

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

**Commissioned by the Medical Board
of Australia and the Australian Health
Practitioner Regulation Agency**

Report by Professor Ron Paterson

February 2017

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Foreword

The introduction of the National Registration and Accreditation Scheme (the National Scheme) for health professions in 2010 was a major step forward in the regulation of health practitioners in Australia. The Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), is regarded internationally as innovative and progressive.

The National Law places public protection at its heart. The first objective of the National Scheme is 'to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered' (s 3(2)(a) of the National Law). Public protection is especially important in protecting patients from sexual advances or sexual assault by a practitioner.

Health professional codes of ethics have long forbidden sexual contact between practitioners and patients, recognising that it is a violation of trust. Even if 'consensual', such behaviour is unethical and unprofessional. If there is no legitimate clinical justification for an examination, the conduct is unlawful and may result in criminal conviction.

A critical challenge for any health regulator faced with allegations of sexual misconduct by a health practitioner, is deciding what, if any, immediate action should be taken to protect patients and the public pending an investigation. Internationally, health regulators (especially medical boards) have imposed chaperone conditions as an interim protective measure – permitting the practitioner to continue working, but with a condition on their registration that should, in theory, protect patients.

This review, called by the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) in the wake of allegations of indecent assault on multiple male patients by Melbourne neurologist Dr Andrew Churchyard, has led to a timely re-examination of the appropriateness and effectiveness of chaperone conditions. I commend the MBA and AHPRA for their willingness to review current practice, hear the views of stakeholders, and learn from evidence in Australia and internationally.

I have received full cooperation and access to confidential files, from the MBA and AHPRA. I acknowledge the openness of AHPRA staff and MBA members, and their commitment to improving the operation of the National Scheme. I am also grateful for the assistance provided by co-regulatory entities in New South Wales (NSW) and Queensland, which operate under a variation of the National Law, but also impose chaperone conditions.

Comparing the practice of leading international medical regulators has been a valuable part of this review. I acknowledge the generous assistance provided by medical boards in New Zealand, the United Kingdom, Canada and the United States. In each of these countries, to varying degrees, chaperone conditions are used to protect patients while allegations of sexual misconduct by a health practitioner are investigated.

Finally, this review could not have happened without the time and thought so many individuals and organisations put into their submissions and meetings with me. I acknowledge the patients who, having suffered at the hands of predatory health practitioners, came forward to tell me their story. I also thank the many health practitioners who contributed their views.

My recommendations reflect my conclusion that there are better ways to protect and inform patients when allegations of sexual misconduct are made against a health practitioner. Improvements can and should be made in the handling of sexual misconduct cases. I have identified practice changes for implementation by AHPRA and the National Boards. However, the justice sector, including tribunals and courts, also has an important role to play. Finally, legislators need to progress pending reforms to the National Law – and to consider further reforms to better protect the public.

Patients, practitioners and the public deserve prompt, thorough, fair and consistent action in the interim period while the truth of sexual misconduct allegations is examined. Interim restrictions must be workable, acceptable to patients, and adequate to protect the public. Sexual advances or sexual assault by a health practitioner is a harm that society will not tolerate.

Professor Ron Paterson

Independent Reviewer

Part A: Executive summary and recommendations

Executive Summary

Background

This review was commissioned by the MBA and AHPRA in August 2016, in the wake of media reports that a Melbourne neurologist – facing criminal charges following allegations of indecent assault on a patient – had been permitted to continue to practise for eight months subject to a condition on his registration that an approved chaperone be present for all consultations with male patients. Dr Andrew Churchyard was only suspended by the MBA in February 2016, following a further notification, from a second patient, who alleged that Dr Churchyard had indecently assaulted him behind a pulled curtain, while a chaperone was present.

Purpose of review

The purpose of the review is 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. The full Terms of Reference are set out in *Part 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 a public call for submissions, with 45 submissions received from patients, health practitioners, colleges and professional organisations, medical defence organisations, health complaints entities and regulators, state and territory health departments and other interested parties. Meetings were held with submitters who wished to be seen in person and with regulators and relevant experts. Facilitated discussions about the use of chaperone conditions occurred at a consumer forum hosted by the Health Issues Centre in Melbourne, at the International Association of Medical Regulatory Authorities’ 12th International Conference on

Medical Regulation, and at the Australasian Association of Bioethics and Health Law Conference.

In-depth analysis of MBA case studies and AHPRA data, policies and processes, and discussion with AHPRA staff and MBA members, has informed the review. Relevant case law from tribunals and courts has been examined. Meetings were held with health regulators in NSW and Queensland, where co-regulatory arrangements are in place. International practice (in handling allegations of sexual misconduct by doctors) was reviewed by meetings with senior officials from leading international medical regulators in the United Kingdom, Canada, the United States and New Zealand.

Context

Patients who confide deeply personal health information in their health practitioner, and permit intimate examinations, do so trusting that they are safe within a professional relationship. They trust practitioners never to use patients for their own sexual gratification, and that regulators will protect them if there are any concerns about inappropriate behaviour by practitioners. When that trust is abused, patients suffer emotional and physical scars and long-term psychological harm.

Chaperone conditions have been used as an interim protective measure in Australia for many years, well before the National Law, and approved by tribunals and courts. Chaperones continue to be used as a regulatory intervention in the comparable jurisdictions of New Zealand, the United Kingdom, Canada and the United States (including following proven sexual misconduct). As in Australia, the media in these countries has highlighted shocking cases of sexual abuse of patients by predatory doctors, and there have been calls for ‘zero tolerance’ for offenders. Yet the use of chaperone conditions endures.

In the United Kingdom, more emphasis is placed on the risk of loss of public confidence in health professions and their regulatory bodies, if allegations turn out to be true and practitioners have been permitted to continue seeing patients (even with chaperone conditions) in the interim. In Ontario, a recent task force has recommended against the use of gender-based restrictions (on the basis that an accused doctor who cannot be trusted to see patients without a chaperone should be suspended) and the Minister of Health has introduced legislation that will limit the use of chaperones.

Data on mandated chaperones in Australia

In January 2017, 48 health practitioners (including 39 doctors) in Australia were subject to a chaperone condition. The other nine health practitioners subject to a chaperone condition were three nurses, two physiotherapists, two chiropractors, one dentist and one Chinese medicine practitioner. Only one of the chaperone restricted practitioners (a nurse) was female.

The 39 doctors comprised 20 general practitioners, two psychiatrists, two neurologists, one dermatologist, one ophthalmologist and 13 medical practitioners without specialist registration. All the doctors appeared to be in private practice. Overseas-trained doctors, who comprise approximately 33% of the medical workforce in Australia, accounted for 59% (23 of 39) of the doctors subject to a chaperone condition.

Approximately 60% of current chaperone conditions were imposed as an immediate action restriction while allegations of sexual misconduct were investigated. The remaining 40% resulted from disciplinary or registration decisions made by a tribunal or the MBA following proven sexual misconduct. This is contrary to the *Litchfield* decision of the NSW Court of Appeal that a doctor who cannot be trusted to see patients without the presence of a chaperone is not fit to practise medicine at all.¹

Current practice

Analysis of current practice reveals significant inconsistency in immediate action decisions of Board committees of the MBA.² Chaperone conditions are sometimes imposed in situations where a practitioner is facing similar complaints from several patients or has a previous history of complaints of sexual misconduct, and in cases where criminal offending is alleged. There is very little evidence of vexatious complaints alleging sexual misconduct by a health practitioner.

Interim chaperone conditions often continue in place for a long time. Analysis of 27 interim chaperone conditions in place in September 2016 found, on average, they had been in place for 1.8 years; 56% of chaperone conditions had been imposed more than two years previously.

Key findings³

1(a) Chaperones are of limited effectiveness in protecting patients⁴

Chaperone conditions are not wholly effective to prevent patients being exposed to harm and, in some cases, sexually assaulted. Their use is largely confined to private medical practice. The system relies on inadequately informed and trained chaperones, many in a conflicted situation by being employed by the practitioner they are to observe and report on. There are many reported examples of practitioners breaching chaperone conditions. Predatory practitioners who have come to view patients as sexual objects may not be deterred by a safety mechanism that still leaves the practitioner in control.

1(b) Chaperone conditions as currently applied are inappropriate given the importance of trust and informed consent between patients and health practitioners

The mandated chaperone system keeps patients in the dark. They do not know *why* a chaperone is required. This is the most significant flaw in the current system. Even the word 'chaperone' is inappropriate – patients find it old-fashioned and paternalistic.

1(c) Chaperone conditions are inappropriate in some situations

A chaperone condition is inappropriate in psychotherapeutic practice such as by psychiatrists, due to the highly personal and confidential nature of therapy and the intrusive presence of a chaperone.

Chaperone conditions are also not appropriate in situations where they are unlikely to be effective to avert risk to patients: to protect patients from inappropriate 'relationship' type behaviour by health practitioners, since most contact of this nature will occur in unchaperoned time, outside a consultation, and in situations where a practitioner works in multiple locations and there are practical difficulties in monitoring compliance.

In general, chaperone conditions are not appropriate – and a stricter restriction or suspension should be imposed – where the practitioner is the subject of allegations of sexual misconduct from more than one patient; where the practitioner has been subject to a previous

¹ *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 639F.

² The MBA exercises its decision-making powers by delegation to its state and territory Boards and committees (Board committees).

³ The numbering of key findings mirrors the Terms of Reference.

⁴ The offer of a chaperone as an observer for the doctor is regarded in Australia and internationally as good medical practice for intimate examinations – and is not the focus of this review.

notification or complaint of sexual misconduct; where an indecent assault, sexual assault, rape or other criminal offending is alleged; where the police have laid charges; or where there is any history of deliberate non-compliance with chaperone conditions or other restrictions on practice.

1(d) Improvements are needed to inform and protect patients, if chaperone conditions are retained

Chaperones must be fully informed about the nature of the allegations against the practitioner, what their role is and what behaviour they should be watching for, and properly trained. Patients should be adequately informed, at the time they book their appointment or present for an unbooked appointment, why a chaperone is required; and given fuller information if they ask. The compliance and monitoring system needs further improvements to make it more effective. However, additional requirements would add to the complexity and expense of the current monitoring system.

1(e) Board committees are inconsistent in assessing the need for immediate action and use of chaperone conditions

The current approach of Board committees is not consistent between states and territories throughout Australia (and even within single jurisdictions) at the immediate action stage. Serious allegations that lead to a gender-based prohibition or suspension in one state or territory may result in a chaperone condition in another state or territory. Some Immediate Action Committees appear to over emphasise 'minimum regulatory force' or least restrictive intervention, without sufficient regard to the need for the intervention to be adequate to protect the public.

1(f) Improvements are needed in the national Chaperone protocol, current practice and escalation processes

A mandated chaperone should be a registered health practitioner who is not an employee of the monitored practitioner and not patient-nominated. A registered health practitioner brings obvious advantages to the role, including their clinical background, ethical obligations of confidentiality, and regulatory obligations under the National Law. Independence is important because of the difficulties of power imbalance when an employee is asked to report on an employer.

Only an informed and trained health practitioner can be an effective watchdog. Chaperones must be provided with full information about the nature of the allegations made against the practitioner and be fully briefed and trained in their role before they commence duty. There should be much lower tolerance by Board committees for breaches of chaperone conditions.

Chaperone conditions often remain in place far too long for an 'interim' measure, due to delays in investigations. Responsibility for delays cannot simply be laid at the door of the MBA and AHPRA. The justice system also has a critical role to play.

All interim restrictions and suspensions should be reviewed at least every six months and earlier if there are triggers for review, such as the laying of criminal charges, committal to stand trial or convictions, which should trigger a further immediate action process and consideration of the need to suspend the practitioner.

2 More restrictive regulatory measures should be used to protect patients while allegations of sexual misconduct are investigated

Given the inappropriateness and limited effectiveness of chaperone conditions, there should be greater use of gender-based prohibitions or prohibitions on patient contact, and suspension, to protect patients while allegations of sexual misconduct are investigated – as well as escalation processes to reassess information on the basis of new information.

3 No change is needed to the *Regulatory principles for the National Scheme*⁵

Clearer guidance is needed for National Boards in relation to the exercise of immediate action powers, including the threshold for taking immediate action and the appropriate level of intervention. However, the *Regulatory principles* themselves do not need amendment.

4 Legislative reform should be considered by Ministers to better protect patients while allegations of sexual misconduct are investigated

Important changes to the National Law have been approved by Health Ministers and need to be progressed. They include adopting the NSW test requiring a National Board to take immediate action if it is 'in the public interest' to do so,⁶ expanding the definition of employer in the National Law to cover all forms of practice arrangement, including employment, self-

⁵ AHPRA, *Regulatory principles for the National Scheme* (2015): www.ahpra.gov.au/About-AHPRA/Regulatory-principles. The National Scheme is the National Registration and Accreditation Scheme.

⁶ Health Practitioner Regulation National Law (NSW), s 150

employment, engagement under a contract for services, voluntary and honorary appointments, and clarifying that a National Board may set a review period when exercising its powers to change a condition imposed on a practitioner or student.

Legislative reform or practice changes should also be considered in four areas:

(a) Information for patients and chaperones

The National Law may need to be amended 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. Unless disclosure to patients and chaperones is clearly authorised by statute, there will continue to be a gaping hole in the level of protection afforded to patients by chaperone conditions.

(b) Information on national *Register of practitioners*

The national *Register of practitioners* currently contains less information than public registers in some overseas jurisdictions. The limited information on the register is insufficient to inform patients and the public and does not reflect a commitment to transparency. Patients should not have to resort to Dr Google to find information about a doctor's previous disciplinary or criminal record for sexual misconduct. The register should include web links to published disciplinary decisions and court rulings.

(c) Communication with notifiers

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.

(d) Removal of privilege against self-incrimination

Health practitioners may be unwilling to provide information or produce documents during investigations because statements they make or evidence they produce may be used against them in criminal proceedings. This unwillingness contributes to delays in investigations of allegations of sexual misconduct, which are often the subject of concurrent criminal investigations. Inclusion of a provision in the National Law removing the entitlement to refuse to answer a question or produce a document if the answer or production might tend to incriminate the practitioner (while still preventing its use in

criminal proceedings) would likely reduce delays in investigations and provide National Boards with important information to assess the need for and appropriate level of interim action.

Overall conclusion

It is time to abandon chaperone conditions as an interim restriction, given their dubious appropriateness and the evident holes in the safety net they are meant to provide. Predatory practitioners can evade chaperone conditions, causing harm to patients and loss of public confidence in health professions and their regulators. This is a harm that society will not tolerate – and does not accept in other contexts, such as in public hospital and childcare settings.

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.

This review also identifies a number of areas for improvement in the handling of sexual misconduct cases by the MBA and AHPRA: to ensure that notifiers (especially victims) are treated with empathy and sensitivity, that immediate action and speedy investigation is undertaken where warranted to protect the public, that regulatory decisions are taken on a consistent basis, in accordance with the National Law and policy guidance, and that practitioners are treated fairly.

Recommendations

(a) No chaperones and improved handling of sexual misconduct cases

1. The use of mandated chaperones as an interim restriction in response to allegations of sexual misconduct be abandoned.
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.
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.
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.
5. The MBA develop highly specialised delegated decision-makers for regulatory decision-making about sexual misconduct cases.
6. The MBA undertake an audit of all sexual misconduct immediate action decisions, to ensure they are adequately protecting the public.
7. AHPRA implement operational changes to improve communication with notifiers who report sexual misconduct, in particular notifiers personally affected by practitioner conduct.
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.
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).
10. The public *Register of practitioners* include web links to published disciplinary decisions and court rulings.

(b) 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.
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 (ie, disclosing that sexual misconduct has been alleged) if they seek more information.
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.

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.
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.
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.
21. Subject to implementation of recommendations 16-20, the requirement for a practice sign be discontinued.

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.
23. A patient-nominated chaperone may not be approved as a chaperone.
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.
25. Chaperones be fully briefed and provided with training about the functions and requirements of the chaperone role before commencing duty as a chaperone.
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.
27. The monitoring of chaperone conditions be the responsibility of a national specialist team within AHPRA.
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.

Part B: Background

Terms of Reference

The purpose of this review is 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.

The Terms of Reference require the review to:

1. consider:
 - a) whether chaperone conditions are an effective measure to protect patients
 - b) whether chaperone conditions are appropriate given the importance of trust and informed consent in the professional relationship between patients and their health practitioners
 - c) in what circumstances chaperone conditions are not appropriate
 - d) if chaperone conditions are appropriate in some circumstances, what steps need to be taken to ensure patients are protected (including effective monitoring of chaperone conditions to ensure compliance) and are adequately informed
 - e) the approach of Board committees in assessing the need for immediate action and use of chaperone conditions, and
 - f) the national *Chaperone protocol* and current practice, including processes for monitoring and compliance, notice to employers and places of practice, provision of information to patients, information sharing with other agencies, and escalation processes in the case of a suspected breach
2. recommend any other regulatory measures to protect patients while allegations of sexual misconduct are investigated
3. recommend whether any change is needed to the *Regulatory principles for the National Scheme*, and
4. recommend what (if any) legislative reform should be considered by Ministers to protect patients while allegations of sexual misconduct are investigated.

I have had regard to the National Law, the *Regulatory principles*, and other relevant legal principles.

Although my review has focused on medical practitioners, I have examined a few cases involving practitioners of other professions as part of my

analysis of the appropriateness and workability of chaperone conditions generally.

Context of review

The review was commissioned by the MBA and AHPRA in August 2016, in the wake of media reports that Melbourne neurologist Dr Andrew Churchyard had been permitted to continue to practise for eight months from May 2015, subject to a condition on his registration that an approved chaperone be present for all consultations with male patients. He had been permitted to practise with a chaperone, despite facing criminal charges following allegations of indecent assault on a 19-year-old male patient, Tom Monagle, who had notified AHPRA. Dr Churchyard was only suspended by the MBA in February 2016, following a further notification, from a second patient, who alleged that Dr Churchyard had indecently assaulted him behind a pulled curtain, while a chaperone was present. In July 2016, Dr Churchyard committed suicide.

AHPRA confirmed publicly that Dr Churchyard had faced a previous complaint of boundary violation, in 2007. He had been cautioned by the Medical Practitioners Board of Victoria to take greater care in informing patients of the reasons for proposed examinations, however the decision was not published and no restrictions were placed on Dr Churchyard's registration.

In early August 2016, the media in Victoria raised concerns about the effectiveness of the chaperone system in light of the allegations about Dr Churchyard. It was reported that multiple male patients were suing Dr Churchyard's estate, alleging sexual abuse. AHPRA confirmed that 47 doctors had a chaperone condition imposed on their registration, due to concerns about sexual misconduct.

The Minister of Health in Victoria called for a national review of the use of chaperones for doctors accused of sexual misconduct. On 10 August 2016, the MBA and AHPRA announced this review.

I acknowledge the courage of Mr Monagle in telling his story publicly and the role that his actions, and media coverage, have played in leading to this review. As at 18 January 2017, 10 cases had been issued in the Supreme Court of Victoria against the estate of Dr Churchyard on behalf of individuals claiming they were sexually assaulted by him. It has been reported that over 100 former patients of Dr Churchyard have made enquiries of Adviceline

Injury Lawyers, who are currently acting for former patients.⁷

Review process

The first stage of the review was gathering information from the MBA and AHPRA. This included face-to-face meetings with key AHPRA staff, including the CEO and Executive Directors, and meeting with the Chair of the MBA. The purpose of these initial discussions was to understand the context for the review and to be briefed on current practices relevant to the imposition of chaperone conditions.

I was provided with key AHPRA and MBA documents, including:

- MBA Internal Guidance document *Board mandated use of chaperones following allegations of sexual misconduct* (dated 24 January 2012 – superseded by the current *Chaperone protocol*).
- AHPRA *Chaperone protocol* (dated November 2015; updated December 2016).
- AHPRA *Operational Policy: Monitoring Chaperone Conditions* (dated August 2016).
- AHPRA *Guide to Decision-Making: Immediate Action* (dated 6 December 2012).
- Draft AHPRA *Guide to Decision-Making: When to recommend chaperone restrictions* (dated October 2016).

At my request, I was given case studies to examine, including papers prepared by AHPRA for consideration by Board committees and subsequent decisions and action papers.

I was keen to see how compliance with chaperone conditions is monitored by AHPRA. I accompanied compliance staff on two site visits in Melbourne during October 2016. The first was an announced visit for the purpose of moving a medical practitioner subject to chaperone conditions to the new *Chaperone protocol*; the second was an unannounced visit to a medical practitioner as part of AHPRA's compliance activities. During these visits, I met with the practitioners and a chaperone, and also observed the required practice sign in the waiting room, advising of the chaperone requirement.

The second stage of the review involved seeking different points of view about the use of chaperone conditions. A call for submissions was made on 5 September 2016 by a media release issued by AHPRA. The media release was uploaded on the AHPRA and MBA websites, and issued to health sector and general media contacts. This resulted

in coverage in a number of news publications, including *The Herald Sun*, *The Age*, *Adelaide Now*, and *The Sydney Morning Herald*, as well as on websites such as *Australian Doctor*, *6minutes* and *Croakey*. The invitation for submissions was sent to key stakeholders, including health consumer groups, and shared by AHPRA via social media. Submissions were received by the Office of the National Health Practitioner Ombudsman and Privacy Commissioner (the NHPOPC), in its role as the secretariat for the review. In total, 45 submissions were received from a range of stakeholders (see *Summary of submissions* at Appendix A).

The third stage of the review involved meetings with submitters who wished to be seen in person and with regulators and experts in this field – to explore key issues raised in submissions. I held face-to-face meetings in Sydney, Melbourne, Brisbane, Canberra and Adelaide (see *Summary of meetings* at Appendix B). I met with the MBA and with some individual Chairs and members of Board committees. I also facilitated discussions about the use of chaperone conditions at a consumer forum hosted by the Health Issues Centre in Melbourne, at the International Association of Medical Regulatory Authorities' 12th International Conference on Medical Regulation, and at the Australasian Association of Bioethics and Health Law Conference. Where an individual comment or opinion is referred to, consent to the publication has been sought from the relevant individual or organisation.

To compare practices in NSW and Queensland (where co-regulatory arrangements are in place) with the other states and territories, I met with regulators in those states. To review overseas practice, I met with senior staff of the Medical Council of New Zealand, the General Medical Council, the Oregon Medical Board, the College of Physicians and Surgeons of British Columbia, the College of Physicians and Surgeons of Ontario, and the Collège des médecins du Québec. These meetings assisted my research on the current practice of leading international health regulators in handling allegations of sexual misconduct against health practitioners.

The next stage of the review was gathering more detailed information from AHPRA regarding issues or concerns expressed in submissions and during meetings, or that became apparent to me during the review process. I reviewed a number of individual files, to better understand the circumstances in which immediate action may be taken by a Board committee. At my request, AHPRA briefed Liesl Chapman SC to provide an

⁷ Bree Knoester (Adviceline Injury Lawyers), 'Churchyard case prompts grave concerns for patient safety' (2 August 2016): www.advicelineinjurylawyers.com.au/2016/08/02/churchyard-case-prompts-grave-concerns-patient-safety.

opinion on case law (from tribunals and courts) on the use of chaperone conditions. AHPRA staff provided data on health practitioners currently subject to chaperone conditions; practitioners subject to gender-based restrictions; and practitioners suspended due to sexual misconduct allegations. Current data for NSW was obtained from the Health Professional Councils Authority (HPCA). AHPRA also prepared analysis of the outcomes of boundary violation matters for the period July 2014 to June 2016.

My analysis of current practice in mandating chaperones in response to allegations of sexual misconduct is set out in *Part D* of this report.

In forming my recommendations, I have carefully considered the key themes emerging from AHPRA data, submissions and opinions expressed to me during the review process, my review of individual files and my analysis of relevant guidelines, policy documents, inquiry reports, statutes and case law on the handling of allegations of sexual misconduct in the doctor–patient relationship.

Acknowledgments

I acknowledge the generous support of Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC), in allowing her Office to serve as secretariat for the review and releasing key staff. Principal Legal Policy Officer Richelle McCausland provided invaluable support throughout the review, attending key meetings and helping to research and draft this report. NHPOPC staff Jessica Micallef and Shantal Giles assisted with website and administrative arrangements and editing the report.

Dr Grant Davies, Health Services Commissioner, Victoria, kindly made office space available to provide an appropriate venue for face-to-face meetings in Melbourne. Susan Biggar and the Health Issues Centre hosted a consumer forum in Melbourne, which was an excellent opportunity to hear and debate ideas.

I am grateful to Martin Fletcher, Chief Executive Officer, and numerous AHPRA staff members from national and state offices, all of whom co-operated fully throughout the review, providing detailed written and face-to-face briefings and access to confidential files. My thanks also to MBA Chair Dr Joanna Flynn, and members of the MBA and Board committees, for their thoughtful contributions.

I acknowledge the assistance given by the co-regulatory jurisdictions of NSW and Queensland. The NSW Health Care Complaints Commissioner (HCCC), Sue Dawson, the Chair of the Medical Council of NSW, Dr Greg Kesby, the Director of the HPCA, Ameer Tadros and the Health

Ombudsman, Leon Atkinson-MacEwen all provided valuable information and suggestions.

International medical regulatory bodies were also generous with their time and assistance. In addition to their senior staff, I thank Medical Council of New Zealand CEO Philip Pigou and Registrar David Dunbar, College of Physicians and Surgeons of British Columbia Registrar and CEO Dr Heidi Oetter, College of Physicians and Surgeons of Ontario Registrar Dr Rocco Gerace and Deputy Registrar Dan Faulkner, Collège des médecins du Québec Director of Medical Education Dr Anne-Marie MacLellan, Oregon Medical Board Executive Director Kathleen Haley and General Medical Council Assistant Director Anna Rowland.

My analysis of overseas law and practice was assisted by the tireless efforts of research assistant John McHardy, Faculty of Law, University of Auckland.

Finally, this review could not have happened without the time and thought so many individuals and organisations put into their submissions and meetings with me. I acknowledge the patients who, having suffered at the hands of predatory health practitioners, came forward to tell me their story. I also thank the many health practitioners and regulatory staff who contributed to the review.

Summary of submissions

A call for submissions on 5 September 2016 resulted in 45 submissions from:

- 7 patients, families / friends of patients and consumer / community groups
- 12 health practitioners (including three health practitioners who also identified themselves as 'patients')
- 10 colleges / professional organisations
- 4 health complaints entities and regulators
- 4 state and territory health departments
- 3 medical defence organisations, and
- 5 other interested persons / organisations.

A *Summary of submissions* is at Appendix A.

A broad range of views were expressed in response to the Terms of Reference, and many submitters made thoughtful suggestions regarding how they believed the imposition and monitoring of chaperone conditions could be improved.

Views on the appropriateness of chaperone conditions

Some submitters (including patients, families and health practitioners) expressed the view that chaperone conditions are not appropriate as they do not effectively protect the public:

‘...[P]ractitioners should not be permitted to consult or treat patients whilst under investigation for serious misconduct, in particular for alleged sexual misconduct. Patients need to be able to trust that Health Professional Boards make patient safety their first priority.’

ACT Health

Examples of alleged breaches of chaperone conditions by health practitioners were cited in some submissions as evidence that chaperone conditions are not effective:

‘It seems the current system simply assumes the presence of a chaperone will automatically prevent any offending behaviour but this has been shown to be incorrect.’

Beth Wilson, former Health Services Commissioner, Victoria

One submitter (a health practitioner who was the victim of sexual misconduct by another health practitioner) suggested that chaperone conditions are inappropriate as failures will inevitably occur because of the interpersonal dynamics inherent in abuse (eg, an abuser will make strenuous efforts to evade observation and the victim will have difficulty stopping the abuse).⁸ Another submitter (the daughter of a victim of sexual abuse), noted how a predatory doctor can deceive the chaperone and the patient:

‘[The doctor] was still able to act inappropriately towards my dad during the consultations the chaperone was present at, covering it with doctor/medical reasons. Dad had full faith and trust in his doctor and had no reason to believe he would be doing anything not required or inappropriate therefore although he thought what was happening was strange, [he] tried to ignore it.’

Ms X, daughter of victim of sexual abuse

Some submitters discussed the flow-on effects of chaperoning for patients. A number of submissions questioned whether the presence of a chaperone alters the doctor–patient interaction in ways that could inhibit effective medical practice (eg, through a reduction of trust in the doctor, an unwillingness to broach delicate issues or undertake intimate examinations, and the inhibition of subtle emotional cues in consultation).

Many submitters queried the workability of chaperone conditions, particularly in rural and remote locations. The Northern Territory Department of Health noted that the effectiveness of chaperoning could be compromised by the difficulty in offering an appointment with an alternative practitioner if the patient does not consent to a chaperone being present, and also by the availability of chaperones, particularly in Aboriginal communities, where strict gender rules impact on the selection of a chaperone.

The cost associated with complying with chaperone conditions (for practitioners practising in both private and public settings) was also raised as a possible problem by some submitters:

‘Some organisations may find it difficult to comply with chaperone guidelines, potentially diverting key resources away from other service delivery priorities.’

The Hon Michael Ferguson MP,
Minister for Health, Tasmania

Looking at the issue from another point of view, some submitters raised concerns about the use of chaperone conditions based on possible harm to the practitioner:

‘Placement of a chaperone, while not evidencing guilt on the part of the practitioner, will demonstrate to most patients that something untoward (probably of a sexual nature) has been alleged against the practitioner. The ramifications of this upon the practitioner could be devastating. During the chaperoning period the practitioner will risk losing the respect and trust of their employer, colleagues, employees and patients.’

Australian Dental Association

Other submitters (including health practitioners, medical defence organisations and professional

⁸ Submission from Dr Y, September 2016.

associations) were more supportive of the use of chaperone conditions as an effective interim regulatory measure while allegations of sexual misconduct are being investigated:

'In certain cases, the use of chaperone conditions pending the outcome of an investigation and/or hearing into an allegation of sexual misconduct is appropriate. The conditions provide flexibility in balancing the need to protect the public and to provide the medical practitioner with procedural fairness and the ability to practice, particularly where the investigation of an allegation of sexual misconduct will involve significant delay.'

MDA National

Some submitters acknowledged that although chaperone conditions may be imperfect, there are limited regulatory alternatives available to decision-makers. Suspension and registration restrictions relating to particular patient groups (eg, based on gender and/or age of patients) were commonly discussed as possible alternatives, and there were mixed points of view. Some submitters expressed the view that a practitioner must be suspended if certain allegations of sexual misconduct are made against them:

'If a doctor is facing allegations of [inappropriate sexual touching of a patient]... he or she must have their registration suspended until the allegations are investigated.'

Dr Sharon Monagle (GP and mother of Tom Monagle, former patient of Dr Churchyard)

However, other submitters raised concerns about possible ramifications of suspension:

'One [alternative regulatory measure]... would be to forbid any practice at all while the investigation was being conducted but this would interrupt continuity of care and be financially disastrous to the practice and most practitioners.'

Australasian College of Dermatologists

Many submitters acknowledged that it would be difficult to formulate specific rules for the

appropriate regulatory response to different types of sexual misconduct. It was suggested that, rather than creating guidelines, decision-makers should have the ability to be flexible based on the particular circumstances of the allegations:

'To shift the focus away from a thorough examination of carefully determined principles of protection, risk and fairness (as ideally should occur now), and towards a system of specific rules and guidelines, could well lead to reduced public protection, and a punitive system for practitioners. To try and specify rules or guidelines for when and where chaperone conditions can and cannot be used runs a significant risk of failing to protect the public by attempting to foresee a wide range of circumstances which cannot be properly appreciated before they occur.'

Medical Insurance Group Australia (MIGA)

Submissions made by complaint-handling bodies and regulators generally supported the view that, while there are some areas for improvement, chaperone conditions should remain part of the 'regulatory toolkit'. A similar view was expressed by medical defence organisations:

'While the circumstances leading to this review are serious, there is little evidence to support the conclusion that chaperoning is not effective in ensuring patient safety or that chaperoning conditions should no longer be part of the regulatory "toolkit".'

Avant

Views on the adequacy of information provided to patients about chaperone conditions

A key theme in many submissions related to what information should be provided to patients when seeing a practitioner subject to chaperone conditions. Discussions generally revolved around what information should be given to the patient, how the information should be given to the patient (verbally, in writing and/or via a sign in the practitioner's waiting room), and who should be responsible for providing the information to the patient (the practitioner, the chaperone, the practitioner's receptionist or another person).

Many submitters stated that patients need to be given sufficient information to enable an informed decision about whether to proceed with the consultation:

‘The use of chaperones...without patient disclosure is highly unethical. To fail to disclose to patients such a serious concern is arrogant and deceitful and prohibits patients from participating as fully as possible in their own health care decisions. The doctor–patient relationship hinges on trust and the use of a chaperone without full disclosure undermines this trust.’

Dr Sharon Monagle (GP and mother of Tom Monagle, former patient of Dr Churchyard)

Other submissions highlighted the need to ensure that the provision of information does not unfairly damage the reputation of the practitioner:

‘Noting that there is already a requirement for a sign to be placed in the surgery waiting areas advising patients of the requirement for a chaperone to be present, this additional requirement seems unnecessary and will only further adversely impact on the respect and trust of the practitioner.’

Australian Dental Association

MIGA also deprecated the use of practice signs where chaperone conditions are imposed as an interim measure while allegations of sexual misconduct are investigated, since a practice sign may raise concern in the minds of patients. The Health Services Commissioner acknowledged both points of view:

‘While the reputation of the practitioner is a consideration, it should not be considered to be of equal or greater value to a consumer’s right to informed consent, particularly in highly intimate and personal situations. Consumers should be made fully aware that the practitioner they are seeing has chaperone conditions applied, for how long and that the chaperone will be present at all times. An additional qualifier could be made indicating the diagnostic and treatment approach of

the practitioner is not under review if that is appropriate. Consumers could, alternatively, be directed to the register for further information, provided there was sufficient information on the register.’

Dr Grant Davies, Health Services Commissioner, Victoria

The timing of provision of information to the patient was a key issue. A number of submitters argued that practitioners should be required to inform patients about the requirement for a chaperone well before the patient arrives for the appointment with the practitioner:

‘If a patient is told that a chaperone must be present at the point when they actually enter their appointment, their autonomy and choice about their care have been substantially reduced. While they have the choice to not attend the appointment, many factors such as costs, time off work, waiting lists, social pressure not to be “rude”, medical urgency etc may pressure them into accepting the presence of the chaperone, when they would not otherwise wish to do so. Thus, it may be more appropriate that practitioners be required to inform patients about the requirement for chaperone presence when they make an appointment, or otherwise are about to begin clinical engagement with a practitioner.’

