court in *Liang Joo Leow* illuminate the proper basis of immediate action in the public interest. In some cases 'it may be necessary to take action to reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession as a whole'.[57] '[T]he relevant issue is public confidence in the provision of services by health practitioners. It requires an assessment of the impact of allowing one practitioner to continue to practise, in circumstances where he or she has been charged with a serious criminal offence, on the reputation of the profession as a whole.'[58] 'The power to take immediate action under s 156(1)(e) in the public interest, and the maintenance of public confidence … underscore that there is a public dimension to the regulation of the health profession that goes beyond the circumstances of individual practitioners. In some cases, to await the resolution of criminal charges before taking any precautionary steps may adversely impact on patient safety, public confidence and, more broadly, the public interest.'[59]

One problem with VCAT's decision in *Liang Joo Leow*[60] was the reliance on the following statement from the Supreme Court of Victoria Court of Appeal in *Lal*: 'The decision to register a particular person to practise medicine is unlikely, in our view, to have any material or lasting effect on the established reputation of the medical profession as a whole'.[61] If applied too indiscriminately, this would undercut the very example (of when immediate action may be taken in the public interest) specified in s 156(1)(e): 'A registered health practitioner is charged with a serious criminal offence, unrelated to the practitioner's practice, for which immediate action is required to be taken to maintain public confidence in the provision of services by health practitioners.'

A recent development that should embolden National Boards in the exercise of their public protective function, including in relation to alleged sexual misconduct, is Policy Direction 2019-1,[62] issued by the Chair of the COAG Health Council under section 11 of the National Law. It is only the second such Direction. It is clearly intended to counter undue reliance by National Boards on regulatory principle 6 of the guiding principles for the National Scheme,[63] about the use of 'minimum regulatory force appropriate to manage the risk posed by [the practitioner's] practice'. The Direction is consistent with my call for more guidance to Immediate Action Committees 'to ensure that they do not over-emphasise the use of "minimum regulatory

[54] The allegation was of surreptitiously removing a condom during intercourse between two males, following insistence by the recipient partner that a condom be worn to prevent the risk of HIV transmission.
[55] *Medical Board of Australia v Liang Joo Leow* [2019] VSC 532.
[56] It appears that VCAT and the Court were influenced by the unusual nature of an alleged rape in a stealthing scenario between two males, seeing it as private conduct and forming the view that the public would not be outraged by the MBA permitting the doctor to continue in unrestricted practice pending the outcome of the criminal process. See para 111 of Court judgment.
[57] Para 81.
[58] Para 95.
[59] Para 108.
[60] Reported as *CJE v Medical Board of Australia* [2019] VCAT 178.
[61] *Medical Practitioners Board of Victoria v Lal* [2018] 110.
[62] See https://www.ahpra.gov.au/About-AHPRA/Ministerial-Directives-and-Communiques.aspx .
[63] See 'Regulatory principles for the National Scheme, at https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx . The principles are issued under the National Law, s 3(3)(c).

force" or least restrictive intervention, without sufficient regard to the need for the intervention to be adequate to protect the public'.[64]

Policy Direction 2019-1 requires National Boards and Ahpra, when determining whether it is necessary for regulatory action to be taken, to take into account 'the potential impact of the practitioner's conduct on the public' and 'the extent to which deterring other practitioners from participating in similar conduct would support the protection of the public and engender confidence in the regulated profession'. In considering whether the practitioner's conduct amounts to unprofessional conduct or professional misconduct, National Boards and Ahpra 'must give at least as much weight to the expectations of the public as well as professional peers', with regards to expected standards of practice by the registered practitioner.[65]

Read as a whole, Policy Direction 2019-1 signals a clear intention that National Boards and Ahpra should place greater emphasis on community expectations and the need to maintain public confidence in regulated professions. Both dimensions have particular relevance to decisions about the need for immediate action, and the appropriate level of restriction, in cases of alleged sexual misconduct. In combination with the new public interest ground for immediate action, it is reasonable to predict that National Boards will in future be less inclined to impose the minimum regulatory intervention – and that over time, public protection will be enhanced.

3 Practice monitors rarely imposed, more gender-based restrictions and suspensions

Recommendations 1 and 2 of the chaperone review report were that the use of mandated chaperones as an interim restriction in response to allegations of sexual misconduct be abandoned, and be replaced by other immediate action conditions (including greater use of gender-based prohibitions or prohibitions on patient contact) and suspensions. It was recommended that chaperone conditions (to be called practice monitor conditions) be imposed only in exceptional cases where (a) the allegation of sexual misconduct involves only a single patient, and (b) the allegation, if proven, would not constitute a criminal offence, and (c) the health practitioner has no relevant notification or complaint history.[66]

Ahpra and the National Boards (including the MBA) have revised regulatory practice to give effect to these recommendations. Since April 2017, practice monitors as interim restrictions have been imposed on only three occasions by the MBA, and none remain in place. This appears to be due both to compliance with the recommendations and recognition of the complexity of implementing and monitoring such conditions.

In February 2020, only 13 medical practitioners in Australia were subject to chaperone or practice monitor conditions, compared with 39 in January 2017, before publication of the chaperone review report. None of the current conditions have been imposed by the MBA since the report – they are historic.

In three cases involving medical practitioners, the MBA imposed a practice monitor condition. On review of summaries of those cases, it appears that the three conditions for exceptional use of such a condition were not fulfilled. In each case, the practitioner had relevant notification history, and in one of the cases, the practitioner was facing charges of aggravated sexual assault. Two of the practitioners were subsequently suspended through further immediate action and the third was suspended by a tribunal. The subsequent

[64] Report p 80.
[65] Policy Direction 2019-1, paras 2-4.
[66] Report, recommendations 11 and 15.

suspensions highlight the need for the SBNC to be cautious in accepting practitioner submissions that this is an exceptional case, in which a practice monitor will sufficiently protect the public – and to be guided by the criteria for recognising a case as exceptional.

Chaperones / practice monitors are infrequently imposed in New South Wales (by the Medical Council of New South Wales) and Queensland (by the Health Ombudsman). Of the above figure of 13, two medical practitioners in NSW were subject to practice monitor conditions, and five medical practitioners in Queensland were subject to chaperone or practice monitor conditions.

Across other health professions, in jurisdictions monitored by Ahpra, chaperone / practice monitor conditions are currently in place for only one chiropractor (WA). Even in Queensland and New South Wales, chaperones / practice monitors are seldom imposed as an interim restriction, suggesting that the findings of the chaperone review report about the limitations of such conditions have been recognised by other health regulators in Australia (in particular, the Health Ombudsman in Queensland and the NSW Medical Council). Chaperone / practice monitor conditions are currently in place for one chiropractor (WA) and one osteopath (NSW), compared to the nine health practitioners (other than medical practitioners) subject to a chaperone condition in January 2017.

As recommended, gender-based prohibitions are being imposed by the MBA more frequently in cases of alleged sexual boundary breaches by medical practitioners. A similar approach is evident from the New South Wales Medical Council and, to some extent, the Queensland Health Ombudsman. In February 2020, such conditions were in place for 41 medical practitioners, 20 imposed by the MBA, 16 by the NSW Medical Council and five by the Queensland Health Ombudsman. Gender-based prohibitions are also sometimes imposed on other health practitioners, with current data showing six such restrictions imposed by National Boards (three psychologists, two physiotherapists and one nurse), two by NSW health profession councils and six by the Queensland Health Ombudsman.

The most serious immediate action, a suspension, is also being imposed more frequently, including when the SBNC recognises that a gender-based prohibition (eg, on a gynaecologist, from seeing female patients) would for all practical purposes amount to a suspension.

The increased use of suspension may reflect increased consistency and confidence in regulatory decision-making brought about by increased specialization in this area, via the SBNC, the national Immediate Action team and specially trained investigators. Factors cited by Ahpra as influencing the higher number of suspensions include:

- increased confidence by SBNC in making the decision to suspend and increasing consistency in decisions, due to experience and education / professional development of members in face-to-face meetings
- use of the new public interest ground for immediate action under the National Law, in some cases of alleged conduct outside practice when the practitioner is facing criminal charges
- management of files by the Immediate Action team, resulting in increased consistency in recommendations to SBNC about the need to take immediate action and the appropriate form of restriction.

