Professional Sexual Misconduct
As a Breach of Trustworthiness

A Moral Typology of Doctors
Who Have Engaged in
Professional Sexual Misconduct

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Declaration

This is to certify that:

I. This thesis contains only my original work towards the PhD

II. Due acknowledgement has been made in the text to all other material used

III. The thesis is less than 100,000 words in length, exclusive of tables, bibliographies and appendices.
Abstract

The importance of trustworthiness in the medical profession seems obvious and beyond question. Despite the importance of trustworthiness for the medical profession, there is no established understanding of what the standards of trustworthiness must be in the context of the doctor – patient relationship. If the medical profession does not hold a shared understanding of the expectations of trustworthiness and its standards, the community it serves certainly cannot.

An established understanding of trustworthiness is necessary as both a normative standard, and as a basis for understanding the ways in which professional misconduct deviates from the standards expected of the medical profession.

I consider philosophical examinations of trustworthiness, and conclude that it is only those versions of trustworthiness which require regard for the preferences of the truster, and an ability to communicate the limits of their own trustworthiness in the trustee that are appropriate for the medical profession. I accordingly define standards of trustworthiness as they must be considered for the medical profession.

Professional sexual misconduct and the ways that professional sexual misconduct is understood as a failure of professional conduct are examined. I argue that existing moral frameworks, which are based upon an understanding of professional sexual misconduct as a failure of informed consent, are problematic. I argue that professional sexual misconduct is readily understood as a breach of trustworthiness, and examine the ways that professional sexual misconduct breaches standards of trustworthiness. I therefore propose the Framework for Trustworthiness in Doctors, which demonstrates potential moral implications of different forms of professional sexual misconduct.

Finally, I demonstrate application of the Framework for Trustworthiness in Doctors to four cases of professional sexual misconduct. I argue that application of this Framework has utility in considering such cases, and reflects the mandate of the Medical Board of Australia as well as reasonable community expectations. I conclude by proposing other potential uses for the Framework, and the research necessary to justify these applications.
For Charlton ‘Watty’ Mead

Who taught me that there is no greatness

where there is no simplicity, goodness and truth
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I am fortunate to be well loved. I hope that the people who I love know how much, and that they make all the difference.
“Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relationships with both male and female persons, be they free or slaves.”

Hippocratic Oath [1]

“You must trust and believe in people or life becomes impossible.”

Anton Chekhov [2]

“Don’t have sex with your patients, you will only disappoint them”

Frieda Fromm-Reichmann [3]

“Trust me, I’m a Doctor”
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Introduction

Trust, Trustworthiness, and the Medical Profession

The importance of trust in the doctor-patient relationship seems beyond question. Patients must trust their doctors to be able to disclose highly personal information, allow intimate physical examination, undergo invasive investigations, ingest potentially toxic medications and undergo surgical procedures. If history taking, physical examination, investigations and treatments are necessary for optimal healthcare, then trust must also be necessary for optimal healthcare.

The importance of trust for the provision of healthcare has been emphasized by the recent literature examining levels of trust, and the factors influencing levels of both interpersonal and institutional trust in the medical profession [4-9]. Some authors have argued that levels of trust in the medical profession are being harmed by changes to healthcare systems, most notably Managed Care in the United States [4-7], and others have suggested that scandals involving unprofessional conduct by doctors, when publicly portrayed in the media, have also act to reduce levels of trust in the medical profession [8, 9]. Although there are widespread concerns that levels of trust in the medical profession are declining, these have been countered with the argument that patients continue to seek healthcare from doctors, even when alternatives are available [10].

Although there is some debate, then, about whether levels of trust in the medical profession are declining, there is a consensus that trust in the medical profession is of fundamental importance. This assumption, and the associated interest in maintaining high levels of trust in the medical profession must be counter balanced with an awareness that trust is inherently associated with risk [11, 12]. Trust is not always responded to with trustworthiness, and in healthcare this can have particularly dire consequences.

I argue that the expectation of trustworthiness from the medical profession must be expected before the expectation of trust from patients can reasonably be established. There is undoubtedly a great deal of trustworthy conduct within the
medical profession. Patients present for healthcare that meets and exceeds their expectations every day. It could readily be argued that established systems of medical education and professional codes promote trustworthy conduct, and that the systems which regulate the medical profession respond to, and minimise, untrustworthy conduct. The accepted importance of trustworthiness in the medical profession belies the fact that there is no established understanding of what it is to be a trustworthy doctor.

In the absence of established standards about what it means to be trustworthy as a doctor, each doctor may have their own, idiosyncratic view. One doctor (a surgeon) might believe that it is their technical competence which renders them trustworthy, while another might believe that it is their adherence to professional codes and regulations. Another doctor might believe that it is their personal religious beliefs which make them trustworthy, while another might believe that they should be considered trustworthy simply because they hold a medical degree. Without defined standards of trustworthiness, there can be no shared understanding within the medical profession about what trustworthiness must be.

If the medical profession does not hold a shared understanding of the expectations trustworthiness and its standards, the community it serves certainly cannot. This understanding of what each patient can expect from their doctor, as well as what the community as a whole can expect from the medical profession would be invaluable. Patients cannot be expected to know or understand all the professional codes that guide each doctor’s conduct. Knowing what they may expect from their doctor in terms of trustworthiness would be more understandable from a lay perspective and would reflect community expectations more directly than complex professional codes and clinical guidelines.

Established standards of trustworthiness for the medical profession would also help us to further understand unprofessional conduct. If there was an established understanding of what the standards of trustworthiness should be, then professional misconduct could be understand in terms of how conduct deviated from an established moral framework. This moral framework, and the deviations from it,
could be used in conjunction with existing approaches for the examination of professional misconduct, as I will argue.

**Professional Sexual Misconduct in Australia**

Sexual behaviour between doctors and their patients has been prohibited in Australia since the 1980’s, at that time by state and territory medical boards. The prohibition is now maintained by the national Medical Board of Australia, which is also charged with responding to notifications from the community about potential cases of sexual behaviour between doctors and their patients.

The prohibition of sexual behaviour between doctors and their patients is based on concerns about the harmful effects of this conduct on patients. These harms result both when the patient has the experience of being exploited, but also because a sexual relationship between a doctor and their patient may distract from, or even preclude the treatment of the condition which the patient initially sought healthcare for. Both the experience of being exploited, and the undermining of healthcare initially sought, may be particularly harmful when the patient is seeking psychiatric and psychotherapeutic care. Although it has never been demonstrated that all patients involved in sexual behaviour with their doctor will be harmed by this behaviour, studies have repeatedly shown that the majority of patients are seriously harmed.

It may be argued that patients who are psychologically vulnerable, due to previous experiences of exploitation, are more vulnerable to harms consequent to sexual relationships with their doctors. However, even these very vulnerable patients have never been demonstrated to always be harmed by these relationships. Importantly, however, there is no way of predicting which patients will not be harmed by a sexual relationship with their doctor. Consequently, the prohibition is based on the expectation that to protect the community as a whole, sexual behaviour between doctors and their patients is prohibited for all.

Despite this prohibition, the Medical Board of Australia continues to receive notifications from the community about sexual behaviour between doctors and their patients. The quote which I have included from the Hippocratic Oath, above,
suggests that this is not a new concern. The persistence of this conduct despite the now established prohibition results in harm beyond individual patients. The community’s perceptions of the medical profession are influenced by the often highly publicised cases of professional sexual misconduct, and the repercussions of this cannot be underestimated.

Beyond the harms resultant from sexual behaviour between doctors and their patients, these relationships can be seen to be ethically problematic because of the fiduciary nature of the doctor - patient relationship. The doctor who pursues a sexual relationship with their patient prioritises their own interests over those of the patient’s healthcare.

**The Framework for Trustworthiness in Doctors**

In this project, I will argue that sexual behaviour between doctors and their patients remains a serious challenge for the medical profession. I will argue that although the ethical framework of the Medical Board of Australia’s declared role of protecting the public [13] is consequentialist, there are other factors guiding the response of the Medical Board of Australia in its responses to doctors who engage in professional sexual misconduct.

In particular, I will describe the influence of Glen O. Gabbard’s psychodynamic understanding of doctors who engage in sexual relationships with their patients [14], and argue that his framework has been applied in ways that Gabbard did not intend. In Australia, the majority of professional sexual misconduct hearings include testimony from a psychiatric expert witness who is often the treating doctor [15]. This psychiatric testimony presents the perspective of the doctor who engaged in professional sexual misconduct according to an illness model, often with the argument that the developmental crisis or illness which was occurring at the time of the professional sexual misconduct is resolved or treated, and that the doctor consequently poses no further risk to the community. Accordingly, it is argued that the doctor has a right to continue practicing.
I will also describe the ways that the Briginshaw Principle, an Australian legal principle [21], requires a higher standard of evidence in cases of professional sexual misconduct. This legal principle also emphasizes the doctor’s right to practice. I will argue that the consideration of the doctor’s psychodynamic motivations and the influence of the Briginshaw Principle are potentially problematic when applied to cases of professional sexual misconduct if these are not acknowledged to the community. I will also suggest that there is an absence of a declared moral framework for use when considering both the ways that professional sexual misconduct deviates from expected standards of conduct, and the ways that the doctor must address these deficiencies.

I will propose a new framework based on the ethical standards of trustworthiness. I will argue that this Framework for Trustworthiness in Doctors is congruent with reasonable community expectations of the medical profession. I will argue that this framework has potential value as a normative set of standards guiding conduct, in the education of doctors as to expected standards of conduct, and also as a tool which may be used when considering doctors who have engaged in professional sexual misconduct. I will argue that the Framework for Trustworthiness in Doctors may be used in conjunction with the existing legal requirements in Australia, including the Briginshaw Principle, and synergistically with models enabling psychodynamic and psychiatric assessment of the doctor.

**Nomenclature**

Sexual behaviour between doctors and their patients occupies as broad a spectrum as sexual behaviour does in the rest of the community. It may range from verbal comments to sexual intercourse. The sexual behaviour may occur with the apparent consent of the patient, without this apparent consent, or even forcibly. Although the overwhelming majority of cases of sexual behaviour between a doctor and a patient are constituted by a male doctor and a female patient, there are cases in which the doctor is female, and also same sex dyads.

Sexual behaviour between doctors and their patients has been referred to by a number of terms. Doctors who acknowledged sexual relationships with their patients
were, as recently as forty years ago, referred to as “erotic practitioners” [page 1324, 16]. More recently, the term “boundary violations” has come to be used almost as a pseudonym in referring to sexual behaviour between a doctor and their patient. This term is problematic.

Boundaries are described in the psychiatric literature, predominantly, as “the edge of appropriate, professional behaviour” [page 89, 17]. Although these concepts have clear implications for all medical specialties, the literature regarding boundaries has very much focused on the psychotherapeutic setting. In this way the term “boundary violations” when referring to sexual behaviour between doctors and their patients might both be less accessible to non-psychiatric doctors, and also imply limitation of the conduct to the psychotherapeutic relationship.

Secondly, the term is problematic because not all boundary violations are sexual in nature. Gabbard [page 253, 18] defines boundary violations as “transgressions that are potentially harmful to or exploitative of the patient”. These transgressions need not be sexual in nature. The doctor who contrives to financially benefit from their relationship with their patient, beyond an agreed fee for care, through the patient’s financial advice, for example, is clearly behaving exploitatively. This conduct may be associated with sexual behaviour but is not sexual in itself.

For both these reasons, I will not use the term “boundary violations” to refer to sexual behaviour between a doctor and their patient.

The term “professional sexual misconduct” is now used by the Medical Board of Australia to refer to all sexual behaviour between a doctor and their patient. Professional sexual misconduct is described as any sexual behaviour between a doctor and their patient, “regardless of whether the patient has consented” [19].

The term “professional sexual misconduct” acknowledges the now well established prohibition on sexual behaviour between doctors and their patients in Australia. It is a legal term contained within the *Health Practitioner Regulation National Law Act 2009* [20]. Use of this term could be seen as presumptive that all sexual behaviour between a doctor and their patients is morally, as well as legally wrong. This is not
my intent. I hope that the reader will be able to understand that I use this term only because it is consistent with the language used first by the state and territory medical boards and now the Medical Board of Australia. The ethical implications of professional sexual misconduct and the doctors engaged in this behaviour are the subject of this project.

**Overview of Chapters**

In Chapter One, I will examine the evidence of the harm caused by professional sexual misconduct. I will argue that these harms extend beyond the patient engaged in the behaviour, and include the community which seeks to receive care from the medical profession, and the medical professions itself. I demonstrate that there are major methodological concerns associated with both types of studies used to attempt to estimate the community prevalence of professional sexual misconduct. Regardless of these concerns, it is clear that professional sexual misconduct remains a significant concern for the community, with the continued notifications made to the Medical Board of Australia representing an underestimate of the prevalence of this conduct in the community. Community responses to professional sexual misconduct are, in this context, particularly important to prevent further harms to patients involved, the community, and the medical profession. The perception that professional sexual misconduct is not being responded to in ways that reflect reasonable community expectations may well compound the harms done by the professional sexual misconduct itself.

In Chapter Two I examine the current community responses to notifications of professional sexual misconduct. I note that the Medical Board of Australia’s declared role is the protection of the public, an apparently consequentialist ethical framework. I argue that this role is at times in conflict with two other perspectives on professional sexual misconduct.

Firstly, in Australia, use of the psychiatric defence has escalated in recent years. The psychiatric typologies of doctors who have enacted professional sexual misconduct are now in use well beyond what was intended by the experts who developed these typologies. The use of these typologies is understandable in that the sick role has the potential to reduce some moral culpability for doctors who are
highly motivated to retain their right to practise. The doctor’s right to practise may conflict with the community’s right to safety, and the use of psychiatric defences may therefore be in competition with the community’s right to safety.

Secondly, in Australia, the *Briginshaw Principle* [21] must be applied to cases of allegations of medical misconduct. According to this principle, the standard of evidence required to prove guilt is higher than would normally be applied in civil cases. Again, this principle reflects the serious implications of de-registration for a doctor.

I argue, therefore, that the declared purpose of the Medical Board of Australia, to protect the public, is tempered with a rights-based approach reflecting the doctor’s right to practise. I am critical of the application of two conflicting ethical models, and the consequent variability in their application across cases. I am also concerned that the lack of transparency in declaring the use of a rights-based approach is not consistent with reasonable community expectations or the stated role of the Medical Board of Australia.

In Chapter Three I argue that professional sexual misconduct should be considered according to an ethical framework, and examine those in use currently. There are two major ethical arguments used to describe professional sexual misconduct; the argument that professional sexual misconduct is unethical because informed consent cannot be obtained for sexual relationships between doctors and their patients, and the argument that professional sexual misconduct is exploitative. I argue that both ethical arguments are problematic in terms of being able to offer a comprehensive and consistent typology of doctors who have engaged in professional sexual misconduct.

The basis of the informed consent ethical prohibition against professional sexual misconduct is the argument that there is a significant power imbalance inherent to the doctor - patient relationship, and in the context of this power imbalance, informed consent is not possible. I am critical of this argument on the basis that;

1. Use of an informed consent framework implies that the responsibility for professional sexual misconduct is shared by the doctor and the patient
2. Use of an informed consent framework suggests that the patient must be 'incompetent' to some degree
3. Use of an informed consent framework does not enable consideration of professional sexual misconduct and the 'slippery slope'
4. Use of an informed consent framework can only offer a categorical classification of professional sexual misconduct
5. Use of an informed consent framework for examination of professional sexual misconduct is reliant upon, and secondary to, the presence of trustworthiness

I acknowledge that the prohibition of professional sexual misconduct in a society may be justifiable based on the use of an informed consent argument, as this argument explains many concerns about professional sexual misconduct for many of the patients involved. However, I argue that this framework cannot explain why professional sexual misconduct is ethically problematic for all patients involved. I also argue that because of the factors described above, a framework based upon informed consent could not be used to consider the moral differences between complex professional sexual misconduct cases.

I also criticise the use of an ethical argument about exploitation as the ethical basis for prohibiting professional sexual misconduct, on the basis that this is a secondary argument. If professional sexual misconduct is exploitative, it may be seen as exploitative in one of two ways.

Firstly, it may be seen as exploitative of the power imbalance that exists between the doctor and the patient, and the way that this undermines the patient's voluntarism, stopping them from being able to make an informed consent. In this way, the argument that professional sexual misconduct is exploitative is secondary to the argument that it is a failure of informed consent. The argument that it is exploitative can therefore be criticised for the same reasons that the argument that it is a failure of informed consent can be.

Secondly, professional sexual misconduct may be criticised as exploitative because the doctor behaves in such a way that is inappropriate for their position or role. This
argument suggests that the doctor should be behaving according to a set of standards that are not defined within the argument. It alludes to the requirement for an ethical standard for the doctor’s conduct, and is consequently secondary to this ethical standard.

The argument that professional sexual misconduct is exploitative is therefore unhelpful, because it is based upon other ethical principles, being either that of informed consent, or other standards of conduct for the doctor. I conclude that defining a standard of conduct for the doctor is needed for the use of the community, the education of doctors, the medical profession’s own standards, and medical regulatory boards attempting to objectively consider how doctors have deviated from those standards.

In Chapter Four, I examine the importance of both interpersonal and institutional trust in the medical profession. I recognise the debate regarding levels of trust in the medical profession, and the consequent research into factors which influence levels of trust. I argue that increasing levels of trustworthiness is more likely to be helpful than attempts to increase trust without attention to the trustworthiness of the trustee. I suggest that attention has not been given to what the standards of trustworthiness in the medical profession should be.

I argue that the standards of trustworthiness in the medical profession must be consistent with ‘thicker’ versions of trustworthiness, with their requirement for higher levels of interest in the preferences of the truster, and expectation that the trustee will experience these preferences and the dependence of the truster to some degree “compelling”. I argue that rich trustworthiness, with its requirement to “reliably signal its presence” [page 26, 22] is ultimately the standard that should be expected of medical practitioners, for the following reasons.

1. Thinner versions of trustworthiness are incompatible with the patient’s reasonable capacity to perform a risk assessment of the doctor’s trustworthiness and are excessively demanding of the patient
2. Thin versions of trustworthiness do not require respect for the patient’s preferences
3. Patients have expectations about the underlying factors which motivate their doctors

I argue that rich trustworthiness is the most appropriate version of trustworthiness that should be expected of doctors as a reasonable community standard. I propose rich trustworthiness’ requirements as the basis for a framework of expectations for doctors.

In Chapter Five I develop and propose an ethical framework based upon the standards of rich trustworthiness, the *Framework for Trustworthiness in Doctors*. I argue that the five core components of trustworthiness for doctors are;

1. The provision of competent, appropriate care,
2. Holding regard for patient preferences,
3. Holding regard for the patient’s dependence upon the doctor,
4. A recognition of the limitations of their own trustworthiness, including clinical competence, and
5. An ability to communicate to patients and significant others regarding appropriate care

I accordingly define how a trustworthy doctor will respond to each of these standards, as well as how the responses of an untrustworthy doctor and an extremely untrustworthy doctor breach these standards when professional sexual misconduct occurs.

In terms of providing appropriate, competent care, I argue that a trustworthy doctor should be competent to respond to a patient’s concerns, or able to refer that patient for specific care if they are unable to provide this care themselves. In contrast, the untrustworthy doctor may allow professional sexual misconduct to undermine the care of the concerns that the patient is initially presenting, or subsequently presents. An extremely untrustworthy doctor is willing to provide inappropriate, unsafe, or even illegal care to promote or maintain professional sexual misconduct. This may include, for example, inappropriate prescribing of medications associated with a risk of dependency.
In terms of having regard for patient preferences, the trustworthy doctor seeks to understand the preferences of their patients and their families, and acknowledges them. The trustworthy doctor experiences these preferences as compelling when they are appropriate and safe. The untrustworthy doctor does not seek to understand the preferences of patients and their families. The untrustworthy doctor does not experience any expressed patient preferences as compelling, and may actually respond to inappropriate preferences, including situations in which the patient expresses a preference to engage in a sexual relationship with their doctor. The extremely untrustworthy doctor is willing to disregard the preferences of the patient to further their own interests. These preferences include those which may be reasonably inferred, such as a patient’s preference not to be harmed. The extremely untrustworthy doctor may be willing to force their preferences by manipulation, coercion, deceit or frank assault.

According to the standard of trustworthiness to have regard for the patient’s dependence upon the doctor, the trustworthy doctor should experience the dependence of the patient as compelling, and seek to minimise any power imbalance by providing information, assistance, or advocacy. The untrustworthy doctor does not recognise or respond to dependence in patients, or does not experience dependence as compelling, even if the power imbalance is marked. The extremely untrustworthy doctor is aware of the patient’s dependence, and actively exploits this for their own gain. They do not recognise or acknowledge extreme dependence caused by serious illness. The extremely untrustworthy doctor may even seek to increase the dependency to promote their own gain, for example, using in appropriate prescription of medications associated with dependency.

In terms of recognising the limitations of their own trustworthiness, including clinical competence, trustworthy doctors maintain an ongoing reflection about the care they are providing. Trustworthy doctors are aware of the potential for any impairment they are experiencing to impinge on the care they provide, and they consequently seek to optimise their own health and clinical competence. Untrustworthy doctors do not recognise the potential for their health concerns or lack of clinical competence to cause harm to patients, and consequently do not maintain these, nor refer patients appropriately. The extremely untrustworthy doctor has been informed of the
potential for their own health concerns or lack of clinical competence to impinge upon patient care, but still does not act to maintain these. The extremely untrustworthy doctor may misrepresent their competence to promote professional sexual misconduct, or repeatedly engage in professional sexual misconduct despite feedback regarding the inappropriateness of this.

In terms of communication to patients and others regarding appropriate care, the trustworthy doctor must communicate to patients what the limitations of their trustworthiness are. The untrustworthy doctor does not communicate to patients what the limits of their trustworthiness are. The extremely untrustworthy doctor may be actively deceptive in their communications with patients about what the limits of their trustworthiness are, including the inappropriateness of boundary crossings, boundary violations, or even professional sexual misconduct.

This framework is advantageous, compared to that of informed consent, for a number of reasons. A framework based upon trustworthiness acknowledges that trustworthiness is the responsibility of the doctor, while a framework based on informed consent the responsibility is shared by the patient. Use of a framework based on the standards of trustworthiness does not require that the patient be deemed ‘incompetent’ in any way. A framework based on the standards of trustworthiness enables consideration of professional sexual misconduct and the ‘slippery slope’, whilst examination of the slippery slope as a failure of informed consent is not feasible. A framework based on the requirement for informed consent could only offer a categorical classification, while trustworthiness can be considered on a continuum. Finally, trustworthiness is a fundamental expectation of the medical profession. It is less dependent upon on other ethical standards than informed consent, which is itself reliant upon the presence of trustworthiness.

Ultimately, this framework is able to offer an ethical structure for the consideration of cases of professional sexual misconduct. No ethical framework has been published for such a purpose. The standards of trustworthiness have not previously been defined for the medical profession according to an ethical framework. I argue that these expectations, and the framework derived from them, are consistent with
reasonable community expectations, and therefore may offer a valuable guide when considering cases of professional sexual misconduct.

In Chapter Six, I apply the *Framework for Trustworthiness in Doctors* to two cases of professional sexual misconduct, which had been substantiated through the then Medical Practitioners Board of Victoria. I demonstrate the applicability of the Framework for such cases of professional sexual misconduct. Beyond this, I note the ability of the Framework to reflect the community’s expectations, and note the disparity between these and the existing approaches to professional sexual misconduct.

In Chapter Seven, I apply the *Framework for Trustworthiness in Doctors* to two cases of professional sexual misconduct in which no patients were directly harmed. In these cases, the role of the Medical Board to protect the public was more complex than when there has been a demonstrable and immediate harm to patients.

In Chapter Eight I conclude by describing the potential uses of this Framework, from education to regulation and research. The Framework has been developed while considering the breach of trustworthiness associated with professional sexual misconduct. An examination of doctors who have committed professional sexual misconduct allows consideration of doctors who have committed an extreme form of professional misconduct, clearly universally prohibited. There is no doubt about the wrongfulness of this conduct in the eyes of the Medical Board of Australia. There is, nonetheless, a wide range of professional misconduct that is non-sexual, and significantly less extreme. Professional sexual misconduct may also be associated with non-sexual professional misconduct. This Framework derived from an examination of professional sexual misconduct may be considered for other forms of professional misconduct. The normative model demanding a standard of trustworthiness may be applied across standards of medical conduct.

