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[redacted]

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Dear Sir/ Madam,

Please accept this submission in response to the Draft Revised Guidelines: Sexual boundaries in the doctor-patient relationship.

As made clear in the pre-amble to this consultation paper, changes to the guidelines under consideration are largely editorial. The behavioral expectations of doctors are not changing.

I believe that the revised guidelines are more clearly stated and hope that this will indeed translate to a better understanding by doctors and patients of what the Law requires. In my experience some doctors have a poor understanding of what these guidelines mean in practice. As well, it is very obvious that patients have great difficulty identifying and naming sexual misconduct when it occurs.

I offer this example:

> I had a conversation with a fellow highly experienced GP whose patient had told her that his specialist had repeatedly conducted genital examinations, including retraction of the foreskin, as part of his management of migraine. When I suggested that this constituted sexual misconduct and must be reported my colleague insisted that it did not. She said “Sexual misconduct is when a doctor has sex with a patient.”

What this patient described was not only sexual misconduct, but sexual assault.

That a doctor with over 25 years experience could not understand this and formulate an appropriate response is alarming to me. This speaks to me of problems with the language used in the existing guidelines and also points to a failure of adequate communication by the Board.

In the same example above, the patient described how he had felt the examinations were not right. He did not know what to do about it, felt powerless, and ultimately simply stopped receiving medical care for his condition.

This example (and the dozens of others we have leant about from the Churchyard case) tell us something about how patients understand, experience and can respond to inappropriate sexual behavior in the context of a doctor-patient relationship. The revised sexual boundaries guidelines are a significant improvement on the existing guidelines in this regard. The Spectrum of behaviours described in Section 3.1 is very well articulated and quite comprehensive.

Having improved this language it will be very important for the Board to communicate this effectively to the public so as to give them the agency they have been lacking in this space. It is not enough to tell doctors how they should behave. Given the power imbalance inherent in the doctor-patient relationship we must also ensure patients are as informed as possible to enable them to identify and act on breaches of sexual boundaries.

The Medical Board of Australia (MBA) provides as an addendum to the draft revised guidelines, a Statement of Assessment. This statement seeks to measure the process adopted in seeking consultation on the revised guidelines against the requirements of the National Law.

It states: "The National Law requires wide-ranging consultation on proposed guidelines."

The statement goes on to say that:

"The Board is ensuring that there is public exposure of its proposals and the opportunity for public comment by undertaking an eight week public consultation process. The process will include the publication of the consultation paper on its website and informing medical practitioners via the boards electronic newsletter sent to more that 95% of registered medical practitioners."

The Board concludes that the consultation requirements of the National Law are met.

I disagree with this assessment. I do not believe this to be an adequate process to gain input and feedback from members of the public (all of whom will at some time be engaged in a patient-doctor relationship). The Board's website is not generally known to the public and nor would you expect people to search the Board's website for something that they do not know is happening. The process described seems to be concerned with asking doctors what they think of the guidelines. Members of the public, as potential patients, are the purported beneficiaries of these revised guidelines – if we are to accept that their intention is about protecting the public. Their views and feedback should be actively sought.

Informing medical practitioners of the opportunity to provide feedback via the Board's electronic newsletter is also likely to be ineffective. In a meeting with Dr Joanna Flynn in 2017 I was told that only 30% of newsletter recipients open this document. With this knowledge of its poor reach, I do not believe the Board can rely on this means of communication to convey important information to doctors. This is relevant now, during this consultation process, and is perhaps even more important when considering how any new guidelines might be effectively disseminated to doctors.

Indeed this mode of communication, if as poorly read as Dr Flynn suggested, fails the Board and the profession all of the time.

In conclusion, I feel that the revised guidelines do represent a significant improvement and I commend you for undertaking this review. I do feel however that the consultation process is too focused on doctors and does not engage with the public. Moreover, the real test of the utility of this review will be in how the final product is communicated to all stakeholders.

Yours faithfully,

Dr Sharon Monagle MBBS, FRACGP, MPH