

Submission to the AHPRA review on the use of chaperoning restrictions

While the issue of chaperoning per se is not one which has affected me directly, I would like to offer the perspective of someone who is both a medical practitioner and who has been severely traumatised by a sexual assault by a health care professional. I want to state in no uncertain terms that the damage caused by a breach of trust of this nature is immense, and cannot be undone. My personal experience is of significant ongoing mental health problems and a negative impact on my relationships with health care professionals, to the detriment of my medical care.

It is my opinion that however rigorous the current chaperoning arrangements may appear on paper, failures will inevitably occur because of the interpersonal dynamics inherent in abuse. In a nutshell, the sort of person who is capable of serially abusing patients in the first place will almost certainly make strenuous efforts to evade observation and reporting so that they can continue that behaviour, and the sort of person who is targeted as a victim will likely have difficulty recognising, stopping or reporting the abuse, regardless of the presence of a chaperone.

As a medical practitioner I appreciate that an allegation of professional misconduct has a potentially devastating personal and professional impact, and that even if an allegation is found to be unsubstantiated there will be long term consequences for the practitioner. I accept that an accused practitioner is entitled to the presumption of innocence and to procedural fairness in the handling of a complaint. However, all of this must be balanced by the need to ensure individual patient safety and the maintenance of confidence in the medical profession as a whole.

Abusers rely for success on the ambiguity of a situation and a difference in power and confidence between themselves and their victims. Before they go as far as overt abuse they will have tested the boundaries of potential victims in more subtle ways, both verbally and behaviourally. Having selected those who are least likely to understand where the boundaries should lie, are least likely to resist or complain, and least likely to be believed or helped if they do complain, they start with a plausibly deniable action and then escalate the abuse, carefully keeping it at a level where the discomfort or risk for the patient of speaking up is greater than that of tolerating it. Particularly when there has been abuse on a previous occasion, victimisation need not involve physical contact or inappropriate behaviour which is obvious to a chaperone. It may simply involve an oblique reference to a previous incident, a particular look, touching of the abuser's own body or subtly drawing attention to evidence of sexual arousal.

If the victim's discomfort reaches a level where they are finally prepared to speak up, the abuser's usual response is to deny their actions completely or to assert that their actions have been misinterpreted, using their greater knowledge and power to persuade or humiliate the patient into silence. The abuser may also engage in punitive behaviour which is difficult to challenge, for example losing or 'forgetting' to sign forms or acting against a patient's stated care preferences on the grounds that the patient lacks the necessary knowledge or insight to make an informed decision (particularly when psychiatric diagnoses are involved). The fact that there is very rarely any overt verbal or physical threat used to compel compliance or silence in a medical setting means that these secondary acts also have plausible deniability.

The abuser will also draw on their personal and professional reputation, eliciting sympathy and support from friends and colleagues in an attempt to enhance their credibility, while simultaneously

using the very characteristics of individuals which make them more susceptible to victimisation (intellectual or cognitive impairment and prior history of victimisation especially if this has resulted in allegations which could not be proven, or has led to dysfunctional behaviour) to reduce their credibility.

These same factors which increase the chances of a particular patient being victimised also increase the likelihood of a physiological 'freeze' response, both physically impairing the patient's ability to stop the abuse or to speak up, and potentially impairing memory formation of the event, with obvious implications for the credibility of the victim. The fact that the freeze response is involuntary and is independent of the victim's apparent level of social and intellectual functioning in other circumstances is something which does not seem to be well understood or accepted, however I can personally attest both to its reality and to the sense of confusion and shame it causes.

The presence of a chaperone may not help, and may in fact make the situation worse.

If a patient is reluctant to speak up for fear of being humiliated by the doctor, a chaperone may be perceived as being merely another party to that humiliation, an even stronger reason not to say anything. If abuse occurs despite the presence of a chaperone, the patient will be made to feel even more helpless, and will also be less likely to be believed because the abuser now has apparent corroboration of their innocence. The abuser may feel emboldened by the knowledge that they have got away with their behaviour. An abuser may even see the presence of a chaperone as a challenge.


A patient-nominated chaperone may not be comfortable directly and continuously observing an intimate examination, and may not be able to see what is happening if the examination is internal or the view is obstructed by the position of the doctor. The chaperone may lack the medical knowledge to understand what touching is appropriate and what is not. The patient may be embarrassed at speaking up in the presence of someone they know, and the chaperone may not be any more confident or comfortable about speaking up than the patient.

Despite measures to exclude those with whom a doctor has a pre-existing relationship which may lead to perceived or actual bias in favour of the doctor, a chaperone approved by the Board may still feel protective of the doctor, particularly if the patient is seen as difficult or unpleasant, or the chaperone does not believe the doctor to be guilty of the alleged misconduct. A chaperone with whom the patient has no prior relationship will not necessarily be perceived by them as independent or trustworthy. The power differential between doctor and chaperone is likely to be less than between doctor and patient, but where it exists will almost certainly be taken advantage of.

Either type of chaperone may be deceived into looking away or leaving the room briefly for reasons that seem perfectly legitimate. This is something which is freely acknowledged by my colleagues.

In summary, there are a number of factors which can contribute to failure of chaperoning to protect patients. An understanding of the dynamics of abuse should lead to certain factors being seen as warning signs of particularly high risk eg multiple allegations against the doctor, the choice of particularly vulnerable victims or a pattern of escalation in the behaviour. In these circumstances the current balance seems to be too far in favour of protecting the doctor and their reputation, at the expense of patient safety.

I have no specific recommendations to make on how these problems might best be addressed, but would suggest that in reviewing the manner in which patient safety is managed in the setting of alleged or admitted sexual misconduct by a doctor, that far more weight be given to the psychological and behavioural aspects of the situation than is currently the case. Chaperoning is not a panacea. It may be helpful to apply a trauma-informed approach and to make use of the considerable knowledge base which exists already as a result of activities such as the preparation of the 2012 Victorian Chief Psychiatrist's guidelines for promoting sexual safety in adult psychiatric inpatient units¹ and the 2013 report on sexual victimisation of women in Victorian psychiatric inpatient units², and the current Royal Commission into Institutional Responses to Child Sexual Abuse.


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¹ 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*

² Victorian Mental Illness Awareness Council (2013) *Zero Tolerance For Sexual Assault: A safe admission for women*