**MR ANDREW TOOK:** Let me introduce you to our second speaker, Mr Phillip Boulten, Senior Counsel. Phillip, as most of you will know, is a very senior criminal practitioner. He appears regularly in courts at all levels in the criminal justice system and in many high profile trials. We have seen him on television on the seven o'clock news on a number of occasions heading off to court. He has a special interest in matters involving national security issues and has defended many people in regards to ASIO investigations and the like. He appears at all levels of inquiries and inquests and he has a developing practice in disciplinary tribunals, the Administrative Decisions Tribunal and of course the Racing Appeals Tribunal.

Phillip is the former president of the NSW Bar Association, the former chair of the Bar Association, Professional Conduct Committee, a member of the Bar Association and a member of the Law Council of Australia's Criminal Law Committee. Join me in welcoming Phillip Boulten.

**MR PHILLIP BOULTEN:** Good evening ladies and gentlemen. Thank you Mr President. It is a very vexed part of my practice to represent doctors. Often it is when they fall within the first category of Jonathan Phillip's trichotomy – bad. That is when they are charged with criminal offences, usually sexually related.

Tonight when we are discussing sexual boundary violations, I am going to put the "bad" category to one side. I will talk about violations that are contrary to ethical considerations that are likely to lead to professional disciplinary proceedings, but which do not constitute criminal offences. There are many more of those than the former category. Sometimes it is very difficult to discern the difference and often the difference will be in the adjudication. In the event I will concentrate on obvious consensual relations between patients and doctors or patients' family and doctors.

There has been some change in the legal basis for dealing with professional boundary violations. This is as a result of the introduction of the National Medical Profession. Up until the end of 2011 the Medical Council of New South Wales had a policy which dictated what was acceptable and what was unacceptable in doctor/patient relationships. Under the State policy then the rule was that there was to be absolutely no sexual connection between doctors and

their current patients. The termination of the doctor/patient relationship prior to sexual activity might have raised a defence to any allegation in a professional misconduct context. However the strength of the defence, said the policy, would be dictated by consideration of factors that included the degree of dependence between the doctor and the patient, the evidence of exploitation in the nature of the relationship, the duration of the professional relationship and the nature of the services provided by the doctor to the patient.

Hence it was, in theory, possible for a doctor to be in trouble for having a sexual relationship with a former patient but now it is much more obviously verboten. Under current guidelines that have been established under s39 of the Health Practitioner Regulation National Law Act, the National Law, it is now much clearer that it is always inappropriate, usually completely against the law to have a sexual relationship with a patient and it will usually be so to have a sexual relationship with an ex-patient.

Under the Good Medical Practice Code of Conduct for Doctors in Australia, chapter 8, section 8.2, professional boundaries are said to be:

> "... integral to a good doctor – patient relationship. They promote good care for patients and protect both parties. Good medical practice involves:
>
> 8.2.1 Maintaining professional boundaries.
>
> 8.2.2 Never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient.
>
> 8.2.3 Avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress."

It is very clear now that doctors should almost always avoid having any sexual and probably personal relationship of deep and intimate meaning with those who are close to their patients, as well as their patients themselves. I am not sure whether this is going to result in a different

pattern of people being dealt with by the Medical Tribunal or by Professional Standards Committees of the Medical Council of New South Wales, but there are certainly early signs that there might be.

One of the first big cases that I had involving doctors who step out of line was acting for a psychiatrist, 15 years ago, whose solicitor is in the room. This was a bad, not sad, but very attractive personality who had a very extensive practice in the suburbs. His wife was very suspicious and with good reason. She thought that he was having an affair, but she was wrong. He was having many affairs. She organised for a private detective to put a video camera in the ceiling of his consulting room. During the course of a week it filmed six patients having quite consensual sex with their psychiatrist in the consulting room. The wife was livid. She did not go to the Healthcare Complaints Commission to complain, she went to Channel 9 and footage of these liaisons was aired on *A Current Affair*, which led to an influx of women coming forward saying "this happened to me as well". However some of them also said they actually did not consent when he did this or that or something else. He
handed in his registration and through the geniuses who appeared for him he did not go to gaol, but barely missed out. This medical practitioner is atypical but simply it would seem because of volume.

Recently I acted for a very well regarded (at least by his patients) cosmetic surgeon who, amongst other things, realised that Botox has particular value. He maintained a sexual relationship with a patient by, amongst other things, providing free Botox treatments to her.

These things are obvious. They are exploitative, degrading, do no good to the patient, are harmful to the patient and harmful to at least one of those doctors. The other one seemed to be living quite nicely despite the television show.