AHPRA Community Reference Group

Many submitters saw it as problematic that the provision of information to patients is currently the responsibility of the practitioner concerned. The Chair of the local South Australian Board of the MBA suggested that the MBA could specify the words to be provided in writing to each patient prior to the beginning of the consultation (perhaps by providing an ‘information sheet’ to each patient). The Consumers Health Forum of Australia also suggested that the *Chaperone protocol* should require any information provided to patients to be translated into languages used within the practice, be made accessible for visually impaired patients, and be provided in simple language for any patients who have cognitive or learning difficulties.

One submission expressed concern that there is currently no adequate way to explain to patients

why a chaperone condition is subsequently removed if no further action is taken in relation to the complaint made against the health practitioner:

'In view of the terrible harm adherence to the [Chaperone] Protocol would wreak on any practitioner's reputation and practice, if a practitioner were exonerated, it would be incumbent on AHPRA to contact every patient affected during the period that the Protocol was in force to inform that patient of the exoneration.'

Australasian College of Dermatologists

Views on monitoring compliance with chaperone conditions

A large number of submitters acknowledged that the effectiveness of chaperone conditions depends on ensuring that the conditions are complied with:

'A chaperone provides an important additional layer of protection to the patient, but the presence of a chaperone does not in itself guarantee patient safety. Whether a chaperone is an effective measure is dependent on a number of other factors including:

- Maintenance of records that demonstrate compliance with the imposed condition;
- Appropriate training of chaperones, ensuring that they have a clear understanding of their role and responsibilities;
- Adequate monitoring by the MBA to support compliance with the condition;
- Availability of immediate reporting to the regulator to ensure any concerns are expeditiously reviewed and further action taken where required.'

Royal Australasian College of Surgeons

Some submitters (including the Australian Medical Association (AMA) and medical defence organisations) expressed the view that the current *Chaperone protocol* could be strengthened, particularly in relation to compliance. A common discussion point was the characteristics necessary

for a successful chaperone. Submitters often focussed on who should nominate and/or approve the chaperone, and many expressed the view that the practitioner who is subject to the chaperone conditions should not be permitted to nominate the chaperone:

'One of the weaknesses of the current system appears to be the power differential between practitioners and the chaperones who are selected and paid by the practitioner. A system could be devised by which the chaperone was not selected directly by the practitioner, but rather by the practice principals, or another appropriate person. The chaperone may be less likely to be influenced by the practitioner to behave inappropriately [such as by falsifying chaperone logs]... if there was no pre-existing relationship between them.'

Professor Anne Tonkin, Chair of the South Australian Board of the MBA

Many submitters agreed that a chaperone should be a registered health practitioner (eg, as submitted by the Australian Nursing and Midwifery Federation), however, the Australian Dental Association submitted that there should be greater opportunity to utilise suitable staff members as chaperones, as this would not carry the same stigma that might attach to an independently-appointed chaperone. The AMA suggested that consideration be given to whether it would be more appropriate for the MBA to appoint and remunerate the chaperone rather than the practitioner, to remove any conflict of interest. Overall, there was relatively little support for the use of patient-nominated chaperones.

Appropriate training for chaperones was also commonly referred to in submissions:

'Appropriately equipping and training chaperones is one of the key steps which can be taken in improving the chaperone system. To be a chaperone goes beyond the mere observation of what occurs, and requires skill and training in ensuring the role is discharged properly. Ideally, a chaperone would be an appropriately trained clinician, such as another practitioner or nurse.'

MIGA

There was some discussion about strengthening AHPRA's auditing activities and suggestions were made about the potential use of 'secret shopper'-style patients.⁹ The Royal Australasian College of Surgeons suggested that a mentor could provide another layer of monitoring and could also support the practitioner, who may be experiencing significant mental, financial or physical distress while being the subject of an investigation.

Summary of meetings

An important aspect of the review was conducting meetings with stakeholders. I held face-to-face meetings in Sydney, Melbourne, Brisbane, Canberra and Adelaide, and also had phone meetings with stakeholders located in Australia and overseas. A *Summary of meetings* is at Appendix B.

Meetings with the MBA and AHPRA

Many meetings were held with AHPRA staff and members of the MBA and Board committees. The purpose of these meetings was to fully understand decision-making processes around the imposition of chaperone conditions and to discuss case examples.

Meetings with other decision-makers in co-regulatory jurisdictions

I was keen to compare practices in NSW and Queensland (where co-regulatory arrangements are in place) with the other states and territories. For this purpose, I met with Ms Sue Dawson (the Health Care Complaints Commissioner in NSW) and senior HCCC staff, the Director of the HPCA in NSW, and members of the Medical Council of NSW. I also met with senior staff from the Office of the Health Ombudsman (OHO) in Queensland. These meetings involved detailed discussion of the processes in NSW and Queensland that may lead to the imposition of chaperone conditions.

Key informants from NSW expressed some support for retaining chaperone conditions as an interim regulatory intervention available to decision-makers when dealing with 'lower level' allegations of sexual misconduct. Commissioner Dawson noted that there is a very difficult balance to be achieved between protecting the public and offering fairness to a practitioner in situations where there is a complaint of inappropriate touching, but no immediately available means of confirming or validating the complaint, no previous

similar complaint on record, and no report to police. Although chaperone conditions are 'an imperfect instrument', they may serve a protective purpose in cases where the only alternative (on the facts that are available) would be to do nothing. The removal of chaperone conditions from the regulatory toolkit would be problematic for that reason.¹⁰ Dr Greg Kesby, President of the Medical Council of NSW, agreed and discussed the difficulties decision-makers face – balancing the need to protect the public with considerations of the practitioner's reputation and livelihood, when assessing risk and considering suspension or imposition of conditions as an interim action while an investigation proceeds:¹¹

'We are talking about the grey edges – when there is a question mark over the person and we are unsure of the truth of the matter. This is the group that chaperone conditions best apply to. Where there is a clear case of sexual misconduct, then the practitioner should be suspended.'

Dr Greg Kesby, President of the Medical Council of NSW

Senior staff of the Office of the Health Ombudsman agreed that the decision to impose chaperone conditions can be difficult:¹²

'The ends of the spectrum [of conduct] are easy. It is the grey area in the middle that is difficult. You need to take into account a mountain of things when making a decision.'

Senior staff of the Office of the Health Ombudsman, Queensland

Meetings with patients

I met with three people who were patients (or relatives of patients) of Dr Churchyard to discuss their experiences. While two of these people wish to remain anonymous, Dr Sharon Monagle (mother of Tom Monagle, former patient of Dr Churchyard) has consented to being identified in this report. Dr Monagle does not believe that chaperone conditions are an effective measure to protect the public while allegations of sexual misconduct are investigated.¹³ Dr Monagle expressed the view

⁹ Submission by MDA National, 8 October 2016.

¹⁰ Meeting with Sue Dawson, NSW Health Care Complaints Commissioner, Sydney, 1 November 2016.

¹¹ Meeting with Dr Greg Kesby, Medical Council of New South Wales, Sydney, 1 November 2016.

¹² Meeting with senior staff of OHO, Brisbane, 18 November 2016.

¹³ Submission from Dr Sharon Monagle, 26 September 2016.

that although she can appreciate the difficulties the MBA must face when it receives allegations about a practitioner, she does not consider that it is the concern of the MBA to think about the practitioner's livelihood; the role of the MBA is to protect the public.¹⁴

I also held meetings with two patients who have been victims of sexual assault by other health practitioners in the past (including one patient who is also a health practitioner). In both cases, the patients described the long-lasting effect that the sexual assault has had on their lives, even decades later: anxiety, delaying necessary medical treatment, and experiencing great distress when undergoing medical examinations. Among this group, there was some ambivalence about whether chaperone conditions should play any role as a regulatory measure. One patient suggested that there may be some role for chaperone conditions during the investigation phase, if the matter is assessed to be low-risk, however, the same patient later expressed the view that this would really be 'window dressing and doesn't actually address the situation'.¹⁵ The other patient took the view that a practitioner should not be allowed to practise if they are being investigated for serious misconduct, and encouraged the regulator to take a more personal approach to assessing matters:¹⁶

[The regulator] needs to err on the side of caution; they need to think about what they would want for their own daughter [as a patient]; they need to ask themselves, would this [seeing a practitioner who has had chaperone conditions imposed on their registration while allegations of sexual misconduct are investigated] be ok for my daughter, mother, sister, friend, wife, lover?

Maree Germech, former patient

A common theme in my discussions with patients was the vulnerable position people are in when seeking treatment: 'Doctors are like gods; patients do not question doctors, and that may not be sensible, but it happens.'¹⁷ This often led to discussions about what the role of a chaperone should be, as well as what information should be given to patients about the requirement for a chaperone: 'Patients cannot make good decisions if they are not provided with all relevant

information.'¹⁸ The following story from a patient demonstrates the key themes raised in many of my discussions with patients.

Case study: Mr Z

Mr Z¹⁹ sought treatment from a medical practitioner for severe migraines. The doctor had chaperone conditions imposed on his registration by the MBA following receipt of allegations of sexual misconduct.

Mr Z alleged that he saw the doctor on two occasions with a chaperone. He recalled that it was not explained to him why the chaperone was present, but he assumed it was for training purposes. He asked, 'Are you doing training?', and the doctor responded, 'Something like that'. Mr Z expressed the view that, 'There should have been something discussed, but nothing was discussed.'

Mr Z also recalled attending one consultation with the doctor without a chaperone being present. Mr Z believes it occurred on a Saturday. When Mr Z asked, 'Haven't you got your training partner today?', the doctor responded, 'No, not today'. Mr Z said that the doctor inappropriately performed a full body examination during this appointment, and although he thought the doctor's conduct was unusual, he wasn't sure what to do: 'How was I meant to know what is normal?' Mr Z also stated that the doctor ended the consultation by opening the door and checking both ways before allowing him to leave the consultation room.

The experience has deeply affected Mr Z: 'I think about it every day. It hurts. I wouldn't wish it upon anyone. I wouldn't want anyone to go through it.'

Mr Z's view is that a doctor should not be allowed to continue to practise while an allegation of sexual misconduct is being investigated: 'I understand that a person is innocent until proven guilty, but [the doctor] should have been pulled out of the system while he was being investigated.' Mr Z compared the situation to a teacher being accused of sexual misconduct: 'Imagine it was a school. You wouldn't let your kid go to school with that teacher.'

14 Meeting with Dr Sharon Monagle, Melbourne, 3 November 2016.

15 Meeting with Dr Y, Melbourne, 2 November 2016.

16 Meeting with Maree Germech, Melbourne, 3 November 2016.

17 Meeting with Patient B, Melbourne, 2 November 2016.

18 Meeting with Patient B, Melbourne, 2 November 2016.

19 Meeting with Mr Z, Melbourne, 14 November 2016.

Meetings with practitioners

The call for submissions to the review resulted in only one response from a medical practitioner who is currently practising with chaperone conditions. I met with this doctor to discuss his experience.

Case study: Dr A

Dr A²⁰ is a medical practitioner who had chaperone conditions imposed on his registration after allegations were made against him relating to sexual misconduct. The allegation that led to the imposition of the chaperone conditions was that Dr A had inappropriately touched a patient during a consultation. A second complaint was subsequently received from another patient alleging that Dr A had inappropriately touched her on a number of occasions during consultations.

Dr A denies the allegations. Dr A explained that his patients are often disadvantaged – homeless, unemployed, and people with serious mental health conditions – who may suffer from paranoia or make incorrect assumptions or complain in the hope of getting compensation.

Dr A explained that he is not against the use of mandated chaperones (as regulators need to act in the best interests of the community), however, he thinks allegations made by patients are taken to be the truth without being properly assessed. In Dr A's opinion, extreme care should be taken not to impose chaperone conditions on the registration of innocent health practitioners. Where it is considered to be necessary to impose chaperone conditions while investigating a matter, investigations should be completed within one month to minimise the damage to the practitioner. One of Dr A's key concerns is that investigations are currently taking too long, with the result that chaperone conditions become a form of punishment for the practitioner before the truth of the matter has been determined: 'It is painful to have to endure it when you are innocent.'

Dr A explained that the imposition of the chaperone conditions has had a devastating impact on his life. A key difficulty has been explaining to colleagues why there is a requirement for the chaperone. Dr A stated that while colleagues who have known him for many years do not believe that the allegations are true, more recent colleagues are prone to think that the allegations must be true because the regulator took action against him. Dr A disclosed that he now no longer attends conferences or meetings with colleagues because he does not

want to answer any more questions about his situation. The situation has also had a negative effect on his health, leading to insomnia, weight loss and the worsening of pre-existing health conditions.

I met with representatives from the Doctors' Health Advisory Service Queensland (DHASQ) and Queensland Doctors' Health Programme (QDHP), which operates a helpline for doctors staffed by volunteer general practitioners. In a general discussion, DHASQ/QDHP identified the importance of understanding the complex issues related to the use of chaperones when examining patients from linguistically and culturally diverse communities. Intrusion into the expected privacy of the doctor–patient relationship is an important issue, which can influence the outcome of the consultation.

DHASQ/QDHP expressed some concerns regarding the mandated use of chaperones, noting that there is a cost in providing a chaperone, who is often a health professional. Regulatory authorities need to understand these issues when placing a chaperone condition on a practitioner, especially when an investigation is still being undertaken and the allegation has not yet been substantiated.

If, however, the MBA assessed that there was a 'substantial and imminent risk to the public', this would justify taking such regulatory action against the practitioner while investigating the relevant allegations. DHASQ/QDHP noted that when an investigation is in progress, it is important for practitioners to be provided with information about the investigation process. Currently the communication from AHPRA can be very harsh and legalistic. The investigation process can be extremely damaging to the doctor and distressing for families, which can lead to family breakdown, alcohol dependence or suicide. When the investigation is drawn out, this adds to the health burden experienced by the practitioner.

DHASQ/QDHP discussed the information that should be provided to others when a condition that a chaperone was required was placed on a health practitioner. They emphasised the importance of the chaperone knowing the details of the allegations made about the practitioner. However, they felt that this detail did not need to be provided to patients: 'The safety of the public is sufficiently ensured just by the presence of the chaperone.' They raised concerns about the current requirement for the practitioner to have a large sign, highlighting the chaperone condition, as this impacts on the practice of that practitioner and the facility where the practitioner works, with a potential cost to reputation. This is particularly

²⁰ Meeting with Dr A, Sydney, 31 October 2016.

concerning when the chaperone condition is placed on a health practitioner while the investigation of an allegation has not been completed.

DHASQ/QDHP also noted that a breach of chaperone conditions may be a failure of the chaperone and emphasised the need for every chaperone to be adequately educated in their role, to ensure they know what is expected of them and their reporting requirements.

Meetings with medical defence organisations

Representatives of Avant Mutual Group (Avant) and MIGA supported retention of the option to use chaperone conditions as an interim measure when allegations of misconduct are made about a practitioner:²¹

'If the option of imposing chaperone conditions is taken away, it would have the result of taking away something from the practitioner. It is meant to be a protective system, not a punitive system.'

MIGA

Avant noted that in its experience the current *Chaperone protocol* was detailed and closely monitored by the regulator and expressed the view that it 'couldn't see how [the current *Chaperone protocol*] could be tightened in a sensible, workable manner'.²² MIGA thought that some improvements could be made to the *Chaperone protocol*, noting that there are inconsistencies across the jurisdictions in relation to immediate action decision-making, and that the public interest test in section 150 of the NSW legislation may be a more useful test for a regulator.²³

Meetings with colleges

I had a useful telephone discussion with the Dean of Education of the Royal Australasian College of Surgeons, who noted the College's 2015 inquiry into discrimination, bullying and sexual harassment. The College of Surgeons has taken a strong stand on these issues, and considers that allegations of sexual misconduct must be treated very seriously, with chaperone conditions used only for the least serious allegations and investigations undertaken promptly. I met with the Dean of the Royal Australasian College of

Physicians, who noted the need for the regulator to balance the expectations of the community for strong and swift action against a practitioner, with its obligation of fairness to an accused practitioner. The College of Physicians supports strengthening chaperone implementation and monitoring processes to reduce the likelihood of circumventing requirements imposed by regulators.

Meeting with the Centre against Sexual Assault

A meeting was held with a representative of the South East Centre against Sexual Assault (SECASA) in Victoria, which offers counselling for victims of sexual assault and family violence. The view expressed was that it is appropriate to use chaperone conditions when an allegation of sexual misconduct has been made, but that the chaperone system should be tightened: more information should be provided to patients about the allegations made about the practitioner and a prominent sign should be posted on the receptionist's counter about the chaperone conditions. It is important that patients be given a choice about whether they wish to continue seeing a practitioner who must practise with a chaperone: 'The key is the information; knowledge is power. It does not empower people if their specialist disappears; then they have no choice about the matter.'²⁴

Meetings with other interested persons

I met with many other individuals who offered helpful points of view regarding the use of chaperone conditions.

I had a useful discussion with Dr John Wakefield, Deputy Director-General, Clinical Excellence Division, Queensland Health.²⁵ In Dr Wakefield's view, the regulator must turn its mind to the following question: 'If it [the allegation made about the practitioner] was found to be true, what would have been an appropriate action [in response to receipt of the allegation]?'²⁶ Dr Wakefield emphasised the importance of timely investigations and highlighted that although using chaperones can be in the best interests of the practitioner while investigations are ongoing, there are also possible negative repercussions, such as psychological damage and financial impacts. In Dr Wakefield's opinion, if chaperones are used, the regulator needs to properly define what that

21 Meeting with representative of MIGA, Sydney, 31 October 2016

22 Meeting with representatives of Avant, Sydney, 31 October 2016.

23 Meeting with representative of MIGA, Sydney, 31 October 2016.

24 Meeting with representative of SECASA, Melbourne, 21 November 2016.

25 The opinions and/or views expressed by Dr Wakefield are his own and do not necessarily reflect those of Queensland Health or the State of Queensland.

26 Meeting with Dr John Wakefield, Brisbane, 17 November 2016.

means: 'If the decision is made that the public needs protection, that needs to be clear, spec'd out action, and there needs to be robust, independent oversight of the condition.'

I met with Beth Wilson, former Health Services Commissioner, Victoria, who drew on her lengthy experience as Commissioner and personal experiences of family and friends of mandated chaperones. In her view, 'If a doctor cannot be trusted to be with patients without a chaperone, the doctor is not trustworthy and shouldn't be seeing patients at all.' Imposed chaperones cannot guarantee patient safety. Ms Wilson thinks that there is a big disconnect between how the public thinks about this issue compared with the medical profession: 'Only the medical profession could think of something as quaint as chaperones to protect patients.'

I met with leading health law expert Ian Freckelton QC, former member of the Medical Practitioners Board of Victoria, and counsel for medical boards and accused doctors. Dr Freckelton recognises that immediate action calls (in the context of allegations of sexual misconduct) may be hard, but in his view, if there is a reasonable belief of serious risk to patients, the doctor should not be practising at all. The mandated chaperone system leaves patients in the dark. Often a 'deceptive/finessing statement' is used, such as 'We're just having auditing at the moment', to explain the presence of the chaperone to the patient. It is also problematic when the chaperone is a nurse employee of the doctor. This places the nurse chaperone in an invidious position: 'It's unfair and unlikely to be efficacious.'

I also had a telephone discussion with Dr Liz Mullins, current Director of Medical Services at Djerriwarrh Health Services in Victoria. Dr Mullins was strongly of the view that chaperones are 'of no use': 'If someone is at risk and needs someone to monitor their practice, they should not be practising at all.'²⁷ Dr Mullins emphasised that the regulator should 'listen to the voice of the consumer' and said that suspending practitioners was the preferable response to a complaint about sexual misconduct: 'You must err on the side of protecting the public. If someone has gone to the trouble of complaining about something as serious as sexual misconduct, particularly when police have been involved, then you have to err on the side to suspend the practitioner pending prompt investigations.'

Dr Sally Cockburn, a high profile GP and radio journalist in Victoria, shared a similar view: 'If the patient needs protection, then the practitioner shouldn't be practising.'²⁸ Dr Cockburn suggested that if there was concern about patient safety, it would be preferable for the practitioner to take time off rather than have a chaperone. If every investigation was completed within a six week timeframe, that would not be too long a period for the practitioner to take leave during the investigation stage. Dr Cockburn emphasised the importance of providing sufficient information to patients about why the chaperone must be present, and also suggested that AHPRA's *Register of practitioners* should provide appropriate historical complaint data about practitioners.

I met with Dr Katinka Morton, forensic psychiatrist, to discuss her view that professional sexual misconduct is a breach of trustworthiness. In summary, Dr Morton stated that doctors who fail to appreciate the vulnerability of their patients and engage in sexual relationships with patients, are not trustworthy and that this behaviour does not meet the community's expectations of trustworthiness in doctors.²⁹ Dr Morton acknowledged that chaperoning may be a component of action taken against low-risk accused practitioners, but identified practical difficulties in the application of chaperone conditions: How can patients give informed consent? How does it not impact on the patient's experience of care? Who would really want to take on the role of chaperone? Dr Morton also identified concerns regarding the use of gender-based restrictions on practice as an alternative regulatory action. Dr Morton suggested that suspension may be the best option for some alleged conduct, particularly in cases where criminal charges have been laid.

Consumer forum

I joined a discussion about the use of chaperone conditions at a consumer forum hosted by the Health Issues Centre in Melbourne. Consumer participants saw very limited scope for mandated chaperones – only in cases where the allegation is of a less serious nature, the practitioner has no history of complaints, the investigation of the complaint is completed within three months, and sufficient information about the requirement for the chaperone is provided to patients.

One consumer, the mother of a son with serious health issues, offered a different perspective:³⁰

27 Meeting with Dr Liz Mullins, Melbourne, 14 November 2016.

28 Meeting with Dr Sally Cockburn, Melbourne, 3 November 2016.

29 Meeting with Dr Katinka Morton, Melbourne, 14 November 2016.

30 Consumer A at Health Issues Centre forum, Melbourne, 3 November 2016.

'My son's condition is difficult to treat, so it is difficult to find a doctor who can treat him... I am not condoning the actions of doctors who sexually abuse patients, but where a doctor has years of experience and a high level of skill, they can still contribute something to society. Chaperones could assist in this situation.'

Consumer

Forum participants agreed that a practitioner subject to chaperone conditions should, as a minimum, volunteer to the patient that the MBA requires that they practise with a chaperone due to allegations of misconduct, and give fuller details (ie, disclosing that sexual misconduct has been alleged) if the patient seeks more information: '[The presence of a chaperone] has a practical, meaningful impact on your consultation, so it becomes an informed consent issue.'³¹ Consumers were strongly of the view that the practitioner should not have the ability to nominate a chaperone. The chaperone should be independently appointed and should have no previous relationship with the practitioner (ie, not a colleague or employee): 'A doctor is not going to pick someone [to act as a chaperone] who has suspicions about them.'³² There was general agreement that 'chaperone' is an old-fashioned and paternalistic term that does not appropriately describe the reason why the practitioner is required to have that person present when practising (ie, to protect the patient from possible harm, rather than to protect the practitioner). The Ontario phrase 'practice monitor' was generally viewed favourably.

Community expectations

During the review, some submitters and meeting attendees referred to the ongoing Royal Commission into Institutional Responses to Child Sexual Abuse. People pointed to the shocking evidence presented to the Royal Commission as showing the importance of effective processes to respond to allegations of sexual abuse of vulnerable individuals by persons in authority.

The Royal Commission was established in January 2013 to investigate how institutions like schools, churches, sports clubs and government

organisations have responded to allegations of child sex abuse in the past. There has been a high level of engagement with the Royal Commission: as at 1 January 2017, 36,649 calls have been handled, 22,686 letters and emails received, and 6,349 private sessions held.³³

The progress and reports of the Royal Commission have been extensively reported in the media. Its report on case study no 27 graphically describes the failure of health care regulators (the NSW Health Care Complaints Commission and the former Medical Board of NSW) to take adequate action on allegations of sexual assault by Dr John Rolleston on several teenage boys.³⁴ Dr Rolleston was subsequently convicted of criminal offences and imprisoned.

The Royal Commission is relevant to this review, in reflecting community expectations about how institutional authorities should respond to allegations of sexual misconduct – and intolerance of inadequate action to protect the public. There are obviously some similarities with the experience of victims of abuse by clergy, and the inadequate responses by church authorities, currently in the spotlight of the Royal Commission. However, during this review I have seen no evidence of current health regulators turning a blind eye.

31 Consumer B at Health Issues Centre forum.

32 Consumer C at Health Issues Centre forum.

33 Royal Commission into Institutional Responses to Child Sexual Abuse website: www.childabuseroyalcommission.gov.au.

34 Royal Commission into Institutional Responses to Child Sexual Abuse. Report of Case Study No. 27: The response of health care service providers and regulators in NSW and Victoria to allegations of child sexual abuse [2015]: www.childabuseroyalcommission.gov.au/getattachment/5ee31c5f-85c1-4a60-b76e-39cfba6464a7/Report-of-Case-Study-No-27.

Part C: Sex in the doctor–patient relationship

Why is sex never appropriate in the doctor–patient relationship?

There is no place for sex in the doctor–patient relationship, either in the guise of a ‘consensual’ sexual relationship, or in the form of sexualised comments or behaviour, or indecent or sexual assault. For good reason, it is sometimes referred to as ‘sex in the forbidden zone’, and compared with sexual abuse by clergy and teachers.³⁵ It is a violation of the trust that patients place in their doctor. As noted by Merrilyn Walton, former NSW Health Care Complaints Commissioner:³⁶

‘Whether the sexual misconduct involves an assault or “loving” relationship the central offending act involves doctors abusing their patients’ trust and putting their own interests first.’

For over 2,000 years, it has been a fundamental tenet of medical ethics that doctors may not enter into sexual relationships with their patients. The Hippocratic Oath (circa 4th century BC) states that in their professional lives doctors must abstain from ‘the seduction of females or males’. The modern rationale is well articulated by Robin Briant, former Chair of the Medical Council of New Zealand:³⁷

‘The doctor–patient interaction is for the patient’s benefit and there is no place in it for a sexual liaison. It would do immense harm to the quality of doctor–patient interactions generally if it were even suspected that intimate or sexual relationships may evolve from medical consultations. Only when people feel safe in a professional relationship can they entrust it with their most private emotional, psychological and physical secrets.’

Maintaining professional boundaries in the doctor–patient relationship is important for several reasons:

- Safety – patients subjected to sexual behaviour in the course of therapy may suffer emotional and physical harm.
- Quality – a doctor who sexualises patients is likely to lose the independence and objectivity necessary to provide good quality care.
- Trust – patients place trust in their doctor, that examinations and treatment will only be undertaken in their best interests, and never for an ulterior, sexual motive.
- Public confidence – members of the community should never be deterred from seeking medical care, permitting intimate examinations and sharing deeply personal information, for fear of potential abuse.

Patients who have been sexually exploited by their doctor suffer from major depressive disorders, suicidal and self-destructive behaviour, relationship problems, misuse of drugs, prescription medicines and alcohol, and disruption to employment and earnings.³⁸ They often experience feelings of shame, guilt, isolation and forced silence, poor self-esteem and denial.³⁹ As noted by one submitter (the daughter of a victim of sexual abuse), the effects on an abused patient and their family can be long lasting and profound:

‘This has affected our family immensely ... All because a man who happened to be his doctor and somebody he completely trusted destroyed his trust and a system that should have protected him has not.’

Ms X, daughter of victim of sexual abuse

Ethical guidelines such as *Sexual Boundaries: Guidelines for doctors*⁴⁰ affirm the requirement for doctors never to sexualise the relationship with patients. *Good Medical Practice: A Code of Practice for Doctors in Australia*⁴¹ articulates the professional standard that:

35 P Rutter. *Sex in the Forbidden Zone: When Therapists, Clergy, Teachers and Other Men in Power Betray Women’s Trust* (1989).

36 M Walton. *The trouble with medicine* (1998) p 56.

37 Medical Council of New Zealand, MCNZ Newsletter (March 1994) p 1.

38 *Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practise panels* (Council for Healthcare Regulatory Excellence, 2008), p 3.

39 Gabbard cites research showing that at least 90% of patients are seriously harmed by sexual boundary violations by psychotherapists; see G Gabbard, *Sexual Exploitation in Professional Relationships* (1989) p xi.

40 MBA, *Sexual boundaries: guidelines for doctors* (2011):

www.medicalboard.gov.au/News/2011-10-28-Sexual-Boundaries-Guidelines-for-doctors-released.

41 MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (2014):

www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.

'Good medical practice involves:

- maintaining professional boundaries
- never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. ...'

Breach of these ethical guidelines and professional standards may lead to professional discipline and the imposition of sanctions, including conditions on practice, suspension or cancellation of registration. The general law also applies to sexual contact between doctors and patients. Under the criminal law, an examination or touching undertaken for illegitimate purposes during a consultation may constitute the offence of indecent assault or sexual assault. Such conduct is unlawful as well as unethical and unprofessional, and the doctor may face criminal prosecution and punishment on conviction.

Trust in regulators and the law

The community expects that only practitioners who are fit to practise will be registered, and that regulators will take action to protect patients from sexual misconduct by health practitioners. The National Law reflects this expectation. Section 3(2)(a) sets as the first objective of the National Scheme, 'to provide for the *protection of the public* by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and *ethical manner* are registered' (emphasis added).

In a recent social research report for the MBA, *Medical Practitioners' ongoing fitness and competence to practise*,⁴² 93% of respondent members of the public rated having confidence and trust in a doctor as 7 or higher (on a 0 to 10 scale, from 'not at all important' to 'very important'). Media reports of sexual misconduct by doctors – often with captions such as 'dodgy doctor allowed to continue to practise' – undermine this high level of trust and confidence.

Loss of confidence is exacerbated if the community learns that regulatory authorities did not respond adequately or appropriately to known risks. When institutional authorities (including medical boards and the police) fail to take adequate action, patients may be unknowingly exposed to the risk of harm

from trusted doctors. If such harm occurs at the hands of a predatory doctor about whom concerns had already been notified, individual patients suffer and the community as a whole loses confidence in the medical profession and its regulators. The appropriateness of the continued use of mandated chaperone conditions, while investigation into an allegation of sexual misconduct by a doctor is ongoing, must be considered in this regulatory context.

Prevalence of sexual misconduct

Notifications to AHPRA alleging sexual misconduct in practice are classified as boundary violations of a sexual nature. For the five years 2011/12 to 2015/16, notifications to AHPRA of sexual boundary violations represented 3.5% of all notifications about medical practitioners.⁴³ The average age of the doctors subject to a notification of sexual boundary violation is 57 years, all male. Almost half of the doctors (49%) are general practitioners.

Sexual misconduct is the main reason that doctors are disciplined for professional misconduct in Australia and New Zealand. In a retrospective analysis of disciplinary cases adjudicated in five jurisdictions (NSW, Victoria, Queensland, Western Australia and New Zealand) in 2000-2009, sexual misconduct towards a patient was the primary issue in 24% of cases, divided into cases of relationship with patient (16%) and inappropriate sexual contact (8%).⁴⁴

The prevalence of sexual misconduct is unknown. It is likely that sexual misconduct by doctors is significantly under-reported. Patients who have engaged in a 'consensual' sexual relationship with their doctor are likely to be embarrassed and unwilling to notify the behaviour. Patients who are subjected to sexualised remarks, sexual harassment or assault may be reluctant to make an official complaint for the same sorts of reasons reported by victims of sexual abuse in other contexts – including concerns that their word will not be believed in the face of a denial by a respected professional.

International studies have suggested that the prevalence of sexual boundary violations by health practitioners may be as high as 6-7%.⁴⁵ Several relatively dated surveys of doctors give some indication of the prevalence of sexual misconduct. In a 1992 survey of 10,000 doctors in the United States (19% response rate), 9% acknowledged

42 MBA, *Medical practitioners' ongoing fitness and competence to practise* (2016): www.medicalboard.gov.au/News/2016-11-10-media-statement.

43 Data supplied by AHPRA, November 2016.

44 K Elkin et al. Doctors disciplined for professional misconduct in Australia and New Zealand, 2000-2009 [2011] 194(9) MJA 452.

45 *Safeguarding Patients* (UK Department of Health, 2007).

having sex with a patient.⁴⁶ In a 1993 survey of 217 general practitioners in New Zealand (response rate 86%), 4% reported sexual contact with a patient.⁴⁷ In a 2002 survey responded to by 977 general practitioners in the Netherlands (response rate 80%), 4.3% of GPs reported sexual contact with a patient.⁴⁸ In Australia, a survey of psychiatrists found that 7.6%, almost all male, reported erotic contact with patients during or after termination of treatment.⁴⁹

It is assumed that the aforementioned surveys reported 'relationship' type sexual contact between patients and doctors. Inappropriate examinations and indecent or sexual assault, being criminal behaviour, is likely to be much rarer. There is no reason to believe that doctors are more likely to commit indecent or sexual assault than other members of the community – but the consultation room obviously provides an opportunity for offending and a pretext for examination and touching.

Surveys of patients reporting sexual contact by their doctor are rare. In a survey of 8,000 members of the public in British Columbia, Canada, in 1992 (31% response rate), 4.1% of respondents (4.7% of women and 1.3% of men) reported touching of a private body part by their doctor 'for what seemed to be sexual reasons', and 5.5% of respondents (6% of women and 2.5% of men) reported experiencing a sexual remark by their doctor that made them feel upset.⁵⁰

One of the striking features of reported cases of sexual offending in the practice setting by doctors, is that publicity surrounding a criminal trial or disciplinary proceedings will often result in other patients coming forward with similar stories of sexual assault – at least if the defendant doctor is not given name suppression. Even in 'relationship' cases, medical boards and health complaints entities sometimes encounter the serial professional philanderer: a doctor who engages in a series of 'consensual' sexual relationships with patients. In this arena, my experience as New Zealand Health and Disability Commissioner was that 'where there's smoke, there's [often] fire'.

Types of sexual misconduct

There is no definition of sexual misconduct in the National Law. The MBA defines sexual misconduct to include:⁵¹

- engaging in sexual activity with:
 - a current patient regardless of whether the patient consented to the activity or not
 - a person who is closely related to a patient under the doctor's care
 - a person formerly under a doctor's care
- making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient.

