SERIOUS DISCIPLINARY PROCEEDINGS AGAINST AUSTRALIAN HEALTH PRACTITIONERS FOR SEXUAL MISCONDUCT

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The Health Practitioner Regulation National Law *('*National Law*') enacted in all the States and Territories currently regulates 15 different health professions in Australia. This research explores how complaints of sexual misconduct under the National Law against the five major health professions — nurses and midwives, doctors, psychologists, pharmacists, and dentists — appear, and are responded to, at the tribunal level. These cases represent the matters deemed the most serious by regulators and referred to an independent tribunal not dominated by the relevant profession to be heard and determined in public. This research examines how decision-makers characterise the seriousness of the conduct and how they articulate and weigh factors used to determine appropriate protective orders.*

Differences in outcomes across professions and across state and territory jurisdictions are explored through a qualitative analysis of the text of reasons in order to understand why such variation is occurring. Areas of divergence included: a lesser likelihood of restrictive sanction for the medical profession compared to the other health professions, varied approaches to agreed sanctions, different emphasis on individual risk rather than general deterrence, and reduction of periods of removal of practice by reference to 'time served' under an interim suspension.

I suggest that greater transparency and consistency could be achieved in health discipline through the nationwide development of qualitative guidance on sanctions broadly, and on the categorisation of seriousness, and the assessment of public safety and public interest in sanction in sexual misconduct matters specifically. I further argue that the current legislative provisions and administrative guidance governing how matters are referred

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to the tribunal system may require attention in order to ensure that sexual misconduct matters are being dealt with more consistently and transparently.

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I Introduction

There has been increased attention to the issue of sexual misconduct and abuse by health professionals in recent years, and on the response of regulators, particularly in dealing with serial offenders.[1] In 2016, the Medical Board of Australia and the Australian Health Practitioner Regulation Agency ('AHPRA') commissioned an independent review ('Paterson Inquiry') of the use of so-called 'chaperone' conditions, which allow doctors to practise while under (and sometimes following) investigation for sexual misconduct.[2] That review was triggered by a public scandal after a Melbourne neurologist indecently assaulted a male patient while practising under 'chaperone' conditions, imposed by reason of an earlier similar complaint; with dozens more patients ultimately coming forward after the issue was made public.[3] Ron Paterson, a former Health and Disability Commissioner in New Zealand, was appointed to

[1] See, eg, *Royal Commission into Institutional Responses to Child Sexual Abuse* (Report of Case Study No 27, March 2016).

[2] Ron Paterson, *Independent Review of the Use of Chaperones to Protect Patients in Australia* (Report, February 2017). See also Australian Health Practitioner Regulation Agency, *Chaperone Protocol* (Report, December 2016).

[3] Paterson (n 2) 13–14.

conduct the wide-ranging review, with the Medical Board of Australia and AHPRA swiftly committing to implementing all recommendations.[4] Throughout 2019, public attention to such issues continued, with media reporting of a string of criminal proceedings against several doctors, each accused of inappropriately touching multiple female patients,[5] and significant adverse media reporting of a tribunal determination in which a doctor, who made a series of

[4] Medical Board of Australia, 'Medical Board and AHPRA Adopt All Recommendations of Chaperone Report' (Media Release, 11 April 2017). Despite the recommendation against the use of 'chaperone conditions', it appears that they continue to be used. For example, a Dr Sudusinghe received a wholly suspended sentence after being convicted of assaulting a patient, yet he continues to practise under chaperone conditions: Warren Barnsley, 'Qld Doctor Walks Free for Sexual Assault', *St George & Sutherland Shire Leader* (online, 1 February 2019) <https://www.theleader.com.au/story/5881460/qld-doctor-walks-free-for-sexual-assault/>, archived at <https://perma.cc/GMR5-PJK2>.

[5] See, eg, Kathleen Calderwood, 'Sharif Fattah is Sentenced to 16 Years in Jail for Sexually Assaulting 10 Patients', *ABC News* (online, 2 August 2019) <https://www.abc.net.au/news/2019-08-02/camden-doctor-sharif-fattah-jailed-sexual-assault-of-patients/11379280>, archived at <https://perma.cc/GZV4-3LJF>; for a case with a charge concerning 19 patients, Melissa Cunningham 'Wangaratta Doctor Stewart Geoffrey Moroney, 68, Charged with Sexual Assault Found Dead', *Illawarra Mercury* (online, 15 February 2019) <https://www.illawarramercury.com.au/story/5906051/doctor-accused-of-sexually-assaulting-patients-found-dead/?cs=7483>, archived at <https://perma.cc/N6W4-7SKB>; Cameron Houston, 'Doctor Accused of Assaulting 50 Women Won't Stand Trial', *The Age* (online, 28 August 2019) <https://www.theage.com.au/national/victoria/doctor-accused-of-assaulting-50-women-won-t-stand-trial-20190828-p52liz.html>, archived at <https://perma.cc/2PTC-QKXJ>; 'Accused Doctor Jeremy Coleman's Sex Trial Moved to Sydney', *Newcastle Herald* (online, 24 October) <https://www.newcastleherald.com.au/story/6456976/accused-doctor-jeremy-colemans-re-trial-over-alleged-sex-assault-moved-to-sydney/>, archived at <https://perma.cc/962U-56JN>. See also reporting from 2018: Australian Associated Press, 'Melbourne Dentist Jailed for Indecently Assaulting Patients and Staff over Two Decades', *The Guardian* (online, 22 November 2018) <https://www.theguardian.com/australia-news/2018/nov/22/melbourne-dentist-jailed-for-indecently-assaulting-patients-and-staff-over-two-decades>, archived at <https://perma.cc/QJ3C-NX7X>.

online comments in favour of rape and domestic violence,[6] was suspended for only six weeks.[7]

Between 2.7% and 7.2% of formal complaints about health practitioners in Australia concern sexual misconduct.[8] Research on patient experience suggests sexual misconduct by health practitioners is underreported,[9] and that patients

[6] See, eg, Melissa Davey, 'Doctor Suspended over Rape Remarks Also Shared Patient X-Rays Online', *The Guardian* (online, 26 April 2019) <https://www.theguardian.com/australia-news/2019/apr/26/doctor-suspended-over-remarks-also-shared-patient-x-rays-online>, archived at <https://perma.cc/GL93-JB4C>; Melissa Davey, 'Melbourne Doctor Who Called for Women to Be Raped Stood Down During Investigation', *The Guardian* (online, 29 April 2019) <https://www.theguardian.com/australia-news/2019/apr/29/melbourne-doctor-christopher-kwan-chen-lee-who-called-for-women-to-be-raped-stood-down-during-investigation>, archived at <https://perma.cc/V9KY-3VG5>; Melissa Davey, 'Doctor Who Called for Women to Be Raped to Be Investigated over Dozens More Posts', *The Guardian* (online, 1 May 2019) <https://www.theguardian.com/australia-news/2019/may/01/doctor-who-called-for-women-to-be-raped-was-not-suspended-until-two-years-after-complaints>, archived at <https://perma.cc/EQ3R-3LKK>. In response, the hospital at which the doctor worked, the Australian Council of Emergency Medicine and the Australian Medical Association all released public statements, and the Victorian Minister for Health asked for a review of the sanction. Following media investigation further matters were uncovered which led to a further interim suspension: Yara Murray-Atfield, 'Doctor Who Repeatedly Called for Women to be Raped Online Condemned for "Appalling" Behaviour', *ABC News* (online, 25 April 2019) <https://www.abc.net.au/news/2019-04-25/doctor-who-called-for-women-to-be-raped-condemned/11046158>, archived at <https://perma.cc/BA9C-ZMN2>; Melissa Davey, 'Doctor Who Said "Some Women Deserve to Be Raped" Suspended Indefinitely', *The Guardian* (online, 7 June 2019) <https://www.theguardian.com/australia-news/2019/jun/07/doctor-who-said-some-women-deserve-to-be-raped-suspended-indefinitely>, archived at <https://perma.cc/JN8B-YV6D>.

[7] *Medical Board of Australia v Lee* [2019] TASHPT 3 ('*Lee 2019*'). Note that this case proceeded on the basis of an agreed sanction, an issue discussed later in this article: see below Part IV(E).

[8] See Matthew Spittal et al, 'Outcomes of Notification to Health Practitioner Boards: A Retrospective Cohort Study' (2016) 14(1) *BioMed Central Medicine* 198, 201; below n 48 and accompanying text. Note that a later study of complaints against three complementary health professions from 2011–16 found a higher proportion of complaints concerned 'sexual boundaries': physiotherapists (7.9%), chiropractors (10.3%) and osteopaths (17.1%): Anna Ryan, Lay San Too and Marie Bismark, 'Complaints about Chiropractors, Osteopaths, and Physiotherapists: A Retrospective Cohort Study of Health, Performance, and Conduct Concerns' (2018) 26(12) *Chiropractic and Manual Therapies* 1, 4. Note that a study of 6,714 health disciplinary cases in the United Kingdom ('UK') from 2014–16 found that sexual misconduct accounted for 9.4% of matters: Rosalind Searle et al, '*Bad Apples? Bad Barrels? Or Bad Cellars? Antecedents and Processes of Professional Misconduct in UK Health and Social Care: Insights into Sexual Misconduct and Dishonesty*' (Report, 2017) 17 ('*Insights into Sexual Misconduct and Dishonesty*').

[9] Paterson (n 2) 27. In the United States ('US'), see the large-scale investigation into sexual abuse by doctors by the *Atlanta Journal-Constitution* from 2016: Carrie Teegardin and Danny Robbins, 'Still Forgiven', *The Atlanta Journal-Constitution: Doctors & Sex Abuse* (Web Page) <http://doctors.ajc.com/>, archived at <https://perma.cc/U43S-FU7C>. The investigators

may be even less likely to report sexual abuse than those who experience sexual abuse in other contexts.[10] Patients may be reluctant to report sexual misconduct because of ongoing loyalty to the practitioner, feelings of shame or guilt, or concern about what the complaint process entails in terms of their own participation.[11] It is also common, in instances of unwarranted intimate touching occurring under the guise of clinical treatment, for patients to be unsure about whether the conduct was a 'normal' part of treatment.[12]

This article explores how complaints of sexual misconduct against health professionals appear, and are responded to, under the *Health Practitioner Regulation National Law* ('*National Law*') regulating health professions in Australia, by examining those cases that appear at tribunal level. Tribunal cases are not necessarily representative of the incidence and types of sexual misconduct occurring in each profession or even of the balance of formal complaints made to health regulators. Rather, they represent the matters deemed the most serious by regulators and referred to an independent tribunal for public resolution.[13]

This research seeks to understand how serious sexual misconduct cases are dealt with in terms of how decision-makers characterise the seriousness of the relevant conduct and how they articulate and weigh factors used to determine appropriate protective orders. Previous work within this broader study identified variations between sanctions for sexual misconduct at tribunal level, with the likelihood of restrictive outcomes differing across the five main health

found that most complaints of sexual misconduct were not followed through by hospitals or clinics with official notifications, and so did not become part of the relevant state disciplinary process: Lois Norder, Jeff Ernsthausen and Danny Robbins, 'Why Sexual Misconduct Is Difficult to Uncover', *The Atlanta Journal-Constitution: Doctors & Sex Abuse* (Web Page) <http://doctors.ajc.com/sex_abuse_numbers/>, archived at <https://perma.cc/7Q5C-36WT>.

[10] See James DuBois et al, 'Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases' (2019) 31(5) *Sexual Abuse* 503, 504.

[11] See ibid; Carolyn Quadrio, 'Sexual Abuse in Therapy: Gender Issues' (1996) 30(1) *Australian and New Zealand Journal of Psychiatry* 124, 125; Merrilyn Walton, 'Sex and the Practitioner: The Predator' (2002) 34(1) *Australian Journal of Forensic Sciences* 7; Patricia Easteal, 'Suppressing the Voices of the Survivors: Sexual Exploitation by Health Practitioners' (1998) 33(3) *Australian Journal of Social Issues* 211.

[12] See Searle et al, *Insights into Sexual Misconduct and Dishonesty* (n 8) 22–3; Easteal (n 11) 214. Note also that the recipients of such reports may not be receptive to them, or take steps to have them formally recorded. For references to patients who made reports to police and health practitioners being 'dissuaded' from pursuing them: see below n 153.

[13] Australian Health Practitioner Regulation Agency, *2018–19 Annual Report: Our National Scheme* (Report, 2019) 74 ('*AHPRA Annual Report*').

professions, and across different State and Territory jurisdictions.[14] This article explores possible reasons for these differences through a qualitative analysis of available decisions.

Part I of this article first outlines briefly the structure of how the *National Law* regulates health professionals; the scope of the study of which this analysis forms a part; and explores how definitions of sexual misconduct appear in the *National Law* through legislation, regulatory guidance and professional level Codes of Conduct. It then provides an overview of the case set in order to contextualise the cases examined.

Within Part II, this article explores how both inherent and relational vulnerabilities are taken into account in cases concerning sexual relationships between health practitioners and patients or former patients, to determine the degree of seriousness. While the terminology of 'mitigating' or 'aggravating' factors is rarely used, explicitly, by Australian health practitioner tribunals, this Part examines the factors that tend towards conclusions of greater or lesser seriousness. It also explores what appear to be differences in approach between some health professions — particularly dentists — about whether evidence of 'extra' vulnerability or exploitation, over and above the therapeutic relationship, is required for the threshold of misconduct to be established.

In Part III, cases involving inappropriate contact between health practitioners and patients are examined. The high level of crossover with criminal proceedings is noted, and consequences of these dual proceedings for the disciplinary process are explored. These include the incorporation of criminal law norms and modes of analysis, such as: a focus on recent complaint, patient prior inconsistent statements, practitioner mens rea, as well as the use of wiretap evidence obtained by police through a process which problematically required patients to re-engage with the practitioner.

Part IV addresses sanction. In that Part the key principles in disciplinary outcomes are first noted, and then areas of divergence in sanctions across jurisdictions and professions, and possible explanations for such variation, are explored. These include: varying degrees of importance placed upon 'denunciation' or general deterrence, jurisdictional difference in 'crediting' periods of interim suspension towards sanction, variation in the use of suspension rather than deregistration, deference to 'special skills', and the role of agreed facts and sanctions.

[14] See Jenni Millbank, 'Health Practitioner Regulation: Has the National Law Produced National Outcomes in Serious Disciplinary Matters?' (2019) 47(4) *Federal Law Review* 631 ('Health Practitioner Regulation').

A *The* National Law *and This Study*

The *National Law* enacted in all the states and territories currently regulates 15 different health professions in Australia, comprising over 700,000 registrants.[15] While there is some jurisdictional variation in terms of which agencies undertake disciplinary investigations,[16] and slight differences in definitions and legislative provisions in some states and territories, the scheme has broadly uniform rules addressing unprofessional conduct and misconduct.[17]

The vast majority of formal complaints against health practitioners (which may be made as mandatory or voluntary notifications under the *National Law*)[18] are handled within the professional board system, in which matters are channelled into health, performance and conduct 'pathways' within each profession, if found to have some basis.[19] Practitioners with health issues are managed by an impaired registrants panel, while those with unsatisfactory professional performance or illegal, unethical or unprofessional conduct face a performance and professional standards panel.[20] An immediate action panel can

[15] See *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) ('*National Law Act (NSW)*'); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law Act 2009* (Qld) ('*National Law Act (Qld)*'); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas); *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic); *Health Practitioner Regulation National Law (WA) Act 2010* (WA). See also 'Release of Consultation Paper on Proposed Legislative Updates to National Registration', *Australian Health Practitioner Regulation Agency* (Media Release, 6 August 2018).

[16] Most significantly, NSW maintained its own well-established complaint investigation and referral disciplinary system within which to apply the law: see Claudette S Satchell et al, 'Approaches to Management of Complaints and Notifications about Health Practitioners in Australia' (2016) 40(3) *Australian Health Review* 311. NSW is thus designated a 'co-regulatory' jurisdiction, and Queensland took a similar approach in 2014 with the creation of the Office of the Health Ombudsman to receive complaints, although that body can refer back to the National Boards and does not manage all complaints: see *AHPRA Annual Report* (n 13) 122.

[17] See generally Belinda Bennett et al, 'Australia's National Registration and Accreditation Scheme for Health Practitioners: A National Approach to Polycentric Regulation?' (2018) 40(2) *Sydney Law Review* 159.

[18] *National Law Act (Qld)* (n 15) pt 8 divs 2–3.

[19] Ibid s 138. In NSW, professional councils perform the same function as boards and in Queensland, this function is performed by the Office of the Health Ombudsman: *AHPRA Annual Report* (n 13) 10.

[20] For a clear overview, including flow charts: see 'Find Out about the Notifications Process', *AHPRA & National Boards* (Web Page, 29 March 2019) <AHPRA https://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx>, archived at <https://perma.cc/L6AS-4LWF>. On the development and functions of impaired registrants panels prior to the *National Law*: see Kay Wilhelm and Alison Reid, 'Critical

be convened by the relevant board at any time if a risk to the public is identified.[21] Each pathway may result in the imposition of conditions on a practitioner's registration or an interim suspension.[22] The specific reasoning and outcomes of these processes are largely opaque to the public, with only very limited de-identified summary information released on a small number of matters,[23] and large-scale aggregate data on complaint types and outcomes.[24]

If the matter is of sufficient seriousness, such that there is a reasonable belief that the 'practitioner may have behaved in a way that constituted professional misconduct', the panel must refer it to a legally-headed disciplinary tribunal;[25]

Decision Points in the Management of Impaired Doctors: The New South Wales Medical Board Program' (2004) 181(7) *Medical Journal of Australia* 372; Naham (Jack) Warhaft, 'The Victorian Doctors Health Program: The First 3 Years' (2004) 181(7) *Medical Journal of Australia* 376.