I have done a review of the cases before the Medical Tribunal over the last two years and agree with Dr Phillips' assessment about the number of people who get caught up in this even now. Seven people over the last two years (2012-13) have been dealt with at the Medical Tribunal for breaches of professional boundaries in one way or another.

I was interested to determine whether or not there was any clear pattern of disposition of these cases. It does seem in some instances the Tribunal has been very understanding of the plight of the doctors concerned - more understanding than they have been of my clients I must say.

Even a quick review of some of these cases is of interest. Recently a psychiatrist was disqualified for an 18 month period in circumstances where he embarked on an inappropriate sexual relationship with two patients. One patient had been diagnosed with a borderline personality disorder at the first consultation when she was 25 years old. A relationship ensued that continued for some time before being discontinued. That patient was then given employment by the doctor for a few hours a week. He later upped the ante with the pay to the point where he provided $20,000 to her for work that was performed in the practice. Subsequently he had some medical problems that led him to disclose the relationship to his treating doctors who had an obligation to report it. This is one of the most common ways that doctors come to notice, because they share with their colleagues, either professionally or personally what is going on. These doctors then have an ethical and legal duty to report this to the appropriate authorities. He got 18 months.

In a sad case a general practitioner, who ran a practice in the inner suburbs of Sydney, struck up a relationship with a patient. The doctor was female and not young. She was in an unhappy relationship herself and she came into contact with the patient, a man, also not young, and whose wife was terminally ill. She treated the wife at the end of her life. She became friends with the husband who had his own problems and attended his own psychologist. They started going out to concerts. They became friends. He went up to her weekender. They spent weekends together. Then he got something wrong with his throat or his chest and she started to provide medication to him. She became concerned about his psychological welfare and referred him to another psychologist. Then their relationship became fraught. Sadly, he committed suicide sometime later and this poor woman was devastated. The Tribunal reprimanded her and put her on conditions.

Another doctor to receive a reprimand was one dealt with in 2012 for having an inappropriate sexual relationship with a

patient. The doctor claimed the patient had pursued him, a common theme from doctors that does not seem to go very well in the Medical Tribunal. The doctor claimed the patient had “jumped” him over several sessions. The Tribunal nevertheless had some sympathy for this relatively young doctor reprimanding him and placing conditions him on.

Also in 2012 a doctor, who was a paediatrician, appeared before the Tribunal. I should tell you, that after psychiatrists, it is gynaecologists and paediatricians who are the most likely to become involved in inappropriate boundary violations. The paediatrician took up with the mother of two of his young patients – a little boy and a little girl. Their mother and the paediatrician became close, kissing and cuddling at the end of consultation sessions. They progressed to outings to the national park and eventually to having a sexual relationship. Then it all went pear shaped. That doctor was given a reprimand with conditions.

There have been people that have done worse but in the last two years or so reprimands have been relatively common. There have been disqualifications for six months and 18 months with the longest being three years. This is apart from my cosmetic surgeon who he did considerably worse but I am not counting my failures.

There is a pattern but it is not universal. It is where doctors are isolated, such as general practitioners in single or small practices; where practitioners have a significant power imbalance, such as psychiatrists and psycho-therapists; and where drugs are involved there is an overlap as well.

Doctors should be wary of patients who ask for out of hours consultations and those who wish to spend a little longer in their consultations. On the other hand doctors who start to tell their patients their life story and who start to let their own guard down become emotionally connected to their patient. A hand on the shoulder becomes a hand on the knee and that becomes a hug and the next thing they are off having dinner and who knows what.

So there are warning signs that we can all see looking at it from arm's length and that it can happen – dare I say it – to anybody. So you do need to be aware that it can happen

in your own room and especially if you are a male. As Dr Phillips has told us, it is not unknown for women to be involved in these problems but it is almost always male doctors who are getting into this sort of trouble.

I think that I was really supposed to focus on whether there has been any change in pattern since the new guideline came in. It is difficult yet to say but what is clear is that there will be a quite hard line taken on relationships with family and the female practitioner that I spoke of who entered into the relationship with the husband of the deceased patient is as good an example as I could find to demonstrate that.

But there is a challenge of which everybody is no doubt on notice. If you do find yourself in this sort of trouble, the worst thing to do is to obfuscate. Telling the HCCC something that is not true or which is distorted or which does not give a proper indication of the nature of the problem is just as much trouble as having had the relationship in the first place. As you can see, if it truly is a human story that can be subjected to empathetic review, there is some hope that continuation in practice will occur, although there is no guarantee. I will finish up here.