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Sex and the Professional: Predator or Victim?

Yolande Lucire

In the time available, I can address only four issues.

First, the legislation governing the HCCC, the Medical Board and its Tribunals, second, the ramifications of zero tolerance of sexual relationships between patients and their doctors, third, the growth of false allegations of sexual 'abuse' by doctors and others and fourth, the capacity of the HCCC and the Medical Board, in their current orientations, to deal with them.

According to the 1992 *Review of the Medical Practice Act*, the Board's role is

... to maintain proper ethical and professional standards, primarily for the protection of the public, also for the protection of the public. (sic)

Criminal proceedings are inherently punitive in nature and involve the State seeking to remove fundamental liberties and rights of one of its citizens.

Proof beyond reasonable doubt is required in such proceedings because of the paramount importance which the law places upon ensuring that innocent people are not punished.

The Board submitted that

... to require a degree of certainty indispensable to a criminal conviction in professional disciplinary cases would clearly entail placing the privileges enjoyed by the medical profession above the protection of the public from incompetent and unethical practitioners.

The review concluded

The department is of the view that the adoption of the criminal standard of proof (i.e. beyond a reasonable doubt) would be inconsistent with the objective of the Medical Practice Act which is the protection of the public and accordingly is not supported.[1]

These sentiments should send a shiver down the spine of any medical practitioner. As I read it, the Medical Board's position is that the presumption of innocence of an accused doctor lies somewhere well below the importance of protecting the public. When I became a doctor, no one told me that the Department of Health would abolish my civil rights. My colleagues who have had experience of the complaints process at any level would attest that it is indeed the case that an accused doctor has less legal protection than a recidivist criminal.

We have a legislated policy bias towards the complainant who does not carry a burden of proof. History, even the recent history of the NSW *Workers Compensation Act*, and that of Victims' Compensation Tribunals everywhere, has repeatedly shown that jurisdictions that have a bias towards the applicant are soon discovered by those people who wish to exploit them.

The purpose of the Medical Practice Act is to protect the public. I would argue that it is created and run by doctors with the main aim of protecting the reputation of the medical profession and its economic interests. In this the *Medical Practice Act* is similar to ecclesiastical law which protects a church from heretics in its midst. Church law does not protect persons charged with heresy because its objective is to get rid of them. Both types of legislation make it easy to find them guilty. Heresies are not independently defined, but are whatever that church believes them to be at that

particular period.

Judging by the huge response to the current State Parliamentary Committee's inquiry into the HCCC, there is a lot of feeling that the procedures of the HCCC and the Board owe nothing to modern jurisprudential concepts and that they ought to.[2] The HCCC and Medical Practice Acts are disgraceful contemporary examples of Star Chamber Law, created by persons who have no comprehension of the 300 years that have made common law what it is now, designed not only to convict the guilty but protect the innocent.

The policy statement of the Medical Board of New South Wales makes it an absolute rule that a medical practitioner who engages in sexual activity with a current patient is guilty of professional misconduct. This kind of policy, mandating a penalty, is called zero tolerance. We are all against sleaze, sexualisation of examinations, coarseness, propositioning over medical procedures or consultations. I do not seek to justify the activities of doctors who see their patients as a source of sexual gratification. None of us wants to see vulnerable persons exploited. If there is an unequal relationship, it is just as wrong of the doctor to exploit it, as it is for a teacher, a lecturer, a lawyer or a rich or powerful person. There is nothing specific to medicine here, but doctors are singled out and dealt with in different courts under a different set of rules from everyone else.

I submit that zero tolerance constructs convenient legal fictions. It is underpinned by three assumptions.

First, that sexual relationships between doctors and patients damage the trust that the public needs to have in the profession.

Secondly, that such relationships cause immeasurable harm to the patient.

Thirdly, that the disparity of power in the physician-patient relationship, is such that a patient cannot ever give meaningful consent to sexual contact.

The HCCC's procedures encourage trivial and spurious complaints by persons with malice as well as those with genuine grievances. It does not differentiate one from the other. Medical defence insurance fees will continue to rise if this culture of complaint is allowed to flourish. Current policy makes it almost impossible for the complaining patient to be told that he or she is wrong, mistaken or simply out of order. None is ever satisfied by the consequences of complaint and doctors are even less satisfied. I am using the example here of allegations of sexual misconduct, in jargon "boundary violation." The doctor is not charged with having had sexual relationship with a patient but he or she has to defend against a charge of being not a fit and proper person to practice medicine, that is, of unprofessional conduct.

