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AMA submission to the independent review of chaperones to protect patients

The AMA welcomes this opportunity to contribute to the independent review of the chaperones to protect patients. Medical regulatory bodies in Australia, and elsewhere, are faced with a very small number of very difficult decisions relating to the registration of health care professionals who are subject to complaints about or have been convicted of sexual assault, sexual indecency or child pornography offences.

Recent high-profile cases have brought the issues surrounding the chaperone system to the media's attention. They reveal that the laws, policies and compliance strategies utilised and adopted by the regulatory bodies involved require review in order to develop a consistent approach that meets the community's expectations of protecting the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner do so.

At its broadest level, the role of the Medical Board of Australia (the Board) is to put in place systems and regulations to support the safe practice of medicine in Australia, both for practitioners and the public. They are risk based regulators. Risk in any system is regarded as two-dimensional: it provides the basis for consumer protection on the one hand (protecting against risk), while encouraging enterprise on the other (encouraging and actively managing entrepreneurship).

The chaperone system implemented by the Board and the Australian Health Practitioner Regulatory Agency (AHPRA) aims to serve a dual purpose of protecting the public through the placement of appropriate restrictions upon a practitioner's registration, whilst allowing the practitioner to continue to treat patients in a safe manner until the complaint has been resolved. Often the Board uses restrictions requiring chaperones as a protective measure while allegations are investigated and/or evidence is tested at a hearing.

Various governments manage situations of serious allegations of misconduct differently. In New Zealand, a condition on the registration or annual practising certificate of a practitioner may require a chaperone to be present at certain types of consultations. This condition is usually as a result of past disciplinary action and is intended to provide protection for patients. It requires a notice to be put up in the waiting and examination areas to inform patients¹.

In the United Kingdom, undertakings (such as holding a chaperone) may only be agreed where the case examiners have decided that the doctor's fitness to practise is impaired (or is likely to be, on recurrence of a medical condition), where to do so would provide sufficient protection to the public

¹ <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/When-another-person-is-present-during-a-consultation.pdf>

and where there is no possibility of erasure should the matter proceed to a medical practitioners tribunal². Given that there is always potential for a case to result in a conviction, practitioners are effectively immediately suspended once a notification is made.

The Australian system is similar to the one operating in New Zealand. A move towards a system like the one operating in the United Kingdom would have the following consequences:

- a) Practitioners with allegations against them will be removed from their practice for a substantial period of time potentially losing their referral base, their professional reputation their standing in practice, or ultimately their business.
- b) Boards may be reticent to impose such a harsh penalty and take a more lenient approach than otherwise desirable (particularly if evidence is difficult to obtain).
- c) Practitioners who are concerned that they may be subject to false claims will need to employ a chaperone to be present at all times to ensure they have a witness as a preventative measure. Patients may bear the cost of this additional resource.

At the outset, the AMA would not support a move to completely remove the ability for the Board to impose a chaperone as a part of a restriction upon a practitioner's practice. The principles of procedural fairness should be maintained. The AMA considers that there are opportunities to considerably strengthen the system to provide better protection for patients and practitioners. The limitations upon the system and options to improve it are discussed below.

Appropriateness of using a chaperone

It is currently not clear what criteria the Board (and the supporting state and territory boards) use to determine if a chaperone is an appropriate restriction to place upon a practitioner's practice. It is also not clear at what stage during an investigation of a practitioner the use of a chaperone becomes appropriate; and whether the appropriateness of this restriction is reviewed as the case progresses. This is particularly relevant when the case proceeds to a criminal investigation, which can be lengthy.

The chaperone system needs to be able to demonstrate a high standard of procedural fairness to ensure a chaperone is an appropriate response to a notification. Decisions to impose chaperones should not be taken lightly. The use of a chaperone is obviously suggestive of an issue with the practitioner's practice and can effect a practitioner's career or income.

