Dr Sharon Monagle
[redacted]

26/09/2016

Professor Ron Paterson
Chaperone Review
c/- National Health Practitioner Ombudsman and Privacy Commissioner
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Vic 3001

Dear Prof Paterson,

I thank you for the opportunity to contribute to the Independent review of chaperones to protect patients commissioned by AHPRA and the Medical Board of Australia.

I am a General Practitioner, a Fellow of the Royal Australian College of General Practitioners and a Medical Member of the Mental Health Tribunal. I graduated from Monash University (MBBS (Hons)) in 1991 and also hold a Masters degree in Public Health from the University of NSW. I have practiced medicine in Australia for over 20 years and am in good standing amongst my peers. I was the joint recipient (with my husband, Shaun) of the Inaugural Monash Alumni Community Service Award and also the Inaugural recipient of the Peter Waxman Award for Contribution to General Practice.

[redacted]

Whilst I will address the key issues articulated in the Terms of Reference of this review which are primarily about the appropriateness and efficacy of the use of chaperones, I will also go beyond the scope of the consultation questions as I feel there are many other areas for improvement if we are to prevent a tragedy of the scope of the Churchyard incident in the future. [redacted] experience following his notification to AHPRA fell short of my expectations of the regulator.

I note that the Terms of Reference state that the review will focus on medical practitioners and I will limit my comments accordingly.

[redacted]

Consultation Questions

1. Do you think chaperone conditions are an effective way to protect the public and why?

Chaperone conditions on a health practitioner's registration are currently used in an effort to protect patients while allegations of sexual misconduct are investigated.
The term sexual misconduct is defined by the Medical Board of Australia, in its document: 'Sexual Boundaries: Guidelines for Doctors' (2) as including a range of behaviours:

- engaging in a sexual activity with a current or former patient (whether or not consent is provided)
- engaging in sexual activity with a person who is closely related to a patient, for example a parent or carer
- making sexual remarks
- touching patients in a sexual way
- engaging in sexual behaviour in front of the patient
- sexual exploitation or abuse
- sexual assault

I do not believe that chaperone conditions are an effective measure to protect the public whilst allegations of sexual misconduct are being investigated and offer the following observations:

- Chaperones are subjected to the same power-imbalances as affect others when dealing with doctors.
  Even if a health care professional, a chaperone may find it difficult to report concerning behavior.

- AHPRA's Chaperone Protocol advises doctors that "it is a general requirement that nominated chaperones are not your direct employees."(3).
  Reviewing details of chaperone requirements listed on AHPRA's website, however, it is not uncommon to find statements that indicate that the doctor "will be responsible for all costs associated with the chaperone." This sounds like the chaperone is in the employ of the doctor. In such a situation - where a chaperone is, or merely feels that he/she is, in the employ of the doctor - this power-imbalance is further amplified.

- In the Churchyard case, patients and other health professionals have found it difficult (indeed have failed) to report this doctor's most serious misconduct.
  Details have emerged since his death of patients feeling utterly unable to report their concerns despite knowing they had likely been sexually assaulted.
  Doctors have evidently also failed to report Churchyard when patients reported their concerns for fear of reproach from their colleagues.
  It is therefore unrealistic to expect that chaperones would not be subject to these same influence[s].

- The AHPRA Chaperone Protocol (3) requires that nominated chaperones be "physically present and directly observe" all contact. In the Churchyard case, sexual assault continued behind a curtain even whilst a chaperone was present. It is evident, therefore, that this requirement is not being adhered to. Moreover, to require a chaperone to be closely present (so as to enhance effectiveness) during intimate examinations is an unreasonable impost on patients and seriously invades their privacy and dignity.

- Chaperones will at times need to leave the consulting room, for example to use the bathroom. This allows opportunities for sexual misconduct (including sexual assault) to occur.

- Sexual assault in the guise of a clinical examination can be difficult to detect. [redacted] Further, doctors and other health professionals (who might act as chaperones) can also fall victim to this deceit.

- Doctors who are allowed to work with the requirement for a chaperone can evade this requirement by not disclosing to AHPRA (as Churchyard did) all of their places of employ. In addition where doctors may undertake home visits, the "workplace" has no boundaries, nor time limits. Doctors can readily avoid the oversight of a chaperone by seeing patients in their home or indeed on a hospital ward. A chaperone requirement is therefore very difficult to enforce and to monitor, rendering it an ineffective tool to protect the public.

