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Introduction

Some recent cases in New South Wales of sexual misconduct by doctors have brought this topic well and truly into the limelight. The increased public awareness and interest in the issue reflects a trend overseas, particularly in America and Britain, where there is a growing body of literature on sexual misconduct in the medical profession (Pope and Bouhoutsos 1986, Gabbard, 1989; Burgess and Hartman, 1986). A recent article in Australian Doctor Weekly (20 March 1992) states that sexual misconduct cases now rank near the top of causes of professional practice litigation in the USA. As our writer graphically states:

"As magically as a kiss can transform certain frogs into princes, a hug can change a patient into a plaintiff, a $40 motel room can become a $1 million dollar lawsuit overnight and, it should be added, a hard-won career can vanish in smoke, never to reappear" (Schneidman, Bulletin 1993).

Another writer argues that sexual misconduct will become the regulatory issue of the 1990's (Reaves, 1993). A sexual relationship between a doctor and his patient obviously challenges the very basis of the sacred `doctor-patient relationship'. Responses range from those which are alleged to take the `high moral ground' if they dare to criticise doctors and which state that doctors should be able to conduct their relationships with patients as they wish, unfettered by external scrutiny, to those which argue that patients are entitled to have absolute confidence and trust in a doctor who is in a unique position regarding physical and emotional proximity to the patient, and that any exploitation of the patient is an abuse of power.

The policy statement of the Medical Board of New South Wales states that it is an absolute rule that a medical practitioner who engages in sexual activity with a current patient is guilty of professional misconduct. According to the Ethics Statement of the Royal Australian and New Zealand College of Psychiatrists sexual relationships between patients and psychiatrists can never be acceptable and constitute unethical behaviour. Opinions vary however over whether a doctor and patient can engage in a sexual relationship after the doctor-patient relationship has ended, and if so as to what length of time should elapse before such a relationship can begin with the ex-patient.

In this paper some of the issues that are raised by the processes of investigating and disciplining doctors will be examined with particular reference to issues of proof in this jurisdiction. A number of recent New South Wales cases will be discussed in order to illustrate the role played by so-called `expert' psychiatric evidence in these cases.

Disciplinary Proceedings

Under the new Medical Practice Act 1992 the procedures for making and dealing with complaints are set out in Part 4 of the Act. Section 39 sets out the following grounds for a complaint - criminal conviction, unsatisfactory professional conduct or professional misconduct, lack of competence, impairment or character. A complaint may be made by any person but according to section 41 it must be made to the Board or the Director-General and must be in writing, contain particulars of the allegations on
which it is founded and be verified by a statutory declaration (section 53). A complainant may be asked to provide further particulars of the complaint (section 45). It is important to note that these requirements act as a screening process for people who may be unsure about whether they want to proceed, for vexatious complaints and for vague allegations which cannot be readily particularised. A number of complaints fall into this latter category and these are the complaints where usually the problem ends up as being defined as a "communication" problem between the doctor and his patient.

The investigation of complaints occurs after they have been referred to the Director-General of the Department of Health for investigation. The Director-General delegates his power to investigate and prosecute to the Complaints Unit. When the new Health Care Complaints Commission Act comes into being there will be statutory recognition of the role of the Complaints Unit in the investigation process.

A complaint of sexual misconduct will usually be referred directly for hearing before the Medical Tribunal, as sexual misconduct if proved, may lead to de-registration. Section 52(1) of the Act states:

"Both the Board and the Director-General are under a duty to refer a complaint to the Tribunal if of the opinion that it may, if substantiated, provide grounds for the suspension or de-registration of a registered medical practitioner."

However, a matter will not be referred to the Medical Tribunal if there does not appear to be a prima facie case. In this respect the Unit may seek advice from counsel, particularly where there are significant evidentiary problems.

The 1992 legislation also refers to a Professional Standards Committee (introduced in the 1987 legislation) to hear less serious disciplinary complaints. This Committee is composed of two doctors and a lay person, and is intended to operate as an inquiry rather than a more legal disciplinary body.

