

29 March 2018

Dr Jo Katsouris
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Via email medboardconsultation@ahpra.gov.au

Dear Dr Katsouris

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MIGA feedback – Sexual boundaries in the doctor-patient relationship

MIGA appreciates the opportunity to provide feedback on the Medical Board of Australia's draft revised guidelines on sexual boundaries in the doctor-patient relationship (**the guidelines**).

This follows its earlier feedback on the initial draft version of the guidelines in 2011.

MIGA's perspective on the issues raised by the guidelines is not limited to its role in advising and assisting its medical practitioner and medical student members. In recent years, it has run interactive seminars across Australia on professional boundaries, covering inappropriate practices within consultation and sexual relationships with patients. More recently, it contributed to both the independent review of the use of chaperones to protect patients by Prof Ron Paterson, and to the COAG Health Council consultation on treating practitioner mandatory reporting.

MIGA's feedback on specific aspects of the guidelines are included in the attached, marked-up version of the guidelines with embedded comments.

MIGA is generally supportive of the proposed revision of the guidelines. Its feedback is mostly around issues for clarification. Key issues it raises include:

- Use of multiple terms to describe sexual boundary breaches, such as 'sexual misconduct' and 'sexual exploitation or abuse' – the better approach is to use a defined term 'sexual boundary breaches', which better reflects the context and terminology of the guidelines
- Uncertainties around whether 'patient' refers to current and / or former patients - more explicit references to current or former patients are warranted at several points
- Conflating concepts of consent and informed consent – the references should be to consent only
- Applying recommendations from the Paterson review around observers being registered nurses – these recommendations were limited to the context of interim practice conditions following allegations of inappropriate conduct, and should not be extended to situations where a doctor or patient choose to use an observer of their own volition.

If you have any questions or would like to discuss, please contact Timothy Bowen, [REDACTED] or email [REDACTED]

Yours sincerely



Timothy Bowen
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MIGA feedback – March 2018

Medical Board of Australia

Guidelines: Sexual boundaries in the doctor-patient relationship

[Effective Date]

Summary

Good medical practice involves *'never using your professional relationship to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient such as their carer, guardian or spouse or the parent of a child patient'*.¹

Sexual misconduct boundary breaches are is an abuse of the doctor-patient relationship.² ~~It~~ ~~They~~ undermines the trust and confidence of patients in their doctors and of the community in the medical profession. ~~They~~ ~~It~~ can cause significant and lasting harm to patients.

These guidelines aim to provide guidance to doctors about establishing and maintaining sexual boundaries in the doctor-patient relationship. These guidelines complement *'Good medical practice: A code of conduct for doctors in Australia'* (*Good medical practice*). *Good medical practice* describes what the Board expects of all doctors who are registered to practise medicine in Australia.

Doctors who breach these guidelines are placing their registration at risk and in some cases could also be committing a criminal offence.

- Sexual misconduct boundary breaches are is an abuse of the doctor-patient relationship and can cause significant and lasting harm to patients.
- It is never appropriate for a doctor to engage in a sexual relationship with a current patient, and may be unethical and unprofessional to engage in such a relationship with a former patient.
- A doctor must only conduct a physical examination of a patient when it is clinically indicated and with the patient's informed consent.
- Good, clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship.
- Doctors are responsible for maintaining professional boundaries in the doctor-patient relationship.

Comment [TB2]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB3]: See comment in MIGA's letter about interchanging use of 'patient', 'current patient' and 'former patient'. For this use, suggest amending as proposed to more clearly represent the guidelines.

Comment [TB1]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB4]: This conflates the concepts of 'consent' and 'informed consent'. It may create confusion around what is legally required, which is consent only, and what is appropriate professional practice or discharge of a duty of care, which is informed consent. Propose changing 'informed consent' to 'consent'.

¹ Medical Board of Australia, *Good medical practice: A code of conduct for doctors in Australia*, (as revised from time to time).

² Doctor/s means registered medical practitioner/s.

Sexual boundaries in the doctor-patient relationship

1 The foundation of the doctor-patient relationship

1.1 Trust

Trust in the relationship between doctors and patients is a cornerstone of good medical practice. ~~Sexual misconduct boundary breaches are~~ a flagrant abuse of that trust. Patients have a right to feel safe when they are consulting a doctor.