[21] See 'Immediate Action', *AHPRA & National Boards* (Web Page, 26 April 2019) <https://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Immediate-action.aspx>, archived at <https://perma.cc/CDP9-D7ES>. For discussion of immediate action provisions under the National Law: see *Bernadt v Medical Board of Australia* [2013] WASCA 259. Paterson (n 2) recommends clearer guidance on when immediate action should be taken in sexual misconduct matters: at 9, 80.

[22] See 'Possible Outcomes', *AHPRA & National Boards* (Web Page, 19 October 2016) <https://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Possible-outcomes.aspx>, archived at <https://perma.cc/JKQ2-5YNG> ('Possible Outcomes').

[23] AHPRA publishes very brief summary information on its website from a limited number of conduct and standards panels: 'Panel Decisions', *AHPRA & National Boards* (Web Page, 7 February 2020) <https://www.ahpra.gov.au/Publications/Panel-Decisions.aspx>, archived at <https://perma.cc/E8KX-WT3M> ('Panel Decisions').

[24] Each National Board reports on complaint outcomes in AHPRA's annual report: see *AHPRA Annual Report* (n 13) 10–46.

[25] *National Law Act (Qld)* (n 15) s 190(b)(i). Prior to the introduction of the *National Law*, Ian Freckelton expressed concern about the possibility 'that regulatory boards will endeavour to categorise unprofessional conduct as often as they can at a low enough level for their internal bodies (such as professional standards panels) to retain jurisdiction over decision-making rather than entrusting it to the external tribunal': Ian Freckelton, 'Trends in Regulation of Mental Health Practitioners' (2008) 15(3) *Psychiatry, Psychology and Law* 415, 418. Examining the limited information on select panel outcomes listed on the AHPRA website from 2010–19, it appears that referral levels may still be quite low: 'Panel Decisions' (n 23). For example, at the end of 2019, there were 15 matters annotated 'Boundary violation — inappropriate sexual relationship', five of which were determined as 'no case to answer'; none of the remainder were referred to a tribunal. Twenty-seven matters were annotated as 'Inappropriate sexual contact' or 'Inappropriate sexual comments' of which 12 were determined as 'no case to answer'; of the remainder, three were referred to tribunal level and 12 were not. Noting that sexual misconduct matters could also have been concealed under descriptors such as 'breach of condition' and 'boundary violation', and that there appeared to be little consistency in the designation of matters (such that matters involving, for example, a practitioner: hugging the patient, inviting her to his home and plying her with alcohol; conducting an unjustified breast examination; conducting an intimate examination without consent; and, asking the mother of a patient

the only body with the power to deregister a practitioner altogether.[26] Tribunals are state-based and are chaired by a legal member with one, or sometimes two professional members, in addition to a non-practitioner or 'community' member.[27] This can be contrasted with National Boards (and their respective Panels and Committees), which are overwhelmingly dominated by members of the relevant profession.[28] Tribunals are the only body in the disciplinary system in which proceedings are generally held in public and reasons are publicly released (usually suppressing the names of patients but not practitioners).[29] The tribunal setting is therefore of significance as the site of determination of the most serious health disciplinary matters in a non-peer setting which is open to public scrutiny.[30]

This work was undertaken as part of a broader study which analysed the first seven years of available tribunal cases under the *National Law*, with the overarching goal of mapping the relationship between type of misconduct and outcome.[31] The study analysed all publicly available Australian tribunal-level decisions concerning complaints of serious misconduct and/or impairment brought against the five most populous regulated health professions from 1 July 2010 to 30 June 2017. The professions were, in order from most to least populous: nurses and midwives, doctors, psychologists, pharmacists, and dentists. The overall dataset comprised 794 cases, of which 765 involved proved matters.

Initial analysis found that doctors were less likely than nurses and psychologists to be deregistered in cases where sexual misconduct was proved.[32] This

about her sexual life, all appeared under the annotations 'Boundary violation — non sexual' and 'Communication — insensitive or inappropriate comments (not sexual)', it seems likely that this snapshot also underrepresents the incidence of sexual misconduct complaints.

[26] For an overview of the potential outcomes of a complaint, including de-registration, see 'Possible Outcomes' (n 22).

[27] Australian Health Practitioner Regulation Agency, *Tribunal Hearings* (Information Sheet, April 2019) ('*Tribunal Hearings*').

[28] See Australian Health Practitioner Regulation Agency, *Panel Hearings* (Information Sheet, April 2019) 1 ('*Panel Hearings*').

[29] See *Tribunal Hearings* (n 27) 1. Cf panel hearings which, by law, are not open to the public: *Panel Hearings* (n 28).

[30] In the Canadian context, see Joan Brockman, 'The Research Challenges of Exposing Physicians' Sexual Misconduct in Canada' (2018) 26(4) *Critical Criminology* 527, which argues that doctors 'benefit from the cloak of secrecy that surrounds professional administrative action': at 527.

[31] See also Millbank, 'Health Practitioner Regulation' (n 14).

[32] Of doctors found to have committed sexual misconduct (n=62), 48.4% were deregistered and 30.6% were suspended; of nurses and midwives (n=37), 73% were deregistered and 10.8% suspended; of psychologists (n=40), 57.5% were deregistered and 37.5% suspended: Jenni

finding is consistent with the limited international research, particularly on recent disciplinary outcomes from the United Kingdom ('UK')[33] and New Zealand.[34] While the number of cases in the dataset means that statistically significant conclusions are not possible within the category of sexual misconduct, it is important to note that a trend of differential outcomes was present across every area of comparison, even when variables such as legal representation were taken into account.[35] So, for example, looking only at cases in this dataset in which male mental health professionals had sexual relationships with female patients, psychiatrists were much less likely to be deregistered, and, when deregistered, were removed from practice for a shorter period compared to psychologists and nurses.[36] One of the questions arising from this research is whether the divergence apparent at tribunal level is an indication that there are underlying differences in how the various regulated health professions understand, and respond to, sexual misconduct.

Millbank, 'Serious Misconduct of Health Professionals in Disciplinary Tribunals under the National Law 2010–17' (2020) 44(2) *Australian Health Review* 190, 197 ('Serious Misconduct of Health Professionals'). The data involving the eight dentists (five of whom were deregistered and two suspended), and three pharmacists (two of whom werederegistered) was not enough to be statistically significant. This finding is consistent with research on outcomes in the New Zealand Health Practitioners Disciplinary Tribunal (comparing the general misconduct of doctors and nurses): Lois Surgenor et al, 'New Zealand's Health Practitioners Disciplinary Tribunal: An Analysis of Decisions 2004–2014' (2016) 24(1) *Journal of Law and Medicine* 239, 250. It is also consistent with findings on outcomes from an early study of complaint data under the *National Law*: Spittal et al (n 8) 206.

[33] A recent review of 232 sexual misconduct disciplinary cases in the UK found a statistically significant association between profession and sanction, with 46% of doctors suspended in proved matters compared to 7.83% of nurses, and conversely 33% of doctors were deregistered compared to 62% of nurses: Rosalind Searle, *Sexual Misconduct in Health and Social Care: Understanding Types of Abuse and Perpetrators' Moral Mindsets* (Report, September 2019) 20 ('*Sexual Misconduct in Health and Social Care*'). See also Searle, *Insights into Sexual Misconduct and Dishonesty* (n 8) 27–9, comparing doctors, nurses and 'allied professionals' (a range of 16 professions, including many that are regulated in Australia under the *National Law*, such as psychologists and paramedics, but also others who are not such, such as social workers). However, note that the sanction analysis in Searle, *Insights into Sexual Misconduct and Dishonesty* (n 8) was undertaken on only a selection of the 265 sexual misconduct cases. For an overview of the UK system, see D Beech, TJ David and S Ellson, 'The Professional Standards Authority: Overseeing the Health and Social Care Regulators' (2018) 2(2) *Manchester Medical Journal* 1.

[34] See, Lois Surgenor, Kate Diesfeld and Martha Rychert, 'Consensual Sexual Relationships between Health Practitioners and Their Patients: An Analysis of Disciplinary Cases from New Zealand' (2019) 26(5) *Psychiatry, Psychology and Law* 766. This study reported on 26 cases: at 772–5.

[35] See also the discussion in Millbank, 'Health Practitioner Regulation' (n 14).

[36] Deregistration was ordered for two of four psychiatrists (50%), 12 of 14 nurses (86%) and 13 of 17 psychologists (76.5%) in this sub-group with an average non-review period of 1.25 years, 2.63 years and three years, respectively.

Variable outcomes across state and territory jurisdictions were also apparent.[37] The smaller states were markedly less likely to order deregistration compared to NSW, Victoria and Queensland.[38] Deregistration for proved sexual misconduct was ordered more frequently in NSW than elsewhere, as was prohibition from working in other health professions.[39]

This article provides a qualitative textual analysis of the reasoning in 160 sexual misconduct decisions to understand how, and why, such cases may be treated differently from one another, in terms of the assessment of the seriousness of the conduct, the risk to the public, and the determination of outcome. Each case is a discretionary decision under broad statutory grounds.[40] The protective nature of the jurisdiction, in which the health and safety of the public is a primary objective, means that discretionary decision-making is both appropriate and necessary. This includes an evaluation of evolving professional norms and ethical codes in determining the seriousness of conduct, and necessarily also involves somewhat speculative reasoning in terms of future risk analysis and deterrence value or 'signals' to the profession and the public in the determination of outcome.

B *What Is 'Sexual Misconduct'?*

It is noteworthy that there is no legal category, nor a definition, of 'sexual misconduct' in the *National Law*. Disciplinary proceedings under the *National Law* rest instead on two broad categories of 'unprofessional conduct' and the more

[37] See also the suggestion by Paterson, that there were inconsistencies in practice across medical board committees in different jurisdictions concerning 'when restrictions are imposed and what level of restriction is deemed necessary': Paterson (n 2) 76. Paterson reported that these differences are 'possibly influenced by varying signals from responsible tribunals': at 77.

[38] Proved sexual misconduct in NSW (n=62) resulted in 74.2% deregistration, 12.9% suspension and was accompanied by a prohibition order in 32.3% of cases; Victoria (n=30) resulted in 50% deregistration, 33.3% suspension and was accompanied by a prohibition order in no cases; Queensland (n=30) resulted in 43.3% deregistration, 40% suspension and was accompanied by a prohibition order in no cases; Western Australia (n=18) resulted in 38.9% deregistration, 22.2% suspension and was accompanied by a prohibition order in 11.1% of cases. South Australia, Tasmania and the Australian Capital Territory ('ACT') combined (n=10) resulted in 40% deregistration, 60% suspension and was accompanied by a prohibition order in no cases. There were no sexual misconduct cases at all available for the Northern Territory, noting that *Medical Board of Australia v Liyanage* [2017] NTCAT 770 was determined after the case set was closed.

[39] Millbank, 'Serious Misconduct of Health Professionals' (n 32) 196.

[40] See, eg, *National Law Act (Qld)* (n 15) s 196.

serious 'professional misconduct'.[41] Whether an act constitutes unprofessional conduct or professional misconduct is understood through the application of profession-specific codes of conduct and professional guidelines, as well as the accepted norms within the profession itself.[42] In the course of disciplinary hearings these norms and standards are routinely evidenced through peer expert opinion evidence, as well as through their formal expression in provisions within codes of conduct and guidelines.

Despite the lack of any overarching definition, it is clear that sexual misconduct is considered to be one of the most serious forms of professional misconduct by virtue of its inclusion in the four categories of mandatory 'notifiable conduct' under the *National Law*.[43] Mandatory notification provisions oblige all registered health professionals to report themselves, and any other registered professional, if they form a reasonable belief that a practitioner has committed such conduct.[44] Thus, inclusion in the mandatory notification categories clearly signals that 'sexual misconduct' is seen to pose a serious threat to the safety of the public, at the same time that it presupposes that professionals know what it is when they see it.

In 2014, AHPRA, in conjunction with the national boards, issued guidance applicable to all registered health professions on mandatory notification obligations under the *National Law*.[45] This included, for the first time, definitional text on 'sexual misconduct' as follows:

[41] In NSW, the statutory category 'unsatisfactory professional conduct' combines both elements of unprofessional conduct and unsatisfactory professional performance from the *National Law*: see *National Law Act (NSW)* (n 15) sch 1 s 139B. For a comparison of the NSW and national provisions, see Mary Chiarella et al, 'Survey of Quasi-Judicial Decision-Makers in NSW and the National Registration Scheme for Health Practitioners' (2018) 25(2) *Journal of Law and Medicine* 357. For a discussion of the difference between unprofessional conduct and unsatisfactory professional performance in the *National Law*, see *Solomon v Australian Health Practitioner Regulation Agency* [2015] WASC 203, [124]–[128] (Mitchell J).

[42] See, eg, *Craig v Medical Board of South Australia* (2001) 79 SASR 545, 548–9 [11]–[12] (Doyle CJ, Williams and Martin JJ).

[43] See *National Law Act (Qld)* (n 15) s 140.

[44] Such notifiable conduct means: (1) practising while intoxicated, (2) engaging in sexual misconduct in connection with their practice of the profession, (3) placing the public at risk of substantial harm because of an impairment, and (4) placing the public at risk of harm by departing significantly from accepted professional standards: see ibid. See also Marie Bismark et al, 'Mandatory Reports of Concerns about the Health, Performance and Conduct of Health Practitioners' (2014) 201(7) *Medical Journal of Australia* 399.

[45] Australian Health Practitioner Regulation Agency, *National Board Guidelines for Registered Health Practitioners: Guidelines for Mandatory Notifications* (Guidelines, March 2014) ('*AHPRA Guidelines for Mandatory Notification*'). These guidelines were revised and updated in 2020 (largely to distinguish obligations when the practitioner being notified is or is not a

> Engaging in sexual activity with a current patient or client will constitute sexual misconduct in connection with the practice of the practitioner's health profession, regardless of whether the patient or client consented to the activity or not. This is because of the power imbalance between practitioners and their patients or clients.
>
> Sexual misconduct also includes making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient or client. Engaging in sexual activity with a person who is closely related to a patient or client under the practitioner's care may also constitute misconduct. In some cases, someone who is closely related to a patient or client may also be considered a patient or client, for example the parent of a child patient or client.
>
> Engaging in sexual activity with a person formerly under a practitioner's care (i.e. after the termination of the practitioner–patient/client relationship) may also constitute sexual misconduct. Relevant factors will include the cultural context, the vulnerability of the patient or client due to issues such as age, capacity and/or health conditions; the extent of the professional relationship; for example, a one-off treatment in an emergency department compared to a long-term program of treatment; and the length of time since the practitioner–patient/client relationship ceased.[46]

This guidance concluded by affirmatively stating that there is an obligation to report a practitioner for

> '(a) sexual activity with a person under the practitioner's care or (b) sexual activity with a person previously under the practitioner's care where circumstances such as the vulnerability of the patient or client results in misconduct'.[47]

Although, again, this is rather circular, being, effectively an obligation to report misconduct if it amounts to misconduct.

It is surprising that AHPRA itself does not record or release complaint data under the category of 'sexual misconduct' even though it is one of the four categories of serious conduct which trigger mandatory notification obligations. Rather, AHPRA complaints may appear under two categories: 'boundary violations' (which also includes non-sexual conduct such as confidentiality

patient of the notifier), Australian Health Practitioner Regulation Agency, *National Board Guidelines for Registered Health Practitioners: Guidelines for Mandatory Notifications* (Guidelines, March 2020).

[46] Ibid 8 [3.4].

[47] Ibid 8 [3.5]. Note that the 2020 revised guidance differs, and is arguably less clear: 'You must make a mandatory notification if you form a reasonable belief that your practitioner-patient has engaged, is engaging in, or is at risk of engaging in sexual misconduct in connection with their practice.You must report past, current and future risk of sexual misconduct that is connected to the practitioner-patient's practice': [3.5].

breaches), and 'offence against other law' (where the conduct has been the subject of criminal conviction prior to disciplinary proceedings, but this category also includes a variety of other criminal offences).[48] Thus, understanding how sexual misconduct complaints are appearing, and are dealt with, through the entire health disciplinary system is difficult.

The current Code of Conduct for Nurses ('Nurses' Code') provides that practitioners should

> avoid sexual relationships with persons with whom they have currently or had previously entered into a professional relationship. These relationships are inappropriate *in most circumstances* and *could* be considered unprofessional conduct or professional misconduct.[49]

Thus, the Nurses' Code treats relationships with both patients and former patients as prohibited, but offers no guidance on when such breach 'could' be considered unprofessional conduct or misconduct. From the advent of the Nurses' Code until March 2018, it was accompanied by a guidance document on boundaries which contained definitions, examples and further explanation of sexual relationships which, while providing additional guidance to practitioners on why such rules are important, did not answer the preceding questions.[50] The Guidance Note provided that

> [s]exual misconduct is an extreme form of boundary violation and includes any behaviour that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the person who is in a therapeutic relationship with a nurse. Sexual misconduct is sexual assault.
>
> Sexual misconduct by a nurse is an extremely serious violation of the nurse's professional responsibility to the person in their care. Even if the person (or their legal representative) consents, or the person initiates the sexual conduct it is still

[48] The *AHPRA Annual Report* (n 13) records that 4.0% of complaints received that year concerned 'boundary violations' and 3.2% concerned 'offences against other laws': at 61. In NSW, the Health Care Complaints Commission ('HCCC') does record 'sexual misconduct' as a subset within the 'conduct' complaint category. In 2018–19, the HCCC recorded that 6.2% of complaints within the conduct category were of sexual misconduct: Health Care Complaints Commission, *2018–19 Annual Report* (Report, 2019) 21.

[49] Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (Code of Conduct, 1 March 2018) principle 4.1(d) (emphasis added).

[50] Nursing and Midwifery Board of Australia, *A Nurse's Guide to Professional Boundaries* (Guidance Note, February 2010) (retired from March 2018).