What Is Sexual Misconduct

Sexual misconduct is not specifically defined in the New South Wales Medical Practice Act 1992. Rather it must be elucidated from the definition of professional misconduct in the Act. In 1987 the Act was amended and a new definition of professional misconduct was introduced. The wording of the legislation changed from `misconduct in a professional respect' to `professional misconduct'. The 1992 Medical Practice Act introduced a further category of `unsatisfactory professional conduct'. Section 36 of the Act states:

"For the purpose of this Act, unsatisfactory professional conduct of a registered medical practitioner includes each of the following:

   Lack of skill etc.
   Any conduct that demonstrates a lack of adequate knowledge, skill, judgment or care, by the practitioner in the practice of medicine..."

Section 36 then goes on to outline all the areas in which unsatisfactory professional conduct may occur. These areas include contravention of the provisions of the Medical Practice Act or regulations, contravention of conditions of registration, offences under other Acts such as the Mental Health Act 1990 or the Health Insurance Act, convictions relating to disclosure of pecuniary interests to patients, offences relating to the supervision of assistants or assisting unregistered practitioners, using false qualifications, failing to render urgent attention, and last but not least the Act refers to "Other improper or unethical conduct". This category would obviously cover sexual misconduct.
The complaints of sexual misconduct investigated by the Complaints Unit of the New South Wales Department of Health fall into four main categories:

1. where there has been an ongoing relationship between the patient and the doctor;
2. where there has been a single incident of a sexual assault of some kind on the patient;
3. where there has been sexual harassment of a patient such as inappropriate touching or suggestive or offensive language;
4. where there has been sexual harassment/assault of employees or fellow workers.

According to Steve Norrish, QC, in a recent paper on sexual complaints against doctors "Sexual misconduct' for medical practitioners has a wide definition, covering a range of conduct from consensual and mutually loving relationships with patients, ex-patients or relatives of patients through to violent and/or non-consensual exploitation of others either in the guise of performance of medical procedures or not even with that pretence" (Norrish, 1992, page 49).

Proof

Sexual misconduct cases pose unique difficulties because of the particular credibility problems they pose, which are encountered far less frequently than in other contexts (Hyams 1992 p. 175). In many cases it is simply the word of the doctor against the word of the patient. Often there are no witnesses. Hyams (1992 p. 175) notes the tendency in American jurisdictions to avoid the precise credibility findings typically found in other areas of law.

In New South Wales the Medical Tribunal is not required to follow formal rules of evidence. Section 161(1) states:

"The Tribunal is to conduct proceedings on an inquiry or an appeal as it thinks fit"

And Schedule 2 also states:

"1. In proceedings before it, a Committee or the Tribunal is not bound to observe the rules of law governing the admission of evidence, but may inform itself of any matter in such manner as it thinks fit."

It has been argued that professional people facing possible de-registration should have the legal protection of the rules of evidence (Pike 1992, p. 41). However, the Medical Tribunal is deliberately constituted as a largely medical body - it comprises two doctors, a lay person and a judge, as matters of fact before it are frequently clinical medical issues. Appeals from Tribunal decisions must be on points of law. Appeals on the facts were abolished on the basis that it would be inappropriate for such decisions to be made by a court consisting solely of judges without the benefit of medical opinion.

The onus of proof in a case of professional misconduct lies on the complainant (Kirumba vs Walton, Unreported, Court of Appeal, 4 October 1990). The standard of proof is that set out by the High Court in Briginshaw v Briginshaw 60 CLR 336. Here it was stated that:
"... it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent likelihood of the occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters, ‘reasonable satisfaction’ should not be produced by inexact proofs, indefinite testimony, or indirect references”.

