Medical Board of Australia

Guidelines

28 October 2011

Sexual Boundaries: Guidelines for doctors

1. Introduction

These guidelines have been developed under section 39 of the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory.

These guidelines complement "***Good Medical Practice: A Code of Conduct for Doctors in Australia***" *(Good Medical Practice)* and provide specific guidance on sexual boundaries in the doctor-patient relationship.

Section 1.4 of Good Medical Practice states:

"Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy."

"Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality."

Section 8.2 of Good Medical Practice states:

"Professional boundaries are integral to a good doctor-patient relationship. They promote good care for patients and protect both parties. Good medical practice involves:

- *maintaining professional boundaries*
- *never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient*
- *avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress."*

2. Summary of these guidelines

Good medical practice relies on trust between doctors and patients and their families. It is always unethical and unprofessional for a doctor to breach this trust by entering into a sexual relationship with a patient, regardless of whether the patient has consented to the relationship. It may also be unethical and unprofessional for a doctor to enter into a sexual relationship with a former patient, an existing patient's carer or a close relative of an existing patient, if this breaches the trust the patient placed in the doctor.

The Medical Board of Australia (the Board) will investigate a doctor who is alleged to have breached these guidelines and if the allegations are found to be substantiated, the Board will take action (see section 10).

3. Understanding and defining sexual boundaries

Sexual misconduct covers a range of inappropriate professional behaviours including sexualised behaviour, sexual exploitation or abuse, entering into a sexual relationship, and sexual assault. Criminal offences will be investigated by the police.

Sexual Misconduct

Under mandatory reporting requirements practitioners, employers and education providers must report 'notifiable conduct' which includes engaging in sexual misconduct in connection with the practice of the profession. Refer to section 10 of these guidelines for more information.

Sexual misconduct includes:

- engaging in sexual activity with:
    - a current patient regardless of whether the patient consented to the activity or not
    - a person who is closely related to a patient under the doctor's care
    - a person formerly under a doctor's care
- making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient.

In managing sexual boundaries a doctor should be aware that:

- sexualised behaviour includes any words or actions that might reasonably be interpreted as being designed or intended to arouse or gratify sexual desire
- sexual exploitation or abuse includes sexual harassment or entering into a sexual relationship
- sexual harassment is unwelcome behaviour of a sexual nature including, but not limited to, gestures and expressions. The doctor's intention in behaving in this way does not minimise the seriousness of the behaviour. However, if they intended to offend, humiliate or intimidate the patient, then the behaviour would be regarded even more seriously. Sexual harassment includes:
    (a) making an unsolicited demand or request, whether directly or by implication, for sexual favours
    (b) irrelevant mention of a patient's or doctor's sexual practices, problems or orientation
    (c) ridicule of a patient's sexual preferences or orientation
    (d) comments about sexual history that are not relevant to the clinical issue
    (e) requesting details of sexual history or sexual preferences not relevant to the clinical issue
    (f) conversations about the sexual problems or fantasies of the doctor
    (g) making suggestive comments about a patient's appearance or body.
- inappropriate disrobing or inadequate draping for a physical examination, and conducting intimate examinations without adequate prior explanation (and thus without informed consent) may be considered a breach of sexual boundaries
- **sexual assault ranges from physical touching (or examination without consent) to rape and is a criminal offence that should be investigated by the police**
- a sexual relationship describes the totality of the relationship between two people, when the relationship has some sexual element, including any sexual activity between a doctor and their patient. This is the case whether or not the sexual relationship was initiated by the patient.

4. Why breaching sexual boundaries is unethical and usually harmful

A breach of sexual boundaries is unethical and unprofessional because it exploits the doctor-patient relationship, undermines the trust that patients (and the community) have in their doctors and may cause profound psychological harm to patients and compromise their medical care.

Power imbalance

The doctor-patient relationship is inherently unequal. The patient is often vulnerable. In many clinical situations, the patient may depend emotionally on the doctor. It is an abuse of this power imbalance for a doctor to enter into a sexual relationship with a patient.

Trust

Trust is the foundation of a good doctor-patient relationship. Patients need to trust that their doctors will act in their best interests. It is a breach of trust for a doctor to enter into a sexual relationship with a patient. This breach of trust may impact on that patient's (or other patients') ability to trust other doctors.

Loss of objectivity

A sexual relationship, even if the patient is a consenting adult, may impair the doctor's judgement and compromise the patient's care.

5. Sexual relationships with former patients

It may be unprofessional for a doctor to enter into a sexual relationship with a former patient, if this breaches the trust the patient placed in the doctor. When considering such allegations the Board would take into account:

- the duration of care provided by the doctor; for example, if there had been long-term emotional or psychological treatment provided
- the level of vulnerability of the patient
- the degree of dependence in the doctor-patient relationship
- the time elapsed since the end of the professional relationship
- the manner in which and reason why the professional relationship was terminated
- the context in which the sexual relationship was established.