> the nurse's responsibility to maintain the professional boundary in the relationship.[51]

From March 2018, that guidance was rescinded, leaving only the Nurses' Code.[52]

The Code of Practice for Doctors ('Doctors' Code') states that good practice requires '[r]ecognising that there is a power imbalance in the doctor–patient relationship, and not exploiting patients physically, emotionally, sexually or financially'.[53] It also requires

> [n]ever 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.[54]

The relevant provisions in the codes of conduct for pharmacists and dentists are identical to the Doctors' Code,[55] but unlike the medical profession,

[51] Ibid 2. Criticism in this article of the category of 'boundary violation' as tending to blur or conceal issues of sexual violence is arguably borne out in this Guidance Note, in that it describes sexual assault as an example of 'over involvement': at 2.

[52] See 'Professional Standards', *Nursing and Midwifery Board: AHPRA* (Web Page, 29 January 2020) <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>, archived at <https://perma.cc/49CS-ULB6>.

[53] Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Code of Conduct, 17 March 2014) principle 3.2.6 ('Doctors' Code'). The medical profession appears to have the longest standing prohibition on sexual relationships with patients, with Australian case law dating back to the 1960s: see *Wilks v Medical Board of South Australia* [2010] SASC 287, [36]–[40] (Gray J) ('*Wilks*').

[54] Doctors' Code (n 53) principle 8.2.2.

[55] See Pharmacy Board of Australia, *For Pharmacists: Code of Conduct* (Code of Conduct, March 2014) [3.2(g)], [8.2(b)]–[8.2(c)] and Dental Board of Australia, *For Registered Health Practitioners: Code of Conduct* (Code of Conduct, March 2014) [3.2(g)], [8.2(b)]–[8.2(c)], which both include the following:

- 'recognising that there is a power imbalance in the practitioner–patient/client relationship and not exploiting patients or clients physically, emotionally, sexually or financially': at [3.2(g)];
- 'never using a professional position to establish or pursue a sexual, exploitative or otherwise inappropriate relationship with anybody under a practitioner's care; this includes those close to the patient or client, such as their carer, guardian, spouse or the parent of a child patient or client': at [8.2(b)]; and
- 'recognising that sexual and other personal relationships with people who have previously been a practitioner's patients or clients are usually inappropriate, depending on the extent of the professional relationship and the vulnerability of a previous patient or client': at [8.2(c)].

pharmacy and dentistry have never elaborated upon their Codes through other guidance.

In contrast to the other professions, which simply state that a sexual relationship with a former patient is 'usually' inappropriate ('depending on the extent of the professional relationship and the vulnerability of a previous patient or client'),[56] psychologists clearly set out both a time period (two years) and a process (involving three steps: consultation, supervision and referral) as prerequisites to establishing an appropriate sexual relationship with a former patient.[57]

One outcome of the Paterson Inquiry was the redevelopment of guidelines for doctors on 'sexual boundaries'.[58] These guidelines represent the clearest and most detailed guidance currently available to any health profession, and merit quotation at length. The guidelines state under the heading, 'Why breaching sexual boundaries is unethical and harmful':

> Doctors are expected to act in their patient's best interests and not use their position of power and trust to exploit patients physically, sexually, emotionally or psychologically. Breaching sexual boundaries is always unethical and usually harmful for many reasons including:
>
> - Power imbalance: The doctor–patient relationship is inherently unequal. The patient is often vulnerable and in some clinical situations may depend emotionally on the doctor. To receive healthcare, patients are required to reveal information that they would not reveal to anyone else and may need to allow

[56] See above n 55.

[57] The Psychology Board of Australia adopted wholesale the Australian Psychological Society, *APS Code of Ethics* (Code of Ethics, 27 September 2007) ('*APS Code of Ethics*'): see 'Codes, Guidelines and Policies', *Psychology Board: AHPRA* (Web Page, 6 March 2020) <https://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies.aspx>, archived at <https://perma.cc/Y2RR-YP8B>. The *APS Code of Ethics* (n 57) provides that '[p]sychologists:

> (a) do not engage in sexual activity with a client or anybody who is closely related to one of their clients;
> (b) do not engage in sexual activity with a former client, or anybody who is closely related to one of their former clients, within two years after terminating the professional relationship with the former client;
> (c) who wish to engage in sexual activity with former clients after a period of two years from the termination of the service, first explore with a senior psychologist the possibility that the former client may be vulnerable and at risk of exploitation, and encourage the former client to seek independent counselling on the matter; and
> (d) do not accept as a client a person with whom they have engaged in sexual activity': 29 [C.4.3] (emphasis omitted).

[58] See, eg, Medical Board of Australia, *Sexual Boundaries in the Doctor–Patient Relationship* (Guidelines, 12 December 2018).

a doctor to conduct a physical examination. A breach of sexual boundaries in the doctor–patient relationship exploits this power imbalance.

- Trust: Patients place trust in their doctor. They have a right to expect that examinations and treatment will only be undertaken in their best interests and never for an ulterior, sexual motive.
- Safety: Patients subjected to sexual behaviour from their doctor may suffer emotional and physical harm.
- Quality: A doctor who sexualises patients is likely to lose the independence and objectivity needed to provide them with good quality healthcare.
- Public confidence: Members of the community should never be deterred from seeking medical care, permitting intimate examinations or sharing deeply personal information, because they fear potential abuse.[59]

In this study, following the work of Elkin and colleagues,[60] I utilise the main category of 'sexual misconduct' with two distinct sub-types: 'relationship' and 'inappropriate contact'.[61] The sexual relationship category covers instances where a health practitioner engaged in an ostensibly consensual relationship with a patient, former patient, or parent of a child patient. Such relationships ranged from a brief sexual encounter, or repeat encounters over a short period of days or weeks, to relationships of several years, including some that were ultimately married or de facto relationships. The 'inappropriate sexual contact' cases include some instances of unwanted touching that could broadly be regarded as sexual harassment,[62] but mostly involved the use of the therapeutic

[59] Ibid 3.

[60] Katie Elkin et al, 'Doctors Disciplined for Professional Misconduct in Australia and New Zealand, 2000–2009' (2011) 194(9) *Medical Journal of Australia* 452. See also Millbank, 'Health Practitioner Regulation' (n 14) 639–40. The recent work of Marie Bismark and colleagues utilises three categories, sexual relationship, sexual harassment and sexual assault: Marie Bismark et al, 'Sexual Misconduct by Health Professionals in Australia, 2011–2016: A Retreospective Analysis of Notifications to Health Regulators' (2020) 213(5) *Medical Journal of Australia* 218.

[61] Paterson notes a third type of case, where the conduct occurs outside the practice setting, 'such as accessing child pornography or a sexual assault on a non-patient': Paterson (n 2) 29. Such cases generally appear at tribunal level by virtue of a complaint, under the *National Law*, of unfitness to practise by reason of criminal conviction — thus, they don't appear in the complaint data as sexual misconduct cases: see, eg, *Nursing and Midwifery Board of Australia v Hugo* [2014] SAHPT 9. See also Kathy Shats and Thomas Faunce, 'Medical Professionals Convicted of Accessing Child Pornography: Presumptive Lifetime Prohibition on Paediatric Practice?' (2008) 15(5) *Journal of Law and Medicine* 704.

[62] In their study, Bismark et al found that sexual assault notifications outnumbered sexual harassment by a factor of more than 3:1: Bismark (n 60). Note that in the UK context, Paula Case observed that sexual harassment and assault inflicted by doctors on junior female staff were

setting to conduct a purportedly necessary 'examination' or 'test' which was clinically unnecessary and was used to justify intimate touching of the (almost always female) patient.[63]

While it is common to blur these two types of conduct under umbrella complaint categories such as 'sexual misconduct', 'sexual boundary violation' or the even more generic 'boundary violation', I believe that it is important to keep them distinct for a number of reasons. First, 'boundary violation' is inadequate to capture the nature of the conduct and obscures understanding of the issues involved. In the psychology setting, 'boundary violation' would include, for example, a situation in which a practitioner asked a patient with a lawn-mowing business to do work on their garden, or a breach of confidence in which the practitioner revealed that someone is their patient without that patient's consent. Second, in matters where the conduct at issue would constitute indecent assault or sexual assault, if proved in the criminal setting, the terminology of 'boundary violation' obscures the fact that it is the patient, not the boundary, who has been violated — physically violated. In publicly accessible data, the continued use of such a generic category masks the sexual nature of the conduct.[64] Specifically focusing upon the kind of conduct involved assists to clearly identify its severity by reference to the breach of trust involved, and the consequent impact upon the patient. This allows decision-makers to appropriately evaluate orders when considering the public interest and the safety of the practitioner for future practice.[65]

generally not regarded as indicating a risk to patients: Paula Case, 'The Good, the Bad and the Dishonest Doctor: The General Medical Council and the "Redemption Model" of Fitness to Practise' (2011) 31(4) *Legal Studies* 591, 600. This finding is of concern as a later study of 232 UK health disciplinary cases by Searle found over 30% of cases involved sexual misconduct against colleagues: Searle (n 33).

63 In a section on 'Resources for Patients', the *Atlanta Journal-Constitution* lists a summary of the kinds of conduct that may occur: 'Resources for Patients', *The Atlanta Journal-Constitution: Doctors & Sex Abuse* (Web Page) <http://doctors.ajc.com/doctors_sex_abuse_resources/>, archived at <https://perma.cc/6434-AJF9>.

64 See, eg, *Psychology Board of Australia v Shahinper* [2016] QCAT 259, [4]–[8] (Deputy President Sheridan, Members Brimstone, Lawrence and Sim) ('*Shahinper*'), in which the Tribunal noted that the practitioner was in breach of undertakings given in previous proceedings in relation to 'boundary violations' concerning two junior colleagues and a vulnerable patient, but did not state either what the boundary violations or undertakings actually were.

65 Note that, in the US in 2007, the most commonly used category of complaint for reports of sexual abuse in the National Practitioner Data Bank was 'not applicable': DuBois et al (n 10) 504. See also criticism of the 'sanitized terminology' of 'boundary violation' in the UK disciplinary context: Mary Halter, Hilary Brown and Julie Stone, 'Sexual Boundary Violations by Health Professionals: An Overview of the Published Empirical Literature' (Research Report, Council for Healthcare Regulatory Excellence, April 2007) 16.

At the outset, I acknowledge that the dividing line between categories is not sharp in every case. For example, if a practitioner traded drugs for sexual favours with a substance-dependent patient, or engaged in a relationship with a patient whose mental health was acutely impaired, the level of exploitation involved or constraint on consent may lead an observer to conclude that the conduct is much more akin to institutionalised sexual abuse than a 'relationship'.[66] In this study, cases were coded as 'relationship' if it appeared from the text of the decision that the patient's perspective on what occurred is that it was 'consensual' at the outset, in the sense that it was not brought about by deception or coercion and the patient was able to exercise volition.[67] This is not to suggest that such consent was unmediated by other factors, or that it was necessarily a wholly positive experience for the patient; just that, at the time the relationship commenced, they saw it as unforced.[68]

The categories of relationship and contact should not be treated as dichotomised in terms of the consent/non-consent of the patient. Indeed, the cases are replete with patient statements indicating that they 'felt like they could not say no', or were 'flattered at first' and then felt increasingly upset or uncomfortable

[66] See, eg, *Nursing and Midwifery Board of Australia and Buckby* [2015] WASAT 19 ('*Buckby*'), in which the nurse threatened a former mental health in-patient with involuntary admission to hospital if she did not engage in sex with him. In that case, the Tribunal put inverted commas around 'relationship' but was constrained in its findings about the coercive nature of the sexual contact because of the way the matter was framed by the Board: at [81]–[82], [116]–[117] (President Curthoys, Senior Members McCutcheon and McCallum). For a rare example of a case where sexual contact with an in-patient in a mental health setting was held to be sexual assault because of the patient's lack of capacity for consent, see *Nursing and Midwifery Board of Australia v Swamy* [2012] VCAT 219, [24] (Senior Member Megay, Members Bylhouwer and Anderson).

[67] The case of a female psychologist who commenced a sexual relationship with an incarcerated inmate when he was 15 or 16 years old was coded as 'contact' because the patient may have been under the age of consent at that time, but also as 'relationship' because the relationship continued for some time after his release and his coming of age: *Health Care Complaints Commission v McKeehan* [2013] NSWPST 2 ('*McKeehan*').

[68] For this reason, I do not draw upon earlier categorisations which divided sexual misconduct into assault, exploitation and 'romance': see, eg, Stephen Smith, 'Doctors, Sexual Misconduct and Contemporary Values' (1997) 5 (November) *Journal of Law and Medicine* 178. Cf Joanna Manning, 'Changing Disciplinary Responses to Sexual Misconduct by Health Practitioners in New Zealand' (2014) 21(3) *Journal of Law and Medicine* 508, in which she appears to suggest that there may be genuinely mutual relationships between health practitioners and patients in instances where they are in 'relatively equal power positions' and that this may not breach professional standards. See also Surgenor, Diesfeld and Rychert (n 34) who implicitly draw on Smith's categories in distinguishing 'consensual activity' from 'other forms of sexual conduct, such as exploitation (eg sexual favours), abuse (eg unwanted touching), or other improprieties (eg sexually demeaning behaviour)': at 775.

about a sexualised interaction with their practitioner.[69] The tribunal decisions on relationships generally display a sophisticated understanding of the manner in which patient 'consent' to a sexual relationship with a treating practitioner is compromised by the inherent power imbalance in that relationship. One of the aims of this article is to examine the ways that legally constituted decision-making bodies understood the gradations of power imbalance in such relationships through their evaluation of patient 'vulnerability' and their assessment of practitioner motivations (for example, as engaged in predatory self-fulfilment,[70] as opposed to a lapse in judgment and/or genuine attachment).

In the same vein, I acknowledge that the categories of relationship and contact do not always involve sharply different 'types' of misuse of power, or even necessarily different conduct on the part of the practitioner. For example, several practitioners appeared to have undertaken both types of conduct with different patients.[71] More subtly, there appeared to be a certain type of 'precursor',[72] or grooming conduct, utilised in the clinical setting capable of producing a different category of case depending upon the reaction of the patient: viz the stroke on the knee,[73] or hug accompanied (or later followed by) an invitation

[69] See, eg, *Medical Board of Australia v Myers* [2014] WASAT 137 ('*Myers 2014*'); *Medical Board of Australia v Azam [No 2]* [2017] QCAT 206, [14] (Deputy President Sheridan, Members Goh, Powell and Halliday) ('*Azam [No 2]*').

[70] See, eg, *Health Care Complaints Commission v Tan* [2016] NSWCATOD 115, [43], [48] (Principal Member Mullane, Members Mares and Anderson, and Kelly).

[71] See, eg, the misconduct engaged in by the same practitioner in the three cases of *Nursing and Midwifery Board of Australia v Scott* [2010] VCAT 1268 ('*Scott 2010*'), *Nursing and Midwifery Board of Australia v Scott* [2014] VCAT 642 ('*Scott 2014*') and *Nursing and Midwifery Board of Australia v Scott* [2018] VCAT 1488 ('*Scott 2018*') (this last case occurred outside of the study period) and by another practitioner in *Medical Board of Australia v Myers* [2013] VCAT 1806 ('*Myers 2013*') and *Myers 2014* (n 69). See also *Medical Board of Australia v Young* [2010] VCAT 1542 ('*Young*'); *Health Care Complaints Commission v Baez* [2014] NSWCATOD 3 ('*Baez*'); *Health Care Complaints Commission v Naiyer [No 1]* [2014] NSWCATOD 54. See also *Shahinper* (n 64), where the practitioner was at the time of the improper relationship in breach of undertakings given in previous proceedings in relation to 'boundary violations' concerning two junior colleagues and a vulnerable patient.

[72] Paterson (n 2) 28. See also the description, given in one of the *Atlanta Journal-Constitution* press series, of conduct in which 'a perpetrator tests the waters to establish a general atmosphere of forced intimacy and to see if his target will protest': Ariel Hart, 'Which Doctors Are Sexually Abusive?', *The Atlanta Journal-Constitution* (online, 2016) <http://doctors.ajc.com/doctors_who_sexually_abuse/>, archived at <https://perma.cc/XXY8-YDF6>.

[73] See, eg, *Medical Board of Australia v Yasin* [2011] QCAT 300 ('*Yasin*'), a case in which a psychiatrist made an early admission of a sexual relationship with a young female patient. Although the Tribunal accepted that the relationship was a 'once off', the decision records some reservation based upon the fact that the practitioner touched the patient's legs in their first

with sexual overtones.[74] This could produce a contact complaint or a relationship case, depending upon whether the patient was receptive to such an approach. In such a case it is not the conduct of the practitioner which varied, necessarily, but the harm experienced by the patient.[75] Some have argued for a continued use of the terminology of 'boundary violation' because it draws attention to the ways in which apparently small and/or non-sexual transgressions 'pave the way' or create a continuum that enables later more egregious violations,[76] in the context of both relationship and contact abuses. I second these observations as useful analytical tools to understand the ways in which sexual misconduct occurs, but not as a category of complaint that takes the place of 'sexual misconduct' itself.

C *Case Set Overview*

There were 160 cases involving a main claim of sexual misconduct. Of these, 150 involved at least one claim being proved, and a total of 10 cases in which the tribunal held that there was no case to answer concerning the claim of sexual misconduct (although there was still a finding of impropriety based upon a personal relationship in three of those 10 cases).[77] Overall, 80.4% of respondent practitioners in sexual misconduct cases were male.[78] There was only one contact complaint concerning a female practitioner.[79] The proportion of women in

consultation: at [11] (Kingham J, Members Dunglison, Pozzi and Lamperd). As at December 2019 the public register recorded that from July 2018 the practitioner was under new conditions imposed by the Office of the Health Ombudsman, including that he not treat any female patients. At the time of publication (August 2020) there is no record of Dr Yasin on the public register.

74 See, eg, *Medical Board of Australia v Cukier* [2017] VCAT 109, [17] (Members Wentworth, Collopy and Reddy) ('*Cukier*'); *Nursing and Midwifery Board of Australia v Singh* [2014] VCAT 1171, [14] (Presiding Member Smithers, Members Pearson and Barry) ('*Singh*'); *Psychology Board of Australia v Huson* [2013] VCAT 145 ('*Huson*'); *Baez* (n 71).