The first type of sexual misconduct involves engaging or attempting to engage in a sexual relationship with a patient. This may cover everything from making sexualised remarks, sending suggestive text messages to a patient or inviting a patient to meet socially, through to entering into a sexual relationship with a patient. Even if the patient is a willing participant in such activity, it is questionable whether the conduct should be classified as 'consensual' or a 'relationship', given the power imbalance between patient and doctor. Many commentators view all sexual contact between doctors and patients as exploitative and a form of sexual abuse, and deprecate the language of 'crossing boundaries' and 'relationship' as disguising the abuse inherent in such situations.

The second type of sexual misconduct by doctors in the practice setting is criminal offending, which may be prosecuted: an inappropriate examination or touching during a consultation (which may constitute the crime of indecent assault) or a sexual assault (including, in an extreme case, rape or unlawful sexual penetration). This is clearly sexual abuse in the doctor–patient relationship.

Obviously some sexualised behaviour by a doctor, such as making comments about the patient's physique or patting or hugging the patient, may be a precursor either to an attempted 'consensual' relationship or to unlawful touching. Other

46 N Gartrell et al. Physician–patient sexual contact. Prevalence and problems (1992) 157(2) West J Med 139.

47 J Coverdale et al. Social and sexual contact between general practitioners and patients in New Zealand: attitudes and prevalence (1995) 45(394) Brit J Gen Pract 245.

48 P Leusink et al. Sexual contact between general practitioner and patient in the Netherlands: prevalence and risk factors (2004) 148(2) Ned Tijdschr Geneesk 1016.

49 A Leggett. A survey of Australian psychiatrists' attitudes and practices regarding physical contact with patients (1994) 28(3) Aust NZ J Psychiatry 488.

50 College of Physicians & Surgeons of British Columbia, *Crossing the Boundaries: the Report of the Committee on Physician Sexual Misconduct* (1992) p 2. College of Physicians & Surgeons of British Columbia, *Crossing the Boundaries: the Report of the Committee on Physician Sexual Misconduct* (1992) p 2.

51 MBA, *Sexual boundaries: guidelines for doctors* (2011): www.medicalboard.gov.au/News/2011-10-28-Sexual-Boundaries-Guidelines-for-doctors-released.

workplace misconduct, such as sexual harassment of a co-worker or trainee, does not fit easily into the relationship or criminal offending categories, but may be the subject of a notification to AHPRA.

Having engaged in 'sexual misconduct in connection with the practice of the practitioner's profession' is defined as 'notifiable conduct' under section 140 of the National Law. This has legal significance given the mandatory reporting requirements under the National Law. A health practitioner who, in the course of practice, forms a reasonable belief that another health practitioner has behaved in a way that constitutes notifiable conduct, is legally required to notify AHPRA.⁵²

A third type of sexual misconduct occurs in a doctor's private life, such as accessing child pornography or a sexual assault on a non-patient. Such conduct may result in a criminal conviction and a consequential disciplinary finding of professional misconduct. Since it does not occur 'in connection with the practice of the practitioner's profession', it does not qualify as 'notifiable conduct'. However, it may come to the attention of AHPRA and lead to the imposition of a chaperone requirement, even in the absence of alleged misconduct involving patients.

Sexual misconduct in a practice setting is the most common sort of sexual misconduct leading to regulatory intervention to protect the public.

⁵² National Law, s 141.

Part D: Current practice

Chaperones in medical practice

Patients may encounter a chaperone during a consultation in two different types of situation: a chaperone as an observer for the doctor, and a chaperone mandated as a condition of the doctor's registration. Both are explained below, but only mandated chaperones are the focus of this review – specifically, when mandated as an interim measure while a doctor is under investigation for sexual misconduct.

Chaperone as observer for the doctor

A doctor may wish to have an impartial observer present during an intimate examination of a patient or for any consultation, particularly with a new patient. Such an observer is typically referred to as a chaperone. The observer / chaperone is essentially a witness to protect the doctor in the event of an allegation of improper behaviour, but may also provide a level of comfort for the patient. The observer is typically a nurse employed in the practice. A patient may decline to have such an observer present. In that case, the doctor has a choice: to proceed with the consultation, or to decline to proceed (in which case the doctor should help the patient find another doctor). Alternatively, the patient may wish to be accompanied by an observer of her or his own choice, sometimes referred to as a support person.⁵³

The use of a chaperone as observer for the doctor is regarded in Australia and internationally as good medical practice for intimate examinations, given the obvious potential for misunderstanding. The offer of a chaperone as an impartial observer during an intimate examination is regarded as 'good medical practice' in the United Kingdom;⁵⁴ as an option that should be explored with the patient in Australia;⁵⁵ and as an option that should be offered to the patient in Canada.⁵⁶

Chaperone mandated as a condition of practice

The second situation where a patient may encounter a chaperone is where a medical board, tribunal or court has required the presence of a chaperone during consultations with all patients,

or with patients of a specified gender and/or age, as a condition of the doctor's being permitted to practise. Such a requirement may follow alleged or proven sexual misconduct by the doctor. It is intended to protect the patient from improper behaviour. The patient cannot waive the presence of a mandated chaperone, since it is a condition of practice. If the patient does not want to have the mandated chaperone present, she or he will need to find another doctor.

Legal basis for mandated chaperone where sexual misconduct is alleged

This review is concerned with the second type of chaperone – a chaperone mandated as a condition of practice – and, specifically, with the interim circumstance where sexual misconduct has been alleged and before an investigation is completed and/or evidence is tested at a hearing. In such cases, the requirement to practise only with a chaperone present may be imposed by a National Board as an interim measure to protect patients. The legal basis for such a requirement is found in section 156 of the National Law, which gives a National Board the power to take 'immediate action'. Several pre-conditions must be fulfilled. The National Board *may* take immediate action if it 'reasonably believes' that the registered health practitioner's conduct (albeit alleged only at this stage):

1. poses a 'serious risk' to persons, and
2. it is 'necessary' to take immediate action 'to protect public health or safety'.

In Queensland, under its co-regulatory arrangements, the test for immediate action is the same, but the Health Ombudsman (rather than the National Board) is usually the entity imposing the requirement.⁵⁷

In the other co-regulatory jurisdiction, NSW, the threshold for intervention is slightly different. The relevant NSW professional Council *must* take immediate action if it is 'satisfied' that:⁵⁸

1. it is 'appropriate to do so for the protection of the health or safety of any person or persons', or

53 In New Zealand, a patient has a legal right to be accompanied by a support person, under Right 8 of the Code of Health and Disability Services Consumers' Rights (except where safety may be compromised or another patient's rights may be unreasonably infringed).

54 General Medical Council, *Intimate Examinations and Chaperones* (2013) para 8: www.gmc-uk.org/guidance/ethical_guidance/21168.

55 MBA, *Sexual boundaries: guidelines for doctors* (2011) para 8:

www.medicalboard.gov.au/News/2011-10-28-Sexual-Boundaries-Guidelines-for-doctors-released.

56 See, eg, College of Physicians and Surgeons of Ontario, *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* (2008) A3: www.cpso.on.ca/policies-publications/policy/maintaining-appropriate-boundaries-and-preventing.

57 Health Ombudsman Act 2013 (Qld), s 58(1).

58 Health Practitioner Regulation National Law (NSW), s 150.

2. it is 'otherwise in the public interest' to do so.

Note that the 'public interest' test for immediate action in NSW is broader than the test in other parts of Australia, since it is not qualified by the need to show 'serious risk' to persons and necessity for protection of public health or safety. A similarly broad test existed in South Australia prior to the National Law, with the regulator empowered to impose interim orders of conditions or suspension 'if of the opinion that it is desirable to do so in the public interest'.⁵⁹ The test for imposition of an interim order in the United Kingdom similarly allows for conditions on registration (or suspension) if it is 'necessary for the protection of members of the public *or is otherwise in the public interest*'.⁶⁰

In all Australian jurisdictions, immediate action (or, in Queensland, 'immediate registration action') is defined to include suspension of, or imposition of a condition on, the health practitioner's registration. In sexual misconduct cases, the least restrictive intervention is usually imposition of a condition that an approved chaperone be present when the practitioner sees patients of a specified gender and/or age (eg, female patients and patients under the age of 18 years, who are often accompanied by a female guardian) or all patients. A more onerous condition is a prohibition on the practitioner seeing patients of a specified gender and/or age. The most restrictive intervention is suspension of the doctor's registration, resulting in loss of the ability to practise.

Section 3(3)(c) of the National Law sets out a guiding principle of the National Scheme, that 'restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality'. This is mirrored in the *Regulatory principles*. Principle 6 states: 'When we take action about practitioners, **we use the minimum regulatory force appropriate**

to manage the risk posed by their practice, to protect the public. ...'⁶¹

A practitioner may seek a review of the immediate action decision taken by a National Board (or by the Queensland Health Ombudsman or a professional Council in NSW) by appealing to the appropriate responsible tribunal.⁶² This may result in substitution of a less restrictive intervention, such as a chaperone restriction in lieu of a Board-imposed prohibition on seeing patients of a specified gender or age. In a recent example, a National Board's immediate action prohibition on a general practitioner seeing female patients or patients under the age of 18 years (imposed following three notifications alleging sexual impropriety during consultations), was substituted with a tribunal-imposed condition that the doctor see such patients only in the presence of a chaperone.⁶³

In addition to the above situations of chaperone restrictions imposed as an interim protective measure, a tribunal or court may require that a practitioner's registration be subject to a chaperone requirement as a result of proven sexual misconduct. This may be part of the penalty decision of a tribunal or court in cases where professional (sexual) misconduct has been proven in disciplinary proceedings, or as a condition of re-registration following suspension or cancellation of registration due to professional (sexual) misconduct.

According to the policy of the MBA, where a doctor has been 'found to have engaged in serious sexual misconduct' (undefined), it is not appropriate for them to continue to practise with a chaperone while consulting patients.⁶⁴ The rationale is that a doctor who cannot be trusted to see patients without the presence of a chaperone is not fit to practise medicine at all, following the *Litchfield* decision of the NSW Court of Appeal.⁶⁵ Although the *Litchfield* precedent appears to be carefully followed by the Medical Council of NSW, and the

59 Medical Practice Act 2004 (SA), s 59(2)(b). An amendment to introduce a public interest test was made under urgency in 2007, following the high profile case of Dr Gregory Wilson, who had been convicted by jury of two counts of indecent assault of a minor who was also his patient (the offending occurred outside of the doctor-patient relationship). The Medical Professional Conduct Tribunal had decided it was not necessary to suspend Dr Wilson in order 'to protect the health and safety of the public' (the test in the original legislation). After the law change, and following further criminal convictions (for unlawful sexual intercourse with another patient, a minor), the Tribunal suspended Dr Wilson on the basis that it was desirable to do so in the public interest, since it would 'shock the public conscience' to allow him to continue to practise, despite the low risk of re-offending given strict conditions and undertakings. The Supreme Court of South Australia declined to set aside the suspension decision: *MBA v Wilson* (Kelly J, SASC, 5 April 2007).

60 Medical Act 1983 (UK), s 41A; emphasis added.

61 AHPRA, *Regulatory principles for the National Scheme* (2015) principle 6 (emphasis in original): www.ahpra.gov.au/About-AHPRA/Regulatory-principles.

62 National Law, s 199.

63 *Helmy v MBA* [2016] ACAT 97.

64 MBA, *Internal Guidance: Board mandated use of chaperones following allegations of sexual misconduct* (2012).

65 *Health Care Complaints Commission v Litchfield* [1997] 41 NSWLR 630 at 639F. *Litchfield* was cited with approval and applied by the Victorian Civil and Administrative Tribunal in *Pettiford v MBA* [2003] VCAT 940 at [61], [62]; and in *MBA v Cukier* [2017] VCAT 109, where it was stated that 'if a practitioner is unfit to see half the population unsupervised, he or she is not fit to hold registration' [at [121]].

equivalent policy appears generally to be followed by the MBA, during this review I identified a small number of cases of current chaperone restrictions imposed by a Performance and Professional Standards Panel of the MBA following proven unprofessional (sexual) conduct.

Overview of tribunal and court decisions

A number of tribunal and court decisions have considered the requirements for the exercise of statutory immediate action powers by health regulatory bodies, and the appropriate level of restriction.⁶⁶

In relation to the standard of evidence required by a regulator, the State Administrative Tribunal of Western Australia in *Liddell* accepted that the level of proof required for disciplinary proceedings (the *Briginshaw* standard) is not required:⁶⁷

‘...Where, for example, two allegations of criminal conduct involving serious sexual misconduct by a medical practitioner are made... it would be impractical for s 156 to require that the Medical Board make urgent findings of fact as to the practitioner’s guilt or innocence. Rather, the mere fact and seriousness of the charges, supported by the untested depositions of witnesses, might well be sufficient to create the reasonable belief as to the existence of a risk because of the alleged conduct of the health practitioner.’

The Queensland Civil and Administrative Tribunal summarised the relevant principles as to standard of proof in a 2013 decision:⁶⁸

1. an immediate action order does not entail a detailed enquiry;
2. it requires action on an urgent basis because of the need to protect public health and safety;
3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;

4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;
6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;
7. a complaint that is trivial or misconceived on its face will clearly not be given weight;
8. the nature of the allegations will be highly relevant to whether the order is justified.

Case law confirms the relevance of taking into account the impact of the proposed immediate action on the practitioner. Fairness to practitioners, and how this fits with the paramount consideration of protection of the public, is discussed in *Part E*.

Because of the lesser standard of proof and the adverse impact of restrictions on the practitioner, courts and tribunals emphasise the need for the taking of immediate action to be an interim procedure and for allegations to be investigated in a timely manner. In the leading authority on point, the Court of Appeal of the Supreme Court of Victoria stated in *Kozanoglu*:⁶⁹

‘...[T]he entire scheme, under the National Law, contemplates that once it has been determined to take immediate action, the matter should ordinarily proceed, forthwith, to a panel or tribunal. 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.’

Delay by the MBA in taking substantive disciplinary action was criticised by the Tribunal in *Gomes*, where a doctor had been suspended as an immediate action in response to allegations of drinking alcohol at work:⁷⁰

⁶⁶ I acknowledge a comprehensive legal opinion by Liesl Chapman SC, analysing the approach taken by tribunals and courts to the exercise of statutory immediate action powers by health regulatory bodies. I have drawn on Ms Chapman’s helpful analysis in preparing this overview.

⁶⁷ *Liddell v MBA* [2012] WASAT 120 at [21].

⁶⁸ *WD v MBA* [2013] QCAT 614 at [8]. The case involved allegations of misuse of drugs, not sexual misconduct.

⁶⁹ *Kozanoglu v Pharmacy Board of Australia* [2012] VSCA 295 at [127].

⁷⁰ *Gomes v Tasmanian Board of MBA* [2014] TASHPT 3 at [22].

'Clearly the applicant has suffered and continues to suffer prejudice because of the suspension of his right to practice. It is now approaching 6 months since this suspension came into effect. Immediate action is, as described, action taken upon what might be limited information or opportunity to reflect upon appropriate sanction or long term conditions on practice. Whilst the safety of the public must necessarily be the primary concern, this needs to be secured without undue or disproportionate harm to the practitioner concerned...'

This criticism of an interim restriction of six months' duration takes on additional force in light of a recent internal audit of 27 interim chaperone conditions in place in September 2016, showing that the average duration was 1.8 years, and 56% of the chaperone conditions had been imposed more than two years previously.⁷¹

AHPRA approach to chaperone conditions

AHPRA advised that the historical approach to chaperone conditions has evolved.⁷² On commencement of the National Scheme, approaches to the management of notifications were generally jurisdiction specific. Over time the jurisdictional approach has been replaced with nationally consistent guidance. In the case of chaperone conditions, the first nationally consistent guidance was issued by the MBA in January 2012 in the form of an Internal Guidance document entitled *Board mandated use of chaperones following allegations of sexual misconduct*. The MBA document provided guidance to decision-makers as to what requirements chaperone restrictions should encompass. It stated that the requirement for a chaperone to be present during consultations should only be used as a protective, temporary measure before an investigation is completed and/or evidence is tested at a hearing, consistent with case law cited above.

The MBA guidance did not differentiate between cases subject to police involvement and provided no guidance in regard to escalating actions where charges were laid by the police or proven before a court. It assumed that if charges were proven before a court, this would provide the necessary

evidence to complete the investigation and prosecute the case before the Tribunal.

AHPRA advised that a national approach to chaperone conditions has been established through the development of the National Restrictions Library (the library). The library was developed to replace jurisdictional and profession specific libraries and guidance documents to:

- ensure consistent recommendations from AHPRA to Board delegates and consistent publication of conditions on the national register
- implement a 'best practice' approach to monitoring
- ensure only 'good restrictions' were being used, which:
 - adequately mitigate risk to the public and are proportionate to the risk identified
 - adequately define requirements for the registrant so opportunities for misinterpretation are minimised
 - enable breaches to be readily identified
 - are able to be adequately monitored through available evidence
 - are capable of being complied with by the registrant
 - are directed at the registrant, not other parties.

The national approach to chaperone conditions was implemented with the commencement of the library in May 2016. At this time the MBA's internal guidance was retired, as the internal guidance on the requirements for chaperones was largely replicated in the national approach. The approach is documented in the AHPRA *Chaperone protocol*⁷³ and an internal document, *Operational Policy: Monitoring Chaperone Conditions* (August 2016). The policy is not designed to provide a guide to decision-making about the imposition of chaperone conditions but is focussed on what such conditions consist of and how they are to be more effectively monitored.

AHPRA advised that, in summary, the new approach to chaperone conditions is as follows:

- the definition of patient is more expansive, ensuring all relevant individuals are chaperoned
- patient contact is defined inclusively, requiring all relevant practitioner/patient interactions to be oversighted by the chaperone where a professional service is provided

⁷¹ AHPRA analysis, September 2016.

⁷² Brief of information for Chaperone Review, October 2016.

⁷³ AHPRA, *Chaperone protocol* (December 2016): www.ahpra.gov.au/Registration/Monitoring-and-compliance/Chaperone-Protocol.

- the practitioner or practice must inform the patient before the consultation that the presence of a chaperone is required
- the chaperone must be physically present and must directly observe all patient contact
- AHPRA has a direct relationship with all Board-approved chaperones to ensure they understand the requirements of the role and compliance requirements
- monitoring is undertaken through reconciliation of appointment diaries, billing data and Medicare data, including direct contact with patients and chaperones to confirm a random sample of chaperone log entries
- standard signage and its placement within the practice is specified and a standard chaperone logbook is issued by AHPRA
- site visits are mandatory within the first week of monitoring and random thereafter to confirm:
 - the practitioner’s understanding of compliance requirements
 - the presence of a chaperone sign in the place and form required under the Protocol, and
 - the approved chaperone(s) understand their role and compliance requirements.

Current data for mandated chaperones

At the time of the announcement of this review on 5 September 2016, AHPRA reported that there were 47 medical practitioners who had chaperone conditions on their registration (0.04% of the total population of registered medical practitioners).⁷⁴

As at 9 January 2017, 48 (out of more than 657,000) registered health practitioners in Australia were subject to a chaperone condition, including 39 doctors.⁷⁵ Only one of the chaperone-restricted practitioners (a nurse) was female. The 39 doctors comprised 20 general practitioners, two psychiatrists, two neurologists, one dermatologist, one ophthalmologist and 13 medical practitioners without specialist registration. It is noteworthy that all the doctors subject to a chaperone condition appear to be in private practice.

⁷⁴ Terms of Reference, 5 September 2016.

⁷⁵ At the end of June 2016, approximately 2,400 health practitioners had a restriction imposed on their registration due to a conduct, health or performance issue (AHPRA *Annual Report 2015/16* (2016) pp 65-67). Chaperone conditions comprise less than 2% of the registration conditions monitored by AHPRA.

⁷⁶ According to data from the Australian Institute of Health and Welfare in 2015, 66.6% of medical practitioners who completed a survey (97% response rate) reported that they gained their initial medical qualification in Australia: www.aihw.gov.au/workforce/medical/who.

Strikingly, 59% (23 of 39) of the doctors subject to a chaperone condition qualified overseas before gaining registration in Australia.

Overseas-trained doctors comprise approximately 33% of the medical workforce in Australia,⁷⁶ and are thus over-represented amongst doctors with chaperone conditions on their registration. The reasons for this over-representation need to be considered further by the MBA and AHPRA.

The other nine health practitioners subject to a chaperone condition were three nurses, two physiotherapists, two chiropractors, one dentist and one Chinese medicine practitioner.

In accordance with the National Law and co-regulatory arrangements, compliance by the 39 doctors with the chaperone conditions recorded on their registration was being monitored by AHPRA (30 doctors), the HPCA in NSW (7 doctors), and the OHO in Queensland (2 doctors). Of the 30 doctors monitored by AHPRA:

- 50% (15) of chaperone conditions were imposed by the MBA as a result of immediate action
- 23% (7) of chaperone conditions were imposed by the MBA as a decision at registration
- 17% (5) of chaperone conditions were imposed by a tribunal, and
- 10% (3) of chaperone conditions were imposed by the MBA at the completion of an investigation (2), or by a Performance and Professional Standards Panel (1).

The chaperone conditions being monitored by HPCA and OHO were imposed as a result of immediate action.

The overall picture shows that a number of chaperone conditions monitored by AHPRA (15) resulted from a disciplinary or registration decision following proven sexual misconduct. Thus, even if the MBA, the Health Ombudsman in Queensland and the Medical Council of NSW ceased imposing chaperone conditions as an immediate action following notifications of alleged sexual misconduct, there would continue to be a number of doctors required to practise with a chaperone following proven sexual misconduct.

A notable feature of interim chaperone conditions is that they often continue in place for a long time. Analysis of 27 interim chaperone conditions in

place in September 2016 found that the average time such a restriction had been in place was 1.8 years, and 56% of the chaperone conditions had been imposed more than two years previously.⁷⁷ Although a Board committee will generally review the ongoing appropriateness of a condition, particularly if new information comes to light, some are not reviewed and simply continue in place while investigation of the allegations continues.

Cases where interim chaperone conditions are imposed

A review of current cases reveals that chaperone conditions are imposed in a wide range of circumstances. Although it is difficult to critique decisions made by immediate action committees (IACs, exercising decision-making powers delegated from the MBA) without the benefit of the full papers and a hearing, it is clear that practice varies between jurisdictions and that there may also be a lack of consistency within a single jurisdiction. This may reflect changing membership of IACs and differing advice from AHPRA staff in local offices, possibly influenced by varying signals from responsible tribunals.

Of the 30 chaperone conditions on doctors being monitored by AHPRA as at 9 January 2017:

- 17% (5) of chaperone conditions followed an allegation of sexual relationship with patients
- 83% (25) of chaperone conditions followed an allegation of inappropriate behaviour during a consultation, and
- 13% (4) of chaperone conditions followed alleged comments or indecent assault on non-patients (of which 3 occurred outside a consultation).

My file reviews provided useful insights into the approach taken by AHPRA staff and IACs.

I examined several full sets of immediate action agenda papers and decisions in relation to notifications of alleged sexual misconduct brought before an IAC, to gain insights into the decision-making of Board committees. Where AHPRA staff form the view that a notification needs to be considered by an IAC for possible immediate action, detailed papers and documentation are prepared promptly and an IAC convened. AHPRA performance indicators require the first, Part 1 IAC hearing to occur within five working days of receipt of a notification that indicates the need for immediate action to be considered. If the IAC decides to propose taking immediate action

(by imposition of conditions or suspension), the practitioner must be notified and invited to make a submission. A second, Part 2 IAC hearing then occurs, to consider any written or oral submissions from the practitioner or legal counsel, and to decide what, if any, immediate action to impose.

Case study: Psychiatrist⁷⁸

In one example, a notification alleged that during a consultation a psychiatrist had showed a vulnerable mental health patient pornography, touched her breast and vulva, and told her he wanted a relationship. A notification had been made one year earlier, by another patient, alleging that during a consultation the psychiatrist had held the patient tight and pulled her top up and her bra down. The MBA had taken no further action on the first notification because of evidential difficulties and lack of previous history. As a result of the second notification, which was detailed and accompanied by a statement to police (who were investigating the allegations), an IAC was convened. A chaperone condition was recommended by AHPRA staff, on the basis that this would address 'the serious risk posed by' the doctor, 'whilst also according the applicable regulatory principle to respond proportionately and use the minimum regulatory force to manage the risk and protect the public'.

Despite the serious allegations of sexual assault, history of a similar allegation, vulnerability of the relevant patient group (mental health patients seeing a psychiatrist in private practice), and police involvement, there is no evidence on file that consideration was given to a gender-based prohibition (ie, a prohibition on the psychiatrist seeing female patients) or a suspension. The IAC agreed to propose a chaperone condition and the psychiatrist was notified of the proposal and invited to respond. By a written submission from his legal counsel, the psychiatrist denied the allegations but agreed to a chaperone condition. The psychiatrist and his lawyer did not appear at the Part 2 IAC hearing, and a chaperone condition was imposed in November 2015. It was still in effect in January 2017, while the police investigation was ongoing.

In some cases, the decision to impose chaperone conditions was an interim measure following receipt of a single allegation of sexual misconduct, where the practitioner had no relevant complaint history. For example, in one case, the MBA took immediate action and imposed chaperone conditions on the registration of a doctor after

⁷⁷ AHPRA analysis, September 2016.

⁷⁸ MBA decision, November 2015. Details of this case, and other MBA decisions noted in this report, were made available to me by AHPRA staff. They are not publicly available.

receiving a single notification alleging that the doctor had indecently assaulted a female in the car park of a hospital.⁷⁹

Another common scenario in which the MBA took immediate action and imposed chaperone conditions was where more than one complaint of sexual misconduct was received at approximately the same time about the same doctor, who had no other relevant complaint history. For example, in one case, three separate notifications were received in relation to the same doctor, but there was no other relevant complaint history.⁸⁰ The notifications included allegations of inappropriate comments and unnecessary/sexualised medical examinations. The MBA took immediate action and imposed chaperone conditions on the registration of the doctor as an interim measure while investigating the three notifications.

In other cases, the MBA took immediate action and imposed chaperone conditions following receipt of allegations of sexual misconduct in situations where the doctor had relevant complaint history. For example, in one case allegations were received that a doctor had inappropriately touched and kissed patients.⁸¹ Further allegations were also made that the doctor had conducted unnecessarily frequent Pap smears and taken a Pap smear at 7am, as well as kissing a patient during a consultation and inappropriately touching a patient's chest. There had been two previous notifications of boundary violations involving kissing and inappropriate touching. The MBA took immediate action and imposed chaperone conditions as an interim measure while the allegations were investigated.

I also noted examples where the MBA imposed chaperone conditions on doctors at the conclusion of an investigation, which is inconsistent with the policy that chaperone conditions can only be used as a temporary measure while an investigation is completed. In one example, the relevant allegations were that the doctor made sexist and racist remarks to a medical student,⁸² and in another, it was claimed that the doctor had acted inappropriately towards colleagues and performed a 'prolonged' vaginal examination.⁸³

I noted one case where a Performance and Professional Standards Panel of the MBA (PPSP)

decided to impose chaperone conditions on the registration of a doctor. In this example, two notifications had been made about the doctor: one alleging that he had conducted an intimate examination without clinical indication, and the other that he had engaged in inappropriate hugging. Chaperone conditions were initially imposed under immediate action powers upon receipt of the first complaint about the doctor. The complaints were then investigated and the MBA decided to establish a PPSP to hear the matter. The PPSP found that the doctor behaved in a manner that constituted unsatisfactory professional performance (in respect of some of the behaviour identified in the complaints) and unprofessional conduct (by breaching the chaperone conditions imposed on his registration). The PPSP decided to caution the doctor and imposed chaperone conditions on his registration.⁸⁴

I found a number of examples where chaperone conditions were imposed by the MBA when making registration decisions. This may occur on an application for re-registration after cancellation of registration (as a result of a tribunal decision). A tribunal may specify conditions (including chaperone conditions) that must be imposed on the doctor if the MBA grants re-registration. However, imposition of a chaperone condition following proven sexual misconduct is not always the result of a tribunal requirement. In one case, the responsible tribunal found that the doctor had engaged in unprofessional conduct (including paying a sex worker patient for oral sex during a consultation, and breaching a specific condition of registration that he not have a sexual relationship with a patient), and cancelled his registration for two years.⁸⁵ The doctor, who had previously been suspended for sexual misconduct, later applied for re-registration. In 2013, the MBA re-registered the doctor, subject to several conditions, including a chaperone requirement for female patients.⁸⁶ The chaperone conditions have now been in place for over four years, and are more akin to an ongoing restriction on practice than an interim measure.

I also noted one example where the MBA's decision to impose chaperone conditions was at the registration stage, following disciplinary action by the MBA.⁸⁷ In this case, an investigation into the doctor's conduct found that allegations of

79 MBA decision, August 2016.

80 MBA decision, November 2014.

81 MBA decision, April 2016.

82 MBA decision, August 2016.

83 MBA decision, April 2015.

84 MBA decision, September 2015.

85 *MBA v Young* [2010] VCAT 1542.

86 MBA decision, January 2013.

87 MBA decision, March 2013.

professional misconduct had been substantiated and that the doctor posed a serious risk to the public. The MBA did not take the option of referring the matter to the relevant tribunal, and instead decided what the ongoing registration requirements should be at the renewal of registration stage. The MBA decided to impose chaperone conditions, which have now been in place for approximately four years. This again indicates the use of chaperone conditions as an ongoing regulatory measure rather than an interim measure.

I reviewed a number of cases where chaperone conditions had been imposed by decision of a tribunal. In the *Helmy* decision, in an interim situation, the Tribunal set aside the decision of the MBA to impose conditions prohibiting the doctor from treating or having non-clinical communication with female patients or patients under the age of 18 years, and substituted a decision to impose a chaperone condition on the registration of the doctor, despite relevant complaint history.⁸⁸

Variation in scope and requirements of chaperone condition

In the past, there has been variation in the scope and requirements of chaperone conditions imposed by the MBA as an immediate action. However, during the course of 2016, with revisions to the AHPRA *Chaperone protocol*, there has been greater uniformity of chaperone conditions. The typical condition states that the practitioner 'must not have contact with any female patients without the presence of a Board-approved chaperone who directly observes the entire contact' and that the practitioner sign the AHPRA Protocol for the use of chaperones. In recent times, the MBA has moved away from chaperone conditions limited to patients of a specified age. Some older MBA chaperone conditions applied only to age groups, such as 'adult female patients' or 'male patients under the age of 18'.⁸⁹

The Medical Council of NSW frequently imposes chaperone conditions limited to patients of a specified age. Current conditions require the presence of a chaperone for consultations with any female patient over the age of 13; over the age

of 14; under the age of 18; or between the ages of 12 and 70 (in the case of a rural doctor whose work included visiting a nursing home, 'so as not to further tax the already overloaded nursing duties and not to distress or cause anxiety to the nursing home residents').⁹⁰ In December 2016, the Medical Council decided to move away from stipulating age parameters in chaperone conditions, and to stipulate only the gender/genders covered by the requirement that a chaperone be present.⁹¹

In my opinion, the specification of an age limit for patients to whom a chaperone requirement applies is misguided. I heard evidence during this review of sexual predators who offend against a wide age range of patients.⁹² If there is considered to be risk of sexual misconduct by a doctor towards female and/or male patients such that immediate action is warranted, any interim restriction should apply to the relevant gender/genders, without any age limit.⁹³

In addition to requiring a chaperone for patients of a specified gender, the MBA occasionally adds a further condition that a doctor is 'not to provide medical treatment of an intimate nature' to patients of the specified gender, with 'medical treatment of an intimate nature' defined as 'any examination of, or treatment involving, the breasts, genitalia or rectum of a patient'. In one case, the MBA specified that, in addition to requiring the presence of a chaperone for contact with any female patient, the doctor 'must not undertake any gynaecological procedures under any circumstances' (ie, 'any gynaecological investigations, tests, examinations or treatment whatsoever').⁹⁴

The chaperone condition typically applies to any 'contact with a patient', defined to include 'consultation, interview, examination, assessment, prescribing for, advising, treating or otherwise seeing a patient, whether it is in person or on a communication device'. The condition may additionally specify that the chaperone 'must observe the content of any written communication (including, without limitation, SMS text messages, emails, MMS messages), and listen to and observe both sides of any audio or video communication'

88 *Helmy v MBA* [2016] ACAT 97. It was alleged that the doctor had been 'grooming' a patient over a three-year period and had been physically inappropriate during a consultation. The doctor had been subject to two previous notifications that had been discontinued; the first alleged that the doctor had been physically/sexually inappropriate with her, and the second alleged that the doctor had engaged in inappropriate sexual conduct with her during consultations.

89 During the course of the review, I noted one unusual, expired chaperone condition applicable to consultations with female patients under the age of 45.

90 De-identified decision of Medical Council of NSW.

91 Information provided by Dr Greg Kesby, President, Medical Council of NSW.

92 Confidential submission, February 2017.

93 Recommendation 13(b).

94 MBA decision, April 2016.

between the doctor and any patient of the specified gender.

The specification of who may act as chaperone is fairly well-defined. The current AHPRA Protocol (December 2016) stipulates that the chaperone must be either a chaperone nominated by the practitioner and approved by AHPRA (in which case the person must be a registered health practitioner without restrictions on their registration, and preferably not a direct employee of the practitioner), or a patient-chosen chaperone (who must be at least 18 years and be a partner, parent/guardian or family member of the patient).

The OHO *Chaperone protocol for registered health practitioners* (August 2016) approves chaperones and patient-chosen chaperones on a similar basis to the AHPRA Protocol. In one case, the Health Ombudsman imposed a chaperone condition requiring a medical practitioner undertaking home visits not to consult female patients without a chaperone present. The order specified that the chaperone be at least 18 years and either a support person present at the consultation or the patient's parent/guardian or a staff member employed by the practitioner's employer. However, 'if the patient does not have a person who can act as a chaperone during the consultation, ... the practitioner's male driver [is] to be the chaperone'.⁹⁵

The *Chaperone Approval Position Statement* of the Medical Council of NSW (March 2016) requires the chaperone to be 'a medical practitioner or nurse currently registered [with no restrictions] in Australia' and does not permit patient-chosen chaperones.