Suspension of a practitioner's registration is obviously the highest level of protection for the public while sexual boundary matter is investigated. When used appropriately, it may increase public confidence in the profession and the regulator. It is also the most onerous restriction on a practitioner, causing stress, loss of

income and damage to reputation. Accordingly, it is a regulatory tool that needs to be applied only after careful assessment of the relevant facts.

As of February 2020, 30 medical practitioners were suspended as an immediate action imposed by the SBNC for an alleged sexual boundary violation. The number and proportion of immediate actions related to alleged sexual boundary violations resulting in the practitioner being suspended has increased significantly. In 2018-19, 43% of immediate actions imposed in sexual boundary matters by the SBNC were suspensions, compared to 6% in 2015-16, 32% in 2016-17 and 31% in 2017-18.[67] Data for SBNC immediate action decisions from 1 July to 31 December 2019 show that 56% of such decisions resulted in a suspension.

As of February 2020, 15 medical practitioners in New South Wales were suspended as an immediate action imposed by the NSW Medical Council for an alleged boundary violation; in Queensland, one medical practitioner was suspended as an immediate registration action imposed by the Health Ombudsman.

4 Some unfinished business and contention about links on the public register

The response to two recommendations requires further work. The development of Memoranda of Understanding (MOUs) with police across Australia (except the co-regulatory jurisdictions of NSW and Queensland), to ensure good communication and information sharing between Ahpra and police (rec 8), has been partly implemented. Ahpra has entered into MOUs with Western Australia Police and Victoria Police. Despite considerable effort on the part of Ahpra, MOUs have not yet been entered with police in South Australia, Tasmania and the Northern Territory. I recommend that MOUs be developed between Ahpra and these two remaining states and the Northern Territory.

Ahpra reports that guidance is being prepared for staff, reminding them to use the appropriate escalation pathways (via State manager to relevant Deputy Commissioner) set out in the MOUs, where they exist; and to follow a similar escalation pathway for jurisdictions that do not have an MOU in place, when attempts to obtain relevant information are hampered or have broken down. Escalation with police has been used to good effect, and notifications have been received from police in relation to sexual misconduct and sexual boundary matters, in accordance with MOUs, resulting in immediate action decisions in some cases.

Ahpra staff routinely provide education to police on the role and powers of Ahpra and National Boards in matters involving a registered health practitioner. Contact lists have been developed for police, listing sexual abuse counselling in support services in their state or territory. An internal policy has been developed by Ahpra, in relation to proactive information disclosure to police, to ensure disclosure of information relating to criminal conduct.[68] Under the policy, all criminal conduct should be referred to police; when the notifier does not consent to the release of the information to police, senior management are engaged to consider the ethics of consent.

Recommendation 20, that the National Law be amended to allow a National Board to require a practitioner to disclose the reasons for a restriction to patients and to permit chaperones / practice monitors to be fully briefed about those reasons, has been only partly implemented. Legislative change is ultimately an issue for Health Ministers and Parliaments, not Ahpra.

The public register recommendation – that the public *Register of practitioners* included web links to published disciplinary decisions and court rulings – was initially implemented more broadly than I had intended. In March 2018, the MBA and Ahpra announced that the register would display links to externally

[67] Briefing papers for SBNC meeting, October 2019.
[68] Policy: When to disclose information to police, January 2020.

published court and tribunal decisions about individual registered medical practitioners who had been involved in disciplinary action with the MBA or Ahpra, when the decisions were public but not when suppression orders were in place.[69] This included links to decisions when no adverse finding had been made or when a previous adverse decision had been overturned.

Ahpra took a literal implementation of my recommendation, providing links to *all* published disciplinary decisions about a doctor on the register, including decisions finding the doctor not guilty of any misconduct, so long as the name of the doctor was not suppressed.

One might query the harm in publication of a decision that *clears* a doctor of wrongdoing. But that ignores the trauma that doctors experience when subject to a complaint, investigation and proceedings. Even a notification that does not lead to an adverse finding is perceived as a stain on a doctor's record; any reminder of the process can be distressing. There was a fierce reaction to the decision to include links to all published decisions on the register. More than 16,000 doctors signed a petition seeking reversal of the position.[70]

After further consideration, the MBA and Ahpra announced in July 2018 that links would be published on the register to 'serious disciplinary decisions by tribunals and courts' when there has been an adverse finding against the doctor. They said the change of position came 'after listening to advice from many doctors and other stakeholders' that the original position was 'not fair when no adverse finding was made about the doctor'.[71]

I was consulted about the change in position. I confirmed that the revision was consistent with the intent of recommendation 10.[72] I noted that although a literal interpretation of the recommendation covered all published disciplinary decisions about a doctor, the chaperone review report makes it clear that I was thinking only of published disciplinary decisions and court rulings when the doctor had been found guilty of serious misconduct, noting that 'it would be anomalous that doctors with "old" chaperone conditions, who have been found guilty of serious sexual misconduct, could continue to have their history shielded from public scrutiny. Currently, the register records only the fact and wording of the condition.'[73]

In October 2018, Aphra and the National Boards announced that *all boards* would start publishing links to disciplinary decisions by courts and tribunals when there has been an adverse finding about the practitioner and serious allegations have been proven – provided that no order suppressing their name is in place.[74] The links are to decisions from 1 July 2010, when the National Scheme became operational.[75]

In my view, it is sensible to have a consistent approach to the publication of links on the register across all health professions in the National Scheme, for all published tribunal decisions (not just those involving

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[69] 'Register changes improve consumer access to public information', 26 March 2018, available at https://www.ahpra.gov.au/News/2018-03-26-chaperone-review-update.aspx .
[70] See 'Help stop AHPRA linking complaints on the register even if they are unfounded' petition, available at: https://www.change.org/p/australian-health-practitioner-regulation-agency-help-stop-ahpra-linking-complaints-on-register-even-if-they-are-unfounded .
[71] 'Board refines policy, publishes disciplinary links only with adverse outcomes', 27 Jule 2018, available at: https://www.ahpra.gov.au/News/2018-07-27-board-refines-policy-publishes-disciplinary-links-only-with-adverse-outcomes.aspx .
[72] Letter from R Paterson to Ahpra CEO, 1 September 2018.
[73] Report p 82.
[74] 'National Board support more public information on register, 29 October 2018, available at: https://www.ahpra.gov.au/News/2018-10-29-media-release-National-register.aspx .
[75] For Western Australia, the operative date is 18 October 2010, when the National Scheme became operational.

sexual misconduct). Ahpra has published a fact sheet on publishing links to tribunal and court decisions on the national register of practitioners, setting out details of how, when and why links are placed on the register.[76] Appropriately, links are not included to decisions when impairment is the only issue.

Practitioners are advised by letter that a link to a published decision is to be inserted in the entry in the national register for their name. In consultation with the National Health Practitioner Ombudsman and Privacy Commissioner, principles for publication of links on the national register have been developed to guide Ahpra staff and National Boards in individual cases.[77] In-house legal counsel advise National Boards on any exceptional circumstances when providing a link would not be consistent with the principles of publication. Given the significance of any links to the affected practitioner, this is an important safeguard.

The publication of links to adverse disciplinary decisions of tribunal continues to be a bone of contention for some affected medical practitioners. During this review, counsel from Medical Defence Organisations submitted that the policy is unfair and punitive, resulting in publication of some decisions (such as an appeal to a tribunal on a technical point) when publicity is unjustified, and that there should be a sunset clause on how long the links remain on the register.