75 See, eg, *Myers 2014* (n 69); *Medical Board of Australia v Azam* [2017] QCAT 156 ('*Azam*'); *Azam [No 2]* (n 69). In the context of clergy sexual abuse see below n 151.

76 See, eg, Glen Gabbard, 'Commentary on Steven H Cooper's Paper "Blurring Boundaries or Why Do We Refer to Sexual Misconduct with Patients as "Boundary Violation"' (2016) 26(2) *Psychoanalytic Dialogues* 223, 226. See also the finding of DuBois et al (n 10) that a majority of sexual assault cases in their dataset were 'preceded by inappropriate comments or touching of the victim or other patients': at 519.

77 Thus, the proved rate in sexual misconduct cases was 93.8%, compared to the overall study in which the proved rate was 96.3%: Millbank, 'Health Practitioner Regulation' (n 14) 637–9.

78 Compared to a gender breakdown in the larger case set of 'inappropriate clinical care' in the study of 65.8% male and 34.8% female practitioners: Millbank, 'Serious Misconduct of Health Professionals' (n 32) 194.

79 *McKeehan* (n 67).

the relationship cases was fairly substantial at 28.3%.[80] Within the dataset there were a number of practitioners who were the subject of multiple complaints over lengthy periods, often spanning several years.[81] Not all of those serial offenders were adequately dealt with in the earlier stages of the disciplinary process.[82]

Notably, there were almost twice as many cases at the tribunal level concerning relationships as there were concerning inappropriate contact.[83] This seems to be a reversal of the proportion of types of sexual misconduct appearing in complaints. A recent study of complaint data concerning sexual misconduct from 2011–16 by Marie Bismark and colleagues found that only a quarter of complaints concerned relationships, with the remainder being sexual harassment and sexual assault.[84] The relationship cases at tribunal level were

[80] Millbank, 'Serious Misconduct of Health Professionals' (n 32) 195.

[81] See, eg, *Myers 2013* (n 71) (conduct spanning 10 years); *Young* (n 71) (three matters over 11 years); *Medical Board of Australia v Henderson* [2011] QCAT 90 ('*Henderson*') (three complainants over nine years); *Scott 2010* (n 71); *Scott 2014* (n 71); *Scott 2018* (n 71) (three sexual misconduct proceedings over an eight-year period, and one other proceeding not sexual in nature: *Nursing and Midwifery Board of Australia v Scott* [2017] VCAT 334). See also references to prior proceedings in *Psychology Board of Australia v Shahinper* [2016] QCAT 259; *Psychology Board of Australia v King* [2016] QCAT 140 ('*King*'); *Health Care Complaints Commission v Priyamanna* [2015] NSWCATOD 138, ('*Priyamanna*'); *Health Care Complaints Commission v Priyamanna [No 2]* [2016] NSWCATOD 3, ('*Priyamanna [No 2]*'); *Health Care Complaints Commission v Schultz* [2012] NSWMT 7.

[82] See, eg, *Health Care Complaints Commission v Rahman* [2013] NSWMT 6, [8]–[9] (Elkaim DCJ, Members Kok, Giuffrida and Berglund), which notes that the doctor refused to answer any questions about the allegations against him during an immediate action hearing, after being charged with aggravated sexual assault on two patients, but the Medical Board nevertheless did not suspend him on the basis that he had not yet been found guilty. The practitioner was only suspended more than a year later, once convicted of 22 counts of indecent assault on 17 patients, including children. See also *Medical Board of Australia v Wong* [2015] QCAT 439, where Dr Wong committed 27 counts of sexual assault in relation to 18 patients and one employee while suffering from schizophreniaHe had been subject to previous health-related registration conditions some years earlier which required him to be treated for his schizophrenia in order to continue practising, but these conditions had been removed in 2003. The Tribunal considered that further health conditions were sufficient to minimise any risk of further relapse. This is a finding that Paterson (n 2) criticises as not in keeping with community expectations: at 49.

[83] Among the 160 cases, there were 108 relationship claims and 60 contact, a total of 168 because eight matters involved a complaint of both types of conduct. This balance of matters reflects findings by Elkin et al (n 60) in their study of Australian and New Zealand tribunal cases concerning doctors prior to the *National Law*: at 454.

[84] Bismark (n 60). Note also that in DuBois et al's (n 10) analysis of 101 US medical disciplinary cases, only 7% of matters were coded as 'consensual sex' with the majority coded as 'inappropriate touching' (33%), 'sodomy' (defined to include all forms of non-penile vaginal penetration) (31%), rape (16%) and 'child molestation' (14%): at 511. Note, however, that these were

distinctly more likely to be proved (98%) than the contact cases (88.8%). Textual analysis of the cases indicates that this reflects the different nature of the evidence and ease of proof in the relationship category, in which there was almost always a significant and revealing trail of text messages between practitioner and patient, often accompanied by, or by the time of hearing leading to, a partial or full admission on the part of the practitioner. In contrast, the contact cases were marked by denials on the part of the practitioner, and so proceeded on the basis of a contest of the complainant's evidence of inappropriate contact versus the practitioner either claiming the touching did not occur at all, or arguing that it was clinically justified and/or was misinterpreted.[85]

It is possible that the greater evidentiary burden in contact cases has influenced referral patterns. Contact cases at tribunal level were strongly associated with prior criminal proceedings (in over 1/3 of the cases)[86] and with 'repeat incidents' involving more than one patient.[87] Strikingly, while less than one in six relationship cases involved more than one patient,[88] almost half of the contact cases involved two or more patients. This suggests that for a contact case to get to tribunal level, it is likely to involve a practitioner who has been the subject of complaints from more than one patient, and/or complaints that have been made to the police and proceeded through the criminal justice system.

Deregistration was significantly more likely to be ordered for proved cases involving contact than those involving a relationship (74.1% compared to 51%), while suspension was a common outcome in relationship cases (36.5%) and rare in contact cases (7.4%).

While in other categories in the broader study, the jurisdictional spread of cases was consistent,[89] there was notable variation in the proportional

coded by the 'most serious' form of abuse and the authors note that most cases involved multiple abuses. Also, note the indications in that study of underreporting and mis-recording of cases such that the dataset may have been skewed towards assault-based abuses: at 504–5.

85 See, eg, *Medical Board of Australia and Veettill* [2015] WASAT 124 ('*Veettill*') (practitioner gave sworn evidence denying the patient's claims); *Azam [No 2]* (n 69) (doctor continually denied allegations).

86 Only two relationship cases involved criminal proceedings, in both instances because the practitioner had physically assaulted the patient in the course of, or at the conclusion of, the relationship.

87 See, eg, *Priyamanna* (n 81); *Health Care Complaints Commission v Sundarajah [No 2]* [2018] NSWCATOD 86 ('*Sundarajah [No 2]*'); *Buckby* (n 66).

88 However, note there was a stark difference depending upon the sex of the practitioner, with 22% of male practitioners in relationship cases facing allegations concerning more than one patient or previous proceedings for sexual misconduct, compared to only 4% of female practitioners: see discussion in Jenni Millbank, 'Female Health Practitioners Disciplined for Sexual Misconduct' (2020) 43 *University of New South Wales Law Journal* (forthcoming).

89 See Millbank, 'Health Practitioner Regulation' (n 14) 644.

appearance of sexual misconduct cases across the jurisdictions. Across the most populous states, sexual misconduct comprised around a quarter of tribunal matters (NSW and Queensland at 23%, Victoria at 29%), but they made up only 11% of cases determined in Western Australia ('WA'), 9% in South Australia and 13% in Australian Capital Territory ('ACT'), Northern Territory ('NT') and Tasmania combined. This raises the question of whether there is an underlying difference across the states and territories in the practice of the National Boards, in terms of whether and when they refer sexual misconduct matters to tribunals within disciplinary processes.[90]

There were some broad differences apparent in the spread of contact and relationship cases across the five professions, in part reflecting their different practice settings and opportunity for such conduct. The sexual misconduct cases against psychologists overwhelmingly involved relationships (with only three of 40 proved cases concerning contact), similarly over 2/3 of cases against nurses were relationship matters. Mental health settings were strongly associated with sexual misconduct matters for nurses, with 21 of 26 proved relationship claims against nurses involving a mental health nurse, and six of 11 contact cases.[91] In contrast, matters involving doctors and dentists were evenly divided between relationship and contact cases, and the three proved claims involving pharmacists were all contact cases.

II Sexual Relationships

There was a high level of consistency in the case law in that the tribunals of all jurisdictions frequently expressed the principle that sexual and intimate relationships between health practitioners and patients are inappropriate. This is because they involve an underlying power imbalance, and create a 'dual' relationship in which the practitioner is compromised in their duty to put the health needs of the patient first.[92] This breach of professional duty was widely

[90] Ibid 644–5.

[91] See also a study of 29 'boundary violation' cases against nurses at tribunal and committee level in NSW prior to the *National Law*: Mary Chiarella and Amanda Adrian, 'Boundary Violations, Gender and the Nature of Nursing Work' (2014) 21(3) *Nursing Ethics* 267. It was noted that 14 of the 29 respondent nurses worked in mental health and a further four in drug treatment facilities: at 270.

[92] See, eg, *Psychology Board of Australia v Cicconi* [2013] VCAT 516, [72] (Deputy President Lambrick, Members Farhall and Power) ('*Cicconi*'), where there was said to be an 'inherent power of psychologist over a patient'. See also *Psychology Board of Australia v Wakelin* [2014] QCAT 516, [6] (Members Thomas, Sullivan, Sim and Christou) ('*Wakelin*'), in which the practitioner was found to have engaged in professional misconduct, in part due to her awareness of a potential 'dual relationship' or conflict between her interest and duty.

understood to be of such gravity as to constitute misconduct in most circumstances.

In the decisions there were a range of factors that were taken into account in determining the severity of the conduct, which could be characterised as 'mitigating' and 'aggravating', although they were rarely named as such in the decisions. Broadly, these factors fell under the rubric of patient vulnerability and practitioner motivation.[93]

Patient vulnerability was a dominant concern and it appeared in two distinct ways. One was the underlying or inherent vulnerability of the patient and the extent to which it was known to the practitioner. Common examples of inherent vulnerability were patients who were suffering or had experienced depression or suicidal ideation, had a background of sexual abuse,[94] or were experiencing domestic violence, and were seeking treatment, or a referral for treatment, from the practitioner for such issues.[95] When patients were young, or much younger than the practitioner,[96] socially isolated (including where the patient was the mother of young children),[97] or economically disadvantaged, this was also noted as contributing to their vulnerability.[98]

The second way that vulnerability was understood was as a consequence of the therapeutic relationship. So, for example, patients who had revealed a significant amount of personal detail or past trauma to a mental health practitioner, or in-patients undertaking treatment under the care of the practitioner, or patients who had undertaken intimate examinations such as pap smears with a medical practitioner, were seen to be rendered more acutely vulnerable in the context of that relationship than patients with limited and/or less intimate

[93] See also General Medical Council and Medical Practitioners Tribunal Service, *Sanctions Guidance: For Members of Medical Practitioners Tribunals and for the General Medical Council's Decision Makers* (Guidance Note, 18 November 2019), [142]–[148] ('*Sanctions Guidance*'), which includes the categories '[a]buse of professional position', '[v]ulnerable patients' and '[p]redatory behaviour'.

[94] See, eg, *Health Care Complaints Commission v Dawes* [2015] NSWCATOD 8, [68] (Principal Member Muller, Members Warren, Blaszczynski, and Taylor) ('*Dawes*').

[95] See, eg, *Nursing and Midwifery Board of Australia v Jackson* [2013] WASAT 140, [11]–[12] (Deputy President Parry, Members Connor and Jones) ('*Jackson*').

[96] See, eg, *Cicconi* (n 92).

[97] See, eg, *Medical Board of Australia v Erhardt* [2011] VCAT 1702; *Health Care Complaints Commission v Ristevski* [2012] NSWMT 23.

[98] In the context of disciplining misconduct engaged in by legal professionals, see Jennifer Schulz-Moore, Kate Diesfeld and Christine Forster, 'Understanding Client Vulnerability in the Disciplining of Legal Professionals in NSW' (2019) 26(4) *Journal of Law and Medicine* 849, 854.

contact.[99] In general, the longer and the more significant the therapeutic relationship, the more seriously the conduct was regarded. Likewise, a failure to end the therapeutic relationship once the sexual relationship commenced was widely regarded as an aggravating factor.[100] In a similar vein, a practitioner prescribing medication, in particular psychotropic medication or potentially addictive medication such as opioids or benzodiazepines, during, or in furtherance of, the sexual relationship was viewed as aggravating conduct.[101]

In general, decision-makers were attentive to, and nuanced in their analysis of, the ways in which the therapeutic relationship in different contexts rendered patients vulnerable. For example, in one case a cosmetic surgeon argued that his surgical consultations with a patient, with whom he had a sexual relationship, were brief and intermittent, such that there was no 'real' therapeutic relationship, and expressly contended that his patient was not as vulnerable as a patient under the treatment of a psychiatrist.[102] The tribunal responded: '[t]he distinction which [the respondent] would draw between surgeons and, for example, psychiatrists … fails to appreciate that those who seek the services of plastic surgeons may have their own vulnerabilities'.[103] In another case, a female mental health nurse argued that her male patient, who was a successful professional man of similar age to herself (who had been undertaking in-patient treatment for alcohol dependence) was not vulnerable, and the patient himself gave evidence in support of this position.[104] The practitioner sought to distinguish her conduct from that in an earlier case involving a female practitioner and a male patient in gaol.[105] The Tribunal responded:

[99] See, eg, *Cicconi* (n 92) [72] (Deputy President Lambrick, Members Farhall and Power), in which the patient was described by the Tribunal as particularly vulnerable due to the practitioner's knowledge of her relevant vulnerabilities.

[100] See, eg, *Ristevski* (n 97) [31] (Elkaim DCJ, Members Ng and Higgins, and Kelly); *Psychology Board of Australia v Tunstall* [2016] VCAT 1263, [22] (Senior Member Proctor, Members Anderson and Farhall).

[101] See, eg, *Medical Board of Australia and Medical Practitioner VI* [2012] ACAT 36, [150]–[151] (Senior Member Chenoweth, Members Faunce and Greagg) ('*Medical Practitioner VI*'); *Health Care Complaints Commission v Athour* [2016] NSWCATOD 5, [53] (Principal Member O'Meally, Members Diamond Chapman-Konarska and Macneill); *Medical Board of Australia v ZOF* [2014] VCAT 1548, [430] (Senior Member Proctor, Members Collopy and Shanahan) ('*ZOF*'); *Schultz* (n 81) [33] (Staff J, Members Giuffrida, Cox and Mair).

[102] *Medical Board of Australia v Vucak* [2015] QCAT 367, [57] (Deputy President Horneman-Wren) ('*Vucak*').

[103] Ibid [59].

[104] *Health Care Complaints Commission v Waddell [No 1]* [2012] NSWNMT 17, [188], [238]–[239] (Deputy Chairperson Hughes, Members Gibson, Newman, and Everett).

[105] Ibid [238].

> In the context of a relationship between a health practitioner and a patient there is no distinction in vulnerability between a prisoner in gaol who is drug addicted, with a patient admitted to a mental health facility for major depression and chronic alcoholism, and where there is a history that these complaints are chronic and protracted, and are accompanied by major physical and financial problems, all of which factors are known to the health professional.[106]

While it may be more probable that an incarcerated prisoner is suffering a higher degree of longer term socio-economic disadvantage than a voluntary patient in a private hospital, and is therefore more inherently vulnerable, the above quote stresses relational vulnerability as *patients*.[107] That is, there is a vulnerability that inheres in the therapeutic relationship, no matter how high-functioning or powerful a patient may be outside of such a relationship. This is the foundational understanding upon which the prohibition of sexual relationships between health practitioners and patients is based, and was a constant refrain in decisions.[108]

This understanding of the therapeutic relationship, as generating vulnerability, meant that the use of the clinical setting to initiate or undertake sexual contact, including the use of clinical records to obtain a patient's phone number or other personal detail in order to enable such pursuit, was also regarded as a serious aggravating factor.[109]

While practitioners frequently led evidence that they were themselves 'vulnerable' as a result of their life circumstances or health conditions, it has to be said that depression and marital disharmony were the rule rather than the

[106] Ibid [252]. The outcome of this case was that the practitioner's registration was cancelled, with a non-review period of three years: *Health Care Complaints Commission v Waddell [No 2]* [2013] NSWNMT 2.

[107] See also *Health Care Complaints Commission v Gachon* [2015] NSWCATOD 158, in which the peer expert opined that there was not a significant 'power differential' because the psychologist was 'infatuated' and the patient 'assertive': at [50] (Principal Member Britton, Members Collins, Purkis and Collier). This opinion does not appear to have carried much weight in the decision, largely because the practitioner failed to participate in proceedings and so no current assessment could be made of the likelihood of recurrence: at [121]. In this case, the practitioner's registration was cancelled, with an 18-month non-review period and a prohibition order was also made: at [123], [127].

[108] See, eg, the Tribunal's statement in *Health Care Complaints Commission v Engel-Jones* [2011] NSWNMT 23, that 'mental health patients are perhaps the most emotionally vulnerable patients a nurse may treat and … the ethical standards of nurses need to be steadfastly maintained in relation to them': at [51] (Chairperson O'Neill, Members Tolly, Warner, and Knibb).

