ANDREW TOOK: It is 6.15 and welcome to the scientific meeting. My name is Andrew Took and this is my last scientific meeting as president before I hand over. It is nice to see you all here tonight and we have a good topic with which to conclude my presidency.

We have two distinguished speakers, Professor Jonathan Phillips and Mr Phillip Boulten, who are going to take us through the interesting area of sexual violations in regard to developments at the Tribunal level.

Our first speaker will be Jonathan Phillips who is a general and forensic psychiatrist with a lot of experience in both the public and private sectors. He has a busy clinical practice involving general and medico-legal psychiatry. I am sure many of you would know Jonathan through his work in the medico-legal area.

Jonathan is an ex-president of the Royal Australian and New Zealand College of Psychiatrists, an ex-chairman of the Committee of Presidents of the Australian Medical College and ex-chairman of the Specialist Medical Review Council. He has been a State Director of Mental Health and Chief Psychiatrist. He is a senior teacher within the Masters Programme in Forensic Mental Health at the University of New South Wales. He has considerable experience in the assessment and treatment of doctors. He has been an expert witness at the Medical Tribunal on a number of occasions.

Jonathan has a variety of other interests, including contemporary art and the creative process. He contributes each year to a Melbourne art forum called Art Think Art Shrink. Join with me in welcoming Jonathan Phillips tonight.

A/PROF JONATHAN PHILLIPS: Mr Chairman, ladies and gentlemen. It was perhaps 15 years ago when I first spoke on this complex and unfortunate topic at the Medico-Legal Society. To be asked to come back has prompted me to question whether anything significant or radical has occurred over the last decade and a half. I fear not. But let me take a further look at the topic through 2014 eyes.

However, before doing so, it is important to put sexual abuse of patients by members of the medical profession in some sort of historical perspective.

The problem unfortunately is hardly new. Hippocrates was well aware of it when he crafted his Oath circa late fifth century BC. The Oath states in part and I quote:

"In every house where I will come, I will enter only for the good of my patients, keeping myself free from all intentional ill-doing and all seduction and especially from the pleasure of love with women or men be they free or slaves."

Whilst Australian doctors do not currently swear a Hippocratic Oath, the Code of Ethics promulgated by various divisions of organised medicine takes a very similar position.

Simply there is in effect a total prohibition on sexual encounters between medical practitioners and their current patients. I place the word "current" in the sentence because I detect some ambiguity when it comes to sexual contact with former patients. I hasten to point out that my own College would view the prohibition as being life-long, rather than for the period of therapeutic contact with the patient or client.

Whilst I think it would be correct to state that medical practitioners accused of sexual contact with patients have come from just about every craft group within medicine, the problem appears to be significantly greater among psychiatrists. This will require a degree of exploration.

Indeed, psychiatry has been termed, and I quote "the perilous profession", and for understandable reasons.

But let me first look at the statistics as far as it is possible. Taking a period of approximately 10 years, I estimate that about five medical practitioners each year have faced hearings before the Medical Tribunal on the basis of boundary violations. I fear that this is but the tip of the iceberg. If I am correct, sexual interaction between medical practitioners and patients will be rather more common than most of us want to believe.

Additionally, the medical literature supports the very reasonable view that almost without exception the encounters are highly destructive to the medical practitioner and to the patient or former patient.

The first point I want to make this evening is that there is a very great power differential between the medical practitioner and the patient. This is probably heightened in the often intense interaction between psychiatrist and patient, where strong transference and counter-transference forces are likely to prevail.

In simple form, transference occurs when a patient imbues the psychiatrist (or other medical practitioner) with powerful feelings which started elsewhere. Counter-transference is a similar process but where the therapist has powerful feelings for the patient which again take origin elsewhere. Transference and counter-transference can include all sorts of feelings, but they will commonly be sexual in type. Because such feelings are thought to begin at an unconscious level (that is beyond everyday awareness) they are poorly understood by either party.

Much of traditional psychiatry (particularly psycho-therapy) exists as a fairly intense emotional interaction between patient and psychiatrist. This becomes a fertile breeding ground for strong, but poorly understood feelings. In this medical micro-climate, it is not unfair to adopt the phrase, as I said before, the “perilous profession”.

Whilst the following is not offered in any form as an excuse for sexual relationships between a medical practitioner and patient, such relationships involve two persons, and can be driven overtly or covertly by both parties. I intend to focus on the medical practitioner predominantly, but in fairness, it is reasonable to consider the other side of the dyad as well.

Most medical practitioners who enter a sexual relationship with a patient are men, but this is not always the case. The medical practitioner may be young and naïve, at the high point of his career or at the end of his professional life. I do not think there is useful evidence to suggest any vulnerable period in the cycle of professional life. Although I am going to use the male gender as I continue, this is not exclusive.

It was my view 15 years ago that offending medical practitioners might be divided into three broad groups but with some overlap. I have no reason to change this opinion. Simply it has been said that the medical practitioner who

becomes involved in boundary violations is either sad, bad or mad.

