Sexual misconduct by doctors

Mandatory reporting and civil liability consequences

By Tina Cockburn & Bill Madden

'Whatever houses I may visit, I will come for the benefit of the sick, remaining free of ... sexual relationships with both female and male persons...'[1]

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SEXUAL MISCONDUCT BY DOCTORS

It is well accepted that doctors have an ethical obligation to 'avoid engaging in sexual activity with their patients'.[2] This ethical obligation arises due to the power imbalance in the doctor-patient relationship,[3] and has recently been enshrined in the Australian Medical Board's Good Medical Practice: A Code of Conduct for Doctors in Australia.[4]

When a doctor engages in an inappropriate sexual relationship with his or her patient, the quality of healthcare is threatened, the integrity of the medical profession is damaged, and there may be long-lasting, adverse consequences for the patients concerned and their families.[5]

MANDATORY REPORTING OF SEXUAL MISCONDUCT

In *Council for the Regulation of Health Care Professionals v General Medical Council*,[6] Leveson J observed that the General Medical Council had identified 'sexual misconduct and dishonesty with specific reference to falsification of a curriculum vitae, as two of the most serious types of misconduct which may require erasure'.[7]

In recognition of the need to protect the public from the exploitation of the power imbalance implicit in the doctor-patient relationship, national legislation has now been enacted that imposes a mandatory reporting obligation >>

> The public needs protecting from the potential to exploit the power imbalance implicit in the doctor:patient relationship.

on medical practitioners to report their peers when a reasonable belief[8] is formed that a peer has 'engaged in sexual misconduct in connection with the practise of the practitioners profession'.[9]

The Australian Medical Board has released Guidelines[10] that specify what constitutes a 'reasonable belief', including that it:

- must be formed in the course of practising the profession;
- must be more than a mere suspicion, mere speculation, rumours, gossip or innuendo;
- will generally involve direct knowledge or observation of the behaviour giving rise to the notification or, in the case of an employer, it could also involve a report from a reliable source or sources; and
- includes an objective element – facts are present that could cause the belief in a reasonable person; and a subjective element – that the person making the notification actually has that belief.

As to what constitutes sexual misconduct, the guidelines state, *inter alia* that:

- The sexual misconduct must be in relation to persons under the practitioner's care or linked to the practitioner's practise of his or her health profession.
- Engaging in sexual activity with a current patient or client will constitute sexual misconduct in connection with the practise of the practitioner's health profession, regardless of whether the patient or client consented to the activity or not.
- 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 – for example, the parent of a child patient or client.
- Engaging in sexual activity with a person formerly under a practitioner's care (that is, after the termination of the practitioner-patient/client relationship) may also constitute sexual misconduct. Relevant factors will include:
  - 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.

Accordingly, the sexual misconduct rule is potentially broad enough to include not only sexual relations with existing patients but, also, depending on the particular facts and circumstances, former patients.[11] In addition, as patients are often accompanied by third parties, with whom the doctor may interact and communicate with and be in a position to offer information, advice and support, and who may be deeply involved in the medical decision making and clinical encounter, the sexual misconduct rule may also extend to relationships with key third parties of patients, such as spouses or partners, parents, guardians, and health attorneys.[12] The guiding principle is a consideration of the extent to which the sexual relationship occurred as a result of the use or exploitation of trust, knowledge, influence, or emotions derived from the professional relationship.

In addition to triggering the mandatory reporting obligation, sexual misconduct may give rise to disciplinary proceedings and/or civil liability on the part of the doctor, as exemplified in the recent NSW District Court decision, *Lee v Fairbrother*.[13]

CIVIL LIABILITY CONSEQUENCES OF SEXUAL MISCONDUCT BY DOCTORS

Most claims for compensation that arise out of harm alleged to have been suffered as a consequence of an improper sexual relationship are framed as negligence claims.[14] In *Lee v Fairbrother,* damages were awarded to a woman for a psychiatric condition said to arise from a sexual relationship with a medical practitioner. This claim for compensation followed on from earlier disciplinary proceedings.[15]