[109] See, eg, *Health Care Complaints Commission v Firth [No 2]* [2015] NSWCATOD 84 ('*Firth [No 2]*'); *Health Care Complaints Commission v Mayr* [2017] NSWCATOD 52, [105] (Principal Member Shub, Members Haigh, Sheridan, andTaylor) ('*Mayr*'); *King* (n 81) [66] *Health Care Complaints Commission v Mortlock* [2015] NSWCATOD 136, [57] (Principal Member Britton, Members Tolhurst, Selkirk, and Hooker) ('*Mortlock*').

exception in relationship cases, and so matters such as illness, therapeutic intervention, and so on, were generally addressed as factors that were relevant to sanction (in terms of the likelihood of recurrence) rather than as relevant to the assessment of seriousness.[110] Human frailty was an accepted part of the context, but decision-makers were clear that it was professional conduct and standards that were in issue. So, for example, in a case concerning a doctor who assaulted a patient in an altercation that occurred at the end of their lengthy clandestine relationship, the Tribunal noted (on application for review, reinstating the practitioner with conditions) that

> [w]hile the applicant's conduct was at the lower end of the spectrum of abusive conduct seen by courts in criminal cases, it fell at the high end of the spectrum of wrongful conduct by a person trained as a medical practitioner. A physical assault in a social setting by a medical practitioner is reprehensible.[111]

If the relationship occurred a significant amount of time prior to the hearing, and if the practitioner had been in practice for a number of years since with no subsequent complaint, the matter was more likely to be assessed at the lower end of seriousness and to result in non-restrictive sanction.[112]

In matters where there was a social relationship between the parties that predated the therapeutic relationship,[113] or a mixed therapeutic and social[114] or

[110] See, eg, *Young* (n 71), where the Tribunal considered the practitioner's psychiatric condition in the context of determining an appropriate sanction, rather than in assessing the seriousness of his misconduct: at [68]–[104] (Senior Member Davis, Members Clarke and Burge).

[111] *Ristevski v Medical Council of New South Wales* [2016] NSWCATOD 18, [52] (Deputy President O'Connor, Members Messner, Fogarty, and Berglund).

[112] See, eg, *Medical Board of Australia v Petrovic* [2011] VCAT 795 ('*Petrovic*') (relationship occurred 14 years earlier, resulted in counselling condition only); *Medical Board of Australia v North* [2012] QCAT 546 (relationship occurred 10 years prior to hearing, resulted in a one-month suspension); *Psychology Board of Australia v Anderson* [2016] VCAT 1407 (relationship occurred 20 years earlier, resulted in a three-month suspension). But see *Nursing and Midwifery Board of Australia v Stephenson* [2016] SAHPT 6 (relationship with wife of patient occurred 10 years earlier and the practitioner also committed a sexual offence against a non-patient 13 years earlier, resulted in deregistration with a four-year non-review period).

[113] See, eg, *Medical Board of Australia v Trewren* [2015] SAHPT 5, ('*Trewren*') (six-month suspension); *Medical Board of Australia v Poon* [2010] VCAT 1840, (one-year condition).

[114] See, eg, the two-year suspension issued to the practitioner in *Medical Board of Australia v Gilliland [No 2]* [2014] QCAT 699('*Gilliland [No 2]*'); *Medical Board of Australia v Gilliland [No 3]* [2014] QCAT 700 ('*Gilliland [No 3]*'). See also the conditions imposed on the practicioner in *Health Care Complaints Commission v Eftimoski* [2015] NSWCATOD 51 ('*Eftimoski*').

collegial relationship,[115] the conduct was assessed as somewhat less serious.[116] There was some ambiguity in the way that lengthy relationships were treated; on some occasions a longer period was seen as an aggravating factor,[117] while in others it was taken as proof that the practitioner's motivation was 'romantic' rather than 'exploitative' or 'predatory'.[118] If the relationship between the parties was seen to be a 'genuine' one which resulted in a long term partnership (including the patient appearing at the hearing in support of their now spouse), this tended to result in more moderate assessment of the breach.[119]

[115] See, eg, *Medical Board of Australia v Jones* [2012] QCAT 362 ('*Jones*'); *Petrovic* (n 112; *Health Care Complaints Commission v Bracco* [2016] NSWCATOD 127 (although note that the receptionist–patient in that case lost her job as a result of the relationship, while the doctor did not). Cf cases in which the tribunal characterised the receptionist–patient in the practice as being in a position of dependence and power imbalance: *ZOF* (n 101) [364]–[367]; *Ristevski* (n 97) [31] (Elkaim DCJ, Members Ng, Higgins, and Kelly).

[116] Cf *Medical Board of Australia v Skehan* [2011] VCAT 2424, in which the personal relationship was also characterised as improper. The reasons included the fact that the doctor also treated the patient's husband and obtained a financial advantage through the husband on other dealings. The outcome in this case was deregistration: *Medical Board of Australia v Skehan [No 2]* [2011] VCAT 1935, [52] (Vice President Howard, Members Reddy and Collopy).

[117] See, eg, *Medical Board of Australia v Love* [2013] QCAT 608, in which the five-year duration of a covert sexual relationship was taken to have exacerbated the exploitative nature of the relationship with a young female patient, in particular because the patient remained in obviously poor mental health throughout that time: at [27]–[29] (Deputy President Horneman-Wren). See also *Ristevski* (n 97) [39].

[118] See, eg, *Jones* (n 115) [11], [18] (Deputy President Kingham, Members Congdon, Jordan and Rosengren) (the Tribunal accepted that the practitioner had 'genuine feelings' for the patient, which resulted in a two-month suspension); *Medical Board of Australia v Leggett* [2015] QCAT 240, [6], [12] (Deputy President Horneman-Wren) ('*Leggett*') (the Tribunal characterised this relationship with a former psychiatric patient of 10 years as being 'caring' and 'intimate', which resulted in the practitioner not being removed from practice); *Health Care Complaints Commission v Amigo* [2012] NSWMT 13, [46]–[47], [57] (Kavanagh J, Members Yeo, Kok, and Houen) (resulted in no removal from practice). Cf *Health Care Complaints Commission v Scully* [2011] NSWNMT 28, in which the nurse's claims of genuine romance were held to reflect a lack of insight into the power imbalance, with the two-year relationship resulting in the practitioner being deregistered with a one-year non-review period: at [123], [131]–[132] (Chairperson O'Neill, Members Anderson, Carlin, and Smith).

[119] See, eg, *Health Care Complaints Commission v Nikolova-Trask* [2014] NSWCATOD 149 ('*Nikolova-Trask*') (three-month suspension); *Vucak* (n 102) (three-month suspension); *Health Care Complaints Commission v Kreft [No 2]* [2012] NSWPST 1 ('*Kreft [No 2]*') (six-month suspension); *Psychology Board of Australia v IVX* [2016] VCAT 35 ('*IVX*') (nine-month suspension); *Psychology Board of Australia v Bakjac* [2016] SAHPT 3 ('*Bakjac*') (15-month suspension). Cf the arguably anomalous outcome in *Health Care Complaints Commission v Watson* [2015] NSWCATOD 148, in which the male nurse had provided brief respite care to a female patient of similar age. At the hearing they were married, and she vigorously objected to the proceedings as disability discrimination: at [5], [26] (Senior Member Grant, Members Johnston, Tolhurst, and Selkirk). Here, the result was deregistration with an 18-month non-review period: at [82]–[83].

To illustrate the lower end of the spectrum: a female GP entered into a relationship with a male patient of similar age, with whom she already had a strong social relationship. In that case, the doctor and patient were living in a small community in which 'dual' social-therapeutic relationships were common; she had provided limited care to him during the therapeutic relationship; they subsequently married and had a child together.[120] At the high end: a male psychologist used the therapeutic context to foster a sexual relationship with a young female patient over several months.[121] In that case, the patient had been seeking assistance for methamphetamine use and she reported to the psychologist her history of childhood sexual abuse and neglect, and an eating disorder.[122] The psychologist encouraged her to engage in, and film, a variety of sexual acts with himself, other men, and dogs, in order to fulfil his own long-standing sexual fantasies. This conduct resulted in long-term psychological and physical harm to the patient.[123]

At the core of the analysis of severity of the conduct was an overarching concern with the degree of power imbalance in the relationship, while sanction evaluation often centred on the likelihood of recurrence, such that judgments about the motivation of the practitioner were enmeshed in both. A 2017 Queensland case illustrates the extent to which analysis of seriousness bled into risk assessment and sanction. In that matter, a doctor used the therapeutic context to make sexual approaches to two different female patients, one of whom engaged in a brief sexual relationship with him.[124] When the doctor learnt that one patient had made a complaint, he tried to pressure her, and other witnesses, to change their evidence, hired a private investigator who stalked, attempted to bribe and intimidate the patient, and falsified his chaperone register to try to conceal his breach of conditions.[125] These factors weighed strongly against the doctor's expressions of regret and led to the finding that he was not a fit and proper person to hold registration.[126]

As noted in the introduction, there was some variation in how sexual misconduct was understood in the different professions. In cases concerning nurses, doctors and psychologists, even where sanctions differed, the sexual relationship itself was characterised as misconduct in almost every case in the

120 *Nikolova-Trask* (n 119).

121 *Dawes* (n 94).

122 Ibid [50]–[56].

123 Ibid [17], [288]. The outcome in this case was deregistration with a 10-year non-review period and a permanent prohibition order: at [313].

124 *Azam* (n 75); *Azam [No 2]* (n 69).

125 See *Azam* (n 75) [77]–[128].

126 *Azam [No 2]* (n 69) [16]–[19], [32].

dataset.[127] However, from the four dental cases concerning relationships, it appears that the dental profession may be resistant to the idea that a sexual relationship with a patient is in and of itself such a serious breach as to generally amount to misconduct. In a 2011 Victorian case concerning a relationship that occurred before the advent of the *National Law*, the practitioner conceded that the conduct was a serious breach of the previous Code on the basis that he 'did not act in [the patient's] best interests', and a suspension of three months was imposed.[128] However, in a 2013 NSW decision, the peer expert called by the statutory complainant opined that, in relation to a relationship that had taken place before the *National Law*:

> There was no legislated prohibition of a Dentist entering into a personal/sexual relationship with a patient. The [*Dental Practice Act 2001* (NSW) and *Dental Practice Regulation 2004* (NSW)] … did not specifically mention this type of scenario … there was also no mention of this type of situation in the Australian Dental Association's Code of Ethics …[129]

As a result, that case largely focused upon a later contact complaint concerning the same patient.[130]

In a 2015 NSW case, the expert witness for the statutory complainant opined that 'there was nothing in the [current dental] code of conduct preventing a sexual relationship with a client'.[131] The expert dismissed sections of the Dental Code concerning sexual relationships and boundaries, as applying only if there were some additional power imbalance or exploitation.[132] He further characterised the Code as applying only when a sexual relationship arose

[127] But see *Petrovic* (n 112). In that case, concerning a relationship some 14 years earlier, the male patient had worked at the clinic and had limited consultations with the female doctor which ceased two months prior to the relationship commencing. The Tribunal concluded that the lack of power imbalance meant that the breach did not amount to misconduct: at [26]–[28] (Deputy President Lambrick, Members Reddy and Clarke).

[128] *Dental Board of Australia v Gazelakis* [2011] VCAT 726, [6] (Deputy President Lambrick, Members Story and King) ('*Gazelakis*').

[129] *Health Care Complaints Commission v Sunda* [2013] NSWDT 1, [12] (Chairperson Shub, Members Lester, Lobo, and Milne) ('*Sunda*').

[130] *Sunda* (n 129). The practitioner later faced proceedings in *Health Care Complaints Commission v Sundarajah* [2017] NSWCATOD 182 ('*Sundarajah*') and *Health Care Complaints Commission v Sundarajah [No 2]* [2018] NSWCATOD 86 ('*Sundarajah [No 2]*'): see below n 198 for discussion. It does appear in this matter that the relevant Council was reluctant to take restrictive immediate action. When faced with complaints concerning sexual assault and then stalking, some years apart, it imposed chaperone conditions on both occasions: *Sunda* (n 129); *Sundarajah* (n 130).

[131] *Eftimoski* (n 114) [23].

[132] Ibid. The relevant sections of the Code are extracted earlier in this article: see above n 55.

directly from the therapeutic context.[133] Such a circumscribed reading of the professional responsibilities of dentists is remarkable, especially given that the Dental Code is identical in wording to the Medical Code, and that of most other registered health professions, in expressly proscribing sexual relationships with patients.[134] In that case, the Tribunal held that the conduct did not rise to the level of professional misconduct because the parties had a longstanding social relationship (which in fact predated the therapeutic relationship), but implicitly rejected the peer expert view in still finding that the sexual relationship constituted unsatisfactory professional conduct.[135]

In contrast, nursing and psychology were dominated by relationship cases. Several nurses and doctors attempted to minimise the seriousness of the conduct by claiming that the sexual relationship commenced after the therapeutic relationship had concluded and so did not involve a 'patient'. This was generally given little weight by tribunals, which focused on the ongoing effect of the therapeutic relationship (and often the brief period of time which had passed) such that a 'patient' and 'former patient' were similarly situated.[136] Further, the abrupt cessation of treatment, without referral or other steps to ensure continuity of care, was frequently found to itself comprise a professional breach.[137] However, the regularity with which these issues surfaced does suggest that many other health professions could benefit from the kind of clear guidance offered to psychologists about how to appropriately manage a transition between a therapeutic and personal relationship. The positive obligation put on psychologists to seek supervision when faced with sexual attraction to a patient, and their clearer duties concerning 'dual relationships', leaves that profession with far less wriggle room on such issues, and there was arguably greater clarity in the reasoning and outcomes concerning such breaches.[138]

[133] *Eftimoski* (n 114) [23]. The expert also expressed the view that the 20-year age difference between the parties was irrelevant: at [20].

[134] By inference, it is possible that such a view could be present at board level and that it may, therefore, affect how complaints of sexual misconduct in that profession are handled, in particular whether they are viewed as potential misconduct and referred to tribunal level at all. Noting that there were no relationship cases at all involving pharmacists at tribunal level over the seven-year period of the study, it is possible that referrals concerning sexual relationships could also be an issue in that profession.

[135] *Eftimoski* (n 114) [84].

[136] See, eg, *Jackson* (n 95) [57] (Deputy President Parry, Member Connor and Sessional Member Jones). See also Jenni Millbank, 'Sexual Relationships between Health Practitioners and Former Patients: When Is It Misconduct?' (2020) 213(5) *Medical Journal of Australia* 212.

[137] See, eg, *Medical Practitioner VI* (n 101).

[138] See *APS Code of Ethics* (n 57) 28 [C.3.2], 29 [C.4.3(c)].

III Inappropriate Contact

Cases involving unjustified touching under a clinical pretext almost all involved doctors, usually in a general practice setting. Doctors dominated the inappropriate contact category, comprising 34 of the 60 contact cases, with nine cases each concerning nurses and psychologists, five dentists and three pharmacists. Looked at as a breakdown per profession, more than half of the matters concerning doctors and dentists involved contact, as did all of the small number of cases against pharmacists.

Only four of the contact cases concerned male patients, three of whom were boys or young men at the time of the incidents. All except one of the practitioners in the contact matters were male.[139]

Half of the contact cases involved more than one patient; generally this was two patients, but there were five cases in which allegations concerned three patients, two cases involved four patients and a further two cases involved 10 and 17 patients, respectively.[140] Cases in which criminal charges had been laid were associated with a higher number of patients. As noted earlier, contact cases were more likely than relationship cases to be 'not proved'. Among the total of 10 not proved cases,[141] seven involved inappropriate sexual contact (concerning six doctors, all in general practice, and one nurse in a hospital setting). Six of those seven not proved contact cases involved allegations by a single patient.

Contact cases were strongly associated with criminal proceedings, with 20 of the contact cases involving a respondent who was previously charged with (and generally convicted of)[142] a criminal offence in relation to the same conduct. There were a number of ways in which tribunal decisions on contact appeared to import or rely upon criminal law processes and norms. I suggest that these may not have been appropriate in the disciplinary tribunal context, where: the rules of evidence do not apply, public protection is the overarching objective, and the respondent's state of mind is not always relevant to whether

[139] See above n 67.

[140] See also DuBois et al (n 10), finding that in 57.4% of the US medical disciplinary cases in their dataset (101 cases, of which the majority were contact cases), there were five or more victims: at 513.

[141] In three cases, the name of the practitioner was suppressed in the decision. Among the seven named practitioners, at the time of writing one had ceased to hold registration, one was deregistered for a subsequent sexual misconduct offence, and one was working under subsequent conditions that he have no contact with female patients.

[142] Of the 18 finalised criminal proceedings, 15 involved guilty findings or pleas, two were not guilty and one was admitted but diverted by reason of a mental health order. There were a further three cases noting a police report was made, but did not lead to prosecution.

the conduct is below the required professional standard or is improper or unethical.

In the seven not proved cases, when the tribunal did not accept the patients' versions of events, they dissected the patient account in a manner more commonly associated with sexual assault trials. This involved findings that the patient's lack of protest at the time,[143] delay in making a complaint (eg until the next day),[144] or minor differences in the detail of their account as it was recorded on different occasions (to police, to the regulator, in the formal statement prepared for the proceedings) rendered the patient's evidence less credible.[145] This was possibly inappropriate in some circumstances, for instance, where there were multiple, or prior, similar complaints, or where the patient was still hospitalised at the time of giving an account and/or did not appreciate how the account was going to be used.[146] Furthermore, there are powerful, longstanding and compelling critiques of requirements of 'recent complaint',[147] and on the undue focus on consistency in prior accounts (particularly in relation to peripheral detail) when determining credibility.[148] These critiques arise in a number of other legal fora in which issues of sexual victimisation are addressed, such as criminal proceedings for sexual assault and in refugee status adjudication.[149] It is also worth recollecting that the common practice of holding

[143] *Health Care Complaints Commission v Nguyen* [2013] NSWMT 18, [111]–[112] (Levy DCJ, Members WrightToh, and Houen) ('*Nguyen*').

[144] See *Nursing and Midwifery Board of Australia v JPH* [2014] VCAT 1090, [117] (Deputy President Lambrick) ('*JPH*').