- The AHPRA Chaperone Protocol states: "in general a requirement to practice with a chaperone is applicable only to practitioners who are engaged in private practice." This statement is made with no explanation. Given that the primary purpose of a chaperone requirement is to protect the public I do not understand why a distinction would be made between private and public practice.

- Where sexual misconduct takes the form of sexual activity with a patient/former patient or person close to a patient a chaperone provides no protection whatsoever. Such activity typically occurs outside of the consultation room and can be mediated by phone, email and social media contact. The use of a chaperone is clearly ineffective in this situation.

2. If chaperone conditions are effective in some circumstances, what steps do you think need to be taken to ensure patients are protected and adequately informed?

I do not believe that mandatory chaperone conditions are effective to protect the public in any circumstances where a doctor has been accused of sexual misconduct.

The only place for use of a chaperone is where a doctor wishes to have a chaperone present (and the patient consents to same) for the protection of him or herself. This is an entirely different matter to the use of chaperones for the protection of the patient and is patently not what this review seeks to address.

Not only is a chaperone condition ineffective at protecting the public from doctors who might transgress sexual boundaries, the use of a chaperone without explanation is unethical. The AHPRA Chaperone Protocol requires only that patients be informed that a chaperone will be present. There is no requirement for doctors to disclose to patients that a chaperone is *mandated,* why this is the case or indeed for the term "chaperone" to be used.

This is an inappropriate protocol.

In Churchyard's case (and in accord with current AHPRA directions regarding the use of mandated chaperones), patients were offered no explanation of why a chaperone would be present and were afforded no legitimate opportunity to refuse the presence of a third person. Indeed if a patient had refused, Churchyard would have had to say: "Well, in that case I cannot see you."

This places patients in an impossible situation and possibly even a position of duress. [redacted]

How would patients have felt were they told the truth: "I must have a chaperone present because there is a concern that, if not, I might sexually assault you." Clearly this too is not acceptable.

The use of chaperones is ineffective and their use without patient disclosure is highly unethical. To fail to disclose to patients such a serious concern is arrogant and deceitful and prohibits patients from participating as fully as possible in their own health care decisions.

The doctor-patient relationship hinges on trust and the use of a chaperone without full disclosure undermines this trust. Whether with or without patient consent, mandatory chaperones are not compatible with patient-centred care.

3. Can you suggest an alternative regulatory measure to protect patients while allegations of sexual misconduct are investigated?

As alluded to earlier in my submission, the term sexual misconduct in this context encompasses a range of behaviours including, but not limited to, inappropriate sexual comments, engaging in a sexual activity (e.g. with a patient or parent), behaving in a sexual manner, through to sexual assault of a patient.

In considering this question I think it is useful to distinguish between these various offences which we clumsily group together under the term 'sexual misconduct.' This distinction is necessary both because the offences are very different but also because we ought to use language that identifies very clearly what we are actually talking about.

Some of the behaviours we refer to as sexual misconduct constitute offences under the criminal code, whereas others (inappropriate relationships for example) are unprofessional conduct but not crimes per se.

Sexual misconduct which involves inappropriate or clinically unnecessary examinations is properly called sexual or indecent assault or, where penetration occurs, rape. We should be very clear about what we are talking about and our regulatory responses should be proportionate and relevant to the conduct.

I intend therefore to consider principally the situation where sexual misconduct refers in fact to inappropriate sexual touching of a patient (that is sexual or indecent assault or rape).

If a doctor is facing allegations of this form of sexual misconduct he or she must have their registration suspended until the allegations are investigated. Suspension of registration is proportionate to the seriousness of the allegation and the risks posed and there is no lesser way that community safety can be ensured.

Additionally such matters, once reported to AHPRA, MUST be reported to the police.

Many doctors will say that this is unduly harsh, that such a standard would have serious financial and reputational implications for doctors. Some will say: "What about the presumption of innocence", others: "What about all the vexatious complaints?"

To these I make the following comments:

- Sexual misconduct (sexual assault/indecent assault/rape) is a most serious allegation and particularly so when it is alleged to have occurred in the context of a relationship of trust and unequal power: as is the doctor-patient relationship.

