

Maintaining Clear Sexual Boundaries Between Doctors and Patients and the Conduct of Patient Examinations

2019

1. Professional boundaries

1.1 Doctors have an ethical and legal duty to maintain appropriate professional boundaries with patients. Essentially, professional boundaries define the limits of the therapeutic relationship between doctors and patients not only in terms of physical space but also social, emotional and psychological space.

1.2 There is a potential power imbalance in the doctor-patient relationship. While doctors have the highly specialised knowledge and skills patients require to obtain good quality health care, patients may feel vulnerable or are potentially vulnerable and exposed due to the very personal and physical nature of the doctor-patient relationship. For example, patients who seek care may be sick, injured, anxious and distressed. Further, they may be asked to undergo a physical examination which may cause discomfort and embarrassment or be asked to provide very personal and sensitive information about their health and lifestyle or relevant information about their family members.

1.3 Because of the power-imbalance in the doctor-patient relationship, it is essential that doctors adhere to very strict professional boundaries to ensure that patients feel confident and safe when seeking medical care. Maintaining appropriate professional boundaries facilitates trust in the medical profession, promotes patient care and protects both doctors and patients.

1.4 In order to maintain professional boundaries, a doctor should not use their professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with patients or those close to patients such as their carers, guardians or close family members including spouses or parents of a child patient.ⁱ Violating professional boundaries undermines the doctor-patient relationship and may cause psychological harm to patients and compromise their medical care. In addition, such violations undermine the trust the community has in the profession to act with professionalism at all times, may constitute criminal conduct and may be subject to police investigation as well as disciplinary action.

1.5 Doctors should be aware that professional boundaries apply not only to face-to-face patient consultations but also in the use of social media and other forms of electronic communication and consultation (such as emails, text messages and telehealth).ⁱⁱ

2. Maintaining appropriate sexual boundaries with patients¹

2.1 An important component of professional boundaries is sexual boundaries. Breaches of sexual boundaries can range from sexualised behaviours, sexual exploitation, sexual harassment and sexual assault.

2.2 Maintaining appropriate sexual boundaries requires doctors to practise self-awareness which includes:

-) recognising their own emotional stressors;
-) judging particular situations where boundaries may be (or have been) crossed; and
-) minimising personal vulnerability.

2.3 A doctor must not engage, or seek to engage, in sexual activity with a current patient. This extends to behaviours of a sexual nature such as making sexual remarks, flirtatious behaviour, touching patients in a sexual way or engage in sexual behaviour in front of a patient as well as conducting a physical examination that is not clinically indicated or in the absence of patient consent.

2.4 It is the doctor's responsibility to maintain appropriate sexual boundaries regardless of a patient's behaviour. Even if a patient has initiated sexual contact with the doctor, it is inappropriate for the doctor to engage in sexual activity with the patient. In these circumstances, the doctor should attempt to re-establish professional boundaries. In some situations, the doctor may decide to end the therapeutic relationship and transfer care to another doctor. The doctor should note the patient's behaviour and any decisions regarding the therapeutic relationship in the patient's medical record.

2.5 A doctor should not solicit or engage in a sexual relationship with a patient's carer, guardian, spouse or close family member (such as a spouse or parent of a child patient) if this may compromise care. There is also a power imbalance between the doctor and the individual close to the patient, particularly if that person makes health care decisions on the patient's behalf.

2.6 It may be inappropriate for a doctor to engage in a sexual relationship with a former patient even if the therapeutic relationship has ended.

¹ This section adapted from the Medical Board of Australia. *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship*, 12 December 2018, breaches of which may place the doctor's registration at risk and may also comprise a criminal offence. Refer to the Board's guidelines for a comprehensive list of behaviours that potentially breach sexual boundaries. As defined in the Board's guidelines, sexual exploitation or abuse in the doctor-patient relationship means a doctor using the power imbalance, knowledge or influence developed in the doctor-patient relationship to abuse or exploit the patient's trust or vulnerability for sexual purposes or sexual gratification, including by conducting unnecessary physical examinations. Sexual harassment means any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. Sexual harassment is a type of sex discrimination and the *Sex Discrimination Act 1984 (Cth)* makes sexual harassment unlawful in some circumstances.

2.7 A doctor should recognise the influence they have had on patients and that a power imbalance could continue long after the professional relationship has ended. The doctor should consider carefully whether they could be exploiting the trust, knowledge and dependence that developed during the doctor-patient relationship before they decide whether to pursue or engage in a relationship with a former patient. Important factors to consider include:

- the duration, frequency and type of care provided by the doctor; for example, if they had provided long-term emotional or psychological treatment;
- the degree of vulnerability of the patient;
- the extent of the patient's dependence in the doctor-patient relationship;
- the time elapsed since the end of the professional relationship;
- the manner in which, and reason why, the professional relationship ended or was terminated;
- the context in which the sexual relationship started.