Mandatory law replaces, at a lesser cost to the medical community, those soundly based judicial activities, which strive to protect the innocent and punish the guilty.

Zero tolerance is bad law, lazy man's law, cheaper to administer than case-by-case law. Doctors in the broader interests of the medical profession have accepted this legislation, but it sacrifices the rights of individuals who collectively make up the profession. I put to the reader:

Assume that you are single, widowed or divorced and free to pursue a non-adulterous relationship.

You guess that your physician, similarly placed, would like to meet you away from his office. It is an inclination based on detailed acquaintance. You have always liked each other.

Do you believe that you should be deemed to be incompetent to give consent to a sexual relationship should one develop?

Would you like the doctor, your potential partner, to live in a state of mortal sin, boundary violation and, forever to endure snide remarks to the effect that he or she married a patient?

Would you accept that you are more likely to have done yourself harm if it had not worked with the

doctor than with your neighbour, lawyer or workmate?

Would you like your relationship to be called 'sexual abuse'? Do you believe that the profession of medicine would have been harmed by your relationship?

If at least some reasonable people would say no, then we need to reconsider exactly where vital boundaries are to be calibrated. The taboo that society seeks to codify is one against predatory sexual activity that arises out of medical practice. The law should be targeted against behaviour that makes people unable to trust doctors with their wives and children. Many similar jurisdictions make this easy and clear distinction and do not leave reasonable people at the mercy of the caprices of public servants who have the power to prosecute or not, free of legal guidelines to restrict them.

There is no need at all to legislate against relationships which arise out of the social friendships that develop every day between doctors and their patients, most obviously in small communities. We cannot reasonably argue that the morality of an activity depends on the size of the community where it occurs.

Is immeasurable harm done?

The truth is that we simply do not know a great deal about how much of this goes on in the real world. The literature is generated by observing patients who have complained and psychotherapists who have been complained about. Scientists would recognise a reporting bias and be careful about drawing conclusions. Its underlying assumptions are revealed by its universally value-laden jargon terminology: sexual abuse, perpetrator, victim, survivor.

Suicide is occasionally reported. Many researchers have reported anger, shame, humiliation, depression, and anxiety and that patients who had engaged in sexual contact with their health care provider suffered from "mistrust of and anger toward men" and had more symptoms after termination of treatment. Feldman-Summers and Jones found harm done did not differ significantly between therapists and other health care providers and that those patients who had a lot of sex with their doctors were no more badly affected than those who had only one or two contacts.[3]

In the aftermath of an exploitative relationship, those left are hurt and angry and their new therapists find them to be so and this is deemed 'harm'. Others write novels glorifying and dramatising their experiences. Still more protest that their civil rights and privacy are being violated and want Medical Boards out of their lives.

Good research might compare like with like, those seduced and abandoned by their doctors with those who find themselves in a similar position after relationships and marriages with their lawyers or accountants have failed, while controlling for the condition for which they were consulting a health care provider.

We all have friends who are apparently happily married to persons whom they first met as patients. Several American and British studies have uncovered that 9-3% of doctors and therapists admit, in confidence, that they have had sexual relations with patients, but a great number of patients complain that their previous psychiatrists made sexual advances. The majority of reports are generated by repeat offenders.

Those who write reports should not assume that 'harm' is done just to underline that this activity is undesirable. They will stigmatise some patients by presuming them to be damaged when they might not be. There is no other legislation that prevents consenting adults from entering into relationships that may well fail.

Many attempts have been made to classify transgressing doctors in terminology which assumes a clinically accessible treatable "impairment".[4] Some Boards demand examination of doctors on the presupposition that offenders are 'impaired' in a way accessible to treatment. What they actually should say is that exploiters and serial offenders who believe that they are performing a good

service are of bad character and unfit to practice medicine.

Some of the lovesick doctors and most reasonable people are neither psychiatrically impaired nor immoral. When these modern day Eloises and Abelards declare themselves to be in love, they should acknowledge the situation and be given a chance to act responsibly. The law need not make pariahs of them. Appropriate medical care may need to be found for the patient. The couple might see an 'authorised person' for investigation and advice. They should agree to a cooling off period.