- The effects of sexual misconduct (sexual assault/indecent assault/rape) by doctors on patients are devastating and long lasting. They are not trivial or unimportant. If an allegation of this form of sexual misconduct is made, it must be taken very seriously. The alleged victim must be listened to and acknowledged, including acknowledgement in the form of an appropriate and timely response.

- In addition to the direct harm caused by sexual assault, when this is inflicted by a doctor it can have serious repercussions for a patient's ongoing medical care. Certainly in the Churchyard case there are accounts of patients who have been unable to access medical care (for sometimes very severe and enduring neurological conditions) following his criminal actions. The duty of regulators to protect patients from this sort of harm is therefore very substantial.

- Regulators and doctors should remember that a presumption of innocence is a fundamental and essential tenant of our criminal justice system, but it is not the primary objective of our medical regulator. That is, rather, to protect the public from harm.

- A regulatory culture which listens to the voice of the victim (or alleged victim) and takes this seriously is one which instills and amplifies trust in the profession. If ALL allegations of sexual misconduct (sexual assault/indecent assault/rape) resulted in a suspension from practice this would not be seen to necessarily imply guilt. It would, rather, reflect the primacy of protecting the public. It would speak loudly to the enormous responsibility that regulators accept in protecting the public. It would acknowledge moreover that the trust that the public puts in doctors is well-placed, hard earned and is not taken for granted

- One only needs to look to the disability sector, where (in Victoria at least) this is now the standard. Following an allegation of sexual misconduct the staff member is immediately stood down, the allegation is reported to the police and support is provided to the victim (4). Similarly, one would not expect a teacher to remain in a classroom following allegations of sexual misconduct involving a student. Indeed, if this were to happen there would be outrage. It does not mean that we presume the teacher is guilty. It means that we acknowledge that the children are vulnerable and worthy of our protection.

- It is also worth reminding ourselves that the criminal justice system can impose far greater restrictions on alleged perpetrators of sexual assault, indecent assault and rape than mere suspension from their work. Indeed it is possible for one to be remanded in custody until a later court hearing. This step, taken to protect the public, is a far greater imposition than being unable to undertake clinical duties which puts one in contact with vulnerable patients.

- As to claims of large numbers of vexatious reports of serious sexual misconduct, I would ask to see the evidence of this. Whilst acknowledging that some such reports are no doubt made, I suspect that these are very few. In my 20-plus years of clinical practice I am yet to encounter a doctor who has been such a victim.

Obviously where a doctor is accused of sexual misconduct (sexual assault/indecent assault/rape) and is suspended from clinical practice you would hope that the matter could be resolved as quickly as possible. However doctors have no particular entitlement to treatment different to the rest of the community. Where doctors *are* different is that the power imbalance is even greater and they possibly have greater access to vulnerable people.

Regarding the issue of reporting to police, I feel that this is absolutely critical. The Royal Commission into Institutional Sexual Abuse has shown us that self-regulation is fraught and is ineffective in dealing with sexual predators. Medical regulators are no different and must defer to police if a doctor is alleged to have committed a criminal offence such as sexual or indecent assault or rape. Indeed the Medical Board of Australia states in the document 'Sexual Boundaries: Guidelines for Doctors' (2): "Criminal offences will be investigated by police."

Clearly this standard is not being adhered to by AHPRA, where reporting of complaints of sexual assault by Churchyard were not necessarily referred by AHPRA to police.

[redacted]

4. Do you have any general comments for the review to consider?

[redacted]

1. Public safety first

When a report of a serious nature is made against a doctor AHPRA must act primarily to protect the public safety. Whilst doctors are of course entitled to a presumption of innocence, this needs to be balanced against the very real harm that can be done to patients. The presumption of innocence underpins our criminal justice system but is not the primary consideration for our health regulators. Rather, their primary focus should and must be on ensuring the safety of the public. I feel that AHPRA have (at best) failed to understand this distinction.

This of course should particularly apply where an allegation of sexual assault has been made. Sexual assault is a most serious offence and has the potential to cause enormous harm. Immediate action in the form of suspension of clinical practice should be taken.

[redacted]

[redacted]

2. Communication of criminal matters to police

I have commented already on the importance of communication between health regulators and police in cases of allegations of criminal conduct. I have referenced the Medical Board document that states that this will happen. I understand that there are not legal barriers to the sharing of such information.

