



## Statement on Sexual Relationships between Health Practitioners and their Patients

One role of the Medical Board of Queensland, other Health Practitioner Boards and the Queensland Nursing Council (for simplicity, referred to as a Board from here on) is to receive, assess and investigate complaints about the conduct of doctors, nurses or other health practitioners.

Following an investigation, a Board may prefer a charge to be heard before a disciplinary tribunal. This statement has been prepared to provide guidance to health practitioners and nurses (from here on, for simplicity, referred to as health practitioners) and to inform the public of the expected standard of conduct.

This statement must be read in conjunction with the *Health Practitioners (Professional Standards) Act 1999*, the *Nursing Act 1992* and the *Health Rights Commission Act 1991*.

### 1. PREAMBLE

1.1 The public and the health professions have an expectation that the therapeutic context is a safe one for patients. Safety is an integral aspect of health. The proper and professional relationship between a patient and health practitioner is one where the health of the patient is of primary concern.

1.2 It is the health practitioner's responsibility to behave ethically at all times, and to maintain professional boundaries with patients and the patient's immediate family members and significant others.

1.3 The relationship between a health practitioner and a patient is not one of equality, because the patient is seeking assistance and guidance, and may need to reveal intimate physical and emotional details.

1.4 While health practitioners may not be aware of their influence, patients usually perceive a power differential between themselves and their treating health practitioners. Given this power differential, any exploitation of the relationship between the patient and the health practitioner for the gratification of the practitioner, is an abuse of power.

1.5 Consent by the patient is not an acceptable defence in the case of sexual behaviours within a relationship between a patient and a medical practitioner, nurse, occupational therapist or psychologist. It may be a defence in other allied health professions provided the consent was an informed consent.

1.6 Adequate contact with professional peers, supervisors and / or mentors should be maintained to allow for professional and personal support, advice and critical opinion on how best to manage difficult situations.

This is particularly important for health practitioners who are isolated by distance or practice area. It is important to seek the support and advice of peers and to keep meticulous records.

1.7 Where there is a suspicion that the activity is criminal in nature, the relevant Board may report the matter to the police or to another appropriate authority for investigation and / or action.

## **2. DEFINITIONS**

2.1 Sexual behaviour is defined as any words or actions that might reasonably be interpreted as being designed or intended to arouse or gratify sexual desires.

2.2 Sexual exploitation or abuse may be considered under two categories:

- Sexual harassment
- Sexual relationship

2.2.1 Sexual harassment is unwelcome behaviour of a sexual nature including, but not limited to, gestures and expressions. The intention of the person performing the behaviour is immaterial, but if that person intended to offend, humiliate or intimidate the patient, then the behaviour of the practitioner would be considered more serious. The conduct of the person performing the behaviour will be judged according to the standards of members of the same profession who are of good repute and competence. Sexual harassment incorporates (but is not limited to):

- a) making an unsolicited demand or request, whether directly or by implication, for sexual favours;
- b) inappropriate disrobing or inadequate draping;
- c) intimate examinations without informed consent (can also be defined as sexual assault and may be referred to the police);
- d) irrelevant mention of a patient's or practitioner's sexual practices, problems or orientation;
- e) ridicule of a patient's sexual preferences or orientation;
- f) comments about sexual performance that are not pertinent to the professional interaction;
- g) requesting details of sexual history or sexual preferences not relevant to the professional interaction;
- h) conversations regarding the sexual problems or fantasies of the health practitioner;
- i) making suggestive comments about a patient's appearance or body. (s119, Anti Discrimination Act 1991)

2.2.2 A sexual relationship describes the totality of the relationship between two people, where the relationship has some sexual aspect, including any sexual activity between a health practitioner and a patient. This holds whether the relationship is initiated by the patient or not and whether consented to or not. It includes, but is not limited to, physical stimulation, kissing, penetration, masturbation, or genital activity.

2.3 Sexual assault is also known as criminal assault which is defined in the Criminal Code as:

S245

A person who strikes, touches, or moves, or otherwise applies force of any kind to the person of another, either directly or indirectly, without his (sic) consent, or with his consent if the consent is obtained by fraud ... is said to assault that other person, and the act is called an assault.

2.4 The term Patient used in this document includes client, consumer or health service user.

2.5 Professional boundaries are legal and interpersonal limits deemed appropriate by members of the same profession who are of good repute and competence. These limits are the basis for a relationship of honesty and integrity. They create a safe space for treatment, allowing openness and personal disclosure by the patient. Dual relationships are not appropriate. That is, where a professional relationship exists, other kinds of relationships must be avoided to reduce the likelihood of role confusion and boundary violation.

Physical contact is an integral part of healing.

Supportive physical gestures can be essential in helping someone, or giving reassurance. However, such contact must always be non-erotic in intention.