Patients must be told of the required presence of the chaperone before the consultation commences. In the event the patient declines to have a chaperone present, the consultation cannot proceed and, where practicable, the patient should be offered an appointment with another practitioner. There must also be a clearly visible A3-size practice sign in the patient waiting area, alerting patients to the chaperone requirement. In my observation of practice signs in two general practices in Melbourne, the sign was difficult to read in a patient waiting room area amidst multiple notices on display and unlikely to be noticed.⁹⁶

AHPRA chaperone conditions have strict requirements that, after each chaperoned consultation, the chaperone signs the chaperone log (to be maintained by the practitioner),

confirming the presence and direct observation of the chaperone for the entire patient contact. Medical Council of NSW and OHO chaperone conditions similarly require a chaperone log to be maintained, but do not appear to require a practice sign.

Cases where gender/age-based prohibition or suspension imposed

In some cases where a notification of sexual misconduct is received, the regulator imposes a more restrictive condition on practice. The next logical step up is a condition prohibiting the practitioner from seeing patients of a specified gender and/or age, sometimes referred to as a gender-based prohibition.

Such a condition appears to be imposed relatively rarely as an immediate action by the MBA, presumably because a chaperone condition is considered sufficient to manage any risk to patients while allegations are investigated. As at 9 January 2017, outside NSW and Queensland, four doctors and one Chinese medicine practitioner were subject to an interim prohibition on seeing patients of a specified gender and/or age, and another three doctors were subject to such a restriction following proven sexual misconduct. In one example, the doctor had been subject to a chaperone condition when seeing female patients, following notification of an alleged sexual relationship with a patient. Due to non-compliance with the chaperone condition, the MBA substituted a condition that the doctor not have contact with female patients.⁹⁷

In another case, the MBA imposed a condition that a doctor not have contact with female patients, as an immediate action following notification from the police of an alleged sexual assault on a patient during a visa medical examination, and details from the police of five other female patients who alleged inappropriate visa medical examinations or comments by the doctor that made them feel uncomfortable. The doctor had ignored employer instructions that medical examination panel physicians use a chaperone. The MBA considered 'a condition not to consult with female patients' to be 'the minimum regulatory force to mitigate the risk posed by [the doctor's] alleged conduct', but did not consider suspension necessary, noting that none of the complaints related to treatment of male patients.⁹⁸

95 The driver was an employee of the practitioner's employer and not of the practitioner (advice from OHO, February 2017).

See OHO immediate registration action decision against Dr Ritesh Upadhyah, May 2016: www.oho.qld.gov.au/immediate-registration-action-taken-against-dr-ritesh-upadhyah.

96 Site visits (one announced and one unannounced) with AHPRA monitoring and compliance staff, October 2016.

97 MBA decision, November 2016.

98 MBA decision, October 2016.

Decisions published on the website of the OHO suggest that the Queensland Health Ombudsman occasionally imposes gender and age restrictions as an 'immediate registration action', with one nurse, one physiotherapist and one Chinese medicine practitioner subject to such a condition.⁹⁹ Gender-based prohibitions seem to be more frequently imposed in NSW. The HPCA advised that 11 health practitioners (including four doctors) were prohibited from seeing a particular class or cohort of patients as at 18 January 2017.

The most restrictive immediate action is suspension of the doctor's registration, resulting in loss of the ability to practise. Suspension may be imposed as an immediate action by health professional Councils in NSW and the Queensland Health Ombudsman, following complaints alleging sexual assault or inappropriate examination. The HPCA advised that, as at 18 January 2017, 11 health practitioners (including eight doctors) were suspended as a result of a complaint alleging sexual assault or inappropriate examination. A search of the immediate action decisions of the MBA 2014-2016 showed nine cases involving doctors where the outcome of a notification of sexual misconduct was immediate suspension.¹⁰⁰ Analysis shows that these cases usually involved criminal charges or convictions or evidence of sexual offending, or new allegations against a doctor with a notifications history relating to similar conduct.

In some cases, suspension follows imposition of a chaperone condition as an immediate action decision of the MBA. The restriction may be increased in cases where there is evidence of breach of chaperone conditions; evidence of inappropriate conduct despite the chaperone condition; or progress in related police investigations such as charges, a guilty plea or convictions. A search of the 2014-2016 immediate action decisions of the MBA showed ten cases (involving nine doctors and one chiropractor) where a chaperone condition was replaced with suspension.¹⁰¹

In one case a doctor had been required to see female patients with a chaperone after a notification of inappropriate sexual remarks and touching during a consultation. Four more notifications (received during the course of one

month) alleged inappropriate sexual remarks and touching, including an incident when a curtain was pulled and the chaperone was unable to view the conduct. The further notifications, together with information from the police, led the MBA to suspend the doctor on the basis that he continued to pose a serious risk to patients.¹⁰²

In a recent case, the MBA decision suspended a doctor who had been subject to a chaperone condition for two years, following notification of an alleged sexual assault on a patient who was 22 weeks pregnant. The suspension followed new information that the police had charged the doctor with rape of the patient, on the basis that 'the alleged conduct is egregious, and the Board now has before it strong, cogent information in support of the alleged conduct'. A gender-based prohibition – that the doctor only consult with male patients – was considered 'not sufficiently protective'.¹⁰³

The MBA decision to suspend Dr Andrew Churchyard is another example of the Board imposing a suspension following an initial chaperone condition. The Board's action followed a second notification alleging that Dr Churchyard had indecently touched a patient behind a pulled curtain, while the chaperone was in the room.¹⁰⁴

Cases where no immediate action taken

Although AHPRA staff recognise that notifications of sexual misconduct are potentially indicative of 'high risk', after initial assessment the majority are not put before a local Board committee with recommendations of immediate action. A recent internal audit of 'open'¹⁰⁵ notifications of boundary violations found 244 health practitioners subject to an allegation of boundary violation, but that immediate action had been taken against only 84 (34%).¹⁰⁶ Not all boundary violations are sexual in nature (approximately 85% in 2011-2015) and some notifications will be assessed as 'low risk'.

However, AHPRA's audit identified 58 open notifications of boundary violations where the allegations, if proved, suggested high risk to the public. Examples included a notification that a doctor had sexually assaulted a patient during an examination, performed inappropriate vaginal examinations and naked massages and had a

99 Information provided by AHPRA, 13 January 2017. See decisions published at: www.oho.qld.gov.au/news-updates/immediate-actions/immediate-registration-action.

100 Information supplied by AHPRA, December 2016.

101 Information supplied by AHPRA, December 2016.

102 MBA decision, August 2012.

103 MBA decision, November 2016.

104 MBA decision, February 2016.

105 An 'open' notification is one where investigation is ongoing or no decision has been made to take no further action.

106 AHPRA internal audit, September 2016.

history of similar allegations; and an allegation of rape of a patient during a home visit. In some cases that suggested a high risk, a restriction had been considered but not ultimately imposed by the MBA. The final decision about whether to impose a restriction is taken after consideration of the notification plus any information gathered through an assessment or investigation process and any submissions made in response by the practitioner. The audit considered the notifications in light of all information available to date and concluded that none of the matters required immediate action.¹⁰⁷

Decisions to take no further action on notification of alleged sexual misconduct

A National Board may decide to take no further action on any notification – including a notification of sexual misconduct – on certain statutory grounds, including if ‘the Board reasonably believes the notification is frivolous, vexatious, misconceived or lacking in substance’, if the passage of time since the relevant events makes it ‘not practicable’ to investigate or otherwise deal with the notification, or if the matter has already been dealt with adequately by the National Board and/or is being dealt with adequately by another entity.¹⁰⁸ A National Board may take a ‘no further action’ decision after preliminary assessment of a notification or after considering a report of an investigation of the notification.¹⁰⁹

For the two years 2014/2015 and 2015/16, 56% of notifications of boundary violation (228 of 408) were ‘closed’ after a National Board decided to take ‘no further action’. A high proportion of notifications of boundary violation over these two years – 72% (294 of 408) – involved alleged sexual misconduct.¹¹⁰ These figures are relevant context to this review, since an observer might think that if so many notifications of alleged sexual misconduct ultimately lead to no further action, a cautious approach should be taken to the imposition of immediate action restrictions on practice. Alternatively, a reviewer might query whether the regulator is taking too ‘hands off’ an approach.

In my assessment, neither view is justified. By way of comparison, health complaints entities regularly exercise statutory powers to take no further action on a complaint.¹¹¹ Review of the 228 AHPRA boundary violation files closed by a ‘no further action’ decision in 2014/2015 and 2015/2016 showed the following breakdown of reasons:¹¹²

107 Advice from AHPRA National Director Operations, 19 January 2017.

108 National Law, s 151(1)(a), (b), (d), (e).

109 National Law, s 151(1), 167(a).

110 The relevant subcategories were inappropriate sexual comments (57), inappropriate sexual contact (149) and inappropriate sexual relationship (88).

111 For example, in NSW the Health Care Complaints Commissioner (HCCC) discontinued 2,626 (45%) of complaints in 2015/16, and 2,334 (46.7%) in 2014/15; see HCCC Annual Reports 2016, 2015; in New Zealand, the Health and Disability Commissioner (HDC) decided to take no further action in 1,145 (57%) of complaints closed in 2015/16; 1,114 (58%) in 2014/15; see HDC Annual Reports for 2016, 2015.

112 Information supplied by AHPRA following detailed case review, January 2017.

Table 1: Reasons for no further action in boundary violation notifications closed in 2014/15 and 2015/16

No. of cases	% of total	Overview of categories	Explanation
28	12%	Adequately dealt with	Issues identified in the notifications had been adequately addressed, for example by action by the employer (termination of employment or internal investigation); the practitioner has undergone relevant education or training; or the matter has been investigated or resolved by a health complaints entity.
2	1%	Conduct not related to practice	Where the alleged conduct was low risk and there was no link to the practitioner's practice of the profession.
167	73%	Insufficient evidence	The notifier or alleged victim has withdrawn from the notifications process or requested not to be involved; or A significant amount of time has elapsed since the alleged conduct and it is not practicable to gather relevant evidence; or The evidence substantiates the practitioner's version of events (eg, a witness confirms the practitioner's version of events); or The notifier was anonymous and the information available was not sufficient to demonstrate the alleged conduct, and there were not viable avenues of enquiry without further information from a notifier.
13	6%	No longer registered	Where the practitioner has surrendered or not renewed registration, or registration has been cancelled, and it is not otherwise in the public interest to continue with the notification, given the low level of seriousness of the allegation.
18	8%	Not unprofessional conduct	Where the alleged conduct was of low risk and could not be categorised as unprofessional conduct, notwithstanding that it had been classified as a boundary issue.
Total:	228	100%	

For several reasons, it is essential that sexual boundary violation notifications are thoroughly assessed by experienced staff and detailed statements obtained from notifiers and practitioners, where practicable. A key reason is the high risk nature of such notifications, given the potential risk to other patients, and to public confidence in health practitioners and health regulatory bodies, if a sexual misconduct allegation on which 'no further action' is taken later turns out to be well founded. Other factors are the reluctance of patients to make a notification about inappropriate sexual behaviour by a health practitioner (eg, where the examination may have been legitimate but the patient has serious doubts whether the doctor's manner and behaviour was appropriate) and the fact that the relevant conduct will often occur in a consultation room with only the practitioner and patient present. A single complaint may be the 'canary in the coal mine', alerting a National Board to concerns about a practitioner's conduct.

Thus, the statutory ground for discontinuance of 'lacking in substance'¹¹³ should not be lightly invoked. Following assessment (when the practitioner has responded to the notification), where any Board committee member believes there are matters that need to be investigated, the notification should be investigated. However, there will inevitably be a significant proportion of boundary violation notifications where the evidence does not justify the taking of immediate action, and which cannot be progressed by an investigation – and ultimately lead to a 'no further action' decision.

A decision by a National Board to take no further action on a notification does not prevent a Board taking the notification into consideration at a later time 'as part of a pattern of conduct or practice by the practitioner'.¹¹⁴ The fact that the National Law enables prior notification history to be taken into account in assessing a subsequent notification means that a pattern of conduct may emerge, even if a first notification is closed for lack of evidence.

¹¹³ National Law, s 151(1)(a).

¹¹⁴ National Law, s 151(2).

A National Board may then be able to take appropriate action.

Vexatious notifications and complaints

Vexatious complaints within the medical profession were identified as an area of concern in the recent *Senate inquiry into the medical complaints process in Australia*.¹¹⁵ The inquiry heard many witnesses who argued that complaints are too often made for vexatious reasons, using the complaints process as a tool for bullying and harassment.¹¹⁶

In her submission to the Senate inquiry, the National Health Practitioner Ombudsman and Privacy Commissioner, Samantha Gavel, noted that her experience in handling complaints about the administrative actions of AHPRA and the National Boards 'does not suggest that there is a high incidence of people intentionally using notification processes for vexatious purposes'.¹¹⁷ Her Office received two such complaints in 2014-15 (1% of the total) and two in 2015-2016 (3% of the total).¹¹⁸

The CEO of AHPRA, Martin Fletcher, advised the Senate inquiry that AHPRA data and research indicates that vexatious complaints is 'a very small problem' and noted that AHPRA intends to launch a portal for online complaints, asking the notifier to declare that the content of their complaint or concern 'is true and correct to the best of their knowledge and belief'.¹¹⁹ However, in its inquiry report, the Senate Community Affairs Reference Committee stated that it was 'not convinced that AHPRA's processes are adequate for the purpose of identifying complaints made vexatiously'.¹²⁰ A further Senate inquiry into the complaints mechanism administered under the National Law has been announced.¹²¹

During this review, practitioners and medical defence organisations expressed concern about the risk of vexatious notifications and complaints and noted that, if the imposition of chaperone

conditions were to be removed from the regulatory toolbox, practitioners could face the imposition of a prohibition on seeing a cohort of patients, or even suspension, from a patient making a notification in bad faith. However, it was difficult to find any specific examples of a vexatious notification alleging sexual misconduct. One example cited was a South Australian case, where a patient claimed to have been sexually assaulted during a consultation and a chaperone condition was imposed in response to a notification from a doctor who examined the patient at a rape and sexual assault service. After investigation, her complaint was found to be misconceived and possibly untruthful given inconsistencies in the evidence provided, and a Performance and Professional Standards Panel of the MBA decided to remove the chaperone condition and take no further action on the matter.¹²²

The experience of health complaints entities and health regulatory bodies is that vexatious complaints or notifications are exceptionally rare. This accords with my own experience as New Zealand Health and Disability Commissioner. My impression was reinforced during discussions with AHPRA staff and people interviewed during the review. Although a practitioner is likely to find a complaint vexing, that does not mean it was made vexatiously, in the sense of being an abuse of process.¹²³ In my opinion, close scrutiny of all documentation and interview statements, and careful assessment by experienced staff, will enable the rare vexatious notification to be identified and closed without further action.

115 Senate Community Affairs Reference Committee, *Medical complaints process in Australia* (November 2016): www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report.

116 Inquiry report, para 2.29.

117 Inquiry report, para 2.31.

118 Written answer to questions taken on notice (item 5):

www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Additional_Documents.

119 Inquiry report, paras 2.37, 2.35. Recent qualitative research suggests that under-reporting of notifiable conduct may be a more significant problem than over-reporting. Three types of inappropriate reports may occur: misconceived reports resulting from misunderstanding reporting thresholds; vexatious reports made with the intention of causing trouble for another practitioner; and avoidable reports where the threshold for reporting need not have been reached if colleagues or employers provided early appropriate support. See LA Thomas and M Bismark. Vexatious, misconceived, and avoidable reports by peers to medical regulators: a qualitative study of health practitioners in Australia (2017) 24 *Journal of Law and Medicine* 1.

120 Inquiry report, para 2.39.

121 Senate Community Affairs Reference Committee, 1 December 2016:

www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ComplaintsMechanism.

122 MBA decision, September 2012.

123 G Haysom. The vexed problem of improper complaints (13 February 2017) MJA InSight:

www.doctorportal.com.au/mjainsight/2017/5/vexed-problem-of-improper-complaints.

Part E: Appropriateness of mandated chaperones

An old-fashioned and unclear term

The use of the term chaperone to describe an observer of a patient-doctor consultation is curiously old-fashioned in the context of contemporary practice. The origins of the word are from the French *chaperon*, meaning a hood or covering to protect the head. The use of chaperone in English dates from the early 18th century, when it was used to describe 'an older woman responsible for the decorous behaviour of a young unmarried girl at social occasions'.¹²⁴ The concept of an adult who accompanies young adults to ensure their appropriate behaviour has all but disappeared, and the term itself is rarely heard in this context. Yet it survives in medical practice.

Discussions with members of the public indicate that many people are unclear what the term means. This was evident to me in a consultation meeting I convened as New Zealand Health and Disability Commissioner on sexual abuse in the doctor-patient relationship, following which I commented to the medical media that 'like the term chastity, chaperone sounds a bit quaint for the year 2000'.¹²⁵ It sounds no less quaint in Australia in 2017. Similar comments were made at the consumer forum organised by the Health Issues Centre during the current review. Consumer participants saw chaperone as an old-fashioned and paternalistic term that does not appropriately describe the reason why the practitioner is required to have an observer present when practising.

A study in England found that 29% of patients attending a GP practice were unaware of the term chaperone and emphasised the need for a modern word and communication style (printed and verbal).¹²⁶ Research on the use of chaperones in general practice in Australia – albeit in relation to the offer of a chaperone for intimate examinations – found that many patients were unaware of the option of a chaperone, and that the medical profession needs to communicate in a language appropriate to the patient group.¹²⁷

During this review, people responded well to my suggestion that the term 'practice monitor' be used instead of chaperone. In recent years, the College of Physicians and Surgeons of Ontario (CPSO), the medical regulator in Ontario, Canada, has used practice monitor interchangeably with chaperone. A practice monitor may have chaperone functions (in the room during physical examinations), and also other clinical or administrative duties.¹²⁸

In my opinion, the term 'practice monitor' is a more accurate description of a mandated chaperone. Their role is to monitor the practice of the doctor, to ensure no inappropriate behaviour. Practice monitor has a modern flavour and sounds like a regulatory requirement – which is what a mandated chaperone is. I recommend that the term 'chaperone' be replaced with 'practice monitor' when imposed as a condition of practice by health regulatory bodies in Australia.¹²⁹

I note that in December 2016, the Medical Council of NSW resolved to remove 'chaperone' and 'chaperoning' from its regulatory lexicon, replacing the terms with 'practice monitor' and 'practice monitoring'.¹³⁰

Patient and doctor views on concept of chaperone

Many patients are uncomfortable with the concept of a chaperone. As noted in *Part B*, some submitters were concerned about the flow-on effects of chaperoning on patients. The presence of a chaperone may alter the doctor-patient interaction in ways that could inhibit effective medical practice (eg, through a reduction of trust in the doctor, an unwillingness to broach delicate issues or undertake intimate examinations, and the inhibition of subtle emotional cues in consultation). Similar concerns were expressed during a focus group meeting convened by the New Zealand Medical Council in 2001. Participants thought that the offer of a chaperone could be counter-productive to forming a trusting relationship with a doctor, and that it introduced an element of awkwardness in the doctor-patient relationship.¹³¹ The sense of intrusion is likely to be even greater

124 See the definition of chaperone in the Oxford Dictionary: en.oxforddictionaries.com/definition/chaperone.

125 *New Zealand Doctor* (6 December 2000), p 13.

126 K Pydah, J Howard. The awareness and use of chaperones by patients in an English general practice (2010) 36(8) *Journal of Medical Ethics* 512.

127 O van Hecke, K Jones. The attitudes and practices of general practitioners about the use of chaperones in Melbourne, Australia (2012) *International Journal of Family Medicine* Article ID 768461.

128 Information provided by Dan Faulkner, CPSO Deputy Registrar.

129 Recommendation 15.

130 Information provided by Dr Greg Kesby, President, Medical Council of NSW. The change followed my discussion with Council members in November 2016.

131 C Bear. *Sexual Boundary Policies and Processes: Evaluation and Action Plan* (Medical Council of New Zealand, 2002), p 20

for mandated chaperones whose presence is a strict regulatory requirement.

Doctors are more comfortable with the concept of a chaperone, reflecting their familiarity with College, MBA and medical defence organisation guidance recommending their use for intimate examinations – even though many practitioners do not offer a chaperone.¹³² Some doctors are forthright in their advice that doctors should always offer a chaperone for intimate examinations: ‘Get over it: just provide a chaperone and patients will accept her.’¹³³

In my opinion, the offer of a chaperone for intimate examinations is appropriate in contemporary medical practice, but it may be sensible to adopt a new term, such as ‘observer’, to describe the proposed third person in the consultation room. Patients should be told at the time of booking the appointment, or upon arrival at the health facility, that it is proposed to have an observer present and a simple statement of reasons (eg, ‘It’s our practice policy for intimate examinations’). It should also be made clear to the patient that she or he has the option to decline to have an observer present, but that the doctor may then not wish to proceed with the consultation, in which case a referral to another doctor should be offered, where practicable.

Views of patients, doctors and stakeholders on mandated chaperones

I heard a wide range of views about whether mandated chaperones are appropriate. The differing views are summarised in *Part B*. Some views were unsurprising. For example, colleges, professional associations and medical defence organisations saw a continued place for chaperone conditions, as an appropriate regulatory safeguard while allegations of sexual misconduct are investigated. However, some doctors questioned the appropriateness of chaperone conditions, noting the embarrassment and humiliation of explaining the necessity to patients and the potential reputational harm from speculation about the requirement.¹³⁴ Some doctors considered that a voluntary undertaking not to practise (while

investigations are ongoing) might be a better approach.

It is understandable that patients who have been subjected to sexual abuse from a doctor argue that the doctor should be suspended while the matter is investigated, and that a chaperone condition is an inadequate safeguard. In meetings with submitters, I found the views of a doctor who had been sexually abused as a patient, and of Dr Sharon Monagle, mother of Tom Monagle, especially powerful. They understood the natural justice concerns of requiring an accused practitioner to stand down, but came down firmly on the side of public protection by suspension, having seen first hand the impact of sexual abuse.

Many submitters also queried the workability of mandated chaperone conditions, particularly in rural and remote locations, but also in public hospital settings. In *Weettill*, the State Administrative Tribunal of Western Australia noted that the cost of employing a nurse chaperone in a public hospital was prohibitive, and the chaperoned doctor needed to be redeployed into a role without patient contact.¹³⁵

New Zealand submitters during a public consultation on sexual boundary policies in medical practice noted that the use of chaperones may not always be logistically feasible, given the wide variation in practice settings and the relationship of individual doctors and patients, and resource limits.¹³⁶ Discussion of the appropriateness of mandated chaperone conditions cannot be divorced from consideration about whether they are workable in practice.

I was struck by the views of some experienced medical regulators, health complaints entity heads, patient safety experts, health lawyers and government officials. Beth Wilson, the former Health Services Commissioner, Victoria, is someone who shares my experience of many years as a complaints commissioner, balancing the need to protect the public while being sensitive to complainants and fair to accused practitioners. Ms Wilson has shifted from accepting a place for mandated chaperones as an interim measure, to viewing them as inappropriate. In her view:

¹³² A pilot study of general practitioners in Melbourne found that 95% had never or only occasionally used a chaperone: K Jones et al. Chaperones for intimate examinations in family medicine: findings from a pilot study in Melbourne, Australia (2015) 55(1) *Medicine, Science and the Law* 6.

¹³³ I St George. Professional probity post-Fernando: A terrible beauty is born (2007) 34(4) *New Zealand Family Physician* 282 at 283.

¹³⁴ Note the concerns of the doctor in *Helmy v MBA* [2016] ACAT 97 at para 27, albeit in response to a gender and age-based prohibition, and the comments of the Tribunal that even a chaperone condition (which it decided to substitute) might not address his concerns and ‘[i]t may be that he will choose not to return to practice ... notwithstanding the financial, personal and practical effects of the cessation of his practice’ (para 75).

¹³⁵ *MBA v Weettill* [2015] WASAT 124, Reasons for decision, para 29.

¹³⁶ C Bear. *Sexual Boundary Policies and Processes: Evaluation and Action Plan* (Medical Council of New Zealand, 2002), p 20.

'If a doctor cannot be trusted to be with patients without a chaperone, the doctor is not trustworthy and shouldn't be seeing patients at all.'

Beth Wilson, former Health Services Commissioner, Victoria

Senior officials within medical regulatory bodies, with long experience of the use of mandated chaperones, were sceptical about their appropriateness in 2017.¹³⁷ Australia's leading health law practitioner, Ian Freckleton QC, after many years of sitting on disciplinary tribunals and prosecuting and defending professional misconduct cases, sees no place for mandated chaperones – on the basis that if there is a reasonable belief of serious risk to patients, the doctor should not be practising at all.

I found the submission from ACT Health Director-General, Nicole Feely, compelling in the view that 'patients consulting a practitioner in the private sector are entitled to the same protections they receive in the public sector. ... The use of a chaperone to permit a practitioner to continue to work carries a level of risk contrary to the provision of high quality and safe health care, and may undermine public trust in our health system.' It is difficult to see how a mandated chaperone can be appropriate in the private system but not in the public system. If the restriction is being imposed almost exclusively on practitioners in private practice (as my review of current conditions indicates), it is hard to resist the conclusion that in effect it is being used to protect the income of accused practitioners, who in the public system would usually be stood down on full pay.

Many commentators drew an analogy with how allegations of sexual misconduct are dealt with in other professions and queried why doctors are treated differently from people in other occupations. A compelling observation was made by Ameer Tadros, Director of the NSW Health Professional Councils Authority, that if an allegation of serious impropriety is made against a rugby league player, particularly if criminal charges are laid, the player is immediately stood down, even if the allegation is related to the player's personal life and is unrelated to their performance on the field. Several submitters and interviewees made comparisons with school teachers and childcare workers, noting that it would be unthinkable to allow the supervisor of a childcare centre to work with a chaperone while facing allegations of sexual misconduct.

A community member of a National Board suggested that the mandated chaperone system 'puts a whole lot of effort into a mechanism that does not meet community expectations'.¹³⁸

Between these polar opposites, some equally thoughtful submitters saw a continued, very limited place for mandated chaperones. They included the consumer participants at the Health Issues Centre forum, subject to two important caveats: (1) that the practitioner tell the patient that the medical board requires that they practise with a chaperone due to allegations of misconduct, and give fuller details (ie, disclosing that sexual misconduct has been alleged) if the patient seeks more information; and (2) that the chaperone be independently appointed and have no previous relationship with the practitioner.

The AHPRA Community Reference Group also saw a limited place for chaperone conditions, but argued that practitioners should be required to inform patients about the requirement for a chaperone well before the patient arrives for the appointment with the practitioner, since if they are not told until they present at the facility, 'their autonomy and choice about their care have already been substantially reduced'. The issue of the timing of disclosure of a chaperone requirement is discussed further in *Part F*.

I benefitted from a lengthy joint discussion with the heads of the medical regulatory system in NSW, Dr Greg Kesby, Chair of the Medical Council, and Sue Dawson, Health Care Complaints Commissioner. They stressed the need for immediate and decisive action where there is any corroborative information or evidence of concerning behaviour in the past and acknowledged the limitations of mandated chaperones. However, they would be reluctant to see chaperone conditions removed entirely from the suite of possible regulatory restrictions as an interim measure where the facts are still scant. In their view, a chaperone condition should be imposed infrequently, in limited circumstances and for a limited time, where it is appropriate in the public interest. An example might be an allegation at the 'lower end' of the spectrum (eg, where it is not yet clear whether an examination may have been clinically appropriate but inadequately explained or where there is some possibility that touching may have been inadvertent given the treatment situation), and where the practitioner has no history of similar complaints and police charges are not pending or have not been laid. They acknowledged that there is an immediate need for improved monitoring of compliance whenever chaperone conditions are in place.

¹³⁷ I acknowledge helpful discussions with Dr Joanne Katsoris, Executive Officer – Medical, AHPRA and Sandra McCulloch, Director Investigation and Resolutions, College of Physicians and Surgeons of Ontario.

¹³⁸ Confidential National Board discussion, November 2016.

I have come to the conclusion that, in terms of community expectations in Australia in 2017, it is highly debatable whether mandated chaperone conditions are appropriate. My reservations are reinforced once the additional key considerations of information for patients, effectiveness and efficiency are taken into account – matters discussed below and in *Part F*.

The presence of a mandated chaperone is likely to be particularly intrusive in any consultation with a psychotherapeutic element (eg, with a psychiatrist or psychologist), due to the highly personal and confidential nature of therapy.¹³⁹ I note that on 1 January 2017, two psychiatrists were subject to chaperone requirements. I do not consider it appropriate to require the presence of a chaperone in the context of psychotherapeutic practice, such as by psychiatrists.¹⁴⁰ If a regulator receives a notification or complaint of sexual misconduct by a psychiatrist practising psychotherapy, and action is appropriate or necessary to protect the public or otherwise in the public interest, a gender-based prohibition or suspension should be imposed.

A chaperone condition is sometimes supplemented by a further condition that the practitioner is ‘not to provide medical treatment of an intimate nature’ or ‘must not undertake any gynaecological procedures under any circumstances’. I do not consider it appropriate for a regulator to limit practice in this way, to address concerns about sexual misconduct. It is one thing for patients to agree to the presence of a chaperone during a consultation, but another matter for the practitioner’s ability to provide appropriate clinical care to be constrained by the regulator (when the issue of concern is not one of standard of care).

If the regulator considers it necessary to limit practice in this way, in my view it should either impose a prohibition on all patient contact, a gender-based prohibition or a suspension, depending on the circumstances.¹⁴¹

Adequacy of information given to patients about mandated chaperones

The lack of information currently given to patients about the need and reasons for a mandated chaperone is, in my opinion, the most significant flaw in the current system.

The Australian courts have led the world in their recognition of the need for patients to give informed consent to medical procedures, notably through the High Court of Australia decision in *Rogers v Whitaker*.¹⁴² A majority of the High Court held: ‘The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in a particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.’¹⁴³

This proactive duty of information disclosure has been affirmed in legislation in Queensland, Tasmania and Victoria,¹⁴⁴ and forms the basis of the equivalent duty in right 6(1) of New Zealand’s Code of Patients’ Rights. Of course, there is an important difference between a patient’s right to be told about the risks of a medical procedure, and being told about any restrictions on the doctor’s right to practise. The latter information is specific to the practitioner, rather than the procedure.

However, if one starts from the underlying principle of trust in the doctor–patient relationship and the ethical principle of patient autonomy, and asks what information a reasonable patient would want to be told before a consultation, it seems obvious that a patient would want to know about any restrictions on their doctor’s practice. The law is beginning to move in the direction of recognising a doctor’s duty to disclose his or her own experience in a procedure and personal performance data, as well as restrictions on practice. A decision of the ACT Civil and Administrative Tribunal has recognised ‘a professional obligation to disclose, if relevant, any undertaking restricting the ability of a surgeon to carry out surgical procedures’ and ‘a legal obligation as well as an ethical and

139 The Psychology Council of NSW considers that the imposition of chaperone conditions as an immediate action is inappropriate for this reason, and that suspension should be used to protect patients, where a complaint of sexual misconduct is made against a psychologist; see NSW HCCC, ‘Chaperone conditions in NSW: a review’ (October 2016), p 7.

140 Recommendation 12(a).

141 Recommendation 13(a).

142 *Rogers v Whitaker* (1992) 175 CLR 479.

143 *Rogers v Whitaker* (1992) 175 CLR 479 at 490.

144 Civil Liability Act 2003 (Qld), Civil Liability Act 2002 (Tas), and Wrongs Act 1958 (Vic).

professional obligation to disclose restrictions on practice when pertinent to proposed treatment'.¹⁴⁵

A decision from the New Zealand Health and Disability Commissioner has held that a doctor subject to a voluntary restriction on his surgical practice (agreed with the Medical Council) was required to disclose that fact, since it was relevant information that may have influenced a reasonable patient's decision to consent to surgery.¹⁴⁶ The case for disclosure is even stronger in relation to a mandated condition of practice imposed by a medical board.

I note that in *Rogers v Whitaker* terms, information about the requirement to practise with a chaperone appears to fall within the first limb of the High Court test, being information that any reasonable patient would want to know, rather than the second limb, being information that the particular patient (eg, a patient asking lots of questions about the doctor's scope of practice) might want to know.

The reality for patients seeing doctors subject to chaperone requirements in Australia is a long way from this level of information disclosure. There are two problems: the information given is very general, and leaves many patients with the impression that this is simply an audit or training requirement; and the person who makes the disclosure is the doctor whose trustworthiness is at issue, a chaperone condition having been imposed because of alleged sexual misconduct.

At interview, patient Mr Z recalled seeing a doctor subject to a chaperone condition on two occasions when a chaperone was present. It was not explained to him why the chaperone was present, but he assumed it was for training purposes. He asked 'Are you doing training?' and the doctor responded, 'Something like that.' Mr Z expressed the view that 'There should have been something discussed, but nothing was discussed.'¹⁴⁷

Ian Freckelton QC noted that often a 'deceptive/finessing statement' is used, such as 'We're just having auditing at the moment,' to explain the presence of the chaperone to the patient. Such deception is inappropriate in the patient-health practitioner relationship.

Transparency is a buzzword in modern health systems, public services and regulation in Australia and internationally, at least in democratic states. The first guiding principle of the National Scheme, adopted by all state and territory parliaments, is that 'the scheme is to operate in a *transparent, accountable, efficient, effective and fair way*'.¹⁴⁸

The way the mandated chaperone system operates in Australia is far from transparent. Although a diligent search of the *Register of practitioners* may reveal the fact that a health practitioner is subject to a condition, and (on a separate webpage) a reader may 'View Details', the details given reveal merely the requirement to practise with a chaperone, any restrictions on the gender/age of patients and the nature of procedures to be performed, and the specifics about who may be a chaperone, practice sign, chaperone log, etc.

Patients are left in the dark about why a chaperone is required. Obviously an astute patient may suspect that the doctor has been accused of sexual impropriety, but many members of the public do not check the *Register of practitioners* and would not appreciate why a chaperone is required, even if a doctor makes a full 'I am required to practise with a chaperone' statement. Certainly, from my observation of practice signs in two general practices in Melbourne, the sign was difficult to read in a patient waiting room area amidst multiple notices on display and unlikely to be noticed.¹⁴⁹

It may fairly be said that the current system of minimal disclosure asks patients to accept that the regulators (AHPRA and the National Boards) know the full picture; as patients, they do not need to know the details, but should rest secure in the knowledge that they will be kept safe.¹⁵⁰ Quite apart from limitations in the effectiveness of mandated chaperones, it seems paternalistic and inconsistent with the transparent operation of the National Scheme, for patients and the community to be kept in the dark in this way.

