AHPRA
Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology
Australian Health Practitioner Regulation Agency

Review of the Use of Chaperones

3 October 2016

Submission by The Community Reference Group to the Review of the Use of Chaperones

In preparing this submission the Community Reference Group (CRG) sought individual input from each of its members, with a view to being able to raise issues about the use of chaperones, rather than to prepare a single response or opinion which purported to represent the consolidated and agreed view of the group as a whole. As a result, some views did not receive support from all members. This submission attempts to distinguish between those views shared b y the group as a whole and those put forward by individual members.

Do you think chaperone conditions are an effective measure to protect patients, and why?

Two members expressed a personal preference to avoid using chaperones at all, primarily on the basis of what the types of conduct giving rise to the imposition of chaperone conditions may say about the practitioner's fitness to practise at all. However, the same member also acknowledged the interim and intended protective nature of such conditions.

In the responses of other members to this question, it was clear that some members of the CRG do think that chaperone conditions can be an effective measure to protect patients. However, it was also clear that those members considered that the imposition of conditions requiring the use of chaperones is not fool proof. Practical illustrations of the limitations of the use of chaperones included:

- a patient being examined behind a screen while the chaperone is in the room but does not have sight of the patient and the practitioner; and
- consultations initiated and conducted by phone, by either a practitioner or a patient, neither of whom requests the presence of a chaperone or informs the chaperone that the call is to be made.

In the first case, the requirement for the presence of a chaperone is complied with in form only. In both cases, the chaperone is deprived of the ability to monitor the conduct of the practitioner.

The publicly available documents in relation to the use of chaperones presently include the statement that 'In general a requirement to practice with a chaperone is applicable only to practitioners who are engaged in private practice', but without explanation of why that is the case. While clearly the difference is the result of the greater levels of supervision and management control that may be available in larger or public practices, that may not be clear to individual members of the public and possibly would benefit from more information or explanation.Consistency and education, in public hopsitals and private practice, in how the policy is implemented would be paramount.

One responding member also questioned how the regulator or anyone else would know that patients who have been informed for the need of a chaperone have really understood the reason for it. There is substantial care taken with the selection of chaperones and the provision to them of information about their responsibilities. On the other hand, it is likely that the general public, who will be the users of the services of a practitioner who is required to have a chaperone, will be informed mainly or wholly by the

signs posted in the affected practice. These contain little information, and do not necessarily take into account language and literacy factors or cultural considerations. The potential for the lack of information to affect patient choices about the presence of a chaperone or the substance of any required consent, including the consent to some examinations or procedures, to be adversely affected. This led the member to form the concern that a patient may not have a full understanding of the reasons for the chaperone requirement in any given case. Currently there is no consent form required from the patient to indicate that they understand the need for a chaperone.

The same member raised the issue of how much advance notice is given to a patient to arrange for their own chaperone or to agree to the chaperone that is being provided or offered. It was also not clear what attention was given to accommodating alternative arrangements, which may be required where a patient prefers a male or female or someone from a similar culture.

One responding member noted that the appointment of a chaperone is a temporary measure to protect patients, allowing a practitioner to continue in practice while an investigation of an allegation of serious misconduct takes place. However, as with some other conditions imposed as temporary measures, it represents a limitation on a practitioner's ability to practise and puts the onus on the Medical Board of Australia and the Australian Health Practitioner Regulation Agency to prioritize the investigation and complete it expeditiously. While speed of investigation in such circumstances is desirable, other considerations affecting an investigation may mean that it continues for some time. Speed of investigation may not be consistent with the need for thorough and appropriate investigation, and the restrictions on practice may remain in place for some considerable time.

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

One member put the view that there is a need for training of chaperones to enable them to deal with the communication needs of patients with particular types of disabilities, for example limited or no verbal communication, intellectual impairment (including dementia), or those who come from different cultural backgrounds. This may require some chaperones to specalise.

More than one response supported the view that information for patients is critical and that patient preference should be given priority. In this view, as already noted, the timing of advising patients of the requirement for chaperones is also critical. It is preferable that the information and the requirement for a decision not be at the last minute, as this may have the damaging consequence that the patient may come under indirect or direct influence from the practitioner to go ahead with the interaction.

