Physicians, Patients, Sex and Chaperones: Rethinking Medical Regulation

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Introduction

The regulation of sexual misconduct is a challenging area for medical boards. Complaints alleging sexual abuse should always sound alarm bells. They touch on deeply personal matters, the evidence is highly contested, patients are often traumatized, physicians are naturally defensive and boards know that their decisions may be contested and exposed to media scrutiny. Care, sensitivity and fairness in regulatory decision-making is essential.

One crucial challenge following allegations of sexual misconduct is deciding what, if any, interim action should be taken to protect patients and the public pending an investigation. Traditionally, medical boards have imposed chaperone conditions as an interim protective measure — permitting the physician to continue working, but with a condition on practice that should, in theory, protect patients. But some boards are now rethinking the traditional approach, and are instead imposing gender-based restrictions or suspension as interim protective measures.

How should boards balance protection of patients, fairness to individual physicians, and maintenance of public confidence in the medical profession and regulators, when handling such sensitive allegations? This paper examines "the forbidden zone" of sex with patients, notes recent research insights and describes contemporary context. Looking to Australia, it summarizes the findings of my 2017 report, "Independent Review of the Use of Chaperones to Protect Patients in Australia,"[1] and explains the rationale for my recommendations, adopted by the national health practitioner regulator, to abandon the use of chaperones and respond to an old problem in new ways.

The Forbidden Zone

For more than 2,000 years, it has been a fundamental tenet of medical ethics that physicians may not enter into sexual relationships with their patients. The Hippocratic Oath (circa 4th century BC) states that in their professional lives, physicians must abstain from "the seduction of females or males." There is no place for sex in the patient-physician relationship, either in the guise of a "consensual" sexual relationship, or in the form of sexualized comments or behavior, 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.[2]

There are several reasons for the strict prohibition on sex in the patient-physician relationship.[3] It is an abuse of the *trust* patients place in their physician; exploitation of the *power* imbalance between physician and patient; a *safety* issue, because patients subjected to sexual behavior in the course of therapy may suffer emotional and physical harm; a *quality* issue, because the physician's judgment and objectivity is clouded; and a *public confidence* issue, because it undermines confidence that a consultation is purely for assessment, diagnosis and treatment purposes.

Codes of ethics and professional guidelines have traditionally adopted a "zero tolerance" approach to sexual relationships with current patients, and have deprecated relationships with former patients,

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depending on the duration and nature of the prior professional relationship. Law and ethics set clear standards for informed consent to intimate examinations, and an examination without clinical justification is a sexual assault that may lead to criminal charges.

Unsurprisingly, however, a small minority of practitioners fall foul of professional guidance and even the criminal law. The medical community has its share of sexual predators. More common are misguided physicians who fall in love with their patients and clumsy physicians who fail to explain

the need for an intimate examination. Modern technology, with the ability to use social media to contact patients, also offers errant physicians more ways to breach professional boundaries.

Research Insights

New research offers insights into the characteristics of physicians who sexually abuse[4] patients. In the United States, DuBois et al., in an examination of 101 cases of sexual violations in medicine, found that the only highly consistent markers were male gender (100%), age > 39 (92%), not being board certified (72% of non-consensual sex cases) and examination of patients alone (85%) in non-academic settings (94%).[5] Alarmingly, 19% of cases of sodomy occurred with a chaperone, parent, nurse or other individual in the room with the patient-victim and physician.

Discipline for sexual misconduct across the United States is highly variable. A study of 1,039 U.S. physicians reported to the National Practitioner 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.[6]

In Australia, a recent landmark study of 1,507 reports of sexual misconduct to health practitioner boards between 2011 and 2016 found that 75% of reports involved medical practitioners, psychologists, chiropractors and osteopaths, who comprise only 22% of the registered health practitioner workforce.[7] The rate was higher for regional and rural than metropolitan practitioners, and 88% of complaints were about male practitioners.