Professional sexual misconduct is ethically unacceptable because of the power imbalance inherent to the doctor - patient relationship, and the medical profession’s sanctioned role in the community. It has been suggested that the delay in interest in trust and trustworthiness by philosophers is due to a traditional emphasis on
contractual relationships between equals [22, 23], with trust and trustworthiness having greater significance for those relationships characterised by power imbalance. Both professional sexual misconduct and trustworthiness have particular significance for those who are most vulnerable to a power imbalance, the most disadvantaged members of our community. Establishing standards of trustworthiness within the medical profession will benefit the community as a whole, but the vulnerable and disadvantaged most of all.
Chapter One: Professional Sexual Misconduct and its Significance for the Community

1.1 Defining Professional Sexual Misconduct

Sexual contact between doctors and their patients was prohibited by the Hippocratic Oath [1]. The translation of this ancient prohibition into medical regulation, and the enforcement of this regulation through medical regulatory bodies, is a comparatively more recent phenomenon.

The development of regulations prohibiting sexual relationships with patients, and defining these relationships as professional sexual misconduct, has occurred within Australia over the past thirty years. Despite this prohibition, cases of professional sexual misconduct continued to be substantiated by state and territory medical boards, and since its establishment in 2010, by the Medical Board of Australia.

Within this chapter, I will define professional sexual misconduct, and describe the ways in which it occurs in medical practice. I will examine the potential harms which result from professional misconduct to the individual patients involved, as well as to the medical professional and the community as a whole. Given these harms, and the persisting prevalence of professional sexual misconduct within the community, I will argue that professional sexual misconduct remains an extremely serious concern for the medical profession and the community in which it operates.

I will argue, then, that the way that professional sexual misconduct is responded to is crucial, and that opportunities to minimise harms resultant from professional sexual misconduct must continue to be sought.

1.1.1 Boundaries and Their Importance

The concept of boundaries, must be defined before we can consider the ways in which boundaries can be violated. The boundaries to be considered are professional boundaries, the boundaries which exist within a professional
relationship. Boundaries as they occur within doctor-patient relationships in particular will be considered. Although boundaries may be defined differently within other professional fiduciary relationships, and have an indefinite number of meanings in the broader community, these definitions are beyond the scope of this discussion.

Within the medical literature, boundary violations are discussed at length and with an apparent shared understanding of their meaning. Many articles proceed to such discussion without defining what is thought to be implicitly understood, the underlying concept of a boundary [14, 18, 24, 25]. This may be because much of the literature focuses on extreme boundary violations, such as sexual relationships with patients. These boundary violations cross all therapeutic boundaries, and the exact definition and subtleties of boundaries may be not be necessary for these considerations. The lack of definition of boundaries also reflects a lack of consensus about the exact nature of the boundaries, either between medical specialties (what might be appropriate for a gynaecologist will likely be inappropriate for an orthopaedic surgeon), or within them.

The context-specific nature of boundaries is seen in a definition by Gutheil [page 89, 17], in which boundaries are defined as “the edge of appropriate, professional behaviour”. This “edge” is defined in the therapeutic relationship by a consistent understanding between clinician and patient about acceptable behaviour in a number of realms. Gabbard and Nadelson are more specific in their definition of boundaries as “the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service” [26]. Chadda and Slonim [27] categorize these according to: role, time, place and space, money, clothing, language, self-disclosure, physical contact, and gifts.

Gutheil and Gabbard [page 410, 28] describe the purpose of establishing clear boundaries as “to create an atmosphere of safety and predictability within which the treatment can thrive”. That is, patients can seek medical care with an understanding about what behaviour they may expect from the medical practitioner, and in turn what behaviour the medical practitioner may expect of them.
In psychiatric practice, Gutheil and Gabbard argue that these external boundaries are particularly important, given the nature of the psychotherapeutic relationship. They state that; “external boundaries are established so that psychological boundaries can be crossed through a variety of mechanisms common to psychotherapy, including empathy, projection, introjection, identification, projective identification, and the interpretation of transference” [page 410, 28].

Boundaries are important in all doctor-patient relationships, however. These boundaries define the role of the doctor and their obligations to the patient. The patient, in turn, can be aware of what they may expect, and what is expected of them within the relationship. These expectations are defined to a large degree by professional codes and legislation external to the relationship. Through understanding, for example, that their doctor is obliged by professional codes to maintain confidentiality about any information disclosed, a patient can be more reasonably expected to disclose adequate information for optimal diagnosis and care. Some boundaries will not be externally defined, however, and will be negotiated between doctor and patient. These might include, for example, times for appointments, payment expected, and the language used.

Boundaries defined external to individual doctor-patient relationships are defined in this way because they are seen to be both universal in their relevance to all doctor-patient relationships, and also because their importance is seen to be such that they are a matter of community interest. Although there may be variations between specialties, and between individual doctor-patient relationships, there are some standards set by the community as necessary for the therapeutic framework that optimizes the likelihood of successful medical treatment. They are deemed essential for optimal care. Transgression of these boundaries can occur as either boundary crossings or boundary violations.

1.1.2 Boundary Crossings
Boundaries, then, enable the doctor-patient relation to function as a fiduciary relationship. Breaches of these boundaries may occur as either boundary crossings or boundary violations.
Within psychotherapeutic relationships, boundary crossings are differentiated from boundary violations by their nature and the consequences. As above, because of the importance of boundaries in these relationships in particular, boundaries are maintained in different positions to those in other fields of medicine. Examples of this include the complete absence of physical contact, compared to other medical specialties. In psychotherapeutic relationships, therefore, boundary crossings are described as distinct from boundary violations.

Gutheil describes boundary crossings as “transient, nonexploitative deviations from classical therapeutic or general clinical practice in which the treater steps out to a minor degree from strict verbal psychotherapy. These crossings do not hurt the therapy and may even promote or facilitate it” [page 89, 17]. Gutheil and Gabbard [page 410, 28] suggest that these are often “fully appropriate human responses to unusual events that might involve physical contact”, such as assisting a patient who has stumbled and fallen, to their feet. Boundary crossings may occur unpredictably in psychotherapeutic relationships, but for them to be crossings (rather than violations), they are consistently responded to in ways that support the ongoing treatment.

Glass [page 430, 29] describes boundary crossings as “distinct discussable departures from an established treatment framework. They are not part of a progressive escalation of exploitative changes in the relationship”. In this way, they are distinct from boundary violations.

1.1.3 Boundary Violations

Gutheil [page 89, 17] describes boundary violations as “essentially harmful deviations from the normal parameters of treatment – deviations that do harm the patient, usually through some sort of exploitation that breaks the rule ‘first, do no harm’. Usually it is the therapist’s needs that are gratified by taking advantage of the patient in some manner. The therapy is not advanced and may even be destroyed by such violations.”

This potential for professional sexual misconduct to preclude or undermine the healthcare that the patient initially sought might be most obvious in
psychotherapeutic care. However, it can readily be seen that, if distracted by the possibility of a sexual relationship, or the development of one, both patient and doctor may be less likely than usual to prioritise healthcare that is incongruent with this relationship, or just a distraction from it. The patient may not wish, for example, to present aspects of their own health that they believe are unattractive. The doctor may be distracted from the health concerns the patient does present by the developing relationship.

The essential components of boundary violations according to Gutheil, are, therefore [page 90, 17];

1. That they harm the patient, at a minimum by undermining treatment, and potentially substantially more, depending on the type of violation,
2. That the therapist's needs are placed ahead of those of the patient
3. That this exchange occurs in the context of a fiduciary relationship in which there is an inherent power imbalance
4. That prior to entering the fiduciary relationship, the patient did not consent to the boundary violation, and once in the relationship they cannot consent due to the power imbalance within the relationship

In contrast, Gabbard [page 253, 18] defines boundary violations as “transgressions that are potentially harmful to or exploitative of the patient”. Gabbard emphasizes boundary violations to be potentially harmful because, he suggests, it is often difficult to immediately assess whether harm has occurred. Gabbard argues that “The idea of focusing on potential harm also recognizes the fact that the therapist can never know the ultimate impact a boundary transgression will have on a patient”.

Both Gutheil and Gabbard agree, then, that boundary violations are not therapeutic, and constitute instances within the fiduciary relationship in which the doctor places their own needs ahead of the patient’s, acting exploitatively. They differ in their argument about whether the behaviour has to be demonstrably harmful to the patient, but both suggest that these violations are likely to be harmful, even if this cannot be readily demonstrated acutely.
I agree with Gabbard that a boundary violation need not be proven to be harmful for it to be said to be a boundary violation. It may be impossible to prove harm for reasons directly related to their harmful effects. The patient who has been engaged in a sexual relationship with their doctor may testify on their doctor’s behalf that this relationship is not harmful for a number of reasons. They may wish to maintain the relationship for complex reasons, or may wrongly blame themselves for the relationship. As I will describe below, in Section 1.2.2, the harms associated with professional sexual misconduct may include inappropriate guilt, and often ambivalence. The establishment of a boundary violation should therefore not include proof of harms as a result of the doctor’s conduct.

Boundary violations are classified as sexual or non-sexual in nature [18]. Non-sexual boundary violations include breaches of confidentiality, employment of a patient by the doctor, or engaging a patient in a business relationship. Sexual boundary violations involve “oral or genital contact, fondling of breasts or genitals, or sensual kissing” [page 253, 18]. Sexual boundary violations may also include verbal sexual comments [30] that occur either in isolation, or preceding physical contact.

Gabbard [31] describes the ‘slippery slope’ phenomenon as “boundary violations that begin as minor and apparently harmless”, but which “gradually escalate to major violations that are damaging to the patient”. He suggests that “long before the first physical contact between analyst and patient” the psychotherapist feels “a special kinship” with the patient. There are increasing acts which transgress boundaries, over a period of time, as a result of the doctor’s emotional response to the patient. Sexual boundary violations may be preceded by non-sexual boundary violations, then, with progression over time towards sexual boundary violations.

Pope and Bouhoutsos [32] have described ten common interpersonal pathways through which sexual boundary violations may develop;

1. Role Trading – in which the therapist becomes the patient, and their wants and needs become the focus
2. Sex Therapy – therapist-patient sex is fraudulently presented as a legitimate treatment for sexual dysfunction, or even other difficulties
3. As If – the therapist responds to positive transference as if it were not a result of the therapeutic relationship
4. Svengali – the therapist creates and exploits an exaggerated dependence on the part of the patient
5. Drugs – the therapist uses illicit drugs or prescribed medications as a part of the seduction
6. Rape – the therapist uses physical force or means of intimidation in frank sexual assault
7. True Love – the therapist uses rationalisations that discount the significance of the therapeutic relationship, and legitimises the sexual relationship as a romantic one
8. It just got Out of Hand – there is a failure to monitor and respond appropriately to the intimacy that develops in psychotherapeutic relationships
9. Time Out – the therapist does not acknowledge that the therapeutic relationship continues outside of the therapist’s office
10. Hold me – the therapist interprets a patient’s desire for non-sexual contact as a desire for sexual contact, and responds to this sexually

Sexual boundary violations may therefore range from verbal comments to frankly criminal acts of sexual assault to apparently consensual relationships. The overwhelming majority of cases of sexual boundary violations involve a male doctor and a female patient [18, 33], but cases involving female doctors and male patients also occur, as do same-sex dyads. Sexual boundary violations may involve adult or child patients, and either a single patient, or involve multiple patients during the same time period. As well as often being noted to follow a ‘slippery slope’ of non-sexual boundary violations, sexual boundary violations often also occur in conjunction with other, non-sexual, boundary violations, such as inappropriate prescribing.

1.1.4 Professional Sexual Misconduct
Within medical fiduciary relationships, boundaries are particularly important to delineate the limits of appropriate behaviour, when physical and psychological integrity may be compromised by both illness and treatments. To this end, codes of professional conduct regarding boundaries have been described by medical
regulatory bodies, professional organisations, and clinical services. These professional codes of conduct stipulate the limits of professional boundaries.

Professional sexual misconduct, then, is when sexual boundary violations that have been defined by a medical regulatory body as unacceptable professional conduct occur. This prohibition was established in Australia through state and territory medical boards, but has been the responsibility of the Medical Board of Australia since its inception in 2010.

The language used to describe professional sexual misconduct within the literature has changed over time. What was described as “professional erotic indiscretion” in 1968 [34] committed by “erotic practitioners” [page 1324, 16] is more recently described as “patient sexual exploitation” [page 380, 35], “physician-patient sexual relationships” [page 45, 36], “physician sexual abuse of patients” [37]. In accordance with modern legislation, I will refer to all sexual behaviour between a doctor and their patient as professional sexual misconduct.

“Professional sexual misconduct” will henceforth be used to describe any sexual boundary violations within this document. Although all boundary violations are potentially harmful to patients, and therefore warrant consideration, professional sexual misconduct is the primary subject of this investigation, rather than other forms of boundary violations. Professional sexual misconduct has been selected for examination for a number of reasons.

Firstly, professional sexual misconduct has been prohibited across all states and territories in Australia, most recently by the National Health Practitioners’ Act [38]. This prohibition on sexual relationships with current patients is now well established, and has been communicated unambiguously for some time. Examination of cases of doctors found guilty of professional sexual misconduct, then, enables consideration of a group of doctors who have acted despite a known, established prohibition.

Secondly, and considered further in Section 1.2.2, professional sexual misconduct has been demonstrated to be harmful to patients. Examination of cases of doctors
who have committed professional sexual misconduct, then, enables consideration of a group of doctors who have acted in a way that could reasonably be expected to cause harm to the patients involved. Beyond the direct harm experienced by patients engaged in a sexual relationship with their doctor, I will argue further in Sections 1.3.2 and 4.2.3 that professional sexual misconduct results in broader harms across the whole community, by causing damage to the trust that the community has in the medical profession.

Thirdly, although all doctors who commit professional sexual misconduct are similar in that they do so against established prohibitions, and act in such a way that could reasonably be expected to cause harm, there is an infinite number of ways in which professional sexual misconduct may occur. If professional sexual misconduct is any sexual behaviour between doctor and patient, the range of types professional sexual misconduct is at least as extensive as the range of human sexual behaviour. Professional sexual misconduct ranges from verbal comments of a sexual nature toward the patient, to apparently consensual relationships, to overt sexual assault. Beyond the sexual activity which occurs, the nature of professional sexual misconduct may vary according to factors within the doctor-patient relationship, such as the pre-existing duration of the relationship, and factors in the patient, such as age, or health concerns. Examination of professional sexual misconduct enables examination of a diverse range of forms of wrong doing, then, within the doctor-patient relationship.

Finally, patients involved in professional sexual misconduct are not infrequently exposed to other forms of boundary violations. These other boundary violations may occur as antecedents to the professional sexual misconduct, or may occur concurrently. An examination of professional sexual misconduct may therefore have implications for the ways that non sexual boundary violations are considered, given their potential to progress to professional sexual misconduct.

1.1.5 Doctors Who Commit Professional Sexual Misconduct
The majority of doctors who commit professional sexual misconduct with patients are male, and they do so with female patients [18]. In one large cohort of doctors who
had been found to have had sex with patients, eighty percent of cases involved a male therapist, and twenty percent involved same sex dyads [33].

Doctors from all specialties have been found guilty of violating boundaries with patients. However, as a group, psychiatrists who had sex with their patients have been studied more than any other group. Gabbard has assessed and treated more than seventy psychiatrists who have had sex with their patients. As a psychoanalyst, Gabbard is interested in the underlying psychodynamic factors which may contribute to boundary violations. After psychiatrically assessing more than seventy patients, Gabbard developed a typology according to the psychodynamic factors *within the psychiatrist* which led to the boundary violation.

Gabbard’s typology proposes four main groups of analysts who violate boundaries with patients [39]. Although this classification was developed after the examination of psychoanalysts as a group, there are implications for all doctors involved in boundary violations.

Gabbard’s first group is those doctors with *Psychotic Disorders* [page 93, 39]. He suggests that it is “rare” for these disorders to result in sexual boundary violations, and when they do, are usually associated with manifestations of psychosis outside the doctor’s work role. The rarity of these cases, with underlying organic causes of psychosis, often involving the frontal lobes of the brain, means that they have been poorly studied as a group.

Gabbard’s second group is doctors with *Predatory Psychopathy and Paraphilias* [page 93, 39]. He includes within this group, not only those with antisocial personality disorder, but also the severely narcissistic, and makes the point that it is the behaviour of the doctor that is psychopathic, rather than all doctors in this group having frank psychopathy. Gabbard suggests that for these doctors to be willing to act out their paraphilias or perversions with patients, they must have the severely compromised superego associated with the narcissistic-to-antisocial spectrum of personality disorders. Gabbard suggest that this group of doctors are usually male, and there is often a history of sexually predatory behaviour that is life-long, as well as a history of unethical behaviour dating to their training. They lack empathy, and
their boundary violations often involve multiple patients and extreme or sadistic behaviours. Consequently, they may be over-represented in media reports about boundary violations.

The third group of doctors described by Gabbard are described as experiencing Lovesickness [pages 96-98, 39]. Gabbard suggests that the majority of analysts committing boundary violations are within this category, and they are categorised by a significant narcissistic vulnerability, but with greater superego integration than the doctors with predatory psychopathy and paraphilias. Usually male, Gabbard describes the “typical scenario” as that of a middle-aged doctor who “falls madly in love” with a female patient who is significantly younger. This usually happens after a major stressor in the doctor’s life. The infatuated doctor may experience euphoria, but with this there is a serious loss of judgement and reality testing. The doctor has a reduced ability to appreciate the potential harm to the patient, or indeed themselves, in this context.

The final group described by Gabbard are those doctors experiencing Masochistic Surrender [pages 98-99, 39]. This group of doctors seek masochistic gratification from their role, often seeing more “difficult” or treatment resistant patients. They may also have difficulties setting any limits, or boundaries with patients, experiencing this as sadistic. They may, therefore, be unable to maintain appropriate boundaries in response to requests or demands from their patients, and in this way, progress down a slippery slope to the sexual boundary violation. This group of doctors often recognise the unethical nature of their behaviour, and attempt to seek help, even reporting themselves.

There are additional typologies, such as that of Schoener and Gonsiorek [33], which attempts to predict treatment prognosis. This typology divides psychotherapists into six groups;

1. Uninformed and naive
2. Healthy or mildly neurotic
3. Severely neurotic and socially isolated
4. Impulsive character disorder
5. Sociopathic or narcissistic character disorder
6. Psychotic or borderline personality disorder

The authors suggest that the first two groups of doctors may respond well to education and treatment, whilst the latter four groups, and most particularly, the last two groups, may be very poorly responsive to attempts at rehabilitation [33].

Of those doctors who are found to have committed professional sexual misconduct, psychiatrists are over-represented [40-42]. This finding may not represent community prevalence rates of professional sexual misconduct, and there may be particular features of the specialty of psychiatry that increase the likelihood of a report of professional misconduct, in comparison to increasing the likelihood of professional sexual misconduct itself. However, the basis for an over-representation has been considered, with factors such as the likelihood of solitary/isolated practice and prolonged contact with patients noted [40]. With general practice and obstetrics and gynaecology also over-represented [42], the effects of an ongoing relationship with a patient, and the intimacy associated with this, might be considered as an important risk factor for professional sexual misconduct.

1.2 The Significance of Professional Sexual Misconduct for the Patient

The significance of professional sexual misconduct for an individual patient will vary unpredictably depending on factors within the patient, as well as the nature of the professional sexual misconduct. Although some patients may be more vulnerable to both professional sexual misconduct and its negative consequences, the nature of the doctor-patient relationship places all patients at risk.

1.2.1 The Characteristics of Doctor - Patient Relationships

The doctor – patient relationship has some features common to all professions. However, this relationship is also characterised by additional specific features attributable to the particular nature of medical conditions and health care.

The doctor is a member of the medical profession. As noted by Bayles [43], there is consensus that for an occupation to be a profession, it should be associated with “a rather extensive training”, “a significant intellectual component”, and “an important service in society”. Bayles also notes that “consulting professionals”, such as doctors, are characterised by a further three features, in that they; “all provide an
important service”, “have a monopoly over the provision of services”, and “have claimed and been accorded a large degree of self-regulation”. The doctor, therefore, sits within a highly educated group that provides an important service that the general public is highly dependent upon, and that remains significantly self-regulating. There is, therefore, a significant potential power imbalance between doctor and patient, and a consequent need to define reasonable expectations within the relationship.

In characterising the professional – client relationship, Bayles [43] argues that any model should ensure that “the professional’s superior knowledge is recognised, but the client retains a significant authority and responsibility in decision making”. Bayles refers to the legal concept of a fiduciary relationship, in which “both parties are responsible and their judgments given consideration. Because one party is in a more advantageous position, he or she has special obligations to the other”. Bayles’ descriptions of both the requirements for an occupation to be a profession, and the professional – client relationship, are widely accepted.

The doctor – patient relationship has additional features beyond those of a member of a profession. Patients see a doctor because they are concerned that they may have a medical condition, or be at risk of developing one. Within the doctor – patient relationship, the doctor holds medical knowledge and expertise that the patient is dependent upon for their health, and perhaps their life. The patient may have limited alternatives for obtaining healthcare elsewhere, either due to factors within the healthcare system, or the urgency of the medical condition. This concern, the doctor’s greater level of knowledge enabling diagnosis and treatment, as well as the doctor’s access to particular aspects of healthcare, results in a power imbalance that is inherent to all doctor-patient relationships, albeit to varying degrees.

There is also an imbalance in terms of the amount of personal information typically disclosed by the patient, compared to the doctor. In particular, the patient is often expected to disclose highly personal information, and undergo highly intimate physical examination, to receive healthcare. Physical examination may form part of the initial assessment or be required on an ongoing basis to assess disease progression or response to treatment. The doctor is therefore required to interact
with the patient in an extremely intimate way that might not be immediately understandable to the patient. However, the emotional intimacy associated with a longer term clinical relationship, particularly if the patient has a chronic illness and hence a degree of dependency on the doctor, might be even greater for some patients. All these factors contribute to a context that is characterised by dependency, and socially sanctioned as such.

Beyond the intimacy required within the doctor-patient relationship, and the power imbalance inherent to all doctor-patient relationships, some patients are particularly vulnerable because of the way that their illness undermines their capacities. Medical conditions are inherently debilitating and may undermine the patient’s usual capacities in an indefinite number of ways. The capacity to consent will be considered in detail in Chapter Three. Doctors are expected to be sensitive to issues around the patient’s capacity to consent to care and participate in treatment. Specifically, doctors are expected to be able to recognise any reduced capacity to consent, and respond in ways that prioritise the patients’ needs and preferences. The patient, with their dependency enforced by illness and their requirement for intimate disclosure required for treatment, is undoubtedly in a relationship characterised by a significant power imbalance.

1.2.2 Clinical Consequences of Professional Sexual Misconduct

Within psychotherapeutic relationships, both the presence of transference and the parallels with parent/child relationships have led some authors to note that professional sexual misconduct is not only “symbolically incestuous” [44, 45], but has comparable consequences for patients involved [44, 46, 47]. Internationally, Pope [48] described a “Therapist-Patient Sex Syndrome” that has many common features with the effects of incest, including prominent ambivalence and guilt. Patients may experience an exacerbation of the symptoms for which they presented to a psychiatrist [44, 49].

Gabbard also described a “Therapist-Patient Sex Syndrome” [pages 40-45, 44], emphasizing prominent ambivalence and guilt, and their resemblance to the feelings associated with incest. Gabbard also describes the “Therapist-Patient Sex Syndrome” as including feelings of emptiness and isolation for the patient, sexual
confusion, an impaired ability to trust that undermines future therapy, an identity and role reversal that also resembles that which occurs in incest relationships, emotional lability or dyscontrol, suppressed rage, increased suicidal risk, and cognitive dysfunction resembling that of posttraumatic stress disorder.

In Australia, the disastrous effects of professional sexual misconduct on patients seeking psychotherapeutic care have been well documented by Quadrio [46, 50, 51]. Of a series of forty women previously sexually abused in psychotherapeutic relationships, it was noted that the majority experienced depression, and suicidal ideation was frequent. A marked deterioration in interpersonal and occupational functioning was widespread, with long term disability. Ambivalent feelings towards the abuser often compromised subsequent engagement with care, and rehabilitation.

The alarming combination of deliberate self-harm ideation and (understandable) difficulties engaging with subsequent therapists emphasizes the serious potential consequences of professional sexual misconduct. In addition to the psychological consequences of professional sexual misconduct, however, the patient involved in professional sexual misconduct may be harmed by not receiving the healthcare that they were seeking when they presented to the doctor [52]. Even when continuing to receive some care, it is likely that they quality of this care is undermined by the presence of the sexual relationship [53].

The assessment of harms caused by professional sexual misconduct can be difficult, however, because it is known that one group of patients who are at higher risk of exploitation by psychotherapists are those who have a childhood experience of incest [page 88, 39]. In Quadrio’s case series, two thirds of the women involved in professional sexual misconduct had themselves experienced childhood sexual abuse [51]. Gabbard (page 88) [39] argues that, for these patients, “the boundary less situation of childhood is re-enacted in the analytic setting”. Pope and Bouhoutsos have also included post-traumatic stress disorder as a risk factor for professional sexual misconduct [32], and argued that patients involved often meet diagnostic criteria for this diagnosis and borderline personality disorder. Ellard [page 47, 54] notes that not all patients involved in professional sexual misconduct “exhibit psychopathology”, and that borderline personality disorder increases vulnerability.
Importantly, adverse effects are experienced by almost all patients involved in professional sexual misconduct, with authors [44, 55] suggesting that at least 90% of patients involved in professional sexual misconduct, are harmed. This opinion has been emphasized in the medical literature, including one important editorial which described professional sexual misconduct as “almost always harmful” [56].

