Submission to Medical Board of Australia

Sexual boundaries: A guide for doctors and patients

Personal submission of Dr Kerry Breen

General comments

I am not sure that it works well to try to combine a guide for patients with one for doctors. It might be better to write it for just doctors and then (a) mention that it could also be useful for patients and (b) add a less detailed addendum giving distressed patients information about sources of help and where to lodge complaints. At present the long list of sexual assault centres seems to unbalance the document. This list seems out of place in a regulatory guideline – but would be essential if it really were being written for the general community.

In its present state, the draft guide seems to fall part way between being an educational tool and being a bald regulatory statement. This needs to be resolved and I would favour a little more emphasis on education. The document will probably be used as an educational tool for medical students and young doctors. In the past, educators looking for authoritative and up to date material could examine the offerings of eight medical boards. In their absence, I suggest that there is a great onus on the Medical Board of Australia to use every opportunity to ensure that its guidelines have both a regulatory and an educational focus.

The guide seems to this reader to appear "out of thin air". While the link to the new Australian Code of Conduct is appropriate, links to the long tradition of the medical profession in this area and to similar guides issued in the recent past by state and territory Medical Boards are not mentioned. Perhaps this could be addressed by emphasising that this guide is updating and consolidating the work of the previous state and territory medical boards (and if true, is aligned with international standards).

There is mention early in the document of "managing sexual boundaries". I doubt that this is accurate as the document gives advice about prevention (especially of the commonest form of notification which is about sexually intrusive examinations) and not management.

The draft lacks any definition of sexual misconduct. I suggest that the guide needs such a definition and that this would be best placed ahead of the current Para 6. There is no single internationally accepted or recognised definition. I like the one developed by the Queensland Medical Board in 2000. It is reproduced on page 157 of our textbook Good Medical Practice: Professionalism, Ethics and Law, published by Cambridge University Press in 2010. You might be able to use this definition as a starting point and improve on it.

As patients may take their complaints to the police, to sexual assault centres, to health complaints commissions and even to medical colleges and the AMA, this aspect might need more attention should you decide that the document is truly intended for potential complainants.

Specific comments

Para 1 ***Introduction***: I suggest that the following version might more accurately describe what the document aims to do. "This guide (or these guidelines) explains the reasons why sexual boundaries must be respected and maintained by doctors, defines sexual misconduct and provides advice that may prevent some of the more common misunderstandings in clinical practice that can lead to allegations of boundary violations".

Para 2 ***Who needs to use these guidelines?***: This rhetorical question (and a response) is commonly found in many modern guidelines. I doubt that it is needed in Medical Board documents and I suggest that you think a little more about this.

Para 3 ***Summary of these guidelines***: In a relatively short document, it is probably not necessary to provide a summary. The present summary focuses just on sexual relationships, yet the full document has a lot to say about communication failure that can lead to misunderstandings and allegations of sexual misconduct. The material now in the summary would make a good first paragraph of the actual guidelines.

Para 4 ***Background:*** I am not sure that this is truly "background" material – rather it is core material. It might work better to omit mention of Section 4.1 of Good Medical Practice and instead use the more specific quote of Section 8.2 of the Code in an expanded introduction – thus making it clearer that this/these guide/guidelines is/are intended to expand on the Code.

Para 5 ***The patient-doctor relationship:*** This section at present combines information about some general aspects of the doctor –patient relationship with more specific information about why breaching sexual boundaries is ethically unacceptable. I suggest that this para be renamed "***Why breaching sexual boundaries is ethically unacceptable"*** and the para be redrafted to focus on this aspect. For this to work well, it needs to be preceded by a definition of sexual misconduct, as suggested above. In a redrafted para, I don't think the four sub-headings will be needed, although the existing content will be. Omitting the subheadings will help the "look" of the document. This is a really important section as there still exists a small percent of doctors who do not agree that all breaches are wrong and/or put patients at risk of harm. If these doctors ever came face to face with those patients who have been harmed, they might be convinced. As this is unlikely to happen, the document needs to somehow more strongly convey a sense of the past experiences of your predecessor state and territory medical boards about the harm that can be done (to patients primarily, but also to the medical profession generally).

Para 6 ***Maintaining boundaries***: The current version does not seem to flow logically. It mixes up the issues of poor communication and possible misinterpretation of intrusive physical examinations, the use of chaperones etc, with the separate issue of the doctor who enters into a sexual relationship with a patient. I suggest that the first six dot points could be moved to a later separate section, perhaps headed "***Professional standards for (or Good practice in) sexually intrusive physical examinations***". The current para 7 could more usefully form an introduction to this new section. I thus suggest that the existing para 6 would then focus more on the later five dot points of "should

nots". You might also consider bringing the later section (para 9) on "warning signs" up into this section.

Para 7 ***Effective communication***: See comment above.

Para 8 ***Former patients:*** This is important information. I think that (if you accept my earlier suggestions), this para might flow better if it immediately followed after "***Why breaching sexual boundaries is ethically unacceptable".*** If the existing dot points of para 8 are intended to reflect an order of importance, I suggest that the third dot point might be placed first.

Para 9 ***Warning signs:*** See suggestion above about relocation this para. I am not sure that the phrase "and can start easily" adds anything, so I suggest omitting it.

Para 10 ***Doctors – what to do if you notice warning signs***: This para will need to be relocated to follow Para 9 (if it is relocated). I also suggest some minor rewording as follows:

"If a doctor <u>senses</u> any of these warning signs or <u>senses that a patient may be developing</u> inappropriate feelings towards the doctor etc", and in the next sentence add "trusted and <u>appropriately experienced</u> colleague".

Para 11 ***Patients – what to do if boundaries are crossed***: The heading assumes that a breach has occurred – perhaps use "<u>may be being crossed</u>". I sense that this short section does not adequately address two different types of boundary violations. What is currently written might help a person who wonders if a physical examination was done for sexual purposes but it does not touch the surface of the issues for the person who has entered a sexual relationship with a treating doctor(eg with a trusted treating psychiatrist who has "brainwashed" the patient to accept that this is OK). As mentioned above under "General comments", you may want to rethink if it is the role of the Board to attempt to give detailed advice to patients. If you do decide to keep this focus, then you may want to add detail about how the Board handles any allegations (eg employing trained interviewers, hopefully of the same gender as the complainant, referring matters to misconduct inquiries etc).

Final comment

I suggest that you may wish to consider adding a paragraph about the responsibility of any doctor who becomes aware (via a patient) that a boundary violation may have taken place. In addition to the legal duty under the national law to report such an allegation, this section might want to also touch on additional advice. This could include advice to the doctor that it is not his/her task to try to assess the validity of any allegation. You might also want to touch on the reality (especially for psychiatrists) that in establishing sufficient trust with a second psychiatrist for the patient to have the courage to talk about abuse by a previous psychiatrist, it can be extremely difficult for the new psychiatrist to act in accord with the law, without destroying that newly won trust.

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