The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

11 October 2018 Our ref: MT18-512

Kanny Ooi
Senior Policy Adviser and Researcher
Medical Council of New Zealand
PO Box 10-509
WELLINGTON 6011

By email: kooi@mcnz.org.nz

Dear Ms Ooi

Consultation on sexual and professional boundaries

Thank you for giving The Royal New Zealand College of General Practitioners the opportunity to comment on the draft standards on sexual and professional boundaries. The College considers these documents to be very important. However, we do have several suggestions for how both documents could be improved. Our comments are outlined below.

Background

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, The Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

Submission

The College welcomes the opportunity to give feedback on both the sexual boundaries and professional boundaries statements. In its current form the sexual boundaries statement does not fully acknowledge the seriousness of sexual harassment and assault and as such we have recommended numerous changes to this document.

Conflating sexual harassment and assault with intimate examinations and sensitive consultations

One of our fundamental concerns with the approach in this statement is that it often conflates issues of sexual harassment and assault with clinical consultations and examinations that may be sensitive or intimate. This approach provides the impression that some consultations, for example, the taking of a cervical smear, have a sexual nature, when that is not the case.

Our view is that a more useful approach would be to separate the statement into two documents: one on breaches of sexual boundaries; and a second on best practice during sensitive consultations and intimate examinations. As it stands, having both within one document can be confusing and could make doctors unsure about what appropriate conduct might involve. For example, the draft describes 'examining the patient intimately without their consent' as 'sexual impropriety'. Our view is that there are actually two points in here that need to be teased out and dealt with separately: 1) examining a patient intimately when there is no clinical justification is sexual assault; and 2) when conducting a necessary intimate examination of a patient unable to give consent (for example, checking a urinary catheter for infection in a bed-bound patient with dementia) doctors need to be especially careful to ensure that the requirements of Right 7 of the Code of Health and Disability Services Consumers' Rights are appropriately adhered to.

When patients breach professional boundaries

One of our members reported that they constantly face sexual harassment from patients, and that this is not uncommon for female doctors. As such we recommend the Council adds a section to the statement that provides doctors with advice on what to do when they are subjected to sexual harassment from patients, and where they can turn to for help. The College would welcome the opportunity to work with the Medical Council on such a document.

Comments on specific clauses within the draft documents are outlined below.

Comments on specific sections of the Sexual Boundaries resource

Definition of 'sexual boundaries' should be in a text box

Our view is that this document needs to define what is meant by 'sexual boundaries'. A definition would help ground the document and provide clarity as to why maintaining sexual boundaries is important.

Use of the term 'zero tolerance'

Your consultation document asks for our view on the use of the term 'zero tolerance'.

The College agrees that there should be zero tolerance for doctors entering into a sexual relationship with current patients. However, the Council uses the term 'zero tolerance' more broadly, as in the statement 'The Council has a zero-tolerance position on doctors who breach sexual boundaries with a current patient'. One of the problems of using the term 'zero tolerance' in this broad context is that it means that doctors might be less likely to disclose incidents for fear of a punitive response. For example, a GP who witnesses what appears to be an inappropriate discussion between a colleague and a patient might be less willing to intervene out of a fear that this will necessarily result in a formal disciplinary process. We prefer some of the language used in the text box which opens the revised statement, such as 'Doctors are responsible for maintaining

professional boundaries in the doctor-patient relationship' and 'It is never appropriate for a doctor to engage in a sexual relationship with a patient'.

We also note that the text box at the start of the document is the only place where it is explicitly made clear that a sexual relationship between a doctor and a current patient is never appropriate. Our view is that this point also needs to be made within the detail of the statement.

Best practice during a consultation

Although the section on 'Best practice during a consultation' provides useful guidance, our view is that it is out of place in a document on sexual boundaries. Furthermore, by having this in the standard it tends to imply that some consultations have a sexual nature, when that is not the case.

Furthermore, considering the findings of Malpas et al. on the lack of consent from patients for sensitive examinations, there appears to be some real value in the Medical Council creating a separate standard on how to conduct an intimate examination and best practice on this.[1] This standard would be helpful for both patients and doctors, as it would clearly outline what both parties should expect, the duties of doctors, and the rights of the patient under the Code of Patients' Rights.

Discussing a doctor's own sexual desire with a patient may constitute sexual harassment

In the vast majority of possible scenarios, a doctor discussing their sexual desires or practices with a patient is, in the College's view, not just a 'danger sign', but a form of sexual harassment.[2] We would suggest removing this from the 'danger sign' section and instead make it explicit that such behaviour will likely be regarded as a breach of sexual boundaries.

