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Three years on from the chaperone review, AHPRA celebrates changes to the regulatory landscape of sexual boundaries notifications

In 2017 Professor Ron Paterson delivered the *Independent review of the use of chaperones to protect patients in Australia* report (the **Chaperone Report**), which made 28 recommendations to AHPRA and the Medical Board of Australia (the **MBA**) for improving the handling of sexual boundary notifications in Australia.

Among other things, the Chaperone Report recommended that the use of mandated chaperones as an interim restriction in response to allegations of sexual misconduct be abandoned, and replaced by other immediate action conditions such as gender-based prohibitions or suspensions. The Chaperone Report also highlighted the need for expertise and training of the staff handling sexual misconduct cases, and recommended the development of highly specialised investigators and delegated decision-makers for regulatory decision-making about sexual misconduct cases.

Three years on, AHPRA and the MBA have recently published Professor Paterson's review report (the **Review Report**), which revisits each of the original recommendations and assesses the regulatory and administrative changes that have been made since then. The Review Report also considers whether more could be done to improve the management of sexual misconduct notifications in Australia. (The Review Report is available to read in full here).

By way of a summary statement, the Review Report makes an overall finding that "changes made by AHPRA and the MBA, in response to the chaperone review report have been wide and deep."[1] Nearly all 28 recommendations have been fully implemented, resulting in significant changes in regulatory practice in this area. Without attempting to canvas the full breadth of the findings and recommendations, there are several key points which are likely to be of particular interest to health practitioners and medical defence organisations alike:

[1] *Three years on: changes in regulatory practice since 'Independent review of the use of chaperones to protect patients in Australia',* May 2020, page 6.

Abandonment of chaperones in favour of gender-based restrictions and suspensions

The Review Report notes that the most remarkable impact of the recommendations has been the "abandonment of the use of mandated chaperones."[2] Where a sexual misconduct allegation triggers the MBA or another National Board to reasonably believe there is need for immediate action to protect public health or safety, or in the public interest, the regulatory tools most often used are now gender-based prohibitions or suspensions. In particular, there has been a significant increase in the number and proportion of suspensions implemented as a result of immediate action proceedings, with the Review Report citing that 43% of immediate actions were suspensions in 2018-19, compared with 6% in 2015-16, 32% in 2016-17 and 31% in 2017-18.

However, the Review Report also raises concerns that the shift away from using chaperones has not permeated the decision-making of some tribunals. Citing several decisions wherein tribunals continued to countenance the use of a chaperone condition as an adequate risk mitigation strategy, Professor Paterson comments that "judicial officers may not yet have grasped what an Ontario Court of Appeal judge has referred to as 'the shift that has taken place in society's understanding of the consequences of physician sexual abuse and its tolerance for such behaviour.'"[3]

Establishment of the Sexual Boundaries Notification Committee

In July 2017, a single delegate committee of the MBA was established to handle allegations of sexual boundaries violations in an attempt make decision-making in this area more consistent.

The Review Report credits the establishment of the Sexual Boundaries Notifications Committee (the **SBNC**) with the improvement in consistent decision-making, noting that in 2018-19 immediate action was not taken after being proposed in only 11% of cases, compared with 43% of cases in 2017/18.[4] In an audit of SBNC decisions over the past 6 months, the Immediate Action Committee also accepted the recommendations from AHPRA in 15 out of 23 cases.[5]

The establishment of the SBNC has coincided with a new focus on developing AHPRA staff understanding about the complexities of handling sexual boundary notifications, and building expertise through specialised training. AHPRA has invested in educational seminars and materials, drawing on resources such as those available from Victoria Police, and including a three-day 'Sexual Boundaries Investigations Training' course which is offered to staff every six months.[6]

[2] Ibid, page 6.
[3] Ibid, page 7 – 8.
[4] Ibid, page 8.
[5] Ibid.
[6] Ibid, page 9.

Increased number of immediate action decisions and six monthly reviews of interim restrictions

The Review Report notes that AHPRA has developed a regulatory risk assessment tool, which takes into account the characteristics of a notification, the practice, the practitioner and the practice setting, and uses these characteristics to assign the notification a risk rating.[7] Alleged boundary violations are presumed to be high-risk and assigned a 'red flag', which means that they are escalated to a team leader as soon as practicable for further review and consideration of referral to the Immediate Action team. Perhaps not unexpectedly, there has been an increase number of immediate action decisions in sexual boundary matters since the Chaperone Report, noting that the MBA took immediate action 31 times in 2018/19 compared with 20 times in 2017/18.[8]

AHPRA has also introduced more rigorous compliance monitoring of conditions, and six-monthly reviews of all interim restrictions and suspensions. As part of this review, it considers the need for immediate action or further/alternative restrictions to ensure that the risk to patients and the public is appropriately reassessed.[9]

Call for emboldened use of the "public interest" immediate action power

Several weeks ago, Meridian Lawyers published a Health Insight exploring the relatively new "public interest" immediate action power under the National Law (if you missed that article, you can find it here). The new power came into effect in 2018, and enables the National Boards to take action against health practitioners in circumstances where they hold a reasonable belief that the immediate action is otherwise in the public interest.[10]

The Review Report states that the "SBNC has been grappling with the application of the new 'public interest' ground"[11], noting that jurisprudence is still emerging in this area, however Professor Paterson calls for emboldened exercise of the "public protective function[12]". In his view, Immediate Action Committees should "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.'