Similarly, any social contacts must be conducted in ways that do not confuse the patient about the professional relationship, or lead them to believe that a sexual relationship is possible. The patient can expect empathy, sincerity, unconditional regard and confidentiality but not a sexual relationship.

### **3. CURRENT PATIENTS**

3.1 All forms of sexual behaviour in a relationship between a health practitioner and a current patient are improper and unprofessional. Any report of such activity will be investigated by the relevant Board and action may be taken if there is evidence of such a relationship.

3.2 Sexual behaviour with a patient may affect the clinical judgement of the health practitioner in the management of the patient.

3.3 The existence of actual harm to the patient is not relevant to the consideration of whether the sexual behaviour is exploitative or abusive.

3.4 A sexual relationship with a member of a current patient's immediate family may also be considered improper and unprofessional. Each case will be assessed individually.

3.5 The presence of the health practitioner in a small community will be a factor to be noted when cases of a relationship with a current patient are individually assessed.

#### 4 FORMER PATIENTS

4.1 A former patient is a person who was in a treating relationship with the health practitioner.

4.2 A sexual relationship between a health practitioner and a former patient will be considered individually by the relevant Board. It may be deemed to be improper and unprofessional if any of the following apply:

4.2.1 the professional relationship involved psycho-therapy, long term counselling or support;

4.2.2 the patient suffered a disorder likely to impair judgement or hinder decision making;

4.2.3 the health practitioner is aware that the patient had been sexually abused in the past;

4.2.4 the patient was under the age of 18 when the personal / sexual relationship commenced;

4.2.5 the treating relationship has not been properly terminated, with appropriate referral arrangements for continuing and future health needs made.

4.3 In any case of a sexual relationship between a health practitioner and a former patient it will be deemed improper and unprofessional if it can be shown that there was any exploitation of power imbalance or of any knowledge or influence gained by the practitioner within the professional relationship.

4.4 Where violation of the professional boundary occurs as a result of the behaviour of the patient, but not of the health practitioner, the health practitioner should seek the opinion of a member of the same profession. Any decision made to either continue or terminate must always be in the best interests of the patient.

4.5 The termination of the relationship between a health practitioner and a patient prior to the commencement of sexual activity may be raised as an exonerating or mitigating factor by the health practitioner. The strength of the factor will depend on a number of considerations including (but not limited to ):

4.5.1 the strength and duration of the treating relationship;

4.5.2 the time interval since the end of the professional relationship;

4.5.3 the existence of an intervening period of no contact;

4.5.4 the existence of a period of social contact prior to the initiation of sexual contact;

4.5.5 whether another health practitioner was treating the patient when the sexual activity began.

Termination and referral to another practitioner alone may not be considered sufficient preparation for establishing a sexual relationship with a former patient.

4.6 Similar considerations apply to relationships with family members of former patients.

4.7 The presence of the health practitioner in a small community will be a factor to be noted when cases of a relationship with a former patient are individually assessed.

## **5 REPORTING A SEXUAL RELATIONSHIP BETWEEN A HEALTH PRACTITIONER AND A PATIENT**

5.1 A health practitioner who becomes aware that another practitioner has behaved improperly and unprofessionally by engaging in sexually exploitative or abusive behaviour toward a patient or former patient should take appropriate action including reporting to the relevant Board or the Health Rights Commissioner and / or encouraging the patient to report the matter.

5.2 When informed by a patient that another health practitioner may have been involved in sexually exploitative or abusive behaviour, health practitioners have an obligation to:

5.2.1 inform the patient of their rights;

5.2.2 endeavour to answer any questions the patient raises about the issue of sexual exploitation or abuse by health practitioners;

5.2.3 ask whether the patient wishes to make a report to the Health Rights Commissioner or appropriate Board;

5.2.4 refer them to an independent third party who may provide support and assistance in writing their report;

5.2.5 keep accurate and detailed records of the patient's disclosure of the other health practitioner's behaviour.

5.3 If the patient does not want their name revealed, but still wants the matter reported, the health practitioner should report to the appropriate Board, disclosing the details provided by the patient, and the reasons for anonymity.

5.4 If the patient does not want to report, the health practitioner needs to make a judgement based on the specifics of the case weighed against the patient's choice. While there is no obligation for the health practitioner to take the matter further, evidence of, for instance, ongoing abuse, exploitation or criminal activity would be grounds to disregard the patient's wishes.

## 6 RECEIVING AND HANDLING COMPLAINTS

6.1 The Health Rights Commission has an integral role in the management of complaints about sexual misconduct by health practitioners.