There is a well recognised link between a doctor suffering a mood disorder and sexual violations. However, it is probably not as common as some may think. Additionally, a medical practitioner coming before the Medical Tribunal will sometimes try to hide behind the appellation of a mood disorder (most commonly a bipolar mood disorder). Clinical and legal skepticism are always important.

Notwithstanding the caveat, there is no doubt that from time-to-time a medical practitioner will become depressed, usually in a context of overwork, marital stress or break up, or loss of any other type. In this situation it becomes all too easy to seek affection from a readily available person and this will often be a patient. The medical practitioner is likely to have a poor understanding of the psychodynamics of the situation and it becomes a short step to sexual contact.

As problematic as this situation may be, the next one is much worse. I focus here on the psychopathic medical practitioner who believes himself to have a particular right with his patient, and not uncommonly, to have special (narcissistic) power which he holds will assist his patient. Persons within this group will often consciously set out to seduce a patient attractive to them, using charm and power as sexual tools. There have been a number of high profile cases before the Tribunal where medical practitioners (of both genders) have entered sexual relationships with multiple patients, sometimes within the same period of time. The main feature with this group of medical practitioners is an abnormality of personality with a grandiose/narcissistic sense of power which becomes very obvious.

The third group of medical practitioners is far smaller. These persons are highly disturbed from the psychiatric point of view and sometimes suffer a psychotic illness. The offending practitioner is likely to have delusions of grandeur or even to experience psychotic voices and instruction directing him to pursue sexual interaction with a patient.

My second point therefore is that there is no obvious stereotypic medical practitioner who is likely to embark on

the sexual journey of destruction, not only in relation to himself but also in relation to the patient or former patient.

With considerable caution I will now attempt to look at features within the patient which may contribute, at least to some extent, to the sexualised pathway.

Every psychiatrist will tell you they have encountered patients who overuse sexual channels of communication. Perhaps the most likely patient to do so will be the person with a so-called borderline personality disorder or at least strong borderline features within the structure of personality.

The patient most commonly is a younger woman. She is often highly intelligent and attractive. For a variety of reasons she uses her good looks and her charm as predominant mechanisms of communication. The patient does this because more mature methods of communication have failed to develop. The patient may dress in a somewhat provocative and inappropriate manner (at least in terms of her attending therapy), she will tend to use flattery in her verbal interactions and she will give hints of sexual desire (or a wish for greater intimacy).

Take these patient characteristics and introduce them into the situation where the medical practitioner is depressed, psychopathic or deeply disturbed and anything can happen. The mix, quite frankly, is inflammatory.

Perhaps the most vulnerable and most needy group of women who experience delayed personality maturation are young women with eating disorders. Despite their obvious thinness, this group of women will often relate in therapy in a pseudo-sexual manner which is hard to understand or avoid. It is not surprising therefore that male medical practitioners working in this vexed area of psychiatry are particularly at risk.

The third point I wish to make is that all medical practitioners, particularly those of male gender, should be aware of the distorted and sexualised methods of communication that might be adopted by a particular group of patients. Foreseeability is a valuable tool. It is better to be on-guard, than sorry.

Frankly, I do not think the medical profession has made significant gains in 15 years to stamp out or even reduce the sexual abuse of patients. Are there things which might be done to improve the situation?

However, before trying to explore methods to reduce the problem, let me touch on the damage that inevitably comes to the offending medical practitioner and if time permits, to the patient victim.

It almost goes without stating that the Medical Tribunal has traditionally taken a hard line on sexual transgressions. The general pattern is that the medical practitioner who is found guilty of a boundary violation will no longer be allowed to continue in medical practice (at least as a doctor). Few would argue with this.
The medical practitioner may have the opportunity of returning to the Tribunal at a later time and seeking return of his right to practice.

This is a very hard road to follow. Usually the ex-medical practitioner will face the hurdles of having to prove that his therapy has been successful, that he no longer suffers from a diagnosable psychiatric disorder or personality disturbance, that he has full insight into what happened and that he is properly contrite.
Additionally, the ex-medical practitioner will need to demonstrate currency of medical knowledge.

As you might imagine much will rely on the advice of medical experts who have been instructed to examine the ex-medical practitioner. The Tribunal was conceived, as I understand it, as an inquisitional forum and does not operate in an adversarial manner. However, this sometimes will not prevent a stand-off by the experts who seem to bring benefit to no-one. It would serve the process better, I believe, if there could be joint experts appointed by both parties to undertake the process.

It is not difficult for the expert to determine whether or not an ex-medical practitioner continues to suffer from a diagnosable psychiatric disorder. Should that person have ongoing active psycho-pathology, then he should not proceed further. The problem arises however with the hurdles which follow. The Tribunal almost always wants the expert to determine whether the ex-medical practitioner has full insight into the boundary violation and why it occurred.