In the normal course of clinical care, patients have the right to choose who will be present during a clinical encounter, including by definition whether they wish to have a chaperone present. In cases where the chaperone is required by conditions, this choice, and thus the patient's right to control over their privacy, is compromised. If a patient is told that a chaperone must be present at the point when they actually enter their appointment, their autonomy and choice about their care have been substantially reduced. While they have the choice to not attend the appointment, many factors such as costs, time off work, waiting lists, social pressure not to be 'rude', medical urgency etc may pressure them into accepting the presence of the chaperone, when they would not otherwise wish to do so. Thus, it may be more appropriate that practitioners be required to inform patients about the requirement for chaperone presence when they make an appointment, or otherwise are about to begin clinical engagement with a practitioner.

It may also be appropriate to distinguish between different groups of patients. There may be a valid distinction between groups who are loyal to the practitioner (in the sense that they are longer standing) and those who are not. In the case of the former group, it may be appropriate that they are notified in advance, in writing or by email, that a chaperone condition is in place and they have the option to choose their own chaperone, go ahead with an AHPRA chosen one, or choose another practitioner. If a requirement of this nature were to be examined further, it would also be appropriate to consider how much detail would be required in the disclosure, and to consider the impacts of disclosure on the practitioner's practice.

One member strongly supported the requirement that chaperone conditions imposed on a practitioner be published on the register. The reasons advanced in support of this view include:

- patients have a right to known that such conditions are being imposed, so they can make informed decisions about whether they wish to engage with the practitioner;

- this provides better surveillance of compliance, because there are more 'eyes on the ground' who know what the practitioner should be doing, and are able to report it if they are not; and
- it ensures new employers who check the register are informed of the conditions.

If chaperone conditions are public information, and awareness of chaperone conditions is in the public interest, then it is also appropriate that practitioners be obliged to be upfront with potential or actual patients about chaperone conditions imposed on their practice, and the reasons for these. Given that the substantial bulk of chaperone conditions result from instances of sexual impropriety, the need to protect patients from the significant harm of sexual abuse may be seen to override a practitioner's privacy.

If a patient asks why a chaperone is required, the practitioner should be obliged to inform them truthfully and accurately.

To the greatest extent possible in the circumstances, the chaperone should be independent of the practitioner. Members generally opposed the idea of practitioners choosing or nominating their own chaperones on the basis that there is an inherent perceived conflict of interest in doing this, even in the light of the existence of protocols for choosing. One member favoured excluding family, friends, colleagues and employees from being chaperones, on the basis of the significant power imbalances likely to affect the relationships of any member of any of these groups with the practitioner, particularly those of employees. In the view of this member, there is evidence in the criminology literature, and in case law, that those who engage in, excuse or cover up sexual offending often manage to 'find each other', and can be complicit in group behaviours of offending or supporting offending. Allowing practitioners to choose their chaperones may allow such a pattern to occur. Secondly, in this member's view there is strong evidence of toxic power dynamics in healthcare systems that could mean a chaperone, chosen due to their vulnerability, may feel pressured to 'keep their mouth shut' about ongoing suspect behaviour or misconduct.

In what circumstances do you think chaperone conditions are not appropriate, and why?

The use of a chaperone as a protective measure while allegations are investigated and/or evidence is tested at a hearing tends to be contrary to the fundamental principle of the presumption of innocence. Since the imposition of a chaperone restriction is likely to have very serious reputational implications for the practitioner, which in turn may have significant impact on their livelihood, it is considered inappropriate until there is sufficient, and sufficiently robust, evidence to support the restriction.

One member expressed a strong concern about addressing the cultural needs of patients especially indigenous and CALD patients where the choice of chaperone is critical and may on any particular occasion need to take into account gender, clinical procedure, communication, or a number of other considerations. An understanding by these patients of the concept of a chaperone cannot necessarily be assumed and therefore merely giving them a choice may disregard important cultural considerations. It may be preferable, even necessary, for these categories of patients to be clearly offered another practitioner whilst the investigation proceeds.

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

One alternative suggested by one member may be to prevent the practitioner dealing with a particular group or cohort of patients while the allegations are investigated and examined. In the same way as the imposition of conditions about chaperones does, such a proposal necessarily raises the implication that matters should or could be expedited so that the length of time it takes to investigate and conclude the matter could be limited.

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

There is experience that suggests, albeit anecdotally, that patients can be confused, may misunderstand, and even be afraid to raise a complaint about sexual misconduct. This gives rise to the suggestion that some information and knowledge based prevention strategies may be considered. Patients being aware of and knowing the contents of the code of conduct for practitioners for example can be useful and may work towards patients speaking up sooner, or avoiding situations in which inappropriate conduct may occur.