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RACP feedback to Ahpra on draft Guidance: Sexual Misconduct and the National Law

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 23,200 physicians and 8,700 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

The RACP *Professional Practice Framework* underpins our adherence to the highest standards of professional behaviour; it describes professional attributes expected of RACP members through its focus on professional values, ethical practice, cultural safety, and continuous quality improvement. We are committed to supporting professional regulatory processes that protect the safety and wellbeing of both patients and practitioners whilst proactively mitigating conduct risks.

Contact Peter Lalli, Senior Policy & Advocacy Officer for any inquiries or questions relating to this document via: policy@racp.edu.au

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The RACP welcomes the opportunity to provide feedback on Ahpra's draft *Guidance: Sexual Misconduct and the National Law* (the Guidance).

This feedback focuses on consultation questions 1 and 5, covering the adequacy and appropriateness of the proposed Guidance, outlining key areas in need of improvement and highlighting the need for further information and support to ensure that the document is fit for purpose.

The feedback is particularly focused on three areas of concern for our members:

- Clear recognition that sexual misconduct occurs between practitioners as well as practitioners and patients
- Differentiation and refinement of definitions of various types of behaviour that might qualify as sexual misconduct
- Need to deliver improved safety, transparency and proportionality in regulatory processes addressing sexual misconduct.

Recognise that misconduct affects physicians and trainees

A safe and well-supported health workforce is the foundation for delivering quality of care and ensuring patient safety. Sexual misconduct encompasses a set of problematic behaviours that can arise both between practitioners and in practitioner-to-patient relationships.

As drafted, the Guidance is primarily framed around practitioner behaviours directed toward patients, neglecting the issue of problematic or criminal behaviours between practitioners. Sexual misconduct is enabled by workplace and professional hierarchies and gender and power inequalities, with significant consequences including silencing, shaming and victimisation of practitioners.

We propose that the Guidance recognise sexual misconduct between practitioners as well as between practitioners and patients. This would include clearly signalling Ahpra's commitment to a supportive, transparent and psychologically safe regulatory approach for registered practitioners as well as promoting safe and confidential notification pathways.

Refine parameters on behaviours defined as sexual misconduct

Ahpra lists a wide range of behaviours that could constitute sexual misconduct by a regulated health professional. As the Guidance itself acknowledges, sexual misconduct is difficult to define and extends beyond criminal conduct as it would be defined in state and territory laws. The broadness of the concept of sexual misconduct allows National Boards flexibility in its interpretation and application, which also potentially widens the risk for Ahpra registrants. The Guidance must distinguish between levels of conduct rather than treating all behaviours as equivalent in seriousness.

The current list of behaviours captures both serious criminal conduct and lower-level interpersonal behaviours and in doing so risks conflating inadvertent or isolated incidents with deliberate, exploitative, or predatory behaviours.

The Guidance should distinguish between:

- Serious sexual misconduct and criminal offences: intentional, repeated, unwarranted behaviours or those constituting a criminal offence under state or territory law, which must be regarded as serious and reportable
- Inadvertent or lower-level conduct, such as misplaced humour or a once-off unintentional gesture
- Consent processes in legitimate clinical care, particularly in procedures involving breast, genital or other sensitive areas, where inadequate explanation, miscommunication or oversight may cause misunderstanding but remains clinically justified.

The Guidance needs to differentiate conduct thresholds that account for registrant intent, awareness, frequency of behaviour, presence or absence of consent, and impact on the patient or practitioner. Serious criminal misconduct must always be recognised as grave and reportable irrespective of intent. However, conflating minor actions with serious or predatory misconduct risks undermining regulatory credibility.

Another concern is the risk of unintentional over-regulation of legitimate human interactions in medicine and the need to account for circumstantial factors. The draft Guidance must distinguish between misconduct and legitimate human interactions that may be entirely appropriate. For instance:

- The Guidance should not inadvertently judge registrants for showing legitimate empathy. Behaviours such as hugging when a practitioner comforts a family member or offers a supportive gesture to a colleague under acute stress would demonstrate empathic support rather than engaging in misconduct. Labelling these interactions as potential misconduct creates unnecessary fear and anxiety among registrants and risks weaponisation of the regulations.

- Some clauses also risk capturing interactions between regulated professionals, where consensual and non-exploitative romantic relationships or friendships form or where informal communication styles occur within collegial networks. These interactions may be supportive in nature but could be misinterpreted as misconduct.

- The Guidance also risks capturing registrants who appropriately manage romantic interests which emerge in provision of care. It is a regulatory requirement for registrants to discontinue a clinical relationship when a patient expresses a romantic interest. When provision of a regulated health service is transferred or ceased in an appropriate manner, registrants should not be punished under terms such as “conveying a desire or willingness to enter a sexual relationship”.

