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From the President

23 March 2018

Dr Joanna Flynn AM
Chair
Medical Board of Australia
GPO Box 9958
MELBOURNE VIC 3001

Via Email: medboardconsultation@ahpra.gov.au

Dear Dr Flynn

Draft revised guidelines: Sexual boundaries in the doctor-patient relationship

Thank you for your email of 29 January 2018 inviting The Royal Australasian College of Physicians (RACP) to provide feedback on the Medical Board of Australia's draft revised guidelines '*Sexual boundaries in the doctor-patient relationship'.* We have consulted with relevant expert groups across the RACP to prepare this considered response.

The RACP connects, represents and trains over 15,000 physicians and 7,500 trainee physicians in Australia and New Zealand across a wide range of specialties, including rehabilitation medicine, public health, palliative medicine and geriatric medicine.

Overall

In general terms the RACP is supportive of the proposed revisions to the current 2011 guidelines, which clarify the professional and ethical conduct expected of medical practitioners by the Board, health practitioners, patients and their families and the community.

The proposed revisions, many of which are editorial in nature, improve the utility and readability of the guidelines. Importantly, the revisions clarify the power imbalances that characterise sexual misconduct in professional contexts, the harms that result from sexual misconduct, the need to respect sexual boundaries with individuals close to the patient as well as with the patient, the need for doctors to only conduct physical examinations of intimate areas when it is clinically indicated and the obligation upon doctors to ensure that students acting under their supervision also respect sexual boundaries in the therapeutic relationship. The RACP is supportive of the clarifications provided in the revised draft guidelines.

The RACP is also supportive of the proposed revisions that align the current draft with the principles and recommendations of Professor Ron Paterson's report of the *Independent review of the use of chaperones to protect patients in Australia* (February 2017).

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Three comments
We have three specific concerns with the new revised guidelines for your consideration:

1) an omission from the guidelines that is relevant to the matter;
2) concerns regarding a statement about asking a patient about their sexual history or preferences; and
3) use of the phrase "sexualised behaviour" (for example, page 3, Section 3).

Our first concern is there is no mention of the patients with limited decision-making capacity or the vulnerable patient (not necessarily the same). This area needs to be given more attention in the guidelines. For example, there could be provision to have a next of kin, carer, guardian or potentially the practice nurse present when consent is being sought from an individual for a physical examination of intimate areas. If the patient consents, the patient can then say if they would like their next of kin/ guardian or carer to stay in the room. If they do not want another person in the room, then their wishes should be respected unless the doctor considers there is a risk the patient may forget the circumstances during the examination, in which case a practice nurse could be present if the other options are decided against.

The second concern relates to a statement on page 3, Section 3 'Breaches of sexual boundaries' (spectrum of behaviours) of the revised guidelines ("asking a patient about their sexual history or preferences, when these are not relevant to the patient's clinical issue"). Our concerns here are:

- That the current wording may discourage clinicians from undertaking screening for sexual health conditions which would be beneficial to the patient's overall health. It is possible to contextualise questions about a patient's sexual history, for example, by introducing the issue as an important part of health screening and asking consent from the patient to proceed.
- The term "clinical issue" is too narrow (fourth dot point). We suggest this term be replaced with the phrase "overall health care including opportunities for preventative activities and screening".

Importantly, the statement is not consistent with The Royal Australian College of General Practitioners, *Guidelines for preventive activities in general practice* (9th edn., 2016), section 6.2 Sexually Transmissible Infections which states:

> *Many patients and doctors feel uncomfortable discussing sexual histories even when indicated or the patient is requesting STI testing. Taking a sexual history is an important part of the assessment and management of STIs, and it should not be a barrier to offering STI testing.*

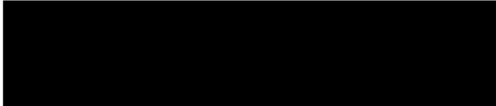
The RACP's third concern is about use of the phrase "sexualised behaviour" (for example, page 3, Section 3). The term is described in the section but a definition is not included in the definitions section (page 6), where other key terms are defined such as 'sexual harassment'. The previous guidelines (2011) used the term to describe the behaviour of patients, and given the term 'sexualised behaviour' is often used to refer to behaviours exhibited by young children who have been victims of inappropriate sexual behavior, we suggest the Medical Board of Australia not use this term to describe the behaviour of doctors.

On an editorial note, the MBA has used the phrase 'intimate examination' as well as the term physical examination throughout the guidelines. It is RACP's suggestion that a 'physical examination of intimate areas' is a preferable term to 'intimate examination'.

The guidelines acknowledge the serious implications of and need to reinforce understanding of the imbalanced dynamics within the doctor-patient relationship. The RACP also supports all efforts to refer cases requiring immediate action to the Medical Board for high level address without undue delay.

Please contact Dr Kathryn Powell, Senior Policy Officer on +61 2 92565497 or Kathryn.Powell@racp.edu.au should you require further information.

Yours sincerely



Dr Catherine Yelland PSM