6. Establishing and maintaining boundaries

Doctors are responsible for establishing and maintaining boundaries with their patients. A doctor should not:

- enter into a sexual relationship with a patient even with the patient's consent
- discuss his or her own sexual problems or fantasies
- make unnecessary comments about a patient's body or clothing or make other sexually suggestive comments
- ask questions about a patient's sexual history or preferences unless this is relevant to the patient's problem and the doctor has explained why it is necessary to discuss the matter.

7. The importance of good communication

The Board regularly receives notifications from patients who have felt that a doctor's actions were inappropriate and/or sexually motivated. All notifications are taken seriously and when a matter is investigated, some notifications are found to arise from a doctor's poor communication. It can emerge that the consultation was appropriate and the examination was clinically indicated, but that the doctor did not explain (or the patient did not understand) why he or she asked particular questions or conducted a particular examination. Good, clear communication is the most effective way to avoid misunderstandings.

8. Professional standards in physical examinations

Good medical practice in conducting physical examinations includes:

- explaining to the patient what is to occur in the examination and providing an opportunity for the patient to ask questions
- gaining the consent of the patient to conduct an examination
- being sensitive to any sign the patient has withdrawn consent
- not continuing with an examination when consent is uncertain, has been refused or has been withdrawn
- allowing a patient to undress and dress in private. A doctor should not assist a patient to undress or dress unless the patient is having difficulty and requests assistance
- providing suitable covering during an examination
- using gloves when examining genitals or conducting internal examinations
- not allowing the patient to remain undressed for any longer than is needed for the examination
- gaining the patient's permission if anyone else, including medical students, is to be present during an examination or consultation
- allowing a patient to bring a support person who may be a family member, close relative or friend

Use of chaperones when conducting intimate examinations

When discussing what is to occur in an intimate examination, a doctor should respond sensitively to a patient's questions and concerns. A doctor should explore with the patient the value of a chaperone being present during the examination or allow the patient to bring a support person of their choice, if this would make the patient feel more comfortable.

Sometimes a chaperone is not available, or the patient may not be comfortable with the choice of chaperone. Under these circumstances the doctor should offer to postpone the examination until an appropriate chaperone is available, if this is does not impact on the patient's health care.

A doctor should ensure the patient does not feel compromised or pressured into proceeding with an examination if a chaperone, or an acceptable chaperone, is not available.

If a doctor provides a chaperone, the chaperone must:

- be qualified e.g. a registered or enrolled nurse or appropriately trained, that is, the chaperone understands the support role they are performing on behalf of the patient
- be of a gender approved by the patient or the patient's support person such as a parent, carer, guardian or friend
- respect the privacy and dignity of the patient.

9. Warning signs

The beginning of a sexual relationship between a doctor and a patient may not always be immediately obvious to either doctor or patient. Doctors need to be alert to warning signs that indicate that boundaries may be being crossed. Warning signs include:

- patients requesting or receiving non-urgent appointments at unusual hours or locations, especially when other staff are not present
- inviting each other out socially
- a doctor revealing intimate details of his or her life, especially personal crises or sexual desires or practices, to patients during a professional consultation
- patients asking personal questions, using sexually explicit language or being overly affectionate

- patients attempting to give expensive gifts.

If a doctor senses any of these warning signs, or if a patient talks about or displays inappropriate feelings towards the doctor or exhibits sexualised behaviour, the doctor should consider whether this is interfering with the patient's care and/or placing the doctor (or the patient) at risk. In such instances, the doctor should seek advice from an experienced and trusted colleague or a professional indemnity insurer on how to best manage the situation.

If there is a possibility that the doctor may not remain objective or that boundaries could be breached, the doctor should transfer the patient's care to another practitioner.

10. Obligations of medical practitioners to report allegations of sexual misconduct

Engaging in sexual misconduct in connection with the practice of the profession is "notifiable conduct" under the National Law.

Under mandatory reporting requirements, practitioners, employers and education providers must report 'notifiable conduct', as defined in s. 140 of the National Law, to the Australian Health Practitioner Regulation Agency (AHPRA), to prevent the public being placed at risk of harm.

Notifiable conduct includes engaging in sexual misconduct in connection with the practice of the profession. This means engaging in sexual misconduct with persons under a doctor's care or linked to a doctor's practice of his or her profession.

For more information about mandatory notifications refer to the Guidelines for mandatory notifications on the Board's website at www.medicalboard.gov.au.

11. The role of the Medical Board of Australia

All medical practitioners practising in Australia must be registered with the Medical Board of Australia (the Board).

The primary role of the Board is to protect the public by ensuring that only medical practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

The Board can investigate concerns about the professional conduct, performance, and/or health of registered medical practitioners. It can also take a range of actions to protect the public.

In cases of serious unprofessional conduct, the Board has the power to suspend registration and/or refer a matter to a tribunal or court, where a medical practitioner's registration may be cancelled. In cases involving allegations of less serious unprofessional conduct, the Board has the power to impose conditions on the doctor's registration, require the medical practitioner to undergo counselling, supervision, undertake further education, caution the practitioner or accept an undertaking from the practitioner.

Review

These guidelines will take effect on 28 October 2011. The Board will review these guidelines from time to time.