The College of Physicians and Surgeons of Ontario (CPSO) employs various practices to inform patients about required practice monitors.¹⁵¹ The specific requirements are set out in the relevant undertaking or Discipline Order and can include that:

¹⁴⁵ *MBA v Hocking* [2015] ACAT 44 at [124]

¹⁴⁶ *Nelson Marlborough District Health Board, General Surgeon, Dr C* (Health and Disability Commissioner, Opinion 12HDC01488, 10 March 2015) para 135.

¹⁴⁷ Meeting with Mr Z, Melbourne, 14 November 2016.

¹⁴⁸ National Law, s 3(3)(a), emphasis added.

¹⁴⁹ Site visits (one announced and one unannounced) with AHPRA monitoring and compliance staff, October 2016.

¹⁵⁰ One sign noticeable on the wall of a patient waiting room I visited was the colourful AHPRA poster, 'BE SAFE IN THE KNOWLEDGE'.

¹⁵¹ Information provided by Sandra McCulloch, Director Investigation and Resolutions, College of Physicians and Surgeons of Ontario, February 2017.

- the physician post a sign in the waiting room and examination rooms
- reception staff notify patients about the need for a practice monitor when they book their appointments
- the practice monitor announce the reason for her/his presence at the beginning of each appointment, examination or home visit
- patients sign an acknowledgment that they are aware of the Order, have read the Committee's decision and reasons, and understand the need for a practice monitor
- patients sign consents prior to video monitoring.

Of the CPSO's currently open compliance monitoring files that have a practice monitor, 19% require explicit notification to patients beyond posting a sign. Some physicians and practice monitors also verbally notify patients of their own volition.

Under current Australian practice, leaving it to the impugned doctor to tell the patient compounds the inadequacies of information disclosure about the required presence of a chaperone. It is very much a case of the fox guarding the henhouse. In addition to the need for fuller disclosure of the reasons why a chaperone is required, it seems advisable to require another person – perhaps an employee of the practice (such as a receptionist) or the chaperone (assuming he or she is fully informed and properly trained) – to make the disclosure, and for the patient to sign and date an acknowledgement of having been told of the chaperone requirement and agreeing to the chaperone's presence.¹⁵²

Fairness to practitioners

A review of the appropriateness of mandated chaperones needs to consider fairness to practitioners, and the impact of restrictions on the practice of practitioners where misconduct is alleged but not proven. As many submitters noted, a health practitioner is innocent until proven guilty, no less than an individual accused of committing an offence. The requirements of natural justice – enshrined in elements of the National Scheme such as the 'show cause' process – mean that a practitioner must have a fair opportunity to answer the case against them.

Nonetheless, the first objective of the National Scheme is 'to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner' are registered. The *Regulatory principles*, adopted by AHPRA and the National Boards, make it clear that 'While we balance all the objectives of the National Registration and Accreditation Scheme, **our primary consideration is to protect the public**'.¹⁵³

Tribunal decisions recognise the primacy of protection of the public. As noted by the State Administrative Tribunal of Western Australia in *R*, 'Section 156 of the National Law clearly contemplates that, if a complaint is made against a practitioner, it may be necessary to take protective steps for the safety of the public prior to and during the course of the substantive investigative process that will follow.'¹⁵⁴

How does fairness and the impact of immediate action restrictions on accused practitioners fit within the legislative scheme? The first guiding principle of the National Scheme is that 'the scheme is to operate in a transparent, accountable, efficient, effective and *fair way*'.¹⁵⁵ Case law from tribunals and courts recognise the importance of fairness to practitioners in the immediate actions context – but that the impact of conditions on the practitioner must be weighed against the paramount consideration of public protection.

The statutory preconditions for a National Board's taking immediate actions make it clear that the legislature recognised the need for safeguards before a practitioner's registration can be restricted. A National Board *may* take immediate action if it 'reasonably believes' that the registered health practitioner's conduct (albeit alleged only at this stage):¹⁵⁶

1. poses a 'serious risk' to persons, and
2. it is 'necessary' to take immediate action 'to protect public health or safety'.

The necessity qualification is reinforced by section 3(3)(c) of the National Law, which states as a guiding principle of the National Scheme that 'restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality'.

¹⁵² Recommendations 16, 17, 18.

¹⁵³ AHPRA, *Regulatory principles for the National Scheme* (2014) principle 3 (emphasis in original): www.ahpra.gov.au/About-AHPRA/Regulatory-principles.

¹⁵⁴ *R v MBA* [2018] WASAT 28 at [104].

¹⁵⁵ National Law, s 3(3)(a), emphasis added.

¹⁵⁶ National Law, s 156(1)(a).

The show cause process, whereby the practitioner is notified of the proposed immediate action and given an opportunity to make a submission to the Board committee in response, is specific recognition of the need to hear the practitioner's views about the impact of the proposed restriction. Case law confirms that the impact of the immediate action measure on the practitioner is a relevant consideration that 'cannot be underestimated'.¹⁵⁷

The Queensland Civil and Administrative Tribunal in *Pearse* noted that any conditions imposed should specifically address the relevant risk and otherwise be the least onerous possible.¹⁵⁸ The ACT Civil and Administrative Tribunal summarised the requirements in *Hocking*:¹⁵⁹

'Because the taking of immediate action involves the identification of specific risks and both suspension and the imposition of conditions can have a significant adverse impact on a practitioner, the approach identified in *Pearse* is appropriate. Without compromising public health or safety, the action taken should be limited to that which is necessary to address the identified risk pending investigation and where relevant, further action – nothing broader or more onerous.

It follows that a decision to suspend – the most onerous of the decisions that may be made – should be made only where the serious risk is so significant or broad ranging, that nothing short of suspension can protect public health and safety; in other words, that suspension is necessary. In my view, a Board considering suspension as an immediate action should ensure that the option of using conditions to protect public health or safety has been considered and found to be inadequate for that purpose.'

Inevitably, in some cases where restrictions are imposed as an interim measure, the investigation will conclude that there is no basis for further action and the restriction will be withdrawn by the MBA or, even if misconduct is established, the final sanction may be less onerous than the interim sanction. In England, academic analysis of the use of interim suspension orders by the General Medical Council has criticised the approach as over-inclusive and excessively precautionary.¹⁶⁰ The criticism is made with the benefit of hindsight,

when the allegations have been tested. The fact that allegations are not ultimately proven or, if proven, warrant less restrictive ongoing measures does not mean that it was wrong for a medical board to impose an interim restriction it considered necessary to protect patients or appropriate in the public interest.

My review suggests that in some cases, a regulator or tribunal may be unduly influenced by concern about the impact of a restriction, and emphasise rehabilitation of the practitioner at the expense of public protection. As I have noted elsewhere:¹⁶¹

'Medical boards are often decidedly risk-averse, by which I mean aversion to organisational risk (such as the threat of judicial review of board action by defence lawyers) rather than aversion to patient risk. The voice of the doctor, amplified by legal representation, is usually louder and more articulate than the voice of the patients, and it often seems that backing away from strong measures is the "safer" approach. Furthermore, harm to the practitioner, in the form of suspension, is immediate and quantifiable, while risk of harm to the public is distant and uncertain.'

In *Wong*, the Queensland Civil and Administrative Tribunal was unpersuaded by submissions from the MBA that a GP who had been charged with 27 counts of sexual assault on 19 patients was not fit to practise and that his registration should be cancelled. The GP was suffering from schizophrenia and the sexual misconduct occurred when he failed to take his medication. His criminal charges had been referred to a Mental Health Court, which found he was suffering from 'unsoundness of mind' and acquitted him. There had been similar incidents many years earlier, leading to the imposition of conditions that he attend psychiatric treatment and take prescribed medication. The MBA submitted that the risk of relapse meant that even with similar conditions and close monitoring, public safety could not be ensured. However, the Tribunal considered that treatment and medication conditions minimised the risk of relapse by the impaired GP, and he was permitted to return to restricted practice.¹⁶² It is hardly surprisingly that such decisions are greeted with incredulity by the media and patients who have been abused by such a practitioner.¹⁶³

¹⁵⁷ *MLNO v MBA* [2012] VCAT 123 at [5].

¹⁵⁸ *Pearse v MBA* [2013] QCAT 392 at [18].

¹⁵⁹ *Hocking v MBA* [2015] ACAT 22 at [20], [21]. The case involved unsatisfactory professional performance in relation to clinical (not sexual) issues.

¹⁶⁰ P Case. Putting public confidence first: doctors, precautionary suspension, and the General Medical Council (2011) 19 *Medical Law Review* 337.

¹⁶¹ R Paterson. *The good doctor: what patients want* (2012) p 81.

¹⁶² *Medical Board of Australia v Wong* [2015] QCAT 435.

¹⁶³ 'North Brisbane doctor still practising after sexual assault acquittal sparks anger', *Brisbane Times*, 8 August 2016.

This approach may be contrasted with the statement of Hutley J in a New South Wales Court of Appeal decision:¹⁶⁴

‘The public has an interest in the maintenance of the ethical standards of the medical profession, and [the doctor] deliberately committed a fundamental breach of those ethics. The maintenance of ethical standards is not possible if the good motives of those who break them are treated as justifying their relaxation. The maintenance of professional and ethical standards requires not kindness but hardness, not flexibility but intransigence.’

Mandated chaperones as a risk-based regulatory intervention

AHPRA describes itself as a ‘risk-based regulator’ in undertaking its statutory functions. Its approach has been applauded by other medical and health regulatory bodies, as was evident in the responses of a large audience of international delegates at the International Association of Medical Regulatory Authorities conference in Melbourne in September 2016.

The regulatory philosophy of AHPRA and the National Boards is stated clearly in the *Regulatory principles*, which articulate a ‘responsive, risk-based approach to regulation across all professions’. One of the regulatory principles is that in all regulatory decision-making, the approach taken by AHPRA and the National Boards is to:¹⁶⁵

- **identify the risks** that we are obliged to respond to
- **assess the likelihood and possible consequences** of the risks, and
- **respond in ways that are proportionate and manage risks** so we can adequately protect the public.

This approach sensibly focuses on risk assessment and evidence-based decisions. It reflects research from the Professional Standards Authority (PSA) in the United Kingdom, under Chief Executive Harry

Cayton, which supports an approach of ‘right-touch regulation’,¹⁶⁶ namely the application of the minimum regulatory force to achieve the desired result.

Right-touch regulation is avowedly not ‘light-touch regulation’, but seeks to identify and address the causes of harm, rather than responding after the event. A precautionary approach is justified only ‘where the severity of the theoretical harm is very high, and it is not possible to quantify the risks robustly’.¹⁶⁷ However, the PSA recognises the difficulties involved in evaluation of risk, and notes that difficult moral decisions must be made about the ‘tolerability’ of a risk. ‘If the risk cannot be tolerated, action will need to be taken – although a further decision will need to be made about whether it can be effectively addressed through regulatory means.’¹⁶⁸

Risks to patients from potential sexual predator practitioners are an example of risks that may be very difficult to quantify, for example in the situation of a sexual allegation against a practitioner with no similar complaint history. Yet harm to a future patient who may be assaulted or sexually abused by that practitioner’s unrestricted practice is severe, albeit theoretical harm, given the ample evidence of the significant physical and psychological harm suffered by sexual abuse victims. It falls in the category of a harm that society will not tolerate.

A decision about whether a chaperone condition, a gender/age-based prohibition, or a suspension is an appropriate intervention requires consideration of its effectiveness in reducing risks. What is the least restrictive intervention necessary to protect the public? What is the relevance of likely harm to public confidence in a health profession and its regulators, if allegations of sexual misconduct are later proven and a practitioner has been allowed to continue seeing patients in the interim? The *effectiveness* of chaperone conditions is considered in *Part F*.

Comparison with other professions

A common issue raised in submissions and during discussions with stakeholders was how allegations of sexual misconduct are dealt with in other professions. People queried whether doctors are treated differently from people in other

¹⁶⁴ *Skinner v Beaumont* (1974) 2 NSWLR 106 at 109.

¹⁶⁵ Regulatory principle 5 (emphasis in original).

¹⁶⁶ Professional Standards Authority, *Right-touch regulation Revised* (2015):

www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.

See also Professional Standards Authority, *The role of risk in regulatory policy* (2015):

www.professionalstandards.org.uk/docs/default-source/publications/research-paper/risk-in-regulatory-policy-2015.

¹⁶⁷ *Right-touch regulation Revised*, p 11.

¹⁶⁸ *Right-touch regulation Revised*, p 11.

occupations. Several submitters and interviewees made comparisons with school teachers and childcare workers. A frequent comment was that it would be unthinkable to allow the supervisor of a childcare centre to work with a chaperone while facing allegations of sexual misconduct.

To explore this line of reasoning further, a meeting was held with representatives of the Victorian Department of Health and Human Services (the DHHS) to consider how allegations of sexual abuse are dealt with in relation to out of home carers for children in Victoria.¹⁶⁹

Out of home carers for children registered in Victoria

The *Guidelines for responding to quality of care concerns in out-of-home care: Technical update 2014* applies to children and young people who spend time living away from home in out of home care. The guidelines focus on the management of quality of care concerns raised about the care for children and young people living in out of home care.¹⁷⁰ The guidelines outline processes for the screening, management and investigation of allegations by the out of home care service provider and Child Protection, DHHS.

All allegations of sexual or physical abuse of a child or young person in out of home care are required to be reported by the service provider to DHHS within one working day, and also to Victoria Police.

As the safety of the child is paramount, once an allegation of physical or sexual abuse is received, a decision about the safest location for the child is made by Child Protection in consultation with other relevant parties. In addition, a quality of care case will be initiated under the *Guidelines for responding to quality of care concerns in out-of-home care: Technical update 2014*. This means the allegation will be examined, screened, and where appropriate referred for investigation, by the service provider and Child Protection.

Part 3.4 of the Children, Youth and Families Act 2005 (Vic) (the CYF Act), establishes the framework for the registration, notification, investigation and disqualification, by the Suitability Panel, of out of home carers in Victoria. An 'out of home carer' is a foster carer for an out of home care service, or a person employed or engaged by an out of home care service as a carer for children or as a provider of services to children at a residence managed by the service.¹⁷¹ The names of registered out of home carers in Victoria are recorded in a register

maintained by the Secretary of the DHHS. Out of home care agencies are required under the CYF Act to consult the register before employing or engaging a person to care for children.

The Suitability Panel is established under the CYF Act to decide whether an out of home carer who is alleged to have sexually or physically abused a child in his/her care should be disqualified from being a carer and removed from the register of out of home carers (s 80(5)). Before a matter can come before the Suitability Panel, however, a stipulated process must be followed. In summary:¹⁷²

1. A notification of the alleged abuse is made to the Secretary of the DHHS where a person is reasonably satisfied that an investigation by the Secretary is warranted. Upon receipt of the notification, it is noted in the Register of Carers that the carer is 'under investigation'.
2. The Secretary of the DHHS may refer the matter for independent investigation. Importantly, the Secretary must report any allegation of sexual or physical abuse to police.
3. If, at the completion of the investigation, the investigator finds on the balance of probabilities that the abuse occurred, and if the Secretary considers the person poses an unacceptable risk to children, the Secretary may decide to refer the matter to the Suitability Panel.
4. If referred to the Suitability Panel, the Panel has the power to make a finding of misconduct against the out of home carer and can make a determination that the carer poses an unacceptable risk to children and should be disqualified from the Register of Carers. This may also result in the withdrawal of the person's Working with Children Check.

It is interesting to note what happens to the carer during the DHHS processes. The welfare of the child concerned is the primary focus. Once an allegation of physical or sexual abuse is received, a decision about the safest location for the child is made by Child Protection in consultation with other relevant parties. The CYF Act provides Child Protection with the ability to take immediate action to ensure the safety of the child, including removing the child from the carer's care.

As children are removed from an unsafe environment, chaperones are not used to protect children from out of home carers against whom an allegation has been made. The employer of the carer (ie, the out of home care service), in

¹⁶⁹ Meeting with representatives of the Department of Health and Human Services (Victoria), Melbourne, 14 November 2016.

¹⁷⁰ Children, Youth and Families Act 2015 (Vic), s 101

¹⁷¹ CYF Act, s 74.

¹⁷² See generally CYF Act Part 3.4.

consultation with Child Protection, is required to determine if the carer should continue to work with the child or young person. In the case of foster carers, the child or young person is usually removed from their care. Very occasionally the 'perpetrator' leaves the house. Carers, who are employees of an out of home care service, are usually stood down on paid leave while an investigation is undertaken, unless there is an allegation of gross misconduct, in which case the carer's employment will generally be terminated immediately.

There is an obvious analogy with the public hospital system. Several submitters noted that in the public system, employers place health practitioners on paid leave while allegations of sexual misconduct are investigated. Dr John Wakefield noted that in the public hospital system in Queensland, clinical staff accused of sexual misconduct are immediately stood down while the employer undertakes its own investigation.¹⁷³ Relevant factors in standing down staff include the duty of care to patients, the reputation of the employer and the possible liability of the employer if the allegations turn out to be true.

Mandated chaperone conditions are seldom imposed on practitioners employed in the public hospital system, and far more commonly imposed on self-employed practitioners. Many doctors are self-employed (as general practitioners or other specialists). The nature of self-employment gives rise to different considerations – a self-employed practitioner does not have the option of taking paid leave and will suffer a financial blow by taking unpaid leave. Use of the immediate action powers under the National Law allows self-employed practitioners to continue to practise while allegations are investigated, which may avert risk to the public during the interim period. However, particularly given the difficulty in ensuring strict adherence to chaperone conditions, the upshot is that patients of self-employed health practitioners may be exposed to risks that are not tolerated for children in the out of home carer system in Victoria, nor for public hospital patients throughout Australia.

¹⁷³ Meeting with Dr John Wakefield, Deputy Director-General, Clinical Excellence Division, Queensland Health, Brisbane, 17 November 2016. The opinions and/or views expressed by Dr Wakefield are his own and do not necessarily reflect those of Queensland Health or the State of Queensland.

Part F: Effectiveness of mandated chaperones

The appropriateness of mandated chaperones cannot be viewed in isolation from consideration of their *effectiveness* in protecting the public from harm.

As noted in *Part B*, submitters expressed a range of views about effectiveness, from opponents who noted that chaperones are not a failsafe protection for patients, to supporters who viewed chaperone conditions as an important part of the regulatory toolkit. Most submitters and discussants expressed reservations about the effectiveness of mandated chaperones, along the lines of the following submission:

‘While the use of chaperoning conditions appears to be a well-meaning regulatory mechanism, it may not always be the most effective or practical measure to protect patients or practitioners.’

The Hon Michael Ferguson MP,
Minister for Health, Tasmania

Chaperone conditions for ‘relationship’ type sexual misconduct

As noted in *Part D*, of the 30 chaperone conditions on doctors being monitored by AHPRA as at 9 January 2017, 17% (5) conditions followed an allegation of sexual relationship with patients. I regard the use of a mandated chaperone as ineffective to protect patients from inappropriate ‘relationship’ type behaviour by health practitioners. A moment’s reflection makes it obvious that in the age of social media, most initiation of sexual contact by a practitioner is likely to occur by sending a text or Facebook message, outside a consultation and often outside work hours. Although a chaperone condition sometimes specifies that the chaperone ‘must observe the content of any written communication (including, without limitation, SMS text messages, emails, MMS messages), and listen to and observe both sides of any audio or video communication’ between the doctor and any patient of the specified gender, it is difficult to see how this can be monitored.

In my opinion, the use of chaperone conditions should be abandoned in circumstances where there is no allegation of criminal offending, and the intention is solely to prevent inappropriate

remarks or initiation of a sexual ‘relationship’ by the health practitioner.¹⁷⁴ Chaperone conditions are inapt to protect patients from this sort of predatory behaviour, which may be covert and undetectable by an observer, or overt but taking place outside the consultation room. If there is a need to protect patients from such behaviour in an interim situation, or taking action is considered in the public interest, a gender-based prohibition or suspension should be imposed.

Monitoring of compliance with chaperone conditions

In examining the *effectiveness* of chaperone conditions, a useful starting point is to assess whether current compliance activities provide assurance that chaperone conditions are protecting the public.

AHPRA’s *Operational Policy: Monitoring Chaperone Restrictions*¹⁷⁵ states that the following compliance activities must be undertaken when monitoring chaperone conditions generated using the National Restrictions Library:¹⁷⁶

- site visit
- practice sign
- data reconciliation
- contact with patients, and
- contact with chaperones.

Prior to the introduction of this operational policy in August 2016, the MBA’s internal guidance document, *Board mandated use of chaperones following allegations of sexual misconduct*, provided limited information regarding the scope of monitoring activities, stating only that:¹⁷⁷

‘The Board or AHPRA may audit compliance with the conditions imposed on registration or the undertakings accepted by the practitioner at any time. This may include comparing information from Medicare Australia against the practitioner’s Patient Log/Chaperone Report or auditing the practitioner’s practice including the clinical records and appointment arrangements.’

This internal guidance has evolved into a far more comprehensive schedule of activities in the current operational policy. Key differences include:

¹⁷⁴ Recommendation 12(b).

¹⁷⁵ AHPRA, *Operational Policy: Monitoring Chaperone Restrictions* (August 2016).

¹⁷⁶ The policy is also intended to provide ‘guidance’ regarding monitoring activities for practitioners who had chaperone conditions imposed prior to the recent establishment of the library.

¹⁷⁷ MBA, *Internal Guidance: Board mandated use of chaperones following allegations of sexual misconduct* (2012).

- AHPRA now has a direct relationship with all Board-approved chaperones
- monitoring is undertaken through reconciliation of appointment diaries, billing data and Medicare data, including direct contact with patients and chaperones to confirm a random sample of chaperone log entries
- standard signage and its placement within the practice is specified and a standard chaperone logbook is issued by AHPRA, and
- site visits are mandatory within the first week of monitoring and random thereafter.

The monitoring activities are supported in the current *Chaperone protocol*. The practitioner must provide acknowledgement to AHPRA that it may do the following things for the purposes of monitoring compliance:¹⁷⁸

- contact, communicate with and obtain information from Medicare Australia
- conduct random practice inspections
- contact and communicate with patients, chaperones, staff or employers
- contact private health insurers, where relevant, and access practice billing data (both public and private) for the purpose of monitoring compliance with the restriction, and
- access, copy or retrieve appointment diaries, patient booking schedules and the like.

A standard condition in the National Restrictions Library requires the practitioner to provide evidence the employer/senior person in the practice are provided with a full copy of the restrictions. However, the *Operational Policy* provides no further guidance in relation to contact and communication with staff or employers, or in relation to contact with private health insurers, despite these compliance activities being mentioned in the *Chaperone protocol*. In order to avoid inconsistencies in the approach to these activities, some guidance should be provided in the *Operational Policy*.

More generally, there is a possibility of inconsistent monitoring practices developing within AHPRA, as the monitoring of chaperone conditions is currently managed separately within each state and territory office. This poses challenges in ensuring the consistent development and maintenance of the skills necessary to:

- educate and support chaperones

- undertake the data reconciliation necessary to identify non-compliance
- effectively and consistently review each case when a trigger for review occurs (eg, when non-compliance is identified), and
- easily gather intelligence on decision-making and practitioner compliance to enable early intervention.

I recommend that the monitoring of chaperone conditions be the responsibility of a national specialist team within AHPRA.¹⁷⁹

Practice locations

Health practitioners subject to an AHPRA monitored chaperone condition are required to notify AHPRA of the identity and address of their current employer or persons occupying a position of authority at their place of work (and any new details while the condition remains operative), to enable monitoring of compliance by the practitioner. This works well for practitioners working in one or two locations, but becomes complicated where a practitioner, such as a visiting medical specialist, sees patients in multiple locations. It may also be difficult to identify some places of practice, such as visits to patients' homes or group home settings.

When chaperone conditions were imposed on Dr Andrew Churchyard in May 2015, the MBA understood that he was working at four locations. By June 2015, the MBA was on notice that Dr Churchyard had at least nine practice locations. Approving chaperones and monitoring compliance becomes unwieldy in such a case and calls into question the feasibility of a chaperone condition.

AHPRA's latest internal guidance concludes that no more than two or three practice locations within a geographic area are practical and capable of being effectively monitored, and that as a general rule, no more than four chaperones should be approved for each of the practitioner's workplaces.¹⁸⁰ Where a practitioner has a geographically diverse practice and/or has numerous places of practice, it may be appropriate to recommend that a National Board impose not only chaperone restrictions but also restrictions that limit the number of places where the practitioner is permitted to practise.

Multiple practice locations may also mean that multiple chaperones need to be approved, with the consequent difficulties for training, information disclosure and monitoring. If chaperone conditions are to be retained as an interim restriction, they

¹⁷⁸ AHPRA, *Chaperone protocol* (December 2016).

¹⁷⁹ Recommendation 27.

¹⁸⁰ AHPRA, *Guide to Decision-Making: When to Recommend Chaperone Restrictions* (draft, October 2016).

should 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.¹⁸¹

It should be also made clear, in any immediate action decision of a National Board imposing a chaperone condition, that the practitioner cannot practise until all practice locations are known and chaperones have been approved, briefed and trained.¹⁸²

Site visit

It is mandatory for the designated AHPRA officer to conduct a site visit within seven days once the practitioner has commenced practice under the chaperone conditions, all practice locations are known by AHPRA, and chaperones have been approved by the Board committee.¹⁸³ The exception is where the site visit is not cost-effective (due to the location of the practitioner's practice), in which case contact is made with the practitioner and chaperone by phone.

The purpose of the site visit is to:

- confirm the practitioner understands the restriction and *Chaperone protocol*
- provide education to the practitioner on compliance with the restriction, where necessary
- confirm the presence of a practice sign and that it is in accordance with the *Chaperone protocol* requirements, and
- where relevant, confirm the approved chaperone understands their role and the requirements of the restriction and *Chaperone protocol*.

It is also open to the AHPRA case officer to conduct random site visits when necessary to confirm ongoing compliance with the chaperone conditions.

In my view, there are two possible weaknesses in the site visit requirement. First, AHPRA staff do not conduct a site visit at every practice location, nor meet all approved chaperones. I acknowledge that it is resource intensive to visit every practice location and meet every chaperone. However, only visiting one practice location (if there is more than one) and meeting with only one chaperone (if there

are several) limits the effectiveness of the site visit requirement.

Aside from these issues, my understanding is that AHPRA staff do not have explicit conversations with MBA-approved chaperones about the reasons for the imposition of chaperone conditions during site visits, but only confirm that the chaperone is aware of the existence of the conditions and may provide education regarding compliance.¹⁸⁴ A key question raised in this review is how much information should be provided to the chaperone regarding the allegations that have been made about the practitioner. In order to be an effective watchdog, the chaperone must be fully informed about the nature of the allegations that have led to the chaperone condition – so that she or he knows what sort of behaviour to watch for. A briefing of the chaperone by AHPRA staff should occur before the chaperone commences duty.¹⁸⁵ The site visit could provide an opportunity for AHPRA staff to have a follow-up discussion with the chaperone about the reasons for the chaperone requirement.

Practice sign

The *Chaperone protocol* states that the practitioner must place a sign setting out the requirement for the presence and direct observation of a chaperone in a clearly visible location in the patient waiting area or equivalent of each and every place where the practitioner practises.¹⁸⁶ AHPRA issues the practice sign (in an A3 format that is not able to be edited) to the practitioner and compliance with this requirement is confirmed during the mandatory site visit conducted by AHPRA staff.

I note that the superseded version of the *Chaperone protocol* (dated November 2015) stated that the sign 'should not be obscured in any way at any time'.¹⁸⁷ It is not clear why this statement was removed from the current version of the *Chaperone protocol*.

The majority of submitters thought that practice signs are not an effective form of communication. Waiting rooms are generally busy and noisy locations, with pamphlets, signs, televisions and other material often covering the walls. The result is that the practice sign may not attract the attention of patients and may go unread. As one consumer explained, 'I'm blind to the stuff on my GP's wall!'¹⁸⁸ The two site visits I attended personally confirmed this impression. I note that

181 Recommendation 14.

182 Recommendation 26.

183 AHPRA, *Operational Policy: Monitoring Chaperone Restrictions* (August 2016).

184 Meeting with AHPRA compliance staff, Brisbane, 17 November 2016.

185 Recommendation 25.

186 AHPRA, *Chaperone protocol* (December 2016).

187 AHPRA, *Chaperone protocol* (November 2015) [superseded].

188 Consumer B at Health Issues Centre Consumer Forum, Melbourne, 3 November 2016.

the Medical Council of New South Wales does not require a practice sign as a part of chaperone conditions.

I do not consider that there should be an ongoing requirement for a practice sign to be displayed.¹⁸⁹ This is subject to the key proviso that patients are individually informed about the need for a chaperone, as recommended above. One benefit for affected practitioners (in particular those working in multi-practitioner facilities) is that there would no longer be a general notice to all patients in a shared waiting room – thus alleviating the shaming effect of a practice sign.

Data reconciliation

The *Chaperone protocol* requires the practitioner to maintain a chaperone log confirming the presence and direct observation of a chaperone for the entire contact with a patient in each case that the chaperone conditions apply to.¹⁹⁰ It is specified that the log must be completed in indelible ink at the end of the contact, be co-signed by the chaperone at that time, and must detail:¹⁹¹

- the full name of the patient and their date of birth
- date and time of the consultation
- the full name of the chaperone
- the chaperone's contact address and telephone number, and
- the chaperone's signature.

The *Operational Policy* states that the AHPRA case officer is to conduct data reconciliation of all entries in the practitioner's chaperone logs, their billing data, and appointment diaries. In particular, the case officer's review focuses on whether:¹⁹²

- a chaperone was present for all contact with patients when required by the practitioner's conditions
- the chaperone was an approved chaperone, within the definition in the practitioner's conditions
- the log entries were completed correctly
- the log entries appear to have been made contemporaneously with the patient contact
- all patient contact took place in practice locations the practitioner had declared

- the information in the log is consistent with that provided by the chaperone and/or patient (where information is known)
- the information in the log is consistent with the practice billing data, and
- the information in the log is consistent with the Medicare data.

It is expected that the reconciliation of this data will be undertaken on at least a weekly basis for the first month after the imposition of the conditions; if no concerns are identified during this time, reconciliation can then be decreased to a maximum of monthly while the restrictions are in effect. The *Operational Policy* states that if there is suspected non-compliance at any time, the reconciliation must again be undertaken on a weekly basis.

Data received from Medicare must be reconciled with the entries in the practitioner's chaperone logs, practice billing data and the appointment diary on at least a quarterly basis while the conditions remain in effect under immediate action powers.

Where discrepancies and/or breaches of the *Chaperone protocol* are identified, the matter is escalated in accordance with AHPRA's *Operational Policy: Managing Critical Compliance Events*.

Much of the data reconciliation activities undertaken by AHPRA rely on data that could be manipulated by the practitioner (ie, the practice billing data and the appointment diary). According to the *Operational Policy*, the only independent source of data regularly used in the data reconciliation is from Medicare. A key concern with the use of data from Medicare is the time lag between when the practitioner sees the patient to when the data confirming that consultation is provided by Medicare to AHPRA. This may take several months. New arrangements have recently been made, including a single point of contact nationally for AHPRA and Medicare interactions, a new agreed form and process for requesting data from Medicare, and a new agreed classification for the urgency of requests for information.¹⁹³ Although these arrangements should result in improvements in the time taken for data to be provided to AHPRA, I remain concerned that there may still be some time lag.

I also heard concerns about the appropriateness of relying on Medicare data: 'Medicare data is not

¹⁸⁹ Recommendation 21.

¹⁹⁰ AHPRA, *Chaperone protocol* (December 2016).

¹⁹¹ AHPRA, *Chaperone protocol* (December 2016).

¹⁹² AHPRA, *Operational Policy: Monitoring Chaperone Restrictions* (August 2016).

¹⁹³ Meeting with AHPRA compliance staff, Brisbane, 17 November 2016.

reliable enough for a regulator to confidently say they can rely on it for the basis of taking regulatory action, largely because of delay on occasions in getting the information and also due to anomalies with Medicare data.¹⁹⁴

I also note that practitioners may see patients outside Medicare – for example, international patients or when providing advice for medico-legal purposes.¹⁹⁵ In these cases, AHPRA compliance staff are more reliant on information provided by the practitioner, such as practice billing data and appointment diaries, to perform reconciliation of data in the chaperone log.

Contact with patients and chaperones

According to the *Operational Policy*, AHPRA officers randomly select a number of entries in the log representing 5% of the total number of entries in the chaperone log. Using the information recorded in these entries, AHPRA officers contact the patient (where the patient is over the age of 18)¹⁹⁶ and the chaperone to confirm the veracity of the information in the chaperone log and to compare the information provided by the patient and the chaperone about the contact with the practitioner.

Contact with patients and chaperones is undertaken on at least a monthly basis for the first quarter after the imposition of the conditions. Thereafter, if there are no identified concerns, reconciliation may be decreased to a maximum of quarterly while the restrictions are in effect. The quarterly time frame for reconciliation is, however, increased to monthly if there is suspected non-compliance.¹⁹⁷

Where discrepancies are identified and/or breaches of the *Chaperone protocol* are identified, the matter is escalated in accordance with AHPRA's *Operational Policy: Managing Critical Compliance Events*.

In meetings with AHPRA staff, I queried whether patients react negatively to contact from AHPRA. Apparently feedback from patients is generally positive and they seem receptive to phone calls

from AHPRA compliance staff.¹⁹⁸ It would be sensible for staff of the relevant practice (at the time of notifying patients that a chaperone is required and seeking their agreement to proceed with the consultation) to inform patients of the possibility of being contacted as part of an AHPRA audit (with any objection noted and notified to AHPRA). Subject to this, I regard telephone contact by AHPRA compliance staff with a sample of randomly selected patients as a sensible way of checking whether patients observed a chaperone in the consultation room and the consistency of their recollection with the chaperone log.