The prohibition of professional sexual misconduct is based, then, on the understanding that sexual relationships between doctors and their patients is almost always harmful to the patient, and that doctors should not harm their patients. Individual doctors considering a sexual relationship with a patient may argue that their individual action will not necessarily result in harm. As argued by Cullen [page 485, 57], it is the combination of a likelihood of harm, and the lack of ability to predict which patients will be harmed, that justifies the prohibition on professional sexual misconduct.

1.3 The Significance of Professional Sexual Misconduct for the Community
Despite the widespread prohibition of professional sexual misconduct, Medical regulatory bodies continue to be presented with complaints about doctors who are ultimately found to be guilty of this conduct. Two main groups of studies examine the rates of professional sexual misconduct: physician surveys and studies through Medical regulatory bodies. Both types of studies are complicated by significant methodological concerns. Even individual cases of professional sexual misconduct cases can have a significant impact on a community, with reporting in the media resulting in community awareness far beyond those directly affected.

1.3.1 Prevalence Rates of Professional Sexual Misconduct

1.3.1.1 Physician Surveys of Professional Sexual Misconduct
The incidence of professional sexual misconduct is not known. Studies examining the incidence of professional sexual misconduct have made use of anonymous questionnaires, sent to physicians, asking them directly about whether they have ever committed professional sexual misconduct. The validity of the results of these studies is undermined by poor response rates. It is likely, also, that doctors are
aware of the stigma associated with professional sexual misconduct, as well as the professional implications of this. There have, consequently, been concerns that these studies reflect an underestimate of professional sexual misconduct within the community [52, 58-60].

Despite these limitations, there have been some consistent findings in surveys of doctors working within different specialties, and in different countries.

In a 1973 United States (US) survey of 1000 physicians, Kardener et al [61] obtained a response rate of 46%. Of the respondents, 7.2% answered affirmatively to some “erotic” behaviour with patients. In 1981 the Washington Psychiatric Society surveyed its 1060 membership, with a response rate of 58.6%. 6.6% of respondents acknowledged having a sexual relationship with patients [62]. In comparison, a 1987 [63] survey of Psychiatrists across the US obtained only a 26% response rate, with 6.4% of these respondents admitting to sexual contact with patients.

In 1992 in the US Gartrell et al [64] surveyed 10,000 family practitioners, internists, obstetrician-gynaecologists and surgeons. With a response rate of less than 20%, 9% of respondents reported sexual contact with at least one patient. In the same year in the Netherlands, [65] 975 physicians, who were either obstetrician-gynaecologists or ear, nose and throat specialists were surveyed. With a response rate of 67%, 4% of respondents acknowledged sexual contact with a patient. In Canada a 1994 study [66] obtained a 78% response rate from of all 792 members of the Society of Obstetricians and Gynaecologists of Canada, with 3% acknowledging sexual involvement with a patient.

The above studies, then, suggest that a community prevalence rate of between six and ten percent of doctors have committed professional sexual misconduct. This estimate is consistent with Gabbard’s estimate of 7-10% of all North American doctors as having perpetrated professional sexual misconduct [44].

Within Australia, a 1994 survey [67] of 506 Fellows of the Royal Australian and New Zealand College of Psychiatrists had a response rate of 68%. 4.7% of respondents acknowledged sexual contact with a current patient. The significance of this result is
difficult to interpret. Although the response rate is higher than for some of the North American surveys, the group involved (Psychiatrist Fellows of the Royal Australian and New Zealand College of Psychiatrists) may have had higher levels of awareness about the potential stigma associated with professional sexual misconduct. In this context, they may have been less likely to disclose professional sexual misconduct behaviours, or less likely to respond to the survey if they had committed professional sexual misconduct. There are no further Australian surveys of doctors.

1.3.1.2 Reporting Rates of Professional Sexual Misconduct
Rates of practitioners referred to medical regulatory bodies reflect detection of professional sexual misconduct [51], rather than the community prevalence of professional sexual misconduct. Detection rates are a substantial underestimate of the prevalence of professional sexual misconduct due to under-reporting of professional sexual misconduct by patients to medical regulatory boards.

Under-reporting occurs due to complex variables, including traumatic investigative procedures, ambivalent attachments to the doctor, and poor responses to disclosures [50]. Rutter [68] noted that female patients are often unaware of the professional standards that can be expected of doctors, and may also tend to blame themselves for not stopping the sexual relationship. Patients may also anticipate the legal disciplinary hearing, and being asked highly personal questions in this setting [52]. The factors which lead to under-reporting of professional sexual misconduct have substantial overlap with the factors that lead to under-reporting of criminalised sexual assault. It has consequently been noted that it is likely that the cases which are reported to Medical regulatory bodies may well be distinctive, compared to those not reported [47].

It is difficult to establish, then, what the relationship of reporting rates might be to the community prevalence of professional sexual misconduct. This relationship may vary with differing levels of public awareness, reporting procedures, or even legislation [56, 59, 69-71]. It may vary, therefore, both between countries or within countries, over time.
Although the relationship of detection rates to the community prevalence rates may be difficult to predict, detection rates have significance in themselves. They may offer an indication, albeit crudely, of change. Increasing detection rates may raise concern about the community prevalence of professional sexual misconduct, but these rates may also indicate improved community awareness of the inappropriateness of professional sexual misconduct, or accessibility of reporting processes. Conversely, reductions in the detection rates of professional sexual misconduct may raise the question of a reduction in the community prevalence of professional sexual misconduct, but should also prompt review of reporting processes, which may inadvertently discourage notifications. Detection rates may helpfully alert medical regulatory bodies to the possibility of change within the community, and prompt further examination. Finally, these rates have an importance in terms of the number of cases presenting to the public record, which are often heavily publicised in the media.

Within these limitations, two of studies have examined cross-sectional reporting rates over time, within jurisdictions, to consider whether reporting of professional sexual misconduct is changing over time.

One 2004 Oregon study examined changes in rates of professional sexual misconduct over time. Rates of professional sexual misconduct presented to the Oregon Board of Medical Examiners from 1991 to 1995 [42] were compared to those from 1998 to 2002 [69]. The average rate of 5.9% in the years 1991 to 1995 was significantly higher than that in the later study, of 3.1%. This was attributed to improved physician awareness of professional sexual misconduct and its potential consequences, and an associated reluctance to acknowledge any professional sexual misconduct, even in an anonymous survey.

Conversely, in a 1998 [41] United States study, rates of professional sexual misconduct held in a national database were compared from 1989 to 1996. In that time the number of reports increased from 42, or 2.1% of disciplinary orders to 147, or 4.4% of all disciplinary orders. The increase number and proportion of complaints was attributed to increased community awareness of professional sexual misconduct, and a consequent increase in notifications.
These two studies have produced conflicting results. It is likely that within different jurisdictions, over time, the different factors which influence reporting have different degrees of influence. Both studies do demonstrate significant ongoing rates of professional sexual misconduct being reported to the local medical regulatory boards.

Single cross sectional examinations of professional sexual misconduct have also been performed with the intent of gaining an understanding of the doctors involved in professional sexual misconduct. Morrison [72] reviewed all doctors within California, who were disciplined by the California state medical board between October 1995 and April 1997. Three hundred and seventy five doctors were disciplined during this period, with an additional seventy three doctors voluntarily surrendering their license, and therefore stopping an investigation before discipline. Psychiatrists and anaesthetists were over-represented. In a follow up study [40] examining the psychiatrists disciplined, the authors found that psychiatrists were significantly more likely than non-psychiatrist doctors to be disciplined for professional sexual misconduct. This over-representation of psychiatrists is a consistent finding in professional sexual misconduct reporting studies [41, 42].

One small review examined Australian doctors about whom a complaint of professional sexual misconduct incidental to psychiatric treatment was made, in New South Wales in the years 1989 to 1991. In this time, there were eight enquiries about seven medical practitioners. Six were psychiatrists and one was a trainee. Six were male and one female. Six provided evidence about their recent psychiatric treatment, and two were having their own psychotherapy at the time of their misconduct. The psychiatrists were described as having “notable energy, ambition and industry”, and occupying “positions of leadership and influence”. Two were prominent psychodynamic psychotherapy practitioners. This very small study suggested that seniority within the profession, and even expertise in psychodynamic psychotherapy, were not protective in preventing involvement in professional sexual misconduct.
Studies of reporting rates of professional sexual misconduct are confounded by the factors which influence reporting, and these factors often cannot be generalised beyond the jurisdiction where the study was performed. However, these studies have demonstrated persisting rates of professional sexual misconduct before Medical regulatory bodies, as well as the over-representation of some medical specialties, most notably psychiatry.

1.3.2 The Costs of Professional Sexual Misconduct for the Community

Professional sexual misconduct has, then, been demonstrated to be harmful for the patients involved. Reporting and detection studies have demonstrated persisting levels of professional sexual misconduct within all communities studied. Professional sexual misconduct is a persisting phenomenon that continues to cause serious harm to the number of individual patients involved. What, however, are the costs of professional sexual misconduct for the broader community?

Firstly, the community may well be seen to bear the costs associated with the harm done to individual patients involved in professional sexual misconduct. Patients involved in professional sexual misconduct may have complex medical and mental health treatment needs following an experience of professional sexual misconduct, and in communities where the costs of healthcare for the individual are supplemented, these costs will be met by the community. Beyond the costs of healthcare, any degree of disability which results from the professional sexual misconduct may have far-reaching social effects for the individual affected, as well as their community. Although it seems likely that the serious mental health consequences of professional sexual misconduct described by Quadrio [50, 51] would be associated with significant disability, establishing the extent of this and its costs has not been attempted by any researchers internationally.

Medical education is extremely expensive. Although the individual doctor may be required by their university to pay for some portion of their medical education, there remains a substantial proportion that is borne by the university in Australia. There is a financial cost to the community, then, of producing a doctor. The community pays this cost in the knowledge that the graduating doctor will provide a necessary service that is otherwise unavailable. Doctors who are found to have committed professional
sexual misconduct, however, are usually either suspended from clinical practice for a period of time, or permanently deregistered. The community, then, will have a reduction in the expected return from this doctor.

In addition to this financial cost, the number of positions within medical schools is limited. When a doctor is either temporarily or permanently unable to work, the community experiences a reduction in its medical workforce. Although medical workforce shortages are most extreme in developing nations, the phenomenon of “brain drain”, and doctors leaving developing nations to fill workforce shortages in developed nations, means that the workforce issues of developed nations are connected with those of developing nations. Even within developed nations, medical workforce shortages are noted with the aging population and the associated increased healthcare requirements, as well as in non-urban settings and within some specialties, including general practice. Deregistration of a doctor found guilty of professional sexual misconduct, then, has a cost beyond the financial, in terms of medical workforce shortages.

In addition to these costs to the community, professional sexual misconduct also has a cost in terms of the effect on the community’s ability to trust the medical profession. Cases of professional sexual misconduct are usually highly publicised as they are considered by medical regulatory bodies. Although this publicity may have important positive functions in terms of clearly communicating the unacceptability of this conduct, and ensuring that the processes around responding to professional sexual misconduct are transparent, this publicity does offer the community a reminder that not all doctors are trustworthy. This reminder and the ways that it may influence public perception is, in turn, a challenge for the medical profession. The implications of professional sexual misconduct for trust in the medical profession will be considered further in Chapter Four’s examination of trustworthiness as an expectation of the medical profession.

1.4 The Significance of Professional Sexual Misconduct for the Medical Profession

The significance of professional sexual misconduct for the medical profession can be seen in terms of the direct effects of individual cases, and the indirect effects that
result as cases of professional sexual misconduct are processed through medical regulatory bodies, in the eyes of the community. The two phenomena are, of course, related.

1.4.1 When the Doctor Becomes Aware of Professional Sexual Misconduct by a Colleague

Individual cases of professional sexual misconduct may come to attention through a patient’s disclosure to another doctor, or when a doctor’s suspicions are raised by the behaviour of another doctor. Doctors may therefore be involved in the notifying of cases of professional sexual misconduct involving a colleague. This is likely to be an intensely stressful process for the doctor, in some ways similar to that of a patient considering a notification. The doctor may, like the patient, carry some ambivalence about their involvement in the notifications process, with awareness of the potential implications of a notification of professional sexual misconduct for the doctor in question. The doctor may over-identify with the doctor accused, and even hold some doubts about the veracity of the patient’s complaint.

This reluctance by doctors to make a notification has been well documented [24, 48, 73, 74, 75] and can result in delays and even deterrents in actual notifications. In a number of cases of professional sexual misconduct, it has retrospectively been noted that a number of their colleagues had had longitudinal concerns about their colleague’s conduct, but been dissuaded from making a notification because of their own doubts. These cases have often included prominent and well-respected doctors, with senior academic roles within training hospitals [24]. The doctors who have not made notifications may be motivated by factors as far-ranging as their own doubts as to whether they had enough ‘evidence’, nihilism about the likelihood of the doctor being held account, genuine concern for their colleague whom they may perceive as ‘impaired’, and fears for the implications of such a notification for their own career, if they are seen as a ‘whistleblower’.

Consequently, there have been a number of cases recorded, and potentially others that have not come to attention, when a patient has disclosed that they had had, or were having, a sexual relationship with one doctor, to another doctor. The doctor to whom the patient makes the disclosure has responded in such a way that the patient
is dissuaded from making a notification to a medical board. The doctor who receives the disclosure may be motivated by a range of beliefs, including disbelief that such conduct occurred, concern for the patient about the experience of making the notification and subsequent medical regulatory body investigation processes, or even an overt desire to protect their colleague.

Gabbard [pages 45-51, 44] has described in detail the factors which may contribute to a poor response to a patient’s disclosure of an experience of professional sexual misconduct. They are categorised as follows;

1. Ignorance that therapist-patient sex is wrong – although this is increasingly difficult to believe, with clear prohibition of professional sexual misconduct by professional organisations, ignorance by colleagues continues to be presented as a reason for inappropriate response to a patient’s disclosure
2. Ignorance that mental health professionals have prohibited therapist-patient sex
3. Narrow preconceptions about the occurrence of therapist-patient sex – not recognising behaviour as prohibited because it is atypical
4. Bizarreness of the episode
5. Misunderstanding informed consent – believing that the patient has consented to the sexual behaviour may lead to a doctor’s inappropriate response to the disclosure
6. Guilt – the doctor who receives the disclosure may collude with the patient’s inappropriate sense of responsibility for the professional sexual misconduct, and therefore fail to recognise the responsibility of the treating doctor
7. Apparent functioning – because the patient is apparently functioning at a reasonable level, it may be difficult for subsequent doctors to recognise the harm done, and deny this
8. Attributing damages to a pre-existing condition – the distress experienced by the patient may not be recognised and associated with their experience of professional sexual misconduct, but rather, attributed to pre-existing difficulties
9. Continuing sexual involvement – the patient’s ongoing sexual relationship with their previous therapist may lead the doctor to consider this to be a non-harmful relationship
10. The patient’s anger, motivation, or style – the doctor to whom the patient makes the disclosure may be influenced by the patient’s presentation of their experience of professional sexual misconduct, to either find them less credible, or less able to be engaged with appropriately.

11. Inappropriate boundaries of therapy – doctors may be unaware that sexual relationships between doctor and patient are just as harmful, even if they occur outside of the treatment setting.

12. Defensive pride in the profession – the doctor to whom the patient makes their disclosure may be reluctant to support a notification of professional sexual misconduct because of concerns about how a notification may lead to discrediting of the profession, and consequent increases in external regulation.

13. Sympathy for a colleague – Gabbard states that subsequent therapists who receive the patient’s disclosure may believe “there but for the grace of God go I”, leading to a “conspiracy of silence”.

14. The Bad Samaritan – doctors, like other people, may simply not want to get involved in situations which they anticipate will be difficult.

15. Sense of omniscience – the doctor to whom the patient discloses their experience of professional sexual misconduct may be influenced by their inappropriate sense of confidence that they are able to know what is right and wrong without a full assessment or understanding.

16. Attraction to the harmed patient – the doctor who feels attracted to the patient may minimise the patient’s concerns, or respond inappropriately.

17. Bias – the doctor may respond inappropriately to the patient’s concerns because of their own beliefs about patients who have been involved in professional sexual misconduct.

In Australia, however, the Australian Medical Association’s Code of Ethics obliges members to ensure that any patient who makes an allegation of professional sexual misconduct is informed of all options available to them in having the allegation dealt with [76]. All Australian State and territory medical boards have issued clear policy statements regarding professional sexual misconduct [page 92, 52]. More recently, the Health Practitioner Regulation National Law Act 2009 [20] has mandated mandatory reporting of colleagues who are suspected of professional sexual misconduct.
1.4.2 When a Colleague is Found Guilty of Professional Sexual Misconduct

Beyond the notifications process, doctors may be directly affected by professional sexual misconduct when their colleagues are found guilty of it. The doctors found guilty of professional sexual misconduct are not infrequently in senior and academic positions. The impact on their colleagues of their misconduct may be particularly serious because of their role or seniority. When doctors who occupy roles as mentors, educators or leaders, are found to have committed professional sexual misconduct, this may leave other doctors questioning the integrity of the profession as a whole, and their own place within it. Doctors may struggle additionally in response to a disclosure of professional sexual misconduct when the perpetrator is well known to them, or when the media portrayal of a case of professional sexual misconduct is prominent.

1.4.3 Consequences for Doctors Themselves Found Guilty of Professional Sexual Misconduct

The group of doctors most obviously affected by professional sexual misconduct is, of course, doctors accused of this behaviour. The medical regulatory boards’ investigation may involve exposure of the accusation to the doctor’s colleagues and patients, with the Hearings themselves usually open to the public. The media are understandably increasingly interested in presenting information from these Hearings to the general public, and there may consequently be detailed information presented to the community as a whole, with varying degrees of salaciousness in the reporting.

For the doctor involved, there is an immediate and dramatic change in their role in the community. They are ‘transformed’ from idealised and trusted to dangerous and deviant. The doctor’s whole sense of themselves as an individual may be based in that of the traits of ‘a doctor’, and the loss of this role may leave them with little else that is familiar. Their family and colleagues may, in turn, also struggle to reconcile the accusations with their perception of the person. If the doctor’s professional sexual misconduct occurred whilst they were in a marriage or committed relationship, the doctor and their partner will have the implications of infidelity to deal with, without privacy. For the doctor and their family there will also be pragmatic implications in terms of restrictions on the ability to practice if found guilty of
professional sexual misconduct. The consequent loss of income may result in major changes in lifestyle for a doctor not qualified or skilled to work in any other way.

Cases of professional sexual misconduct can be seen to directly impact on members of the medical profession as potential notifiers of professional sexual misconduct, as colleagues of doctors accused of professional sexual misconduct, as perpetrators of professional sexual misconduct, and as members of the same profession. The broader implications for the medical profession not directly involved are no less serious.

Above I have described a loss of trust in the medical profession as harm to the broader community, resulting from professional sexual misconduct. Although the community may experience this harm in terms of being able to trust the medical profession, the medical profession also sustains a harm. The perception of the medical profession as an institution, as well as its individual members, is altered by professional sexual misconduct. The perception of the medical profession as trustworthy is crucial for its differing roles in the community, and damage to this perception is therefore serious. The implications of professional sexual misconduct for trust in the medical profession will be considered further in Chapter Four’s examination of trustworthiness as an expectation of the medical profession, and as a framework for examination of professional sexual misconduct.

1.5 Conclusions
Professional sexual misconduct is defined as a sexual boundary violation prohibited by a medical regulatory body. A sexual boundary violation is any sexual conduct between a doctor and their patient, including verbal comments, and regardless of whether the conduct appears consensual.

In Australia, professional sexual misconduct is prohibited by the Medical Board of Australia. This prohibition has been established for a number of reasons. It is clear that many patients involved in professional sexual misconduct are harmed by it. Estimates as to what proportion of patients are harmed vary, and will be difficult to reliably establish because of the under reporting of professional sexual misconduct.
It does not need to be confirmed that all patients involved in professional sexual misconduct are harmed, to justify the prohibition. Instead, the fact that a significant number are harmed, and that it is impossible to predict which patients will be harmed, justifies prohibition for all.

Professional sexual misconduct results in other harms beyond the patients directly involved in professional sexual misconduct. The community is harmed with the betrayal of trust by the doctor. In turn, the medical profession is harmed if the community perceives that the profession as a whole is less trustworthy than hoped. There are economic implications resulting from deregistration of doctors, with expensive educations that the community has invested in. There are also major social implications if the community becomes less trusting in its medical profession.

Despite these serious consequences, and the established prohibition on professional sexual misconduct in Australia, the Medical Board of Australia continues to receive notifications about what is later substantiated to be professional sexual misconduct. The number of notifications of professional sexual misconduct is difficult to establish currently, based on publically available data. Reported rates of professional sexual misconduct are underestimates of community prevalence rates, and reported rates, although difficult to confirm exactly, are not trivial. The responses of the community to professional sexual misconduct are crucial in terms of protecting the community from further harms, including a loss of confidence in the medical profession. Opportunities to improve the community’s responses to professional sexual misconduct, including prevention, must continue to be sought. Current community responses to professional sexual misconduct will be considered next.
Chapter Two: Current Community Responses to Professional Sexual Misconduct

2.1 Established Processes for Responding to Professional Sexual Misconduct in Australia

Sexual behaviour between doctors and their patients has been prohibited in all Australian states and territories since the 1980’s. Since the prohibition of professional sexual misconduct, Australian medical regulatory boards have been faced with the challenge of how to best respond to allegations of professional sexual misconduct.

Until July 2010, these medical boards were state and territory based. In July 2010 the introduction of legislation of the *Australian Health Practitioner Regulation National Law Act 2009*, the Medical Board of Australia became the body responsible for regulating the medical profession. The Medical Board of Australia continues to receive notifications regarding professional sexual misconduct.

The Medical Board of Australia seeks prevention of professional sexual misconduct, communicating the prohibition to the community and doctors, and encouraging education for undergraduate, graduate and postgraduate doctors regarding this prohibition. The Medical Board of Australia is also responsible for responding to notifications of professional sexual misconduct, for identifying doctors who pose a risk to the public, and for intervening to attempt to remove this risk.

It is this intervention which is the most challenging. The Medical Board of Australia’s stated primary role is to “protect the public” [13]. This is role is compatible with a consequentialist ethical framework, seeking to maximise good for the Australian community. If the Medical Board’s sole intent was to protect the public, deregistration of doctors at increased risk of further professional sexual misconduct would be the expected outcome.

The outcomes of Panel Hearings conducted by the Medical Board of Australia are far more complex, however, and refer to other factors in determining the outcomes. In
particular, the significance of the Briginshaw Standard of evidence, and the presence of any apparent illness in the doctor are frequently raised and influential in Panel Hearings.

These factors suggest that ethical frameworks other than consequentialism are relevant in Panel Hearings, and indeed in the conduct of the Medical Board of Australia. I argue that the consideration of these factors equates with a rights-based approach regarding the doctor’s position. I therefore suggest that the current approach used by the Medical Board of Australia in their consideration of cases is a consequentialist one tempered by a right-based consideration of the doctor’s eligibility to practice. I argue that this framework may reflect neither the declared role of the Medical Board of Australia nor community expectations. The mismatch between the Panel Hearing processes and community expectations in particular has the potential to be problematic, and to be perceived as cronyism.

I argue that professional sexual misconduct should be considered according to an ethical framework, but that this framework should be consistent with reasonable community expectations, and able to respond to the complexities of professional sexual misconduct.

2.1.1 The Australia Health Practitioners Regulatory Agency, the Medical Board of Australia and the Health Practitioner Regulation National Law Act 2009

Allegations of professional sexual misconduct by a doctor in Australia are responded to through the now well-established Australian Health Practitioner Regulatory Agency (AHPRA). This Agency is governed by the *Health Practitioner Regulation National Law Act 2009* [77], which was enacted from July 1 2010. Under this act, for the first time in Australia, ten health professions are regulated by legislation that is nationally consistent. The medical profession is one of the professions regulated by this act. This regulation occurs through the Medical Board of Australia (MBA), which is supported by AHPRA. Prior to the establishment of AHPRA and the MBA, each Australian state or territory independently enacted local, state-based legislation to regulate medical practitioners working in that state or territory.
The establishment of a National Health Practitioner Agency, and with it, a National Medical Board, was done after the Australian Productivity Commission raised concerns about the ability of a state and territory based system to enable national medical workforce planning [78]. In essence, it was impossible to understand how many doctors were working in Australia, as many were registered in multiple states and territories. In turn, the different states and territories were all keeping different data necessary for understanding an aging medical workforce and planning for a future medical workforce.