Sometimes it is obvious to that person what the reasons for transgression were. More commonly there will be little insight and the ex-medical practitioner will struggle to understand why things happened, even with the best of therapy. There is, of course, a belief that in the absence of full and true insight the offending party will do it again. I am less sure that this is really the case. It seems to me, from long contact with people in this situation, that a hard earned, practical and pragmatic understanding is usually a major protective factor.

The next hurdle is even more problematic. Understandably the Tribunal wants to be certain that the ex-medical practitioner is properly contrite. Further, it is common for the Tribunal to delegate this task principally to the expert psychiatrist. Frankly, I doubt that a psychiatrist, even when greatly experienced, has the skill or capacity to make useful comment about contrition. Even worse, how does the expert make a meaningful distinction between contrition and pseudo contrition? I can state categorically that the ex-medical practitioner who will demonstrate maximum contrition is the psychopathic person or at least the person with marked disturbance of personality. That person will fool the expert and the Tribunal. In keeping with this, I hold significant doubt that the hurdle of contrition has legal or scientific merit.

The final hurdle is more obvious and more practical. This relates to medical knowledge - currency of practice. Unfortunately attrition of knowledge (medical, legal or otherwise) happens very rapidly. We all know this after a long holiday or a sabbatical break. The ex-medical practitioner may be away from his field for a long time. He will lose knowledge and skills and will find it hard to keep up with the cutting edge of his specialist group.

Additionally, it is hard for the ex-medical practitioner to attend specialist meetings, courses of instruction and so on.

Almost invariably the ex-medical practitioner will have difficulty proving to the Tribunal that he is up-to-date and/or competent. Directions made by the Tribunal will not uncommonly be that the re-registered doctor must find work in a hospital setting. I understand the wisdom of such a direction, but hospital administrators do not usually have jobs to give away. Additionally, the very same

administrators are wary of appointing an out-of-date medical practitioner to any position. The hospital has no wish to put itself at risk.

So stepping back a bit, we currently have a system in operation which does a fair job in protecting the public but is stacked against rehabilitation of the ex-medical practitioner. Perhaps this is a reasonable end point. If this is the case, we should proceed no further. Simply, if the Tribunal finds the doctor to have broken such important ethical boundaries, then all is over. The person will not return to practice. Case closed!

However, if our society at large, the administrators of justice, and your profession and mine believe that professional rehabilitation is worthwhile, then we should rethink the process from the beginning. This would be a complex and vexed task. It would rely on separating those persons capable of rehabilitation and reform from those who are not. Essentially, this might come down to a separation of those persons suffering from a treatable psychiatric disorder and those persons who have a fixed and unshakeable disturbance of personality. Further, it would require the justice system and the medical profession (the latter through its specialist colleges and medical institutions) to construct a thorough and highly managed rehabilitation pathway where the person enters that pathway at an early time and before professional currency is totally lost. Obviously if the person concerned was to break that formal arrangement in any manner, then he would leave the profession forever.

Whilst I think a rehabilitation pathway of this type might be developed, the task would be complex and the various players would need high motivation and co-operation. To speak further about such a pathway is beyond the brief of tonight's discussion.

I am a great believer in collegial opinion. I took my brief offering for tonight to my peer review group, all highly esteemed psychiatrists who are known to many of you. The universal message was clear. The criminal law when dealing with a sex offender goes to great trouble to consider factors of possible mitigation. There is a strong perception within the senior ranks of my profession that such a process is less obvious when matters go to the Tribunal. I really do not know whether this is the case,

but it is something worth contemplating. My colleagues advise additionally that far too little effort is placed currently on the rehabilitation of that group of doctors who are unlikely to offend again.

The old adage, “prevention is better than cure”, has real attractions. I am unconvinced currently that our medical schools, specialist colleges, health services and hospitals pay nearly enough attention to the teaching of ethics. We know that good and enduring education is best built by the process of repetition. The medical student should come to know about boundary violations early in his tertiary education, and the risk to patients and doctors needs to be highlighted as the student passes along the educational pathway. Further, it should be required that each College educational program should give proper attention to the topic and make clear the damage that occurs to each party, and also to highlight the grim penalties which will apply. The same needs to be a feature of all health service and hospital educational programs. Sadly, this is not the situation currently. My belief is that if our students and medical practitioners were better aware of the problems of boundary violations, better aware of the consequences of such acts both in terms of damage and penalty, and were better equipped to speak up and seek counselling/guidance/treatment when necessary, then much pain and suffering might be avoided.

Can change come about? I doubt this will occur in the current environment in New South Wales and for that matter in other states or territories. If there is any desire for change (particularly in relation to professional rehabilitation) and the guts to bring it about, then it is time for a working party to be established which includes the Australian Medical Board, the prosecuting authorities and key members of the medical and legal professions. I would love to see this happen, hopefully as a first step in improving a process which is currently problematic.

Thank you.