6.1.1 Under Section 51 of the Health Practitioners (Professional Standards) Act 1999 and Section 102A(2) of the Nursing Act 1992 where a Board receives a complaint about a health service provider from or on behalf of a health service user, the complaint must be referred to the Health Rights Commissioner for assessment unless:

- the Board and the Commissioner agree it is in the public interest for the Board to deal with the complaint or refer the complaint to another entity;
- the Board immediately suspends or imposes conditions on the practitioner's registration; or
- the complaint is about a matter that occurred before July 1991 and the complainant was aware of the matter before July 1991.

6.1.2 If the complaint is referred to the Commission, the Board is then to take no further action unless the Commissioner refers the complaint back to the Board under the Health Rights Commission Act 1991.

6.1.3 Under Sections 68, 74 or 77 of the Health Rights Commission Act 1991, the Commissioner may, following consultation with the provider's registration Board, refer a matter to the Board for investigation. The Board must provide the Commissioner with a report of the findings from the investigation and any action taken or proposed to be taken by the Board.

6.1.4 Under Section 130 of the Health Right Commission Act 1991, the Commissioner may intervene in disciplinary proceedings and become a party to the proceedings before a Registration Board, the Professional Conduct Committee, the Health Practitioners Tribunal or a professional conduct review panel.

6.2 *Boards will ensure complainants are treated fairly by:*

6.2.1 providing information about the complaints procedure and disciplinary proceedings;

6.2.2 ensuring, as far as possible, that the identity of the complainant is not released to the practitioner until the complainant's authority to do so is received, or the matter progresses to a charge being heard before the Professional Conduct Committee or Health Practitioners Tribunal;

6.2.3 explaining the procedure for formal complaints to any person wishing to make a complaint;

6.2.4 providing practical assistance in writing a formal complaint (including translation service);

6.2.5 accepting a complaint on behalf of another person where the person is not able to complain on their own behalf (e.g. because of a mental illness or intellectual disability);

6.2.6 providing as much information as may be practicable to the complainant about the outcomes of any investigation or hearing, including any conditions on the health practitioner's registration and the conditions under which they may return to practice;

6.2.7 handling complaints in a timely manner, and carrying out investigation promptly;

6.2.8 advising complainants of appropriate counselling services;

6.2.9 ensuring complainants are aware of any right to legal representation, advocacy and personal support;

6.2.10 advising complainants of the possibility of the disciplinary tribunal ordering that the hearing be closed to the public, that evidence may be taken by teleconference, video or with the witness screened from the practitioner, and if the complainant wishes, making submissions to the tribunal that these measures be considered;

6.2.11 advising complainants that interpreters, private waiting rooms, and appropriate adjournment procedures are available to ensure they are able to give their evidence, and making submissions to the tribunal to consider these measures where necessary;

6.2.12 ensuring that the issues of gender balance and consumer representation on the hearing panel or tribunal are considered.

6.3 Boards will ensure that the rights of the health practitioner are protected by: 6.3.1 informing the practitioner of the receipt of a complaint where the Board plans to take action on the complaint;

6.3.2 informing the practitioner of the particulars (details) of the complaint;

6.3.3 informing the practitioner of their right of response to the complaint;

6.3.4 informing the practitioner of their right to legal or other representation;

6.3.5 informing the practitioner of appropriate counselling services without any presumption of guilt;

6.3.6 investigating the complaint promptly; 6.3.7 informing the practitioner of their right to refuse to answer questions from an investigator or the tribunal on the grounds of self-incrimination, where that right exists;

6.3.8 providing the practitioner with a copy of any transcript or tape recording of any interview they have with an investigator;

6.3.9 providing the practitioner with an outline of adverse findings from the investigation;

6.3.10 informing the practitioner of the appeals mechanism;

6.3.11 ensuring that the health practitioner is given an adequate opportunity to present their case;

6.3.12 instituting procedures for receiving and processing anonymous complaints which record the facts of the complaint and protect the confidentiality of the person complained against.

*6.4 When assessing complaints, the Board will use the principle that when the health or safety of the complainant is at risk, the rights of the complainant will take precedence.*

*6.5 Boards will take action to ensure their staff are adequately prepared to receive and handle complaints of this nature by:*

6.5.1 providing training for staff for receipt of such complaints; 6.5.2 providing training where appropriate for investigators and prosecutors in procedures designed to minimise for complainants emotional trauma from the hearing process;

6.5.3 providing appropriate resources for the receipt and handling of complaints, including time, privacy, and support for staff;

6.5.4 being aware that publication of reporting processes and disciplinary arrangements may lead to an increase of reports, and having resources available to deal with these expeditiously.

## **7. MANAGEMENT OF OFFENDERS**

### 7.1 Introduction

7.1.1 The first priority of the Boards is protection of the public.

7.1.2 While any sexual behaviour with a patient is unprofessional and improper, in determining appropriate action, each case must be examined individually in relation to:

- the degree of dependency between the patient and the health practitioner;
- the duration and nature of the professional relationship;
- extent and pattern of sexual behaviour by the health practitioner;
- evidence of exploitation;
- the nature of the services provided;
- outcomes for the patient.