The prohibition on professional sexual misconduct was established prior to the establishment of the MBA, but has been responded to by this body since July 2010.

Any member of the community who has a concern about the conduct of a doctor may make a “notification” to AHPRA. Since July 2010, all health professionals have been obliged to make notifications about professional sexual misconduct if they hold a “reasonable belief” that another health professional is engaged in this conduct. Most notifications are voluntary notifications, and may be in response to concerns that:

- “the practitioner’s professional conduct is or may be of a lesser standard than that expected by the public or the practitioner’s professional peers
- the knowledge, skill or judgement possessed, or care exercised by the practitioner is or may be below the standard reasonably expected
- the practitioner is not, or may not be, a suitable person to hold registration
- the practitioner has, or may have, an impairment
- the practitioner has, or may have, contravened the National Law
- the practitioner has, or may have, contravened a condition of his or her registration or an undertaking given to the Board and/or
- the practitioner’s registration was, or may have been, obtained improperly” [79]
When AHPRA receives a notification about a doctor, a preliminary assessment is made. The Board may decide to proceed with an investigation if there are concerns that:

- “the practitioner has or may have an impairment or
- the way the practitioner practises is or may be unsatisfactory or
- the practitioner’s conduct is or may be unsatisfactory” [79]

When notified regarding sexual behaviour between a doctor and their patient, a performance and professional standards panel conducts a Panel Hearing once the preliminary assessment is completed.

These panel hearings have the capacity to impose conditions on the registration of the doctor, including deregistration, as well as to caution or reprimand the doctor [19].

### 2.1.2 The Primary Purpose of the Medical Board of Australia

The MBA, in enacting the *Health Practitioner National Law Act 2009*, states its primary role to be the “protection of the public” [13]. This is the primary role of all ten national health practitioner boards, and no other secondary roles are identified. The role of the MBA is described on its website as “to:

- register medical practitioners and medical students
- develop standards, codes and guidelines for the medical profession
- investigate notifications and complaints
- where necessary, conduct panel hearings and refer serious matters to Tribunal hearings
- assess International Medical Graduates who wish to practise in Australia
- approve accreditation standards and accredited courses of study” [13]

All of these roles can clearly be related to the protection of the public, through the establishment of standards, the communication of those standards, and the response to concerns about whether those standards are being adhered to. By stating that the protection of the public is the Board’s primary role, there is some inference that there are also secondary roles. However, these secondary roles or
purposes are not identified or declared by the MBA, and are certainly not communicated to the general public.

2.1.3 Consequentialism as the Medical Board of Australia’s Ethical Framework

The protection of the public is, then, the sole identifiable or explicit role of the MBA, and the Board’s stated primary role. The MBA does not make explicit the ethical framework from which they are operating. However, the Board’s declared primary purpose of protecting the public is compatible with a consequentialist framework.

Consequentialism is defined as “the view that the consequences of an act are what make it right or wrong” [80].

If the Board’s principle function is the protection of the public, it is prioritising desired consequences. These desired consequences are the protection of the welfare of the community as a whole. The MBA must therefore be seen to be acting according to a consequentialist ethical framework, with this ethical principle being compatible with its sole declared purpose.

How, then, is this ethical principle enacted through the prohibition of professional sexual misconduct? As we have considered in Chapter One, professional sexual misconduct cases continue to present before the Medical Board of Australia, despite an established prohibition. These cases may well represent only a small proportion of the professional sexual misconduct occurring in the community. Professional sexual misconduct has been shown to be harmful to patients involved, as well as having implications for the medical profession and the community as a whole, by undermining community trust in the medical profession. The prohibition of professional sexual misconduct would therefore seem to be compatible with a consequentialist framework.

Although the MBA’s declared role is compatible with an ethical framework of consequentialism, there are a number of reasons to argue that the MBA’s response to notifications about cases of professional sexual misconduct is not completely in keeping with this ethical framework. Professional sexual misconduct causes serious
harm to many of those patients involved. The MBA, according to a strict consequentialist model, would be intent upon reducing the amount of harm caused to a minimum. This would include preventative strategies, such as the establishment of guidelines and the communication of those guidelines. These guidelines are in place, and the prohibition regarding professional sexual misconduct is publicised in a number of ways, including through the Board’s website.

In addition to preventing professional sexual misconduct through education, if acting solely according to a consequentialist framework, the Board would also seek to ensure that doctors at higher risk of enacting professional sexual misconduct were not able to do so. There is a very limited literature on the prediction of professional sexual misconduct. Although doctors who have committed professional sexual misconduct have been comprehensively described by Gabbard according to their psychological status, it has never been suggested that all doctors with such difficulties are at predictable risk of professional sexual misconduct. Although primary prevention of professional sexual misconduct is compatible with the Board’s purpose of protecting the public, and a consequentialist framework, at the current time there is very little research into the ways in which such prevention may occur, or evidence that it may occur effectively.

There have been a number of cases of professional sexual misconduct in which the doctor had a history of previous professional sexual misconduct. Rates of recidivism of professional sexual misconduct are not known, and are likely to be difficult to establish, due to under-reporting. However, a consequentialist framework of protecting the public would emphasize ensuring that potentially recidivist doctors were not allowed to continue practicing, and potentially cause further harm. There is no evidence that there are any factors which enable recidivism to be predicted, other than having committed professional sexual misconduct at least once. That is, doctors who commit professional sexual misconduct are at some increased risk of committing professional sexual misconduct in the future, compared to the general population of doctors. If the MBA is acting with the sole purpose of protecting the public, and this group of doctors is at increased risk of causing harm to the public, permanently deregistering this group of doctors would be one way of reducing the likelihood of harm to the public.
Neither the MBA nor the State and Territory Boards have acted in this way, however. Doctors who have been found to have committed professional sexual misconduct are allowed to continue practicing within the community, albeit often after a period of suspension of their registration. Could this be consistent with the Board’s sole declared purpose of protecting the public? This could be argued to be consistent with protection of the public in three circumstances only:

1. If the cause of the professional sexual misconduct was able to be identified and reversed, and there was, therefore, no further risk of professional sexual misconduct from that cause,
2. If measures were able to be put in place to prevent professional sexual misconduct in the future, regardless of the cause(s), or
3. If there was an ongoing risk of professional sexual misconduct was recognised and acknowledged, but the potential harm associated with further professional sexual misconduct is thought to be outweighed by the benefits, for the community, of the doctor continuing to practice

I will argue that none of these criteria are met in cases of professional sexual misconduct before the MBA.

Criteria One argues that there is a specific, reversible cause of professional sexual misconduct. This argument neglects the complex nature of professional sexual misconduct, and the deficits in our understanding of the causes. Although some treatment programs offer psychotherapy for the doctors found to have committed professional sexual misconduct, this has not been demonstrated to prevent further professional sexual misconduct. Indeed, of the doctors found to have committed professional sexual misconduct, many have previously undertaken psychotherapy, and some are engaged in psychotherapy at the time of the professional sexual misconduct. Similarly, supervision has not been shown to guarantee safety for the community.

Criteria Two’s requirement for measures to prevent further professional sexual misconduct is plagued by the same difficulties as Criteria One, in terms of factors within the doctor which can be reversed to prevent further professional sexual misconduct. Prevention may also, however, include external factors which control
the doctor’s behaviour. This would essentially result in the requirement for a permanent chaperone if there was to be an attempt to ensure an absolute guarantee of no further professional misconduct. No chaperone could ensure that the doctor was not seeing additional patients, perhaps out of hours, without their knowledge, however. Even the required presence of an additional person may not prevent professional sexual misconduct if the doctor is not committed to work in this way. Although Medical Boards have required use of chaperones for some doctors following professional sexual misconduct, this requirement has been time limited and specific to the early phase of return to clinical practice for the doctor.

Finally, in terms of Criteria Three, no Australian Medical Board (state, territory, or national), has ever argued that it is reasonable that a limited number of patients be expected to experience professional sexual misconduct, because the benefits for the community as a whole of the doctor continuing to practice outweigh any harm done.

The three criteria described above would enable the continued practice of doctors found to have committed professional sexual misconduct, and be compatible with a singularly consequentialist ethical framework. I argue that Criteria One is not in keeping with any evidence-based literature, that Criteria Two is not feasible, and Criteria Three is not in keeping with any policy of the MBA or its predecessor Boards. The continued registration, and clinical practice, of doctors who are found to have committed professional sexual misconduct suggests the presence of competing ethical principles guiding policy.

2.2 Alternate Factors Guiding the Responses of the Medical Board of Australia to Complaints of Professional Sexual Misconduct, and the Implied Ethical Frameworks

I will argue that there are three other factors which act to moderate the board’s explicitly declared priority of protecting the public. The psychodynamic motivations of the doctor and the Briginshaw Principle are influential during Board Panel Hearings.

The Briginshaw Principle is applied when considering the outcomes of the Hearing. The Briginshaw Principle is consistently referred to in professional sexual
misconduct hearing reports from Australian Medical Boards. Under this principle, the implications of a finding of professional sexual misconduct for the doctor accused are weighed to require a higher standard of evidence than may be required for some civil hearing cases. This principle therefore emphasizes the implications of de-registration for the doctor.

The presence of impairment in the doctor has not been demonstrated to predict a higher or lower likelihood of future recidivism in the future. Although it may be argued that the presence of a treatable, reversible illness may reduce the likelihood of recidivism, the very high rates of use of psychiatrists as expert witnesses during Medical Board processes have broader implications, as noted by Kiel [15]. The process of considering illness in the doctor is only congruent with the principle of protecting the public if the misconduct is attributable to the illness, and the illness is reversible. In Panel Hearings, illness is referred to in a far more general way.

2.3 The Briginshaw Principle

The Briginshaw Principle or Standard is a legal principle which relates to the standard of evidence required for civil legal cases in Australia in which the potential implications for the alleged wrong are very serious [21]. The Briginshaw Principle was established in the case of Briginshaw v Briginshaw (1938) 60 CLR 336.

In the case of Briginshaw v Briginshaw, Mr Briginshaw sought divorce from his wife. In Australia in 1938, in order to be able to proceed with divorce, either the husband or wife was required to prove ‘grounds’ for this, in the form of wrongdoing on the part of the other. In the case of Briginshaw v Briginshaw, Mr Briginshaw sought to prove that Mrs Briginshaw had committed adultery. This would then provide the basis for a divorce.

In Australia until that time, case law had established two standards of evidence, required for legal cases [21]. For civil cases, the standard of evidence must be such that there is adequate evidence to prove allegations on ‘the balance of probabilities’. In contrast, for criminal cases, the standard of evidence must be adequate to prove allegations ‘beyond reasonable doubt’. The standard of evidence for criminal cases is clearly a greater one than that required for civil cases.
In *Briginshaw*, however, the judge declined to grant a divorce to Mr Briginshaw on the grounds of adultery, stating that he was not satisfied that adultery had occurred, *beyond reasonable doubt*. That is, the judge cited a criminal, rather than a civil, standard of evidence. Mr Briginshaw appealed to the High Court of Australia, arguing that the criminal standard of evidence should not be applied to divorce. The High Court agreed that because divorce was not a criminal offence, a criminal standard of evidence should not apply. However, the High Court also recognised that the implications of a finding of adultery against Mrs Briginshaw in Australia in 1938 were extremely serious, and argued that the standard of evidence available was inadequate. Consequently, the High Court rejected Mr Briginshaw’s appeal.

The *Briginshaw Principle* therefore directs that in certain civil cases, “If the finding is likely to produce grave consequences, the evidence should be of high probative value” [21]. The standard of proof remains a civil one, as ‘on the balance of probabilities’. However, the “strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove” [81].

The types of civil cases in which the *Briginshaw Principle* is applied are classified by de Plevitz [21] as:

A. Allegations of Serious Misconduct in Civil Proceedings
   1. Murder
   2. Sexual abuse of children
   3. Gross medical negligence
   4. Fraud
   5. Serious and wilful conduct warranting dismissal from employment

B. Where the outcome of the decision may be irreversible
   1. Loss of liberty
   2. Sterilisation of young women
   3. Whether a person is of a particular race
   4. Doctors and lawyers struck off or suspended from their professional roll

C. All Australian Anti-Discrimination Jurisdictions, because of the seriousness of any allegation of discrimination or harassment.
Cases of professional sexual misconduct are included in those civil cases to which the *Briginshaw Principle* is applied, as a type of case “Where the outcome may be irreversible” with “Doctors and lawyers struck off or suspended from their professional roll” [21]. This is evidenced by direct reference made to the *Briginshaw Principle* within Formal Hearing Reports documenting cases of professional sexual misconduct before the MBA [82-85]. What, then, are the ethical implications of use of the *Briginshaw Principle*?

### 2.3.1 Ethical Implications of the *Briginshaw Principle*

The *Briginshaw Principle* recognises the serious implications of the outcomes of some civil cases for the individual(s) accused of wrongdoing. As such, it offers protection for those individuals from excessive harms potentially done. The Briginshaw Principle protects, then, the rights of an individual from potential losses and harms.

The MBA’s mandate is, as we have considered, protection of the public. However, the *Briginshaw Principle* does not have protection of the community as its priority. It could be argued that by enabling more doctors to continue to practice, the *Briginshaw Principle* may have some indirect, or incidental, benefit to the broader community. However, these doctors may similarly cause harm, and the *Briginshaw Principle* may therefore act to in ways that do not contribute to the Board’s desired outcomes.

The *Briginshaw Principle* ultimately acts independently of the Board’s principle of protecting the public. It is also possible for standards according to the *Briginshaw Principle* to undermine the Board’s primary role, and there is some inherent tension between the Consequentialist goal of the Board, considering the broader needs of the community for safe healthcare, and the individual rights of the doctor, seeking to continue to practice despite concerns raised about their safety to do so. The two competing priorities are ultimately balanced within Panel Hearings, with protection of the public ultimately tempered by some consideration of the rights of the doctor.
2.3.2 Strengths and Weaknesses of Applying the Briginshaw Principle When Considering Professional Sexual Misconduct

The Briginshaw Principle is used across a range of civil court cases. The implications of application of the Briginshaw Principle vary depending on the type of case. There are unique implications associated with the application of the Briginshaw Principle to cases of professional sexual misconduct, by doctors, when being reviewed by the MBA.

There are obvious strengths associated with the use of the Briginshaw Principle, particularly for the doctor charged with professional sexual misconduct. With a higher standard of evidence required, the doctor cannot be charged with cases of professional sexual abuse where the level of evidence is inadequate. The doctor is protected from false allegations, and his or her right to practice is protected. This is particularly important because being found to have committed professional sexual misconduct is enormously stigmatising for the doctor. The finding of professional sexual misconduct, or even an unsubstantiated allegation, may therefore have irreversible implications for a doctor who is deregistered.

The protection of the rights of the doctor is undoubtedly the main strength of the Briginshaw Principle. It could be argued that there is an additional benefit to the community in which the doctor works, if the doctor is enabled to continue to practice. In this way, the community is able to access a resource (medical care) that may be limited in availability. This is not the primary intent of the Briginshaw Principle, however.

On the other hand, the application of the Briginshaw Principle is associated with some potential hazards when used to determine appropriate outcomes for doctors charged with professional sexual misconduct. Firstly, this principle prioritises the rights of the doctor (to practice) over the rights of the community (to safe care). If the MBA prioritises the rights of the doctor in this way, this may promote an appearance of cronyism to the broader community, right at the point that serious harms are being highlighted.
The *Briginshaw Principle* may also raise the standard of evidence in cases where it is particularly difficult to ever meet this standard. Establishing the standard of evidence in any legal case concerning sexual behaviour will potentially be extremely complex. In professional sexual misconduct cases, the power imbalance between doctor and patient, as well as the presence of the patient’s health care within the relationship, may make it even more complex to meet the required standard of evidence. The *Briginshaw Principle* may place such a burden of evidence in these cases that the standard cannot be established because of the context in which the harms occurred.

Finally, the *Briginshaw Principle* does not make any claim to predict recidivism, nor protect the community from future harms. The application of this principle, and its prioritising the rights of the doctor, could be argued to be acting contrary to the MBA’s stated principle of protecting the public. At the very least, it is clearly an additional principle guiding responses from the MBA.

### 2.4 Illness Factors Within the Doctor Which Contributed to the Professional Sexual Misconduct

#### 2.4.1 Current Classifications of Doctors Who Have Committed Professional Sexual Misconduct

The predominant model used to classify doctors who are involved in professional sexual misconduct internationally is that developed by Professor Glenn Gabbard. As described in Chapter One, this model is based upon a psychoanalytic understanding of the factors within the doctor, and then between doctor and patient, which contribute to the professional sexual misconduct.

This classification has been developed after extensive study and assessment of psychotherapists who have been found guilty of professional sexual misconduct, through the Menninger Clinic program [31]. The relevance of this model to the broader population of non-psychotherapist doctors involved in professional sexual misconduct has not been argued by Gabbard.
Although this model has applications for the treatment and rehabilitation of all doctors, and has been applied for these purposes through the Menninger Clinic’s program, it has not been demonstrated to reduce the likelihood of future sexual misconduct. If a doctor who has committed professional sexual misconduct is able to address or reduce the intrapsychic factors which contributed to the professional sexual misconduct, it could be argued that there is a subsequent reduced likelihood of further professional sexual misconduct. However, change consequent to engagement in psychotherapy has never been demonstrated. Demonstrating this effect is likely to be fraught with both the well-established range of factors which undermine psychotherapy research, in addition to the research difficulties described in Chapter One into establishing rates of professional sexual misconduct.

2.4.2 Strengths of Gabbard’s Psychodynamic Model

Gabbard’s psychodynamic model of doctors who have committed professional sexual misconduct has been enormously important for a number of reasons. Firstly, this model has contributed immeasurably to the understanding of doctors who commit professional sexual misconduct. This understanding is essential not only for the doctors involved, but the broader community. Through examination of the psychodynamic antecedents to professional sexual misconduct, as well as the professional sexual misconduct itself, this model has promoted consideration and discussion of a subject that the medical profession was previously reluctant to engage in.

Gabbard’s model has undoubtedly contributed to the education of doctors, and their understanding of professional sexual misconduct. It has been argued this understanding, if it leads to individual reflection and awareness, may contribute to the prevention of professional sexual misconduct [31, 86].

As well as presenting his classification of doctors as a way of understanding doctors who have committed professional sexual misconduct, Gabbard has sought to change the medical profession’s beliefs about these doctors and professional sexual misconduct [31]. In particular, Gabbard argues that much of the medical profession considers itself invulnerable to professional sexual misconduct. Doctors who are found to have committed professional sexual misconduct are consequently
demonised by the remainder of the profession. Gabbard argues that all doctors have some potential vulnerability to engaging in professional sexual misconduct, and that this vulnerability may be increased or decreased depending on external and internal stressors. He argues that continued reflection on our own vulnerability is a potential pathway for prevention of professional sexual misconduct.

Thirdly, beyond prevention of professional sexual misconduct, Gabbard’s framework has been used extensively in the treatment and rehabilitation of doctors who have committed professional sexual misconduct. Gabbard’s psychodynamic classification of doctors who have committed professional sexual misconduct was developed in the context of the treatment of those doctors through a treatment centre. This model has been used extensively within the Menninger Clinic’s treatment setting for doctors found to have committed professional sexual misconduct. The largest centre of its type internationally, the authors argue that this model has been important in treatment of these doctors, and also for the potential for this treatment to reduce the likelihood of recidivism [14, 44].

Despite these three important contributions, Gabbard’s model was not developed for the purposes of predicting recidivism or the allocation of responses to doctors found guilty of professional sexual misconduct, with the intention of protecting the community.

2.4.3 Limitations of Gabbard’s Psychodynamic Model

Gabbard’s model, then, has been profoundly important in terms of promoting understanding of, and discourse about, professional sexual misconduct. Its use has been extended far beyond these roles, however, and in fact far beyond anything recommended by Gabbard.

Gabbard’s psychodynamic model has, over time, been generalised to the assessment processes and investigations of medical regulatory boards responding to notifications of professional sexual misconduct. Gabbard has never suggested that this was an appropriate use for his model. I will argue that there are a number of concerns associated with use of this model when it is used by medical regulatory bodies considering appropriate responses to professional sexual misconduct.
2.4.3.1 The inappropriateness of an illness model when considering responsibility for professional sexual responsibility, and the associated appearance of cronyism

There are a number of hazards associated with use of a clinical framework in considering doctors who have committed professional sexual misconduct. This may appear to confer benefits associated with the sick role inappropriately, and be sought excessively by doctors invested in continuing to practice. In turn, impairment may come to be associated with misconduct in such a way that stigmatises impairment further. Finally, the presence of doctors testifying on behalf of other doctors regarding their mental health may be associated with some perception of cronyism by the community.

The potential consequences of a notification before the MBA are extremely serious for the doctor involved. Depending on the outcome of their Panel Hearing, the MBA may deregister a doctor temporarily or permanently. Permanent deregistration means that the individual can no longer work as a doctor, and may therefore have to find alternative employment to support themselves and their family. Beyond the financial losses that result from deregistration, there are also significant losses associated with the loss of the social standing that is associated with being a doctor in most western countries, and the direct and indirect benefits conferred by this. Additionally, many of the Panel Hearings that result in deregistration are highly publicised, and there is undoubted stigma for the doctor involved.

Society has long held strong views about the medical profession. Although there may be some ambivalence, overall the doctor is held in extremely high esteem in most western societies. For the individual doctor who gained entry to medical school as an adolescent, and who is continually exposed to society’s perceptions of doctors, there are powerful reasons driving formation of identity as based in being a doctor. When a complaint of misconduct results in a threat to the doctor’s registration, their very identity may also be threatened, with the potential loss of ‘being a doctor’.

The stakes are therefore high for the doctor about whom a serious allegation of professional misconduct is made. Within Australia, the MBA does refer a small
proportion of their complaints for police investigation each year. Notifications do therefore have the potential to result in criminal charges, albeit infrequently. In Australia, the notifications which are referred for police investigation are those in which the police would be involved even if the alleged perpetrator was not a doctor; that is, for criminal acts to which the doctor is not exempt culpability because they are a doctor. In other western countries, however, including the United States of America, there are additional criminal charges to which the doctor is subject because they are a doctor. The criminalisation of some types of professional misconduct has a range of implications for the doctor involved, but undoubtedly also increases the stakes associated with a complaint of profession misconduct.

In the context of these very high stakes for doctors against whom a notification alleging professional sexual misconduct is made, it has been suggested that: “Some doctors go to extraordinary lengths to either defend themselves or to explain their behaviour, relying in many cases on psychiatric evidence. This is particularly true in cases involving sexual misconduct.” [page 132, 15].

Kiel documents that between 1980 and 2005, 40 doctors appeared before the New South Wales Medical Tribunal “in relation to a complaint of sexual misconduct” [15]. Of these doctors, 35 were de-registered, and the remaining five were reprimanded or had conditions placed on their registration. Twenty one of the forty doctors called psychiatric evidence to either “explain or justify their behaviour” [page 133, 15].

In this way, the doctors accused of professional sexual misconduct may be seen to be making use of a psychiatric sick role defence. With the exception of a very small group of psychotic doctors committing professional sexual misconduct, Gabbard does not argue that his psychiatric framework excuses doctors involved with professional sexual misconduct. Nonetheless, psychiatric defences are now being extensively used in hearings in ways that clearly suggest reduced responsibility.

Use of psychiatric frameworks in this way has a number of potential implications. If the doctor is responded to as if they were not, in fact, fully responsible for their conduct, this response may be result in the doctor being enabled to continue with
clinical practice. This may lead to further professional sexual misconduct if the doctor’s propensity to this conduct persists.

However, other doctors will also likely be aware of MBA responses to professional sexual misconduct, including any psychiatric defence and inference of impairment. This awareness may have a number of implications. It may create an ambiguous or unclear message about each doctor’s responsibility to prevent professional sexual misconduct. This may, in turn, be associated with a risk of other doctors committing professional sexual misconduct. Although this risk is impossible to predict or estimate, there is no doubt that it is essential that the message that all doctors are responsible for their own behaviour is clear.

Doctors may also come to associate misconduct with impairment. In this way, impairment may be additionally stigmatised, and this stigma may influence help-seeking. This may in turn be associated with some consequent risk to the community, if doctors are reluctant to seek care for impairments, which may then influence clinical competence if not professional conduct.

Finally, the community may observe hearings in which doctors provide defences for other doctors, and reasonably wonder about the presence of cronyism. This concern about cronyism may undermine the community’s trust in the medical profession even more than the actual misconduct does. Trust in the systems expected to protect the community may also be undermined, and there may consequently be a reduction in reporting of complaints against doctors.

