Addition to submission to AHPRA Chaperone Review

Since my original submission in September 2016, I have researched the topic a little further to back up the statements I made and would now like to make additional comments in three areas:

1. specific recommendations regarding chaperoning
2. risk assessment
3. the importance of language in the wording of the Review findings

Again, I request that my name and details be removed from my comments before publication for privacy reasons.

Recommendations regarding chaperoning

I believe that the use a of mandated chaperone has no place in the management by AHPRA of admitted/proven sexual misconduct by a medical practitioner.

There may be a limited role for chaperoning during the investigative phase only, in situations of low risk, solely to ensure procedural fairness for the medical practitioner concerned. I don't think a chaperone offers any real protection, and using chaperoning in this setting is litttle more than window dressing. If anything other than trivial risk is perceived, chaperoning is inappropriate. Certainly in situations of high risk such as I described in my original submission OR if new complaints come to light during the investigation against a doctor who is chaperoned, the doctor should immediately be removed from clinical contact with patients until such time as he or she is cleared of misconduct.

Consideration should also be given to the situation of other bodies reversing the decision of the Board on appeal eg the recent case of Helmy v Medical Board of Australia ACAT appeal, keeping in mind that there is little, if any, recourse against administrative appeals tribunals or AHPRA itself, should the decision result later in harm to a patient ie at present the patient is the one bearing all the risk.

References:

Kiel, H 1992? *Sex, discipline and doctors: the NSW experience* accessed online, source unknown

Kiel, H 2006 *Drugs, sex and the risk of recidivism: psychiatry in the witness box* Psychiatry, Psychology and Law 13(1)132-142

Hyam, A 1992 *Expert psychiatric evidence in sexual misconduct cases before state medical boards* American Journal of Law and Medicine 18(3) 171-201

ACAT Civil and Administrative Tribunal proceedings dated 19 August 2016
Helmy v Medical Board of Australia (Occupational Discipline) [2016] ACAT97

Risk assessment in the context of sexual misconduct

There is a need for more data on which to base the risk assessment, and care should be taken to ensure that an appropriate risk management model is used, as models are not comparable across industries or situations.

Although risk management models from aviation have successfully been translated to the medical setting, most of these are centred around *errors* rather than *deliberate acts*. It is important to distinguish between risk management data relating to error and those relating to deliberate acts such as inappropriate or unprofessional behaviour.

There are important differences between risk management relating to behaviours where there is a *safety threshold* which allows for accumulation of information on *sub-threshold incidents* before intervening eg anger management problems, poor communication, and that in which *every incident is serious* enough as to warrant investigation and intervention eg sexual misconduct.

Defining a class of sub-threshold behaviours to monitor in the context of sexual misconduct would require a major attitudinal shift in a medical culture rife with sexism and sexual harassment (see also the quoted comments of a colleague in section 3).

There are also differences between risk management relating to situations where a behaviour is *directly harmful* eg sexual misconduct, or the case of Dr James Peters whose actions directly resulted in the transmission of hep C to 55 patients; and those where there are *multiple steps to harm* or *harm does not occur on every occasion* eg substance abuse, inappropriate prescribing of drugs of addiction.

Much of the data on the risk of sexual misconduct recidivism relates to a criminal setting where the legal goals and the standard of proof is different from the AHPRA setting.

My conclusion is that sexual misconduct is a unique risk management situation and any risk management tools used, and the data on which these are based, need to be specific and appropriate.

References:

Kapur, N et al 2015 *Aviation and healthcare: a comparative review with implications for patient safety* Journal of the Royal Society of Medicine Open 0(0) 1-10 DOI 10.1177/2054270415616548

Wilf-Miron, R et al 2003 *From aviation to medicine: applying concepts of aviation safety to risk management in ambulatory care* Quality and Safety in Health Care 2003;12: 35-39

Bismark, M and Bradfield, O *Predicting medico-legal risk: latest research and its application to practice* Avant webinar 22 May 2014
(in particular the tiered intervention based on Gerry Hickson's work at Vanderbilt University)

Paterson, R *Not so random: patient complaints and 'frequent flier' doctors* Quality and Safety in Health Care 2013;0:1-3 DOI 10.1136/bmjqs-2013-001902

Attention to use of language

The language which is used to discuss the findings and recommendation of this Review will have a significant impact on the way in which it is received.

One example of this principle in practice is the use of language in the 2012 Chief Psychiatrist's guideline 'Promoting sexual safety' which is discussed in the VMIAC 2013 report 'Zero Tolerance for sexual assault: a safe admission for women'.

Another is the wording of the Medical Board report of the recent tribunal decision relating to Dr Robert Wolman which relates to sexual misconduct and the use of chaperoning. Few doctors go so far as to read the tribunal proceedings themselves, relying instead on the summary provided in the medical board newsletter. The newsletter summary uses the phrase 'sexual relationship' in addition to 'inappropriate sexual contact' to describe the nature of the sexual contact between Dr Wolman and the three complainants. This wording is in stark contrast to the that of the tribunal proceedings themselves, which describes the actual activities, consisting of multiple incidents of inappropriate sexual contact occurring in the consulting room during supposed medical consultations.

The common usage of the term 'sexual relationship' is for a consensual relationship occurring in a social setting means that its use in the medical board newsletter in this setting is likely to create a false impression of the nature of the conduct, minimising its inappropriate and serious nature. One colleague, reading out this article from the newsletter joked that this 'sexual relationship' "had lasted longer than most marriages", with the implication that it was somehow comparable and hence more acceptable.

Given that the recommendations are the Review will be just that - recommendations, with no legal force, I would urge that very careful consideration be given to the wording.

References:

State of Victoria, Department of Health (June 2012) *Chief Psychiatrist's guideline: Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units*

Victorian Mental Illness Awareness Council (2013) *Zero Tolerance For Sexual Assault: A safe admission for women*

Australian Medical Board newsletter, October 2016

Western Australia State Administrative Tribunal *Orders for the Medical Board of Australia, Robert Wolman VR:94/2015* and *Annex A* to the order.

October 2016