It would be beneficial if AHPRA and the Board established a clear escalation process within the protocol for the use of chaperones. This process should identify when it is appropriate to impose the use of a chaperone as a restriction, under what circumstances this restriction should be reviewed, and under what circumstances it is no longer appropriate for a chaperone to be used.

This protocol should then be consistently applied by all of the boards.

Requirements upon chaperones

The practitioner with the restrictions is required to inform the chaperone of the requirements of the chaperone protocol and the Board's expectations of the practitioner to the chaperone. Whilst the protocol specifies that the practitioner is to observe the interactions with the patient, given the

² http://www.gmc-uk.org/DC4599_CE_Decision_Guidance_Making_decisions_on_cases_at_the_end_of_the_investigation_stage.pdf 58070536.pdf

repeated failures to do so³, it would appear that chaperones are not clear about their responsibilities.

The AMA would prefer that the AHPRA case officer inform the chaperone of their responsibilities. This would ensure that the chaperone was properly informed of, and actually understands, their duties and expectations. This would also allow the case officer to have greater insight into the ability of the chaperone to perform their duties prior to agreeing to their appointment. This is most relevant where the patient can choose their own chaperone, such as a family member.

Finally, the chaperone protocol, states that 'contact' between the doctor and patient is not confined just to the consultation but includes seeing a patient in person or via a *communication device*. As the chaperone is to be physically present and observe all contact, it is not clear how the protocol supports observing instances where the doctor and patient talk over the phone (for example, to discuss test results). The chaperone protocol should be amended to add the requirement that "the chaperone to be present when the practitioner sees a patient via a communication device".

Choice of Chaperones

The Chaperone protocol allows the practitioner to choose their chaperone. It would appear that provided they meet set criteria the chaperone will be endorsed by AHPRA. The criteria note that the chaperone should not be friends or relatives of the doctor, nor should they be employees or have a financial relationship with the doctor.

However there is an exemption, where

"In particular circumstances, where it can be demonstrated that it is not possible to access chaperones which meet the above criteria, individuals who are directly employed by you and/or who are not registered health practitioners may be approved as chaperones".

This protocol should be strengthened to ensure a chaperone does not have a real or perceived conflict of interest, and whilst difficult for some practitioner's permanent employees of the practitioner should not be able to be a chaperone. There is a clear imbalance of power and conflict of interest. The review may wish to consider whether it would be more appropriate for the Board to appoint and remunerate the chaperone rather than the practitioner in order to remove any conflict of interest.

Further, the Chaperone Protocol doesn't address patients who lack decision-making capacity (and thus need a substitute decision-maker to consent to the chaperone). The AMA believes the protocol would be strengthened with the inclusion of a provision to allow a substitute decision-maker to appoint a chaperone.

Who is to be notified of the chaperone restrictions?

The *Health Practitioner Regulation National Law Act (2009)* appears to let AHPRA seek information about the practitioner's *employer* for the purposes of implementing restrictions. However, the current wording appears to limit AHPRA in its ability to ensure that all places of practice are monitored. Given the variety of methods of engaging a person for their services that are used in the

³Dr Gomez <https://www.ahpra.gov.au/News/2015-11-18-doctor-suspended.aspx>

Dr Rall <http://www.medicalboard.gov.au/News/2016-06-01-unable-to-reapply.aspx>

Mr Black <http://www.hccc.nsw.gov.au/Publications/Media-releases/2015/Mr-Robert-Anthony-John-Black---professional-misconduct-found-by-the-NSW-Civil---Administrative-Tribunal>

medical industry, a broader definition that allowed AHPRA to interact with all places of practice is required.

Summary

The chaperone system aims to protect the public through the placement of appropriate restrictions upon a practitioner's registration, whilst allowing the practitioner to treat patients in a safe manner. The chaperone system needs to be able to demonstrate a high standard of procedural fairness to ensure a chaperone is an appropriate response to a notification and the imposition of a chaperone as a restriction should be considered carefully. The AMA advocates for the legislation and protocol that support this system to be strengthened as outlined above to provide greater protection to the public.

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