Patients need to trust that their doctor will act in their best interests, treat them professionally, not breach their privacy and never take advantage of them. Exploitation of the doctor-patient relationship undermines the trust that patients have in their doctors and the community has in the profession. It can cause profound psychological harm to patients and compromise their medical care.

1.2 Good communication

Good, clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship. Good medical practice includes:

- listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences
- informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment
- trying to confirm that your patient understands what you have said
- responding to patients' questions and keeping them informed about their clinical progress.

2 Why breaching sexual boundaries is unethical and harmful

Doctors are expected to act in their patient's best interests and not use their position of power and trust to exploit patients physically or sexually. Breaching sexual boundaries is always unethical and ~~usually can be~~ harmful for many reasons including:

- **Power imbalance:** The doctor-patient relationship is inherently unequal. The patient is often vulnerable and in some clinical situations may depend emotionally on the doctor. To receive health care, patients are required to reveal information that they would not reveal to anyone else and may need to allow a doctor to conduct a physical examination. For a doctor to ~~engage in sexualised behaviour~~ **engage in a sexual boundary breach** with a patient exploits this power imbalance.
- **Trust:** Patients place trust in their doctor. They have a right to expect that examinations and treatment will only be undertaken in their best interests and never for an ulterior, sexual motive.
- **Safety:** Patients subjected to ~~sexualised behaviour~~ **sexual boundary breaches** from their doctor may suffer emotional and physical harm.
- **Quality:** A doctor who ~~engages in sexual boundary breaches~~ **sexualises patients** is likely to lose the independence and objectivity needed to provide them with good quality health care.
- **Public confidence:** Members of the community should never be deterred from seeking medical care, permitting intimate examinations or sharing deeply personal information, because they fear ~~sexual boundary breaches~~ **potential abuse**.

3 Breaches of sexual boundaries (spectrum of behaviours)

There is a wide range of behaviours that breach sexual boundaries, from making ~~unnecessary inappropriate~~ comments about a patient's body or clothing to criminal behaviour such as sexual assault. Unnecessary physical examinations or ~~inappropriate~~ touching during a consultation and examinations without ~~informed consent~~ **can be a** criminal offence. AHPRA will advise and support notifiers³ to report criminal behaviour to the police.

3.1 Spectrum of behaviours

Breaches of sexual boundaries ~~can include:~~

³ Notifier/s means a person who has made a notification (complaint) to AHPRA about the alleged conduct of a health practitioner.

Comment [TB7]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB5]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB8]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB9]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB10]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB11]: Use of the broad term 'unnecessary' may cause confusion, whereas the term 'inappropriate' focuses on what is required for clinical care.

Comment [TB12]: There are a range of human 'touchings', such as handshaking, which occurs without consent and which is normal. Patients can also initiate physical contact without warning, such as hugging a doctor or reaching for their hand to hold, which of itself does not mean the doctor has done anything wrong. Suggest changing 'touching' to 'inappropriate touching'.

Comment [TB13]: This conflates the concepts of 'consent' and 'informed consent'. Lack of consent can be a criminal offence, but not lack of informed consent.

Comment [TB14]: Although many cases where there is no consent would constitute a criminal offence, it cannot be said all cases would and it would be better to reflect this reality.

Comment [TB15]: Inclusion of 'can' is designed to address issues around when the examples given may be breaches for a current patient, but not necessarily for a former patient, as otherwise it could be inconsistent with section 5 of the guidelines.

Comment [TB6]: A neutral term would be better in the context of guidelines

- engaging or seeking to engage in a sexual relationship with a **current patient** regardless of whether the doctor believes the patient consented to the sexual relationship
- conducting a physical examination which is not clinically indicated or when the patient has not consented to it. An unnecessary physical examination may constitute sexual assault **or abuse**.
- sexualised behaviours, meaning, any behaviour of a sexual nature that also includes:
 - making sexual remarks
 - flirtatious behaviour
 - touching patients in a sexual way
 - engaging in sexual behaviour in front of a patient
 - using words or acting in a way that might reasonably be interpreted as being designed or intended to arouse or gratify sexual desire
- asking a patient about their sexual history or preferences, when these are not relevant to **why the patient is seeing the doctor the patient's clinical issue**
- sexual exploitation or abuse⁴
- sexual harassment⁵
- sexual assault.