Lee v Fairbrother: the facts and issues before the court

The defendant was a general practitioner in a regional area north of Sydney, NSW. There was no dispute that he was consulted by the plaintiff in January 2004, firstly in connection with a dog bite suffered by her son, and subsequently by the plaintiff on her own behalf in connection with a pre-existing obsessive compulsive disorder, which had been exacerbated by the dog bite and her concerns about its effect upon her son and his welfare.[16]

There was also no dispute that the plaintiff and the defendant had a sexual relationship of some duration in 2004 when they lived together for a period. That relationship ended acrimoniously in early 2005.[17]

There was, however, a dispute as to when the sexual relationship began and whether it had overlapped with any medical treatment of the plaintiff by the defendant.

The following three main issues were identified by the trial judge for determination:[18]

- whether the defendant had an inappropriate relationship with the plaintiff that was in breach of his duty of care to her as her medical practitioner;
- whether the plaintiff was incapable of forming the necessary consent to the sexual relationship, such that the defendant's conduct may have amounted to assault; and
- if the answer to either of the above questions was yes, whether the plaintiff suffered from any psychiatric deterioration arising out of the defendant's conduct as a medical practitioner, or whether her problems were

due solely to a consensual sexual relationship unrelated to the defendant's status or conduct in his capacity as a medical practitioner, that relationship having come to an acrimonious conclusion.

Breach of duty

The trial judge found that the sexual relationship was a product of the doctor-patient relationship,[19] that the defendant knew full well that the plaintiff was emotionally and psychiatrically vulnerable, and that the trust placed in the defendant by the plaintiff was subsequently abused and ultimately broken.[20]

The existence of the sexual relationship in the context of a simultaneous medical treatment relationship, the plaintiff having psychiatric problems, was held to constitute a breach of duty of care.[21]

The judgment reasoning on this issue was brief, without reference to earlier authority. This suggests that the defendant medical practitioner may in effect have conceded that the existence of the sexual relationship in the context of a simultaneous medical treatment relationship (which he had denied) would constitute a breach of his duty in tort.

Similarly, the court appears not to have been required to consider whether a sexual relationship without the psychiatric history and vulnerability would have sufficed as a breach of duty.[22]

Causation

As noted above, the defendant argued that the plaintiff's psychiatric condition was caused not by the relationship with him, but by other matters.[23]

The trial judge addressed the expert medical evidence and was ultimately satisfied of a sufficient causal connection between the defendant's breach of duty and the plaintiff's psychological deterioration after the relationship broke down.[24]

Application of the civil liability exclusions

Section 3B, *Civil Liability Act* 2002 (NSW) provides:

> '*3B Civil liability excluded from Act*
>
> (1) *The provisions of this Act do not apply to or in respect of civil liability (and awards of damages in those proceedings) as follows:*
>
> (a) *civil liability of a person in respect of an intentional act that is done by the person with intent to cause injury or death or that is sexual assault or other sexual misconduct committed by the person – the whole Act...*'[25]

In *Lee v Fairbrother*, the court was not persuaded that the plaintiff was incapable of consent to the sexual relationship;[26] although she was vulnerable, it remained a consensual, voluntary relationship. Hence, the exception for sexual assault could not apply.

However, s3B(1)(a) exception goes on to refer to 'other sexual misconduct', and it was that part of the exception that the court held to apply:[27]

> 'Counsel for the plaintiff informed me that this is a provision yet to be considered by the superior courts, and that there is no case law to guide my determination on the question. In my view, the defendant's conduct falls within the phrase "other sexual misconduct". It is clear that the legislature was intending to provide for conduct not amounting to criminal conduct. In my view, professional misconduct by a doctor involving sexual activity with a patient is such a circumstance. I find, therefore, that the defendant's conduct falls within s3B(1) of that Act, with the consequence that the Act does not apply. Damages, therefore, fall to be assessed under the general law, without restriction.'