Capacity to consent might be evaluated taking into account the situation between them, the doctor's intentions, the patient's condition, and her knowledge of the doctor's prior marital and sexual history and the implications of that.

As the law stands, the doctor is forever at risk. The patient's new wife might change her mind some years later, if the marriage fails, and declare herself to have been improperly seduced. Although political correctness demands this position, not all doctors are seducers and not all patients are exploited. Gabbard suggests that any attempt to lump all the transgressing therapists into one politically correct category is reductionist and misguided.[5] The same must apply to patients. Some complainants, true and false ones, may be thrill seekers or sadists who are already planning to enjoy their revenge. Legislated procedures are needed to protect the doctor from a lover who turns vindictive, from a compensation seeker or an estranged spouse. Hell hath no fury like a woman spurned and everyone is reasonable during the courtship period.

Erotic transferences are also a source of danger. The unsophisticated Tribunal may take what the patient has said to others as evidence of the truth. Further reform of the Act is needed to anticipate the defence of a psychiatrist whose patient starts bragging to her friends that her doctor is in love with her. Such a patient may be making frequent or late night phone calls, stalking the doctor, turning up where he is eating out, threatening to kill herself unless he sees her after hours. Gutheil recommends that once the patient-therapist relationship and the anticipated transference becomes eroticised, the therapist should present the case to a colleague, supervisor, or consultant for input and perspective.[6] Such patients put about the notion that their doctors are in love with them. The HCCC and Medical Board seem to think that this type of patient is attractive and exploitable.

Persons afflicted with erotomanic beliefs can be convincing to the unwary. Therapy-induced 'false memories' are now recognised as confabulations.[7] Some medical tribunals are unaware of the range of psychopathologies with which psychiatrists have to deal in the course of their work.. In the past, lay members have not listened to the advice of experienced psychiatrists on the Tribunal. .

False allegations are a growing problem worldwide. The USA saw the nine-year ordeal of eminent psychiatrist, Jules Masserman, former president of the American Psychiatric Association, whose patient wrote a book called *You Must Have Been Dreaming*. She was indeed dreaming. When her allegations and those of the copycats were subjected to proper investigation and forensic procedures, Masserman was acquitted.[8][9]

Given its biases and regulations, can the Board deal with false allegations? Both theory and experience suggest not. An increasing number of my colleagues are being convicted and deregistered still denying that they ever did what they were charged with. Their alleged sexual offences had no witnesses, and no physical evidence was ever presented. The accused, but innocent, doctor is at serious jeopardy and the Board and its tribunals do not recognise the presumption of innocence nor rules of evidence.

The term, 'spectral evidence' originated in Salem in the last two decades of the seventeenth century. As more and more people were implicated in witchcraft by 12-year-old Abigail Williams and her cousins, less and less was independently observed.[10] No one saw the accused witches near the girls and they left no physical evidence of their activities. The ecclesiastical courts, biased towards protecting the church repeatedly found that it was not the witch herself that had done the act. The Salem Magistrates took the view that the ghost of the witch, her spectre, had visited at night leaving no trace. This was called 'spectral evidence,' a term that has come to mean not only that there is no evidence at all but also that there is no corroboration of what should have been

highly visible events. Convictions on spectral evidence are characteristic of moral panic.

Sex leaves DNA and pubic hair at a very minimum. Monica Lewinsky at twenty-one kept her proof and anyone who has proof can reasonably be seen as capable of producing it. The NSW Medical Tribunals pay little heed to Professor Edmond Locard's Exchange Principle which changed forever the investigation of crime in 1920:

Wherever he steps, whatever he touches, whatever he leaves, even unconsciously, will serve as a silent witness against him. ... Physical evidence cannot be wrong, it cannot perjure itself, and it cannot be wholly absent. Only its interpretation can err. Only human failure to find it, study and understand it can diminish its value.[11]

It is the doctor who wants to reclaim his civil rights, the presumption of innocence, rules of evidence, protection of the criminal law and is demanding standard of proof at 'beyond reasonable doubt'.

Doctors accused of sexual violations want proper investigation procedures and forensic services to look for physical evidence and, if there is none, to demand that the accuser withdraw. They want appeals on 'the facts' to the Court of Criminal Appeal, an avenue open to all mistrial criminals. This is only fair as the penalty is enormous, loss of career, reputation and livelihood.