Ahpra has taken the view that, since a tribunal decision remains in the public record in perpetuity, once published, the link on the register should also remain in perpetuity. In my view, Ahpra's approach is sound and consistent with a commitment to transparency for the benefit of members of the public who choose to check the register. One aspect of transparency and the public's right to know is that 'full details of any disciplinary decisions that are not suppressed (with links to relevant decisions) should be available on the public register'.[78] As I have noted elsewhere, 'Providing such information is an important way for regulators to be transparent and accountable to the public they are charged with protecting.'[79]

I note that some jurisdictions go further than a link in the register. In California and Washington, under state law physicians who have been sanctioned for sexual misconduct are required to notify patients of that fact, with a copy of the relevant order, at the first time they book an appointment or consult the doctor.[80]

5 Few unintended consequences from implementation of recommendations

From the vantage point of three years on, there appear to have been few unintended consequences of implementation of the recommendations in the chaperone review report. Indeed, there has been significant upside. The shift to a truly national approach in handling sexual boundary notifications about medical practitioners, including to the taking of immediate action, and in monitoring compliance with restrictions, points the way to improved handling of notifications across a wider range of matters (not just alleged breaches of sexual boundaries) and for all registered health professions (not only medical practitioners).

The scale of change required and the intensity of training and professional development needed for Ahpra staff and SBNC members was probably not anticipated. The emotional stress and potential trauma for staff and members exposed to a solid diet of unpleasant allegations and distressed notifiers, patients and

[76] Fact sheet: Publishing links to tribunal and court decisions on the national register of practitioners.
[77] Principles for the publication of links on the National Register (2019).
[78] Report p 82.
[79] R Paterson. *The good doctor: what patients want* (2012), p 125.
[80] See *Physician Sexual Misconduct*, FSMB (2020) and Revised Code of Washington, 18.130.063, effective 1 October 2019.

practitioners may also have been underestimated. Support for staff and SBNC members' wellbeing is important. This is discussed further under point 7 below.

Implementation of the recommendations occurred during the rise of the #MeToo movement and heightened publicity and societal understanding about the risks of sexual abuse in relationships characterised by one party (usually a male) having power and opportunity. This parallel societal shift may have resulted in less resistance from advocates within the medical profession who would ordinarily be quick to criticise more intrusive regulatory interventions. However, in fairness, it must be said that within the medical profession as a whole, there is little sympathy for practitioners who cross boundaries with patients.

Ahpra has commissioned research to examine whether the evidence supports common claims about notifications, such as that complaints about practitioners are often made vexatiously. Research by Marie Bismark and colleagues concluded that while practitioners naturally find it vexing to be subject to a notification or complaint, the best available evidence suggests that truly vexatious complaints are very rare, and that under-reporting of well-founded concerns is likely a far greater problem.[81]

As noted above, one major unanticipated consequence was the fierce reaction of the medical profession to an overly broad interpretation of the recommendation to publish links to tribunal and court decisions on the national register. This has now been corrected by a sensible policy revision.

6 Reflecting notifier and practitioner voices in regulatory processes and decisions

An important question for this review is how effectively Ahpra is capturing and ensuring the 'voice' of practitioners and notifiers (and potentially the public) are reflected in processes and decisions. Ensuring that complainant and respondent voices are properly heard and acknowledged is one of the most difficult challenges faced by any regulator.

A public regulator will usually have an express statutory purpose, with a broad scope such as 'protection of the public' and guiding principles or objectives, such as transparency, fairness and efficiency. In practice, how regulators achieve this, and what information they publish about the experiences of their 'customers', varies greatly.

Regulators typically try to show they are listening to the people who use or are subject to their processes, by stakeholder forums, publication of individual stories in annual reports, and collection of feedback survey data. Ahpra is employing all these methods, together with interviews of willing participants and occasional podcasts and videos. A webpage on 'Understanding the notifications experience' acknowledges that 'the notifications process can be stressful for notifiers, practitioners and their support networks' and says that 'we are listening to the perspectives and stories of people who have been involved in the process'.[82] Two excellent videos are published on the webpage, in which medical practitioners talk about their experience of being subject to a notification (not relating to an alleged sexual boundary violation).

Notifiers may be reticent to talk publicly about their experience of making a notification, since they may need to disclose confidential health information – although unhappy notifiers sometimes take their concerns to the media. Practitioners are often even more reluctant, given the perceived shame and stigma

[81] See J Morris, R Canaway, M Bismark, 'Reducing, identifying and managing vexatious complaints', Centre for Health Policy, Melbourne School of Population and Global Health (2017).
[82] Available at: https://www.ahpra.gov.au/Notifications/A-notification-has-been-made/Understanding-your-experience.aspx .

associated with being the subject of a complaint. Anonymous surveys of parties to a notification that has been closed is one way of soliciting feedback. This information is collated every quarter and trend reports, with simple graphics on a 'Notifier and practitioner engagement dashboard', and sent to senior management at Ahpra and the governing Agency Management Committee. Being treated with empathy and understanding, and being regularly updated on progress of a notification, are common areas of concern.

A National Engagement Advisor, Susan Biggar, has since January 2017 led initiatives by Ahpra and the National Boards to listen to the concerns and learn from the experiences of notifiers and practitioners, and make changes to regulatory processes and decisions to better reflect their voices. In 2019, Ahpra's work to improve notifier and practitioner experience received international recognition through a regulatory excellence award from the Council on Licensure, Enforcement and Regulation (CLEAR).

Ahpra's engagement work is highlighting concerns about legalistic official letters, a lack of empathy, inadequate updates and delays. In February 2020, a keyboard search of all open-ended notifier survey responses since mid-2017 found three typical responses:

'I do understand that AHPRA did all they could do and for that I am glad. I think there was potential for me to be updated more often than what I was. There was silence for more than 6 months from AHPRA. That creates a lot of anxiety. I think staff could go through some training on how to talk to people on the phone that are disclosing such sensitive and traumatic information. The staff member I spoke to was good. There were times I was really stressed on the phone, often angry and unable to continue the conversation. They handled it well but perhaps some sensitivity training could help.'

'I do believe some aspects could have been improved such as: 1) Knowing what to expect. I found that out as we went along. Notifying me of what to expect (like several phone calls in one week, each lasting more than an hour, where I would repeatedly be disclosing what happened whilst a statement was drafted. This would have been good to know ahead of time because I was at work when this happened. 2) I was told there would be an outcome in 6 months' time. It was closer to 12 months. At the 6-month mark, no one had contacted me.'

'What would have made this process simpler or easier? 1. Speed of response 2. Be human about the process. You're dealing with a real person / people whose lives have been drastically altered due to negligent practice. 3. Continue to engage proactively even if you don't have an update.'

In addition to gathering feedback from notifiers and practitioners, Ahpra consults regularly with two advisory groups to gather feedback, information and advice on its work: the Community Reference Group and the Professions Reference Group. They provide a useful community and professional perspectives on the work of Ahpra and the National Boards.

The Medical Defence Organisations (MDOs), which provide medico-legal advice to practitioners, keep a watching brief on developments in the approach by SBNC and Ahpra to notifications alleging breaches of sexual boundaries. They also have regular contact with Ahpra's Legal team. During this review, I had telephone interviews with representatives of three MDOs.[83] They reported acceptance of the move away from chaperone / practice monitor conditions and improved consistency of approach to interim restrictions, but stressed the importance of procedural fairness and the risk of taking an unduly restrictive

[83] MDA National, Avant and MIGA.

approach (e.g. defining 'patient' to include 'any spouse, guardian or carer' in the gender-based restrictions policy[84]).

A further valuable source of feedback comes from the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC), who is able to hear concerns raised by notifiers and practitioners about the administrative actions of Ahpra and the National Boards, determine whether the actions were lawful and reasonable, and make practice recommendations to Ahpra. The majority of complaints relate to the handling of a notification, and around 80% come from notifiers rather than practitioners.[85]

Specific issues raised by NHPOPC with Ahpra about notifications involving allegations of sexual misconduct include: the need for personalised and tailored communication in letters, especially when explaining no further action decisions after a sexual misconduct allegation; the need to be mindful of notifier wellbeing; transition issues when Ahpra briefs external lawyers; the need for support for notifiers during tribunal processes; and the importance of ensuring that notifiers do not learn the outcome of tribunal proceedings through the news media.[86] Ahpra is adapting its processes to address these concerns. A pilot for a notifier support service is due to be commenced, and is discussed further under point 7 below.