3.2 Other behaviours that may breach sexual boundaries

Other behaviours that may breach sexual boundaries include:

- asking a patient to undress more than is necessary or providing inadequate privacy screening or cover for a physical examination
- engaging in sexualised behaviour with an individual who is close to a patient under the doctor's care, such as a patient's carer, guardian, spouse, family member or the parent of a child patient.
- engaging in sexualised behaviour with a former patient.

⁴ See 'Definitions' in these guidelines.

⁵ See 'Definitions' in these guidelines.

4 Guidance on maintaining sexual boundaries with current patients

Doctors are responsible for establishing and maintaining sexual boundaries with their patients, regardless of their patient's behaviour.

A **current patient** cannot give their informed consent to a sexual relationship with their doctor because of the power imbalance in the doctor-patient relationship and their reliance on the doctor for their health care. **Patient eConsent by a current patient** is never a valid reason for doctors to engage in **sexualised behaviour/sexual boundary breaches**.

The start of a sexual relationship between a doctor and a patient may not always be immediately obvious to either the doctor or patient. Doctors need to be alert to warning signs that could indicate that boundaries are being, or are about to be crossed.

Possible warning signs include but are not limited to:

- patients requesting or receiving non-urgent appointments at unusual hours or locations, especially when other staff are not present
- patients asking personal questions, using sexually explicit language or being overly affectionate
- patients attempting to give expensive gifts
- patients and doctors inviting each other out socially
- a doctor revealing to a patient intimate details of their life, especially personal crises or sexual desires or practices
- a doctor who finds themselves daydreaming or fantasising about a patient.

If a doctor senses any of these warning signs, or if a patient talks about or displays inappropriate feelings towards a doctor or exhibits sexualised behaviour, the doctor should consider whether this is interfering with the patient's care and/or placing the doctor **and / or** the patient at risk. In these situations, the doctor should try to constructively re-establish professional boundaries and seek advice from an experienced and trusted colleague **and / or** their **medical defence organisation / professional indemnity insurer** about how to best manage the situation.

If there is a possibility that sexual boundaries could be breached, or that the doctor may not

Comment [TB16]: See comment in MIGA's letter about interchanging use of 'patient', 'current patient' and 'former patient' – it should be current patient here, recognising what is set out in sections 3.2 and 5 of the guidelines.

Comment [TB19]: See comment in MIGA's letter about interchanging use of 'patient', 'current patient' and 'former patient' – it should be current patient here, recognising what is set out in section 5 of the guidelines.

Comment [TB17]: 'Abuse' is more commonly used around repeated behaviours. Equating unnecessary examination with possible sexual assault is sufficient.

Comment [TB20]: See comment in MIGA's letter about interchanging use of 'patient', 'current patient' and 'former patient' – it should be current patient here, recognising what is set out in section 5 of the guidelines.

Comment [TB21]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB22]: Given some of the examples could have less concerning explanations, such as patients asking personal questions, it would be better to indicate these are possible, not actual, warning signs.

Comment [TB18]: This phrase better addresses the context of history-taking from a patient, dealing with the situation of where a question may need to be asked, but given later investigation and subsequent diagnosis the question is no longer relevant to the ultimate clinical issue.

Comment [TB23]: Use of 'or' only may cause confusion

Comment [TB24]: In various circumstances it will often be best to seek both perspectives. Adding terminology reflect the language of the medical profession.

remain objective, the doctor should transfer the patient's care to another doctor. It be may a doctor feels a transfer of care is appropriate given a patient's behaviour, even though the doctor considers they themselves can remain objective. This should be done sensitively so that a potentially vulnerable patient is not further harmed. If necessary, there should also be an appropriate handover of care to the new doctor.

5 Guidance on maintaining sexual boundaries with former patients

It may be unethical and unprofessional for a doctor to engage in sexualised behaviour/sexual boundary breaches with a former patient, if this breaches the trust the patient placed in the doctor. Doctors should recognise the influence they have had on patients and that a power imbalance could continue long after the professional relationship has ended.

A doctor should consider carefully whether they could be exploiting the trust, knowledge and dependence that developed during the doctor-patient relationship, before they decide whether or not to pursue or engage in a relationship with a former patient.

Doctors should also consider whether their field of practice or specialty has a position on sexual relationships or other sexual boundary violations with former patients.