The judgment deals with the sexual misconduct issue succinctly and, given the facts, the conclusion of the trial judge is likely to be uncontroversial.[28]

The key benefit to a plaintiff in avoiding the application of the civil liability legislation, as was the case in *Lee v Fairbrother,* is to permit a more generous assessment of damages, including the possible award of aggravated and exemplary damages.[29] In *Lee v Fairbrother*, the plaintiff was awarded total damages of $153,500, which included $50,000 as general damages and $10,000 as aggravated damages.[30]

No award was made for exemplary damages, as the defendant medical practitioner was said to have already been punished by the order made by the NSW Medical Board that he be removed from the register or medical practitioners for a minimum period of two years.[31]

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CONCLUSION

Doctors who engage in sexual misconduct face being reported under the mandatory reporting provisions. They also face the prospect of disciplinary proceedings and civil liability. Recently, in *Lee v Fairbrother*, the NSW sexual misconduct exception to the application of the civil liability legislation[32] – which also applies to various extents in Tasmania, Western Australia, Victoria and South Australia[33] – was applied so as to remove the case from the restrictions on damages awards which arose under the civil liability regime.

For lawyers, sexual misconduct arising in a medical treatment context raises a number of complications. While, on the one hand, plaintiffs may derive some legal and financial benefit from avoiding the application of civil liability legislation, the plaintiff may also be disadvantaged by insurance policy exclusions for such conduct, making recovery from an asset-poor defendant problematic, at least in the private sector.

As yet untested is the possibility of recovery not from the medical practitioner directly at fault, but rather from another medical practitioner who knew of the misconduct yet failed to report same before further damage was done to the patient. That issue may be addressed should the interlocutory matter, *Glennie v Glennie*,[34] find its way to a hearing of the substantive issues. ■