There is ongoing discussion among health practitioner regulators internationally about what it means to be a humane regulator,[87] particularly when a regulator is perceived by members of a profession to have taken punitive and excessive action. A notable example of indignant professional reaction was the #iamhazida social media movement after the General Medical Council (GMC) sought to have Dr Hazida Bawa-Garba struck off the medical register. The GMC appealed a disciplinary sanction of suspension only, following Dr Bawa-Garba's conviction of gross negligence manslaughter for lapses in her treatment of a paediatric patient.[88] The GMC was widely seen to have over-reached and its actions were trenchantly criticised.[89]

Increasing publicity about the risks to mental health and wellbeing of medical practitioners in the current practice environment adds to the pressure on regulators to be sensitive in their handling of notifications and complaints. However, as noted in the chaperone review report, there are limits to what Ahpra and the National Boards can do. 'Their job is to protect the public, not to support practitioners. Equally, it is important that legal powers be exercised with due sensitivity to the impact on practitioners. … The timing, tone and mode of communication of potentially distressing information to a practitioner should always be given careful consideration.'[90]

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[84] Operational Policy: Monitoring gender-based restrictions (June 2017).

[85] See *Annual Report 2018-19*, National Health Practitioner Ombudsman and Privacy Commissioner (2019), available at: https://nhpopc.gov.au/wp-content/uploads/NHPOPC-annual-report-2018-19.pdf . Personal communication from NHPOPC, December 2019.

[86] Correspondence between NHPOPC and Ahpra CEO, May-August 2018.

[87] See S Biggar, L Lobigs, M Fletcher, How can we make health regulation more humane? A quality improvement approach to understanding complainant and practitioner experiences. *Journal of Medical Regulation* 2020, 106(1), 7-15.

[88] Although the GMC's appeal resulted in Dr Bawa-Garba being deregistered, further proceedings overturned the erasure and substituted suspension: *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879.

[89] See 'The General Medical Council has lost its way', Editorial, Lancet 2018; 391: 1456.

[90] Report pp 83-84.

7 Recommendations for further improvement

Set out below are a number of recommendations for further improvement, based on my assessment of the current state of Ahpra and the National Boards' development in the handling of sexual boundary notifications.

The recommendations are made against the backdrop of a National Scheme that is, compared with international health practitioner regulators, highly advanced in how it operates in this complex and demanding area.

Mandatory specialised training for staff handling sexual boundary notifications

As part of its commitment to develop highly specialised staff and investigators for handling sexual misconduct cases (rec 3), Ahpra now offers a three-day 'Sexual Boundaries Investigations Training' course. The intention is that all staff involved in handling sexual boundary matters undertake the training. However, not all Ahpra staff who could benefit from the training have taken it – including staff in the Notifications and Immediate Action teams who handle these cases.

Ahpra's internal practice has not gone as far as one progressive regulator, the Washington Medical Commission, where state law requires all victim interviews conducted as part of an alleged sexual misconduct investigation, to be 'conducted by a person who has successfully completed a training program on interviewing victims of sexual misconduct in a manner that minimizes the negative impacts on the victims'.[91] Notifications staff at Ahpra, who have not had the opportunity to attend specialist training, may take initial interview information from a notifier. This is less than ideal – for the notifier, the staff member, the quality of the information gathered and the appropriate resolution of the case.

This is complex and emotionally stressful work. I recommend that Ahpra require all staff involved in handling sexual boundary matters to undertake the three-day sexual boundaries training course; offer periodic, refresher courses for investigators; and develop a shorter sexual boundaries training course available to all staff.

Better communication with notifiers

In my view, Ahpra and National Boards, including the MBA, need to continue to improve their communications with notifiers. This area was not the subject of a formal recommendation in the chaperone review report, but I stated:[92]

'Notifiers personally affected by sexual abuse are especially vulnerable. They are likely to be traumatised by their experience. They may find it difficult to report what happened and will be anxious to learn of any developments in "their case". … Ahpra should implement practice improvements to improve communication with notifiers who report sexual misconduct, in particular notifiers personally affected by practitioner conduct.'

Particular areas of focus for Ahpra should be:

(a) Training with an emphasis on taking a humane approach during the intake and management of sexual boundary notifications

[91] See Revised Code of Washington, 18.130.060(2) and Procedure: Processing Complaints of Sexual Misconduct through the Sexual Misconduct Analysis Review Team (SMART), Washington Medical Commission, January 2017.
[92] Report pp 82-83.

My interviews with Ahpra staff indicate that there is a need for such training, and that it would be welcomed. It should form part of the recommended mandatory specialised training for staff handling sexual boundary notifications.

(b) Further guidance on updates and communication of no further action (NFA) decisions

This recommendation is based on my review of a random sample of three-monthly update letters and NFA letters sent to notifiers and practitioners in sexual boundary matters.

It is difficult to give a meaningful update if a case is stalled, especially if that is due to external processes, such as an ongoing police investigation. However, a letter stating simply that 'This investigation is ongoing. We will provide another update in three months' time …' is understandably frustrating for all parties. A brief phone call from the staff member responsible for the investigation, who is suitably trained and has had previous contact and established rapport with the notifier or practitioner, would be good practice before sending a formal letter stating 'the investigation is ongoing'.

More work is needed on the tone and content of NFA letters. Written communications, especially formal decision letters, are not an easy vehicle for expressing empathy, but my impression is that more could be done to make letters less legalistic and to show greater acknowledgment of the notifier's reported experience, which has usually been traumatic for them and has prompted them to take the stressful and time-consuming step of making a complaint to an official body. I noted one NFA letter which said it was 'regrettable that you felt uncomfortable … however your discomfort may have been formed on your subjective interpretation of Dr [X's] behaviour …'.[93] In my experience of official complaints handling for all sorts of complaints (not just alleged sexual misconduct), this sort of language is upsetting to notifiers and leaves them feeling that their concerns have not been heard or taken seriously.

The SBNC Chair advised that the committee understands the need to make sure its reasoning is explained empathetically and, when appropriate, that there is an acknowledgement of the patient's experience. In some circumstances, this may extend to an expression of being sorry for the distress experienced by the patient. This is seen as being particularly important for matters concluding with an NFA letter. The SBNC appreciates the importance of reasons being able to be easily understood by notifiers and being able to explain when a practitioner's actions were consistent with good medical practice (e.g. in some cases when a notification has been made about a clinically indicated examination that was carried out in the appropriate manner, such as by placing a stethoscope beneath clothing).

During the course of a meeting, usual SBNC practice is to specify any additional requirement for an empathetic response, an acknowledgment of the patient's experience, an apology for any delay in a matter and any other statement the SBNC wishes to makes. I recommend that any such additional statement from SBNC be formally signed off by the committee (i.e. that the wording be included in papers reviewed and signed off by the committee). Since it is not realistic or practical for SBNC or other committee chairs to see the final correspondence sent by Ahpra staff on their behalf (the settling of correspondence being a matter for Ahpra), I recommend that Ahpra undertake periodic internal audits to ensure that committee reasons are faithfully reflected in letters to the parties.

(c) Support for notifiers (and patients, in the case of third party notifications), particularly when a case proceeds to a tribunal hearing. Notifiers who have been victims of sexual abuse often find legal proceedings

[93] Ahpra 'Investigation complete, no further regulatory action' letter to notifier, 20 February 2019.

highly stressful and sometimes re-traumatising. This is an area for improvement identified by NHPOPC, as noted earlier.

Ahpra and National Boards must maintain independence and objectivity in the exercise of their regulatory functions. It is not their role to be advocates for individual notifiers. However, in my view best practice in this area includes ensuring that appropriate counselling and support is available from an independent provider.[94] Ahpra is considering running a pilot program for a notifier support service, initially focused on medical and psychology sexual misconduct-related matters in Victoria, to provide 'appropriate support and information' to notifiers and/or witnesses in Ahpra matters that proceed to VCAT (the Victorian Civil and Administrative Tribunal).[95] In my view, this is an excellent initiative, which should be progressed.

