Responding to Sexual Boundary Notifications: The Evolving Regulatory Approach in Australia

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ABSTRACT: A sexual boundary violation by a health practitioner has an immense impact on a patient, and the trust and confidence in the health care system and the health care regulator are negatively affected. The Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia (MBA) in 2017 commissioned an independent review in response to a specific high-profile case of multiple physician-patient* sexual boundary violations. In response to recommendations for process improvement, Ahpra and the MBA worked to transform the regulatory management of sexual boundary notifications.The purpose of this paper is to explore the structural and cultural changes that have been made to manage sexual boundary violation notifications and lessons learned through the process. Three factors — specialized decision-making, training for investigators and policy and cultural changes — were identified as key elements of the change process. Since the changes in 2017, the rate of immediate regulatory action taken in response to sexual boundary notifications has increased substantially, with a higher proportion of decisions resulting in suspension of a physician's registration. Further work on the experience of those who are part of the notification process and supporting people to share their stories and experiences through the notification and tribunal process is ongoing.

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Introduction

There is no place for sexualized conduct in the relationship between physicians and their patients. Trust between a person seeking health care and their physician is crucial to the provision of safe and effective care.[1,2] A sexual boundary violation is a serious breach of trust which can have far-reaching consequences for the individual patient.[1-6] Confidence and trust in physicians, the health care system and the health care regulator may all be negatively impacted as a result of a sexual boundary violation.[1,6] This has seen medical regulators in many jurisdictions rethinking their approach to dealing with such concerns.[7]

This paper describes the changes that the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (Ahpra) have made over the past three years to the way that notifications about sexual boundary violations are managed. As regulators, we have made these changes to better protect the public when an allegation of a sexual boundary violation is made about a physician.

The impetus for the changes arose in 2016 from a high-profile case of multiple alleged sexual boundary violations by a physician who had abused the trust of patients. The case highlighted the shortcomings of the regulatory processes, at that time, as this behavior continued despite regulatory action to require the presence of a chaperone during patient consultations.[1]

The MBA and Ahpra commissioned an independent expert review by Ron Paterson, LLB(Hons), BCL, Emeritus Professor of Law at the University of Auckland and former New Zealand Health and Disability Commissioner, of its processes for managing sexual boundary matters.[1] In particular, the review focused on the issue of whether board-mandated chaperones (an observer present for the duration of a consultation in which a physician might undertake a physical or intimate examination of a patient) remained an appropriate regulatory tool to protect the public, as an interim step while serious allegations about the physician were investigated. It has been common practice for regulators around the world to use chaperone conditions in this way. In Australia, at times, chaperone conditions were also imposed as a protective measure at the end of a disciplinary process.

The review found that the use of board-mandated chaperones did not meet community expectations and did not always keep patients safe.

Following the publication of Professor Paterson's report in April 2017,[1] it was clear that the findings called into serious question the effectiveness of chaperones. The publication also led the MBA

*The term "physician" here and throughout this article refers to all medical practitioners who practice in Australia. Please note that in Australia, osteopathic practitioners do not have equivalent training to medical practitioners.

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and Ahpra to reconsider the policies, processes, understandings and culture underlying our regulatory response to sexual boundary issues.

Soon after the Paterson report, the Final Report of the Australian Government's Royal Commission into Institutional Responses to Child Sexual Abuse was published.[8] The findings of the Royal Commission highlighted the systemic failures of many institutions to protect vulnerable members of our community. The Royal Commission's subsequent recommendations, along with Professor Paterson's report, reinforced the need for institutions, including regulators, to fundamentally rethink their approach to complaints of sexual boundary violations.

In response to the findings of Professor Paterson's independent review and informed by the report of the Royal Commission, the MBA and Ahpra have made significant changes to the ways in which sexual boundary notifications are managed. The focus of these are:

- Discontinuing the use of chaperone restrictions. Implementation of more suitable protective practices when allegations of sexual misconduct are made, including gender-based restrictions, restricting patient contact or suspending the physician's practice
- Establishing a specialist, national, medical board committee to make decisions about all boundary violation cases, supported by specially trained Ahpra investigators to manage all sexual boundary notifications
- Auditing all open notifications about allegations of sexual misconduct by physicians and reviewing all physicians currently subject to chaperone conditions in order to ensure the public is adequately protected
- Delivering appropriate, regular professional development for committee members and investigators to ensure that myths and misconceptions around victim and offender behavior are not promulgated
- Improving our engagement with victims of boundary violations, including adopting whole story interviewing techniques to engender greater confidence in our regulatory processes and better inform ourselves of predatory behavior by practitioners
- Sharing the findings of the Paterson report with responsible tribunals, who ultimately deal with the most serious allegations on referral from the MBA
- Seeking better relationships with all police departments in Australian states and territories to establish clear inter-agency protocols to better share information and experiences around physician offending, particularly in relation to sexual offending

The purpose of this paper is to outline those changes, their impact and lessons learned, for the information and interest of other regulators.