The HCCC calls 'experts' who endorse the complainant's complaint. They call in 'peers' who attest to the bad character of the accused doctor and comment on the complaint itself which might be denied. Peers are doctors, not moralists. Expertise is not the issue, fairness is. In a criminal court the expert needs to have some expertise in the matter at hand. He signs a declaration and swears his evidence. Peer reviewers who practice character assassination are rarely recognised as true peers of the accused doctor. A peer reviewer may be not in the same specialty or sub specialty and, as well as that, he may be 20 years junior to the accused doctor. In the Tribunal courts, it is common practice to get advice from psychiatrists who effectively support the accuser's credibility while devaluing the accused doctor. Old colleagues, friends and rivals have been routinely used against an accused doctor.

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. Yet the Medical Tribunal has ignored its medical members and convicted on a two-two vote with the judge using a second, casting vote.

There is a precedent in *Farrell v the Queen*, (HCA 50 1998) which allows that an expert give evidence on 'reliability' of the complainant where a psychiatric condition influences it. The HCCC denigrates the possibility that the patient's borderline, histrionic and antisocial personality disorder predisposes her to make false allegations, misreport, misconstrue and misremember the past. Kiel believes that psychiatrists use their tools of trade to discredit the accusers.[12]

At common law, a verdict may be appealed to the Court of Criminal appeal if it appears unsafe and unsatisfactory. Appeals from the Medical Tribunal are allowed on points of law, not on the facts. But if 'facts' have been constructed without due process, and not in accordance with the rules of evidence, the conviction is likely to be unsafe and unreliable. Motivation to complain also should be subject to analysis and challenge. Revenge and money provide reasons for false allegations.

Is there a solution? Some of us are hopeful that the parliamentary inquiry will lead to reform. There are both structural and systemic problems. We need to decide what we want to forbid, and enforce it justly.

The HCCC performs two functions: investigating and prosecuting. I cannot see how the one organisation can do both without a conflict of interests. As much as a doctor owes a duty of care to his patient, the HCCC and Medical Board owe a duty of care to the doctor. The table below highlights some of the differences between the criminal code and the Medical Tribunals. It is as if 200 years of due process have been neglected in favour of the hoped for wisdom of doctors.

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COMPARISON OF CODES (Linked)

[1] *Final Report of the Review of the Medical Practice Act, 1998*.NSW Department of Health.

[2] Committee on the Health Care Complaints Commission (2001). *Inquiry into Procedures followed during Investigations and Prosecutions Undertaken by the Health Care Complaints Commission.* Legislative Assembly. NSW Parliament.

[3] Feldman-Summers, S. & Jones, G. Psychological impacts of sexual contact between therapist or other health care professionals and their clients. *Journal of Consulting and Clinical Psychology, 52, 1054-106 . 1984.*

[4] Schroener, G Assessment, Treatment, & Supervision of Professionals Who Engaged in Boundary Violations presented at the 1st Australian & New Zealand Conference on Sexual Exploitation by Health Professionals, Psychotherapists, & Clergy, 12 April, 1996 at the University of Sydney, Sydney, Australia. *http:// www.advocateweb.org/hope/rehabilitation.*

[5] Gabbard, G. Sexual misconduct. In *Review of Psychiatry. Vol. 13, pp. 433 -456,* 1994 Oldham and J. Riba, M. (eds.).Washington D.C.: American Psychiatric Press.

[6] Gutheil, Borderline Personality Disorder, Boundary Violations, and Patient- Therapist Sex: Medicolegal Pitfalls, *146 American Journal of Psychiatry 597,597-602* 1989.

[7] Confabulation and child abuse in Kaplan HI, Saddock BJ, ed. Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R). 3rd (revised) ed. Washington: American Psychiatric Association, 1990.p:1840.

[8] Barbara Noel with Kathryn Watterson *You must be dreaming* Poseidon Press New York 1992

[9] Masserman J. Sexual *Accusations and Social Turmoil: What Can Be Done.* Regent Press. 1994

[10] Rosenthal B. Salem Story: Reading the Witch Trials of 1692. Cambridge: Cambridge University Press, 1993.

[11] The Locard Exchange Principle. Edmund Locard (1877-1966) French Criminologist .1910.

[12] Kiel H. Sex, Discipline and Doctors: the New South Wales Experience. Law, Medicine and Criminal Justice, Queensland: Australian Institute of Criminology, 1993: *http://www.aic.gov.au/conferences/medicine/.*

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