[145] See eg *Health Care Complaints Commission v CNU* [2016] NSWCATOD 50, [175] (Principal Member Mullane, Members Abouyanni, Rotenko, and Sundquist) ('*CNU*'); *Nguyen* (n 143) [130]–[131]. See also *Medical Board of Australia v Saddik* [2010] VCAT 1440, involving a young trainee receptionist whose evidence was said to include a 'number of discrepancies': at [48]–[50] (Senior Member Davis and Member Davis). Unusually, this decision features a dissent: at [65]–[149] (Member Reddy).

[146] See, eg, *JPH* (n 144) [9]–[12] (Deputy President Lambrick).

[147] See, eg, Julia Quilter, 'Re-Framing the Rape Trial: Insights from Critical Theory about the Limitations of Legislative Reform' (2011) 35(1) *Australian Feminist Law Journal* 23, 43–9.

[148] See, eg, Deborah Tuerkheimer, 'Incredible Women: Sexual Violence and the Credibility Discount' (2017) 166(1) *University of Pennsylvania Law Review* 1; Annie Cossins, 'Expert Witness Evidence in Sexual Assault Trials: Questions, Answers and Law Reform in Australia and England' (2013) 17(1) *International Journal of Evidence and Proof* 74, 81–2; Sarah Zydervelt et al, 'Lawyers' Strategies for Cross-Examining Rape Complainants: Have We Moved Beyond the 1950s?' (2017) 57(3) *British Journal of Criminology* 551, 564–6.

[149] See, eg, Hilary Evans Cameron, 'Refugee Status Determinations and the Limits of Memory' (2010) 22(4) *International Journal of Refugee Law* 469; Jane Herlihy, Peter Scragg, and Stuart Turner, 'Discrepancies in Autobiographical Memories: Implications for the Assessment of Asylum Seekers' (2002) 324(7333) *British Medical Journal* 324; Jane Herlihy and Stuart Turner, 'Should Discrepant Accounts Given by Asylum Seekers Be Taken as Proof of Deceit? (2006) 16(2) *Torture* 81.

disciplinary proceedings only after criminal proceedings had concluded meant that long delays, often of four or five years, between the events themselves and the hearing, were the norm and not the exception.

Analysing all of the contact cases together, it was striking that almost every patient in proceedings who was subject to intimate touching under the pretext of a medical examination or procedure reported a feeling that something was 'off' or unlike previous procedures, and felt increasingly uncomfortable, upset or violated. However, these patients did not confront the practitioner within the clinical setting at the time it was occurring. While a small number of patients reported that they physically tensed or withdrew, or hurried an appointment to its close, others tried to ignore or brush over what was happening or even to rationalise or normalise it.[150] More than one patient was so resistant to the idea that the conduct was abusive that they returned to the same doctor for subsequent consultations before making a complaint.[151] The authority position of the doctor and the ingrained expectation of deference in the clinical setting meant that submission and distrust of their own perception of violation was the norm. Once away from that setting, often after a period of reflection, patients who could not shake a feeling of 'wrongness' then confided in a trusted person — usually a partner, friend or parent; and it was that support person who was often the catalyst for the complaint being brought.[152]

In general, when allegations were brought to the police, the health disciplinary process paused until the criminal process was completed.[153] As a consequence, the disciplinary hearing in contact matters frequently included material from the criminal investigation and proceedings, including trial transcripts and expert reports. The presence of such material further coloured the contact

[150] See Searle et al, *Insights into Sexual Misconduct and Dishonesty* (n 8) 22–3.

[151] Women subject to clergy sexual misconduct report similar experiences — mistrusting their own perception and normalising behaviour that is increasingly transgressive: see, eg, Kathryn Flynn, 'In Their Own Voices: Women Who Were Sexually Abused by Members of the Clergy' (2008) 17(3–4) *Journal of Child Sexual Abuse* 216, 231; Diana Garland, 'Don't Call It an Affair: Understanding and Preventing Clergy Sexual Misconduct with Adults' in Claire Renzetti and Sandra Yocum (eds), *Clergy Sexual Abuse: Social Science Perspectives* (Northeastern University Press, 2013) 118; Margaret Kennedy, 'Sexual Abuse of Women by Priests and Ministers to Whom They Go for Pastoral Care and Support' (2003) 11(2) *Feminist Theology* 226; Patricia L Liberty, '"It's Difficult to Explain": The Compromise of Moral Agency for Victims of Abuse by Religious Leaders' (2001) 3(3–4) *Journal of Religion and Abuse* 81.

[152] See, eg, *Gachon* (n 107).

[153] On occasion, the publicity around criminal proceedings led to additional patients coming forward: see also Paterson (n 2) 28. See, eg, *Medical Board of Australia v Moodley* [2014] QCAT 476, noting two of the seven patients 'made complaints to police but were dissuaded from pursuing them' in 2003 and a third patient made a complaint to a nurse and a doctor in 2008 but 'was persuaded not to take the matter further'.

cases with the norms and modes of criminal law and procedure. For example, when police were faced with a contact complaint, they typically engaged an expert medical opinion to determine whether the intimate touching could be justified by reference to any standard medical procedure. However, in contrast to the disciplinary setting, where the question is whether on the balance of probabilities the conduct was substantially below the accepted professional standard, the question in the criminal setting was whether there could be reasonable doubt about whether the touching was unjustified. This meant that doctors expressing opinions for the police were really searching for any plausible explanation for the conduct, rather than asking whether it was best, or even acceptable, practice in the circumstances.[154] Such opinions were not intended for disciplinary proceedings, and were arguably ill-suited to them in some instances.

In four cases, arising from NSW, Queensland and Victoria, in which police were the first point of complaint, the police provided a listening device and sent the patient back to confront the practitioner, presumably in the hopes of gathering an admission.[155] This appears to have been at best a troubling, and at worst a traumatic, experience for the patients. It also backfired in the sense that the evidence gathered was subsequently used in the tribunal setting in an exculpatory or minimising way by the practitioners. In two cases, the doctors' generic expressions of apology or regret for how the patient 'felt' about what had happened were interpreted by the tribunal to the practitioner's credit, and as demonstrating that the patient had 'misunderstood' what had occurred (including the doctor in one case apologising for his breach of the patient's trust and 'what got over' him that day).[156] Even in a case in which the complaint was proved, the doctor's statement ('I am sorry if I offended you'), recorded by the wiretap, was held not to 'advance' the issue of whether the conduct had

[154] See, eg, *Priyamanna* (n 81) in which the patient stated that the practioner had massaged her breast while placing a stethoscope on her chest, had stroked her thigh and had clutched her crotch. The police doctor hypothesised that the patient's fever could have altered her perception and caused her to misinterpret an examination of her heart and glands: at [37]–[38]. In fact, the practitioner had not claimed that he was examining the patient's heart, nor did his contemporaneous records reflect such an examination, although he later made such claim (and the Tribunal held that this was in order to rely upon the police doctor's opinion): at [165]. Two further expert opinions were produced for the disciplinary proceedings, and the decision contains a detailed and considered discussion of memory and credibility issues.

[155] It is hard to imagine why a practitioner who perpetrated abuse on a patient through deception and a veneer of clinical necessity, would then admit it to the patient's face rather than continuing the deception.

[156] See *CNU* (n 145) [174] (Principal Member Mullane, Members Abouyanni, Rotenko and Sundquist); *Nguyen* (n 143) [187]–[188], [243]–[246] (Levy DCJ, Members Wright, Toh, and Houen).

occurred.[157] In a case concerning a psychologist indecently touching an adolescent female patient, the consequence of the wiretap was that the police, and subsequently the Board, proceeded only upon the more limited admission made by the practitioner on the recording, not upon the more serious conduct of which the patient actually complained.[158]

In a small number of cases, tribunals went so far as to focus on the practitioner's state of mind — as if mens rea concerning 'sexual gratification' were a required element of the legal standard in disciplinary proceedings. For example, in a 2016 Queensland case, concerning a doctor who subjected two female patients to prolonged vaginal examinations in which he also touched their clitorises, the Tribunal stated at the outset of the decision that

> [t]he primary point for this Tribunal to determine will be whether or not it is satisfied to the required standard of proof that Dr Rall's conduct involved sexual self-gratification. If it did, [a finding of misconduct] will be appropriate. If, on the other hand, the case establishes no more than irregularity in procedure and/or some medical incompetence or inadequacy, a finding may still be open under [the lesser offence of unsatisfactory professional conduct].[159]

With respect, framing sexual misconduct cases to require proof of subjective sexual 'gratification' on the part of the practitioner may mislead the inquiry.[160] If intimate touching is found to be objectively clinically unjustified, or otherwise inappropriate in the circumstances (such as a mental health professional massaging patients), an assessment must be made as to whether conduct is below the required professional standard and/or objectively improper.[161] Then,

[157] *Medical Board of Australia v Rall* [2016] QCAT 228, [25], [37] (Judicial Member Thomas, Members Evans, Parker and Taylor) ('*Rall*').

[158] *Psychologists Registration Board of Victoria v Didenkowski* [2010] VCAT 183.

[159] *Rall* (n 157) [10]. Further, '[t]he central contested issue would require a finding as to Dr Rall's state of mind … On the evidence, as it stands, I am not prepared to find the sinister state of mind that is alleged': at [49]. But see, the later decision of the NSW Court of Appeal, holding that '[t]here is no category of unsatisfactory professional conduct which is not capable, depending on the circumstances, of giving rise to professional misconduct': *Chen v Health Care Complaints Commission* (2017) 95 NSWLR 334, 340 [20] (Basten JA) ('*Chen*').

[160] For example, this might mislead the inquiry into questions such as whether there was evidence of a male practitioner experiencing an erection at the time, rather than whether the touching was justified by any clinical standard. On a broader level, it also confuses the sexualised misuse of power with sexual acts.

[161] Impropriety can be inferred from objective evidence, such as a lack of clinical documentation of intimate examinations. It can also be found as a reasonable inference when there is no other purpose to the examination: *Medical Board of Australia v Naim* [2013] VCAT 329, [84] (Vice President Macnamara, Members Collopy and Reddy) ('*Naim*').

the question is whether it is of such severity or repetition as to rise to the level of misconduct.

Although also a feature of relationship cases, it was notable that in many of the contact cases the patient's health condition was used by the practitioner in an attempt to discredit her. For example, in a case where two young women recovering from general anaesthetic reported that they had been inappropriately touched by a male nurse, the case turned on the degree of disorientation and confusion commonly experienced by patients in such a setting. One of the patients was further discredited because she had a diagnosis of schizophrenia and was present in the hospital as a result of an episode of self-harm.[162] Female patients in acute mental health settings, in particular if they were young women who had a diagnosis of borderline personality disorder, were liable to be labelled attention seeking and struggled to be believed.[163] It was the rule rather than the exception that the practitioner had access to, or control over, the healthcare records of the patient, so it is worth noting that care should be taken in how they are used in assessing patient credibility. In some cases, it appears that the practitioner altered clinical records to provide a 'pre-emptive strike', or cover for himself, for example, by labelling the patient delusional,[164] or claiming that she had been sexually inappropriate with him.[165]

Because the contact cases commonly featured denials on the part of the practitioner, there was considerably less focus on claims of mitigation, such as the practitioner's own health, remediation efforts, or special skills, than in the relationship cases.[166]

[162] *JPH* (n 144) [101]–[117] (Deputy President Lambrick).

[163] See, eg, *Nursing and Midwifery Board of Australia v Dalton* [2013] VCAT 2147 ('*Dalton*'), in which there were records showing that the mental health nurse had telephoned the patient over 400 times: at [74] (Senior Member Smithers, Members Archibald and Pearson). The patient's account of a sexual relationship was not accepted because her schizophrenic condition meant she was unable to give oral evidence: at [161]–[168]. A second patient's account of sexualised conduct by the nurse was rejected because she had delayed in making the complaint: at [58]. But see *Nursing and Midwifery Board of Australia v Isgrove* [2015] QCAT 522, [45] (Deputy President Horneman-Wren), in which the practitioner instructed the patient to recant and say that her allegation was part of her 'attention-seeking' disorder. In that case, the Tribunal explicitly found that in doing so, he compromised her care and took it into account as an aggravating factor: at [46]. The outcome in this case was deregistration with a nine-year non-review period: at [55].

[164] See, eg, *Health Care Complaints Commission v Jangodaz* [2016] NSWCATOD 71, [23] (Senior Member Millbank, Members Cockrell, Sinclair, and Floyd) ('*Jangodaz*').

[165] See, eg, *Singh* (n 74) [292] (Presiding Member Smithers, Members Pearson and Barry); *Baez* (n 71) [119] (Colefax DCJ, Members Giuffrida, Houen and Cox).

[166] But see *Huson* (n 71), in which the practitioner hugged a patient and told her he wanted a relationship with her. In this case, the practitioner's depression was taken into account: at [23]–[25] (Presiding Member Butcher, Members List and Manning).

IV Disciplinary Outcomes

A recent overview study of health disciplinary systems found that international literature, including regulator guidance and other public material (such as websites), indicates broad 'consensus' on the relevant factors in determining sanction. The study commented, however, that this is very rarely codified or integrated into the approach of regulators to defining and managing misconduct.[167]

In 2018, the UK General Medical Council redeveloped 'Sanctions Guidance' for use in the medical disciplinary system, offering qualitative guidance on factors to be considered in determining the seriousness of misconduct and when warnings, conditions or removal from practice are likely to be appropriate at both Board and tribunal level, which was then further updated in 2019.[168] There is no equivalent guidance within the Australian system.

Under the *National Law*, if unprofessional conduct is proved, a tribunal may impose conditions or issue a reprimand or caution or, in certain circumstances, a fine. Removal from practice through deregistration or suspension is only available for misconduct (or if the practitioner is not competent to practise or is unsuitable or, by reason of criminal conviction, unfit in the public interest to practise).[169] Although the category 'removal from practice' is commonly used by researchers and policy makers, there is a significant difference between deregistration and suspension orders. A suspension is finite; it must be limited in time and, when that time passes, registration is automatically restored. Deregistration persists until the relevant Board (or in NSW, the Tribunal) determines that the practicioner is safe to return to practice. A set time may be ordered before such reapplication is permitted, and the passage of time alone does not establish fitness; the practitioner bears the onus of proving that they are safe to return to practice at the time of reapplication.[170] Restoration of registration may be unconditional, accompanied by conditions, or in some cases, repeatedly denied.[171] A prohibition order, preventing the practitioner from providing one or more other health services for a period of time or permanently, is available only if the practitioner is removed from practice and they pose a substantial risk to the health of members of the public.[172]

[167] Marie Bryce et al, *Fitness to Practise: Impairment and Serious Misconduct* (Final Report, March 2018) 35–41.

[168] *Sanctions Guidance* (n 93).

[169] See, eg, *National Law Act (NSW)* (n 15) s 149C.

[170] See 'Possible Outcomes' (n 22).

[171] See, eg, *Bahramy v Medical Council of New South Wales* [2014] NSWCATOD 116; *Bahramy v Medical Council of New South Wales* [2017] NSWCATOD 146; *Wilks* (n 53).

[172] See, eg, *National Law Act (NSW)* (n 15) s 149C(5).

The jurisdiction is protective of the public and not punitive, even though sanctions such as the cancellation of registration may have a negative impact on the practitioner.[173] The cases demonstrate that there is broad acceptance of the guiding principles, as involving both specific protection of patients and more general protection of the public, through the setting of professional standards and 'signalling' of those standards to the profession and the public.[174] Justice of Appeal Meagher of the NSW Court of Appeal expressed this as follows:

> The objective of protecting the health and safety of the public is not confined to protecting the patients or potential patients of a particular practitioner from the continuing risk of his or her malpractice or incompetence. It includes protecting the public from the similar misconduct or incompetence of other practitioners and upholding public confidence in the standards of the profession. That objective is achieved by setting and maintaining those standards and, where appropriate, by cancelling the registration of practitioners who are not competent or otherwise not fit to practise, including those who have been guilty of serious misconduct. Denouncing such misconduct operates both as a deterrent to the individual concerned, as well as to the general body of practitioners. It also maintains public confidence by signalling that those whose conduct does not meet the required standards will not be permitted to practise.[175]

Courts and tribunals around Australia have all expressed similar principles in their approach to protective orders.[176] These are often synthesised over decades

[173] *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630, 637 (Gleeson CJ, Meagher and Handley JJA) ('*Litchfield*').

[174] See also the three 'limbs' of the statutory duty to protect the public in the UK in *Sanctions Guidance* (n 93) [14]:

(a) protect and promote the health, safety and wellbeing of the public

(b) promote and maintain public confidence in the medical profession

(c) promote and maintain proper professional standards and conduct for the members of the profession.

[175] *Health Care Complaints Commission v Do* [2014] NSWCA 307, [35] (Meagher JA). See also *Craig v Medical Board of South Australia* (2001) 79 SASR 545, 553–5 [41]–[48] (Doyle CJ).

[176] In Western Australia, the same factors are referenced, along with others, such as insight and trustworthiness, in a 12-point checklist: *Buckby* (n 66) [106] (President Curthoys, Members McCutcheon and McCallum) (citations omitted):

1) any need to protect the public against further misconduct by the practitioner;

2) the need to protect the public through general deterrence of other practitioners from similar conduct;

of case law, concerning both legal and medical disciplinary matters, under a variety of common law and statutory schemes pre-dating the National Law.[177]

However the broad acceptance of common principles in sanction was not always reflected in their application. Areas of divergence included: the relative importance of 'general' versus 'specific' deterrence; the consideration to be given to any interim period the practitioner had been removed from practice pending determination; the appropriateness of suspension versus deregistration; whether there is a 'rehabilitative' function of orders, that is, an express consideration of the orders as directed to the reform and return of the practitioner to practice;[178]and, relatedly, whether there is a public interest in the public having access to 'special skills' possessed by the practitioner;[179] and the

> 3) the need to protect the public and maintain public confidence in the profession by reinforcing high professional standards and denouncing transgressions and thereby articulating the high standards expected of the profession …;
>
> 4) in the case of conduct involving misleading conduct, including dishonesty, whether the public and fellow practitioners can place reliance on the word of the practitioner;
>
> 5) whether the practitioner has breached any Act, regulations, Guidelines or Code of Conduct …, and whether the practitioner has done so knowingly;
>
> 6) whether the practitioner's conduct demonstrated incompetence, and if so, to what level;
>
> 7) whether or not the incident was isolated such that the Tribunal can be satisfied of his or her worthiness or reliability for the future;
>
> 8) the practitioner's disciplinary history;
>
> 9) whether or not the practitioner understands the error of [their] ways, including an assessment of any remorse and insight …;
>
> 10) the desirability of making available to the public any special skills possessed by the practitioner;
>
> 11) the practitioner's personal circumstances at the time of the conduct and at the time of the sanctions. However, the weight given to personal circumstances cannot override the fundamental obligation of the Tribunal to provide appropriate protection of the public interest …;
>
> 12) the Tribunal may consider any other matters relevant to the practitioner's fitness to practice and other matters which may be regarded as aggravating the conduct or mitigating its seriousness. In general, mitigating factors such as no previous misconduct or service to the profession are of considerably less significance than in the criminal process because the jurisdiction is protective not punitive.