Background

Since 2010, Ahpra, in partnership with National Boards for all regulated professions, has managed the regulation of registered health practitioners in Australia. Under legislation established in 2010 (the National Law), a previous system that operated separately across individual states and territories came together under one national system of regulation. The National Law[9] established Ahpra and the National Boards, which now work in concert to regulate more than 800,000 health practitioners in 16 professions across 15 National Boards.

The National Board responsible for regulating medical physicians is the MBA, which receives about 5,000 notifications of concern about physicians each year. Notifications vary in the gravity of complaint from poor engagement and bedside manner to serious criminal offenses. In 2019–2020, 209 sexual boundary notifications were made regarding 175 medical practitioners, (representing 0.14% of the medical workforce in Australia).[10] Sexual boundary notifications deal with a variety of concerns, including sexualized comments, unwarranted intimate examinations, intimate examinations undertaken without appropriate informed consent, sexual relationships between physicians and patients, sexual exploitation, harassment and assault. When concerns about boundary violations are notified, they are often serious, have significant impacts on patients, and have a significant impact on the public's trust in physicians, [1,3] as well as in the health care regulator.

Transforming the Management of Sexual Boundary Notifications

Lesson 1: Specialized Decision-Making

The Paterson report highlighted the need for specialized decision-makers for sexual boundary notifications. Professor Paterson recommended that a specialized skill-set was required to ensure that these notifications were handled in an appropriate and sensitive manner. In response, the MBA formed a Sexual Boundaries Notifications Committee (SBNC), which commenced operation in mid-2017, after an initial, intensive, two-day training workshop for all members.

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The SBNC is a delegated decision-making committee of the MBA, and has the responsibility for all decision-making concerning sexual boundary matters about physicians. It meets as a national committee at least once per week, with five to six attendees each week being drawn from a pool of about 12–18 trained members. All members are already experienced regulatory decision-makers, either medical practitioners or community (lay) members, who receive additional specialized training before joining the SBNC. These members are recruited from the MBA's other delegated decision-making bodies. Members are asked to submit expressions of interest, and are interviewed prior to being appointed to the SBNC by the MBA. The committee is currently chaired by a community member. Members are remunerated with a standard fee for their attendance at a meeting.

Current regulatory decision-makers across our scheme receive specialized training before the commencement of their term on the SBNC committee to support effective regulatory decision-making. Given the sensitive and complex nature of sexual boundary matters, this initial training is also supplemented by ongoing training of committee members. This training has been developed in response to findings and recommendations from the Paterson report, observations of the criticisms directed at institutions identified in the Royal Commission report for failing to adequately respond to sexual offending against vulnerable individuals, and our own, ongoing and evolving sense of the expectations of regulators by the public.

The training is delivered by a combination of:

- Legal practitioners
- Statutory decision-makers
- Rape and sexual assault experts
- Psychologists
- Criminologists
- Police
- Medical practitioners, including psychiatrists

The training is tailored for decision-makers and is delivered over a period of approximately two months through a range of methods, including readings, webinars, podcasts, observation of committee meetings and discussions with other committee members. It helps members understand and prepare for the personal impact that frequent consideration of traumatic events might have. Additionally, Ahpra and National Boards have extended coverage of their Employee Assistance Program to members of the committee given the potential for vicarious trauma.

Representatives from sexual offense crisis centers have contributed to training decision-makers by sharing experiences of aiding victims of sexual trauma. Coupled with engagement by a criminologist with a policing background, this has reinforced the understanding of the psychological impacts of trauma on a victim. In particular, training has led to a better understanding of the impacts of trauma on memory, including suppression of events or details that would be helpful to recall for the purposes of investigation.