If a doctor is considering a relationship with a former patient, they should consider seeking advice from:

- an experienced colleague/s
- their college / professional association; and / or
- their medical defence organisation / professional indemnity insurer

before initiating any steps towards such a relationship.

When deciding whether a doctor used the doctor-patient relationship to engage in or pursue an inappropriate relationship with a former patient, the Board will consider a range of factors including:

- the duration and type of care provided by the doctor; for example, if they had provided long-term emotional or psychological treatment, as contrasted with a time-limited or intermittent treating

relationship involving short term physical health issues only

- the degree of vulnerability of the patient
- the extent of the patient's dependence in the doctor-patient relationship
- the time elapsed since the end of the professional relationship
- the manner in which, and reason why, the professional relationship ended or was terminated
- the context in which the sexual relationship started.

6 Guidance on maintaining sexual boundaries with individuals close to the patient

A patient usually has a personal or emotional relationship with the individual⁶ involved or interested in their health care. This individual may provide them with support and advice. In some cases, such as when they are the parent of a child patient, they may make decisions on behalf of the patient about their health care. The individual close to the patient also relies on the doctor and trusts that the doctor is acting in the best interests of the patient.

Engaging in sexualised behaviour/sexual boundary breaches with an individual close to a patient may affect the judgement of both the doctor and the other individual and as a result, may undermine the patient's health care. A sexual relationship between a doctor and an individual close to the patient may be unethical if the doctor has used any power imbalance, knowledge or influence obtained as the patient's doctor to engage in the relationship.

When deciding whether a doctor used the doctor-patient relationship to engage in or pursue an inappropriate relationship with an individual close to the patient, the Board will consider a range of factors including:

- the duration and type of care provided by the doctor to the patient; for example, if they had provided long-term emotional or psychological treatment, as contrasted with a time-limited or intermittent treating relationship involving short term physical health issues only

⁶ An individual close to a patient includes a parent of a child patient, a spouse, carer, guardian or family member.

Comment [TB30]: Where a discretionary factor is given which uses an example of something more likely to be inappropriate, it is preferable to provide a contrast of something less likely to be inappropriate.

Comment [TB25]: This would provide comfort to doctors in situations where they are acting appropriately, but feel a transfer of care would be in the best interests of all involved.

Comment [TB26]: Reinforcing expected practice where there may be some confusion about what to do in these circumstances.

Comment [TB27]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

Comment [TB28]: This reflects the differing views between specialties given the nature of a treating relationship with a patient, such as in psychiatry. It also avoids potential issues around doctors considering the guidelines in isolation from relevant professional standards.

Comment [TB31]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion.

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Comment [TB29]: This is consistent with guidance around what to do if there are possible warning signs of a boundary violation, and provides the opportunity for objective input to a decision being made by a doctor before anything is done.

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Comment [TB32]: Where a discretionary factor is given which uses an example of something more likely to be inappropriate, it is preferable to provide a contrast of something less likely to be inappropriate.

- the degree of emotional dependence on the doctor by the individual close to the patient

- whether the doctor used any knowledge or influence obtained through their role as the patient's doctor to engage in a sexual relationship with the individual close to the patient

- the comparative seriousness of the patient's condition and its consequential effects on both the patient and the individual close to them, the importance of the patient's clinical treatment to the patient and to the individual close to them

- the extent to which the patient is reliant on the individual close to them.

- providing suitable covering during an examination so that the patient is covered as much as possible, to maintain their dignity

- using gloves when examining genitals or conducting internal examinations

- not allowing the patient to remain undressed for any longer than is needed for the examination

- obtaining the patient's permission if medical students or anyone else is to be present during an examination or consultation

- allowing a patient to bring a support person who may be a parent, carer, guardian, spouse, family member or friend.

Comment [TB33]: On one view, the current wording would mean any information obtained in that context, such as a person's name, could not be used. The provision should not apply to information which would normally be available outside a therapeutic relationship.

Comment [TB34]: The current wording is quite vague and may be challenging to interpret – the proposed wording is clearer.

7 Physical examinations

Doctors should only conduct a physical examination if it is clinically warranted. An unnecessary physical examination may constitute sexual assault. This includes conducting or allowing others, such as students, to conduct examinations on anaesthetised patients, when the patient has not given explicit consent for the examination and the involvement of others.