Contemporary Context

Two phenomena are important contemporary context. Investigative journalism has brought to light the hidden problem of sexual abuse in the health professions. And, in the #MeToo era, the willingness of victims of sexual abuse to speak up and seek redress, and the success of high-profile prosecutions, has led to profound changes in how the public, professions and authorities recognize and respond to this issue.

In a series of articles in 2016, investigative journalists from the *Atlanta Journal-Constitution* reported that two-thirds of physicians disciplined for sexual misconduct in Georgia were allowed to return to practice.[8] The investigation widened to examine more than 100,000 medical board orders in 50 states relating to disciplinary action against physicians since 1999. The survey found that Georgia was not unusual, and that the system "too often protects doctors from accountability, leaving patients vulnerable."[9] The risk of multiple offending by a predatory physician was highlighted in the case of gymnastics sports physician Larry Nassar of Michigan State University.[10] The media spotlight prompted many medical boards to review their handling of such cases.

INVESTIGATIVE JOURNALISM HAS BROUGHT TO LIGHT THE HIDDEN PROBLEM OF SEXUAL ABUSE IN THE HEALTH PROFESSIONS.

Since 2017, following publicity about multiple sexual abuse allegations against film producer Harvey Weinstein, the #MeToo movement has gained a huge social media following around the world. There has been an unprecedented level of discussion in the print and social media about sexual abuse by individuals (predominantly male) in positions of power in the church, sports teams, the entertainment industry, workplaces and the health and legal professions.

Authorities have increasingly been willing to prosecute even historic cases of alleged abuse. In Australia, the Royal Commission into Institutional Responses to Child Sexual Abuse has had a major impact.[11] In a series of reports, the Commission highlighted the prevalence of myths about reporting of sexual abuse and weaknesses in the traditional responses of authorities and the criminal justice system to allegations of sexual abuse, and noted the importance of trauma-informed approaches to such cases.

These developments are all important context for recent major changes in the handling of sexual misconduct allegations by the Australian health practitioner regulation agency (Ahpra) and the Medical Board of Australia (MBA). As noted in my recent report: "The zeitgeist has changed, with victims more willing to speak up; recognition that sexual abuse by trusted professionals or people in positions of authority is less rare than previously assumed; intolerance of slow or ineffective responses by authorities to whom abuse is reported; increased sensitivity to the needs of victims; and growing

awareness that the handling, investigation and determination of allegations of sexual abuse requires specialized skills and training."[12]

Patients Speak Up in Australia

The catalyst for an independent review in Australia was media revelations that a neurologist accused of molesting a male patient, 19-year-old law student Tom Monagle, had been permitted to continue in practice for eight months, subject only to a condition that an approved chaperone be present for all consultations with male patients — even though criminal charges had been laid and another patient had made a similar complaint eight years previously, which had led to a caution.[13] The neurologist was only suspended following a new complaint from a patient who alleged he had been indecently assaulted behind a pulled curtain while a chaperone was present.

In August 2016, Mr. Monagle courageously told his story publicly.[14] News media ran a headline story, "Dozens of doctors being watched due to sexual misconduct allegations,"[15] and the Minister of Health in Victoria called for a national review of the use of chaperones for physicians accused of sexual misconduct.

Reviewing the Effectiveness and Appropriateness of Chaperones

I was commissioned by Ahpra and the MBA to review whether, in cases of alleged sexual misconduct, chaperone conditions are *effective* to protect patients and *appropriate* given the importance of trust and informed consent in the patient-physician relationship. I was also asked to recommend changes to regulatory practice and law in order to better protect patients and the public.

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It is important to distinguish two different types of chaperone patients may encounter during a consultation: a chaperone as an observer for the physician and a chaperone mandated as a condition of the physician's licence to practice. The *chaperone as observer for the physician* is present at the physician's request, and is essentially a witness to protect the physician in the event of an allegation of improper behavior. The use of a chaperone in this way is regarded internationally as good medical practice for intimate examinations, given the obvious potential for misunderstanding.