Legal issues impacting decision-making, particularly in relation to professional misconduct and the committee's powers to take immediate action (both defined under the National Law) are addressed through regular engagement by Ahpra's General Counsel with the committee. From time to time, expert legal input is sourced from members of the Australian bar.

The training includes consideration of inherent bias in the decision-making process. It addresses common misconceptions about behaviors of victims and perpetrators in sexual boundary matters.

Overall, the training has enabled decision-makers to critically assess submissions that seek to cast doubt on a notifier's/victim's story through promulgating common myths and misconceptions about sexual offending. One of the very important changes that has followed this education is an understanding that false accusations of this type are rare. Another change is to recognize that a patient can feel sexually violated and suffer harm even if there is no apparent sexual motivation on the part of the physician. For example, an intimate examination performed without adequate explanation and informed consent can lead to significant distress for the patient.

Having a decision-making group that has a deep and thorough understanding of the evidence and background to inappropriate sexualized behavior has provided greater abilities to implement recommendations from the Royal Commission and the Paterson report. Members of the SBNC are also in an opportune position to determine when specific trends and issues related to sexual boundary violations become apparent across Australia.

Lesson Two: Training for Investigators

Once a notification is made about a physician, investigators within Ahpra make further enquiries about the notification. In the case of a sexual boundary

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notification, the investigation often includes interviews with the physician and notifier and, where the notifier has expressed concern on behalf of another person, with that person. Prior to 2017, these interviews were conducted by the investigator who had been allocated to the matter, regardless of whether the investigator had received any specialized training.

Considering recommendations from the Royal Commission and the Paterson report, Ahpra developed a bespoke three-day investigator training program. The training was developed by an expert in the field who had worked with a state police force and a Sexual Offenses and Child Abuse Investigation Team. Forming connections with others who have experience in criminal investigations has been invaluable, providing links to a wider set of stakeholders to enable more collaborative responses to sexual offending by physicians.

In response to the training, Ahpra made significant changes to investigative practices to better manage sexual boundary notifications.

Based on expert advice, the model of statement taking changed to a whole story approach. This approach involves investigators exploring a patient's story from the time they first interacted with a physician until the present day. Crucially, extending the information gathering to events preceding boundary violations helps in cases where predatory behaviors might have been apparent long before the current allegation. This information is vital to presenting a more comprehensive picture of offending to the SBNC, and ultimately the responsible tribunals, to which the most serious matters are referred by the MBA.

WITHOUT THE CONFIDENCE OF THE PUBLIC IN OUR SYSTEM OF REGULATION, WE ARE UNLIKELY TO RECEIVE REPORTS FROM THE PUBLIC TO IDENTIFY CONCERNS ABOUT CONDUCT....

This approach has enabled investigations to uncover behaviors consistent with predation that may have been overlooked using previous processes. Evidence might include information disclosed early within a treatment relationship about areas of vulnerability which, when combined with our current understanding of sexual offending behavior, makes grooming and predatory forms of sexual offending much more easily identifiable.

Investigators were introduced to sexual offense victim support services. For investigators, these connections have enabled their own exploration of the concepts of unconscious bias that could impact the way they interpret information. It has also served to increase recognition of the myths that exist related to the disclosure of sexual offending that might previously have permeated our investigation culture. Investigators have improved skills to recognize trauma and more sensitively deal with individuals lodging notifications.

Connection with victim support services has increased our understanding of the importance of referring notifiers to appropriate support services to ensure their wellbeing can be better supported during our investigations. We have worked through significant, ethical dilemmas focused on when and how matters should be reported to the police in circumstances where the notifiers themselves are reluctant to report to the police. A notifier might be reluctant to raise concerns with police because of historical involvement with police, cultural background or from a fear of engagement with the criminal justice system.

As a result of the ethical considerations required, Ahpra established an information-release committee, with expertise provided by an independent ethicist to help inform internal decisions in the face of a notifier's reluctance. This is because there are some concerns raised with us that can only properly be dealt with via the criminal justice system, where the jurisdiction has an emphasis on punishment for offending rather than a specific focus on public protection, which is our remit as regulators.

Given the potential impacts on patients if they suspect their story will not be believed, Ahpra now ensures that all cases of sexual boundary allegations are managed only by investigators who are specially trained in the management of these matters.

Lesson Three: Culture and Policy Changes

Together, Ahpra and the MBA have worked to ensure that the changing culture related to sexual boundary violations, within the regulatory system, is reflected in changes made to policy and procedures.