Support for staff and SBNC members

Ahpra senior managers and the Chair of SBNC are conscious of the emotional impact that handling sexual boundary notifications can have on staff and committee members. There is a risk of vicarious trauma through repeated exposure to disturbing information or (on rare occasions) from learning that a notifier, or a practitioner subject to suspension or another restriction, has self-harmed.[96] Support is offered to staff and committee members, including through Ahpra's Employee Assistance Program (EAP). In my view, all SBNC committee members should be strongly encouraged to have an annual one-to-one EAP session to reflect on issues encountered in their committee work.

Ahpra has also instituted a wellbeing and support program,[97] with leadership from senior Regulatory Operations staff. Initial workshops with external facilitators have been held for Ahpra staff handling sexual boundary cases in the Notifications and Immediate Action teams, and senior managers. A special session was conducted for SBNC members. Reports from participants have been favourable. The second tranche of the program, to be rolled out in 2020, will have a specific focus on vicarious trauma.

During the course of this review, in interviews with the SBNC Chair, an Ahpra investigator and senior managers, the need for more wellbeing support was emphasised. Ahpra and the National Boards are also examining the risks for members and delegates of National Boards who are exposed to disturbing material.

This is necessary and important work. I recommend that Ahpra staff and Board or Committee members dealing with sexual boundary matters receive specialised support to address the risks of vicarious trauma.

Timely handling of notifications

Although some improvements have been made, the timely handling of notifications remains a challenge. This is partly a reflection of the growing workload of Ahpra and the National Boards, with a 13.8% increase in notifications overall in 2018/19 compared with 2017/18, and significant annual increases in sexual boundary notifications.

Much work continues to be done by Ahpra to respond to the increased demand. Assessment and consideration of the need for immediate action occurs promptly on receipt of a sexual boundary

[94] I note that the FSMB Workgroup report on *Physician Sexual Misconduct* (2020) recommends that state medical boards have a specially trained patient liaison or navigator on staff who is capable of providing one-to-one support to complainants and their families (rec 9).
[95] National scheme notifier support service: proposed pilot, Ahpra, October 2019.
[96] As tragically occurred when neurologist Andrew Churchyard suicided following suspension by the MBA and the laying of criminal charges by Victoria Police – see report p 13.
[97] Wellbeing and Support program Framework, May 2019.

notification. Case conferencing is increasingly being employed for complex or stalled investigations and is reported to be helpful for Notifications staff.

Notwithstanding the imposition of more onerous restrictions when immediate action is taken by SBNC, the median time to take immediate action has remained relatively unchanged in the past two financial years. From 1 July 2019 to the end of February 2020, for notifications of alleged sexual boundary violations by medical practitioners, the average time to complete an assessment was 64 days (98 completed assessments). The time from receipt of a notification to imposition of an immediate action restriction or suspension was, on average, 41 days (nine matters where IA taken). Perhaps more relevant is the time from receipt of 'trigger' information (i.e. specific information that triggers the need for consideration of immediate action) to the taking of immediate action. For the same nine matters, the average time from the 'trigger' event was 21 days.

Inevitably, volume and complexity mean that delays are a common feature of sexual boundary matters. In October 2019, the average time to complete a matter was 317 days, and the average age of open notifications, 336 days.[98]

In September 2016, the average duration of interim chaperone conditions was 1.8 years. I am informed that obtaining average duration information for interim restrictions currently in place would require a time-consuming manual reconciliation. However, from files I have reviewed, it appears that many are in place for more than six months. As noted by the Court of Appeal of the Supreme Court of Victoria in *Kozanoglu*, 'the entire legislative scheme breaks down if there is a lengthy delay between an IAC [Immediate Action Committee] decision and a complete hearing on the merits'.[99]

Some of the delays cannot be laid at the door of Ahpra. In internal records of the duration of open notifications, a distinction is drawn between 'notifier days' (i.e. the number of days from receipt of the notification, when the duration is due to Ahpra handling) and 'responsible days' (i.e. delays due to external factors such as concurrent police investigation or criminal proceedings), when the matter is placed 'on hold' in accordance with Ahpra guidelines.[100] Data provided by Ahpra in February 2020 showed that the average time for completion of a sexual boundary matters across all registered professions, from 1 July 2017 to date, ranged from 218 to 273 'notifier days' and 186 to 235 'responsible days'. These are long time frames – doubtless causing stress to notifiers and practitioners.

In a paper prepared for this review, based on feedback from 12 Ahpra managers,[101] delays were attributed to a wide range of factors including: difficulties in engaging with vulnerable witnesses, multiple related notifications, historic allegations (an increasing feature of this area, perhaps associated with the #MeToo movement), mandatory reports (e.g. from a colleague, employer or treating practitioner), complexity (e.g. the need for search warrants or forensic analysis) and shortage of specially trained Ahpra investigators.

There is no quick fix to the problem of investigation delays. Ahpra faces an ongoing challenge of how best to prioritise investigation resources, given the competing demands for timely action on other conduct investigations, such as into performance concerns. However, the delays in concluding investigation of sexual boundary notifications need to be reduced, in the interest of public protection and public confidence

[98] SBNC Chair presentation to Tasmanian Board of MBA, October 2019.
[99] *Kozanoglu v Pharmacy Board of Australia* [2012] VSCA 295 at [127].
[100] Guidelines for Part 8 matters being placed on hold, Ahpra, July 2016.
[101] Review of timeframes for completion of sexual boundary matters and factors that may cause delay in progression, February 2020.

in the efficiency, effectiveness and fairness of the National Scheme.[102] This may require additional training, management oversight and additional or redeployed resources.

I recommend that Ahpra prepare and implement an action plan, to address the problem of delays in completion of sexual boundary notifications.

Learning from the work of SBNC

The findings of this review show that implementation of recommendation 5, that the MBA develop highly specialised decision-makers for regulatory decision-making about sexual misconduct cases, has improved the quality and consistency of decision-making. I heard praise for the leadership provided by SNBC Chair Christine Gee and saw evidence of the commitment of committee members. Ahpra staff working with SNBC, including the two national Operations Managers, Boundary Violation and Sexual Misconduct, report that the model is an excellent one.

It is also worth noting that the SNBC Chair is a lay chair. At a time of increasing emphasis on the need for National Board decisions to reflect community expectations, there may be advantages for any delegate committee such as the SBNC, dealing with notifications that are not (in the main) clinical in nature, to have a lay chair who is not a member of the relevant profession.

I recommend that the model of a single, specialised delegate committee handling sexual boundary notifications be rolled out across other registered health professions. Within many health professions, there are very few sexual boundary notifications. In some professions other than medicine, notably psychology, chiropractic and osteopathy, such notifications do feature as a small proportion of total notifications. In my view, a multi-profession SBNC would ensure a reasonable volume of cases and enable consistency of practice. I note that a multi-profession Immediate Action committee is already operating across the smaller health professions (excluding nursing, medical, psychology, pharmacy and dental).

Over time, the recommended multi-profession SBNC could encompass all professions, including medicine. In the meantime, for consistency of practice it would optimal to have a common chair (preferably a lay member) for any sexual boundaries notifications committee.

It is also important that learning from the decisions of SBNC is reflected in the ongoing work of investigators. The monthly newsletter with updates from the SBNC should continue to be circulated to Ahpra staff, and the SBNC Chair and key staff who regularly brief the committee should be encouraged to present Zoom presentations for Ahpra staff, to ensure that lessons are being shared and used for continuous quality improvement.

Finally, as noted earlier, the SBNC has been grappling with the application of the new 'public interest' ground for taking immediate action. Recent Policy Direction 2019-1 signals a clear intention that National Boards and Ahpra should place greater emphasis on community expectations and the need to maintain public confidence in regulated professions. It will be an ongoing challenge for the SBNC to ensure that its decisions continue to reflect community expectations and the importance of public confidence in the medical profession and its regulator.