To support his view, Professor Paterson refers to Policy Direction 2019-1 issued by the Chair of the COAG Health Council which requires:

> *…National Boards and AHPRA, when determining whether it is necessary for regulatory action to be taken, to take into account 'the potential impact of the practitioner's conduct on the public' and 'the extent to which deterring other practitioners from participating in similar conduct would support the protection of the public and engender confidence in the regulated profession'. In considering whether the practitioner's conduct amounts to unprofessional conduct or professional misconduct, National Boards*

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[7] Ibid, page 11.
[8] Ibid, page 10.
[9] Ibid, page13.
[10] Section 156(1)(e) Health Practitioner Regulation National Law
[11] *Three years on: changes in regulatory practice since 'Independent review of the use of chaperones to protect patients in Australia',* May 2020, page 13.
[12] Ibid, page 14.

> *and AHPRA 'must give at least as much weight to the expectations of the public as well as professional peers', with regards to expected standards of practice by the registered practitioner.*[13]

The effect of Policy Direction 2019-1, according to Professor Paterson, is to signal a clear intention that National Boards and AHPRA should place greater emphasis on community expectations and the need to maintain public confidence in the regulated professions, when determining the need for immediate action, and the appropriate level of restriction, in cases of alleged sexual[14] misconduct. He states:

> *In combination with the new public interest ground for immediate action it is reasonable to predict that National Boards will in future be less inclined to impost the minimum regulatory intervention – and that over time, public protection will be enhanced.*[15]

Professional guidance required for physical examinations

In December 2018, the Medical Board of Australia released new professional boundaries guidelines titled *Guidelines: Sexual Boundaries in the doctor-patient relationship* (the **Guidelines**). The Guidelines include a breakdown of the spectrum of behaviours considered to breach sexual boundaries, from making unnecessary comments about a patient's body or clothing, to sexual assault[16].

One particularly important inclusion on the spectrum, is the act of conducting a physical examination which is not clinically indicated or when the patient has not consented to it.[17] The Guidelines emphasise that unwarranted physical examinations or inappropriate touching during a consultation and examination may constitute sexual assault, and that AHPRA will advise and support notifiers to report criminal behaviour to the police.[18]

The Review Report identifies physical examinations as an area of difficulty in sexual boundary cases, in terms of assessing whether the examination in question was clinically necessary and simply not well explained in advance, leaving a patient feeling uncomfortable.

An audit of SBNC matters conducted for the preparation of the Report, found that there has been a significant increase in notifications involving physical examinations, and in particular, around the use of a stethoscope – there were five such notifications in 2017, which had risen to 14 in 2019.

The Review Report recommends that further education for health practitioners is required in this area, including case studies and guidance on good communication around physical examinations. It also identifies a broader

[13] Ibid, page 15.
[14] Ibid.
[15] Ibid.
[16] *Guidelines: Sexual Boundaries in the doctor-patient relationship,* guideline 3.
[17] Ibid, guideline 3.1.
[18] Ibid, guideline 3.

issue for the community in improving health literacy, including why health practitioners may need to undertake physical examinations.[19]

Comments

Meridian Lawyers has seen a trend in the frequency and type of notifications involving misunderstandings around physical examinations. These notifications are incredibly stressful for the practitioners involved, because they are handled by the SBNC and therefore managed under the umbrella of the full spectrum of sexual boundaries violations.

In our experience, a prosecuting health authority, such as the Health Care Complaints Commission in NSW and the Medical Board of Australia in Victoria, will not itself make a determination whether alleged sexual or inappropriate conduct occurred, and will prosecute the health practitioner before the Tribunal so that the evidence of the patient and practitioner can be tested and credibility assessed. This of course escalates the stress, time and effort for the practitioner in defending such allegations.

It is clear from the Review Report that a crucial risk-management tool for health practitioners, as well as only conducting clinically justified examinations, is a proper understanding and implementation of the informed consent process.

Meridian Lawyers can assist you to understand your professional obligations, including any aspect of the *Guidelines: Sexual boundaries in the doctor-patient relationship*.

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[19] *Three years on: changes in regulatory practice since 'Independent review of the use of chaperones to protect patients in Australia',* May 2020, page 28.