177 In NSW, the Court of Appeal has expressly disapproved of the importation into the *National Law* of restrictive interpretations or 'glosses' from other settings, such as the requirement from legal disciplinary matters that 'probable permanent unfitness' is necessary to justify deregistration: *Chen* (n 159) 351–2 [69]–[75] (Payne JA). The Court of Appeal stated that the *National Law* is a 'detailed statutory regime' that cannot be limited by reference to previous common law: at 348 [59].

178 See, eg, *Cicconi* (n 92) [83] (Deputy President Lambrick, Members Farhall and Power).

179 See, eg, *Health Care Complaints Commission v King* [2013] NSWMT 9, [27] (Murrell DCJ, Members Berglund, Kertesz and Yeo).

degree of deference given to 'agreed sanctions'. Some of these areas of divergence were more pronounced in certain jurisdictions, while others appeared more marked in decisions about particular professions. These areas of divergence are explored below.

A *General versus Specific Deterrence, Denunciation or Standard Setting*

Determinations concerning removal from practice were often inflected with the therapeutic language of 'insight', 'remorse' and 'reformation', but ultimately rested upon a balancing of whether the practitioner could be trusted in the future to comply with regulation and if they posed a future risk to the public.[180] The emphasis given to broader deterrence and denunciation messages varied. If a tribunal determined that a practitioner did not pose a specific risk to the public, removal from practice was considerably less likely in most jurisdictions. However, there were still a number of cases in which a practitioner was removed from practice, even in the face of a clear finding that they posed no future risk, on the basis that the message sent to the profession regarding the seriousness of the conduct was of such importance.[181] Decisions in NSW appeared to devote more attention to the question of standard setting and 'signals' to the profession, and this could go some way towards explaining the trend of higher levels of deregistration in that state.

The setting of a period of suspension, or a non-review period in cases of deregistration, is said to serve two purposes: to set a period of time in which the practitioner can establish themselves as safe to return to practice, and to send a signal to the profession and the public about the seriousness of the conduct.[182] These 'signals' were not always easy to determine, as tribunals appeared anxious to avoid 'punitive' language by referencing criminal law norms in setting a penalty, such that the period set was usually a 'global' one that was justified by generalised reference to 'seriousness' and 'risk', but not disaggregated by different complaints or elements of the misconduct. This meant that there was very rarely any consideration given to whether a longer period of non-review

[180] See, eg, *Dawes* (n 94) [307]–[308] (Principal Member Muller, Members Warren, Blaszczynski, and Taylor).

[181] See, eg, *Psychology Board of Australia v Garcia* [2015] VCAT 128, [45]–[47] (Senior Member Butcher, Members Farhall and Manning); *Health Care Complaints Commission v Ledner* [2017] NSWCATOD 90, [77]–[78] (Senior Member Titterton, Members Shires,Wilcox, and Turner).

[182] *Chen* (n 159) 345 [42] (Payne JA).

was required to send a stronger 'signal' when the conduct involved multiple patients or occurred over a long period.[183]

B *'Time Served': Reducing Periods of Removal from Practice*

A number of jurisdictions, in particular South Australia, Victoria and Queensland,[184] regularly took into account the amount of time that a practitioner had been out of practice by reason of interim suspension to reduce a period of suspension or the non-review period for deregistration orders.[185] This 'time served' approach led to significantly shorter periods of removal from practice following findings of misconduct, sometimes to nothing.[186]

In NSW, the Tribunal has not adopted a 'time served' approach. In 2015, a doctor argued on appeal that the tribunal had erred in setting a non-review period of four years by failing to take account of the three and a half years she

[183] For a rare example of a disaggregated period of time being applied for deregistration, see, *Buckby* (n 66), where the practitioner was deregistered with a non-review period of seven years, five years for one patient and two years for the other. Note that in a recent UK study of disciplinary outcomes in sexual misconduct in health professions, Searle found no statistically-significant difference in sanction for 'repeat offenders', and she expresses concern over the 'signal' this sends: Searle, *Sexual Misconduct in Health and Social Care* (n 33) 29, 31.

[184] There was also a period of some years in which the Queensland Tribunal 'suspended' all or part of a period of suspension while conditions were in place: see, eg, *Medical Board of Australia v Yasin* [2011] QCAT 300, until it was determined that such a form of order was not authorised under the National Law. This practice appears to still be occurring in New Zealand: see Surgenor, Diesfeld and Rychert (n 34) 772.

[185] This was also done by 'backdating' suspensions: see, eg, *Tasmanian Board of the Medical Board of Australia v Visagie* [2013] TASHPT 2 ('*Visagie*').

[186] See, eg, *Leggett* (n 118) [18] (Deputy President Horneman-Wren), in which the Tribunal expressed the view that 'backdating' of suspension was not authorised by the National Law but that it was 'entirely appropriate to take into account … a de facto period of suspension, which a practitioner has experienced in the period of time between when the conduct giving rise to disciplinary proceedings arose and the determination of an appropriate sanction' suspension of 12 months identified as an appropriate period in the ordinary course, no period of suspension applied; *Medical Board of Australia v MBO* [2015] ACAT 69, 1 (Senior Member Brennan) ('*MBO*'), where the practitioner engaged in a sexual relationship with one patient and inappropriate social contact with another patient, and where the agreed sanction of suspension was reduced to three months based on a previous 12 month interim suspension. See also *Pharmacy Board of Australia v Sternes* [2015] QCAT 161, [34]–[36] (Deputy President Honreman-Wren), in which the Tribunal found that a five-year exclusion from the profession would have been appropriate, but did not in fact order any period of deregistration because it took into account the period in which the practitioner had been suspended, and then gaoled, for a sexual offence that was not in the course of his profession. However, note later authority from the Queensland Court of Appeal that, '[i]n general, the practitioner's punishment under the criminal law is not a factor which should moderate the disciplinary sanction, because the purpose of that sanction is not to punish the practitioner, but to protect the public': *Nursing and Midwifery Board of Australia v Faulkner* [2018] QCA 97, [51] (McMurdo JA).

had already spent suspended.[187] The Court of Appeal rejected this ground on the basis that

> [t]hat submission proceeds on a wrong view as to the purpose of the disciplinary powers of the Tribunal. That purpose is not to punish the practitioner concerned but rather to protect the public and maintain proper professional standards …
>
> The matters to be considered by the Tribunal in making what in effect was a four year disqualification order included the period of time likely to be required for the practitioner to change her conduct so that she was competent to practise without risk to the health and safety of the public.[188]

The Court of Appeal went on to say that there was no evidence that the practitioner had accepted or remediated the relevant issues during the period of suspension, such that it could not be considered relevant.[189] By corollary, if a practitioner had, during a period of suspension, admitted the conduct and undertaken steps towards remediation, it would be that remediating conduct itself, and its bearing on public safety, which would be relevant to the determination of orders, not the time period of the suspension per se.

C *Suspension versus Deregistration*

In cases of proved misconduct, it was generally accepted that suspension was an inappropriate outcome where the practitioner demonstrated that they were untrustworthy or not adherent to their profession's values and obligations. For example by: committing multiple offences over an extended period;[190] misleading investigators;[191] coaching, pressuring or bribing the patient to mislead

[187] *Qasim v Health Care Complaints Commission* [2015] NSWCA 282.

[188] Ibid [73]–[74] (Meagher JA) (citations omitted).

[189] Ibid [74].

[190] See, eg, *Medical Board of Australia v Costley* [2013] WASAT 2, [49] (President Chaney, Members Gillett, McCutcheon and Lipon) ('*Costley*'); *Medical Board of Australia v Gale* [2015] SAHPT 3, [32]–[33] (Deputy President Wilson, Members HeahMoy, and McMahon); *Health Care Complaints Commission v Sims* [2010] NSWMT 17, [108]–[109] (Deputy Chairperson Backman, Members Kendrick, Spark and Kiel); *Mortlock* (n 109) [57] (Principal Member Britton, Members Tolhurst, Selkirk, and Hooker); *King* (n 81) [95]–[101] (Deputy President Sheridan).

[191] See *Dalton* (n 163), where even though neither patient's account of sexual misconduct was accepted, the nurse's repeated deception of investigators was held to be sufficiently serious to justify deregistration).

investigators or recant;[192] giving false or misleading evidence to the Tribunal;[193] breaching conditions imposed prior to hearing; or refusing to attend the hearing.[194] As noted above, suspension was a much more common outcome in relationship matters compared to contact cases, and this may reflect the higher occurrence of denial and multiple incidents in the contact cases.

In a 2013 case, VCAT quoted with approval an earlier decision that predated the *National Law*, as follows:

> Cancellation of registration sends a clear message of unsuitability to practice. *Suspension may be thought to indicate confidence in the doctor's future ability to practise once the period of suspension is served.*
>
> There are some cases in which it is abundantly clear that deregistration is the only option available to protect the public from a miscreant doctor.
>
> This is apparent in situations in which the practitioner does not accept the inappropriateness of his conduct or has been shown to be a serial offender.[195]

However, there were several notable cases where, despite the presence of one or more of the above factors (including overt findings of misleading evidence from the practitioner), deregistration was still not ordered.[196] Such cases are hard to explain in the sense that a practitioner has been adjudged untrustworthy, and yet was returned to practise without any further assessment to prove their safety to practise (or was given a further chance to practise under

[192] See, eg, *Nursing and Midwifery Board of Australia v Heather* [2010] QCAT 423; *Health Care Complaints Commission v Sciberras* [2015] NSWCATOD 146; *Shahinper* (n 64); *Jangodaz* (n 164).

[193] See, eg, *Firth [No 2]* (n 109); *Health Care Complaints Commission v Firth [No 3]* [2015] NSWCATOD 118; *Health Care Complaints Commissioner v Bergmeier* [2014] NSWCATOD 75.

[194] See, eg, *Health Care Complaints Commission v Elliott* [2017] NSWCATOD 20; *Mayr* (n 109). See also *Sanctions Guidance* (n 93) [91]–[97].

[195] *Myers 2013* (n 71) [78] (Members Wentworth, Burge and Davis) (emphasis added), quoting *Honey v Medical Practitioner Board of Victoria* [2007] VCAT 526, [43]–[45] (Judge Harbison and Member Davis).

[196] See, eg, *MBO* (n 186) (a sexual relationship with one patient and sexualised conduct with another patient resulted in a three-month suspension); *Psychology Board of Australia v D* (Western Australia State Administrative Tribunal, Chaney J, 15 December 2011) (sexual relationship with two patients resulted in a seven-month suspension); *Health Care Complaints Commission v Kreft [No 1]* [2011] NSWPST 2 and *Kreft [No 2]* (n 119) (a case involving a relationship with one patient and pursuit of sexual relationship with another, including soliciting nude photographs of her under therapeutic pretext resulting in a six-month suspension); *Veettill* (n 85) (here, the Tribunal rejected the practitioner's sworn evidence at the hearing and found that he had gone to the patient's home and sexually assaulted her, yet ordered a one-year suspension followed by chaperone conditions). See also *Gilliland [No 2]* (n 114) and *Gilliland [No 3]* (n 114) (two-year suspension); *Vucak* (n 102) (three-month suspension); *Bakjac* (n 119) (15-month suspension).

conditions when conditions had previously not been adhered to). Allowing return to practice, without any further review of the practitioner's fitness, appeared particularly anomalous in instances where the practitioner was found to have attempted to subvert the disciplinary process by bribing, threatening or intimidating the patient to withdraw the complaint and/or to destroy evidence.[197] Some of these same practitioners returned to the disciplinary system due to subsequent complaints of sexual misconduct.[198]

D *'Special Skills'*

Consideration of the 'special skills' possessed by the practitioner, and the public interest in having access to them, appeared on occasion through claims by the respondent that they serviced a particular clinical niche, or worked in a geographic area with clinical shortages. The underlying notion of a medical practitioner's clinical skills as distinct, and severable, from 'character' and 'conduct' concerns was also apparent in the selective imposition of so-called 'chaperone' conditions. Chaperone conditions implicitly encompass notions of special skill, because they too rest on the premise that, apart from the risk which a doctor poses to unaccompanied female or child patients, he is a competent and safe professional, whose skills should continue to be accessible to the public (and regulatory resources should be deployed to enable this).

NSW Court of Appeal jurisprudence from over 20 years before the Paterson Inquiry held that a medical practitioner who cannot be trusted to see patients

[197] See, eg, *Medical Board of Australia v Topchian* [2013] VCAT 86, (where a one-year suspension was ordered alongside other aggravating factors including the youth of the patient, and the fact that he continued to treat her through the relationship); *Visagie* (n 185), (12-month suspension ordered, where a relevant factor in this case was that the patient had a known history of sexual abuse); *Wakelin* (n 92) (female psychologist coached patient to lie in sworn statement denying the relationship, four-month suspension).

[198] See, eg, *Sunda* (n 129), in which a dentist was found guilty of misconduct for an incident which involved pinning down a patient with whom he had a previous relationship and trying to force her to perform oral sex on him. His evidence to the Tribunal was rejected and he was also found to have breached chaperone conditions in place prior to the hearing, however he was suspended for 18 monthsFollowing his return to practice, a complaint was made that he had stalked and sexually harassed his female solicitor for almost a year, and in response a new set of chaperone conditions were imposed by the Council. A complaint was then made about his breach of those conditions. A further tribunal hearing on the basis of those two complaints, and a complaint of impairment, led to deregistration: *Sundarajah* (n 130), *Sundarajah [No 2]* (n 130). A further complaint, by the practice manager, that he had sexually harassed every female dental assistant in the practice, was noted in the decision, but was not progressed: *Sundarajah [No 2]* (n 130) [48]–[54]).

without a chaperone is not fit to practise at all.[199] Despite this, when Paterson reviewed all chaperone conditions in place in 2017, he found that a stunning 40% of such conditions were put in place following *proven* sexual misconduct.[200] This was also in contravention of internal guidance by the Medical Board, in place since 2012, that chaperone conditions are not appropriate when 'serious sexual misconduct' has been found to have occurred.[201]

The current research reflects Paterson's finding, in that chaperone conditions were being used at both the immediate action,[202] and final determination stage, almost always to keep doctors in practice.[203] There were a number of cases in the dataset in which the tribunal ordered chaperone conditions following proved sexual misconduct, involving both relationships[204] and inappropriate sexual contact.[205] Several other doctors returned to practice following

[199] *Litchfield* (n 173) 639 (Gleeson CJ, Meagher and Handley JJA). See also *Cukier* (n 74) [121] (Members Wentworth, Collopy and Reddy).

[200] Paterson (n 2) 8. See also Office of the Health Ombudsman, *2016–17 Annual Report* (Report, 15 September 2017) 44, reporting that the Queensland Civil and Administrative Tribunal overturned an interim prohibition on a doctor treating female patients after he was convicted in a criminal process of sexually assaulting a female patient, and imposed chaperone conditions instead.

[201] Medical Board of Australia, *Board Mandated Use of Chaperones Following Allegations of Sexual Misconduct* (Internal Guidelines, 2012), cited in Paterson (n 2) 31. See also 'Gender Based Restrictions & Chaperone Protocol', *AHPRA & National Boards* (Web Page, 17 March 2017) <https://www.ahpra.gov.au/Registration/Monitoring-and-compliance/Chaperone-Protocol.aspx>, archived at <https://perma.cc/DLL4-URGF>.

[202] Especially when criminal proceedings were involved, the period between the complaint being raised and the tribunal determination could be lengthy: see, eg, *Health Care Complaints Commission v Rolleston* [2013] NSWMT 12 (chaperone conditions imposed in 2009 and found by the Tribunal to have been breached).

[203] There were only two cases in the dataset in which the beneficiaries of chaperone conditions were not doctors: both were dentists and both were imposed at interim stage: *Sunda* (n 129); *Eftimoski* (n 114). Paterson (n 2) found that of the 48 health practitioners under chaperone conditions in January 2017, 39 were doctors. Among the doctors, half were general practitioners, and all appeared to be in private practice: at 8.

[204] See, eg, *Medical Board of Australia v Blomeley* [2014] QCAT 160 (12 months of chaperone conditions were ordered following a period of suspension). Note that the practitioner was subsequently deregistered when it came to light that he had resumed a relationship with the same patient and not disclosed this during the first tribunal process or hearing: *Medical Board of Australia v Blomeley* [2018] QCAT 163.