2.4.3.2 The absence of any demonstrable evidence that this model may prevent recidivism

Use of an illness model has the potential to create an appearance of cronyism when responding to cases of professional sexual misconduct. Regardless of how this model may appear to favour doctors found to have committed professional sexual misconduct, a perhaps more important concern is the inability of this model to predict recidivism, or alternately, doctors who do not repeatedly present to Boards with professional sexual misconduct.
Gabbard argues that one of the “major barriers” [18] in addressing boundary violations has come from the psychiatric profession. He argues that (parts of) the psychiatric profession tends to consider boundary violations as perpetrated by a small number of “ethically corrupt predatory male clinicians who systematically prey on female patients” [18]. This understanding is problematic, Gabbard argues, because it creates a false sense of reassurance about the rest of the medical profession’s vulnerability to this conduct. Opportunities for prevention of boundary violations, through education and self-reflection, will therefore be missed.

Gabbard argues that all doctors “are potentially at some risk of violating boundaries, especially given certain forms of life stress” [18]. One of the key outcomes of not just his typology, but those developed by others, is to argue that “vulnerability is not limited to a few anti-social individuals” [18]. These typologies emphasize that, of the doctors who have committed professional sexual misconduct, doctors who meet criteria for “predatory psychopathy” are only one of four categories.

Gabbard does suggest that there is a correlation between which category the psychiatrist fits into, and their capacity to respond to a rehabilitation program. He states that “those clinicians who fit the category of predatory psychopathy and paraphilias are not suited for rehabilitation plans. Those who fall into a lovesick or masochistic surrender category are often, but not always, amenable to rehabilitation, depending on the extent of their remorse, their motivation to avoid future transgressions, and the characteristics of their superego or conscience” [18]. Based on this understanding of the typology’s ability to predict prognosis, Gabbard advocates for psychiatric assessment of all doctors (in fact, “clinicians”), found to have committed professional sexual misconduct by their regulatory board.

Gabbard states, therefore, that “A central principle is that a thorough psychiatric evaluation, preferably by a disinterested party, must precede the determination of amenability to rehabilitation” [18]. Gabbard does, therefore, advocate for a psychiatric assessment of doctors who have been found guilty of professional sexual misconduct, with the purpose of considering their suitability for a rehabilitation program.
Although this recommendation makes clear sense based on Gabbard’s framework, there have been a number of concerns in its implementation. Firstly, Gabbard’s typology has been developed based upon examination of psychiatrists and psychotherapists. It is now applied to all doctors involved in professional sexual misconduct. The generalisability of this typology from psychiatry to all medical disciplines has not been considered in the literature. In particular, the relevance of categories based on psychodynamic relationships, formed over time, has not been considered for doctor-patient relationships which are not prolonged. Although professional sexual misconduct seems more likely to occur in ongoing doctor-patient relationships, there are certainly instances when it occurs in first interactions between a doctor and their patient.

Even if these categories are considered relevant for all doctors involved in professional sexual misconduct, it may be that the categories involving unconscious psychodynamic drives may be less represented in the doctors presenting with professional sexual misconduct outside of psychotherapeutic relationships. It could be argued that these psychodynamic factors, which lead to breaching of interpersonal boundaries, may take some time, and the intimacy of a psychodynamic psychotherapeutic relationship, to emerge. Doctors presenting having breached a boundary outside this type of clinical work may, therefore, be more likely to fit within categories other than the masochistic surrender or lovesickness categories. Conversely, doctors who work psychotherapeutically with their patients may be more likely to work this way because of their own unconscious needs, which may in some ways predispose them to professional sexual misconduct. The remaining group of doctors, then, may be less likely to fit into the psychopathic category. There is, then, the potential for psychiatrists and other doctors to differ substantially in terms of their relative likelihood of fitting into any single category.

A second concern in terms of the implementation of assessing doctors for their fit to Gabbard’s typology is the assessment process itself. Gabbard’s assessments occur within a specialist service developed for the purpose of assessing clinicians found to have committed professional sexual misconduct. Such services are few and far between, and currently none exist within Australia. This psychiatric evidence is called, then, by the doctor accused of professional sexual misconduct. The
psychiatrist providing the psychiatric evidence may well be the doctor’s treating
psychiatrist. This is in contrast with Gabbard’s recommendation for an independent
multidisciplinary assessment, with the intent of seeking guidance about rehabilitation,
and held only after the hearing’s processes are complete. Kiel argues that the
psychiatric assessments performed commonly before Australian medical regulatory
boards are performed at the behest of the accused doctor and with the intent that
this evidence would “explain or justify their behaviour” [page 133, 15].

Kiel further expresses concerns about the legal implications of a treating
doctor/psychiatrist providing expert witness testimony before a medical regulatory
board, arguing that the role of “expert witness” is often inappropriately imbued. In
New South Wales the treating doctor, for example, is not obliged by the usual codes
of conduct set for expert witnesses when testifying before the Medical Board,
although they are afforded expert “status”. Regardless of their status as an expert
witness, Kiel notes that there is the potential for the treating doctor “to experience
some degree of conflict between a duty to the court and a sense of loyalty to the
patient” [page 133, 15]. The lack of expert witness enforced standards for treating
doctors in this situation is all the more complex, but in keeping with international
recommendations that treating medical practitioners not act as expert witnesses, nor
perform legal assessments of their patients, due to these conflicts.

Gabbard’s more general concern about the medical profession’s tendency to view
doctors who commit professional sexual misconduct as only a few “bad apples” [31],
with underlying psychopathy, also holds relevance here. If this is the case, and the
treating doctor/psychiatrist does not believe that their patient (the doctor accused of
professional sexual misconduct) is a psychopath, they may be biased towards not
believing that their patient was involved in professional sexual misconduct. That is,
the medical profession’s tendency to dichotomise the doctors who commit
professional sexual misconduct from the rest of the medical profession, may make it
likely that they will believe denials of professional sexual misconduct from those
whom they identify with in any way, or do not consider to be psychopathic.

This denial of professional sexual misconduct, and minimisation of psychopathic
personality traits, will be all the more likely by a doctor accused of professional
sexual misconduct, upon whose career may well depend on a favourable finding by the relevant medical regulatory board. Gabbard advocates for multidisciplinary assessments “in which psychiatrists conduct psychiatric interviews, psychologists do a battery of psychological tests and a social worker interviews family members or significant others” [18]. Gabbard emphasizes that “in the course of this psychiatric evaluation, the presence of collateral information about the accused psychiatrist must be available so the evaluator does not rely exclusively on the psychiatrist’s own self-report”. In Australia, by contrast, there are no multidisciplinary teams offering this expertise, nor requirement for inclusion of any form of collateral information to be considered in the doctor’s assessment. Instead, the role of ongoing treating doctor may further undermine objectivity.

Kiel [15] argues that the above concerns are further exacerbated in the Australian context when the psychiatric assessment includes reference to risk of future professional sexual misconduct. In a review of all cases of professional sexual misconduct before the New South Wales Medical Board from 1980 – 2005, Kiel noted four major themes that were used by clinicians to predict low future risk of recidivism. These were; a prolonged period of time since the misconduct occurred, description of a “one-off incident, or an isolated event”, the “acceptance of adverse finding, contrition and remorse”, whereas “lack of insight” predicted recidivism. Kiel notes that these factors have not been demonstrated to predict future risk. Kiel cites multiple examples in which the treating psychiatrist has referred to the above factors as argument that their patient will not commit further professional misconduct, and the medical practitioner before the Tribunal has subsequently been found to be guilty of further such conduct.

Kiel states that “the Medical Tribunal, at times, also showed a worrying tendency to accept evidence about future risk, even though the evidence was based on clinical judgment alone” [page 136, 15]. Kiel therefore argues that the medicalisation of professional sexual misconduct does not assist Medical Boards with their primary role of protecting the public. Furthermore, Kiel argues for further examination of risk-assessment approaches for “identifying and analysing the factors that lead to complaints against doctors, problem areas could be identified and strategies implemented to reduce the systemic risk factors”, as well as “disciplinary
proceedings against doctors clearly involve reactive risk management. However, a shift to a more systemic, proactive risk management approach and more disciplined use of expert psychiatric evidence in the Medical Tribunal would offer greater protection to the public” [page 140, 15].

Gabbard’s typology was developed based on examination of a specific group of clinicians, working psychotherapeutically and from multidisciplinary backgrounds. This typology emphasized the range of underlying psychodynamic factors which could contribute to professional sexual misconduct, and hypothesized of a correlation between categories and prognosis with rehabilitation. Subsequent to the advocacy of psychiatric assessment to this end within medical regulatory board hearings, there has been an enormous use of psychiatric evaluation as part of a defence within these hearings. The generalisability of Gabbard’s typology, and its applicability in settings without expert multidisciplinary teams, has not been established in the literature. The worst possible outcome, in which the boundaries of a treating doctor role are blurred, to become advocate and predictor of future risk, seems to be occurring to some degree within Australian medical regulatory board hearings.

Finally, even if we are only to consider psychiatrists accused of professional sexual misconduct, and the expertise of an independent multidisciplinary assessment was available, there is one final concern about the application of Gabbard’s typology. There is no literature demonstrating the capacity of psychoanalytic psychotherapy to reduce the likelihood of subsequent sexual misconduct. This is likely largely due to the research challenges associated with this research. This research is likely to be nigh-on impossible to produce, and complicated by both the research issues associated with psychotherapy, including bias, as well as the research concerns associated with professional sexual misconduct, described in Chapter One, and including difficulties with detection. In addition, the ethical issues associated with not providing this treatment, given its established use and the serious consequences of recidivism, make establishing a control group impossible.
2.4.4 Ethical Implications of Considering Impairment

I have argued that doctors involved in professional sexual misconduct are often described according to psychodynamic psychiatric models. According to these models, the doctor is described according to unconscious variables, with reference to life events that may have increased the tendency of the doctor to act according to these unconscious factors. Alternatively, the doctor’s tendency to act according to their unconscious may be explained by frank illness. Whether motivated to act by external stressors or actual illness, both scenarios propose that the doctor is, to varying degrees, impaired. The use of any model which describes professional sexual misconduct as a function of impairment is associated with a number of concerns. These models may present an appearance of cronyism, and inappropriately suggest that doctors involved with professional sexual misconduct hold diminished personal responsibility [15]. Impairment models also do not offer opportunities for prevention of professional sexual misconduct, other than the prevention and treatment of illness and impairment. Nonetheless, these models predominate in the literature.

If impairment is considered in the very broad way that application of Gabbard’s framework allows, then factors which are not causative per se, but rather contributory, are considered as impairment. In this way, the doctor’s right not to be penalised due to impairment is prioritised in determining their right to future practice. The rights of the doctor are again considered in Panel Hearings which declare their sole function to be the protection of the public.

The application of a rights-based approach seeks to prioritise the doctor’s rights at exactly the point that the MBA is expected to be acting to prioritise the safety of the community. Rights-based approaches could be reasonably expected to contradict the consequentialist approach of the MBA, to protect the public.

2.5 Should Professional Sexual Misconduct be Considered According to an Ethical Model?

An alternate to use of clinical impairment models alone when considering professional sexual misconduct is the additional use of ethical or moral models. Ethical or moral models do not imply illness or impairment, although they can include
consideration of this, when it is relevant. Ethical models could be used in the consideration of cases of professional sexual misconduct where illness or impairment are not present, and offer an alternative framework for examining professional sexual misconduct. These frameworks are consistent with the medical profession and the community’s beliefs that professional sexual misconduct is an ethical or moral issue, and are supported by a number of factors.

Firstly, professional sexual misconduct is undoubtedly a moral issue. The exploitation of the power imbalance inherent in all doctor-patient relationships, breach of professional codes and harm done to patients involved clearly all have moral implications. The community recognises this, and expects the moral implications to be recognised as the doctor’s conduct is assessed. The acknowledgement of these moral implications by Medical Regulatory Bodies may convey a sense of transparency and accountability to the community, with consequent implications for the sense of trust in the medical profession.

Secondly, consideration of the moral issues associated with cases of professional sexual misconduct may also be more appropriate than use of illness models alone, even when illness exists. The issues of moral responsibility can only be removed when illness is present to the extent that impairment undermines the doctor’s ability to know right from wrong. Examining the moral issues associated with the various psychodynamic influences may enable consideration of moral responsibility, but cannot be considered in isolation from the doctor-patient relationship, and the predictable consequences for the patient.

Finally, use of a moral model is not incompatible with use of a psychodynamic model, or the application of legal principles such as the Briginshaw Principle. An ethical framework may make more transparent the expectations of the community, and the ways that these expectations are breached in instances of professional misconduct. One of the important strengths of a moral model is its potential for use within the existing systems. It is, after all, unlikely that doctors will cease to presence any defence available to them, so psychiatric expert witnesses will continue to be involved in professional sexual misconduct hearings. Similarly, the Medical Board of Australia must operate within existing legal standards, including the Briginshaw
Consideration of professional sexual misconduct according to a moral framework is not incompatible with these factors.

2.6 Conclusions

I have argued that although the MBA’s declared role of protecting the public is compatible with an ethical framework, other variables influence the ways that the MBA responds to notifications of professional sexual misconduct. These other variables are the presence of apparent consent, the legal standards associated with the Briginshaw Principle, and psychodynamic explanatory models, exemplified by those of Glenn Gabbard.

These other factors are consistent with a right-based approach. Their application may in fact be in direct conflict with the MBA’s role of protecting the public, and the consequentialist ethical principle associated with this. The current response to notifications of professional sexual misconduct could be described as a consequentialist approach tempered by a right-based approach in considering the doctor’s right to practice.

This approach is problematic for a number of reasons. The application of two conflicting models may result in variability in their application across cases. Also, the lack of transparency in declaring the use of a rights-based approach is concerning, and not in keeping with community expectations or the stated role of the MBA.

Nonetheless, I argue that professional sexual misconduct is an ethical or moral issue, and that application of a consistent ethical framework would be useful, and not incompatible with use of information regarding the health of the doctor, or legal standards, such as the Briginshaw Principle. In Chapter Three I will examine the utility of ethical frameworks currently in use.
Chapter Three: Consent, Informed Consent and Professional Sexual Misconduct

3.1 Current Ethical Models of Professional Sexual Misconduct

Professional sexual misconduct has been examined within the medical ethics literature, where it has been extensively considered as a failure of informed consent [26, 46, 53, 56, 87, 88], and hence, undermining individual autonomy. Informed consent is a medical ethical concept. The examination of professional sexual misconduct as a failure of informed consent places professional sexual misconduct as analogous to a medical procedure or intervention.

However, there is also a substantial philosophical literature examining sexual relationships more generally within the community, and the issues of consent feature prominently within this literature. Professional sexual misconduct may also be examined as analogous to sexual relationships as they occur more generally within society. This examination does not, in itself, suggest that professional sexual misconduct is ethically acceptable, or that it should not be prohibited, anymore than the examination of professional sexual misconduct as analogous to informed consent suggests that it is a medical procedure. The intent of this examination is instead to understand the role of consent in sexual relations beyond the doctor-patient relationship, and consider the implications of this for professional sexual misconduct.

Within this chapter, I will examine the philosophical literature about consent and sexual relationships in general. Factors which undermine consent in all sexual relationships are considered. The complexities of consent in relationships with substantial power imbalances will be considered, and the implications for doctor-patient relationships described. I will demonstrate the ways in which professional sexual misconduct can be seen as a failure of informed consent. I will ultimately argue that within the informed consent framework, professional sexual misconduct must be seen as unethical because it is incompatible with autonomy.

I will then demonstrate several concerns about the use of an informed consent framework when examining professional sexual misconduct. Some of these
concerns arise because of the general nature of informed consent; that it is a shared responsibility between doctor and patient, it is conceptualised in terms of defined interventions which have known potential outcomes, and that informed consent can only occur when the doctor involved it trustworthy to facilitate it. I will argue that consideration of professional sexual misconduct as a failure of informed consent is inappropriate because informed consent is a shared responsibility between doctor and patient, while the responsibility for professional sexual misconduct lies with the doctor. I will argue that informed consent does not allow consideration of the ‘slippery slope’ that characterises the antecedents to professional sexual misconduct, and that these antecedents have important moral implications that warrant consideration. Finally, I will argue that informed consent is reliant upon other ethical principles, and as a secondary, or derived ethical framework, is less appropriate than use of a primary ethical framework.

Additional concerns arise from the informed consent framework’s argument that professional sexual misconduct is a breach of autonomy. This argument presupposes a particular view of the doctor-patient relationship, with the patient characterised as having substantially less power than the doctor. This framework consequently invites counter-argument about relationships that are disparate from this description. For example, if the patient is another doctor who could seek alternate medical care if they wished, or a similarly educated professional who saw the doctor only briefly or for a minor complaint, this could be considered an argument against the prohibition of professional sexual misconduct based upon an informed consent framework.

Similarly, the nature of an informed consent framework as categorical has implications for the responses available if this framework is enacted through medical regulation boards. Specifically, doctors may be found to have breached autonomy or not. The ways that they have done this, including degrees of wrongdoing or neglect, cannot be demonstrated by an informed consent framework.

Informed consent frameworks, then, suggest that professional sexual misconduct is unethical because there is a breach of autonomy. Although this can be demonstrated to be the case, there are important aspects of professional sexual
misconduct which are not able to be examined using this framework. Additionally, this framework offers little guidance for medical regulatory bodies charged with responding to professional sexual misconduct.

3.2 Consent and Sexual Behaviour

There is a broad philosophical literature examining all types of sexual relationships, and the moral issues raised by them. Professional sexual misconduct could be seen as a unique subset of sexual relationships. An examination of the broader literature about sexual relationships may consequently have implications for considering professional sexual misconduct.

I will examine a literature that predominantly refers to sexual relationships between men and women. Although professional sexual misconduct almost always occurs across the sexes [18, 33], it does occur between doctors and patients of the same gender, and these same sex professional sexual relationships may have unique moral implications. Although the literature examined below is biased towards examination of consent in heterosexual relationships, I do not believe that its implications are limited to this group of relationships. The concerns associated with power imbalances due to socially constructed gender roles will be considered in terms of power imbalances more generally.

Sex may be evaluated to be either morally acceptable or morally unacceptable. If sex is unacceptable morally, it may also be condemnable or non-condemnable. That is, although morally unacceptable, it may not be realistically able to be addressed or responded to by anyone other than the individuals involved. Morally acceptable sex may in turn be exemplary or non-exemplary. That is, sex may be acceptable, but not morally commendable.

There is clear consensus in the philosophical literature that consent is necessary for individual autonomy to be maintained in sexual relations. That is, sex cannot be morally justified if participants have not consented. Although there is consensus that consent is necessary for sex [89], there is ongoing debate about whether consent is sufficient for sex to be morally acceptable. As noted by Primoratz [89], there are
three main groups of arguments which propose that although consent is necessary for sexual relations, it is not sufficient.

### 3.2.1 Arguments that Consent is Necessary but not Sufficient for Sex to be Morally Acceptable

The first argument is the Catholic Church’s argument that “sex is meant for procreation within monogamous marriage” [89]. According to this argument, the purpose of sex is twofold, and both these purposes can only be achieved within monogamous marriage. The primary purpose of sex is said to be procreation, with the expectation that children should only be raised by married parents. A secondary purpose, raised by *Humanae Vitae* [89], is that of the expression of marital love. The purpose of sex in Western society is clearly not tightly tethered to either purpose. People have sex without any desire for procreation, and in fact with substantive efforts to avoid it. Sex may be an expression of love within the institution of marriage, but may also express love in relationships that are not confined by the institution of marriage. Catholic arguments that consent alone is not sufficient for sex to be morally acceptable, and that sex must additionally occur within a defined type of relationship, will therefore not be further considered.

The second argument that consent is not sufficient for sex to be morally acceptable is the argument that ties sex to romantic love. Sex is seen to be inextricably linked to romantic love by authors such as Scruton [90], and consequently, consent without romantic love cannot morally justify sex. Again, there can be no doubt that sex does occur without romantic love. If this sex is consensual, arguing that it is not morally acceptable suggests that the consent of the individuals involved is not sufficient, because they are not in love. Love would validate the consent in a way that the individuals could not. Their autonomous preferences are paternalistically rejected. This degree of paternalism is unacceptable, and the status of sex as always unacceptable without romantic love is not justifiable without dismissing the autonomy of the individuals involved. Even if it was argued that having sex outside of a romantic relationship was somehow harmful, this harm can still be the autonomous choice of the individuals involved. This argument will also not be considered further.
The third argument which suggests that consent is not sufficient for sex to be morally acceptable is the argument that sex is associated with unique social pressures [91]. These social pressures occur across genders within many societies, and favour the position of men over women. The resultant power imbalances are argued to undermine the ability of women to refuse sexual advances from men. Women are argued, on this basis, to be unable to make a meaningful consent to sex. Consequently, consent cannot guarantee that the woman is making an autonomous choice to have sex. Consent alone is not therefore adequate for sex to be morally acceptable.

This final argument is less readily discounted than the two previous. There are clearly some circumstances where gender imbalances are heightened to the extent that the pressure to have sex may be coercive, and consent undermined. However, to argue that all women are always unable to make an autonomous consent is inappropriately paternalistic.

The question becomes when, or under what circumstances, the power imbalance between sexual partners is heightened to the extent that the sex is morally unacceptable. Although the power imbalance may be created by either the broader society in which the individuals live, it may be further heightened by institutional constructs and power imbalances. Authors such as Superson [92] argue that institutional pressures such as those within an academic setting, and the pressure on female students to have sexual relationships with male academics, reflect broader social pressures on women. Anderson [91] also argues that “Gendered social institutions ... add to the pressures against women”.

Sex may be said to be morally unacceptable even if consent occurs when the power imbalance between the individuals is increased by institutional variables. This may be argued;

1. Even if the consent is a true expression of autonomy, because the consent cannot neutralize other moral concerns, or
2. On the basis that institutional variables will always interfere with consent being made as a true expression of autonomy, or
3. Even if for some individuals the consent is a true expression of autonomy, because some individuals will be unable to make a consent reflecting their autonomy, and in a social context it is reasonable to expect moral safety for the majority.

It is impossible to establish that no consents made in the context of institutional power imbalances can be true expressions of autonomy. I also believe that the implications of disregarding autonomous consent are concerning. Therefore, although I do not argue that consent made in the context of institutional power imbalances are never autonomous, in a social context, sex in the presence of institutional variables which increase power imbalances will often be incompatible with autonomous consent. Sex in these contexts will consequently often be morally unacceptable, and may reasonably be regulated as such.

This potential for institutional pressures to create power imbalances compromising autonomous consent between individuals is recognised by institutions with the establishment of standards of conduct prohibiting sexual relationships between staff of those institutions and others. There are additional moral implications associated with breaching these codes, in addition to those associated with the knowing exploitation of the power imbalance within these sexual relationships.

I have argued that although women should not be generally considered unable to give an autonomous consent to sex, the importance of power imbalances, and their impact on autonomous consent, must be considered. Firstly, sex may or may not be “morally special” [93], but it is seen as extremely important, both for individuals and societies. The impact of sexual relationships which are conducted in a morally inappropriate way therefore has the potential to be extreme for the individuals involved, as well as the institutions which create the power imbalances.

The literature on sexual relationships and consent recognises that power imbalances may be such that consent is not adequate to render the sexual relationship morally acceptable. These power imbalances may be conferred by social institutions in particular. Within a social context when these power imbalances are seen as
significant, regulation may reasonably be used to prohibit sexual relationships which have a significant likelihood of being morally unacceptable.

The importance of consent, and recognition of the impact of institutions and the associated power imbalances, has been recognised for the medical profession with the development of the concept of informed consent. Informed consent assumes that some consideration of the power imbalance between doctor and patient is necessary.

### 3.3 Current Understandings of Informed Consent

Informed consent has been described as being at the “forefront of biomedical ethics” [94] since the Nuremberg trials, and the conviction of the fifteen German doctors on trial, in 1947 [95]. These trials examined the atrocities perpetrated by German doctors and scientists during World War II, in the name of medical experimentation. The participants involved had not been given the opportunity to refuse participation. Many died, and almost all experienced extreme suffering [96].

The Nuremberg Trials documented the atrocities perpetrated. The defence for the accused doctors argued that the experiments that they had conducted were not inconsistent with the history of medical experimentation. A number of experiments conducted in the United States were cited [95], and it was argued that medical experimentation historically held a low level of regard for ethical concerns. Although this defence could not justify the atrocities perpetrated, the Nuremberg Court did acknowledge that there was some truth in the allegation that there was a historical lack of ethical standards guiding medical experimentation with human subjects [96].

The Nuremburg Code was consequently developed by the Court, with ten standards to justify medical experimentation defined. One such standard was the requirement for the “voluntary consent of the human subject” [96] in medical research. The Nuremburg Code raised awareness about the issues around consent for medical research and practice. However, continued, and indeed expanding, research on American prisoners in the 1960’s and 1970’s suggests that the Nuremburg Code, and codes developed subsequently, such as the World Health Organisation’s Helsinki Declaration, did not protect prisoners from medical experimentation [95].
The term informed consent emerged a decade after the Nuremberg Trials [52, 94], with interest increasing in this area during the 1970’s. The elements of informed consent have been described as those factors which inform the patient, such as the disclosure of information and the understanding and acceptance of information, and those factors which enable a valid consent, such as competence and voluntariness [52].