The *mandated chaperone* is present when 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 physician's practice. The requirement may follow alleged or proven sexual misconduct by the physician. It is intended to protect the patient from improper behavior. A patient cannot waive the presence of a mandated chaperone, since it is a condition of practice. If the patient doesn't want the chaperone present, she or he will have to find another physician.

Review Process

In undertaking my review, I researched the topic extensively and consulted widely. After a public call for submissions, 45 submissions were received from patients, health practitioners, colleges, medical-defense organizations, health-complaint entities[16] and regulators, state and territory health departments and other interested parties. I met with victims of sexual abuse by physicians, participated in a consumer focus group organized by the Health Issues Centre in Melbourne, and talked to chaperoned physicians, medical-defense organizations, colleges and medical board members.

In researching the practice of medical boards internationally, I sought the views of board leaders at a special session during an international conference on medical regulation in September 2016.[17] I also met with senior officials from medical boards from the General Medical Council (UK) and the Oregon Medical Board,[18] and visited the Colleges of Physicians and Surgeons in British Columbia and Ontario and the Medical Council of New Zealand.

Problems with Mandated Chaperones

Australia's use of mandated chaperones mirrored regulatory interventions by other international medical boards to protect patients pending a disciplinary investigation or criminal prosecution. Medical boards in the United States, Canada, the United Kingdom and New Zealand routinely impose a chaperone condition as an interim protection.

However, within Australia, patient and health-professional views had shifted. I heard widespread skepticism about the effectiveness and appropriateness of chaperone conditions. Discussions with members of the public indicated that many people were unclear what the term meant. People described it as a quaint, old-fashioned and paternalistic term that does not appropriately describe the reason why the physician is required to have an observer present. They expressed a preference for the term "practice monitor," which had been adopted by the College of Physicians and Surgeons of Ontario.

The concerns about mandated chaperones went beyond semantics. People noted that in practice, chaperone conditions are not wholly effective to prevent being exposed to harm and, in some cases, sexually assaulted. As an abused patient told the news media in New Zealand, after a physician was convicted of sexual offences against patients, even with a chaperone present, "It's trusting the wolf with the sheep."[19]

From a risk-reduction viewpoint, chaperone conditions seem logical. A closely observed practitioner is less likely to engage in inappropriate behavior. One imagines that for many practitioners, the shock of being subject to a notification will prevent any further sexual misconduct. But predatory physicians who have come to view patients as sexual objects may not be deterred by a safety mechanism that still leaves the physician in control. Sexualized behavior — which may be as subtle as the way a physician looks at a patient, or an intimate examination of dubious clinical necessity — may be undetectable by an observer.

Other problems with mandated chaperones were commonly reported. The chaperone is often a practice nurse or other employee, in a subservient relationship with the chaperoned physician who employs her. The chaperone is usually untrained and unaware of the specific conduct she is supposed to be watching out for. Realistically, the chaperone cannot be watching all the time. The upshot is a situation where a predatory physician can evade the scrutiny of the chaperone.

A significant proportion of alleged sexual misconduct involves physicians entering a sexual relationship with a patient. 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 the consultation room and often outside work hours. Such covert behavior is unlikely to be detected by a chaperone.

My conclusions about the limited effectiveness of mandated chaperones were matched by my findings about their appropriateness. Patients are left in the dark about why a chaperone is required — if they did know the reasons, many patients would look for another physician. An astute patient may suspect that the physician 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. 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 was unlikely to be noticed.[20]

The lack of information given to patients about the need and reasons for a mandated chaperone is the most significant flaw in the current system. 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 physician whose trustworthiness is at issue, a chaperone condition having been imposed because of alleged sexual misconduct. I concluded that the way the mandated chaperone system operated in Australia was far from transparent, contrary to one of the guiding principles of the national health practitioner regulatory scheme, that "the scheme is to operate in a *transparent*, accountable, efficient, effective and fair way."[21]

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Other reasons emerged to cast doubt on the appropriateness of mandated chaperones. Patients noted the intrusiveness of a chaperone, whose presence may alter the physician-patient interaction through a reduction of trust in the physician, an unwillingness to broach delicate issues or undertake intimate examinations, and the inhibition of subtle emotional cues in consultation. A mandated chaperone is likely to be particularly intrusive in any consultation with a psychotherapeutic element (e.g., with a psychiatrist), due to the highly personal and confidential nature of therapy.