I note that one AHPRA staff member mentioned that the most common answer to questions asked of patients about chaperone logs is, 'I thought I was signing something for Medicare.'¹⁹⁹ This again raises concerns about what information is provided to patients about why a chaperone is required to be present during contact with the health practitioner. I recommend that 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.²⁰⁰

Monitoring undertaken by the HPCA in NSW

In NSW, the Councils are formally responsible for monitoring compliance with conditions imposed on the registration of a health practitioner. Monitoring activities are conducted by the HPCA on behalf of the Councils.

The Medical Council of New South Wales has a published compliance policy relating to chaperones,²⁰¹ which is read in conjunction with the *Chaperone Approval Position Statement*.²⁰² The content of these documents is not currently as comprehensive as AHPRA's *Chaperone protocol and Operational Policy: Monitoring Chaperone Restrictions*; however the Council's policy is currently being reviewed.²⁰³

The key monitoring activity appears to involve the chaperone log, which must be completed (in the Council-approved format) and submitted

194 Meeting with HPCA, Sydney, 1 November 2016. Sometimes a consultation is attributed to the doctor who is subject to chaperone requirements (due to a data error) and the doctor will then be required to demonstrate that another doctor in the practice saw that particular patient.

195 Meeting with Medical Council of NSW, Sydney, 1 November 2016.

196 In cases where the randomly selected patient is under the age of 18, contact is made with the recorded parent or guardian who signed the chaperone log on behalf of the patient.

197 AHPRA, *Operational Policy: Monitoring Chaperone Restrictions* (August 2016).

198 Meeting with AHPRA compliance staff, Adelaide, 23 November 2016.

199 Meeting with AHPRA compliance staff, Brisbane, 17 November 2016.

200 Recommendation 19.

201 Medical Council of NSW, *Compliance Policy – Chaperone* (1 March 2016).

202 Medical Council of NSW, *Chaperone Approval Position Statement* (dated 1 March 2016).

203 Information provided by Dr Greg Kesby, President, Medical Council of NSW.

within seven days following the end of each calendar month. The *Compliance Policy* states that the practitioner authorises all Council-approved chaperones to inform the Council immediately of any concerns that arise in the course of undertaking the role of the chaperone, and that the practitioner agrees to provide to the Council, within seven days of the imposition of the chaperone conditions or commencing new employment, details of any person or organisation that engages the practitioner to work as a medical practitioner.²⁰⁴

There is, however, no specific reference to site visits, practice signs, data reconciliation or contact with patients and chaperones.²⁰⁵ In NSW, some monitoring activities are instead specifically set out in the conditions, for example:

- 'To authorise and consent to any exchange of information between the Medical Council of NSW and Medicare Australia for the purpose of monitoring compliance with these Conditions'
- 'To authorise and consent to any exchange of information between the Medical Council of NSW and future relevant persons or organisations at locations where he works as a medical practitioner in Australia of any issues arising in relation to compliance with these conditions.'²⁰⁶

My discussions with staff of the HCCC, the Medical Council of New South Wales and the HPCA, indicate that the key monitoring activity undertaken by HPCA staff is ensuring that information found in the chaperone log is consistent with data received from Medicare. The NSW HCCC Commissioner has recommended strengthening monitoring and reporting and the professional councils are supportive of this initiative. Currently, AHPRA's *Operational Policy* appears to require a more comprehensive program of monitoring activities than that in place in NSW.

Monitoring undertaken by the OHO in Queensland

In Queensland, the monitoring of compliance with chaperone conditions is more complex.

In general, the OHO monitors compliance in cases where the OHO has taken action against a practitioner by imposing chaperone conditions on the practitioner's registration. If, however, the chaperone conditions were imposed on the registration of a practitioner by the MBA or as a result of a tribunal decision, monitoring activities are undertaken by AHPRA.

As the OHO was only recently established, on 1 July 2014, some policies and procedures are still in development. I have been provided with draft copies of the OHO's policies in relation to the imposition and monitoring of chaperone conditions. The draft *Chaperone protocol for registered health practitioners* focuses predominantly on the chaperone log as the key compliance monitoring activity. The practitioner must provide a copy of all chaperone logs (in the template provided) to the OHO within five business days of the end of every calendar month, or at such times as requested by the OHO.²⁰⁷

Importantly, there are no specific references to site visits, practice signs, data reconciliation or contact with patients and chaperones in the draft protocol. While the draft *Information for chaperones approved by the Health Ombudsman* document states that an OHO officer may contact the chaperone from time to time in order to monitor the practitioner's compliance with the chaperone conditions,²⁰⁸ there does not appear to be a formal policy regarding contact with chaperones.²⁰⁹

It appears that chaperone conditions imposed by the OHO often include reference to specific monitoring activities. Examples include:

- 'The practitioner will provide a monthly statutory declaration using the OHO Statutory Declaration template, stating that he has complied with the Health Ombudsman's requirements and the conditions on his registration. The completed OHO Statutory Declaration is to be provided to the Health Ombudsman within five (5) business days of the end of every calendar month commencing 30 October 2016.'²¹⁰
- 'Within five (5) business days of the commencement date of the conditions the practitioner must provide written authorisation

204 Medical Council of NSW, *Compliance Policy – Chaperone* (March 2016).

205 The need to obtain objective corroborating evidence in relation to compliance through requesting information from Medicare is now included in Standard Monitoring Operating Procedure documents which are used by monitoring staff.

206 Confidential information provided by HPCA, January 2017

207 OHO, *Chaperone protocol for registered health practitioners* (August 2016) [draft].

208 OHO, *Information for chaperones approved by the Health Ombudsman* (undated) [draft].

209 The Health Ombudsman notes that there is a difference between 'external' and 'internal' OHO documents. Externally, chaperone protocols are focussed on the requirements of the practitioner. Internally, OHO applies the same standard as AHPRA. In one case, regular monitoring of the practitioner's compliance with conditions led to additional disciplinary charges (advice from Health Ombudsman, February 2017).

210 OHO immediate registration action re Dr Gary Whittaker:
www.oho.qld.gov.au/immediate-registration-action-taken-against-dr-gary-whittaker.

(by completing the Authority to access information form) for a representative of the Health Ombudsman to exchange information with his current employer to ensure compliance with the conditions imposed on his registration by the Health Ombudsman.²¹¹

- The practitioner must authorise representatives of the Health Ombudsman in writing within five (5) business days of the commencement of these conditions (by completing the OHO Authority to access information form) to:
 - (a) inspect, take or copy patient clinical records, log books and/or appointment diaries for any patient at such reasonable time or times as the Health Ombudsman shall determine for the purpose of monitoring compliance with the conditions imposed on the practitioner's registration, and
 - (b) exchange information with the practitioner's co-owner/s, co-director/s, and employer/s.²¹²

My discussions with OHO staff indicate that OHO monitoring activities largely rely on information provided by the practitioner, as proactively seeking information from third parties is resource intensive.²¹³ It appears that AHPRA's *Operational Policy* details a more extensive program of monitoring activities than that utilised by staff of the OHO.

Information provided to chaperones

A key discussion point during the review process concerned how much information should be provided to chaperones, particularly in relation to the allegations that have been made about the practitioner. It was commonly suggested that not enough information is provided to chaperones, and there was also concern that there is a heavy reliance on the practitioner to explain the reasons for, and requirements of, the chaperone conditions to the chaperone.

While there have been some recent improvements in the nature of the communications between AHPRA and the chaperone, there is still limited direct contact between AHPRA and chaperones. As per the *Operational Policy*, AHPRA compliance

staff conduct site visits when they seek to confirm that the approved chaperone understands their role and its requirements. Further, the *Operational Policy* indicates that AHPRA staff make contact with chaperones to confirm the veracity of information recorded in the chaperone log.²¹⁴

It is clear, however, that chaperones are not formally provided with any information from AHPRA about the circumstances surrounding the imposition of the chaperone conditions. The *AHPRA Information sheet for chaperones approved by the Board* states that chaperones should ensure they are aware of who is defined as a patient and that this information is available on the sign in the practitioner's practice and in the restrictions on the practitioner's registration.²¹⁵ Similar instruction is given to patient-nominated chaperones in the *Information sheet for patient nominated chaperones*.²¹⁶ In contrast, the *NSW Compliance Policy* states that the practitioner must provide all proposed and approved chaperones with a copy of all publicly available conditions on the practitioner's registration.²¹⁷ The draft *OHO Information for chaperones approved by the Health Ombudsman* document similarly states that the practitioner is required to provide the chaperone with a copy of the schedule of conditions to the chaperone.²¹⁸

During the course of the review, arguments were made that chaperones should be told about the nature of the allegations made against the practitioner, to help chaperones to identify any ongoing inappropriate behaviour by the practitioner. AHPRA's *Operational Policy* does not make reference to the sharing of such information. My discussions with AHPRA staff confirmed that they do not discuss the nature of the allegations made against the practitioner with chaperones. In comparison, the *Medical Council of NSW Chaperone Approval Position Statement* explains that information other than simply the conditions on the practitioner's registration may be provided to the chaperone, 'depending on the constraints of confidentiality in each particular case'.²¹⁹ It does not, however, appear to be standard practice to provide approved chaperones with detailed information about the allegations made against the practitioner.

211 OHO immediate registration action re Dr Vijay Arora: www.oho.qld.gov.au/immediate-registration-action-taken-mr-vijay-arora.

212 OHO immediate registration action re Dr Ritesh Upadhyay: www.oho.qld.gov.au/immediate-registration-action-taken-against-dr-ritesh-upadhyay.

213 Meeting with OHO staff, Brisbane, 18 November 2016.

214 AHPRA, *Operational Policy: Monitoring Chaperone Restrictions* (August 2016).

215 AHPRA *Information sheet for chaperones approved by the Board* (March 2016).

216 AHPRA *Information sheet for patient nominated chaperones* (March 2016).

217 Medical Council of NSW *Compliance Policy – Chaperone* (March 2016).

218 OHO, *Information for a chaperone approved by the Health Ombudsman* (undated) [draft].

219 Medical Council of NSW, *Chaperone Approval Position Statement*, March 2016.

It is interesting to note that the now superseded AHPRA Internal Guidance document *Board mandated use of chaperones following allegations of sexual misconduct* stated that if the MBA decided it was appropriate to require a chaperone as a protective, temporary measure, the conditions imposed could include who would be informed, and by whom, about the need for a chaperone and any other conditions imposed or undertakings accepted, and the reasons for their imposition.²²⁰ The Guidelines went on to state that the chaperone should know of the nature of the allegations made about the doctor. I note that the conditions imposed on the registration of Dr Churchyard in 2015 (when the Internal Guidance document was in effect) included a statement that the chaperone 'should know of the nature of the allegations made about the doctor'.²²¹ It is not clear who was to inform the chaperone of the nature of the allegations. Presumably, it was contemplated that this would be the responsibility of Dr Churchyard.

This guidance on informing the chaperone of the nature of the allegations made about the practitioner was not incorporated into the new AHPRA policy and process. AHPRA advised that it could now foresee a number of problems with including a requirement that it inform chaperones of the nature of the allegations made about the practitioner in anything but the broadest terms.²²² AHPRA explained that it had concerns there would be practical difficulties in communicating this information to patient-nominated chaperones, and that it could be prejudicial to provide specific information to chaperones about allegations and investigations relating to the practitioner.

While I acknowledge these concerns, I believe it is fundamentally important that chaperones are not left in the dark about what behaviour their presence is intended to protect against. If chaperones are to be imposed as an interim restriction, they must be fully briefed and provided with training about the functions and requirements of the chaperone role before commencing duty.²²³

Concerns regarding the appointment of mandated chaperones

The issue of who should be allowed to play the role of the chaperone is highly important. The current *Chaperone protocol* allows patient-nominated chaperones and MBA-approved chaperones.

Patient-nominated chaperones

In general, the *Chaperone protocol* states that where conditions have been imposed on a practitioner's registration requiring the presence of a chaperone, relevant patients may choose to use a chaperone of their own choice (unless the conditions imposed on the registration of the practitioner do not permit patient-nominated chaperones).²²⁴ The patient-nominated chaperone must satisfy the following criteria:

- be at least 18 years of age
- be acceptable to the patient and may be a spouse, partner, parent, other family member, or a guardian/carer of the patient
- be given the information sheet on the role of a chaperone (produced by AHPRA) prior to the contact with the patient commencing, and confirm their agreement to continue in the role after receiving the information sheet.

If the above criteria are satisfied and the contact with the patient proceeds, the chaperone log must include:

- acknowledgement by the chaperone that they received a copy of the information sheet for chaperones prior to the patient contact
- the chaperone's authorisation for AHPRA to contact them for the purposes of monitoring compliance with this restriction, and
- details of the relationship of the chaperone to the patient.

In a 2009 study of patients' attitude towards the use of a chaperone in breast examinations, 32% of the respondents stated that they would prefer their spouse to act as a chaperone, whereas 29% preferred a clinic nurse.²²⁵ The majority of respondents between the ages of 10 and 30 preferred their parents to act as a chaperone. This study supports my impression that many patients

220 AHPRA, *Internal Guidance: Board mandated use of chaperones following allegations of sexual misconduct* (24 January 2012) [superseded].

221 AHPRA, 'Statement from the Medical Board of Australia and AHPRA' (2 August 2016): www.ahpra.gov.au/News/2016-08-02-statement.

222 Email from AHPRA National Director Compliance, 19 December 2016.

223 Recommendations 25, 20.

224 AHPRA, *Chaperone protocol* (December 2016).

225 S Sinha et al. Patients' attitude towards the use of a chaperone in breast examination (2009) 91(1) Ann R Coll Surg Engl 46.

would prefer to choose who will act as a chaperone rather than have an MBA-approved chaperone.

Despite this, some concern was expressed during the course of this review about the use of patient-nominated chaperones:²²⁶

'A patient-nominated chaperone may not be comfortable directly and continuously observing an intimate examination, and may not be able to see what is happening if the examination is internal or the view is obstructed by the position of the doctor. The chaperone may lack the medical knowledge to understand what touching is appropriate and what is not. The patient may be embarrassed at speaking up in the presence of someone they know, and the chaperone may not be any more confident or comfortable about speaking up than the patient.'

Dr Y

To properly fulfil the obligations of a chaperone, that person must do more than merely be present in the consultation room; the chaperone is required to 'directly observe' all contact between the practitioner and the patient. During my discussions with stakeholders, I queried whether family and friends of a patient would be comfortable directly observing an intimate examination, and whether the patient would wish family and friends to directly observe such examinations. One patient commented: 'To have someone watching you closely during an intimate examination is creepy.'²²⁷

In my view, although family and friends can provide valuable support to a patient, the role of the chaperone has unique responsibilities that family and friends are not well suited to fulfil. I consider that the option to use a patient-nominated chaperone should no longer be available.²²⁸

MBA-approved chaperones should be used on all occasions that a chaperone is required; if a patient does not wish to have the MBA-approved chaperone present, the consultation with the practitioner should not proceed and the patient should be referred to a different practitioner.

As a point of comparison, I note that while the OHO's draft policy documents permit the use of

patient-nominated chaperones if certain criteria are met,²²⁹ the Medical Council of NSW's *Chaperone Approval Position Statement* does not make reference to the option of the patient-nominated chaperone; instead it outlines that the Council expects a practitioner subject to chaperone conditions to ensure that any chaperone has been approved by the Council.²³⁰

MBA-approved chaperones

The *Chaperone protocol* requires the practitioner to nominate individuals for approval to act as chaperones, where a chaperone of the patient's choice is not available or permitted. The practitioner is advised to obtain approval for a number of individuals to act as a chaperone in order to allow for chaperone absence or illness.

The approval process involves the practitioner submitting the nomination form to AHPRA, which must indicate that the nominated person meets the following criteria (in addition to any other criteria specifically outlined in the chaperone conditions):²³¹

- the nominated chaperone is not the practitioner's relative or friend, and it is generally also required that the nominated chaperone is not the practitioner's direct employee or otherwise in a direct contractual or financial relationship with the practitioner
- the nominated chaperone is a registered health practitioner without restrictions on their registration, and
- the nominated chaperone is at least 18 years of age.

The nomination should be accompanied by information including:

- contact details, photographic identification and sample signatures of the nominated chaperone
- written confirmation, on the approved form, from the nominated chaperone that they:
 - have received a copy of the information sheet for chaperones and they are aware of the nomination, consent to the nomination and are willing to act as chaperone
 - are not in a social or familial relationship with the practitioner and are not in a direct employment or contractual relationship with the practitioner (where this is a requirement

²²⁶ Submission from Dr Y, dated September 2016.

²²⁷ Meeting with Maree Germech, Melbourne, 3 November 2016.

²²⁸ Recommendation 23.

²²⁹ OHO, *Information for a chaperone selected by a patient* (undated) [draft].

²³⁰ Medical Council of NSW, *Chaperone Approval Position Statement* (March 2016).

²³¹ AHPRA, *Chaperone protocol* (December 2016).

of the restrictions on the practitioner's registration)

- are aware of the meaning of the word 'patient' and 'contact' for the purposes of the restriction
- are aware that, should a patient refuse or demonstrate reluctance to have a chaperone present and directly observing all contact, the contact must not proceed or, if commenced, should immediately cease and the patient should be offered an appointment with an alternate practitioner
- are aware of the Board's expectations in compliance with the restriction, and in particular, the need for prior discussion with the patient, the requirement of a sign in the waiting room, and the requirements of the chaperone log, signed at the end of each patient contact (not pre-signed)
- are aware they may contact AHPRA in order to discuss any concerns or queries they may have in relation to the chaperone requirement or if they feel personally vulnerable, intimidated or threatened while acting as a chaperone, and
- are aware that they may be contacted by AHPRA in order to monitor the practitioner's compliance with the restriction.

It is then for the MBA to make a decision regarding whether the individual should be approved to act as a chaperone.

Some submitters raised concerns that the practitioner is given the ability to choose who will act as the chaperone: 'The practitioner-nominated chaperone raises issues of conflict of interest; it is a structural flaw in the arrangement.'²³² It was suggested by Dr John Wakefield that a system could instead be developed where doctors pay an independent third party to provide an appropriate chaperone.²³³ Similarly, the AMA proposed that consideration be given to whether it would be more appropriate for the MBA to appoint and remunerate the chaperone, in order to remove the possibility of conflicts of interest between the practitioner and the chaperone.²³⁴

The current *Chaperone protocol* states that in circumstances where it can be demonstrated that it is not possible to access chaperones who

meet the criteria outlined above, individuals who are directly employed by the practitioner and/or who are not registered health practitioners may be approved to act as a chaperone.²³⁵ This brings into question the appropriateness of employees acting as chaperones, and of non-registered health practitioners acting as chaperones.

Employees acting as chaperones

The idea that practitioners can use employees as chaperones has frequently been highlighted as an area of weakness in the current *Chaperone protocol*.

While the Australian Dental Association submitted that there should be greater opportunity to utilise suitable staff members as chaperones (as it would not carry the stigma that may attach to a more public outside appointment),²³⁶ the overwhelming view expressed during the review was that employees should not be allowed to act as chaperones.²³⁷

'The individuals performing the chaperone function must be sufficiently senior to be, and to be perceived to be, independent of the practitioner under conditions. So, for example, a practice nurse or administrative officer employed by the practitioner would be inappropriate and lacking in independence. A student practitioner would also be inappropriate as they lack the appropriate seniority and may be supervised by the practitioner or require an assessment of their competence at the conclusion of the clinical rotation.'

Dr Grant Davies, Health Services Commissioner, Victoria

Some members of the public raised concerns about the pressure that the chaperone role may place on working relationships more generally.²³⁸

'They [practitioners subject to chaperone conditions] shouldn't drag colleagues into it... It could create tension between colleagues.'

²³² Meeting with Sue Dawson (HCCC), Sydney, 1 November 2016

²³³ Meeting with Dr John Wakefield, Brisbane, 17 November 2016.

²³⁴ Submission from AMA, dated 7 October 2016.

²³⁵ AHPRA, *Chaperone protocol* (December 2016).

²³⁶ Submission from Dr Rick Olive AM RFD, President of the Australian Dental Association, dated 30 September 2016.

²³⁷ Submission from Dr Grant Davies, Health Services Commissioner, Victoria, dated 3 October 2016.

²³⁸ Consumer B at Health Issues Centre Consumer Forum, Melbourne, 3 November 2016.

Consumer B at Health Issues Centre Consumer Forum

In my view, it is inappropriate for employees of the practitioner to act as a chaperone. A chaperone should have no pre-existing employment, contractual or financial relationship with the practitioner in order to avoid any real or perceived conflict of interest or power imbalance.²³⁹

Individuals who are not registered health practitioners acting as chaperones

Although it is generally expected that MBA-approved chaperones will be registered health practitioners, the current protocol makes provision for the MBA to approve individuals who are not registered health practitioners to act as chaperones in certain circumstances.²⁴⁰ This might include where the practitioner is located in a rural or remote location, and it is difficult to source a registered health practitioner who is prepared to act as a chaperone.

Individuals who are not registered health practitioners may not readily identify inappropriate behaviour, including behaviour that is not clinically necessary. Further areas of concern were identified by the Australian Nursing and Midwifery Federation:

'It is never appropriate to use an individual who is not a registered health practitioner, either as a Board-approved or patient-nominated chaperone...

In accordance with the National Law, regulated health practitioners are required to adhere to their professional codes of ethics and conduct in maintaining privacy and confidentiality of personal health information at all times. Any person who is not a regulated health practitioner, acting as a chaperone, would not be bound by this requirement.'

It appears that a range of individuals have been approved to act as chaperones in the past. As noted earlier, in one unusual case in Queensland, the conditions imposed on the practitioner's registration by the Health Ombudsman allowed the practitioner's male driver (presumably not a registered health practitioner) to act as a chaperone.²⁴¹

²³⁹ Recommendation 22.

²⁴⁰ AHPRA, *Chaperone protocol* (December 2016).

²⁴¹ See note 95 and accompanying text.

²⁴² Recommendation 22.

²⁴³ Confidential information provided by AHPRA, November 2016.

It may be difficult to find a suitable registered health practitioner willing to take on the role of a chaperone in some circumstances – for example, in rural and remote locations where there may already be a shortage of registered health practitioners. Indeed, the Northern Territory Department of Health expressed the view that the effectiveness of chaperoning can be compromised by:

'The availability of chaperones, particularly in Aboriginal communities, where there are strict gender rules which can impact on the selection of a chaperone. This is particularly relevant for male patients in remote settings where there are often limited numbers of male nurses, Aboriginal health workers or receptionists who could undertake chaperoning duties and English is often spoken as a second language.'

Department of Health, Northern Territory

While I acknowledge that the requirement that a chaperone be a registered health practitioner may be difficult to satisfy in some circumstances, I consider that it is essential.²⁴² Registered health practitioners are more likely to be able to assess whether contact between the practitioner and the patient is clinically appropriate and to be comfortable directly observing patient contact during intimate examinations.

It is also relevant to note that the relevant regulatory body (eg, the Nursing and Midwifery Board of Australia) can take action against a registered health practitioner who does not satisfactorily fulfil their duties as a chaperone, an action that would obviously not be possible against a non-registered health practitioner. In a recent case, the Nursing and Midwifery Board of Australia referred a matter to the responsible tribunal after it was identified that a registered nurse undertaking the role of a chaperone falsified chaperone logs (the logs were pre-filled and the chaperone did not have the same working hours as the practitioner subject to the chaperone conditions).²⁴³

Training of chaperones

Consideration of the appropriate qualities of a chaperone also raises questions about whether individuals should be provided with specialised training before commencing the chaperone role. It is not currently a requirement that the chaperone undertake any educational activities in order to act as a chaperone; instead, the responsibilities of the chaperone are formally communicated via a two-page document produced by AHPRA, *Information sheet for chaperones approved by the Board* (or in the case of patient-nominated chaperones, *Information sheet for patient nominated chaperones*). Very little information is provided regarding what must be explained to the patient about the presence of a chaperone, nor is there information about the possible repercussions of failing to properly discharge their duties. Although the information sheets emphasise that the chaperone must be 'physically present and directly observe all contact between the practitioner and either any patient or a particular group of patients', specific training about the role of the chaperone could better clarify expectations, particularly in relation to intimate examinations. As one medical practitioner demonstrated, there is generally a lack of clarity about what the role of the chaperone is:

'Should the chaperone be in the corridor with the door open? Inside the room but outside the curtain? Inside the curtain but at the "head of the bed" (assuming a genital exam)? Actively observing the actions of the doctor ("at the foot of the bed")?'

Dr R

The Health Services Commissioner, Victoria, argued that chaperones need to be fully aware of their roles and responsibilities, and the Royal Australasian College of Surgeons expressed a similar view:

'Training is important to supporting chaperones in effectively carrying out their duties and to ensuring that practitioners understand and comply with the condition(s) imposed by the Board. To support the effective administration

of conditions, the MBA should explore training options to ensure practitioners and chaperones are aware of their obligations and responsibilities.'

Royal Australasian College of Surgeons

The submission from the AHPRA Community Reference Group raised an interesting point that chaperones should be trained to deal with the communication needs of patients with particular types of disabilities and of those from different cultural backgrounds.

MIGA suggested that appropriately training chaperones is one of the key steps that could be taken to improve the current chaperone system:

'MIGA believes it is necessary to do more to educate chaperones than provide an information sheet. Whilst this sheet is helpful, it considers further training is required. It suggests AHPRA give consideration to a focused, pithy and practical training course, for AHPRA-approved chaperones to complete.'

MIGA

In September 2016, the College of Physicians and Surgeons of Ontario appointed a new role of Lead of Supervision Development (of which practice monitoring is a subset), to develop a training program for practice monitors (including chaperones), including training in pelvic examinations, sexual harassment issues, etc.²⁴⁴ The new program is to be rolled out in 2017. The College of Physicians and Surgeons of Alberta has developed a chaperone program, including videos. The Medical Council of New South Wales is currently developing a training module for chaperones, setting out Council expectations, their role and responsibilities, and risk.²⁴⁵ I commend these excellent initiatives to AHPRA.

In my view, appropriate training would better prepare chaperones for their role. Training will help chaperones be able to more quickly identify inappropriate behaviour or warning signs. I recommend that chaperones be provided with training about the functions and requirements of the chaperone role before commencing duty as a chaperone.²⁴⁶

²⁴⁴ Information provided during meetings at CPSO, Toronto, 3 October 2016.

²⁴⁵ NSW HCCC, 'Chaperone conditions in NSW: a review' (October 2016), p 15.

²⁴⁶ Recommendation 25.

Examples of breaches of chaperone conditions and misconduct following imposition of chaperone conditions

Some submitters argued that the very nature of chaperone conditions means that breaches are inevitable, and therefore are an inappropriate regulatory tool.²⁴⁷ There have been many reported examples of practitioners breaching chaperone conditions. In the case that led to this review, it is alleged that Dr Churchyard sexually assaulted patients after the MBA imposed chaperone conditions on Dr Churchyard's registration.²⁴⁸

In some of the cases I reviewed, the practitioner demonstrated a clear pattern of non-compliance but it did not appear that any further instances of sexual misconduct were identified. In other cases, further claims of misconduct followed the imposition of chaperone conditions. Both examples bring into question whether chaperone conditions can effectively protect the public against the risk of harm posed by the practitioner.

In one notable example of ongoing non-compliance, a general practitioner breached the conditions of his registration on 142 separate occasions over a six month period: the GP conducted a least one third of the 142 consultations without a chaperone present, failed to record consultations with female patients in the chaperone log on at least 130 occasions, failed to obtain the chaperone's signature on the chaperone log on at least 132 occasions, permitted a person under the age of 18 years to act as a chaperone on at least 16 occasions, and also declared in statutory declarations that he had complied with the conditions imposed on his registration in circumstances where he knew he had not.²⁴⁹ The matter was referred to the Tribunal for disciplinary proceedings, which resulted in the practitioner's registration being suspended for a period of two years. AHPRA's handling of the matter was also the subject of a case review by the OHO.²⁵⁰ The OHO found that there was a considerable length of time between the breaches and the subsequent suspension of the practitioner's registration, and concluded that:²⁵¹

- AHPRA had evidence of breaches of chaperone conditions on more than a dozen occasions
- if AHPRA had analysed the self-reported data as it became available, AHPRA could have identified the breaches of chaperone conditions and the Queensland Board of the MBA (QBMBA) could have taken action within two months (rather than the 10 months it took for the first evidence to go before the QBMBA)
- no sanctions were imposed by the QBMBA, despite evidence of substantial non-compliance with conditions by the practitioner across a considerable period of time, and
- despite evidence of the practitioner's non-compliance with the conditions imposed on his registration on at least 191 occasions across a two year period, it required evidence of forgery for the practitioner's registration to be suspended.

AHPRA has now fully implemented all recommendations of the OHO's case review. This has improved AHPRA's compliance monitoring activities.²⁵² However, the case graphically demonstrates that some practitioners may not comply with chaperone conditions, and that multiple breaches can occur in a short period of time, placing the public at risk.

Other examples demonstrate that chaperone conditions were not effective in preventing further complaints about sexual misconduct. In another matter that resulted in the suspension of the practitioner's registration, a GP breached chaperone conditions multiple times: on some occasions, the practitioner did not have a chaperone present when required and other breaches related to record keeping (there were 150 identified breaches of the requirement to complete a consent form, and the practitioner asked a staff member to sign as chaperone for consultations that she did not attend).²⁵³ The GP also provided patients with a false and misleading information sheet, which denigrated the (unidentified) complainant and sought to minimise the practitioner's conduct. Two further complaints were received alleging sexual misconduct while the chaperone requirement was in place. The practitioner was ultimately suspended and the

²⁴⁷ Submission from Dr Y, September 2016.

²⁴⁸ For example, see: www.smh.com.au/national/health/sex-abuse-doctor-andrew-churchyard-allowed-to-keep-working-by-cabrini-hospital-20160729-gqgl4k.

²⁴⁹ *MBA v Chandra* [2014] QCAT 271.

²⁵⁰ In Queensland, the OHO's functions include monitoring the health, conduct and performance functions of AHPRA and the National Boards.

²⁵¹ OHO, 'Case Review: Managing practitioner compliance with conditions of registration': www.oho.qld.gov.au/wp-content/uploads/2015/03/Health-Ombudsman-case-review-managing-practitioner-compliance-with-conditions-of-registration.

²⁵² OHO, 'Implementation of recommendations: Progress report': www.oho.qld.gov.au/wp-content/uploads/2016/06/Implementation-of-recommendations-progress-report-4-June-2016.

²⁵³ *MBA v Henderson* [2011] QCAT 90.

Tribunal set out conditions that would need to be satisfied upon any application for re-registration. Importantly, in its reasons for decision the Tribunal noted that the practitioner:²⁵⁴

‘...has demonstrated that, in his case, the chaperone regime is inadequate to protect female patients. The conduct against patients RH and SR occurred when he was subject to either a voluntary or imposed chaperone requirement. There have been cases involving more serious sexual conduct. Nevertheless [the practitioner] exploited the trust inherent in the relationship between doctor and patient and did so at a time he was subject to a regime intended to protect female patients from this very conduct.’

The case of *R v MBA* is similar. The MBA received multiple complaints about the practitioner following the imposition of chaperone conditions; one alleged that the inappropriate sexual conduct occurred when the practitioner closed the curtains around the patient, which prevented the patient’s mother (who was also in the room) from observing the conduct. In its reasons for decision, the Tribunal noted:²⁵⁵

‘The Tribunal further considers that suspension is necessary to protect the public. This is because the chaperone condition placed on the practitioner’s registration after the Board received the complaint from Complainant 1 was ineffective to prevent further complaints.’

Concerns about the ineffectiveness of chaperone conditions was expressed in the high profile case of Dr Clifford Ayling in the United Kingdom:²⁵⁶

‘The presence of a chaperone did not, the Inquiry was told, apparently prevent Ayling from acting unprofessionally and nor did the presence of more senior nursing and midwifery staff apparently deter him from making distasteful and unprofessional comments. Furthermore, even after the presence of a chaperone was mandated by Ayling’s revised bail conditions in 1998, the Inquiry was told by one patient that the chaperone who was present at her consultation with Ayling in 2000 was sent out of the room by him from time to time.’²⁵⁷

These examples demonstrate that chaperone conditions are sometimes ineffective in preventing harm to patients.

I also noted one disturbing case where it was reported that a doctor indecently assaulted a chaperone.²⁵⁸ In this case, the doctor inappropriately touched six female patients and two healthcare workers, including a chaperone, over a 16 month period.²⁵⁹ He was found guilty of 11 counts of indecent assault and was given a three-and-a-half year suspended jail sentence.²⁶⁰ The Tribunal upheld the decision of the Medical Practitioners Board of Victoria to cancel his registration, attaching ‘considerable weight’ to the fact that the doctor indecently assaulted the chaperone required after the initial allegations had been received.²⁶¹ This example indicates that consideration needs to be given not just to the safety of patients, but also to the safety of chaperones, when deciding to impose chaperone conditions. It raises questions about the ability of chaperones to prevent inappropriate behaviour against patients, since the chaperone was powerless to prevent the practitioner from assaulting her.

I have noted with concern several cases where the evidence indicated that non-compliance was not

²⁵⁴ *MBA v Henderson* [2011] QCAT 90 at [26].

²⁵⁵ *R v MBA* [2013] WASAT 28.

²⁵⁶ Dr Ayling was convicted of 13 indecent assaults on 10 women patients and jailed for four years in December 2000.

In 2004, a Committee of Inquiry conducted an investigation into how the National Health Service handled allegations about the conduct of Dr Ayling.

²⁵⁷ Department of Health Committee of Inquiry report, *Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling* (2004).

²⁵⁸ ABC News, ‘Latrobe Valley doctor banned from practising medicine’ (9 April 2003): www.abc.net.au/news/2003-04-09/latrobe-valley-doctor-banned-from-practising/1833244.

²⁵⁹ *The Age*, ‘Doctor convicted of indecent assault loses appeal’ (21 August 2003): www.theage.com.au/articles/2003/08/20/1061368351936.html.

²⁶⁰ ABC News, ‘Latrobe Valley doctor banned from practising medicine’ (9 April 2003): www.abc.net.au/news/2003-04-09/latrobe-valley-doctor-banned-from-practising/1833244.

²⁶¹ *The Age*, ‘Doctor convicted of indecent assault loses appeal’ (21 August 2003): www.theage.com.au/articles/2003/08/20/1061368351936.html.

simply a minor or technical breach, yet breaches of chaperone conditions did not lead to stricter conditions being imposed on the practitioner's registration.