Informed consent has consequently been defined:
“Valid informed consent is premised on the disclosure of appropriate information to a competent person who is permitted to make a voluntary choice” [97]

The three required standards of informed consent are now therefore consistently described as disclosure of information, decisional capacity and voluntarism [98]. In Australia, the term informed consent is now referred to only as consent. Indeed, on the standards described above it would be difficult to imagine an uninformed consent that was valid or meaningful. I have persisted with the use of the term informed consent in deference to much of the research that I have considered, but believe that I am using this term interchangeably with the way the term consent would be used in the Australian context.

3.3.1 Disclosure of Information and Informed Consent
For a patient to agree to a medical procedure or intervention, they must receive adequate information about the procedure or intervention proposed. The information disclosed has been described according to “the nature of the procedure”, “the risks of the procedure”, “the alternatives, if any, to the procedure” and “benefits of the procedure” [99]. The expectations about the nature and extent of the information that must be disclosed for a valid informed consent have changed over time, often under the influence of legal precedents.

3.3.1.1 The Professional Practice Standard
The first, and oldest, standard is the Professional Practice Standard, also known as the Reasonable Doctor Standard [94]. According to this standard, the amount and nature of information that must be disclosed for informed consent is determined by
the “professional community’s customary practices” [94]. This standard was based on the ‘Bolam’ test, in which any doctor was required to “have acted in accordance with the practice accepted as proper by a “responsible body of medical men” [52]. This standard remained prominent in Australia and the United Kingdom until recently [100].

There are several identifiable concerns with the professional practice standard. Firstly, an identifiable standard expectation about the communication of information may be either unclear, or vary widely between different sections of the professional community. Secondly, even if a clear standard is evident, this standard may be inappropriate. Under this standard, “pervasive negligence could be perpetuated with impunity” [94] because if a number of doctors were offering inappropriately low amounts of information for informed consent, their conduct would be seen as defensible under the Professional Practice Standard, on the basis of numbers alone. Thirdly, this standard assumes that the physician is capable of determining what ‘best’ for their patients to be informed of. This paternalistic stance is not in keeping with contemporary health consumer expectations that their preferences will be considered. The professional practice standard therefore has inadequate regard for patient autonomy [94], and has been criticised for being paternalistic. It is not responsive to the expectations of the individual, nor the broader community.

### 3.3.1.2 The Reasonable Person Standard

In the context of the above concerns about the professional practice standard, another standard, called the Reasonable Person Standard, was developed. In 1957 in the United States, a court prescribed appropriate standards about communication between doctor and patient for the first time [52]. This legal standard, arising from the Salgo case [101], directed the doctor to disclose information about the nature, risks and benefits of, as well as alternatives to a procedure. This standard was independent of what the profession viewed as standard practice, and became the basis for the Reasonable Person Standard.

According to this standard, the decision to disclose information must be based upon a consideration of “the significance a reasonable person would attach to it in deciding whether to undergo a procedure” [102]. This standard does address some
of the concerns associated with the professional practice standard, in that the doctor must consider the expectations of the community. Practice that is not acceptable to the community is not sanctioned, even if it is to some degree ‘standard’ professional practice. In this way, the reasonable person standard is more in keeping with modern health care consumer expectations of regard for their individual autonomy in the informed consent process.

The reasonable person standard is associated with its own concerns, however. In particular, it has been noted that there are “conceptual, moral and practical difficulties” [94] associated with this standard. What constitutes a “reasonable person”, and their expectations, is not defined. This standard requires the doctor to anticipate what the reasonable person may wish to know, and does not address the likelihood that different patients may have very different interests in terms of the information disclosed to them. In this way, the reasonable person standard holds some regard for patient autonomy as a concept, and community expectations, but not for the individual autonomous preferences of each patient.

3.3.1.3 The Subjective Standard

The Subjective Standard of disclosure is epitomised by the 1992 Australian High Court case of Rogers v Whitaker [103]. In this case, the adult patient, Maree Lynette Whitaker, had been legally blind in her right eye consequent to an injury at the age of nine years, but had normal vision through her left eye. Ms Whitaker consulted a surgeon, Mr Christopher Rogers, about a surgical procedure to her left eye. The surgical procedure was intended to improve the appearance of her right eye, and also to treat early glaucoma in that eye.

Prior to the surgery, Mrs Whitaker asked numerous questions of her surgeon, regarding the potential risks of the surgery. Mrs Whitaker did not ask whether the surgery on her right eye could affect her vision with her left eye. Mr Rogers advised her that surgery on her right eye would not only improve its appearance, but potentially also restore significant sight through that eye. On this basis, Ms Whitaker decided to have the surgery. The surgeon did not advise her of the very small risk that surgery on her right eye would damage her (normal) left eye [52, 103].
Consequent to the surgery, Ms Whitaker’s right eye did not improve, and her left eye developed a condition called sympathetic ophthalmia. This condition resulted in a loss of sight in Mrs Whitaker’s left eye. Mrs Whitaker successfully sued her surgeon on the grounds that he had been negligent in not informing her of the risk of harm to her other (normal) eye, including the risk of blindness. Mr Rogers was found liable in that he had failed to warn Mrs Whitaker of the potential for sympathetic ophthalmia. Mr Rogers was ordered to pay $808,564.38 to Ms Whitaker. Mr Rogers then appealed to the High Court of Australia.

The evidence before the court was that sympathetic ophthalmia occurred once in approximately fourteen thousand similar procedures. Although the Court stated that it “was not satisfied that proper medical practice required that the appellant (Mr Rogers) warn the respondent (Ms Whitaker) of the risk of sympathetic ophthalmia if she expressed no desire for information” [103], that warning was “necessary” as the patient had requested “relevant” information. Ms Whitaker had particularly expressed concern about potential harm to her “good” eye, but had not been informed of the risk of sympathetic ophthalmia.

In describing the doctor’s requirement to disclose information, the High Court concurred with the reasonable person standard, by stating that “a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it” or “if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it” [103].

The first clause reflects the reasonable person standard. The second clause, describes an additional requirement to anticipate the particular concerns and preferences of the individual patient. For Mrs Whitaker, information about sympathetic ophthalmia was particularly relevant because of her pre-existing medical condition. This case decision set a precedent whereby even if sympathetic ophthalmia occurred so infrequently as to not warrant discussion under the reasonable person standard, the doctor was obliged to consider the particular concerns and preferences of Mrs Whitaker, in disclosing information. This
requirement is known as the subjective standard. It may be defined as follows; “The subjective model judges adequacy of information by reference to the specific informational needs of the individual person, rather than the hypothetical “reasonable person” [94]. The emphasis on the preferences of the patient is clear.

According to the subjective standard, the appropriateness of the information disclosed to the patient is considered according to the “specific informational needs of the individual person, rather than the hypothetical “reasonable person”” [94]. The patient’s interest in particular information may vary according to their past medical history, plans for the future, or personal values or beliefs. The subjective standard has been argued to be the “preferable moral standard of disclosure” [52, 94]. However, the practical application of this standard has proven difficult, with doctors unpredictably able to anticipate their patients’ unique interests and concerns.

### 3.3.2 Competence in Decision – Making and Informed Consent

Regardless of how extensive the information is that is disclosed, the patient must be able to understand the information that is provided for informed consent to occur. The information provided must therefore be presented in language and form such that it is understandable to the patient. The patient must have the opportunity to clarify their understanding of the risks and benefits of treatment, even if the doctor believes that adequate information has been presented clearly.

Appelbaum describes a classification of the requirements of the individual, for an individual to be said to have the decision-making capacity necessary for informed consent [97]. Appelbaum argues that to be capable of making a decision for the purposes of informed consent, the individual must be;

1. Able to communicate their choice
2. Able to understand information relevant to making that choice
3. Able to acknowledge their medical condition, and the potential consequences of the available treatment options
4. Able to process this information, comparing treatment options

Some patients may have particular difficulty understanding any information presented to them, due to either effects of their illness (such as delirium or pain) or a
pre-existing condition which undermines the individual’s ability to comprehend information (such as an intellectual disability). Any barriers to clear communication, including hearing impediments, or when the doctor is speaking in a language that is not the patient’s first language, may also undermine the ability of the patient to understand information that is being provided, if the effect of these communication challenges is not anticipated and addressed.

However, even with the clearest communication, a patient may receive the information provided to them, yet not understand it [94]. This may occur either due to a false belief held firmly by the patient, or non-acceptance of information provided to them. Examples of false beliefs held include denial about the severity of illness, influencing treatment choices, or an excessively optimistic view about the likelihood of the treatment to be successful. These groups of patients may be unable to make a fully informed consent because although appropriate information has been disclosed to them, and they have comprehended it, they may be unable to understand it in the ways necessary to make an informed consent.

Related to these concepts is the idea that patients may be unable to fully understand a potential outcome if it is far removed from their life experience to date. Patients who have not experienced a delirium, for example, may have difficulties imagining what this experience would be like, when they are considering the potential risks of a procedure. Understanding the adverse effects of a procedure may be particularly difficult if these experiences cannot be imagined, as the benefits of procedures will more often presumably be a restoration to improved, or previous function.

### 3.3.3 Voluntarism and Informed Consent

Voluntariness in informed consent is defined as “the degree that (the individual) wills the action without being under the control of another’s influence” [page 93, 94]. Alternatively, this voluntariness, also called voluntarism [98], may be defined as “the individual’s ability to act in accordance with one’s authentic sense of what is good, right, and best in light of one’s situation, values, and prior history”. Voluntarism may be challenged in a number of ways. Failures of voluntarism in the doctor-patient relationship may be categorised according to the domain over which the influence
has occurred. Within one of these domains, the domain of external features and pressures, the particular behaviour of the doctor allows further classification.

Voluntarism can therefore be considered according to the processes which may challenge it. Voluntarism may be challenged by a number of factors [98];

1. Developmental factors, with age reflecting cognitive development, learning, and the capacity to reflect upon personal beliefs and their implications

2. Illness-Related considerations have been noted to have the potential to increase an individual’s resolve to express autonomous preferences [98]. The individual faced with a significant illness may be galvanised to obtain the care that is best for them. However, both physical and psychological factors directly attributable to illness must be considered as threats to voluntarism. These vary enormously in nature, from the cognitive symptoms of neurological disorders, to the mood symptoms of psychiatric illnesses. These symptoms have the potential to undermine voluntarism in ways that are unpredictable, and which may vary over time with the individual, or depending on the medical intervention proposed [104]

3. Psychological issues and cultural and religious values may influence voluntarism for an individual by shaping their own sense of who they are, and what choices are appropriate for them.

4. External features and pressures vary from resource limitations in healthcare, to the treatment setting and roles of family members or carers.

The doctor must understand the impact of all four domains’ “potential influence” [98] on the patient’s voluntarism. However, the doctor’s behaviour may directly impact on voluntarism within the domain of external influences and pressures, and do so in a number of ways.

The patient’s voluntarism may be undermined by coercion or manipulation [94]. Coercion is said to occur if “one person intentionally uses a credible and severe threat of harm or force to control another” [94], and “occurs only if a credible and intended threat displaces a person’s self-directedness”. For a doctor to behave coercively, they must be perceived as able to cause harm in the patient’s life. Patients who may be exposed to coercion are the most vulnerable groups, and
include those receiving treatment within prisons, or as involuntary patients under local mental health act legislation.

Manipulation is “a generic term for several forms of influence that are neither persuasive nor coercive” [94]. A major form of manipulation in healthcare has been described as “informational manipulation, a deliberate act of managing information that non-persuasively alters a person’s understanding of a situation and thereby motivates him or her to do what the agent of influence intends” [94]. Both the content of the information, and the way that it is presented, with nonverbal cues, have been shown to influence the patient’s response.

Factors within the patient, doctor, and context are relevant in terms of compromising voluntarism. Coercion and manipulation are specific interactions between the doctor and patient that may lead to compromised voluntarism.

### 3.4 How Does Professional Sexual Misconduct Breach the Requirements of Informed Consent?

Informed consent has therefore been described according to three components; disclosure of information, competence in decision-making, and voluntarism. For informed consent to occur, each of these components must be fulfilled, but within each of these components, there are also established requirements. Although it has been consistently argued that professional sexual misconduct breaches the standard of informed consent, there is no examination in the literature of the ways that professional sexual misconduct breaches the components of informed consent, nor consideration of whether breaches of the different components of informed consent may have differing moral significance.

#### 3.4.1 Professional Sexual Misconduct and Disclosure of Information

For the theoretical patient to make a theoretical informed consent to professional sexual misconduct, the doctor would need to make a disclosure to the patient about the potential outcomes of the professional sexual misconduct, before embarking upon a sexual relationship. It seems unlikely that a doctor would explain to their patient that professional sexual misconduct is associated with high levels of psychological distress amongst patients involved (as described in Chapter One),
then attempt to embark on a sexual relationship with them. It also seems unlikely that the doctor would advise their patient of the option of making a formal complaint to the local medical practitioners’ registration board, about the doctor’s proposal of a sexual relationship. The likelihood of some bias in the information provided in this situation would be high, due to the potential conflict of interest between the patient and doctor’s preferences.

The Subjective Standard of disclosure requires the doctor to anticipate, as best possible, the information that the patient would wish to have disclosed, according to their individual circumstances. The impact of professional sexual misconduct on the individual patient’s health care would be impossible to anticipate, and a further example of the ways in which professional sexual misconduct precludes informed consent through the standard of appropriate disclosure.

The scenario in which a doctor advises their patient that they are likely to be adversely affected by a sexual relationship with that doctor, both in terms of the health care that they originally sought and consequent psychological distress, and that the patient has the option of making a formal complaint to the local medical practitioners board as a result of the behaviour of the doctor, approaches the ridiculous. The standard of disclosure necessary for informed consent could not be expected to be met.

The most extreme examples demonstrating lack of disclosure in professional sexual misconduct occur when the patient is either not advised of its nature of the interaction, or deliberately deceived. That is, the patient could not even understand “the nature of the act”. Examples of such cases include that of a girl who had sexual intercourse with a doctor, on the understanding that it was part of her medical treatment (R v Case) [105, 106], and that of a woman who agreed to a vaginal examination by a doctor in the presence of his friend, who the woman understood to be a medical student (R v Bolduc and Bird) [107]. These cases demonstrate an additional level of wrongdoing, due to the deceit.

The arguments against professional sexual misconduct as a failure of informed consent have not tended to focus on the component of disclosure. This may be
because of the theoretical possibility that this information may be available to some degree, or more likely because the requirements are so improbable. It would be difficult to imagine a doctor explaining to their patient and prospective sexual partner what the literature suggests about harm sustained by patients engaged in sexual relationships. Even if this bizarre scenario were to occur, it would be difficult to imagine how the patient could make sense of this information, given the relationship context that it was being conveyed in. Even if this disclosure were to occur, the potential for the relationship context to impinge upon voluntarism would persist.

It may be expected that professional sexual misconduct would be associated with a failure of disclosure of relevant information. However, even if disclosure does occur this does not reduce the significance of the doctor patient relationship. Informed consent cannot be said to have occurred, even if disclosure has occurred, because of factors other than the disclosure of information. Professional sexual misconduct must be seen as a failure of informed consent due to factors beyond inadequate disclosure of information.

3.4.2 Professional Sexual Misconduct and Competence in Decision – Making

For a patient to make an informed consent to professional sexual misconduct, they must be capable of making an autonomous decision about whether to proceed with a sexual relationship, based on the information that they have. Although many of the individual patients who are involved in professional sexual misconduct are competent in terms of their decision-making, there are also potential scenarios in which any information provided may not be able to be understood by the patient. That is, even if we assume that an appropriate disclosure has been made by the doctor, the patient may be nonetheless unable to understand the information provided.

This lack of understanding may be due to factors within the patient, due to communication barriers or intellectual disability. The more predatory doctor may select patients unable to understand the nature of the relationship, perhaps in part to avoid detection. However, illness factors may also reduce the ability of the patient to understand what choices they may have, and the potential consequences of professional sexual misconduct for them. The over-representation of professional
sexual misconduct complaints amongst psychiatrists is particularly alarming in this context. Individuals with a psychiatric disorder may be unable to understand the implications of a sexual relationship with a practitioner, or clearly communicate their concerns, if psychiatrically unwell.

As with appropriate disclosure occurring, it is theoretically possible that the patient holds appropriate competence in decision-making to understand the information provided to them by a doctor proposing a sexual relationship. However, even if a patient were to be the recipient of appropriate disclosure, and comprehend the information that they received, their voluntarism must be demonstrated to be uncompromised for them to be able to make an informed consent to a sexual relationship with their doctor. Voluntarism must be demonstrated to be substantially impaired, if the patient has received an appropriate disclosure of information, and comprehended this, to argue that informed consent has not occurred.

**3.4.3 Professional Sexual Misconduct and Voluntarism**

In situations in which the doctor enacts sexual behaviour with the patient without their ‘permission’, it is very clear that the patient’s voluntarism has been undermined, and no informed consent has been made. This behaviour is sexual assault, or rape, and a criminal matter. When the Medical Board of Australia receives a notification regarding sexual behaviour of this nature, the notification is referred for criminal investigation before the Board proceeds further.

Conversely it is also argued that because of the power imbalance between doctor and patient, even if the patient overtly agrees to a sexual relationship with their doctor, that they are not making an informed consent free of coercion [36, 46]. I will argue that it is the doctor’s role as a fiduciary professional, and the unique nature and consequences of that relationship, which compromise voluntarism.

Roberts’ domains [98] categorise the ways voluntarism may be undermined as due to; developmental factors, illness-related factors, psychological issues/cultural or religious values, and external factors or pressures. Across the range of instances of professional sexual misconduct, all four categories of factors may be relevant in some way in undermining the individual’s ability to make an informed consent. It is
the factors and pressures external to the patient, and the psychological issues which may arise as a result of the doctor-patient relationship, which are present to some degree within all instances of professional sexual misconduct. Particular cases of professional sexual misconduct may include additional factors, for example; the developmental factors precluding a child’s consent or the illness factors precluding a demented patient’s consent. However, it is only the factors within the doctor-patient relationship which are consistently present across all instances of professional sexual misconduct. The external factors that are consistently present in professional sexual misconduct are those which result from the conduct of the doctor within a relationship characterised by an inherent power imbalance.

The Nature of the Fiduciary Professional Relationship

The power differential between doctors and their patients arises from a number of factors. The doctor is a member of the medical profession. As noted by Bayles [page 28, 43], there is consensus that for an occupation to be a profession, it should be associated with “a rather extensive training”, “a significant intellectual component”, and “an important service in society”. Bayles also notes that “consulting professionals”, such as doctors, are characterised by a further three features, in that they; “all provide an important service”, “have a monopoly over the provision of services”, and “have claimed and been accorded a large degree of self-regulation” [page 29, 43]. The doctor, therefore, sits within a highly educated group that provides an important service that the general public is highly dependent upon, and that remains significantly self-regulating. There is, therefore, a significant potential power imbalance between doctor and patient, and a consequent need to define reasonable expectations within the relationship.

Bayles’ descriptions of both the requirements for an occupation to be a profession, and the professional – client relationship, are widely accepted. Within the doctor – patient relationship, the doctor holds medical knowledge and expertise that the patient is dependent upon for their health, and perhaps their life. The patient may have limited alternatives for obtaining healthcare elsewhere, either due to factors within the healthcare system, or the urgency of the medical condition. There is also an imbalance in terms of the amount of personal information typically disclosed by each party. In particular, the patient is often expected to disclose highly personal
information, and undergo highly intimate physical examination, to receive healthcare. All these factors contribute to a context that is characterised by dependency, and socially sanctioned as such. The doctor – patient relationship readily meets the criteria described by Bayles. As a result, doctors have the “special obligations” that Bayles refers to.

*Unique Features of the Medical Fiduciary Relationship*

The doctor – patient relationship has additional features beyond those of a member of a profession. The patient will usually seek to see a doctor because they have a medical condition or are concerned about developing one. Medical conditions are inherently debilitating and may undermine the patient’s usual capacities in an infinite number of ways. In particular, the doctor is expected to be sensitive to issues around the patient’s capacity to consent to care, and participate in treatment.

Physical examination may form part of the initial assessment or be required on an ongoing basis to assess disease progression or response to treatment. The doctor is therefore required to interact with the patient in an extremely intimate way that might not be immediately understandable to the patient. However, the intimacy associated with a longer term clinical relationship, particularly if the patient has a chronic illness and hence a degree of dependency on the doctor, might be even greater for some patients. The patient, with some dependency enforced by illness and their requirement for intimate disclosure required for treatment, is undoubtedly in a relationship characterised by an extreme power imbalance.

Transference has been well studied within psychotherapeutic relationships, and is well recognised within psychiatry and psychology. Its presence and significance in non-psychotherapeutic doctor-patient relationships has not been examined as rigorously examined, and is certainly not accepted with consensus across specialties.

Transference is defined as “a process characterized by the development of feelings and attitudes towards another person (or an institution) which represents a concentration of a past attitude or feeling, inappropriate to the present, and directed quite specifically towards the other person or institution” [108]. Transference was
initially described as occurring only within psychoanalysis [108], but it has subsequently been argued that this restriction is “unnecessary” [108]. Transference is important because it offers an opportunity for clinical work, with the recognition of past experiences and their significance. It is a recognised aspect of the psychotherapeutic relationship, and therefore occurs inherently as a part of a recognised treatment.

Transference is also important, however, because the attitudes or emotions that the patient is experiencing are inherently inappropriate to their present context, and the doctor-patient relationship in which they are emerging. The development of idealisation is one form of transference which commonly forms early in psychotherapeutic relationships. With this idealisation, the patient may be highly (and inappropriately) receptive to suggestion by the doctor. Similarly, with development of an eroticized transference, the patient may have strong sexual feelings towards their doctor, which are contingent on the emergence of transference. This group of patients may also be highly receptive to suggestions by their doctor.

Patients are therefore rendered highly receptive to the recommendations of their doctor, due to an outcome of the treatment that they seek. Like the power imbalance inherent (to some degree) to all doctor-patient relationships, transference occurs by the very nature of the doctor-patient relationship when psychotherapy is the treatment used. Exploitation of transference is unacceptable in the same way that exploitation of power imbalance is unacceptable.

Although some clinicians recognise the presence of transference only in relationships which psychotherapy is the predominant means of treatment, most psychiatrists and psychologists would argue that it may occur in any relationship which persists over time. The use of the presence of transference as even part of the basis of an argument suggesting that the patient’s reduced capacity to make a freely informed consent does raise issues around whether this argument is relevant for all doctor-patient relationships, rather than just those between a psychiatrist and their patient. The degree to which transference is present within a specific doctor-
patient relationship may be difficult, and certainly complex to assess, and the degree to which it influences decision-making by undermining voluntarism even more so.

A power imbalance is created between the doctor and their patient because the relationship is a fiduciary professional relationship, but also because of unique features of medical illness and the doctor’s role in treatment. This power imbalance has been argued to be such that when the doctor promotes a sexual relationship with their patient, the patient’s voluntarism is undermined. Although this argument has been well accepted, there are a number of potential concerns associated with the argument that professional sexual misconduct should be prohibited because it is a breach of informed consent.

3.5 Examining Professional Sexual Misconduct as a Failure of Informed Consent

The literature examining the ethical basis for the prohibition of professional sexual misconduct relies heavily upon the argument that professional sexual misconduct is unethical because it undermines the voluntarism of the patient, and cannot meet the standards necessary for informed consent. I have argued that for an informed consent to occur, the disclosure required by the doctor would be bizarre, and that there may be many factors which could compromise decision-making. However, it is the power imbalance inherent to the doctor - patient relationship which undermines voluntarism in such a way that true informed consent may almost never occur.

Although the informed consent framework has been useful in presenting a cohesive argument against professional sexual misconduct, there are a number of problematic aspects to this framework. In particular, the informed consent framework may be inappropriate because it suggests a shared responsibility between doctor and patient for professional sexual misconduct, it can be criticised for being overly paternalistic of modern healthcare consumers, for whom the traditional power imbalance between doctor and patient might be at least lessened, and does not allow examination of ‘the slippery slope’ preceding professional sexual misconduct.
As a result of these limitations, the informed consent framework offers little guidance for medical regulatory bodies charged with responding to professional sexual misconduct.

### 3.5.1 Use of an Informed Consent Framework Implies That the Responsibility for Professional Sexual Misconduct is Shared by the Doctor and the Patient

The first concern about examining professional sexual misconduct as a failure of informed consent is that informed consent is a shared responsibility between the doctor and patient [52]. The doctor cannot ensure that a patient has made an informed consent to a medical procedure without the patient’s participation. The doctor must provide accurate information about the potential risks and benefits of the procedure, anticipating any that may be particularly relevant to that patient, and being vigilant to coercive influences. This alone does not constitute the requirements for informed consent. The patient also has responsibilities; to listen and try to understand the information provided to them, and seek clarification of information that they do not understand. Although the bulk of the responsibility is with the doctor, the patient also holds some responsibility in the processes of informed consent.