Other less immediately obvious problems became apparent during my discussions in Australia. The use of chaperones as a protective measure is confined to the health sector; it is not used in other sectors or contexts, such as child care. Chaperones are generally used only in the private health system, in effect protecting a practitioner's income. 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 recognize their overriding duty of care to patients, and are sensitive to reputational harm if allegations are true.

My review also identified significant concerns about the complexity of monitoring compliance with chaperone conditions. As noted by a community member of an Australian national health practitioner board, the mandated chaperone system "puts a whole lot of effort into a mechanism that does not meet community expectations."[22]

Unsurprisingly, the medical profession expressed support for the continued use of mandated chaperones, while recognizing the need for consistent decision-making and strengthened monitoring. Medical-defense organizations stressed the importance of fairness: A practitioner is innocent until proven guilty, no less than an individual accused of committing an offense. The requirements of natural justice mean that practitioners must have a fair opportunity to answer the case against them. Individual physicians expressed concern about the reputational damage of having to practice with a chaperone where misconduct is alleged but not proven, since patients may surmise that something untoward has occurred. Some members of medical boards also worried that abandoning the use of chaperone conditions might ultimately expose patients to more risk by removing the least onerous restriction from the regulatory toolbox.

SINCE 2017, THE USE OF CHAPERONES AS AN INTERIM PROTECTIVE MEASURE HAS BEEN PHASED OUT IN AUSTRALIA. MANDATED CHAPERONES HAVE ALL BUT DISAPPEARED FROM THE REGULATORY LANDSCAPE.

Overall, I concluded that mandated chaperones didn't meet public expectations and didn't always work very well. The regulatory tool was no longer fit for purpose. My key findings were that:

- The term "chaperone" is outdated
- Mandated chaperones keep patients in the dark, not allowing informed consent
- Chaperones are inadequately informed and trained
- Chaperones are inappropriate in some situations, such as psychotherapeutic practice
- Chaperones are inapt to prevent "relationship" behavior
- Chaperone conditions do not guarantee that patients are protected from harm

Gender-based Restrictions Instead of Chaperones

The headline recommendation from my review was that the use of chaperones to protect patients — while allegations of sexual misconduct are investigated — be replaced by gender-based restrictions (GBRs) and suspensions, and that chaperones, re-named as "practice monitors," be imposed only in exceptional cases, in response to "lower level" allegations of sexual misconduct, where: (a) the allegation of sexual misconduct involves only a single patient; and (b) the allegation, if proven, would not constitute a criminal offense; and (c) the health practitioner has no relevant notification or complaint history.

While accepting the power imbalance inherent in the patient-physician relationship, I was not convinced by the argument that sex in the patient-physician relationship is simply about power. If a physician is accused of sexual abuse of a patient and there is a sufficient evidentiary base to take interim protective measures, in my view it makes sense to take account of the gender-based sexual preferences of the physician in imposing any restrictions.

Since 2017, the use of chaperones as an interim protective measure has been phased out in Australia. Mandated chaperones have all but disappeared from the regulatory landscape.[23] Even though practice monitors have been retained as a possible interim restriction for use in exceptional cases, the MBA has rarely imposed them. In cases where the MBA reasonably believes there is a need for immediate action to protect public health or safety, or in the public interest, a GBR or suspension is imposed more frequently. A few health practitioners have successfully appealed to tribunals and had a chaperone condition substituted as an interim restriction.[24] However, these cases are the exception.

Overall, there has been a dramatic change in regulatory practice in Australia.