The need for cultural and policy changes to ensure trust and public confidence in us as regulators is obvious. Without the confidence of the public in our system of regulation, we are unlikely to receive reports from the public to identify concerns about conduct, especially when it is not observed by employers or peers.

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Just as importantly, the medical profession we regulate relies on us to respond quickly and appropriately to serious regulatory breaches to ensure that strong public confidence in physicians is maintained. Health practitioners also understand the importance of strong action to remove poorly-behaving physicians from the profession to retain the profession's high standing in the community and to ensure better health outcomes for patients and community confidence to seek appropriate health care.

Recognition that the MBA and Ahpra are willing to believe, and support, victims of boundary violations is critical. An expectation of lack of belief, shown in stories shared with notifiers through the Royal Commission process and report,[8] is a major barrier to reporting. Anecdotally, it is widely accepted that there is more likely to be under-reporting rather than over-reporting in relation to sexual offending by practitioners.[1] As recommended in the Paterson report, weblinks have been constructed from the Register of Health Practitioners to published Tribunal findings in cases where physicians have had an adverse finding and which are otherwise in the public domain. This makes it easier for members of the public to find out more about a physician they may have been considering attending. Other public-facing activities to support the change in culture include:

- Publishing videos on the Ahpra website that encourage notifiers/victims to share their stories and experiences with us
- Adapting policies and procedures to ensure that Ahpra's engagement approach changes from overly bureaucratic to informal and approachable

Internal actions have included:

- Establishment of regular consultation with two advisory groups, a practitioner reference group and a community advisory reference group, which provide reflections of contemporary community views on sexual boundary violations by registered practitioners, among other things
- Establishment of interagency protocols with jurisdictional law enforcement agencies to improve communication when sexual boundary matters are reported both to Ahpra and the criminal justice system
- Development of a policy and process to better support disclosure of potential criminal offending to police
- Development of a policy on reviewing immediate action restrictions arising from allegations of sexual boundary violations

Cooperation with Law Enforcement

When a boundary violation may also be a criminal offense, it is important that both the regulatory system and the criminal justice system respond. An important outcome of the MBA and Aphra improvements to managing sexual boundary notifications has been our increased interaction with state and territory law enforcement.

Cooperation between Ahpra and law enforcement agencies ensures that there is less chance of high-risk persons or behaviors escaping detection and sanction. Historically, there was less cooperation between the police and Ahpra. As a result, there were times when information was not shared, though it could have ensured that a physician was identified as a possible risk to the public. To improve this information flow, Ahpra has worked with several jurisdictional police services, establishing interagency protocols and memoranda of understanding that provide mechanisms and procedures to enable Ahpra to release information related to criminal offenses and for police to reciprocate with information regarding potential risks to the public from both health practitioners and those who purport to be health practitioners.

Through this cooperation, Ahpra and the MBA have been able to act upon notification from the police regarding a potential sexual boundary violation, and to suspend or restrict the registration of a health practitioner, where necessary, prior to a judicial process being completed. This provides better protection than previous situations—where practitioners could continue to practice unrestricted for a number of years while police investigations and criminal proceedings are undertaken.

Policy Development

Immediate action refers to the interim steps that can be taken to address a risk to patient safety by a physician. A new policy titled "Review of Immediate Actions Restrictions Arising from Allegations of Sexual Boundary Violation" outlines the process where all regulatory actions arising from immediate action taken following allegations of sexual boundary violations relating to physicians are reviewed at least every six months, or earlier if there are triggers for review. These triggers may include confirmed or suspected non-compliance with the restrictions, charges being made by the police, the physician being committed to stand trial in relation to any charges, or if the police close an investigation into the conduct without making charges.

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This policy would not be possible to enact if there were not strong cooperation between jurisdictional law enforcement and Ahpra. The changes in culture and understanding that have been made over the past three years have been instrumental in enabling Ahpra and the MBA to implement a range of policies and procedures that better protect people who make notifications of sexual boundary violations.

Ahpra and the MBA, supported by the findings of the Paterson report, urged changes to the National Law to enable immediate action to be taken not only where a serious risk to the public is identified, but also where it is in the public interest to do so. Legislative amendments were made to the National Law in 2017 that ensure more responsive interim actions can be taken to protect the public.