The SBNC, by definition, has jurisdiction only over sexual boundary notifications. There is risk that committee members will become inured to such matters. Naturally, some matters will appear relatively 'mild', in the scale from unexplained but clinically necessary intimate examinations, or slightly

[102] See National Law, s 3(3)(a).

inappropriate comments, through to forming a sexual relationship with or sexually assaulting a patient. Practitioners will often give persuasive evidence of remediation or risk mitigation steps that have been taken after 'lesser' conduct and will argue that no further action is required. However, it is important for the SBNC (and Ahpra staff supporting it) not to lose sight of the intolerance of patients and the community for any form of sexual advances[103] by a health practitioner – and to ensure that appropriate deterrent actions (such as cautions or the imposition of conditions) are taken.

Professional guidance on physical examinations

One area of particular difficulty in sexual boundary cases is assessing whether a practitioner's physical examination of a patient was clinically necessary but not well explained in advance, leaving a patient feeling uncomfortable or unsure about what happened. The MBA, in its 2018 *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship*, emphasises the importance of good communication to avoid misunderstanding and notes that before conducting a physical examination, good medical practice involves 'explaining to the patient why the examination is necessary, what it involves and providing an opportunity for them to ask questions or to refuse the examination' and obtaining the patient's informed consent to proceed.[104]

A medical practitioner's use of a stethoscope, to listen to heart and lung sounds, is sometimes an occasion for misunderstanding. An audit for this review identified 29 SBNC matters involving the use of stethoscope during a patient consultation. Immediate action was taken on eight occasions in relation to six practitioners. Eighteen matters (90%) resulted in an NFA action. There has been a significant increase in such notifications, from five in 2017 to 14 in 2019.

I recommend that Ahpra publish case studies drawn from these cases, to be used for educational purposes, and disseminated to Medical Defence Organisations, medical schools and colleges. The case studies could provide useful examples of how to put the MBA guidance on communication about physical examinations into practice, and illustrate the risks of clumsy or poorly explained examinations. However, decision-makers in Ahpra and the National Boards should also remain alert to the possibility that an examination was clinically unnecessary and undertaken for ulterior purposes.

A broader issue for the community is the challenge of improving health literacy. At a time when members of the community appear to have better antennae for inappropriate sexual behaviour in professional settings, there is a surprising lack of knowledge and understanding of basic health information, including why health practitioners may need to undertake physical examinations.

[103] Including conduct interpreted by the patient as a sexual advance.
[104] Guidelines section 7.

Appendix A Table of actions taken by the MBA and Ahpra to implement recommendations of chaperone review report

Recommendation	Status
No chaperones and improved handling of sexual misconduct cases (Recommendations 1 - 10)	
1. The use of mandated chaperones as an interim restriction in response to allegations of sexual misconduct be abandoned.	**Change implemented** The Medical Board of Australia (MBA) has issued guidance for decision-makers confirming that it accepts all the recommendations in the report, including that the use of mandated chaperones as an interim restriction in response to allegations of sexual misconduct be abandoned. No new decisions have been made to impose chaperone conditions as an interim restriction in response to allegations of sexual misconduct by MBA and/or other National Boards.
2. The use of chaperones be replaced by other immediate action conditions (including greater use of gender-based prohibitions or prohibitions on patient contact) and suspensions.	**Change implemented** Since the report was released, MBA decision-makers who have taken immediate actions in relation to new allegations of sexual misconduct have not imposed conditions requiring chaperones. Conditions requiring practice monitors were, however, imposed on three occasions. All three practitioners were subsequently suspended: two through immediate action due to alleged breaches of the conditions and one through tribunal proceedings related to the sexual misconduct (no breach of conditions).
3. Ahpra develop highly specialised staff and investigators for handling sexual misconduct cases, who can establish rapport and deal with victims empathetically, invest in specialist training and skills, and prioritise the investigation of allegations of sexual misconduct.	**Change implemented** In November 2017, the National Operations Manager Sexual Boundary Notifications was appointed as a dedicated resource with a background in investigating sexual offences. The incumbents of this role, now titled Operations Manager, Boundary Violation and Sexual Misconduct, work with investigators and MBA Sexual Boundaries Notifications Committee (SBNC) members to continue to broaden expertise with respect to assessing and investigating boundary violation and sexual misconduct matters; improving engagement

	with the parties involved; and improving consistency in regulatory responses to these notifications. Specialised investigation training sessions have been completed for Ahpra staff (including investigators and intake and assessment officers) who deal with sexual boundary matters. A total of 57 Ahpra staff attended the training in 2018 and 2019, and another 16 attended the session in February 2020. These specialist Ahpra staff manage notifications related to concerns about sexual misconduct and boundary violations and communicate regularly with the relevant parties such as the notifier and practitioner. Notifiers personally affected by practitioner conduct are dealt with sensitively and referred to support services where appropriate. Face-to-face interviews are conducted in most matters and support is also provided where necessary to assist notifiers in reporting matters to police. The members of the SBNC and the staff who engage with victims have engaged in training and ongoing professional development, including with current and former Victorian Police (VICPOL) officers working in the area of sexual assault and other specialists in the field. This has led to changes in the manner of engagement with patients reporting sexual misconduct and practitioners alleged to have engaged in inappropriate conduct. A risk tool that identifies sexual boundary issues as 'red flag' concerns has been embedded, and this escalates the management of any notification identified in this category as a presumptive high-risk concern. High risk concerns are escalated to managers and to the National Immediate Action Team where required.
4. Ahpra revise the guidance for National Boards on relevant factors in the exercise of immediate action powers, including the threshold for taking immediate action and the appropriate level of intervention.	**Change implemented** Comprehensive advice about immediate action has been provided to the MBA and other National Boards. Immediate action is now managed by a specialist team of Ahpra staff in the National Immediate Action Team, under the guidance of the National Operations Manager, Immediate Action. This has meant a more consistent approach to assessing the relevant thresholds and triggers for recommending immediate action, as well as the form of immediate action taken. A change to the immediate action powers set out in the *Health Practitioner Regulation National Law* (the National Law) has occurred since the publication of the chaperone

	review report. This change introduces a public interest test for taking immediate action. This additional power increases the scope for National Boards to take immediate action even where there is no direct correlation between sexualised conduct and clinical practice; which was identified as a gap prior to the inclusion of the new power. All National Boards have been comprehensively briefed in the use of the public interest test.
5. The MBA develop highly specialised delegated decision-makers for regulatory decision-making about sexual misconduct cases.	**Change implemented** MBA has established the SBNC as a new (virtual) committee responsible for decision-making in all cases involving medical practitioners where there is an allegation of a sexual boundary violation or sexual misconduct. Meetings commenced at the start of July 2017 and members have received specialised development on an ongoing basis through face-to-face meetings, which are generally held twice per year.
6. The MBA undertake an audit of all sexual misconduct immediate action decisions, to ensure they are adequately protecting the public.	**Audit completed** During the period July 2017 to July 2018, an audit was conducted of all notifications about medical practitioners, open as at 1 May 2017, where one or more of the issues raised in the notification or being investigated related to an allegation of sexual misconduct and/or a sexual boundary violation. The audit was conducted in two phases: the first phase consisted of matters where immediate action had been considered and the second phase consisted of matters where immediate action had not been considered. The auditor prepared a report on each matter for consideration by the Sexual Boundary Notifications Committee. Where appropriate, the auditor recommended additional measures be considered to ensure adequate protection of the public, including that a matter be considered for immediate action. A total of 101 notifications related to 59 practitioners were audited. Immediate action was considered on four occasions during the audit: immediate action was taken once in phase one and once in phase two and considered but not taken twice in phase one.