[205] See, eg, *Veettill* (n 85). See also *Priyamanna* (n 81) noting a 2007 Queensland tribunal order of chaperone conditions that was imposed after the Tribunal was not satisfied as to sexual motivation. See also, *Health Care Complaints Commission v Vastrad* [2011] NSWMT 1; *Azam [No 2]* (n 69) in which the Board sought an order of deregistration, or chaperone conditions in the alternative. The practitioner in that case had been found to have previously falsified his chaperone records and breached chaperone conditions. See also chaperone conditions as a

deregistration under chaperone conditions imposed by the Medical Board,[206] or had such conditions imposed subsequently.[207] It is noteworthy that in at least three cases in the dataset, the doctor was found to have committed the sexual misconduct in the matter while practising under chaperone conditions.[208]

Noting their 'dubious' effectiveness in protecting patients from harm, and the resulting loss of public confidence in health professions and regulators, Paterson reiterated that chaperone conditions are never appropriate as a final outcome and called for them to be replaced at immediate action stage with gender-based practice restrictions or suspension.[209]

When 'special skills' were raised overtly, this was also almost exclusively in relation to doctors. In fact, the claim usually related to the lack of general practice providers in a given rural or regional area; that is, it was not the doctor's inherently rare or special skill,[210] but rather a skill shortage which was being claimed.[211] All of these cases concerned sexual relationships, and resulted in an outcome that was less onerous than the average. There was only one case in

final order in *Health Care Complaints Commission v A* [2012] NSWMT 11. The case was not included in the dataset as the assaults did not concern a patient. In the words of the Tribunal, '[t]he doctor was convicted of five sexual assault charges [concerning relatives] committed some 33 years ago and long before the doctor has earned 23 years of unimpeachable conduct as a medical practitioner': *Health Care Complaints Commission v A* [2012] NSWMT 10, [6] (Kavanagh J, Members Higgin, Diamond, and Robinson).

206 See, eg, *Young* (n 71); *Naim* (n 161). Both of these practitioners are still listed on the register with chaperone conditions at the time of writing in December 2019. See also Paterson (n 2) 37, in which he characterises such 'conditions as an ongoing regulatory measure rather than an interim measure'.

207 See, eg, a practitioner who had relationships with three separate patients over a lengthy period had his registration cancelled: *Costley* (n 190).In 2015, the practitioner re-registered with chaperone conditions in 2017. These are still current as at December 2019: see 'Register of Practitioners: Dr Terence Alexander Costley', *AHPRA & National Boards* (Web Page, 24 October 2019) <https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx?q=MED0001545552&t=AE8t8iwTlRu1ChoDqQtf>, archived at <https://perma.cc/ZA2X-XTKD>.

208 See *Young* (n 71); *Health Care Complaints Commission v Naiyer [No 2]* [2014] NSWCATOD 58; *Henderson* (n 81). See also Paterson (n 2) 65–6.

209 Paterson (n 2) 10–11.

210 But see *Medical Board of Australia v Smith* [2016] VCAT 243.

211 *Nikolova-Trask* (n 119) (three-month suspension); *Trewren* (n 113) (six-month suspension); *Visagie* (n 185) (12-month suspension); *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (12-month suspension). See also a case where the practitioner worked in a 'deprived' and underserviced urban community, the outcome being a reprimand and conditions: *Health Care Complaints Commission v Small* [2012] NSWMT 18, [30] (Elkaim DCJ, Members Cox Gordon, and Ettinger).

which a health practitioner, who was not a doctor, made a special skills claim: a psychologist who was one of only three psychologists in the town.[212]

Elkin has expressed concern that the inclusion of 'supply considerations' as one of the six objects in the National Law[213] effectively 'granted permission' to tribunals to include the special skill of doctors in sanction considerations.[214] Elkin argued that this would be misplaced, as 'supply considerations may have relevance to registration decisions' but should not sway a disciplinary decision when the doctor has already been determined to pose a heightened risk to the public.[215] I second such concerns, and note that their differential application to only one profession is not justified by the legislation. Further, I suggest that an isolated or underserviced community may thereby be placed at even greater risk if their only option for health care is an unsafe practitioner.

If the trend of lesser likelihood of deregistration for doctors continues, compared to the other four major health professions, this would arguably be a retrograde 'signal' to send to the professions and the public concerning the seriousness with which sexual misconduct by health professionals is viewed. In a recent large-scale analysis of UK health disciplinary decisions, Rosalind Searle similarly found that lesser sanctions were applied to doctors in sexual misconduct matters,[216] and also found that there was no difference in sanction for doctors who committed multiple offences.[217] Searle concluded that

> any signals of a reduced level of sanction for this professional group is very concerning. It may lead some to feel that they can evade the consequences of their actions. … There needs to be more attention to understanding the parity of sanctions across professions, especially for repeat offenders.[218]

E *Agreed Sanctions*

Every jurisdiction, to a greater or lesser degree, utilised agreed statements of facts and 'agreed sanctions' or consent orders, negotiated directly by the

[212] *IVX* (n 119) (nine-month suspension).

[213] See, eg, *National Law Act (Qld)* (n 15) s 3(2)(e), which provides that an object of the *National Law* is 'to facilitate access to services by health practitioners in accordance with the public interest'.

[214] Katie Elkin, 'Medical Practitioner Regulation: Is It All about Protecting the Public?' (2014) 21(3) *Journal of Law and Medicine* 682, 698. See also Helen Kiel, 'Regulating Impaired Doctors: A Snapshot from New South Wales' (2013) 21(2) *Journal of Law and Medicine* 429.

[215] Elkin (n 214) 698.

[216] Searle, *Sexual Misconduct in Health and Social Care* (n 33) 20.

[217] Ibid 31.

[218] Ibid 29. See also at 31.

statutory complainant and practitioner. While the tribunal still had to be independently satisfied that the orders were appropriate, the agreed sanction cases were strongly associated with less detailed reasons (and in WA, numerous matters were released as case summaries only, featuring dot point findings of around half a page) and with less restrictive sanctions.

Several cases from Victoria, and some from Queensland, Tasmania and South Australia, cited the case of *Secretary to the Department of Planning and Community Development v Muto* ('*Muto*') as authority for the proposition that the Tribunal should defer to agreed sanctions.[219] In *Muto*, President Ross of VCAT, hearing a matter concerning the misconduct of a local council member, stated:

> In proceedings in respect of civil penalties there is now a well established line of authority in support of the proposition that where a regulatory body and a respondent have reached a negotiated settlement and the penalty proposed is, broadly speaking, within the 'permissible range' (having regard to all the circumstances) the court (or in this case the Tribunal) should not depart from the agreed sanction. I propose to adopt the same approach to the matter before me. The question then becomes whether the sanction proposed is within the permissible range.[220]

The degree of deference afforded to agreed sanctions in the cases analysed appeared considerable, including at least one matter in which the Tribunal openly doubted that the non-review period was long enough, but still ordered the agreed sanction.[221] Indeed, while there was repeated reference to the need for the Tribunal to be independently satisfied, there did not appear to be any sexual misconduct case in the dataset in which the Tribunal had actually rejected an agreed sanction.[222] Thus, the prosecutorial posture of the relevant professional board was heavily influential on the outcome. So, for example, in a case in

[219] [2011] VCAT 328 [16], cited in *Gazelakis* (n 128) [9] (Deputy President Lambrick, Members Story and King); *Medical Board of Australia v Grant* [2012] QCAT 285 [55] (Deputy President Kingham); *Lee 2019* (n 7) [71]–[72] (Chairperson Webster); *Medical Board of Australia v Murphy* [2015] SAHPT 6.

[220] *Muto* (n 17) [16].

[221] *Cicconi* (n 92) [96]–[97] (Deputy President Lambrick, Members Farhall and Power). In this case, deregistration with a 15-month non-review period was ordered. Aggravating factors included the patient's clear vulnerability in that she was a child sexual abuse survivor with a suicidal history, that the practitioner was 20 years older, that he exploited her dependence and was also violent to her: at [16], [72], [75]. Furthermore, the practitioner had misled the Board: at [75].

[222] Cf a case outside of the data collection timeframe in which the Tribunal rejected agreed facts and took a more serious view of the conduct as a result: *Psychology Board of Australia v Sullivan* [2017] ACAT 104.

which a specialist doctor was convicted of two counts of sexual assault and three counts of indecent assault on a patient, the Medical Board sought only a reprimand on the basis that 'with the obvious exception of the offences' the doctor 'had made a very valuable contribution to the community as a medical practitioner',[223] and the tribunal accepted this agreed sanction. It is impossible to know on what basis the tribunal satisfied itself that such an outcome was within the 'permissible range' of sanctions, as the decision was issued as a summary only.

There are a number of issues of concern in the manner in which agreed sanctions appeared in the cases. First, there is a certain circularity in the operation of the *Muto* approach: if agreed sanctions themselves dominate the landscape of outcomes, any identifiable 'permissible range' has itself been strongly influenced by agreed sanctions. Moreover, there is the question of whether there can really be said to be any such 'permissible range'.[224] In 2012, the NSW Court of Appeal strongly cautioned against the use of simplistic comparator sentences in the health disciplinary context.[225]

[223] *Medical Board of Australia v Durani* [2014] WASAT 179.

[224] The Queensland Court of Appeal recently doubted that the case law demonstrate any 'general range' of sanction in cases involving sexual relationship and dishonesty to regulators: *Shahinper v Psychology Board of Australia* [2017] QCA 96, [27] (Holmes CJ, McMurdo JA and Bond J). See also *Liyanage v Medical Board of Australia* [2019] NTSC 11, [25] (Blokland J), citing *Lee v Health Care Complaints Commission* [2012] NSWCA 80, [34] (Barrett JA) ('*Lee 2012*'), to find that there was no 'unifying principle' in the sexual misconduct cases to which it was referred.

[225] *Lee 2012* (n 224) [25] (Barrett JA). Justice of Appeal Barrett, for the Court, considered the issue at length, noting that there is no 'fixed starting point' in the legislation, in contrast to criminal matters: at [24]. His Honour held that the 'overwhelming emphasis' in these Tribunal matters is with the protection of the public: at [31]. His Honour also held that 'while a history of sentencing can establish a range of sentences that have in fact been imposed, such a history "does not establish that the range is the correct range, or that the upper or lower limits to the range are the correct upper and lower limits"': at [25], quoting *Hili v The Queen* (2010) 242 CLR 520, 537 [54] (French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ). The NSW Court of Appeal went on to find that:

> (a) comparison with the outcomes in earlier cases may be useful if those earlier cases show some discernible range or pattern;
> (b) such a range or pattern, even when discernible, cannot be regarded as a precedent indicating what is 'correct';
> (c) the range or pattern is, at best, a reflection of the accumulated experience and wisdom of decision-makers;
> (d) the range or pattern will potentially be of value only if it is possible to gather from it an appreciation of some unifying principle;
> (e) since the predominant consideration is the protection of the public, a decision can only be made by reference to the facts of the particular case and by considering what measures are needed to ensure that the future behaviour of the particular practitioner is shaped in a way that is consistent with that protection; and
> (f) the Medical Tribunal, as a specialist tribunal, brings special skill and experience to the task of formulating protective orders: at [34].

Second, there is a strong argument to be made that health disciplinary matters do not involve 'civil penalties' and should not be considered to fall under case authority drawn from the very different context of trade practices and consumer law, such that their injunctions of deference have any bearing. The *National Law* is a complete statutory scheme, with the first-named objective being 'to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered'[226] (and in Queensland and NSW, protecting the 'health and safety of the public' is the 'paramount guiding principle' and the 'paramount consideration', respectively).[227]

Matters are required by the legislation to be referred to tribunals from boards because they are so serious that deregistration is possible. Recollecting that, unlike boards, tribunal membership is not dominated by the relevant profession and their proceedings take place in public, it arguably subverts the purpose of having a separate tribunal level for serious matters if that tribunal routinely defers to orders sought by the board. This process could also be seen to impede the public interest in the independent oversight of the health professions, including through community representation on the tribunal in most jurisdictions,[228] and in open justice. It is worth recalling here that the six week suspension of Dr Lee in 2019 for misconduct based upon repeated online statements promoting physical and sexual violence against women was an agreed sanction, to which the tribunal (citing *Muto*) explicitly deferred.[229] The subsequent strong public (and professional) response to this outcome suggests that it was not in accord with community standards or expectations. In addition, if the agreed sanction process leads to suppression or truncation of reasons, the public interest in having access to findings is lost.[230]

[226] *Health Practitioner Regulation National Law Queensland* (Qld) s 3A. The protection of the public is also expressed as a 'primary consideration' in balancing the objects of the scheme under the regulatory principles for the National Scheme: 'Regulatory Principles for the National Scheme', *AHPRA & National Boards* (Web Page, 4 April 2019) principle 3 <https://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>, archived at <https://perma.cc/8FXV-7RW8>.

[227] *Health Practitioner Regulation National Law Act* (n 226) s 3A; *National Law Act (NSW)* (n 15) s 3A.

[228] On the importance of the tribunal as a specialist panel comprising legal, 'professional and community views and expectations' (prior to the *National Law*) see: *Medical Board of Queensland v Thurling* [2003] QCA 518, [12] (de Jersey CJ, Davies JA and Mullins J).

[229] *Lee 2019* (n 7) [71]–[72], [76] (Chairperson Webster).

[230] Brockman expresses similar concern about 'consent agreements' in British Columbia, Canada: Brockman (n 30) 534–5.

Similarly, if the agreed sanction process leads to unjustified variations in outcomes among the professions because some professions' boards routinely seek less onerous outcomes for the same kind of misconduct — whether because they take a less strict view of the significance of sexual misconduct, because they view the public interest in access to their professions' skills as more pressing, or for some other reason — the integrity of the system as a whole is undermined. There is also the prospect that the tribunal's ability to assess the specific risk posed by the practitioner to the public is impaired, by reason of being limited to an agreed statement of facts.[231] While a statement of agreed facts and agreed sanction may save a patient or patients from the potential distress of cross-examination, it may also lead to a minimised or sanitised representation of the factual matrix.[232]

For all of the above reasons, it is suggested that the prevalent approach to agreed sanctions, particularly in sexual misconduct cases, may merit reconsideration.

V Conclusion

This research has analysed the first seven years of available cases under the *National Law* on serious sexual misconduct committed by the five most populous health professions, decided in the public fora of state and territory tribunals. The cases were divided into the sub-categories of sexual relationship and inappropriate sexual contact, with each category exhibiting distinct features. Examining issues of seriousness and sanction, the research concluded that high level accord on the relevant principles was not always followed by consistency of application.

The decisions on sexual relationships demonstrate a high degree of consistency in terms of the approach to the assessment of seriousness and understandings of vulnerability. The inappropriate contact cases appeared to be strongly influenced by criminal processes and norms, which were not always apposite to the health disciplinary setting. The regularity with which patients in contact matters approached the police, or were directed to them, also indicates the need for more closely co-ordinated responses between agencies in the criminal and disciplinary realms.

There were areas of divergence in outcomes that do not appear to be objectively justifiable, in particular, in the lesser likelihood of restrictive sanction for

[231] Note that any reasoning on sanction which strays beyond the agreed facts may result in appealable error: see, eg, *Lal v Medical Board of Australia* [2018] WASCA 109, [69] (Martin CJ, Beech JA and Pritchard J).

[232] As possibly occurred in *Didenkowski* (n 158).

the medical profession compared to the other health professions for similar misconduct. This was at least in part a result of both latent and overt regard for doctors' 'special skills'. It was also possibly the result of different prosecutorial postures of different professional National Boards in the context of widespread use of 'agreed sanctions'. There was also jurisdictional variation in outcome, arising from differing degrees of deference accorded to agreed sanctions; emphasis on individual risk rather than general deterrence; and, reduction of periods of removal of practice by reference to 'time served' under interim suspension.

The presence in the dataset of practitioners whose sexual misconduct occurred over many years, and the fact that half of the contact cases and around 15% of the relationship cases, involved more than one patient, may prompt further consideration of whether current systems of public protection are effective and timely in dealing with those who are wilfully abusive or serial offenders. A number of recent developments, including the Paterson Inquiry, and the redevelopment of guidance on sexual boundaries, indicate that the medical profession is committed to taking issues of sexual misconduct seriously.[233] These developments post-date the data collection period for this analysis, so it remains to be seen how such developments will ultimately flow through to impact upon decisions on serious sexual misconduct at the tribunal level.

Statutory duties on health professionals of mandatory notification, and the statutory duty of external referral to tribunal adjudication that applies to professional boards and panels, arise when a practitioner has 'engaged in sexual misconduct in connection with their practice of the profession',[234] and where there is a reasonable belief that the conduct is 'misconduct', respectively.[235] For these obligations to be effective, it is crucially important that there are clear, consistent and common understandings about what constitutes sexual misconduct. The extension (and/or adaptation) of the renewed guidance from the medical profession on 'sexual boundaries' to the other health professions may be helpful in this regard. In the UK context, Searle has argued that such policies can be a 'useful tool in reducing ambiguity' and that they also assist to 'deter perpetrators by imposing external boundaries' and inform awareness among

[233] See also the introduction in 2017 of a specialist committee to deal with sexual misconduct notifications by the Medical Board: 'Significant Progress Made on Chaperone Recommendations' (Media Release, Australian Health Practitioner Regulation Agency, 4 August 2017) <https://www.ahpra.gov.au/News/2017-08-04-chaperone.aspx>, archived at <https://perma.cc/55LR-N4VY>.

[234] See *AHPRA Mandatory Notifications Guidelines* (n 45) 6–10 [3].

[235] See ibid 6 [2.1].

other staff members and the public.[236] Likewise, the use of more specific complaint categories, and the nationwide development of qualitative guidance on seriousness and sanction, that could operate across both tribunal and board levels, would be beneficial in achieving greater transparency and consistency in how health regulators respond to sexual misconduct.

Further research on referral patterns and processes, concerning all the professions and jurisdictions, would also be helpful to understand how and why sexual misconduct cases are diverted from the public forum of tribunal determination and addressed through non-public, professionally dominated, fora. Current legislative provisions and administrative guidance governing the referral of matters to the tribunal system may require attention in order to ensure that sexual misconduct is being consistently categorised as serious misconduct and appropriately referred to the public tribunal forum. Further consideration should also be given to whether the public interest is being adequately ventilated in current processes, and how both public expectations and public safety are addressed.

[236] See Searle, *Sexual Misconduct in Health and Social Care* (n 33) 28–9.