I wonder therefore what circumstances would lead AHPRA to do anything other than to report criminal behaviour to police. [redacted]

Shortly after reporting Churchyard to AHPRA, [redacted] made a police report. [redacted]

Sadly, this is somewhat reminiscent of the Catholic Church (and other institution's) handling of sex abuse cases, whereby complaints were dealt with in-house and not reported to police.

More recently it has come to our attention that there were complaints made to the Medical Board about Andrew Churchyard as far back as 2007:

Were these complaints also about sexual misconduct?
If so, were they reported to police?
What systems exist to allow the Medical Board, AHPRA, the police or, indeed, the public, to detect a pattern of repeated behaviour that transgresses professional and/or criminal boundaries?

All of these are important questions that must be asked if opportunities to prevent the sexual abuse of patients are not to be missed.

3. Communication with patients

[redacted]

[redacted]

When a chaperone condition was imposed on Churchyard, there was no way for us (nor any of his patients) to identify when that condition had been put in place. Such information is not available on the AHPRA website. This was true also when Churchyard's registration was eventually suspended. There are many other cases I could point to on the AHPRA website where doctor's have restrictions, reprimands or conditions (including chaperones) on their practice – but with little if any further information to help the reader to discern either the background or the timing of these

[redacted] AHPRA's complete deference to criminal proceedings – rather than continuing to pursue their own investigation into Churchyard's professional misconduct– was surprising to me.

Of course the question of his guilt or innocence in relation to the allegations of sexual assault must be determined by a court. But this surely does not limit or diminish AHPRA's role in protecting the public. If this were to be done seriously then a more full and robust assessment of the risks ought to have been made. [redacted]

[redacted]

4. Doctors as advocates

It is incumbent upon all of us in the medical profession to listen when patients report an experience with another doctor that has made them feel uncomfortable or that they feel has transgressed a boundary. It can be difficult for patients to know where the line is between a clinically necessary and acceptable examination and one that is neither of these things.

We all need to be advocates for our patients and to listen carefully when they report a concern. In particular, doctors need to understand what does and does not constitute sexual misconduct. Following on from this we need to support our patients to report concerns to AHPRA and, indeed, to report other doctors ourselves (whether mandatory or not).

I offer this example: I had a conversation with a fellow GP whose patient had told her that his specialist had repeatedly conducted genital examinations, including retraction of the foreskin, as part of his management of migraine. When I suggested that this constituted sexual misconduct and must be reported the GP insisted that it did not. She said “That’s when a doctor has sex with a patient.” Such grave misunderstanding places our patients at risk. It also points to a failure of the regulator in communicating with health professionals about the expectations and responsibilities of health professionals.

5. Making notifications to AHPRA

Following the Churchyard incident some victims have expressed their complete ignorance about how, where or when to report concerns about a doctor. This is a significant problem. AHPRA cannot be an effective agent in protecting the public if the public do not know they exist or how to contact them.

Finally, I have recently had cause to make a mandatory notification of a health professional to AHPRA. In doing this it became evident to me that the notification form that is provided for this purpose is inadequate. The notifying doctor must identify oneself as either (a) the patient, (b) the patient’s nominated representative or (c) the patient’s legal representative. As a doctor making a mandatory report I was none of those things. The notification form needs to be made more clear and to encompass the scenario I describe. Otherwise health professionals may be discouraged from reporting.

Further, the notification form insists that one must identify the patient. There is a potential conflict where a doctor must make a mandatory report and where an adult patient does not consent to being identified. It is possible that doctors might be discouraged from making notifications, that patients may be harmed and that doctor-patient relationships may be undermined. Health professionals making mandatory notifications need more information in order to reassure their patient of what will happen, including whether AHPRA will contact them and whether they will be identified as the complainant.

I thank you for the opportunity to make this submission. [redacted]

I would be grateful of an opportunity to meet in person to discuss these matters further.

Yours faithfully,

Dr Sharon Monagle [redacted]

References

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(2) Sexual Boundaries: Guidelines for Doctors, Medical Board of Australia, Oct 2011
medicalboard.gov.au, Accessed 21/09/2106

(3) AHPRA Chaperone Protocol November 2015

(4) NDS Zero Tolerance 2016
nds.org.au/resources/zero-tolerance, Accessed 26/09/2016