2.8 Doctors have an ethical and legal duty to report colleagues or other registered health care professionals who engage in sexual misconduct.²

3. Patient examinations

3.1 *Consent to physical examination*

3.1.1 It is essential that the patient consent to the examination (there may be an exception in emergency circumstances). Depending on the circumstances, consent may be implied, verbal or written.

3.1.2 In many circumstances, a patient who presents to their doctor with a particular ailment, injury or other medical concern will need to undergo a physical examination in order to assist the doctor in making a diagnosis.

3.1.3 Physical examination often requires the doctor to touch the patient. Some physical examinations may require the patient to undress (in part or in full). Some may result in a level of physical discomfort for the patient. The doctor should be aware the patient may feel vulnerable, anxious, embarrassed or physically uncomfortable depending on the nature of the examination and, as such, the examination will require particular care. Doctors should be aware of these sensitivities when examining patients.

3.1.4 If the doctor has not appropriately explained, or the patient has not understood, the nature and reason for a particular examination or aspect of an examination (which includes not only physical examination but also why particular questions are asked), a patient could

² For more information on doctors' duty to report colleagues or other registered health care professionals who breach sexual boundaries, refer to the Medical Board of Australia's *Guidelines for Mandatory Notifications*.

misconstrue this as inappropriate sexual behaviour. Patient examinations may be a source of complaint against a doctor.

3.1.5 Whilst the doctor may understand the purpose and nature of conducting a particular physical examination, the patient may not. A doctor should explain to a patient so they understand and appreciate:

-) why the examination is necessary;
-) what parts of the body are to be examined. If undressing is required, this should be explained to the patient;
-) what the examination entails. This may include any discomfort or sensations the patient may feel;
-) if anyone else will be present in the room when the examination is being undertaken;
-) the implications of not undergoing an examination.

3.1.6 The doctor should also obtain and record explicit consent from the patient for the following situations:

-) if photos or videos will be taken;
-) if anyone else is to be present during an examination or consultation including interpreters, observers or support persons;
-) if medical students or junior doctors will be present or will examine the patient for the purpose of education and training.

3.1.7 A doctor should not conduct an examination if the patient does not consent or the consent is uncertain (there may be an exception in emergency circumstances). Where the patient does not consent or the consent is uncertain, the doctor should reiterate the importance of the examination with the patient. If practical, and with the patient's consent, the doctor may offer the patient an observer or support person to be present during the examination. If the patient continues to refuse to consent to the examination, the doctor should defer the examination or refer the patient to another doctor. The patient's refusal to undertake the examination should be recorded in the medical record along with any relevant discussion between doctor and patient. The doctor should record the recommended course of action; for example, defer the examination to another time, engage an observer or support person to be present during the examination or refer the patient to another doctor.

3.1.8 If an examination is in progress and the patient withdraws consent, the doctor should cease the examination immediately. The doctor may wish to explore why consent has been withdrawn, defer the examination or refer the patient to another doctor. The patient's withdrawal of consent should be recorded in the medical record along with any relevant discussion between doctor and patient. The doctor should record the recommended course of action.

3.2 Patients who lack decision-making capacity

3.2.1 Some patients may have limited or impaired decision-making capacity at the time a specific health care decision must be made regarding consent to physical examination.³ Such patients should be encouraged to participate in the consent discussion consistent with their level of capacity at the time the decision needs to be made. Some patients may be able to make a supported decision while others may require a substitute decision-maker to make the decision on their behalf.

3.2.2 Children and young people under the age of 18 may have decision-making capacity to consent to an examination depending on their maturity as determined by a doctor. If the doctor determines the individual does not have the capacity to consent to a physical examination, consent should be sought from their guardian or parent.

3.2.3 A familiar individual such as a family member or carer should generally accompany an individual who does not have decision-making capacity during the examination.