7. Ahpra implement operational changes to improve communication with notifiers who report sexual misconduct, in particular notifiers personally affected by practitioner conduct.	**Change implemented** See Recommendation 3.
8. Ahpra develop procedural guidance to clarify when staff should notify police and progress work, including possible Memoranda of Understanding (MOUs) with police, to ensure good communication and information sharing between Ahpra and police.	**Change progressing** Ahpra has appointed a Senior Legal Advisor–Information Disclosure who will take the lead on managing relationships with police. Ahpra has written to all police departments seeking to develop clear inter-agency protocols for sharing information. Western Australian (WAPOL) and VICPOL have entered in to MOUs with Ahpra, but other jurisdictions are currently not intending to enter into MOUs. Ahpra has escalated matters to Deputy Commission level in accordance with MOUs and notifications are received from police in relation to sexual misconduct and sexual boundary matters, although individual officers' knowledge of the powers and scope of the regulator remains relatively low. A process has been developed for escalation to obtain information from VICPOL and WAPOL in instances where information requested has not been received within the requested timeframe. The process is being rolled out to staff during January 2020. In other jurisdictions, where there is an absence of an MOU, process guidance has been developed for escalation from State Manager to Deputy Commissioner where information requested has not been received within the requested timeframe. Ahpra has published (internally only) a policy around proactive information disclosure to police. The policy, '*When to disclose information to police*' has been developed to ensure disclosure to police of information relating to criminal conduct. The policy determines that all criminal conduct should be referred to police and when the notifier does not consent to the release of the information to police, that senior management are engaged to consider the ethics of disclosure in the absence of consent of the notifier. Ahpra staff routinely provide education to police on the role and powers of Ahpra and Boards in matters involving a registered health practitioner.

9. All interim restrictions and suspensions be reviewed at least every six months, and earlier if there are triggers for review; and not remain in place more than 12 months, except in exceptional cases of delay necessitated by external decision-makers (police, tribunals or courts).	**Change implemented**
	
	In September 2017, a policy '*Review of immediate action restrictions arising from allegations of sexual boundary violations'* was implemented whereby all immediate action conditions arising from allegations of sexual boundary violations relating to medical practitioners are reviewed at least every six months, or earlier if there are triggers for review.
	
	The triggers for review include:
	• confirmed non-compliance with the restrictions
	• suspected non-compliance, where the risk posed by the nature of the non-compliance is considered moderate or high
	• receipt of any information that may indicate the risk posed by the practitioner has altered. This information may or may not be related to monitoring or risk management activity. At a minimum a review must occur when, in relation to the conduct that gave rise to the restrictions:
	  ○ an investigation is commenced by police
	  ○ charges are laid by the police
	  ○ the Practitioner is committed to stand trial in relation to any charges
	  ○ there is an outcome from any hearing in relation to the charges, or
	  ○ the police close an investigation into the conduct without laying charges
	• receipt of any new notification, regardless of whether the notification relates to similar allegations or issues from which the immediate action restrictions arise.
	
	The policy requires that notification matters must be escalated to the SBNC on each occasion that a trigger for review is identified.
	
	In September 2017, guidelines '*Review of immediate action restrictions arising from allegations of sexual boundary violations'* were also implemented to establish how the review is to be undertaken and how to refer triggers to the appropriate team (eg, National Immediate Action Team).

10. The public Register of practitioners include web links to published disciplinary decisions and court rulings.	**Change implemented** In 2018, the National Boards decided to publish links to adverse tribunal (disciplinary) decisions and court outcomes on a practitioner's record on the national register. Links are included for all adverse disciplinary decisions and court outcomes relating to a registered practitioner, where the decision is already public, and the name of the practitioner has not been suppressed.

Use of chaperones (practice monitors) in exceptional cases only (Recommendations 11 - 28)	
Chaperones in exceptional cases only If mandated chaperones do continue to be used as an interim restriction, they should be imposed only in exceptional cases, subject to the following limits:	
11. Chaperone conditions only be considered where: a) the allegation of sexual misconduct involves only a single patient,and b) the allegation, if proven, would not constitute a criminal offence,and c) the health practitioner has no relevant notification or complaint history.	**Change implemented** Recommendations 11 to 28 have been achieved by Ahpra updating its processes to reflect the requirements of the recommendations. A new practice monitor restriction and related protocol is now in place that includes all of the changes recommended in the report. The practice monitor restriction and protocol are also supported by an operational policy and guideline for monitoring of the restriction. The new protocol will be used only in exceptional cases by Ahpra and MBA.
12. Chaperones not be imposed in the context of: a) psychotherapeutic practice such as by psychiatrists, or b) allegations that a health practitioner has engaged or sought to engage in a sexual relationship with a patient, where no criminal offending is alleged.	
13. Chaperone conditions not specify: a) the type of clinical examination permitted to be performed by a practitioner,or b) any limit on the age of the patients for whom a chaperone is required.	
14. Chaperone conditions only be imposed where the practitioner commits to work in no more than three locations, with no more than four chaperones to be approved for each of the practitioner's workplaces.	
15. The term 'chaperone' be replaced with 'practice monitor'.	
Information for patients	
16. Patients be told that the National Board requires that their practitioner practise with a chaperone due to allegations of misconduct, and given fuller details (i.e., disclosing that sexual misconduct has been alleged) if they seek more information.	**Change implemented** In June 2017, a Practice monitor protocol was implemented by Ahpra for the management of practice monitor restrictions on the registration of a health practitioner.

17. The above information be given to the patient: a) at the time of booking an appointment or, in the case of an unbooked appointment, at the time of presenting at a health facility and seeking an appointment, and b) by someone other than the doctor subject to the chaperone condition, such as a receptionist or the chaperone, who should be fully informed as to reasons for the chaperone condition and properly trained.	**Change implemented** The Practice monitor protocol requires that patients must be told of the requirement for a practice monitor at the time of booking the appointment or, in the case of an unbooked appointment, at the time of presenting at the practice seeking an appointment. This information must not be provided by the practitioner personally, but rather this information must be provided by the approved booking staff at each location. If the patient requires additional information before confirming the appointment, the nominated booking staff may specify that the misconduct is sexual in nature. Where a patient refuses or demonstrates any reluctance to have a practice monitor present the contact must not go ahead or, if started, must cease immediately. Where practical the patient should then be offered an appointment with another practitioner. Practice monitors must meet the following criteria: • must not be a relative or friend of the practitioner • must be a registered health practitioner with at least 5 years' experience and who has no restrictions on their registration, who is not subject to investigation or other action under the National Law and who does not have an employment, contractual or financial relationship with the practitioner before the practice monitor restrictions were imposed • must have at least 5 years' post registration experience as a health practitioner. Practice monitors must provide a copy of their curriculum vitae and: a. contact details, photographic identification and sample signatures b. written confirmation that they have received a copy of the information sheet for practice monitors and they: I. are aware of the nomination, consent to the nomination and are willing to act as a practice monitor II. are not in a social or familial relationship with the practitioner and were not in a direct employment or contractual relationship with the practitioner before the practice monitor restrictions were imposed III. have been provided by the practitioner with a full copy of the restrictions that have been imposed on the practitioner's registration IV. have been provided by the practitioner with a full copy of the most recent document from the reasons for Board decision imposing restrictions or the tribunal referral notice, and V. are willing to undertake training provided by Ahpra about the functions and requirements of the practice monitor role before

	starting duty as a practice monitor.
18. The patient be asked to sign and date an acknowledgement of having been told of the chaperone requirement and agreeing to the chaperone's presence.	**Change implemented** The practitioner must maintain a Practice Monitor log for all patient contact, confirming the presence and direct observation of a practice monitor for the entire contact. The log is signed by the practice monitor to acknowledge that: • The patient was provided with information at the time of booking the appointment, that a practice monitor would be required • The patient agreed to the presence of the practice monitor • The patient agreed that Ahpra may contact them in order to monitor compliance with practice monitor requirements, and • The patient acknowledges that if they object to such contact it will be noted and advised to Ahpra. In some circumstances the practice monitor log format may also require a patient signature to acknowledge that they were provided with information about the practice monitor requirements at the time the appointment was booked and that they: • had agreed to the presence of the practice monitor • had read the privacy and collection statement within the log • acknowledge Ahpra may contact them in order to monitor compliance with practice monitor requirements, and • acknowledge if they object to such contact it will be noted and advised to Ahpra.
19. Patients be told that Ahpra may contact them in order to monitor compliance with the conditions imposed on the practitioner's registration, and that any objection will be noted and notified to Ahpra.	**Change implemented** See Recommendation 18
20. The National Law be amended as necessary to allow a National Board to require a practitioner to disclose the reasons for a restriction to patients and to permit chaperones to be fully briefed as to those reasons.	**Change partially implemented** The National Law has not been amended, but the Practice monitor protocol states that if a patient requires more information, booking staff may specify that the misconduct is sexual in nature. The protocol also requires that practice monitors be provided with a full copy of the restrictions imposed on the practitioner's registration and a full copy of the most recent