7.1.3 The disciplinary tribunal may determine to cancel the health practitioner's licence and / or not entertain any future application for restoration of that licence. However, in some cases, the tribunal may recommend that the health practitioner undergo assessment and rehabilitation.

### *7.2 Assessment and Rehabilitation*

7.2.1 Rehabilitation of offending practitioners may not always be successful, but assessment and treatment will be available.

7.2.2 The onus is on the practitioner to meet the proper standards of rehabilitation before reregistration or restoration of an unconditional licence to practice.

7.2.3 The practitioner is responsible for meeting the costs of assessment and rehabilitation, and of assessment of progress.

7.2.4 Successful rehabilitation requires the practitioner to admit the impropriety of the behaviour and demonstrate an understanding of the adverse effects for the exploited or abused patient and for others such as the patient's family.

### 7.3 Assessment

The Boards will nominate a panel of psychiatrists and psychologists with expertise in sexual abuse matters. An offending health practitioner may be assessed by an appointee from the panel. The recommendations arising from that assessment may be used by the disciplinary tribunal to assist in their deliberations.

### 7.4 Rehabilitation

Where rehabilitation is assessed to be possible, the offender may nominate the therapist, provided the therapist has expertise in the treatment and rehabilitation of sexual offenders. The nomination must be approved by the Board. The aim of the therapy will be to ensure, as far as possible, that the health practitioner will practise safely in the future.

### 7.5 Reassessment

Before hearing any application for re-registration or for the lifting of conditions on practice, the Board will require an assessment of the health practitioner's progress following therapy. The aim of the assessment is to ascertain whether it is safe for the practitioner to be allowed to return to unrestricted practice.

The assessment will, wherever possible, be carried out by the same assessor(s) who conducted the initial assessment. If this is not possible, the assessment will be carried out by assessors drawn from the panel of assessors. A full report of the assessment will be made available to the Board. If the report indicates that sufficient progress has been made, it will include a practice plan that may be developed into conditions on the practitioner's licence to practice. Conditions may include, but are not limited to:

7.5.1 a requirement to be supervised by a suitably qualified practitioner nominated by the Board;

7.5.2 an agreement not to work in isolated settings (either geographically or professionally isolated);

7.5.3 the times and places at which the practitioner may provide a health service.

## 8. RISK MANAGEMENT

8.1 There are known precursors or risk factors to boundary violation for which health practitioners should be alert. These include, but are not limited to:

- Giving inappropriate special status to the patient, such as seeing the patient at odd hours in the absence of an emergency or compelling clinical reason, or at a venue other than the usual (especially when other staff will not be present);
- Sharing intimate details of the health practitioner's life, especially personal crises or sexual desires or practices;
- Stating an attraction to the patient;

- Inappropriate discussion of sexual problems that should be referred to another therapist;
- Extending personal social invitations, or having professional interactions in social settings, for example, over meals;
- Requesting or pressuring a patient to perform a task or joint activity for the primary benefit of the practitioner;
- Entering into a dual role with the patient, for instance offering assistance outside the usual scope of therapy such as to become the patient's supervisor.

8.2 There are also factors that increase the likelihood of health practitioners engaging in activities that violate professional boundaries. Health practitioners should be alert for the following factors in their own lives, and take steps to ensure they do not adversely affect their professional relationships with patients:

- Personal life stress;
- Breakdown of the practitioner's personal relationships;
- Drug or alcohol abuse;
- Professional isolation; and / or
- Mental illness.

8.3 The use of chaperones may be a strategy to consider in some situations. Chaperonage is not the only method of avoiding situations involving risk. Patients have the right to a mutually acceptable third party being present during examinations or treatments if they wish.

Patients should be informed that they may bring a person of their choosing with them. In some cases the health practitioner or institution may be able to provide a third party.

8.4 Where health practitioners believe that the situation is risky, they have the right to insist that a mutually acceptable third party be present during examinations or treatments. Health practitioners may refuse to conduct examinations or treatments if the patient refuses consent for an appropriate third party to be in the room. In such a situation, appropriate referral to another health practitioner should occur.

With acknowledgments to:

1. the Medical Council of New Zealand brochures and policy statements on sexual abuse in the doctor / patient relationship.
2. the Physiotherapists Board of Queensland policy statement re physiotherapists and sexual misconduct.
3. the Medical Board of Queensland's Policy on Sexual Misconduct by Medical Practitioners.
4. Health Care Complaints Commission of NSW draft brochure on Sexual Misconduct by a Member of a Health Profession.
5. Final Report of the Review of Professional Indemnity Arrangements for Health Care Professionals Compensation and Professional Indemnity in Health Care November 1995.