In 1984 a landmark decision by the Court of Appeal in Qidwai v Brown (1984) 1 NSW LR 100) determined the test for whether a complaint of professional misconduct was made out. This test was conduct which "would reasonably incur the strong reprobation of the professional brethren of good repute and competence". More commonly, this test is referred to as ‘peer review’. The assumption is that peers are the best people to decide whether someone of their own profession has acted unprofessionally. However, in Re: D A R and the Medical Practitioners Act 1938 (Medical Tribunal of New South Wales, 18 November 1991) it was argued that the Qidwai test should not apply if the doctor suffered from a psychiatric condition when the misconduct took place. In this case a specialist psychiatrist engaged in sexual relations with his patient during scheduled consultations. This doctor kept a striped flannel sheet in the bottom drawer of his desk and he and the patient regularly had sex on a mattress from his examining couch which was placed on the floor of the consulting room during consultations. This form of ‘therapy’ continued until the doctor began to reject the patient when she became too demanding. The patient became very distressed to the point of being suicidal and had to be hospitalised under the care of another psychiatrist. It was soon after this that she made the complaint. In the Tribunal it was argued on behalf of the doctor that the Qidwai test should not apply because the doctor suffered from a bipolar affective disorder so that his conduct, in the circumstances otherwise reprehensible, did not attract the strong reprobation of his peers and therefore did not constitute professional misconduct.

The Tribunal did not accept this argument and concluded that the mild bipolar affective disorder was only

"a minor contributing factor to the episodes of sexual intercourse with (the patient) which impaired the respondent's conduct to some extent, though not to a degree sufficient to excuse his conduct."

The Tribunal ordered that the doctor's name be removed from the register for a period of two years after which he could re-apply to be registered again. The Tribunal set out the factors it took into account in making its orders. These were:

"1. The protection of the community, which includes consideration of:

   (a) risk of re-offending;
   (b) contrition;
   (c) nature and extent of harm occasioned to the patient.

2. Maintaining the standards of the medical profession.

3. Maintaining public confidence in the profession”.

In a much publicised case Childs v Walton NSW Court of Appeal, Unreported, 13 April 1990 it was held that the new definition of professional misconduct (in the 1987 amendments to the Medical Practitioners Act 1938) had significantly broadened the range of conduct by a medical practitioner which could be described as ‘misconduct’, to include ‘unprofessional conduct’. As noted earlier, ‘unprofessional conduct’ is now
specifically recognised in the *Medical Practice Act* 1992. The new definition at the same time significantly confined the area by the introduction of the words "in the practice of medicine". The Court of Appeal made an interesting interpretation of the phrase stating that:

"The phrase 'in the practise of medicine' does not have a temporal meaning, but rather a qualitative or descriptive character. It does not circumscribe the period during which the conduct impugned must occur if it is to be capable of satisfying the prescription; it describes its nature. The conduct must be such as to demonstrate the lack of a quality (for example, adequate knowledge) necessary in the practice of medicine. The conduct is the vehicle by which a specific defect is revealed ... It need not be conduct which occurs in the course of treating a patient."

It is arguable that if the conduct did not occur in the course of treating a patient that it was not 'in the practise of medicine'. However the court in its wisdom thought otherwise.

This finding is highly significant and is one which is yet to be challenged. As noted in the introduction to this paper, the Code of Ethics of the Medical Board of New South Wales states it is an absolute rule that a medical practitioner who engages in sexual activity with a current patient is guilty of sexual misconduct. This statement arguably leaves open the situation in relation to ex-patients. The rigid stance of 'once a patient always a patient' is obviously highly debatable.

**Psychiatry, Sex And The Medical Tribunal**

Psychiatrists may appear in Tribunal hearings in a number of different capacities, as one of the medical members hearing the evidence, as expert witnesses, or as the subjects of disciplinary proceedings themselves.

The Medical Board of New South Wales has four psychiatrists on its panel of medical members who are regularly called upon to sit as members of the Tribunal when it is felt that their expertise could be of benefit to the Tribunal. The discretion as to who should sit upon particular matters is left to the Registrar of the Medical Board.

*Sexual Misconduct by Psychiatrists*

A recent article in the Australian and New Zealand Journal of Psychiatry, which reviewed sexual relationships arising in and following psychotherapy states that the prevalence of the problem is approximately 10 per cent. Offenders are predominantly male, one half are said to be "ruthless" and "exploitative" whilst the remainder are often "lovesick" (Quadrio, 1991, p. 346).