3.3 Conducting a physical examination

3.3.1 Patient privacy and modesty should be respected in all situations before and after physical examination. The physical environment in which the examination takes place, however, will determine exactly what privacy measures can reasonably be taken. For example, more stringent privacy measures can be undertaken in a private doctor's office than in an emergency room. Depending on the physical environment, appropriate measures to preserve a patient's privacy and modesty may include:

-) providing a screen behind which the patient can dress and undress;
-) excusing oneself from the consulting room whilst the patient is dressing and undressing;
-) turning away while the patient is dressing and undressing;
-) ensuring the door is closed when the patient is dressing and undressing;
-) providing suitable cover such as a sheet or gown during the examination;
-) avoiding exposing more of the patient's body than necessary;
-) ensuring the patient remains undressed no longer than is needed for the examination;
-) having an observer or support person present during the examination.

3.3.2 The doctor should generally not assist a patient to undress or dress unless the patient is having difficulty and requests assistance. Sometimes, such as where a patient is elderly or frail, it may be appropriate for a doctor to offer to assist a patient to undress or dress. In these circumstances, it would be appropriate for a doctor to offer to assist.

³ Patients with limited or impaired decision-making capacity may include:

-) those who never had decision-making capacity;
-) patients with a mental illness or other condition resulting in permanent impairment of decision-making capacity;
-) patients with decision-making capacity for some, but not all, decisions;
-) patients with fluctuating decision-making capacity.

3.3.3 The doctor should not make inappropriate verbal or non-verbal expressions during the examination.

3.3.4 The doctor should minimise unnecessary interruptions.

3.3.5 Intimate examinations such as examination of the genitals, breasts or internal examinations can cause a patient particular distress. Doctors should be aware that patients have their own views regarding what constitutes an intimate examination. Gloves should always be worn when conducting an internal examination.

3.3.6 Whilst the examination is being undertaken, it is important for the doctor to continue to communicate with the patient. The position of the doctor during the examination should be explained (this is particularly relevant when the doctor is standing behind the patient). If the steps of the examination differ to what was outlined during the consent discussion, explain to the patient the reason for this.

3.3.7 Patients should be given the opportunity to ask questions before, during (where possible) and after the examination.

3.3.8 The doctor should be alert to a patient experiencing undue distress during an examination or any verbal or non-verbal sign the patient has withdrawn consent.

3.3.9 Following an examination or investigation, the findings should be communicated to the patient.

3.4 Observers⁴

3.4.1 As defined by the Medical Board of Australiaⁱ, an observer is essentially a witness to the examination and may be a member of the clinical team such as a registered nurse. Ideally, an observer should understand the nature of the examination and how it is normally performed.

3.4.2 A doctor or patient may choose to have an observer present during a physical examination. An observer is different to a support person which is often a relative or friend. Relatives and friends may not be appropriate to serve as observers as the patient's confidentiality may be breached due to the nature of the examination or because the patient may be embarrassed to undertake the examination in front of their relative or friend.

3.4.3 Where an observer is provided, the observer should respect the patient's privacy and be of a gender approved by the patient.

⁴ These guidelines do not address the role of chaperones, where a doctor is subject to a requirement that they must have contact with patients only in the presence of a Medical Board of Australia approved chaperone. Refer to the Australian Health Practitioner Regulation Agency's *Chaperone Protocol* for relevant information.

3.4.4 While the presence of an observer may provide some comfort to the patient, particularly during an intimate examination, it may also be an important risk management strategy as an observer can give an impartial account of the examination should allegations of inappropriate conduct arise.

3.4.5 There are certain situations where the patient, as well as the doctor, may wish to have an observer present during an examination. For example,

-) where the patient requests an observer;
-) during an intimate examination;
-) where a patient appears particularly uncomfortable, reluctant or distressed to be examined;
-) where the doctor is uncomfortable in examining the patient without an observer.

3.4.6 The patient must consent to having an observer and must agree to the individual who will serve as the observer. The observer's name and patient consent to the observer should be recorded in the patient's medical record.

3.4.7 If an observer is not available, or if the patient is not comfortable with the choice of observer, the doctor should offer to postpone the examination until an appropriate observer is available, if this does not impact on the patient's health care. A doctor should ensure the patient does not feel compromised or pressured into proceeding with an examination if an observer is not available.

3.4.8 If the doctor has concerns about a particular patient and would like to have an observer present, but the patient does not consent, the doctor does not have to perform the examination. The doctor may wish to defer the examination or refer the patient to another doctor.

3.5. Support persons

3.5.1 A support person is someone chosen by the patient and is often a family member, carer or friend of the patient. A patient has the right to ask to be accompanied in their consultation by a support person of their choice.

3.5.2 It is important to ensure that the patient consents to the support person being present during the examination.

ⁱ Medical Board of Australia *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship*, 12 December 2018.

ⁱⁱ Australian Health Practitioner Regulation Agency. *Social Media Policy*. March 2014.