Before conducting a physical examination, good medical practice involves:

- explaining to the patient why the examination is necessary, what it involves and providing an opportunity for them to ask questions or to refuse the examination
- obtaining the patient's informed consent
- assessing whether a patient who is a child or young person is capable of giving informed consent and if they are not capable, seeking consent from their legal parent or guardian.

When conducting a physical examination, good medical practice involves:

- being aware of any sign the patient has withdrawn consent
- not continuing with an examination when consent is uncertain, has been refused or has been withdrawn
- allowing the patient to undress and dress in private. A doctor should not assist a patient to undress or dress unless the patient is having difficulty and asks for assistance

7.1 Use of observers

Patients may find intimate examinations stressful and embarrassing. The definition of an intimate examination⁷ depends on the patient's perspective, which may be affected by cultural values and beliefs. Intimate examinations usually include examination of the breasts, genitalia or an internal examination. Doctors should be sensitive and respectful of a patient's views when discussing the reasons for an intimate examination and should ensure the patient's comfort, dignity and privacy when conducting an intimate examination.

A doctor may choose to have an observer present during an intimate examination of a patient or in any consultation. The observer is essentially a witness to the consultation. Ideally it would be a registered nurse employed in the practice or alternatively another appropriate practice staff member. Generally a patient's family members or other person accompanying them to the consultation should only be used as an observer if there is no suitable practice member available. An observer can provide an account of the consultation if later there is an allegation of improper behaviour. Their presence may also provide a level of comfort for the patient.

A patient has the right to decline having an observer present. In that case, the doctor can proceed with the consultation without the observer, or choose not to proceed and instead help the patient to find another doctor. The patient has the right to ask to be accompanied by a support person of their choice.

Comment [TB35]: There is arguably no such concept as explicit consent – there is either consent or no consent, and use of 'explicit' may cause confusion.

Comment [TB36]: Informed consent is not a requirement, and the elements of informed consent are contained in the above paragraph. Use of the term informed consent could imply that there would need to be a discussion around potential risks of examination, which would not normally be expected professional practice.

Comment [TB37]: Assessment of capacity using Gillick competency or the mature minor test does not contemplate an assessment of whether a patient can give informed consent, only consent.

Comment [TB38]: The proposed wording essentially imposes a requirement or at least expectation that an observer be a registered nurse. This takes the recommendations of the Paterson review out of their context of allegations of inappropriate conduct against doctors, and applies them to any clinical practice. This is inappropriate and unwarranted. It is also impractical, particularly for many practices who would not have a registered nurse on staff.

⁷ See 'Definitions' in these guidelines.

8 Social media

The principles in *Good medical practice* apply to the use of social media as well as to face-to-face consultations with patients. The Board expects doctors to maintain professional boundaries when using social media to communicate with patients. Doctors must not use social media to pursue a sexual, exploitative or other inappropriate relationship with a [current patient, and such actions may also be inappropriate with a former patient](#).

If a patient tries to engage with a doctor through social media about matters outside the professional relationship, the doctor should politely decline to interact with them and direct them instead to the doctor's usual professional health care communication channels.

For more information, the Board's Social Media policy is accessible from www.medicalboard.gov.au.

9 Obligation to report allegations of sexual misconduct

The National Law requires registered health practitioners, employers and education providers to report 'notifiable conduct' to AHPRA (or the relevant authority in a co-regulatory jurisdiction), to prevent the public being placed at risk of harm⁸.

'Notifiable conduct' includes engaging in sexual misconduct in connection with the practice of the profession. This means engaging in sexual misconduct with individuals under a doctor's care or linked to a doctor's practice of their profession.

Mandatory notification requirements aim to prevent the public being placed at risk of harm. The law requires health practitioners to notify AHPRA (or the relevant authority in a co-regulatory jurisdiction) if they believe that another health practitioner has behaved in a way which presents a serious risk to the public. Health practitioners also have a professional and ethical obligation to protect and promote public health and safety, [which may in certain circumstances mean a - and may therefore](#)

⁸ There are some limited exceptions to the requirement of health practitioners to report 'notifiable conduct' in Western Australia and Queensland in certain circumstances. The requirement of education providers to make a mandatory notification relates to students and only applies where a student has an impairment that may place the public at substantial risk of harm. [See the Guidelines for Mandatory notifications for more information, available at \[www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx\]\(http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx\)](#)

[make a voluntary notification is appropriate. If facing such a situation, doctors should consider:](#)

- [relevant professional standards or ethical codes, and](#)
- [whether to consult an experienced colleague/s, their college or professional association and / or their medical defence organisation / professional indemnity insurer.](#)

For more information about the obligations of health practitioners, employers and education providers to report 'notifiable conduct', refer to the Board's *Guidelines for mandatory notifications* accessible from www.medicalboard.gov.au.