In the three years up until March 1992 medical tribunals in New South Wales ordered the removal of the names of seventeen doctors from the medical register. Seven of these seventeen cases involved sexual misconduct in the context of psychiatric treatment, "a significant and disquieting proportion" (Dawson, 1992, p. 1).

In each of these cases the Tribunal ordered the name of the practitioner to be removed from the Register and in most cases fixed periods of two to five years which had to elapse before the practitioner could apply to be re-registered. Three appeals to the Supreme Court failed. In one the Court of Appeal ordered a Tribunal review on a legal technicality but the orders remained unaltered. One application for re-registration was dismissed (Dawson, 1992).

In a fascinating analysis of these seven cases, Eleanor Dawson (a retired private psychiatrist herself), found the following. Six of the psychiatrists were men, one was a woman. Their median age was fifty three. All were married or had been married
except one who was living with a partner. Five were members of the College, one was
in training with the aim of membership and one had been accorded standing by a
national accreditation committee. A fascinating profile of these people emerges from
Dawson's study. She notes:

"In the professional lives of the respondents notable energy, ambition and industry were
common if not universal. A number of practitioners occupied positions of leadership
and influence. Those lecturing, teaching and supervising in psychotherapy had been
doing so in teaching hospitals, under the aegis of the long established Universities of
Sydney and of New South Wales; or under the aegis of the New South Wales Institute of
Psychiatry, a statutory body."

Dawson also notes that evidence was given about recent personal psychiatric treatment
about all respondents except one. She states:

"Two of the psychiatrist respondents had been receiving personal psychotherapy at the
time of their misconduct. One of those had two discrete periods of treatment some
years earlier, after graduating in medicine but before qualifying in psychiatry. When
hearings were pending, at least four of the seven respondents were undergoing
psychiatric treatment and they were still in treatment at the time of their hearing. The
treating psychiatrists of three of them were called as witnesses by counsel for the
respondents" (Dawson, p. 7).

Specific behaviours mentioned in the complaints included developing inappropriately
close social relationships with patients, inappropriate revealing of a therapist's own
difficulties or sexual experiences to a patient, conducting psychotherapy sessions in
coffee shops and restaurants, revealing confidential information about other patients
and illegally prescribing drugs of addiction to a known addict.

Complaints of a sexual nature included sexual relations between therapist and patient
during consultation sessions as a prescribed part of therapy over a long period, sex in
motels and in a therapist's home in the de facto's absence, premature termination of
therapy to engage in a mutually desired sexual relationship or as a prelude to living
together, experimenting with personal sexual identity with the patient as the object of
the experiment, and complaints of prescribing drugs in return for sexual favours
(Dawson, 1992 p. 5).

Dawson's paper also provides a very interesting analysis of the patients' background,
and of the role other members of the College of Psychiatry played in the hearings as
expert witnesses or in other capacities. The role of the psychiatrist as expert witness
deserves closer examination.

*Psychiatrists as Expert Witnesses*

Psychiatrists tend to be called as witnesses for both the prosecution and defence in
sexual misconduct cases. In the United States one of the most common uses of
psychiatrists by prosecutors is to support an assertion of 'rape trauma syndrome' or
'post-traumatic stress disorder' to explain delays in reporting assaults, or a victim's
seemingly inexplicable behaviour. A significant number of patients delay reporting
because they cannot believe they are actually being abused.

Defence lawyers also use psychiatric evidence, not only in relation to evidence about
the accused doctor, in order to testify about the current or past psychiatric treatment or
problems of the doctor, but also to indicate whether the behaviour of the offending
doctor is likely to be repeated. Psychiatric evidence is used also to discredit the victim
accusing the doctor. The aim of this evidence is usually to support an assertion that a
psychiatric disorder has led a victim to make false accusations against her psychiatrist.
This is an extremely complex and difficult area. Obviously the presence of a
psychiatric condition on the part of a victim does not discredit her story but it does make the investigation of the complaint extremely difficult, particularly if, for example, the victim suffers from some kind of delusional disorder.