In one case, AHPRA compliance staff had identified discrepancies in a practitioner's chaperone log – in particular, data from Medicare suggested that the practitioner had engaged in approximately 300 consultations over a two month period without completing the required chaperone log. The practitioner gave various reasons for the breaches, including that he did not realise the chaperone log needed to be completed if the patient had an accompanying person with them; patients were seen in the presence of a chaperone but it was not reflected in the chaperone log; he did not realise he should not see chaperones as patients; and he did not realise he could not consult with patients who declined a chaperone.

The MBA decided to caution the practitioner to ensure he complied with all requirements of the chaperone policy in the future, but the conditions on the practitioner's registration remained unaltered. Shortly after the caution was issued, it came to the attention of AHPRA that there were another 120 apparent instances of the practitioner consulting with female patients without a chaperone and seven instances of the practitioner seeing a chaperone as a patient. When the MBA subsequently proposed to take immediate action in the form of suspending the practitioner, the practitioner requested (and was granted) an extension, supported by an interim undertaking not to practise. The MBA later decided to suspend the practitioner on the basis that the practitioner had breached, and appeared to be continuing to breach, the conditions on his registration, appeared to have breached the undertaking not to practise, and had been convicted of two serious sexual offences.²⁶²

Examples of non-compliance demonstrate that the requirement for a chaperone can be easily breached by a practitioner – largely because heavy reliance is placed on the practitioner to personally ensure that they do not consult with relevant patients without a chaperone, and some practitioners may simply choose not to comply. While non-compliance may later be detected by AHPRA, or reported to AHPRA by others (including the chaperone), by then patients have been

exposed to harm and the practitioner may have behaved inappropriately.

I appreciate that there may be administrative reasons for non-compliance, which should not of themselves lead to a decision to impose a stricter restriction. However, I consider that there should be much lower tolerance for breaches of chaperone conditions. I note the view of the New South Wales HCCC that where the relevant health regulatory body 'is reasonably satisfied that a breach of chaperone conditions has occurred, this should automatically trigger a further [immediate action process] and suspension of registration'.²⁶³

Such an escalation is warranted both to protect patients and because of the practitioner's disregard for conditions of registration, which raises questions about his or her trustworthiness and fitness to practise. Even where a practitioner is compliant with chaperone conditions, if new additional evidence comes to light (in the interim period before the allegations are proven in a tribunal or court hearing), which casts doubt on the practitioner's trustworthiness, imposition of a more onerous restriction or suspension should be considered.²⁶⁴

I recommend that 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.²⁶⁵

²⁶² MBA decision, October 2016.

²⁶³ NSW HCCC, 'Chaperone conditions in NSW: a review' (October 2016), p 19.

²⁶⁴ See, eg, *MBA v Lal* [2017] WASAT 23. In January 2014 the MBA imposed a chaperone condition on Dr Lal following notification of an allegation of sexual contact with a patient. In March 2015 Dr Lal admitted to an AHPRA investigator that he had provided false information in his original response to the notification (see para 3.3 of WASAT decision). In September 2016, Dr Lal admitted that he had lied to the police, the MBA and AHPRA (see para 75). Despite this evidence of lack of trustworthiness, the chaperone condition was left in place. On 31 January 2017, four years after the chaperone condition had been imposed, Dr Lal's registration was cancelled by the State Administrative Tribunal of Western Australia, for sexual misconduct and serious dishonesty.

²⁶⁵ Recommendation 28.

Part G: International comparison (NZ, UK, Canada, US)

As part of this review, I have examined current practice of international medical regulators – in particular, in New Zealand, the United Kingdom (UK), Canada and the United States – to see whether, and if so in what circumstances, mandated chaperones are used to protect patients while allegations of sexual misconduct are investigated.

Based on previous contact with international medical regulators, I identified the General Medical Council (UK), the College of Physicians and Surgeons of British Columbia, the College of Physicians and Surgeons of Ontario, the Oregon Medical Board (US) and the Medical Council of New Zealand as leading regulators whose practice could usefully be compared with that of the MBA.

I found that chaperones continue to be used as a regulatory intervention in the comparable jurisdictions of New Zealand, the UK, Canada, and the United States.

Chaperones are, in some circumstances, used as part of interim protective measures in the UK. The justification for an interim protective measure in the UK, in addition to risk to patients, includes an emphasis on the risk of loss of public confidence in health professionals and their regulatory bodies, if doctors have been permitted to continue seeing patients (even with chaperone conditions) and allegations turn out to be true. In Ontario, where (like Australia) there have been several high profile cases of patients assaulted by doctors during consultations, the College of Physicians and Surgeons of Ontario (CPSO) uses chaperones as an interim protective measure, but their use is controversial and may not survive a recent inquiry and pending legislative change.

My detailed analysis of the practice of international medical regulators is set out below.

New Zealand

Despite taking a strong stand since the early 1990s on the importance of clear boundaries in the doctor–patient relationship, including a ‘zero tolerance’ approach to a doctor having any sexual contact with a current patient, the Medical Council of New Zealand (MCNZ) and the medical profession in New Zealand has faced media and

public criticism when cases of serial sexual offending by doctors has come to light. In August 2016, the *Herald on Sunday* and *New Zealand Herald* ran feature articles entitled ‘Predatory health professionals still practising’ and ‘Dodgy doctors continue to practise’.²⁶⁶

New Zealand has a co-regulatory system for health practitioners, with an independent health complaints entity, the Health and Disability Commissioner (HDC) investigating complaints of breaches of a patient’s rights,²⁶⁷ and prosecuting registered practitioners before the Health Practitioners Disciplinary Tribunal. Under the Health Practitioners Competence Assurance Act 2003 (HPCAA), the Medical Council of New Zealand (MCNZ) is the ‘responsible authority’ for doctors. As regulator, MCNZ is responsible for determining what measures are necessary in the interim period between a receipt of a complaint of sexual misconduct by a doctor and its disposition. It may impose any condition on a doctor’s scope of practice that it ‘believes on reasonable grounds to be necessary to protect the safety of the public’.²⁶⁸ The HPCAA specifically allows an order for interim suspension or the placing of conditions on a doctor’s practice where he or she is ‘alleged to have engaged in conduct’ that is relevant to a pending criminal proceeding or to an investigation by HDC or MCNZ, and which MCNZ believes on reasonable grounds ‘casts doubt on the appropriateness of the practitioner’s conduct in his or her professional capacity’.²⁶⁹

Conditions may also be imposed by the Health Practitioners Disciplinary Tribunal in cases of ‘professional misconduct’. Thus, in New Zealand, chaperones and gender-based restrictions are imposed both as interim conditions and following proven sexual misconduct. For example, as a result of a tribunal decision, a doctor found guilty of professional misconduct that included sexually harassing a vulnerable patient (sending inappropriate texts), was censured and suspended for nine months, then permitted to return to practice subject to chaperone conditions for female patients.²⁷⁰

When chaperones are imposed as a practice restriction, a notice detailing the condition must be displayed in the doctor’s waiting room and examination areas ‘to inform patients’, and

²⁶⁶ O Carville, ‘Predatory health professionals still practising’ *Herald on Sunday*, 14 August 2016; O Carville, ‘Dodgy doctors continue to practise’ *The New Zealand Herald*, 15 August 2016.

²⁶⁷ Rights 4(2) and 2 of the Code of Patients’ Rights affirm a patient’s right to compliance by a doctor with professional and ethical standards, and to be free from sexual exploitation.

²⁶⁸ HPCAA, s 22(3)(h).

²⁶⁹ HPCAA, s 69.

²⁷⁰ *Re Dr Vijay Harypursat*, NZ Health Practitioners Disciplinary Tribunal decision no 729/Med 15/316D.

the doctor 'should' inform any employer of the condition and, if asked by a patient, 'should disclose the reason behind the [chaperone] requirement'.²⁷¹

Generally, all complaints received by MCNZ are initially considered by the Complaints Triage Team (CTT). A key role for CTT is identifying any potential risk of harm, particularly where the complaint contains allegations of sexual misconduct. CTT will consider if the circumstances support the Registrar issuing a section 35 'risk of harm' notice.²⁷² Under that section, MCNZ is required to notify employers and relevant agencies (including HDC) if it 'has reason to believe that the practice of the health practitioner may pose a risk of harm to the public'.²⁷³

In practice, MCNZ uses the threat of such notification to incentivise the doctor's agreement to a detailed voluntary undertaking, such as to cease practice or to practise only with a chaperone. Although voluntary, and thus not a condition of registration appearing on the public register, a central tenet of undertakings is that those affected by or in a position to reinforce the terms of the undertaking are made aware of it. Undertakings can therefore include requirements that employers and relevant associates be informed. Chaperone notices are required. Undertakings contain releases allowing the MCNZ to police compliance (the use of a 'secret shopper' to monitor compliance is common) and provisions acknowledging that breach will result in formal conditions being imposed.

MCNZ accepts voluntary interim chaperone conditions in situations where the MBA would be likely to impose a more onerous condition. For example, in one case, despite ten charges of indecent assault (following complaints by two female patients to the police), the doctor was permitted to continue practising with a voluntary undertaking to use a chaperone for any examination of a female patient.

MCNZ monitored compliance with the undertaking over the next year. One year later, nearly three months following the doctor's conviction on six charges of indecent assault, MCNZ suspended him.²⁷⁴

In a recent case, MCNZ was notified by the police of an allegation that a medical practitioner had

sexually assaulted an 18-year-old student after consciously sedating him to treat a dislocated finger. MCNZ accepted a voluntary undertaking that the doctor not use conscious sedation, have a chaperone present during consultations, and consent to MCNZ monitoring.²⁷⁵

When a new allegation was made by another patient – of indecent assault while sedated for treatment of an abscess – MCNZ imposed interim suspension, but a court stayed the suspension and imposed chaperone conditions. The police subsequently charged the doctor with five charges of stupefying patients and eight charges of indecent assault. MCNZ again imposed interim suspension, noting that the doctor had, on the basis of the allegations, demonstrated the capacity to manipulate his clinical environment and isolate patients from chaperones and other clinical staff. Thus, chaperone conditions would be an insufficient safeguard.

This time the suspension was upheld by the courts. The District Court accepted that 'the risk to public safety could not be sufficiently mitigated with conditions on practice rather than suspension'; suspension on an interim basis was 'an appropriate and proportionate response to that risk'.²⁷⁶ The High Court upheld the District Court decision, and noted that maintenance of public confidence in the medical system was not an irrelevant consideration.²⁷⁷

In summary, chaperones are used by New Zealand's medical regulator, but a voluntary undertaking to use a chaperone is often used in the interim situation, and there appears a higher threshold than in Australia, before mandated interim chaperone conditions or suspension is considered necessary.

United Kingdom

Chaperones are sometimes imposed as part of interim protective measures in the UK. Allegations of sexual assault/inappropriate examination cover a wide range of conduct. For the most serious allegations, for example rape or sexual misconduct with children, the General Medical Council (GMC) seeks an order of interim suspension prior to a doctor being charged with a criminal offence. For other allegations, an order for interim conditions that includes a chaperone requirement may be sought prior to a doctor being charged

271 MCNZ, *The Importance of Clear Sexual Boundaries in the Doctor–Patient Relationship* (2006) Appendix 1, at [13]–[15].

272 MCNZ 'Medical Council Complaints Triage Team: Terms of Reference' (May 2016), at 1–2.

273 HPCAA, s 35.

274 Case details provided by MCNZ, 6 September 2016.

275 *Lim v MCNZ* [2016] NZDC 2149 at [8].

276 *Lim v MCNZ* [2016] NZDC 2149 at [63], [72].

277 *Lim v MCNZ* [2016] NZHC 485 at [28], [29].

with a criminal offence. In those cases, if the doctor is subsequently charged with a criminal offence an order for suspension will likely be sought. While a condition requiring chaperoning (or a similar undertaking) is also available for substantive outcomes, it generally is not used as, if it is proved that someone has undertaken an inappropriate examination, it is likely that they will be suspended.²⁷⁸

Interim orders may be imposed by the Interim Orders Tribunal (IOT). The test for imposition of an interim condition, or suspension, is set out in section 41A(1) of the Medical Act 1983: 'Where an IOT ... on their consideration of a matter, are satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of a fully registered person, for the registration of that person to be suspended or to be made subject to conditions', the IOT may make an order for the imposition of conditions, or suspension, for up to 18 months. The interim order must be reviewed at least every six months.

A striking feature of the use of interim orders in the UK is the interpretation of the public interest limb of the test for their imposition. Although the wording is identical to that in the NSW legislation,²⁷⁹ case law in the UK has applied a much more liberal interpretation of when an interim order is justified. This may be attributable to the 'Shipman effect' and wave of reactive regulation, following the conviction of GP Harold Shipman for the murder of 15 of his patients and scorching criticisms of the GMC by Dame Janet Smith in her inquiry reports.²⁸⁰ An academic critique of the use of precautionary suspension by the GMC compares the 'patient protection narrative' with the 'public confidence narrative' in the interpretation of section 41A of the Medical Act, with the latter narrative being used to justify a lower threshold for interim suspensions based on the public interest in maintaining public confidence in the medical profession.²⁸¹ The courts have noted that the section 41A(1) public protection test is not qualified by the word 'necessary'.²⁸²

A precautionary approach is well embedded in regulatory practice in the UK, and is reflected in guidance from the GMC and the Medical Practitioners Tribunal Service (MPTS). Examples of cases that GMC guidance states may require referral to an IOT are:²⁸³

'...[W]here the allegations, if substantiated, would demonstrate that the doctor poses a risk to the public if allowed to continue in unrestricted practice. This category includes allegations of indecent assault ... [and] where the doctor faces allegations of a nature so serious that it would not be in the public interest for the doctor to hold unrestricted registration whilst the allegations are resolved, even though there may be no evidence of a direct risk to the public. The question would be whether public confidence in the profession might be seriously damaged by the doctor concerned holding unrestricted registration whilst the allegations are resolved.'

The MPTS guidance mirrors the GMC guidance, for example recommending referral to an IOT:²⁸⁴

'[4] ...where the doctor faces allegations of a nature so serious that it would not be in the public interest for the doctor to hold unrestricted registration whilst the allegations are resolved even though there may be no evidence of a direct risk to patients. The question would be whether public confidence in the profession may be seriously damaged by the doctor concerned holding unrestricted registration whilst the allegations are resolved.'

...

[6] 'It may also be in the interests of public safety and public confidence to refer matters to the IOT where a doctor is alleged to have breached the guidance on relationships with patients in Good Medical Practice. Where there is evidence to suggest a doctor has used their professional position to establish or pursue a sexual or improper relationship with a patient or someone close to them ... this is a strong indicator that a referral is appropriate.'

278 Information provided by Anna Rowland, Assistant Director, GMC.

279 Health Practitioner Regulation National Law (NSW), s 150.

280 In particular, *Fifth Shipman Report: Safeguarding Patients: Lessons from the Past – Proposals for the Future* (2004): www.webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/fifthreport. The first Shipman inquiry report estimated that he had probably killed more than 200 other patients.

281 P Case. Putting public confidence first: doctors, precautionary suspension and the General Medical Council [2011] Medical Law Review 339.

282 *Sandler v GMC* [2010] EWHC 1029 (Admin) at [14]. The allegations against the doctor concerned fraud in completing cremation certificates, not sexual misconduct.

283 See www.gmc-uk.org/concerns/hearings_and_decisions/interim_order_tribunal_referrals.asp#when.

284 MPTS *Imposing Interim Orders: Guidance for the Interim Orders Tribunal, Tribunal Chair and the Medical Practitioners Tribunal* (February 2016).

In the *Sosanya* case, the High Court approved a broad interpretation of public confidence:²⁸⁵

'The statutory test is there, and that is the one to be applied. One would like, all the same, to think that in all these kinds of cases of potential interim suspension an interim orders panel would at least be asking itself, as part of its thought process, the following: will it be acceptable for us not to suspend in a case of this kind if at the end of the day the charges are proved and the guilt of the applicant is established? That is one aspect. Another part of the thought process should be: will it be acceptable for us to suspend an applicant in a case of this kind if, at the end of the day, the applicant may be acquitted of all charges? Those considerations should form at least part of the thinking of [the IOT], as it seems to me.'

The IOT will weigh the strength of the evidence when deciding whether an order is required initially, and will sometimes leave conditions (as opposed to suspension) in place even when a doctor has been charged with a criminal offence if they think, in the particular circumstances of the case, the conditions are workable, enforceable and sufficient to protect the public and the wider public interest.²⁸⁶ The courts have accepted IOT restrictions should be the minimum necessary to protect patients and the public interest.

The application in practice is illustrated by the *Abdullah* case.²⁸⁷ It concerned allegations of a doctor's sexual misconduct with one of his patients – that he had, while examining her in his surgery, rubbed her breasts and, on a later occasion, had sex with her after he said that he would not provide her a sickness certificate unless she did. There were also extensive records of his having communicated with the patient by text messages. The police determined that the evidence was not sufficient to support a prosecution of rape and referred the matter to the GMC, which sought an interim order.

The IOT was satisfied that an interim suspension was necessary. Noting that 'significant public confidence issues' were likely to arise, the IOT was not capable of formulating any practicable conditions due to the 'serious nature' of the alleged acts. While it took 'account of the ... principle of proportionality' and acknowledged the adverse effect on the doctor, the practitioner's 'remaining in unrestricted practice could seriously undermine the trust that members of the public are entitled to place in the medical profession and its practitioners'.

The High Court dismissed the doctor's challenge to interim suspension, noting that it was necessary and proportionate. A chaperone condition was impracticable, since most of the contact had occurred outside the clinical setting, but in any event it would still not have addressed the risk of harm to public confidence in the medical profession from letting the practitioner remain in practice.²⁸⁸

In summary, chaperones are sometimes used as part of interim protective measures in the UK. A precautionary approach is taken, weighing the risk of loss of public confidence in the medical profession (and in its regulatory system) together with any risk to patients.

British Columbia

The Health Professions Act 1996²⁸⁹ (HPA) governs the regulation of health professions in British Columbia and establishes (or continues) colleges for registered health professions, including the College of Physicians and Surgeons of British Columbia (CPSBC). Interestingly, in a requirement not replicated in other Canadian provinces, health profession colleges are required to establish 'a patient relations program to seek to prevent professional misconduct of a sexual nature'.²⁹⁰

Educating doctors, patients and the community about appropriate boundaries in the doctor-patient relationship, and proper handling of complaints of sexual misconduct, was the focus of an important 1992 report commissioned by CPSBC, *Crossing the Boundaries: The Report of the Committee on Physician Sexual Misconduct*.²⁹¹ CPSBC has well established procedures for handling allegations of sexual misconduct, and chaperones are used both in the interim situation and following proven

²⁸⁵ *R (on application of Sosanya) v GMC* [2009] EWHC 2814 (Admin) at [35]. The case involved allegations of money laundering, and the High Court overturned the interim suspension order.

²⁸⁶ See para 38 of MPTS guidance on imposing interim orders.

²⁸⁷ *Abdullah v GMC* [2012] EWHC 2506 (Admin).

²⁸⁸ *Abdullah* at [106].

²⁸⁹ Health Professions Act [RSBC 1996] ch 31.

²⁹⁰ HPA, s 16(2)(f).

²⁹¹ *Crossing the Boundaries: the Report of the Committee on Physician Sexual Misconduct* (CPSBC, 1992).

misconduct. They occupy a relatively uncontentious place in the CPSBC's regulatory toolkit.²⁹²

The Inquiry Committee of CPSBC reports that 'the number of complaints alleging intimate relationships between physicians and current or former patients has declined in recent years. Most complaints alleging sexual misconduct are found to involve misperception of sensitive exams.'²⁹³

The use of chaperone conditions is guided by Chaperone Levels Guidelines that differentiate three levels of intensity to the conditions and provide standardised information for chaperones and inspectors. At level one, chaperones are required to be continuously present either for all interactions, or sensitive or unclothed examinations only, with patients of one or both genders, and another staff member must be on the premises. There are signage and documentation requirements at the first level. Level two requires all that level one does plus notification of the requirement to the practitioner's colleagues and the use of only CPSBC approved chaperones. Finally, level three requires the chaperone to provide detailed weekly reports on all the practitioner's consultations.

An inquiry committee may impose interim conditions or suspend a registrant if the committee considers such action 'necessary to protect the public during the investigation or pending a hearing of the discipline committee'.²⁹⁴ The test for interim action is: (1) whether action is necessary to protect the public; and, if yes, (2) will conditions (as opposed to suspension) protect the public and, if so, what conditions will suffice. If the inquiry committee decides that an interim order is necessary, 'it should not automatically impose an interim suspension but should first consider whether an interim conditions of practice order would be sufficient and proportionate'.²⁹⁵ The Tribunal must 'consider all reasonable alternatives to an interim suspension that may be available and that the restrictions or conditions imposed must be the least severe possible, while protecting the public'.²⁹⁶

In practice, CPSBC frequently relies on voluntary agreements by a physician accused of sexual

misconduct to use a chaperone or to withdraw from practice (for very serious allegations); these voluntary arrangements are still enforceable and monitored. For example, a general practitioner accused of sexual assault on a 16-year-old patient was permitted to sign a voluntary agreement not to practise; following his conviction and sentence to one year's imprisonment, CPSBC cancelled his registration.²⁹⁷ CPSBC reports that given the full cooperation of registrants in agreeing to and complying with chaperone requirements, mandated interim conditions are infrequently used.²⁹⁸

Gender-based restrictions are occasionally imposed in cases of proven sexual misconduct, having been sanctioned by the British Columbia Court of Appeal in *Wakeford*.²⁹⁹ The case involved an obstetrician and gynaecologist who had been struck off after being found guilty of seven charges of 'infamous or unprofessional conduct': six involved indecent conduct with three former patients and one of sexual intercourse with one former patient, in the period 1989-1992. He was denied application for reinstatement on four occasions over five years, before the Court of Appeal remitted the matter back to CPSBC for reconsideration, and he was re-registered with a prohibition on seeing female patients.

In summary, chaperones are used by British Columbia's medical regulator, but a voluntary undertaking to use a chaperone is often used in the interim situation, and there appears a higher threshold than in Australia, before mandated interim chaperone conditions or suspension is considered necessary.

Ontario

Sexual abuse of patients in Ontario has been the subject an extraordinary level of scrutiny by reviewers over the past 25 years. Human rights lawyer Marilou McPhedran has chaired three high profile task forces on the topic, in 1991, 2000 and 2016. The first report argued for zero tolerance by health regulators for sexual misconduct by health professionals,³⁰⁰ and led to law changes including automatic revocation of registration for certain types of sexual abuse, including sexual intercourse and specified sexual acts

292 Advice from CPSBC Registrar and CEO, Dr Heidi Oetter, 30 September 2016.

293 CPSBC Committee reports 2015/16: www.cpsbc.ca/files/pdf/2015-16-AR-Committee-Reports.pdf.

294 HPA, s 35(1).

295 *Scott v College of Massage Therapists of British Columbia* 2016 BCCA 180 at [55].

296 *Larre v College of Psychologists* 2007 BCSC 41 at [23].

297 CPSBC media release re disciplinary action re Dr Farrokh Rohani, 28 October 2013: www.cpsbc.ca/files/disciplinary-actions/2013-10-28-Rohani.

298 Advice from CPSBC Registrar and CEO, Dr Heidi Oetter, 24 January 2017.

299 *Wakeford v CPSBC* 1993 CanLII 1723 [BCCA].

300 M McPhedran et al. *The Final Report of the Independent Task Force on Sexual Abuse of Patients*, CPSO, 1991.

with a patient.³⁰¹ McPhedran's 2016 report, *To Zero*,³⁰² is a radical prescription for change, with numerous recommendations, including creation of an independent statutory entity to handle all complaints of sexual abuse by health practitioners in Ontario, and a ban on gender-based restrictions (GBRs), ie, chaperone conditions or prohibitions applying to one gender only.

McPhedran argues that 'sexual abuse of a patient is about the abuse of power, authority and trust within the context of a health care relationship, and not about the sexual preferences of the health professional' and that a GBR 'is missing the point and continues to place the public (or a segment of it) at risk for future abuse'. McPhedran does not distinguish clearly between allegations of sexual misconduct and proven sexual misconduct. She argues that 'Once a health professional is found to have sexually abused a patient, the health professional has, by extension, betrayed the public's trust in preserving the safety and well-being of all patients.'³⁰³ This rationale is close to the *Litchfield* principle applied by the MBA – that a doctor who cannot be trusted to practise without a chaperone, is not fit to practise at – however, in Australia the principle is only applied once the misconduct has been proven.

In December 2016, the Ontario Minister of Health and Long-Term Care introduced a new Protecting Patients Act to implement some of the *To Zero* recommendations.³⁰⁴ There is no commitment to create a new independent statutory authority and it appears that colleges will be left to regulate their professions, though possibly with greater Government intervention.³⁰⁵ However, under the new law, the range of sexual acts leading to automatic revocation will be expanded (to include 'groping', ie, any touching of the genitals, anus, breast or buttocks unless for a clinical purpose); colleges will be authorised to impose interim restrictions during the investigation process; and GBRs, whether as interim or final orders, will be prohibited.

From an Antipodean perspective, the Ontario legislature and the health regulatory colleges have taken a firm stance on sexual abuse by health practitioners. The College of Physicians and Surgeons of Ontario (CPSO) launched an extensive Sexual Abuse Initiative in 2014 and has sought increased legislative powers.³⁰⁶ However, sexual abuse of patients by doctors, and CPSO's handling of allegations of sexual misconduct, has continued to be the focus of fierce media criticism.³⁰⁷

It remains to be seen how CPSO will respond to the proposed law changes, if enacted. The expanded powers to impose interim suspension or conditions will fill a legislative gap, since currently the Regulated Health Professions Act 1991 (RHPA) requires an investigation of misconduct to have been completed and the matter referred to the Discipline Committee, before interim powers can be exercised.³⁰⁸ It will become possible to impose conditions at the investigation stage. These may include non-GBRs, such as conditions requiring practice monitors for all consultations (with female and male patients), or age or practice restrictions; or interim suspension in the most serious cases. However, the usual sort of 'chaperone' condition (ie, a GBR requiring a practice monitor with only female or male patients) will no longer be an option available to the regulator.

In terms of current practice, given the lack of interim powers until a matter has been investigated and referred to discipline (which, on average, takes at least six months), CPSO often relies on voluntary undertakings, particularly if a doctor has been charged with a sexual offence and released on bail, or where there are several complaints. Thus, patients in Ontario are currently less well protected than patients in Australia, where immediate action can follow promptly after receipt of an allegation.

Interim conditions or suspension may be imposed (at the referral to discipline stage) if CPSO's Inquiries, Complaints and Report Committee (ICRC) 'is of the opinion that the conduct of the member exposes or is likely to expose his

301 A physician whose registration has been revoked for sexual abuse may reapply after five years.

302 M McPhedran et al. *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Professions Act 1991*, Ontario Ministry of Health and Long-Term Care, 2016: www.health.gov.on.ca/en/common/ministry/publications/reports/sexual_health/taskforce_prevention_of_sexual_abuse_independent_report.pdf.

303 *To Zero*, p 120.

304 Reported in the media as 'Ontario government cracks down in health care abuse', *Toronto Star*, 8 December 2016: www.thestar.com/news/gta/2016/12/08/ontario-government-cracks-down-on-health-care-sex-abuse.

305 The proposed Bill 87 provides numerous regulation making powers for the Minister, including to clarify how College investigation and discipline committees perform their functions in relation to sexual abuse, and allowing committee, quorum and member qualifications to be defined by regulation making authority of the Minister.

306 CPSO letter to Minister of Health and Long-Term Care, 19 October 2015.

307 For example, 'Ontario must do more about doctors who abuse patients', *Toronto Star*, 5 January 2016.

308 RHPA, SO 1991, ch 18, Schedule 2 (Health Professions Procedural Code) s 37(1)(a).

or her patients to harm or injury'.³⁰⁹ There is a significant body of case law about the use of this 'extraordinary power', indicating that it is to be used sparingly, when necessary for public protection, and that the least restrictive intervention to address the risk of harm to patients should be imposed.

In practice, the majority of referrals to discipline for alleged sexual misconduct will have some condition, often including a GBR, either through a voluntary undertaking or an imposed condition by ICRC.³¹⁰ The *Maharajh* case is an example where no interim condition was imposed, after the practitioner had given a voluntary undertaking not to see female patients unless supervised by a chaperone.³¹¹ CPSO had accepted that undertaking when aware of only one of 11 to 13 victims of boundary violation. At the Discipline Committee penalty hearing, the doctor admitted engaging in repeated acts of inappropriate behaviour (kissing the breasts of female patients), and it was held that the only way to ensure the public's protection was to impose an indefinite prohibition on treating female patients.

An interim chaperone condition may be escalated to a gender-based prohibition and/or suspension if breaches are detected. The *Tadros* case is a striking illustration. Following allegations of sexual abuse of two patients, an interim practice monitor condition for female patients was imposed. The doctor was found non-compliant on the basis of repeated unchaperoned interactions with female patients, his refusal to post the practice sign (despite requests by the CPSO and his chaperone to do so – he had ripped up the sign), and his refusal to allow the CPSO to interview his chaperone during an inspection. An interim order was imposed prohibiting the doctor from treating female patients. The doctor treated multiple female patients in breach of the prohibition, and an order of interim suspension was then imposed. Upon reviewing the facts, the Discipline Committee concluded that the practitioner had 'repeatedly demonstrated that he is ungovernable as a professional' and deregistered him.³¹²

CPSO is investing heavily in improving its handling of sexual abuse allegations, including providing three hours' independent legal advice for witnesses/patients in sexual abuse cases. It is developing a training program for chaperones/practice monitors.³¹³ CPSO also operates a sophisticated program of monitoring compliance with practice restrictions, including the use of private investigators.³¹⁴

In summary, chaperones have been imposed by interim and final orders in Ontario, but that looks likely to change in light of the *To Zero* report and proposed law changes. CPSO has adopted a policy that the imposition of GBRs (including gender-based chaperone conditions) are difficult to justify after proven sexual misconduct, given the importance of public confidence in the integrity of the medical professional and in the system of medical self-regulation.³¹⁵ It remains to be seen whether the proposed prohibition on use of any GBR will have a flow-on effect that chaperone conditions (for all patients, male and female) are not considered acceptable as an interim protective measure.

United States (Oregon)

Good evidence about the use of mandated chaperones as an interim protective measure by state medical boards in the United States was difficult to obtain. On the recommendation of the Federation of State Medical Boards (FSMB), I approached the Oregon Medical Board, which is regarded as a leading medical regulator in the US.

FSMB guidelines for state medical boards on discipline following a finding of sexual misconduct note that conditions may be imposed on the physician, including a requirement that 'chaperones are routinely in attendance and sign the medical record attesting to their attendance during examinations or other patient interactions as appropriate'.³¹⁶ There is no reference to imposed chaperones (or suspension) before sexual misconduct is proved, but simply a general statement that '[i]f the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct,

309 RHPA, SO 1991, ch 18, Schedule 2 (Health Professions Procedural Code) s 37(1)(a).

310 Information provided by CPSO, 24 January 2017.

311 See Discipline Committee decision re Dr Maharajh, 5 November 2013: www.cpso.on.ca/Whatsnew/News-Releases/2013/2013-11-26.

312 *Ontario (College of Physicians and Surgeons of Ontario) v Tadros* 2015 ONCPSD 27.

313 CPSO uses the term 'practice monitor' interchangeably with chaperone. A practice monitor may have chaperone functions (in the room during physical examinations), as well as other clinical or administrative duties. Information provided by Dan Faulkner, CPSO Deputy Registrar.

314 See Discipline Committee decision re Dr Lambert, 2 November 2011: [www.cpso.on.ca/Whatsnew/News-Releases/2013/Discipline-Committee-Decisions-\(12\)](http://www.cpso.on.ca/Whatsnew/News-Releases/2013/Discipline-Committee-Decisions-(12)).

315 See attachment 2, 'Decision-Making Framework for Gender-Based Restrictions', CPSO letter to Minister of Health and Long-Term Care, 19 October 2015.

316 FSMB, *Addressing Sexual Boundaries: Guidelines for State Medical Boards* (2006) at pp 7-8.

the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large'.³¹⁷

The Oregon Medical Board confirmed that Interim Stipulated Orders (ISO) are used, early in the investigative phase, where the Board has sufficient information to take action. Imposition of an ISO is a negotiated outcome, and takes into account the entirety of the physician's history with the Board. An emergency interim suspension would require detailed allegations that would hold up in a contested case hearing. Sometimes the evidence warrants a restriction rather than removal from practice. The primary incentive for physicians to sign an ISO is that the Board limits the facts contained in the document. Both emergency suspensions and ISOs are public documents and reportable.

In Oregon, a chaperone requirement as an interim measure, by use of an ISO, appears to be very rare. A decision to require the use of chaperones is based on the belief that the physician is safe to practice so long as there is some oversight. In that type of case, the facts may show that there is a possibility of sexual transgression but the Board has limited evidence of ongoing patient risk. In rare instances a physician agrees to a chaperone for male and female patients, if there is some evidence that the physician crosses boundaries with both genders or that the practice involves a particularly vulnerable population.³¹⁸

It is difficult to make general observations about the use of mandated chaperones in the US, but it appears that they are very infrequently imposed as an interim protective measure. Recent research indicates that discipline for sexual misconduct across the US is highly variable. A study of 1,039 US physicians reported to the National Data Bank for Sexual Misconduct, 2003-2013, found that two thirds of physicians with either sexual misconduct related clinical privileges actions or malpractice payments (both strong evidence that misconduct occurred) were not disciplined for sexual misconduct by state medical boards.³¹⁹

Media reports in the US suggest inadequate regulatory responses to proven sexual misconduct by doctors. A series of articles published in 2016, by investigative journalists in *The Atlanta Journal-*

Constitution, found that two thirds of doctors disciplined for sexual misconduct in Georgia were allowed to return to practice. The investigation widened to examine over 100,000 medical board orders in 50 states relating to disciplinary action against doctors since 1999. The investigation found that Georgia was not unusual, and that the system 'too often protects doctors from accountability, leaving patients vulnerable'.³²⁰ Even registered sex offenders have been permitted to return to practice. Requirements for chaperones and other restrictions (such as bans on breast and pelvic examinations) are apparently sometimes concealed in private agreements that are not available to the public.³²¹ These reports by investigative journalists suggest that the US may not be an exemplar of regulatory responses to alleged and proven sexual misconduct by physicians.