How will the Board use these guidelines?

Section 41 of the National Law states that an approved registration standard, or a code or guideline approved by the Board, is admissible as evidence of what constitutes appropriate professional conduct or practice of the profession, in proceedings against a registered health practitioner under this law or a law of a co-regulatory jurisdiction.

The Board or the relevant authority in a co-regulatory jurisdiction will investigate a doctor who is alleged to have breached these guidelines. If the allegations are substantiated, the Board or the relevant authority in a co-regulatory jurisdiction will take action to protect the public.

Definitions

AHPRA means the Australian Health Practitioner Regulation Agency.

Intimate examination means an examination that a patient or a member of the public may reasonably regard as intimate, which usually means examination of the breasts, genitals or an internal examination.

National Law means the Health Practitioner Regulation National Law as in force in each state and territory.

Sexual exploitation or abuse [Sexual boundary breaches](#) in the doctor-patient relationship means a doctor using the power imbalance, knowledge or influence developed in the doctor-patient relationship to abuse or exploit the patient's trust or vulnerability for sexual purposes or sexual

Comment [TB40]: The current wording is vague, potentially implying a broader professional obligation to make a voluntary notification which is not necessarily consistent with existing professional and ethical obligations. For example, the AMA Code of Ethics cl 3.1.10 indicates there are obligations to report suspected unethical or unprofessional conduct, which is different to what the current wording contemplates.

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Comment [TB39]: See comment in MIGA's letter about interchanging use of 'patient', 'current patient' and 'former patient' – it needs to be current patient here as otherwise it could potentially be inconsistent with sections 3.2 and 5 of the guidelines

Comment [TB41]: See comments in MIGA's letter about interchanging terms around 'sexual misconduct', 'sexual boundaries' and 'sexual exploitation or abuse', and need for consistent terminology to avoid confusion. The term 'sexual boundary breaches' appears most consistent with the concepts in the guidelines. Introducing an additional term of 'sexual exploitation or abuse' may cause confusion, and the current definition of this does not appear to correlate with how these terms are used in the community

gratification, including by conducting unnecessary physical examinations. It includes a range of behaviours which could be considered as sexual misconduct.

Guidelines for Gynaecological Examinations and Procedures, March 2016

Comment [TB42]: Recognising the language used in the Mandatory Reporting Guidelines, but acknowledging not all boundary breaches will necessarily constitute sexual misconduct.

Sexual harassment means any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. Sexual harassment is a type of sex discrimination and the *Sex Discrimination Act 1984 (Cth)* makes sexual harassment unlawful in some circumstances.

Sexual harassment includes:

- making an unsolicited demand or request for sexual favours, either directly or by implication
- irrelevant mention of a patient's or doctor's sexual practices, problems or orientation
- ridicule of a patient's sexual preferences or orientation
- comments about sexual history that are not relevant to the clinical issue
- requesting details of sexual history or sexual preferences not relevant to the clinical issue
- conversations about the sexual problems or fantasies of the doctor
- making suggestive comments about a patient's appearance or body
- sending sexually explicit emails or text messages
- making inappropriate advances on social media
- behaviour that may also be considered to be an offence under criminal law, such as physical assault, indecent exposure, stalking, obscene communications or sexual assault.⁹

Acknowledgements

The Board acknowledges the following documents, codes and guidelines, which informed the review of the Board's guidelines:

- Professor Ron Paterson, *Independent review of the use of chaperones to protect patients in Australia*, February 2017
- The Medical Council of New Zealand, *Sexual Boundaries in the doctor-patient relationship: A resource for doctors*, 2009
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists,

⁹ Definition adapted from the Australian Human Rights Commission definition of sexual harassment, <https://www.humanrights.gov.au/our-work/sex-discrimination/guides/sexual-harassment>, accessed 16 June 2016

Review

Date of effect: <date>

These guidelines will be reviewed from time to time as required. The Board will review these guidelines at least every five years.

These guidelines replace the guidelines that came into effect from 28 October 2011.

DRAFT

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