Problems with terms 'sexual impropriety, sexual transgression and sexual violation'

The document uses the terms 'sexual impropriety', 'sexual transgressions' and 'sexual violation'. We feel that these terms are problematic for several reasons. First, the lists of actions beneath these terms broadly describe a range of behaviours that appear to meet the threshold of sexual harassment or sexual assault. The term 'sexual impropriety', in particular, seems to minimise the seriousness of these behaviours.

Second, this terminology is used to explicitly outline tiers of seriousness, meaning that some actions are regarded as less serious than others. In particular, we are concerned that performing an internal examination of a patient without their consent, while not wearing gloves and for no purpose, would fall under the definition of 'sexual transgression', when in our view this is serious misconduct that would likely meet the legal threshold of sexual assault.

To state that actions such as those described are simply a transgression or impropriety does not acknowledge their seriousness and the potential impact on the patient. Furthermore, not using the explicit language of sexual harassment and assault, would seem to imply that doctors are held to a lesser standard than members of the general public.

The term sexual violation is also problematic, as the statement does not define what is meant by 'unlawful sexual connection with another person'. As such we would encourage the Medical Council to put in a definition of what is meant by 'unlawful sexual connection' and provide some examples of what this refers to.

---

[1] Malpas PJ, Bagg W, Yielder J, Merry AF. Medical students, sensitive examinations and patient consent: a qualitative review. The New Zealand medical journal. 2018 Sep;131(1482):29-37.

[2] Although we note that there may be some very rare circumstances where this may be appropriate within the context of a sensitive consultation. For example, it might be appropriate for a male GP to provide some limited personal information about his own experiences when talking to a male patient who is experiencing erectile dysfunction.

More information needed under 'Your obligation to notify'

Our view is that the section entitled 'Your obligation to notify' should be expanded to clarify what the responsibility of a doctor might be after a notification is made. For example, if a doctor wishes to pass information (with the patient's permission) to the Medical Council about an allegation of sexual assault, what information will the Medical Council need? Does the doctor need to disclose his or her name? Will their name be released to the accused? Will the doctor be expected to give evidence to the Medical Council, a professional conduct committee and/or the Health Practitioners Disciplinary Tribunal? Will the patient have to talk to the Medical Council or provide evidence at a hearing?

A section is needed to explain what to do if a third party discloses information to you

Allegations of sexual harassment or assault may not necessarily be brought up by a patient or the doctor involved. For example, a doctor may hear rumours of gossip from a receptionist or other staff member. Our view is that the statement should be expanded to provide advice to doctors in these circumstances. This advice should confirm whether it is appropriate or necessary to contact the Medical Council on the basis of a third-party report. And if the doctor does contact the Medical Council, whether the the Council would act on the basis of that information - or whether the doctor should attempt to establish the facts before reporting. Clear pathways need to be established so people know when and where it is appropriate to seek advice or help.

More information needed under 'Disciplinary action'

The section on disciplinary action needs to include guidance on when a doctor needs to advise the Police of their concerns. Again, excluding this information appears to mitigate the seriousness of the behaviours described in this document, especially in the case of sexual assault and rape.

Clarity is needed on former patients

The College would suggest including some examples to clarify the grey areas that relate to relationships with former patients. As currently worded, this section does not provide doctors with clear advice. Another option may be to include some questions that a doctor should consider, such as: would you feel comfortable discussing how you feel about the former patient with a colleague?; and when the person was your patient, was there an emotional element to any of the care you provided?

The College agrees with the inclusion of the section on intimate relationships with family members

The College agrees with the inclusion of this section, and suggests expanding it to explicitly state that if the family member is a parent of a child in the person's care, or another vulnerable person, then the relationship is inappropriate. Our view is that in such circumstances there is a risk to the patient involved.

Professional boundaries in the doctor patient relationship

Gifts

The College agrees doctors should not ask for gifts and should not under any circumstance make it appear that the quality of a patient's care may be affected by gift giving. In our view doctors should be allowed to accept small items of koha where this is freely offered, however, larger items, especially cash, should be declined.

Enduring power of attorney

The College considers it is inappropriate for doctors to have enduring power of attorney over patients, as it puts the doctor at risk if there is perceived undue influence over the patient.

Social media and electronic forms of communication

The College agrees that doctors should try and keep their professional and private lives separate. We would suggest doctors set strong privacy settings on their social media accounts.

Use of personal phones to contact patients

The College suggests doctors only use work phones to contact patients. If a doctor does not have a work phone, we would suggest limiting texts to simple requests, such as confirming an appointment time.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely

Michael Thorn
General Manager – Strategic Policy