The Tribunal has wide latitude in determining the weight or probative value of the evidence before it. In one of the few published American opinions on the use of expert psychiatric testimony in sexual misconduct cases the court refused to allow in to evidence expert testimony as to whether the psychologist accused of sexual misconduct was telling the truth. The court’s decision rested on a Wisconsin evidentiary rule, previously only used in criminal cases, that forbids an expert from testifying “that in the expert’s opinion a witness is telling the truth” (Hyams 1992 p. 180).

Quite often the evidence of one psychiatrist is in direct contradiction to that of another. This is a problem obviously not confined to this jurisdiction, but one which is certainly gaining ascendancy in this area. In a recent case in Sydney where a doctor admitted inappropriate sexual behaviour in the course of examining a patient (he had digitally penetrated her, pulled aside her bra and kissed her nipple) two psychiatrists were called to give evidence. The first psychiatrist told the Tribunal that:

".. the incident occurred at a time when the respondent had been for many months very stretched in his work. He had been feeling despondent for some months, realising that he must slow down his workaholism and change his style of life, particularly because of his diabetes which he had been neglecting to some degree."

This psychiatrist concluded that the likelihood of re-offending was exceptionally remote as long as Dr R continued with the conditions of practice set by the Medical Tribunal pending the appeal against de-registration. The doctor himself had voluntarily imposed conditions when the complaint was laid. The Tribunal continued the conditions that the doctor should not examine a female patient save in the continuous presence of a chaperone, that the patient should be afforded a curtain behind which to dress or undress and a gown to wear during examination where this did not interfere with the proper examination of the patient. It is interesting to note that in another matter where conditions of practice were suggested, the Court of Appeal commented that:

"Treatment or supervision suggest, of course, that the appellant is no longer fully in command of his professional resources and, more to the point, indicates the underlying assumption that contrary to the statement made there is in fact a risk that he will offend again" (Buttsworth v Walton, Court of Appeal 19 December 1991 p. 15).

Returning to the case of Dr R, the first psychiatrist who gave evidence felt that Dr R did not have a psychiatric disorder but that there were psychiatric and behavioural issues which needed to be worked upon. Another doctor who treated Dr R with analytic therapy diagnosed an unconscious but very serious depression which manifested itself as a form of self-destructive attitude in failing to monitor his diabetic condition and also perhaps, the conduct towards the unfortunate patient (Tribunal decision p. 12).

This doctor was seeing the patient for four sessions a week and when asked how long he would expect that to continue he answered:

"A common period of time would be four to five years for analytical treatment."

One can only wonder at the cost to Medicare of this form of treatment. This psychiatrist was of the view that the symptoms of anxiety and depression were causative factors of Dr R’s conduct and that these had diminished due to continued psychoanalysis. He also thought the chance of Dr R re-offending was remote but he did express some reservations on this point. He gave evidence that Dr R could in the future
suffer from a depression of the type which led to the assault. In this matter the Tribunal held that whilst the risk of re-offending was small, it was nonetheless a real risk and it ordered that the practitioner's name be removed from the register and imposed the conditions described above pending the appeal. Yet a third psychiatrist gave evidence at the appeal. The report of this psychiatrist stated that although such an estimate could only be speculative, Dr R was highly unlikely to repeat such behaviour. This psychiatrist stated that the patient did not have a sociopathic personality or a "depression related impulse descontrol syndrome" but rather "became an adult at too early a chronological age, with consequential lacunae of immaturity". In the Court of Appeal it was argued that the Tribunal had erred in finding a "real risk" and had erred in finding that he should be de-registered to protect the public.