Other jurisdictions have taken a different approach. A review of the handling of sexual misconduct allegations by health professional colleges in Ontario reached the opposite conclusion — that chaperone conditions be retained but GBRs never be used. A task force chaired by Canadian human rights lawyer Marilou McPhedran argued 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 "continues to place the public (or a segment of it) at risk for future abuse."[25] This approach led to a legislative ban in Ontario on the use of GBRs,[26] with chaperone conditions still permitted, provided that chaperones are required for consultations irrespective of the patient's gender.

In the United States, a mix of approaches is evident. Some medical boards, such as the Washington Medical Commission, have abandoned the use of chaperones in favor of gender restrictions. The recent Federation of State Medical Boards (FSMB) Report of the Workgroup on Physician Sexual Misconduct steers a middle path.[27] The report notes that "the use of board-mandated chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed." However, the report

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envisages the judicious use of approved, formally trained practice monitors (effectively mandated chaperones by another name), for situations "where there is insufficient evidence to remove a physician from practice altogether, but significant risk is believed to be present." The FSMB House of Delegates has adopted recommendations from the workgroup's report, for stronger approaches to sexual misconduct by physicians.[28]

Improved Handling of Sexual Misconduct Cases

In my 2017 report, I also made a series of recommendations to improve the handling of sexual misconduct cases in Australia, including that:

- Ahpra invest in specialist training for handling sexual misconduct cases and prioritize the investigation of allegations of sexual misconduct
- The MBA develop highly specialized delegated decision-makers for sexual misconduct cases
- Memoranda of understanding be entered with police, to ensure good communication and information sharing
- The public register of practitioners include web links to published disciplinary decisions and court rulings

Ahpra and the MBA accepted all my recommendations. Key changes have included creation of a new specialist committee of the MBA, the Sexual Boundaries Notifications Committee, to ensure consistent decision-making across Australia; significant investment in staff training in handling sexual boundary cases; new memoranda of understanding with police in several states and territories; and publication on the register of practitioners of links to disciplinary decisions by courts and tribunals when there has been an adverse finding about any health practitioner and serious allegations have been proven — provided that no name suppression order is in place.[29]

In a recent assessment, I concluded that "the changes made by Ahpra and the MBA, in response to the chaperone review report, have been wide and deep. The impact of implementing the recommendations has been profound in terms of how notifications of alleged sexual abuse are dealt with by regulators."[30]

An accompanying article describes the experience of the Australian agencies undertaking major reforms in a key area of medical regulation.[31]

Conclusion

The old world — where the public trusted institutions, including regulators — has changed. There is growing skepticism about whether the community can trust the agencies that are supposed to be watchdogs and be confident they're doing their job properly. In the #MeToo era, there is zero tolerance of some risks, including exposure to the risk of sexual harassment or assault. These societal developments are prompting renewed interest in

the problem of sexual abuse of patients by physicians and overdue scrutiny of some long-accepted practices in medical regulation.

Legislatures have reformed laws to improve protection and transparency for patients.[32] Many medical boards are revising their processes for handling

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sexual abuse allegations. Recent examples include an independent review for the College of Physicians and Surgeons of Nova Scotia[33] and the Federation of State Medical Boards Report of the Workgroup on Physician Sexual Misconduct.[34]

This article has described Australia's experience of initiating an independent inquiry in response to a public scandal raising serious concerns about the effectiveness and appropriateness of mandated chaperones as an interim protective measure in cases of alleged sexual misconduct—and responding to review findings with major changes in practice, including abandoning chaperone conditions in favor of gender-based restrictions. ■

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Acknowledgement

The author thanks Martin Fletcher, Chief Executive, and staff of Ahpra, who cooperated fully throughout my reviews, providing detailed briefings and access to confidential files; and MBA Chairs Dr. Joanna Flynn and Dr. Anne Tonkin, and Sexual Boundaries Notifications Committee (SBNC) Chair Christine Gee, for their thoughtful contributions.

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