	document from the reasons for Board decision imposing restrictions or the tribunal referral notice.
21. Subject to implementation of recommendations 16-20, the requirement for a practice sign be discontinued.	**Change implemented** Practitioners with practice monitor conditions are not required to have a sign.
Chaperone requirements	
22. Only a registered health practitioner, who does not have a pre-existing employment, contractual or financial relationship with the practitioner, may be approved as a chaperone.	**Change implemented** See Recommendation 17
23. A patient-nominated chaperone may not be approved as a chaperone.	**Change implemented** See Recommendation 17
24. The chaperone be provided with full information about the nature of the allegations made against the practitioner and a full copy of the conditions that have been imposed on the registration of the practitioner.	**Change implemented** See Recommendation 17
25. Chaperones be fully briefed and provided with training about the functions and requirements of the chaperone role before commencing duty as a chaperone.	**Change implemented** See Recommendation 17
26. A practitioner subject to chaperone conditions not be permitted to practise until all practice locations are known and chaperones are approved, briefed and trained.	**Change implemented** Practitioners are prohibited from all practice until approved locations (no more than three) are published. Approval of practice locations is contingent upon completion of all of the following: • nomination and approval of no more than three practice locations • nomination and approval of no more than four people to act as a practice monitor at each approved practice location • nomination to Ahpra of practice staff at each approved practice location responsible for patient booking arrangements

	• removal of the prohibition on practice from the practitioner's registration and the public register, and • publication of approved practice locations on the restrictions on the practitioner's registration and the public register.
27. The monitoring of chaperone conditions be the responsibility of a national specialist team within Ahpra.	**Change implemented** In October 2019, a national operating model for the Compliance function was commenced. As part of this model, a specialist boundary compliance team was established to monitor all practitioners with restrictions related to boundary violations and sexual misconduct.
28. Any breach of chaperone conditions be brought promptly to the attention of the National Board delegate and consideration given to the need to suspend the practitioner, with a low threshold for imposition of a more onerous interim restriction or suspension if more information emerges indicating a higher risk to patients or to the public interest, or evidence of breach of a chaperone condition.	**Change implemented** In September 2017, the policy *'Review of immediate action restrictions arising from allegations of sexual boundary violations'* and guidelines '*Review of immediate action restrictions arising from allegations of sexual boundary violations'* were implemented to provide guidance on action to be taken when there is a suspected or confirmed breach of conditions, including chaperone and practice monitor restrictions. (See recommendation 9 for more detail about the policy and guidelines.) Suspected breaches of conditions are referred to the SBNC and investigated to gather additional evidence. Confirmed breaches and high-risk suspected breaches are referred to the National Immediate Action Team and then the SBNC for consideration of the appropriate regulatory action, with a low threshold for imposition of a more onerous restriction or suspension.

Appendix B Terms of Reference

Three Years On: Reviewing changes since the Independent review of the use of chaperones to protect patients in Australia (the Review)

In August 2016, the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) commissioned Professor Ron Paterson to

- consider 'whether, and if so in what circumstances, it is appropriate to impose a chaperone condition on the registration of a health practitioner to protect patients while allegations of sexual misconduct are investigated', and
- to recommend whether changes to regulatory practice, and the National Law, are needed to better protect patients and the public.

Professor Paterson's findings and recommendations (the Report) were published in April 2017.

Both the MBA and AHPRA accepted all of the recommendations from the Report. We outlined our approach and put in place actions for implementing those recommendations.

It is now three years since the Review was commissioned and over two years since the publication of the Report. AHPRA and the MBA now seek to understand with reference to medical practitioners:

1. What have we achieved since the publication of the Report?
    - Comparison of outcome and IA data; review timeliness data?
    - Consistency of decisions – has this been achieved through the single committee
    - Review of the implementation of recommendations
        - In terms of specialised skills for investigators?
        - In terms of relationships between investigators, legal services and the SBNC?
    - Other?

2. What impact has our efforts to implement the recommendations had, including by reference to data about the form of immediate action taken by the MBA delegate(s)?

    - Comparison of data
    - Case study on investigation practices
    - Escalation to police using MOU
    - Other?

3. In relation to the specific recommendations that chaperones in exceptional cases only

    - In how many cases have practice monitor conditions been used?
    - Were these cases exceptional cases within the meaning of the Report?
    - Were the practice monitor conditions effective at protecting the public?
    - Data on use of chaperone conditions
    - Review of specific 'practice monitor' cases

4. Are there recommendations that have not been implemented, have only partially been implemented or where implementation went further than what was recommended?

    - Police MOUs
    - Other?

5. Have there been any unintended consequences arising from our efforts to implement the recommendations, and if so,

    a. What are these unintended consequences?

    b. Have they been positive or negative and to whom?

    - Review IA data – are there more suspensions? Is this good or bad?
    - Review campaign re publishing decisions – too little/ too much?
    - Personal accounts from decision makers about the toll of decision-making? Investigators about the toll of investigating?
    - Other?

6. How through our processes are we capturing and ensuring the 'voice' of both notifiers and practitioners are reflected in processes and decisions?

    - Are there exemplars that we should consider?
    - How should we understand and reflect public expectations?

7. What other recommendations arise from the review for AHPRA, the MBA, other National Boards and other regulators of health practitioners?

    - Specific training in contemporary approaches to sexual offending investigations
    - Additional support for notifiers through the process

- Psychological safety and wellbeing for staff and for decision makers
- Literature review – has anyone studied the impacts of decision makers by peers? Is there a potential benefit in non-peer decision-making for sexual boundaries etc?
- Other?

Appendix C Summary of meetings

Melbourne

1	Ahpra staff, including: • Chief Executive Officer • Executive Director, Regulatory Operations • Executive Director, Strategy and Policy • Executive Officer, Medical Board of Australia • General Counsel • National Director, Notifications • National Director, Engagement and Government Relations (teleconference) • National Operations Manager, Immediate Action • National Manager, Notifications • National Manager, Legal Services • National Engagement Advisor • Operations Managers, Boundary Violation and Sexual Misconduct • Senior Notifications Officer, Immediate Action • Investigator (sexual boundary notifications)
2	Richelle McCausland – Ombudsman and Commissioner, National Health Practitioner Ombudsman and Privacy Commissioner
3	Georgie Haysom – Head of Research, Education and Advocacy Andrew Mariadason – General Manager, Professional Conduct Dr Penny Brown – Chief Medical Officer Avant Mutual Group Ltd (teleconference)
4	Annitia Rynhart – Former Ahpra National Operations Manager, Boundary Violations and Sexual Misconduct
5	Professor Peter Warfe – Deputy Chair, Sexual Boundaries Notifications Committee
6	Dr Anne Tonkin – Chair, Medical Board of Australia

7	Mark Bodycoat – Chair, Ahpra Community Reference Group and community member of the Sexual Boundaries Notifications Committee (teleconference)
8	Observed the 4 November 2019 meeting of the Sexual Boundaries Notifications Committee attended by seven members, chaired by Christine Gee
9	Ameer Tadros – Director Health Professional Councils Authority (teleconference)

Sydney

1	Ahpra staff: State Manager, New South Wales
2	Timothy Bowen – Senior Solicitor, Advocacy Claims & Educations Medical Insurance Group Australia (teleconference)

Brisbane

1	Ahpra staff, including: • General Counsel • National Director, Compliance • State Manager, Queensland • National Operations Manager, Immediate Action (teleconference) • National Manager, Notifications (teleconference)
2	Christine Gee, Chair of the Sexual Boundaries Notifications Committee
3	Dr Sara Bird, Executive Manager, Professional Services – MDA National Insurance (teleconference)