Prioritise safety, transparency and proportionality in regulatory processes

Operating principles of safety, transparency and proportionality must be at the centre of all regulatory processes. Risks of reputational harm, psychological distress and, in some cases, suicide or self-harm may arise for both complainants and registrants subject to reports of perceived or actual misconduct. Hence, Ahpra, the Tribunal and the National Boards have clear responsibilities to design and oversee systems that minimise these harms. This includes ensuring that reporting and complaint management processes are conducted fairly, transparently and proportionately to the level of risk, and underpinned by appropriate safeguards.

These principles should be further strengthened in the Guidance and in Ahpra systems and processes that support it:

- Given the sensitivity of this regulatory matter, Ahpra staff liaisons managing these notifications and responses, as well as Boards and the Tribunal, should be upskilled in trauma-informed communication and cultural safety for affected registrants. Further, pastoral care, support services and care referral pathways need to be embedded in the regulatory process at each step, from end to end, and effectively promoted to affected practitioners.

- Proportionality should be strongly embedded through the differentiation of regulatory conditions for minor conduct matters and erroneous and inadvertent conduct that was not intended the way it was received. Boards should be empowered to apply responses such as educational and upskilling approaches, supervised practice and the capacity to request practitioner statements over notification on the register, subject to non-publication.

Registrants would also benefit from greater transparency in the Guidance on:

- Respective and unique roles of the Tribunal versus Boards in managing various levels of conduct, throughout regulatory phases of management.

- Timeframes for reporting retrospective conduct matters beyond serious reportable criminal conduct matters, which are already subject to various jurisdictional statutes of limitations. The Guidance does not clearly or reasonably limit timeframes for the reporting of retrospective instances of inadvertent or lower-level misconduct. Unclear or unreasonable timeframes risk the regulatory system becoming unnecessarily burdened, leading to inefficiencies, delays in addressing more serious conduct and the potential misuse of processes for vexatious purposes.

- The application of due process for affected practitioners and how it will be operationalised, including:
    - the standard of evidence or proof to apply for types of misconduct
    - the roles and requirements of witnesses
    - appeal provisions
    - the role of suppression orders
    - justice pathways when a practitioner has misplaced regulatory orders that are then removed.

  More information on considerations of intent, contrition, impact of conduct, frequency of conduct and likelihood of reoffending for accused practitioners is needed.

- Ahpra's commitment to mitigate vexatious complaints and specific thresholds to filter and close these complaints, recognising that at times inexpert Guidance implementation can increase number of complaints when physicians are already at risk of vexatious complaints. This is compounded in clinical encounters with complex patients who may have distorted perceptions of practitioner intent.

- Said principle of proportionality and how it will be applied in regulatory practice.

Changes for improved Guidance coherence and useability

In addition to the broader themes discussed above, we would like to offer a summary of suggested edits of existing content and content additions.

- Include a short snapshot summary of the Guidance to orient readers.
- Contextual factors for determining sexual misconduct in the Guidance (pages 4-5) should be presented before the categories of sexual misconduct.
- The process map for management of notifications that was included in the consultation paper for the Guidance was not within the Guidance itself and should be incorporated.
- Information on available support services contained in the consultation paper should be replicated within the Guidance.
- Add a glossary to the Guidance to clarify terms such as "Board" and "Tribunal".
- Provide information on sexual offence criminal legislation in each state and territory, including types of offences by jurisdiction within the Guidance.
- Include case studies illustrating each category of misconduct, with clear explanations of breaches, behaviours of concern and lessons for proactive risk mitigation. The *Speaking from Experience* Report and the Australian Human Right's Commission's *Positive Duty* resources are suggested as useful reference sources.
- Provide examples of what a publication of a sexual misconduct finding might look like on the register to improve transparency and understanding.
- Incorporate anticipated FAQs directly into the body of the Guidance.
- Develop checklists as appendices to the Guidance for practitioners on:
    - Obtaining consent for sensitive examinations and procedures.
    - Navigating intimate relationships between practitioners or with adult patients.
    - Steps to take in scenarios that may trigger reporting obligations.

We welcome the opportunity to partner with Ahpra in the development of complementary eLearning and educational resources to support the Guidance. This could include co-produced modules, podcasts, interactive tools, videos and infographics tailored to physician specialties and work settings, to empower

practitioners to recognise signs of misconduct and mitigate risk in trauma-informed, culturally safe ways.

Summary

Thank you once again for the opportunity to feedback on the draft Guidance. This resource will be further strengthened by:

- Clearer definitions and better differentiation in response between serious reportable criminal conduct and minor or inadvertent conduct
- Clear commitment and stress on implementing proportionality in regulatory responses
- Strong safeguards that prioritise safety and transparency and promote fairness across the regulatory processes.

The RACP also asks Ahpra to commit to regular monitoring and evaluation of the finalised Guidance, with public reporting and ongoing consultation with medical colleges to aid continuous improvement efforts.

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