317 FSMB Guidelines, pp 2-3.

318 Information provided by OMB Executive Director Dr Kathleen Haley, 5 January 2017.

319 AbuDagga et al, Cross-sectional analysis of the 1039 US physicians reported to the National Practitioner Data Bank for Sexual Misconduct, 2003-2013, PLOS ONE 3 February 2016: www.journals.plos.org/plosone/article?id=10.1371/journal.pone.0147800.

320 C Teegardin et al, 'License to Betray: A broken system forgives sexually abusive doctors in every state, investigation finds' *The Atlanta Journal-Constitution*, October 2016: www.doctors.ajc.com/doctors_sex_abuse.

321 See, eg, J Rimbach, 'Discipline for abusive doctors remains questionable' *Honolulu State Advertiser*, 1 November 2015 (reporting on cases in New Jersey): www.staradvertiser.com/2015/11/01/breaking-news/discipline-for-abusive-doctors-remains-questionable-2.

Part H: Conclusion

This review, and the allegations of indecent assault on multiple male patients by Melbourne neurologist Dr Andrew Churchyard, has led to a timely re-examination of the appropriateness and effectiveness of chaperone conditions. I commend the MBA and AHPRA for their willingness to review current practice, hear the views of stakeholders, and learn from evidence in Australia and internationally. In this part of the report, I set out my conclusions and cover some remaining matters arising from the Terms of Reference.

Overall conclusion

I do not consider that the continued use of mandated chaperone conditions as an interim protective measure is justified. Their use in this context does not reflect contemporary patient or community expectations.

The use of chaperones as a protective measure is confined to the health sector (mainly in private medical practice). It is not used in other sectors or contexts (such as child care). Chaperones are generally used only in the private health system. Health practitioners employed in the public health system are ordinarily stood down (usually on full pay) while allegations of sexual misconduct are investigated. Public institutions recognise their overriding duty of care to patients, and are sensitive to reputational harm if allegations are true. Private organisations also weigh such considerations, but may not even be aware when visiting medical officers are subject to sexual misconduct allegations.

My review has identified significant concerns about the appropriateness of mandated chaperones, their limited effectiveness, and the complexity of proper monitoring and compliance. Concerns about the current operation of chaperone conditions are reinforced by scrutiny of how and when they are imposed by different Board committees. There are inconsistencies in when restrictions are imposed and what level of restriction is deemed necessary.

From a risk reduction viewpoint, chaperone conditions make sense. A closely observed practitioner is less likely to engage in inappropriate behaviour. One imagines that for many practitioners, the shock of being subject

to a notification will prevent any further sexual misconduct.

Yet it is clear that, in practice, chaperone conditions are not wholly effective to prevent patients from being exposed to harm and, in some cases, sexually assaulted. Predatory practitioners who have come to view patients as sexual objects may not be deterred by a safety mechanism that still leaves the practitioner in control. Sexualised behaviour – which may be as subtle as the way a practitioner looks at the patient, or an intimate examination of dubious clinical necessity – may be undetectable by an observer.

When I first viewed the AHPRA *Chaperone protocol*, I was struck by the multiple requirements in place to make the system work and monitor compliance. Seeking to plug weaknesses identified by AHPRA itself, and in this report, will only increase the complexity of the mandated chaperone system. At some point, it must be questioned whether the system is 'worth the candle'. As noted by a community member of a National Board, the mandated chaperone system 'puts a whole lot of effort into a mechanism that does not meet community expectations'.³²²

No chaperones as interim restriction

Given their dubious appropriateness and the evident holes in the safety net of chaperone conditions, and their limited effectiveness in preventing harm to the public and (in the event of further patients coming to harm) loss of public confidence in health professions and their regulators, it is time to abandon the use of mandated chaperones as an interim restriction.³²³

Consideration should be given to other regulatory options – to better protect the public. They include greater use of gender-based prohibitions. I am not convinced by the argument that sex in the practitioner-patient relationship is simply about power, and that imposed conditions should not take into account gender-based sexual preferences of a practitioner who is the subject of allegations. Where evidence warrants taking immediate action – to protect patients or otherwise in the public interest – a gender-based prohibition may be a sensible and appropriate regulatory response, if limited practice is regarded as safe and suspension

³²² Confidential National Board discussion, November 2016.

³²³ Recommendation 1.

is not considered necessary. It may also be appropriate to impose a condition prohibiting any patient contact but permitting other practice.³²⁴

I recommend that 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.³²⁵

Improved handling of sexual misconduct cases

My review has highlighted the need for improved handling of sexual misconduct cases by the MBA and AHPRA. This is important for several reasons: to ensure that notifiers (especially victims) are treated with empathy and sensitivity; that immediate action and speedy investigation is undertaken where warranted, to protect the public; that regulatory decisions are taken on a consistent basis, in accordance with the National Law and policy guidance; and that practitioners are treated fairly.

There are many competing pressures on the National Scheme. Allegations of serious clinical performance concerns also necessitate prompt and thorough assessment and investigation, given the implications for patient safety. However, sexual misconduct allegations are in a special category. Patients know there are risks in medical interventions. They do not know and should not expect a health consultation to be a place where they may be indecently assaulted. They trust health practitioners never to use patients for their own sexual gratification, and that regulators will protect patients if there are any concerns about inappropriate behaviour by a practitioner.

I recommend that AHPRA develop highly specialised staff and investigators for handling sexual misconduct cases, who can establish rapport and deal with victims empathetically, and invest in specialist training and skills for these staff.³²⁶ It is important that AHPRA staff keep notifiers (in particular notifiers personally affected by practitioner conduct) well informed as to progress in 'their case'. The need for amendments to the confidentiality provisions in the National Law is discussed below. However, AHPRA should

also implement operational changes to improve communication with notifiers who report sexual misconduct, to the extent permitted by the current law.³²⁷

Where an allegation of sexual misconduct does proceed to an investigation, it needs to be undertaken as a priority, given the potential high risk and the impact of interim restrictions on patients, practitioners and health services. Specialist staff will assist in the speedy and thorough assessment and investigation of sexual misconduct cases. Ideally, investigations of sexual misconduct allegations should be completed within six months.

The average duration of current interim chaperone conditions of 1.8 years is unacceptable. Interim restrictions and suspensions should not remain in place more than 12 months, except in exceptional cases of delay necessitated by external decision-makers (police, tribunals or courts).³²⁸ As noted by the Supreme Court of Victoria stated in *Kozanoglu*, 'the entire legislative scheme breaks down if there is a lengthy delay between an IAC and a complete hearing on the merits'.³²⁹ Delay is stressful and unfair to notifiers and practitioners.

However, responsibility for delays cannot simply be laid at the door of the MBA and AHPRA. The justice system also has a critical role to play. There are frequently long delays before charges (following concluded investigations) can be heard by a responsible tribunal. Delays in hearings and decisions from tribunals and courts leave National Boards hamstrung, since they cannot responsibly remove an interim restriction while waiting for cases to be heard. This issue needs to be followed up with the justice sector.

More consistent decision-making

My review of current cases reveals that chaperone conditions are imposed in a wide range of circumstances. The current approach of Board committees is not consistent. The practice varies between states and territories, and there may even be a lack of consistency within a single jurisdiction. This may reflect changing membership of Board committees and differing advice from AHPRA staff in local offices, possibly influenced by varying signals from responsible tribunals.

³²⁴ During the review, this suggestion was made by former Health Services Commissioner Beth Wilson. I also note an example of an immediate registration action imposed by the Queensland Health Ombudsman: 'The practitioner must not practise in any role requiring direct or indirect clinical patient contact (including supervision of other practitioners engaged in [such] contact). The practitioner may only use his professional knowledge to practise in management, education, research, advisory, regulatory or policy development roles.' See: www.oho.qld.gov.au/immediate-registration-action-taken-against-mr-yogeshkumar-m-patel.

³²⁵ Recommendation 2.

³²⁶ Recommendation 3.

³²⁷ Recommendation 7.

³²⁸ Recommendation 9.

³²⁹ *Kozanoglu v Pharmacy Board of Australia* [2012] VSCA 295 at [127].

My impression, confirmed by some members of local Board committees, is that some committees may be overly influenced by risk-averse legal advice and concern to impose the 'minimum regulatory force' or least restrictive intervention, without sufficient regard to the need for the intervention to be adequate to protect the public. I also heard from Board committee members concerned that their decision be appeal-proof.

In a regulatory scheme with appeal mechanisms, it is inevitable that tribunals and courts will sometimes form a different view of what is a necessary and proportionate intervention to manage risk to patients. Board committees will naturally be influenced by precedents from tribunals in their state or territory. However, their focus should be on their responsibility to protect the public rather than on the risk of being overturned on appeal.

I recommend that AHPRA revise and update the *Guide to Decision-Making: Immediate Action* (December 2012), to provide clearer guidance to National Boards on relevant factors in the exercise of immediate action powers and on the appropriate level of intervention,³³⁰ along the lines of the guidance issued by the GMC and the MPTS in the UK.

The MBA needs to ensure that the practice of its delegates is consistent. I recommend that the MBA develop highly specialised delegated decision-makers for regulatory decision-making about sexual misconduct cases.³³¹ Consideration should also be given to the membership of IACs, to ensure that some members experienced in immediate action decision-making sit at each hearing.³³² The MBA should undertake an audit of all sexual misconduct immediate action decisions, to ensure they are adequately protecting the public.³³³

Given the impact on practitioners and health services of the use of more restrictive interventions, and the need to continue to assess risk to the patients and the public, it is important that the continued appropriateness of all interim restrictions be regularly reviewed. All interim restrictions and suspensions should be reviewed at least every six months and earlier if there are

triggers for review, such as the laying of criminal charges, committal to stand trial or convictions.³³⁴ There should also be much lower tolerance for breaches of chaperone conditions, which should trigger a further immediate action process and consideration of the need to suspend the practitioner.³³⁵

Better communication with police

A review in September 2016 of all active chaperone cases identified that AHPRA's interaction with the criminal justice system is variable. There is a lack of clarity about whether AHPRA contacts the police or relies on the notifier to do so. Work currently under way to clarify when and how police are notified of allegations of indecent or sexual assault, and to ensure good communication and information sharing between AHPRA and police, should be progressed.³³⁶ It is important that AHPRA be kept aware of developments in police investigations and that relevant events (eg, laying charges or committal) are triggers for reviewing risk and the need for immediate action. I recommend that AHPRA develop procedural guidance to clarify when staff should notify police and progress work, including possible MOUs with police, to ensure good communication and information sharing between AHPRA and police.³³⁷

Chaperones in exceptional cases

If mandated chaperones do continue to be used as an interim restriction, they should be imposed only in exceptional cases, subject to the limits set out below.

This review does not start from a blank slate. Even if chaperone conditions are no longer to be imposed by National Boards as a result of policy decisions following this review, there will continue to be a number of health practitioners subject to such conditions as a result of Board, tribunal and court decisions – and they will need to be monitored. Furthermore, tribunals and courts, and health regulatory entities in the co-regulatory jurisdictions of NSW and Queensland may continue to impose chaperone conditions as an interim measure.

330 Recommendation 4. The current guidance contains vague statements such as that AHPRA staff should present a notification to an IAC for consideration of whether immediate action is necessary, in cases of 'sexual behaviour that could cause a risk to a specific segment of the community, eg female patients' (p 4).

331 Recommendation 5.

332 I note a similar recommendation by the NSW Health Care Complaints Commissioner in relation to the handling of s 150 hearing panels in NSW: NSW HCCC, 'Chaperone conditions in NSW: a review' (October 2016), p 2.

333 Recommendation 6.

334 Recommendation 9.

335 Recommendation 28.

336 A draft Operational Policy, *Disclosure of information to police where allegations of a criminal nature are made* was prepared in October 2016. The Victorian office of AHPRA is in discussion with Victoria Police about these issues.

337 Recommendation 8.

Thus, I have considered what limits should be set if chaperone conditions do continue to be imposed by National Boards in the future. In my opinion, to protect patients and in the public interest, chaperone conditions should only be considered in response 'lower level' allegations of sexual misconduct, ie 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.³³⁸

In some cases chaperone conditions are simply inappropriate or minimally effective to reduce risk. Chaperone conditions should not be imposed in the context of (a) psychotherapeutic practice such as by psychiatrists (given the intrusive nature of a chaperone's presence); 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 (since most initiation of sexual contact by a practitioner occurs outside the consultation room).³³⁹

To be workable and able to be monitored, chaperone conditions should 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.³⁴⁰ In those exceptional cases where chaperone conditions are imposed, I recommend that the chaperone be described as a practice monitor, which is a more accurate description of the role.³⁴¹

Some current chaperone conditions limit the type of clinical examination that a practitioner may perform. It 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. If, at the interim stage, concerns about a practitioner are such that intimate examinations should not be permitted, a prohibition on all patient contact, gender-based prohibition or suspension should be imposed.³⁴²

Age-limited chaperone conditions are also inappropriate. Sexual predators may offend against a wide age range of victims. If there is thought to be a risk of sexual misconduct by a practitioner

towards female and/or male patients such that immediate action is warranted, any interim restriction should apply to the relevant gender/genders, without any age restriction.³⁴³

Information for patients

If the use of mandated chaperones as an interim restriction is to be continued, patients need to be properly informed about the need for a chaperone, in keeping with the level of trust and informed consent expected in the modern patient-practitioner relationship.³⁴⁴ The National Law may need to be amended 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.

How information is provided is also important. Patients need to be given the information about the need for a chaperone 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. The information should be provided by someone other than the doctor subject to the chaperone, such as a receptionist or the chaperone, who should be fully informed as to the reasons for the chaperone condition and properly trained.³⁴⁵ The patient should be asked to sign and date an acknowledgement of having been told of the chaperone requirement and agreeing to the chaperone's presence.³⁴⁶

Given the need for AHPRA to undertake random audits by telephone to check whether a mandated chaperone was present at a consultation, patients should be told that AHPRA may contact them in order to monitor compliance, and that any objection will be noted and notified to AHPRA.³⁴⁷

The limited information currently published on the public register is insufficient to inform patients and the public. This is of concern given the importance of transparency in the operation of the National Scheme. Prospective patients should not have to resort to Dr Google to find information about a doctor's previous disciplinary or criminal record for sexual misconduct, where that material is in the public domain. The register should include web

338 Recommendation 11.

339 Recommendation 12.

340 Recommendation 14.

341 Recommendation 15.

342 Recommendation 13(a).

343 Recommendation 13(b).

344 Recommendation 16.

345 Recommendation 17.

346 Recommendation 18.

347 Recommendation 19.

links to published disciplinary decisions and court rulings.³⁴⁸

Subject to implementation of these recommendations of better information for patients, the current requirement for a practice sign should be discontinued.³⁴⁹ It is inadequate to notify patients, and unfair to practitioners, in broadcasting the chaperone condition to patients in a health facility waiting for another (unchaperoned) practitioner.

Chaperone protocol and current practice

A number of additional changes are needed to the national *Chaperone protocol*. They include requiring the chaperone to be a registered health practitioner who is not an employee of the monitored practitioner and removing the option of a patient-nominated chaperone.³⁵⁰ A registered health practitioner brings obvious advantages to the role, including their clinical background, ethical obligations of confidentiality, and regulatory obligations under the National Law. Independence is important because of the difficulties of power imbalance when an employee is asked to report on an employer.

Chaperones must 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.³⁵¹ They should be fully briefed and trained in their role before they commence duty.³⁵² Only an informed and trained health practitioner can play the watchdog role envisaged by a practice monitor requirement. Again, the National Law may need to be amended to permit chaperones to be fully briefed about the need for a chaperone requirement.

Information sharing with employers and places of practice also needs to be improved, as highlighted by the case of Dr Andrew Churchyard. This will be enabled by pending changes to the National Law, discussed below. The chaperoned practitioner should not be permitted to practise until all practice locations are known and chaperones approved, briefed and trained.³⁵³

To ensure consistent oversight of compliance, the monitoring of chaperone conditions should be the

responsibility of a national specialist team within AHPRA, rather than being managed separately within each state and territory office.³⁵⁴

Regulatory principles and legislative reform

Terms of Reference 3 and 4 require me to consider whether any change is needed to the *Regulatory principles for the National Scheme*, and what (if any) legislative reform should be considered by Ministers to protect patients while allegations of sexual misconduct are investigated.

Although I have noted concerns about the way the *Regulatory principles* – in particular principle 6 about the use of ‘minimum regulatory force appropriate to manage the risk posed by [the practitioner’s] practice, to protect the public’ – I consider that the principles themselves do not need amendment. There is, however, a need for more guidance to IACs to ensure that they do not over-emphasise the use of ‘minimum regulatory force’ or least restrictive intervention, without sufficient regard to the need for the intervention to be adequate to protect the public. This should be addressed by the recommended revision and update of the *Guide to Decision-Making: Immediate Action* (December 2012); by more consistent legal advice from AHPRA staff; and by the recommended audit by the MBA of all sexual misconduct immediate action decisions by Board committees.

Reforms already approved

Health Ministers have already approved a suite of proposed reforms to the National Law,³⁵⁵ in response to recommendations of the Snowball review of the National Scheme in 2014 and advice from AHPRA.³⁵⁶ Some of the law changes will remedy problems noted during this review. The following changes are important and need to be progressed. I have made observations about the various changes afoot, but have not made specific recommendations.

Public interest test for immediate action

I support the proposed change to the section 156 test for immediate action, by adding the words from section 150 of the NSW statute, that

348 Recommendation 10.

349 Recommendation 21.

350 Recommendations 22, 23.

351 Recommendation 24.

352 Recommendation 25.

353 Recommendation 26.

354 Recommendation 27.

355 The so-called tranche 1 reforms, approved by Ministers in October 2016.

356 K Snowball. *Independent Review of the National Registration and Accreditation Scheme for health professions* (AHMAC, 2014).

immediate action must be taken if the National Board is satisfied that it is 'otherwise in the public interest' to do so.³⁵⁷ This wording recognises the need for immediate action in cases where 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. Equivalent wording has proved pivotal in the move to a stricter, precautionary approach by the GMC and Interim Orders Tribunal in the UK.

I consider it important for the public interest limb of the test for immediate action not to be qualified by the need to show necessity or appropriateness of the proposed action. No such qualification applies to the interim action public interest test in the UK or NSW. In practice, IACs, tribunals and courts will in any event take into account the necessity and appropriateness of proposed restrictions or suspension.

Notice to employers and practice locations

It is proposed that the definition of employer in sections 132 and 206 of the National Law be expanded to cover all forms of practice arrangement, including employment, self-employment, engagement under a contract for services, voluntary and honorary appointments. The aim is to enable a National Board to require information from a practitioner about all places of work; and to give notice of action taken against a practitioner, to people in positions of authority at all places where the practitioner works. This is critical to ensure the effective operation and monitoring of practice restrictions.

Review period for conditions on registration

Currently, where new conditions are imposed on the registration of a practitioner, the National Law does not provide a review period for the conditions. This is unsatisfactory for National Boards, practitioners and the public. It is proposed to amend sections 125 and 126 of the National Law, to clarify that a National Board may set a review period when exercising its powers to change a condition imposed on a practitioner or student. Such reviews would not be mandatory under the revised National Law. As noted above, I have recommended that all interim restrictions and suspensions be reviewed at least every six months, and earlier if there are triggers for review. It may be useful to consider whether the proposed

reforms should make reviews mandatory rather than discretionary.

Reforms for consideration

Health Ministers have approved scoping policy work on a second group of reforms to the National Law,³⁵⁸ in response to recommendations of the Snowball review and advice from AHPRA.³⁵⁹ I understand that this work is at an early stage. It will require policy development, consultation and Ministerial approval.

Four areas identified as areas of concern during this review merit consideration of the need for law changes, and are discussed below. One – information for patients and chaperones – appears likely to necessitate legislative amendment. Removal of the privilege against self-incrimination in health practitioner regulatory investigations, to enable speedier investigations, may also merit legislative change.

Information for patients and chaperones

The National Law may need to be amended 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. Unless disclosure to patients and chaperones is clearly authorised by statute, there will continue to be a gaping hole in the level of protection afforded to patients by chaperone conditions. This will be a contentious policy and legislative issue, but in my view the protection of the public must come before the interests of individual health practitioners.

More information on the national Register of practitioners

The first guiding principle of the National Scheme is that 'the scheme is to operate in a transparent, accountable, efficient, effective and fair way'.³⁶⁰ However, the national register currently contains less information than public registers in some other jurisdictions and does not reflect a commitment to transparency.

357 Health Practitioner Regulation National Law (NSW), s 150.

358 The so-called tranche 2 reforms, approved by Ministers in October 2016.

359 K Snowball, *Independent Review of the National Registration and Accreditation Scheme for health professions* (AHMAC, 2014): www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/68/The-Independent-Review-of-the-National-Registration-and-Accreditation-Scheme-for-health-professionals.

360 National Law, s 3(3)(a), emphasis added.

As noted by a UK expert:³⁶¹ 'Part of good regulation must be helping patients to protect themselves, by making it easy for them to check the register...'. I support comments made by Dr Joanna Flynn, Chair of the MBA, a decade ago:³⁶²

'The public has a right to know if there are conditions on a doctor's registration or if there have been serious disciplinary or criminal offences proven against a doctor. It's long overdue.'

I have noted elsewhere that restrictions on practice (with an explanation of the reasons) and full details of any disciplinary decisions that are not suppressed (with links to relevant decisions) should be available on the public register.³⁶³ 'Providing such information is an important way for regulators to be transparent and accountable to the public they are charged with protecting.'

Many health regulators internationally do no better job of publishing information on the register. However, some regulators do make it easier for members of the public to search a practitioner's history. It is refreshing to see the publication, with names, of immediate actions on a separate web page by the OHO in Queensland.³⁶⁴ In Ontario, the CPSO already provides full practitioner disciplinary history for each practitioner on its public register, and pending reforms may result in new transparency rules that require colleges to post more information on the register.³⁶⁵

Some registered health practitioners in Australia are subject to 'old' chaperone conditions imposed as a result of tribunal and court decisions finding serious sexual misconduct and offences. They include practising doctors who have been found guilty of shocking acts of sexual abuse – where, if a member of the public thought to do so, a search of Dr Google would reveal media reports of the disciplinary findings and offences. If chaperone conditions do continue to be imposed as an interim measure, subject to the greater patient disclosure requirements set out in this report, 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.

I recommend that the public register of health practitioners include web links to published disciplinary decisions and court rulings. This should not require legislative amendment.

Better communication with notifiers

The Snowball review included a specific recommendation that the National Law be amended so that 'notifiers personally impacted by practitioner conduct can be informed in confidence by the National Board about the process, decision and rationale for the decision regarding their case'.³⁶⁶ Notifiers who report being personally impacted 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'. Notifiers expressed concerns of this nature to me during the review.³⁶⁷

AHPRA continues to undertake work to improve 'notifier experience', which has been an area of focus for some time. It faces challenges, well summarised in a joint report with the Health Issues Centre:³⁶⁸

'to be a national body answerable to a group of Ministers and to be locally relevant and responsive; to develop better national consistency of approach and not to create bureaucratic bottlenecks in doing so; to uphold the public interest in protecting consumers and to be responsive to consumers who find themselves in a type of administrative legal process they don't expect or understand; to walk the line of fairness and responsiveness.'

Ensuring responsiveness and sensitivity to consumers is nowhere more important than in relation to allegations of sexual abuse by a health

361 J Stone. Regulation and its capacity to minimise abuse by professionals, ch 15 in F Subtosky et al. *Abuse of the doctor-patient relationship* (Royal College of Psychiatrists, 2010) p 182.

362 C Pirani, 'Fit to practise', *The Australian*, 26 August 2006.

363 R Paterson. *The good doctor: what patients want* (2012), p 125.

364 See www.oho.qld.gov.au/news-updates/immediate-actions. Such publication is consistent with the statutory objective of 'a transparent, accountable and fair system for effectively and expeditiously dealing with complaints...': Health Ombudsman Act 2013 (Qld), s 3(2).

365 Bill 87, Protecting Patients Act 2016 (Ontario): www.ontla.on.ca/web/bills/bills_detail.do?locale=en&Intranet=&BillID=4477.

366 Snowball review, recommendation 9(g).

367 I note in particular the powerful submission of Dr Sharon Monagle, mother of Tom Monagle, former patient of Dr Churchyard.

368 See, eg, *Setting things right: Improving the consumer experience of AHPRA including the joint notification process between AHPRA and OHSC – Final Report* (Health Issues Centre and AHPRA, 2014), p 9.

practitioner. To the extent that confidentiality provisions in the National Law are a barrier to keeping notifiers well informed as to progress in 'their case', law reform should be progressed. In the meantime, AHPRA should implement practice improvements to improve communication with notifiers who report sexual misconduct, in particular notifiers personally affected by practitioner conduct.

Removal of privilege against self-incrimination

Health practitioners may be unwilling to provide information or produce documents during investigations because statements they make or evidence they produce may be used against them in criminal proceedings. The fear of self-incrimination in a criminal investigation or trial was identified by some submitters as a contributory factor to delays in investigations of allegations of sexual misconduct.

The National Law affirms the privilege against self-incrimination (ie, an individual's entitlement to refuse to answer a question or produce a document if the answer or production might tend to incriminate that person) as a 'reasonable excuse' for failing to provide information, answer a question or produce a document during an investigation.³⁶⁹ However, the NSW statute specifically denies a health practitioner the right to refuse to answer a question or produce a document during an investigation, although if the individual objected at the time on the grounds of self-incrimination or was not warned that they could so object, information given in answer to questions 'is not admissible against the individual in criminal proceedings'.³⁷⁰ A similar, though milder version of the abrogation of the right to self-incrimination appears in the ACT National Law.³⁷¹

Inclusion of a provision in the National Law removing the entitlement to refuse to answer a question or produce a document if the answer or production might tend to incriminate the practitioner (while still preventing its use in criminal proceedings) would likely reduce delays in investigations and provide Board committees with important information to assess the need for and appropriate level of interim action. The practitioner could be interviewed by AHPRA investigators and would be required to respond, but have the

protection that any information and documents provided could not be used in the criminal proceedings.

The introduction of such a measure in the National Law may be insufficient to prevent tribunals granting a stay of the substantive disciplinary proceedings.³⁷² However, removing one key barrier to speedier investigations (even if the disciplinary proceedings are not heard until after a criminal process) would enable National Boards to be better placed to assess the need for and appropriate level of interim action.

I draw this issue to the attention of Health Ministers for consideration of the need for legislative amendment.

Other areas for improvement identified in review

A final area of concern was identified in some submissions in this review: the need for support for practitioners subject to a notification alleging sexual misconduct.

There are obviously limits to what AHPRA and the National Boards can do in this area. 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. This is an area highlighted in the recent Senate inquiry into the medical complaints process in Australia³⁷³ and will doubtless be further considered by the current Senate inquiry into the complaints mechanism administered under the National Law.³⁷⁴

There is more that colleges can do to support members in distress, but their ability to do so is constrained by the willingness of practitioners to reveal that they are in difficulty. In its submission, the Royal Australasian College of Surgeons suggested that a mentor could provide another layer of monitoring and could also support the practitioner, who may be experiencing significant mental, financial or physical distress while being the subject of an investigation. This is a good idea – but depends on practitioners being willing for information to be shared.

³⁶⁹ National Law, Sched 5, cl 2[3].

³⁷⁰ Health Practitioner Regulation National Law (NSW), s 164D.

³⁷¹ Health Practitioner Regulation National Law (ACT), Sched 5, cl 2[3],[4].

³⁷² In light of the High Court of Australia decision in *X7 v Australian Crime Commission* [2013] HCA 29.

³⁷³ Senate Community Affairs Reference Committee, Medical complaints process in Australia (November 2016): www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report.

³⁷⁴ Senate Community Affairs Reference Committee, 1 December 2016: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ComplaintsMechanism.

A confidential submission to the review noted that 'it is foreseeable that a medical practitioner charged [with] assault/sexual misconduct by the Police would be at risk of depression and self-harm or other impairment that would affect their judgement' and argued that the MBA owes the practitioner a 'moral duty'. In my experience, health regulators and health complaints entities are acutely sensitive to the impact of their decisions on affected practitioners. The timing, tone and mode of communication of potentially distressing information to a practitioner should always be given careful consideration.

National Boards should also be alert to the need to seek a psychological and/or physical health assessment of the affected practitioner. The US Federation of State Medical Boards guidelines on sexual misconduct note the importance of a comprehensive evaluation of the health of a practitioner,³⁷⁵ and the Medical Council of New Zealand uses a Sexual Misconduct Assessment Team (albeit post findings of sexual misconduct), to inform decisions about whether a doctor may safely return to practice.³⁷⁶

Finally, a predictable stressor for doctors accused of sexual misconduct, particularly those in private practice, is the likely effect on their income if they are required to practise subject to restrictions, or are suspended, while allegations are investigated. Medical defence organisations may wish to give consideration to introducing income protection policies for practitioners whose income is reduced during periods of restricted or suspended practice following allegations of sexual misconduct. Obviously such policies would not cover deliberate wrongdoing by the practitioner.

³⁷⁵ FSMB, *Addressing Sexual Boundaries: Guidelines for State Medical Boards* (2006) at pp 4-6.

³⁷⁶ MCNZ, *Guide for the Sexual Misconduct Assessment Team (SMAT) on assessment of doctors guilty of sexual misconduct* (2004).

Appendix A – Summary of submissions

A total of 45 submissions were received by the Office of the National Health Practitioner Ombudsman and Privacy Commissioner, in its role as secretariat for the review.

Nine of the submissions were received in confidence and have not been published. Two submitters requested that their names be withheld.

Submissions were received from:

1	ACT Health
2	Australasian College of Dermatologists
3	Australian and New Zealand College of Anaesthetists
4	Australian Dental Association
5	Australian Health Practitioner Regulation Agency Community Reference Group
6	Australian Medical Association
7	Australian Nursing and Midwifery Federation
8	Australian Society of Medical Imaging and Radiation Therapy
9	Avant Mutual Group Limited
10	Confidential (Friend of patient)
11	Confidential (Health department)
12	Confidential (Health practitioner)
13	Confidential (Health practitioner and patient)
14	Confidential (Health practitioner and patient)
15	Confidential (Health practitioners)
16	Confidential (Health service)
17	Confidential (Law firm)
18	Confidential (Regulatory body)
19	Consumers Health Forum of Australia
20	Department of Health and Human Services (Tasmania)
21	Department of Health (Northern Territory)
22	Dr Mark Hersch
23	Dr Susan MacCallum
24	Dr Al McKay
25	Dr Vern Madden
26	Dr Sharon Monagle
27	Dr David Ringelblum
28	Mr Brian (surname not provided)
29	Mr Alan Porter
30	Mr Brian Stafford
31	Ms Allison Bryant

32	Ms Kathie Collins
33	Ms Patricia Harper
34	Ms Beth Wilson
35	MDA National
36	Medical Insurance Group Australia
37	Name withheld (Daughter of patient)
38	Name withheld (Health practitioner and patient)
39	Office of the Health Ombudsman (Mr Leon Atkinson-MacEwen)
40	Office of the Health Services Commissioner (Dr Grant Davies)
41	Professor Anne Tonkin (Chair of the South Australian Board of the MBA)
42	Royal Australasian College of Physicians
43	Royal Australasian College of Surgeons
44	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
45	Royal Australian and New Zealand College of Psychiatrists

Appendix B – Summary of meetings

NATIONAL

Adelaide

1	AHPRA staff, including: <ul style="list-style-type: none"> National Director, Legal Services Senior Legal Advisor National Manager, Investigations Head of Performance Reporting Compliance team members
2	Professor Anne Tonkin (Chair of the South Australian Board of the MBA)

Brisbane

1	AHPRA staff, including: <ul style="list-style-type: none"> Queensland Director, Notifications Compliance team members Executive Officer, NRAS Review team
2	Doctors' Health Advisory Service Queensland
3	Dr John Wakefield
4	Health Consumers Queensland
5	Members of the Queensland Board of the MBA, including: <ul style="list-style-type: none"> Associate Professor Susan Young (Chair) Dr Susan O'Dwyer Ms Christine Gee
6	Office of the Health Ombudsman

Canberra

1	Australian Medical Association
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Melbourne

1	AHPRA Agency Management Committee
2	AHPRA staff, including: <ul style="list-style-type: none"> Chief Executive Officer Executive Director, Strategy and Policy National Director, Compliance State Manager, Victoria
3	Associate Professor Marie Bismark
4	Deloitte
5	Department of Health and Human Services, Victoria
6	Dr Andrew Mulcahy (Chair of the Tasmanian Board of the MBA) – by teleconference
7	Dr Sally Cockburn
8	Dr Peter Dohrmann (Chair of the Victorian Board of the MBA)
9	Dr Joanna Flynn (Chair of the MBA)
10	Dr Ian Freckleton QC

11	Dr Oliver van Hecke – by teleconference
12	Dr Sharon Monagle
13	Dr Katinka Morton
14	Dr Liz Mullins – by teleconference
15	Medical Board of Australia
16	Ms Maree Germech
17	Ms Beth Wilson
18	Ms Patricia Harper
19	Name withheld (health practitioner and patient)
20	Name withheld (patient) – by teleconference
21	Name withheld (patient)
22	Royal Australasian College of Surgeons – by teleconference
23	South Eastern Centre Against Sexual Assault

Discussion of the use of chaperones was facilitated at the following events in Melbourne:

- Consumer Forum hosted by the Health Issues Centre
- Australasian Association of Bioethics and Health Law Conference, and
- International Association of Medical Regulatory Authorities' 12th International Conference on Medical Regulation.

Sydney

1	AHPRA staff, including: <ul style="list-style-type: none"> Executive Director, Regulatory Operations National Director, Notifications
2	Avant Mutual Group Limited
3	Health Care Complaints Commission
4	Health Professional Councils Authority
5	Medical Council of New South Wales
6	Medical Insurance Group Australia
7	Name withheld (health practitioner)
8	Royal Australasian College of Physicians

INTERNATIONAL

New Zealand

1	Medical Council of New Zealand
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Canada

1	College of Physicians and Surgeons of British Columbia
2	College of Physicians and Surgeons of Ontario
3	Collège des médecins du Québec

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National Health Practitioner Ombudsman and Privacy Commissioner

nhpopc.gov.au

Australian Health Practitioner Regulation Agency

www.ahpra.gov.au