This concept of a shared responsibility is inappropriate when considering professional sexual misconduct. The doctor is required by legislation and professional codes not to have sexual contact with patients. These professional codes reflect established community expectations of the medical profession, as well as an important way that the profession represents itself to the community.

The legal and professional prohibition of sexual relationships between doctors and their patients is ethically justified on the basis of the potential for harm to patients engaged in sexual relationships with their doctor. As I have described in Chapter Two, it has never been demonstrated that all sexual relationships between doctors and their patients cause harm to the patients involved. It has been demonstrated that a significant number of patients are so harmed, however, and there is no way of accurately predicting which patients will not be harmed. There is, therefore, a likelihood of harm for all patients engaged in sexual relationships with their doctors.
The prohibition stated in professional codes is ethically justified by this likelihood of harm.

Breaches in these codes are the responsibility of the medical profession, regardless of the patient’s behaviour. It remains the doctor’s responsibility to respond to this behaviour appropriately. Informed consent is therefore inappropriate when considering professional sexual misconduct because it suggests a shared responsibility between doctor and patient. As stated by Strasburger, “Attention should focus entirely on the therapist’s behaviour, not on that of the victim” [70].

The implications of this perception of shared responsibility include the potential for patient blaming, reduced responsibility to the doctor, and uncertainty for patients about when to make a complaint. The use of informed consent has serious implications, then, because it places some responsibility for the doctor’s professional sexual misconduct with the patient.

3.5.2 Use of an Informed Consent Framework Suggests That the Patient Must be ‘Incompetent’ to Some Degree

The informed consent argument for a policy of prohibition of professional sexual misconduct requires that the impact of either the perceived power imbalance, or transference, be considered to be such that the patient’s voluntarism is undermined. The extent of the impact on their voluntarism must be such that they are deemed incompetent to make an informed consent to a sexual relationship with their doctor.

This requirement of the informed consent argument can be criticised on the basis that it is paternalistic, and not in keeping with the modern health care consumer’s expectations. Increasingly, relationships between doctors and patients are seen as a partnership between equal parties. Independent of the health care consumer movement, some patients might protest that their voluntarism has not been undermined by any power imbalance within the doctor - patient relationship. Patients who are well educated, assertive, and have the option of seeking alternative care if dissatisfied may argue that their doctor does not assert undue influence over them, particularly if the care that they have sought is minor or trivial, over a short duration, and not technically complex or with serious implications.
Despite arguments that some patients may not experience a power imbalance with their doctor, the doctor who commits professional sexual misconduct has, at the very least, breached the requirements of professional codes and legislation. Professional codes currently stipulate a prohibition of professional sexual misconduct with all patients, regardless of the perceived power balances between doctor and patient. The doctor who breaches these codes, regardless of whether informed consent has occurred or not, has not behaved in a way that could be considered trustworthy by the community.

The prohibition of professional sexual misconduct through these codes can be morally justified even if it can be argued that in some, albeit rare, circumstances, the patient is able to make an informed consent to a sexual relationship with their doctor. These professional codes are developed for the needs of the entire community. There cannot be individual codes for every possible doctor - patient relationship permutation. To use an example of a highly skilled individual driving their car above the designated road speed limit, even when no harm results, this individual has nonetheless broken the law. There are moral implications associated with doing so. There cannot be individual road rules for individual drivers, and even drivers who do not cause harm by speeding are placing those around them at increased risk of harm. Similarly, the doctor who has a sexual relationship with their patient breaches codes designed to protect the community as a whole, and places the particular patient involved at some risk of harm.

Those who argue that the power imbalance said to undermine a patient’s ability to make an informed consent to a sexual relationship with their doctor is no longer relevant or appropriate may defend their position by suggesting that if this power imbalance does exist, it would undermine the patient’s ability to ever make an informed consent. That is, that if patients are experiencing such an undermining of their voluntarism that they cannot consent to a sexual relationship with their doctor, they cannot consent to any medical choices presented to them by their doctor. This argument raises the issue of whether it is the conflict of interest experienced by the doctor seeking a sexual relationship with their patient which acts in combination with the power imbalance to undermine the informed consent.
Use of the informed consent framework does, therefore, raise issues of paternalism. It can readily be argued that there are isolated, specific doctor-patient relationships in which there is no significant and demonstrable power imbalance, or that a power imbalance has not led to a diminished capacity to consent. These circumstances may include situations in which the patient’s health care concern is trivial and transient, they are aware of the nature of the complaint, and have alternate options for health care. In these circumstances, according to the informed consent framework, the professional sexual misconduct which results is not morally wrong.

Under an informed consent framework, then, it is possible to argue that under some circumstances, where there is no significant power imbalance between doctor and patient, it is morally acceptable for a doctor to engage in a sexual relationship with their patient. This argument neglects some important implications of this hypothesized relationship.

Strasburger et al [70] argue that “it is not that the patient cannot consent or that consent has been improperly obtained - as through undue influence of transference or lack of information about risks. The issue is fiduciary breach and abuse of power in the fiduciary relationship.” Even if the patient’s level of power in the relationship is said to approximate the doctor’s, this does not negate the fact that the doctor is using what power they do have, and the unique nature of this power, to meet their own personal needs.

Informed consent fails to allow examination of the harm done in professional sexual misconduct when the patient is argued to be able to make an informed consent. In Chapter Four I will argue that the standard should be of trustworthiness, we can see that the doctor cannot justifiably embark upon a sexual relationship with their patient, even if that individual patient is argued to be able to make an informed consent.

**3.5.3 Use of an Informed Consent Framework Does Not Enable Consideration of Professional Sexual Misconduct and the ‘Slippery Slope’**

The requirements for informed consent can only be met with isolated, overtly significant incidents which have predictable, understandable potential outcomes.
This is why informed consent can be applied to decisions about defined medical interventions. These medical interventions have potential benefits and risks to the patient that can be anticipated and understood by the patient. These interventions must be recognised for their potential significance to the patient.

Professional sexual misconduct, in contrast, often begins with relatively minor changes to standard clinical care. This progression down what Gabbard describes as “a slippery slope” [44] therefore includes apparently insignificant events before overt sexual behaviour emerges. These minor changes, such as seeing a patient for longer than usual, or scheduling their appointment out-of-hours, are not, in themselves, usefully considered using an informed consent framework.

In a case of professional sexual misconduct which was preceded by a period escalating deviations from standard care, a patient may initially be asked to see their doctor more frequently than would be usual, may not be charged the usual fee for service, and sessions may include the doctor making more personal disclosures than would be appropriate, before the relationship becomes overtly sexual. Examining each of these changes in isolation is problematic.

Firstly, each of these in isolation may not necessarily be harmful. Obtaining informed consent for each change may seem trivial when they are considered in isolation. For the patient to make an informed consent, however, they would have to understand the implications of the ‘slippery slope’. This cannot be anticipated in response to the initially minor changes of the slippery slope. The patient cannot anticipate the effects of individual events of the slippery slope, and therefore cannot make an informed consent.

It is the doctor’s responsibility, however, to consider all changes in context. A doctor must have the capacity to monitor the overall care of their patient, and modify the course of that care in response to any deviations from standard clinical care. Informed consent as a framework does not allow an examination of the “slippery slope” that importantly precedes overt professional sexual misconduct. This is a significant deficit in the consideration of professional sexual misconduct within an informed consent framework.
3.5.4 Use of an Informed Consent Framework Can Only Offer a Categorical Classification of Professional Sexual Misconduct

Finally, informed consent offers only a categorical examination of professional sexual misconduct. Informed consent either occurs or does not, and it cannot therefore be used as part of a normative model of professional conduct. Authors such as Gabbard have written on the importance of discouraging a “them versus us” approach to doctors who have been involved in professional sexual misconduct, and recommended that all doctors be recognised as having some vulnerability, depending on circumstances, to professional sexual misconduct [39]. An informed consent-based consideration of professional sexual misconduct does not readily facilitate this.

Cases of professional sexual misconduct cannot usefully be considered according to the ways that the failure of informed consent occurred. As I have described, the disclosure of information by the doctor about the risks of professional sexual misconduct would be bizarre. Even if this were to occur, and be comprehended, it would not obviate the effects that the doctor-patient relationship has on the patient’s voluntarism. I have argued that in almost all cases of professional sexual misconduct, the presence of some power imbalance between doctor and patient is relevant. In considering cases of professional sexual misconduct according to the components of informed consent, then, almost all cases would occur with failure of disclosure and compromise to the patient’s voluntarism. This consideration does not offer any discrimination between almost all cases of professional sexual misconduct.

Consideration of cases of professional sexual misconduct according to an informed consent framework does lead to any potential recommendations for how a doctor found to have engaged in professional sexual misconduct may work to reduce their risk to the community. Disclosure of the risks of professional sexual misconduct to future patients does not render a sexual relationship acceptable. The doctor-patient relationship will continue to hold power imbalances associated with risk to the patient’s voluntarism, so consideration of this is of little value in considering prevention of further professional sexual misconduct.
An informed consent framework does not, therefore, offer any useful structure in assessing the ways in which professional sexual misconduct breached the standards that the community expects from the medical profession, nor appropriate responses to those breaches.

3.5.5 Use of an Informed Consent Framework for Examination of Professional Sexual Misconduct is Reliant Upon, and Secondary to, the Presence of Trustworthiness

Informed consent is itself reliant upon the presence of trustworthiness in the doctor. To ensure that informed consent has been provided, the doctor must be trustworthy in a number of ways. They must be trustworthy to value and enact the appropriate assessment of autonomy, disclose information, and consider potentially coercive or manipulative influences. They must also be trustworthy to consider the limits of their own capabilities. The untrustworthy doctor cannot be presumed to enable informed consent. A doctor who is not trustworthy may inadvertently facilitate an informed consent, but this cannot be assumed. Trustworthiness is fundamental to the informed consent process.

Trustworthiness is most fundamental to community expectations of the medical profession, and undoubtedly breached in instances of professional sexual misconduct. Examining professional sexual misconduct as a breach of trustworthiness will promote a fuller understanding of the ways that clinicians deviate from community expectations when committing professional sexual misconduct.

3.6 Additional Established Ethical Frameworks

Professional sexual misconduct has also been argued to be unethical because it is exploitative [35, 49, 86, 109, 110]. This argument may also be criticised for being a secondary ethical argument. If professional sexual misconduct is exploitative, it may be seen as exploitative in one of two ways.

Professional sexual misconduct may be seen as exploitative of the power imbalance that exists between the doctor and the patient, and the way that this undermines the patient’s voluntarism, stopping them from being able to make an informed consent. In this way, the argument that professional sexual misconduct is exploitative is
secondary to the argument that it is a failure of informed consent. The argument that professional sexual misconduct is exploitative can therefore be criticised for the same reasons that the argument that is a failure of informed consent can be.

Arguments that professional sexual misconduct is unethical because it is exploitative are also problematic if it is argued that an individual may consent to be exploited. At least one author has raised this as a possibility [pages 247-277, 111], and if this is the case, the exploitation argument is all the more weakened by the factors undermining the informed consent framework arguments described.

In the situation in which a patient could be argued to have consented to be exploited by their doctor there is an expectation that the standards of informed consent would be met. The expectations of informed consent when considering professional sexual misconduct are problematic, as I have argued. However, even if these concerns are disregarded, justifying professional sexual misconduct as an acceptable form of exploitation (because of the presence of consent) disregards the other expectations of the doctor, including the requirement for trustworthiness.

Therefore, professional sexual misconduct may be criticised as exploitative because the doctor behaves in such a way that they use their role to seek disproportionate personal gain. This argument suggests that the doctor should be behaving according to a set of standards that are not defined within the argument. It alludes to the requirement for an ethical standard for the doctor’s conduct, and is consequently secondary to this ethical standard.

The argument that professional sexual misconduct is exploitative is therefore unhelpful because it is based upon other ethical principles, being either that of informed consent, or other standards of conduct for the doctor. I will argue that defining a standard of conduct for the doctor is needed for the use of the community, doctors themselves, and medical regulatory boards attempting to objectively consider how doctors have deviated from those standards. The expectation that a doctor not behave exploitatively is again based upon the expectation that the doctor is trustworthy, and can be relied upon to behave in a way that is appropriate. The standard of trustworthiness is again proved fundamental.
3.7 Conclusions

The literature examining professional sexual misconduct has argued that professional sexual misconduct is unethical because it constitutes a breach of informed consent. Under an informed consent framework, it is argued that the power imbalance inherent to all doctor-patient relationships undermines the patient’s voluntarism. Although this argument does address some of the ethical issues raised by professional sexual misconduct, the informed consent argument is limited by a number of concerns.

An informed consent framework does not enable examination of the antecedents to professional sexual misconduct. These antecedents are themselves important because they occur almost universally in cases of professional sexual misconduct, cases may be brought before medical regulatory bodies before frank professional sexual misconduct has occurred, and because these antecedents may in themselves have moral implications.

If it can be argued that there is an attenuated power imbalance between doctor and patient, an informed consent framework may suggest that there is no undermining of the patient’s voluntarism. This assessment would discount community expectations of a medical practitioner, and the medical practitioner’s disregard for those community expectations as expressed through professional codes.

Any ethical framework used to assess professional sexual misconduct must be in keeping with community expectations and requirements. It should be able to assess all aspects of the professional sexual misconduct. A framework should be able to offer more than a dichotomous assessment of whether the misconduct has occurred. Consequently, it should be able to offer some utility for medical regulatory bodies charged with responding to professional sexual misconduct. Trustworthiness is a fundamental expectation of the medical profession, and the basis of other ethical standards, such as informed consent. I will examine what the community expectations of trustworthiness in doctors are in Chapter Four, before examining the ways in which professional sexual misconduct breaches these standards in Chapter Five.
Chapter Four: Trustworthiness as an Expectation of the Medical Profession, and a Framework for the Examination of Professional Sexual Misconduct

4.1 Trustworthiness as an Expectation of the Medical Profession

Professional sexual misconduct has been extensively considered academically according to the psychodynamic factors contributing to this conduct. These psychodynamic frameworks have increasingly found their way into hearings conducted by the Medical Board of Australia, as well as the preceding state and territory medical boards. I have also argued that professional sexual misconduct should be considered according to ethical frameworks, and reviewed the two major ethical arguments currently in use.

I have argued that ethical frameworks based upon the arguments of informed consent and exploitation have significant limitations, both in terms of theoretical underpinnings and also in terms of how they may be practically applied. In this chapter, I argue that any framework should be based upon reasonable community expectations, and be of use to medical regulatory bodies. I argue that ethical arguments based on the requirement for informed consent or concerns about the doctor behaving exploitatively are secondary to the primary ethical principle of an expectation of trustworthiness in the doctor.

A trust-centred perspective is not without precedent in the literature when considering professional sexual misconduct. Professional sexual misconduct has been recognised as ethically unacceptable because it breaches the trust that the community places in the medical profession [35, 38, 44, 112, 113]. Arguments that professional sexual misconduct is unacceptable because it is a breach of trust presuppose the importance of trust in the doctor - patient relationship.

For trust to be justified in the setting of the doctor - patient relationship, there must be some reasonable expectation that it will have a desired outcome. For trust to be associated with the positive outcomes that the trusting patient brings, it must be responded to with trustworthiness. Trust in the absence of trustworthiness could lead to harmful outcomes for the patient. Although the importance of trust for the
medical profession has been acknowledged [38], there is very little exploration of what the reasonable standards of trustworthiness might be.

In this Chapter, I will examine the literature regarding trust and trustworthiness more broadly, and consider the importance of trust and trustworthiness for the medical profession. Of the range of definitions in use, I will argue that it is only rich versions of trustworthiness that are appropriate as a standard for the medical profession, given the nature of the profession’s role.

4.2 The Importance of Trust for the Medical Profession

4.2.1 The Intrinsic Importance of Trust
The importance of trust for doctor-patient relationships has long been understood [114-117]. Doctor-patient relationships are characterised by an extraordinary degree of intimacy, as well as a marked power imbalance in terms of knowledge and skills about healthcare [118]. Patients seeking care are expected to disclose personal information and undergo physical examination before diagnosis and treatment begin.

Trust in the doctor-patient relationship has been described as having intrinsic importance as "a core characteristic" of the doctor-patient relationship [119]. This importance is reflected in the community’s expectations of being able to trust their doctors, which is in turn reflected in professional codes and regulation [119].

4.2.2 The Instrumental Importance of Trust
Beyond trust’s intrinsic value, it has also been described [page 613, 114] as having “instrumental” value. Trust is important not only as a desirable characteristic of the doctor-patient relationship, then, but because of the way that it enables that relationship to function.

Healthcare encounters have been argued to always be associated with anxiety due to both the vulnerability of the patient and the uncertainty of the outcome [120]. The patient who trusts their doctor is more likely to seek appropriate healthcare, to offer more comprehensive and accurate information about their concerns, to agree to
participate in appropriate assessment, then to engage more readily in treatment. During this process the trusting patient is able to experience a reduced burden in terms of their anxiety [11].

The potential benefits of trust within the doctor-patient relationship have been increasingly recognised, in the context of some very public breaches of trust in these relationships [121], and also the increasing awareness of the impact of Managed Care systems in the United States [4, 5, 11, 122, 123]. Consequently, researchers have attempted to quantify levels of trust in the doctor-patient relationship using scales such as the Trust in Physician Scale [124, 125].

The Trust in Physician Scale developed by Thom et al [124, 125] quantifies the level of trust that a patient has in their doctor by asking that patient about how they perceived their doctor and the care that their doctor provides. The Scale comprises eleven items, and has been demonstrated to have high internal consistency [125]. High levels of baseline trust have been shown to correlate with continued engagement with care from that doctor, self-reported adherence to medication, and satisfaction with care [125]. Trust’s instrumental value, includes improved adherence to follow-up and medication regimes necessary for treatment, as well as patient satisfaction with care.

The studies examining correlates of high levels of patient trust in their doctor have a number of limitations. As yet they are small, and with limited patient groups. The results may not be generalisable to all doctor-patient relationships in the society in which the study occurred, and they may also not be generalisable across social groups or cultures. Different authors have used different definitions of trust, and the small number of studies means that many potential correlates have not been examined. Nonetheless, there is some early research suggesting that trust within the doctor-patient relationship may contribute to more open disclosure of symptoms, including those potentially associated with stigma [126, 127], allowing better assessment. One study also notes higher levels of self-reported treatment adherence at six months [125]. Better engagement in both the assessment and treatment phases of care has obvious potential benefits for patient outcomes.
Although these improved outcomes have not been demonstrated, higher levels of satisfaction with care have been described [125].

Some authors have argued that the instrumental value of trust is even greater in some healthcare settings, such as the care of patients with mental illness. These patients are more likely to be experiencing “the two characteristics which make trust particularly necessary - vulnerability and uncertainty” [120] because of both the effects of the illness, and the stigma associated with this [126]. Mechanic demonstrated significant differences in the expectations of patients with different diagnoses [126]. Further research into the effects of trust within the doctor-patient relationship is required, including examination of specific patient groups.

Trust is inherently associated with risk. High levels of trust may have benefits, but is also associated with dangers [12]. Misplaced trust can enable “opportunism, paternalism, and the potential over exposure to risk” [11]. The trusting patient may be less likely to use “more appropriate ways of dealing with uncertainty and risk” [11] such as seeking further information or a second opinion. High levels of trust, regardless of the potential benefits, cannot be sought without an understanding of the potential dangers.

4.2.3 Factors Affecting Levels of Trust in the Medical Profession

The intrinsic and instrumental benefits of trust, above, have been considered in the context of the doctor-patient relationship. This doctor-patient relationship does not occur in isolation, however, and the doctor is likely to be associated with a number of institutions. The medical profession itself is an institution, as is the sub-specialty in which the doctor practices. The doctor may also be associated with other institutions, such as hospitals, clinics, or universities.

When trust occurs within an interpersonal relationship, it is described as interpersonal trust or personal trust [page 616, 114]. An individual may also place their trust in a group of individuals, an organisation, or an institution. This latter form of trust has been referred to as institutional trust [114], impersonal trust [12] or social trust [115, 127]. I will refer to a patient’s trust in their doctor as interpersonal trust, and trust in an institution or group of individuals as institutional trust, hereafter.
Interpersonal trust and institutional trust are, of course, closely related. An individual patient may imbue a particular doctor with a level of trust because they work in a hospital that has a particularly good reputation, or standing, within their community. Conversely, a patient may trust a hospital's care after being referred there by a doctor that they trust. Distrust in an individual can similarly impact upon perceptions of the institution, and concerns about an institution can impact upon perceptions of an individual doctor.

With awareness of the potential benefits of trust in health care, there has been increasing interest in understanding what variables may influence levels of trust. Trust has been noted to be “dynamic” over time [115], and there has been increasing consideration about what factors may change levels of trust. Although interpersonal and institutional trust may influence each other, the factors which determine levels of each are quite different.

4.2.3.1 Factors Affecting Levels of Interpersonal Trust

Interpersonal trust in the doctor - patient relationship is often highly affectively charged [127], and contains “strong elements of transference” [115]. Levels of interpersonal trust are strongly determined by the individual’s experience within that relationship [122, 127].

Research examining what factors increase interpersonal trust in initial doctor - patient encounters have described a number of factors that patients attempt to assess. Studies have described patients attempting to assess their doctor’s communication style [115, 120], the degree to which the doctor appears “patient centred”, or prioritises responding to the patient’s concerns [128], “professional” [128], with a sense of “shared values” [117], and “both competent and caring” [120]. The patient’s experience within this interpersonal interaction, and their sense of their doctor’s “interpersonal competence” [129], influences the level of trust that can be formed.

In established doctor - patient relationships, continuity of care has consistently been described as a factor increasing interpersonal trust [115].
There has been an explosion in literature suggesting that Managed Care in the United States has led to a reduction in levels of patient trust in this context [4, 6, 7, 122, 123, 130, 131, 132]. Managed Care has been argued to reduce trust in the doctor-patient relationship in a number of ways, including reducing continuity of care, the individual’s ability to choose their own physician, and the amount of time that they are able to spend in a consultation. One of the most important factors described, however, is the patient’s fear that their doctor may not be acting in their best interests, due to a conflict of interest (often financial and involving Managed Care funds) that takes precedence over their needs.

Although interpersonal trust is formed and influenced by experiences within the relationship, when that relationship is influenced by external institutions, this can clearly impact upon levels of interpersonal trust.

4.2.3.2 Factors Affecting Levels of Institutional Trust

In contrast with interpersonal trust, institutional trust is “more cognitive and abstract, and typically based on inferences about shared interests and common norms and values” [115], and influenced by “media attention and public discourse” [122, 127]. It is “more remote, influenced by media exposure and general reputation more than by firsthand knowledge” [127].

As I have described, details of cases of professional sexual misconduct are usually available on the public record through medical regulatory boards. Details about professional misconduct by doctors, and particularly sexual misconduct, are of great interest to the media, and in turn, the general public [8, 9]. These cases are consequently widely portrayed in the media, with potential implications for the public’s perception of the medical profession as a whole. There is some evidence that medical misconduct is being increasingly portrayed in the media [8, 9]. This portrayal undoubtedly reflects levels of public interest in the conduct of doctors, but has also been shown to influence public perceptions of the medical profession.

Some authors have argued that levels of trust in communities in general have declined, and that reduced trust in the medical profession has occurred in this
context [4, 133]. Lipset [134] argues that levels of trust in the community generally has declined, and attributes this to the “shift from print media to television”, and argues that “the press looks for failings” that are in turn relayed to the public in a way that encourages them to feel personally involved. Lipset argues that this media coverage, and its bias towards the controversial, has the potential to undermine institutional trust. Mechanic [115] also describes the media’s role in reporting new medical knowledge to the general public, as well as “physician and hospital errors”. The media does therefore improve the general public’s knowledge of medical care, and offer repeated reminders of the dangers in trusting your doctor.

In addition to media reporting, reductions in levels of trust have been attributed to “changes in health care systems” [129]. Health care system changes can impact upon doctor-patient relationships by reducing the amount of patient contact with doctors, patient choice of doctor, continuity of care and by causing conflicts of interest. The perception of doctors as self-interested has been noted by several authors to be a powerful threat to public trust [7, 132, 135], as well as in direct conflict with the fiduciary nature of the relationship [132].

In response to this apparent decline in public trust of the medical profession, others have questioned the reliability of the evidence available. O’Neill [10] has led this charge, arguing that there is no evidence that levels of trust in the medical profession are declining. O’Neill also argues that the current evidence for a declining level of trust is poor, and argues against the position that there is a “crisis in trust”. To this end, O’Neill cites the public’s continued willingness to seek the services of doctors, and argues that this is done even when alternatives are available [10].