Development of Updated Guidelines

Following receipt of the Paterson report, the MBA reviewed and updated its guidelines on sexual boundaries for physicians. The key changes, informed by the report, included a change in the title to make the scope of the guidelines clearer, a new section on social media, replacing the term "chaperone" with the terms "observer" and "practice monitor", and advice to physicians that an unwarranted physical examination may constitute sexual assault. The updated guidelines, published in December 2018, include the summary in Figure 1 (note: in Australia, "doctor" is commonly used, rather than "physician," to describe medical practitioners.)

Figure 1

Extract from Medical Board of Australia Guidelines: Sexual Boundaries in the Doctor-Patient Relationship

published December 12, 2018

- Sexual misconduct 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.
- 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.

Evidence of Effectiveness

Ahpra and the MBA are aware of the importance of evaluating the impact of these changes on the experiences of people who lodge a notification, physicians, Ahpra investigators and specialized board decision-makers. Qualitative improvements in processes and consistency of decision-making have been noted in a follow-up review.[1] We have also examined the outcome data for sexual boundary notifications to look for quantitative effects.

Matters related to sexual boundaries make up around 4% of all medical notifications received (total notifications are approximately 5,000 per year). It is important to note that others (including Bismark[6]) identify that the actual number of sexual boundary violations by practitioners may be significantly higher. After a year-on-year increase in the number of sexual boundary notifications received from 2017 to 2019, there was a slight reduction in new complaints across the 2019-2020 financial year. For many of the reasons highlighted about past responses to reports of sexual boundary violations, it is anticipated that there is under-reporting to both regulators and police.

The rate of immediate regulatory action taken in response to sexual boundary notifications has increased substantially. An early response to serious risks to the public, including suspension of registration or restricting the physician from consulting with a particular gender, has increased from around 11% of matters in 2016–2017 to 26% in 2019–2020. This is, appropriately, a much higher rate of immediate action than for all matters received (around 3%). In addition, the proportion of immediate action decisions that resulted in suspension of a physician's registration increased from 39% in 2016-2017 to 57% in 2019-2020, while the imposition of a requirement for a chaperone (practice monitor) was reduced to three cases over three years. These actions occurred while an investigation took place.

When examining the overall impact of the change in processes the data shows that for medical sexual boundary notifications, in the first two full years following implementation of the committee, the rate of notifications resulting in no further action, decreased from 71% to 60.2% and the rate of referral of notifications to independent panels and tribunals increased from 7.4% of all cases to 17.3%. We intend to continue to monitor and report these outcome data over future years.

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Work Still to Do

What we are still to measure is data on the experience reported by victims of sexual boundary violations. While we have regularly sought feedback from notifiers and physicians about their experience during a notification, we have not to this point enabled the identification of responses specifically related to sexual boundary notifications. This remains a work in progress.

Following the implementation of nearly all recommendations from the Paterson review, Ahpra and the MBA invited Professor Paterson to review what has changed, three years on from his original review of our management of sexual boundary notifications. The report "Three Years On: Changes in Regulatory Practice Since the Independent Review of the Use of Chaperones to Protect Patients in Australia" was published in July 2020.[11]

One recommendation, which suggests that 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 practice monitors to be fully briefed as to those reasons, remains partially implemented. The National Law has not been amended; however, the Ahpra protocol for monitoring practice monitor restrictions allows for booking staff to advise patients that the restrictions relate to sexual misconduct, if the patient requires more information. There is also a requirement that practice monitors be provided with a full copy of the restrictions imposed on the practitioner's registration and a full copy of the reasons for the decision to impose the restrictions.

While the MBA and Ahpra have implemented nearly all recommendations of the Paterson Report, the MBA and Ahpra have not solved every problem. Given the universal underreporting of sexual boundary violations, there is still work to do to ensure people feel supported in sharing their stories and remain engaged throughout the notification and tribunal referral processes. Ahpra also needs to improve support for notifiers and victims through the management of the investigations and to continue to reduce the time taken to investigate these complex notifications. The MBA is also aware of the need to continue to educate physicians about the critical importance of good communication and clear processes for informed consent to avoid misunderstandings and distress for patients. This has also been highlighted by regulators internationally as an important area of focus.[7]

Matters of sexual boundary violations are complex and contentious, and community views and expectations are rapidly changing, making this a dynamic and challenging area. We are, however, pleased to be able to report on the significant work that has been done to date by the MBA and Ahpra, the results achieved, and our plans for future directions. ■

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