The above case demonstrates the tendency to use psychiatrists as expert witnesses in relation to the likelihood of the offences being repeated, and in the case just cited they fairly confidently assert that the incidents are "one off" events. A recent study from the United States notes, however, that sexual misconduct by doctors is rarely limited to one isolated event but instead tends to become chronic over time (Hyams, 1992 p. 175). It is important to note here that the opinion of a psychiatrist is necessarily one-sided. He does not have the benefit of all the evidence heard by the Tribunal but must base his opinion on what the patient selectively elects to tell him.

What is evident in the Australian cases is well summed up in the testimony of one psychiatrist giving evidence on behalf of a colleague who had admitted professional misconduct in relation to a patient with whom he had formed a sexual relationship. The psychiatrist stated that he thought Dr B's situation should be dealt with as a medical one rather than as a disciplinary one (Re Dr Buttsworth, Medical Tribunal of New South Wales 6 September 1991). It would perhaps be more accurate to note that there is clearly a tendency amongst psychiatrists accused of sexual misconduct to use the tools of their own profession to justify their behaviour. Or as the Tribunal put it in one case, "The behaviour complained of ... is open to the conclusion that it manifested badness, not madness" (Kirumba v Walton, Court of Appeal, 4 October 1990).

Discussion

Hyam argues that there is a parallel between child sexual abuse and sexual misconduct by doctors. He notes that in both there exists an imbalance of power, a diminished capacity to make decisions in one's own best interest, weakened self-protective instincts and vulnerability. Other parallels include the elements of secrecy "traumatic disillusionment with the idolised object", "fear of explosive disruptions in relationships" if the secret is revealed, and ambiguous feelings about the experience such as feeling responsible for what happened (Hyams, pp. 191-192).

A legal parallel to child sexual abuse also exists in relation to consent, and in neither case is the victim considered to be able to give informed consent. In all states in America where sexual misconduct by doctors has become a criminal offence, with one exception, consent has been excluded as a defence.

In a recent edition of Australian Doctor Weekly on doctor/patient relations the article entitled "Sometimes it does take two to tango" identified the risk factors for the development of a sexualised doctor/patient relationship. Such factors included breach of the doctor's normal practice principles, for example, extra consultation time, personal disclosure or contact outside the professional setting, non-erotic physical contact such as embracing, holding hands and touching, inability to say 'no' to the patient and sexual and emotional attraction. The article also lists personal factors such as mental illness in either doctor or patient. Interestingly, the patient is usually the person seen as 'seductive'.
One study showed that 90 per cent of patients suffered ill effects after being sexually involved with their doctors, 11 per cent required hospitalisation and 1 per cent suicided (Ellard, 1991, p 136). Yet to be attracted to a patient is said to be a common experience, acknowledged by 86 per cent of male and 26 per cent of female trainee psychiatrists in the United States (Fahy and Fisher, 1992, p. 1519).

It has been argued that certain specialties such as psychiatry and gynaecology may be at greater risk, necessitating as they do the most extreme invasions of patient’s physical and emotional privacy. Clearly the role that women have held in society augment the potential for the exploitation of the therapeutic relationship (Care and Robinson, 1990, p. 126). Lerner writes that "the cultural pressures on women to please men are so profound that the woman's desire to be attractive and admired by her therapist may override a more honest process of self-definition and self-determination" (Lerner, 1982). Needless to say, there is a growing body of literature on the abuse of women in therapeutic relationships.

**Conclusion**

This paper has attempted to identify some of the key issues raised in the process of investigating and disciplining doctors. It has demonstrated the extent to which psychiatrists in particular, will use the tools of their own profession to explain away their behaviour. As Cooper notes "There is no technique of invalidation more respectable, or even sacrosanct, than that which has the blessing of medical science" (Cooper, 1974, p. 11).

It is time to question, however, the appropriateness of using medical or psychiatric labelling processes to obscure the real issues of doctors taking sexual advantage of their patients. The fact that they do so on Medicare highlights their lack of accountability and the ease with which patients can be systematically exploited on alleged therapeutic grounds. Sexual misconduct by doctors is now arguably one of the bandwagon issues of the nineties. Having identified the problem, it is time to started looking seriously at possible solutions. It is a clear that both patients and doctors alike are at risk.

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