Notes: **1** Oath of Hippocrates, Hippocratic Oath, http://www.au.af.mil/au/awc/awcgate/nih/hippocratic.htm, accessed 22 August 2009. **2** See para 1.1i, Australian Medical Association Code of Ethics 2004, editorially revised 2006, available online at http://www.ama.com.au/codeofethics, accessed 20 August 2009. Similar ethical obligations appear in ethical codes internationally; see, for example: Opinion 8.14 - Sexual Misconduct in the Practice of Medicine, American Medical Association Code of Medical Ethics, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion814.shtml and Opinion 8.145 - Sexual or Romantic Relations between Physicians and Key Third Parties, accessed 21 August 2009. **3** This power imbalance has been acknowledged by disciplinary tribunals and the courts. For a discussion, see I Freckelton, 'The Sexually Exploitative Doctor' (1994) 1 *Journal of Law and Medicine* 203; and I Freckleton and K Petersen (eds), *Disputes and Dilemmas in Health Law*, 2006, The Federation Press, Chapter 24, Regulation of Medical Practitioners, p506, citing *re A Medical Practitioner* [1993] 2 Qd R 154 at 162. **4** http://www.medicalboard.gov.au/en/Codes-and-Guidelines.aspx at 3.2.6; 3.14; 8.2. **5** For a discussion, see C Leffler, 'Sexual Conduct within the Physician-Patient Relationship: A Statutory Framework for Disciplining this Breach of Fiduciary Duty' (1996) 1 *Spring Widener Law Symposium Journal*, 501. **6** [2004] EWHC 944 (Admin), http://www.bailii.org/ew/cases/EWHC/Admin/2004/944.html, viewed 29 August 2009. **7** [2004] EWHC 944 (Admin) at [45] (Dr S treated Ms X treated for depression – emotional and sexual relationship developed – Dr S continued to treat her – when relationship came to an end, Ms X was treated by another GP, Dr K, and the matter came to light – Ms X declined to involve herself in the disciplinary process). **8** In the course of practising their profession. **9** Sexual misconduct is 'notifiable misconduct' under s140(b) *The Health Practitioner Regulation National Law Act* 2009, which is set out in the Schedule to the *Health Practitioner Regulation National Law Act* (Qld) 2009. See, generally: Kathleen Jackson and Malcolm Parker, 'Full steam ahead on the ss "external regulator"? mandatory reporting, professional independence, self-regulation and patient harm' (2009) 17 *JLM* 29. **10** Medical Board of Australia, *Medical – Guidelines for Mandatory Notifications* http://www.medicalboard.gov.au/en/Codes-and-Guidelines.aspx **11** For a concise statement of ethical duties in relation to sexual contact with patients and former patients, see: *American Medical Association Code of Medical Ethics*, Opinion 8.14 - Sexual Misconduct in the Practice of Medicine, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion814.shtml, viewed 21 August 2009. **12** For a concise statement of ethical duties in relation to sexual contact with patients and former patients, see: *American Medical Association Code of Medical Ethics*, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8145.shtml, viewed 30 August 2009. See also: CEJA Report 11 – A-98 *Sexual or Romantic Relations Between Physicians and Key Third Parties*, http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_11a98.pdf, viewed 29 August 2009. **13** [2009] NSWDC 192 per Johnstone DCJ; http://www.austlii.edu.au/au/cases/nsw/NSWDC/2009/192.html. **14** For an excellent overview, see T Allen, 'Civil Liability for Sexual Exploitation in Professional Relationships' (1996) 59 *MLR* 56. **15** *Health Care Complaints Commission v Fairbrother*, Medical Tribunal of NSW, 18 December 2008. **16** At [3]. **17** At [4]. **18** At [22] – [25]. **19** At [37]. **20** At [39]. **21** At [42]. **22** Ethical constraints on doctor-patient sexual relationships are clear, however. See *Code of Professional Conduct: Good Medical Practice* 2008 (s99A *Medical Practice Act* 1992 (NSW)), New South Wales Medical Board, clause 2.3.1d: 'Observe professional boundaries with patients. This includes not engaging in personal relationships or sexual behaviour with patients. See, also the NSW Medical Board policy issued 4 December 1991, which provides, at clause 1: 'It is an absolute rule that a medical practitioner who engages in sexual activity with a current patient is guilty of professional misconduct.' **23** At [19]. **24** At [51]. **25** Sexual misconduct exclusions are similar to exclusions contained in: *Civil Liability Act* 2002 (Tas), s3B(1)(a); *Wrongs Act* 1958 (Vic), ss28C(2)(a) and 28LC(2)(a); s3A(1)(a) *Civil Liability Act* 2002 (WA). In SA, the legislation is limited to negligence *or some other unintentional tort or a breach of a contractual duty of care*: s51 *Civil Liability Act* 1936 (SA). There is no express exclusion in *Civil Liability Act* 2003 (Qld), although s52(1)(b) provides that the prohibition on exemplary, punitive or aggravated damages in relation to a claim for personal injury damages does not apply in cases of unlawful sexual misconduct; similarly, *Personal Injuries (Liabilities and Damages) Act* 2003 (NT) is also expressed to apply in s4 to '*all civil claims for damages for personal injuries*' and there is no express exclusion for sexual misconduct, even in s19, which prohibits awards of aggravated and exemplary damages; see, also, s93 *Civil Law (Wrongs) Act* 2002 (ACT), which provides that the damages provisions apply to '*all claims for damages for personal injury*' and there are no exceptions for sexual misconduct. **26** At [43]. **27** At [55]. **28** It would seem that where a professional person is alleged to have engaged in 'sexual misconduct' for the purposes of triggering the *Civil Liability Act* exception, the term 'sexual misconduct' would fall to be determined by the relevant professional codes of conduct; in this context, *the Australian Medical Board's* Good Medical Practice: A Code of Conduct for Doctors in Australia, http://www.medicalboard.gov.au/en/Codes-and-Guidelines.aspx. **29** Under the *Civil Liability Act* 2002 (NSW), such awards are precluded by s21. For a discussion, see: T Cockburn and B Madden, 'Intentional torts to the person, compensation for injury and the Civil Liability Acts: Recent cases and contemporary issues' (2007) 18(1) *Insurance Law Journal* 1; and T Cockburn and B Madden, ' A renewed interest in intentional torts following legislative changes to the law of negligence?' (2006) 14(3) *Tort Law Review* 161. **30** At [84]. **31** At [5], [80]. **32** Section 3B, *Civil Liability Act* 2002 (NSW). **33** See fn 25 above. **34** [2009] NSWSC 154.

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