O’Neill is certainly correct that patients continue to seek the care of doctors when unwell. This does not necessarily prove that their level of trust in doctors is unchanged, however. There could, instead, be increasing levels of entrusting occurring without meaningful trust. Alternately, there may be reduced institutional trust occurring, but this may not (yet) be prohibitive of interpersonal trust within the doctor-patient relationship. As stated by Mechanic, “Eroding social trust in medical institutions forms a threatening backdrop to doctor-patient relationships, but the
strength of patient’s personal trust in their doctors has until now provided considerable insulation against serious conflict” [115].

In terms of considering levels of trust in both interpersonal and institutional relationships in health care, it cannot be assumed that higher levels of trust will always be better. The level of trust should not exceed that warranted by the trustworthiness of the person or institution to be trusted. Buchanan argues for optimal rather than maximal trust because of the risks associated; “the greatest net benefit” [123].

4.2.4 Trust and the Medical Profession
Trust is clearly essential for health care involving the medical profession. This trust has both interpersonal and institutional components, and is dynamic over time for individuals and communities. Whether overall levels of trust in the medical profession are decreasing or not, it is clear that levels of both interpersonal and institutional trust can be reduced by perceptions that the medical profession is not trustworthy. Perceptions of trustworthiness may be influenced interpersonally, in private, or publicly, via the media, with the observation of conduct not in keeping with the community’s expectations of trustworthiness.

4.3 Trust and Trustworthiness Defined
Until relatively recently, philosophers have been reticent to engage in an examination of trustworthiness [22]. This reticence may be due to the same factors which delayed the recognition of the importance of trust. In particular, philosophers have historically been more interested in voluntarist relationships based on contract, with little consideration of the issues that are raised by relationships characterised by a power imbalance between the agents [23]. Trust and trustworthiness are of greatest importance when in relationships in which there is a significant power imbalance between truster and trustee, and the interactions between them cannot readily be regulated by contract.

The importance of trustworthiness is now more recognised by philosophers, largely secondarily to the interest in trust. Any potential truster preparing to trust (or not) must consider, and indeed attempt to evaluate, the trustworthiness of their
prospective trustee, if they wish to optimise their likelihood of trusting successfully. This is not to say that the trustworthiness of the trustee is the only factor which influences the outcome of any trust placed. There may be factors within the truster-trustee relationship or the broader social context which influence the outcome of the trust. Indeed, the truster’s own capacity to assess trustworthiness, amongst other things, will critically influence the likelihood of successful trust [10].

Trustworthiness is a variable within the trustee that influences the outcome of trust. The literature examining trustworthiness importantly varies according to the demands upon the trustee. In particular, there is divergence within the literature about the degree to which the trustworthy trustee must be influenced by the preferences of the truster. The ‘thinner’ versions of trustworthiness, at their extreme, require no interest in the preferences of the truster, on the part of the trustworthy trustee. Progressively ‘thicker’ versions of trustworthiness demand that the trustee have a progressively greater commitment to the truster’s preferences [22].

4.3.1 Thin Versions of Trust and Trustworthiness
The thickness (or thinness) of a definition of trustworthiness is a function of the motivating factors within the trustee which determine their response to the truster’s expectations. Thinner versions of trustworthiness do not demand that the trustee have particular interest in, or concern for, the truster. Thinner versions of trustworthiness are defined by requiring adequate action (by the trustee) to “get the job done” [page 1, 22].

Jones argues that thinner versions of trustworthiness must be paired with thinner versions of trust. This pairing can be seen to hold true with thinner versions of trust being only “risk-assessment accounts” which analyse trust as “a subjective probability that the one-trusted will perform the desired action”. In thin versions of trust, then, the truster A trusts trustee B to do X believing only that B will do X. Correspondingly, Trustee B is trustworthy only to the extent that they will do X. Of note, in these (very) thin definitions of trustworthiness and trust, there is no expectation on the part of the truster that the trustee is influenced by concern for the truster. The motivation of the trustee B to do X may in fact be completely independent of A. The motivating factors required in the trustee in thinner definitions
of trustworthiness, in terms of their interest and concern for the truster, are therefore minimal.

The thinnest versions of trustworthiness in fact do not require the trustee to have any interest in the truster. That is, when A trusts B to do X, B may do X independent of A’s preferences. That is, trustee B may do X because they were intending to do X, prior to A’s trust. The expectations of A are that B will do X, regardless of A’s individual expectations. In this thinnest version of trust, trust may be equated with reliance. Trustworthiness may be equated, consequently, with reliability. Trustworthiness need not, according to these thinnest definitions, equate with any interest in the truster.

Authors who have equated trust with reliance, and for whom trustworthiness may be equated with reliability, are dismissed by Jones [22] as creating a description of trust that is “too heterogeneous a class of dependencies to sustain any useful generalizations”. I agree that these definitions of trust are at the very extreme thin end of the spectrum. They are, however, in keeping with the ways in which the term trustworthiness is in common usage, particularly within the sociological literature. For this reason, these extremely thin versions of trust (and trustworthiness) must be born in mind, even if they do not compel.

An example of one advocate of a thin version of trust is Gambetta. Gambetta defines trust as “a particular level of the subjective probability with which an agent assesses that another agent or group of agents will perform a particular action, both before he can monitor such action (or independently of his capacity ever to be able to monitor it) and in a context in which it affects his own action” [page 217, 136]. In keeping with this definition of trust, trustworthiness is defined as “the probability that he will perform an action that is beneficial or at least not detrimental to us is high enough for us to consider engaging in some form of cooperation with him” [page 217, 136].

Gambetta does not suggest that the trustworthy trustee has any obligation to be influenced by the truster’s preferences. According to Gambetta, trustworthiness is defined only as the likelihood of doing something that is beneficial to the truster,
regardless of motivations to do so. Gambetta’s definition of trust does require the truster to hold a degree of confidence in their trustee. Gambetta’s version of trust is consequently more demanding than those in which trust is equated with reliance. Reliance may occur warily and reluctantly. Gambetta’s expectation of confidence implies more than the minimum standards of reliance.

However, thin versions of trustworthiness are not limited to those in which the trustee has no interest in the individual truster’s preferences. Moving on the spectrum of trustworthiness to thicker versions of trust, thin versions of trust also include those in which the trustee is aware of the truster’s preferences, and influenced by them, but influenced by them because it is in the trustee’s interest to be so. Hardin’s model of trust is a well established example of such a version. Hardin states “The main factor that distinguishes trusting from other types of social relations, such as relations of simple coordination, is the concern of the trusted with the truster’s interests” [page 6, 137, 138].

Hardin has called his model of trust “The Encapsulated Interest” Model. According to Hardin’s model “we trust you because we think you take our interests to heart and encapsulate our interests in your own” typically “because you want to continue our relationship” [page 2, 138]. Hardin therefore suggests that his model of trust is “relational”, and emphasizes the importance of both parties’ commitment to sustaining the relationship as the “primary foundation” of the trustworthiness of agents within a trust relationship. Hardin’s model is differentiated from that of Gambetta, therefore, in that there is some interest in the preferences of the truster. This interest is in turn motivated by the trustee’s preferences to maintain their relationship with the truster.

McLeod [139] contrasts Hardin’s Encapsulated Interest model with what she describes as a “Social Contract view” of trust. In this model, trust seems to be motivated by a concern, by the trustee, of the public or social consequences of appearing untrustworthy, by breaching trust. Once A has entrusted X to B, the two moral agents are seen to have entered a social contract. In this model, the trustee is motivated to consider the preferences of the truster by self interest, with concerns about the social consequences of not acting in this way. The Encapsulated Interest
Model and the Social Contract Model both share an underlying principle that trust is motivated by self-interest; either to prevent loss of a valued relationship, or to prevent the social consequences of appearing untrustworthy. The primary concern of the trustworthy need not be the preferences of the truster, insomuch as the consequences of not responding to those preferences.

Jones [140] describes these views as “risk – assessment accounts” of trust, and suggests that according to these views, people trust other people when they are able to evaluate that the risks of doing so are low.

The thinnest versions of trustworthiness do not require that the trustee is influenced by the truster’s preferences. Trustworthiness can be equated with reliability to perform a certain task. Further along the spectrum, but still at the thin end of the spectrum are “risk-assessment accounts of trust” and their correlating versions of trustworthiness.

4.3.2 Thicker Versions of Trust and Trustworthiness
How do thicker definitions of trustworthiness differ, then, from these thinner versions? Thicker versions of trustworthiness are characterised by the requirement in the trustee, of greater levels of interest in the truster and their preferences. The exact nature of this increased level of interest has been debated by authors, with more and less demanding versions of trustworthiness resulting.

Jones [141] and Baier [23] have both described “goodwill” towards the truster, as a requirement within the trustee, for trustworthiness. Jones [22] has since noted that neither she nor Baier defined what goodwill should be, within this context. Jones has said that trustworthiness requires “an active engagement with dependency” [22]. With this requirement for “engagement” with the dependency of the truster, there must be regard for the preferences of the truster. Jones describes this as Basic Trustworthiness, which is defined as: “B is trustworthy with respect to A in domain of interaction D, if and only if she is competent with respect to that domain, and she would take the fact that A is counting on her, were A to do so in this domain, to be a compelling reason for action” [page 23, 22].
Jones’ definition of trustworthiness therefore requires the trustee to be interested in the truster’s preferences, and to find them, to some degree, compelling. Jones suggests, then, that trustworthiness requires that the trustee be influenced by the truster’s preferences for reasons beyond those of the trustee. That is, the trustee must experience the truster’s preferences as compelling not because of their implications for the trustee, but because these preferences are seen as having some inherent worth. This definition of trustworthiness is certainly more demanding of the trustee than thinner definitions of trustworthiness. It requires that the trustee to some degree prioritise the truster’s preferences, and with this there is the implication that, under some circumstances, they may need to prioritise the truster’s preferences over their own.

Jones acknowledges that the requirement of the trustee to prioritise the preferences of the truster over their own is not absolute, and indicates this in a number of ways. Jones indicates that this trustworthiness is not absolutely compelling by indicating that the trustee may have some “excusing explanation” for not acting according to the truster’s preferences, or that the trustee may “deliberate about what to do” [141]. Thick trustworthiness does not absolve the trustee of other moral responsibilities, and therefore must be considered in the context of the truster-trustee relationship.

4.3.3 Rich Trustworthiness
Jones also refers to the responsibilities of this trustee to indicate the limitations of their trustworthiness, with the concept of rich trustworthiness. Rich trustworthiness is defined by Jones [page 26, 22], as trustworthiness which “reliably signals its presence”. The richly trustworthy are aware of their limitations, and indicate these clearly to the prospective truster. The richly trustworthy must signal both willingness to act as a trustee and competence in such a way that they assist would-be trustees, to find them.

A trustee may be trustworthy, then, and indeed richly so, even if they choose to prioritise their own preferences over those of the truster. The requirement for rich trustworthiness is that they not misrepresent what their capacities might be, and what they are prioritising. When is it morally reasonable, then, for the prospective trustee to deliberate, then, and choose not to prioritise the preferences of the
prospective truster over their own, on the proviso that they will communicate this to prospective trusters?

The morally reasonable expectations of the trustee are of course dependent upon the complex circumstances of the potential trust, including factors within the truster, factors within the trustee, factors within the truster – trustee relationship, including the matter being trusted, as well as the broader social context. I will argue next, that within the doctor – patient relationship, the expectations of the trusting patient are in keeping with thick descriptions of trustworthiness. This can clearly be seen to be more demanding than thin trustworthiness. Thin trustworthiness does not require that the trustee displace their own preferences, and certainly, allows for the presence of trustworthiness even if the trustee is acting predominantly in response to their own concerns. Thicker trustworthiness requires a different level of interest in the truster's preferences, however. These preferences must be somehow compelling to the trustworthy, and be seen to have inherent worth rather than a ‘means to an end’ for the meeting of their own preferences.

4.3.4 Carolyn McLeod’s Description of Trustworthiness

There are other understandings of trustworthiness, including those which consider trustworthiness within the doctor patient relationship. Carolyn McLeod’s description of trust is based upon the assumption that “one of the salient features of trust” is that it occurs in “interpersonal relationships” [page 11, 142]. McLeod criticises Baier and Jones for their requirement of “goodwill” in the trustee, for trustworthiness to be present [page 12, 142], arguing that this standard is “vague”, and should be replaced instead by the requirement for “moral integrity”.

McLeod acknowledges that trust does not only occur interpersonally and that it may occur towards institutions such as governments, for example [page 15, 142]. However, McLeod believes that these instances of trust should be considered according to the ways that they are similar to interpersonal trust. That is, instances of trust towards institutions should only be evaluated as trust – related if they are “sufficiently similar to interpersonal trust relations” [page 15, 142].
In evaluating whether trust may be occurring in a relationship, McLeod argues that the truster must hold “optimism about the competence of the other in certain domains” [page 17, 142]. McLeod argues that these domains include competence to perform the task that the truster is hoping will be done, but argue that competence to complete the task is not itself sufficient for the trustee to be trustworthy.

In addition to competence to perform the task, McLeod argues that the trustee must be appropriately motivated to be trustworthy. McLeod argues that this motivation is not usefully described as goodwill, for a number of reasons. Firstly, McLeod suggests that the standard of “goodwill” is “imprecise” [page 21, 142], and if this is taken to mean a “kindly feeling toward others” this is problematic for two reasons. Firstly, McLeod argues that trust can occur without the expectation of these kindly feelings, and secondly that those trustees who do hold kindly feelings towards the truster may still fail to be trustworthy if they do not respond to the trust in particular circumstances [page 21, 142].

McLeod argues that, to be trustworthy, the trustee must be motivated by moral integrity. McLeod states this be “an enduring commitment to acting in a morally respectful way towards us and we want their actions to accord with that commitment” [page 23, 142].

McLeod’s descriptions of trust and trustworthiness are distinctive for two main features. Firstly, trust is said to be a phenomena that occurs primarily in an interpersonal context, and trust of institutions occurs only insomuch as there is a resemblance with interpersonal trust. Secondly, the trustee can only be trustworthy if they are motivated to act by moral integrity.

I have chosen to use Jones’ descriptions of trust and trustworthiness, rather than those of McLeod, for three reasons.

Firstly, and as described above, there are important differences between interpersonal and institutional trust, and the factors influencing these. I am concerned about McLeod’s reluctance to consider institutional trust as potentially
having significant differences from interpersonal trust, and therefore the narrowness of this definition.

Secondly, McLeod’s standard of moral integrity does seem to be an extremely demanding standard. The requirement for an “enduring commitment”, and for all actions to be in “accord with that commitment” [page 23, 142] is, I believe, excessively demanding. Many doctor patient relationships are not enduring for any significant period of time, and yet the importance of trust and trustworthiness within them is not diminished. For all actions to be in accordance with this commitment similarly seems excessively demanding of the doctor who may inadvertently deviate from this requirement, in trivial ways, yet remain trustworthy.

Finally, I am concerned that McLeod’s requirements of trust and trustworthy offer little guidance about what is required for a trustee to have behaved in a way that is commensurate with their state of being “morally respectful”. Different trustees may well have very diverse beliefs both about what it is to be morally respectful, and also the appropriate ways of expressing this.

Jones’ states requirements that the trustee be engaged with the dependency of the truster, and that they experience the preferences of the truster as compelling. Jones’ expectations of the ways that the trustee should respond to the truster are not only more specific, but I believe that these expectations are of particular value when considering interpersonal trust in the form of the doctor patient relationship, but also institutional trust of the medical profession.

For these reasons, I will not further consider McLeod’s description of trust and trustworthiness, but instead continue with an understanding of trustworthiness based on the standards described by Jones.

4.3.5 Trustworthiness as a Virtue

Trustworthiness was not considered a virtue by classical philosophers [22]. This is perhaps not surprising given philosophy’s comparatively recent interest in trustworthiness, which is of most significance for relationships characterised by a power imbalance, and not governed by contract.
The omission of trustworthiness from the virtues has been justified with the argument that trustworthiness may vary depending in the context. That is, a trustee may be trustworthy within one relationship, but not another.

Jones also argues that trustworthiness is not always employed for positive outcomes. The trustworthiness shared between “evildoers” [22], that facilitates their evil-doing, cannot be seen as virtuous. Jones notes Baier’s [page 232, 23] argument about the need to respond to some forms of trust, not with trustworthiness, but with “trust busting”. Jones argues further that it may be morally reasonable to actively elicit trust, and respond with “trust busting”, and also that it may be very reasonable to refuse to respond to unsolicited trust with trustworthiness.

Potter [143] argues that trustworthiness is a virtue by arguing that other virtues, including honesty, may contribute to harm and should not always be responded to. This argument does not recognise the dynamic nature of trustworthiness across contexts and interactions. For trustworthiness to be a virtue, the trustworthy individual must be motivated by factors that are not context specific. As I will argue in Section 4.4, however, trustworthiness is defined by the interests in the trustee of the preferences of the truster. This interest is itself crucial to the definition of trustworthiness. I therefore suggest that the relational aspects of trustworthiness should never be ignored. Potter’s categorisation of trustworthiness as a virtue fails to consider the different range of trust relationships, and the demands of the thick trustworthiness with its interest in the preferences of the trustee.

Trustworthiness cannot be considered a virtue when there are so many caveats on when and how it may make a positive contribution. It is not, therefore, a simple virtue to be sought in those individuals seeking to be medical practitioners. By rejecting the notion that trustworthiness is a virtue, I am in no way rebuking its importance. Although trustworthiness is not usefully considered as a virtue, this does not suggest that trustworthiness does not require some underlying psychological capacities.
The relationship between trustworthiness and the psychological capacities of the individual will be complex. This will be considered further in Chapter Five.

4.4 The Expectation of Trustworthiness for Doctors – Rich Trustworthiness

Some authors, including Jones [22], have argued if the full spectrum of versions of trustworthiness are considered, that the concept becomes so broad as to be unhelpful. I will not engage in the debate about whether the very thinnest descriptions of trustworthiness are reasonable, nor whether there is one type of trust/trustworthiness pairing, or multiple forms. I will instead acknowledge that the community refers to both trust and trustworthiness with the broadest of expectations, depending on the context. The doctor – patient relationship has a number of unique features which have implications for the type of trustworthiness that might reasonably be sought or expected by the patient, in their doctor.

In particular, I will argue that, in considering the doctor – patient relationship, it is inappropriate to consider anything other than thicker versions of trustworthiness. I will demonstrate this by describing the ways in which thin versions of trustworthiness are incompatible with optimal medical care, and also argue that thicker versions of trustworthiness are most in keeping not only with modern health care consumer expectations, but also the ways that the medical profession presents itself.

Rich trustworthiness appropriately has expectations of the trustee (doctor) to be able to indicate their own limitations to the truster. In this way, the burden of assessing the trustworthiness of the doctor lies not only with the patient. I argue, however, that the moral responsibility lies with the doctor, as the prospective trustee, to be able to correctly signal their own trustworthiness.

With the argument that thicker trustworthiness, with its expectations of the trustee to prioritise the preferences of the truster, is most appropriate when considering the doctor – patient relationship, there are significant implications for both the trustee and truster. Thicker versions of trustworthiness place higher demands on the trustee doctor, whilst at the same time raising substantial challenges for the potential truster patient, who seeks to assess whether thick trustworthiness is present. Thicker
trustworthiness is the only appropriate model of trustworthiness for the doctor – patient relationship, but the requirement for thick trustworthiness raises challenges for both doctor and patient.

I will argue that thinner versions of trust are incompatible with the expectations that patients have not only of their doctors’ trustworthiness, but of the underlying factors which motivate this. That is, that the patient’s expectations of their doctor are not only that they will not act according to very thin definitions of trustworthiness, but also that they will be motivated by more than the minimal factors required in these definitions of trustworthiness. I therefore argue that patients not only expect that their doctors reliably, but that they have underlying motivations in keeping with thicker trustworthiness.

I do not disagree that thinner definitions of trust, and correspondingly trustworthiness, certainly have some validity for particular trust exchanges, and that trust might reasonably be described as trusts, with variation between trust expectations, and trustworthiness requirements, depending on the context. For situations in which there is a significant power imbalance, the trust exchange is socially sanctioned, or the truster is entrusting X which has high personal value, the most appropriate definition of trustworthiness is a thicker version of trustworthiness.

4.4.1 Thin Versions of Trustworthiness Do Not Require Respect for the Patient’s Preferences

The importance of the patient’s perspective is now accepted by the medical profession [144]. The days in which patients were reassured by the statement that “Doctor knows best” have well since passed. The modern health care consumer movement has contributed to a change in the relationships that patients have with their doctors by not so much expecting participation in health care decisions as demanding it. Even prior to the emergence of this movement, however, important legal precedent signalled a change in doctor – patient relationships, and the increasing importance of the patient’s preferences.

The Australian legal case of Rogers v Whitaker [103] is described in detail in Section 3.3.1 in Chapter Three, as influencing the type of information which must be
disclosed for informed consent to occur. The subjective standard is a very clear example of a way in which the community expects doctors to consider patients’ preferences, in their clinical practice. The expectation is defined such that a doctor must find the preferences of their patient compelling. The expectation of interest in the preferences of the truster is a requirement for thick trustworthiness. The legal precedent set by *Rogers v. Whitaker*, and the ongoing expectation of the community that the doctor will be interested in the preferences of their patient, is consistent with the standards of thick trustworthiness.

4.4.2 Patients Have Expectations about the Underlying Factors Which Motivate Their Doctors

Thus far, thin versions of trustworthiness have been argued to be incompatible with the expectations of the doctor – patient relationship because they do not require that the patient’s preferences be considered. Beyond this, however, I will argue that thin versions of trustworthiness are in appropriate because they are incompatible with the expectations that patients have of their doctors’ motivations to act.

Thin versions of trustworthiness stipulate only that the trustee act as they are being trusted to do their own reasons. The doctor may only be motivated by the consequences for themselves, not their patient. The doctor who is only thinly trustworthy may be motivated by a wish to maintain their relationship with the patient (for whatever reasons), or the social consequences of being noted to behave in an untrustworthy manner. They are not required to have any intrinsic concern for the patient or their well being, and must only be concerned about the implications of this for themselves. Although patients might be very willing to acknowledge that of course doctors may take some pride in their professional reputation, and that they receive a financial income, as well as a particular social identity through their work, most would express concern if these were the only factors influencing the doctor’s behaviour. In particular, patients would be unlikely to embrace the idea that they were not considered to have some inherent value, in their interactions with their doctor.

Patients may be concerned about a doctor holding a lack of regard for their intrinsic worth for a number of reasons. Most people would like to think that they have
intrinsic worth in general, but the sick and disabled may also be particularly sensitive to a lack of recognition of this. Patients may be concerned about this also because there is little evidence that when trustworthiness is motivated by self-interest, that it is either predictable or reliable. The reality is that for a doctor to be beset by adverse consequences for being untrustworthy, that this lack of trustworthiness must first be demonstrated and proven. Particularly when this untrustworthy behaviour has occurred within the clinical setting, this can be difficult and distressing for the patient to raise, all the more so if they have been harmed by the behaviour. Patients may have concern that even if they do complain about the behaviour that their concerns may not be responded to, because of the power imbalance within the relationship. Complaints to medical registration boards represent a marked underestimate of the concerns that patients have when they are anonymously surveyed. The perception of cronyism further raises concerns about the capacity of external motivating factors to consistently shape trustworthy behaviour.

To summarise, patients hold expectations of the factors motivating their doctors’ trustworthiness that exceed those mandated by thin trustworthiness. The patient’s expectations of their doctor will be those of thick trustworthiness.

4.4.3 Thinner/Risk Assessment Views of Trustworthiness are Incompatible With the Patient’s Capacity to Perform a Risk Assessment of the Doctor’s Trustworthiness and are Excessively Demanding of the Patient

In thin versions of trust or trustworthiness, described as risk – assessment versions, the patient would be reasonable in trusting their doctor when they assess that there is a high likelihood that their doctor is trustworthy. This assessment is unlikely to be feasible across all doctor – patient relationships, and particularly if the patient is acutely unwell.

Those that argue for a thin version of trustworthiness might argue that patients are able to perform a risk assessment of the trustworthiness of their doctor by considering the assessments and credentials that institutions have provided. They may argue that patients are enabled to perform a risk assessment view of their doctor through the credentialing provided by organisations such as medical registration boards, or hospitals. That is, the argument may be that thin versions of
trustworthiness are not unreasonable, because the patient may utilise the assessments of others to perform their risk assessment.

This argument is flawed. If a patient is incorporating more than their own assessment into their decision-making process, then they are intrinsically acting according to an expectation of rich trustworthiness. That is, they are responding to signals regarding the trustworthiness of the trustee. These signals have been delegated to other institutions, and these in turn must be trusted for their signals to be of value to the truster. The requirement to trust and trust again is an onerous one for the truster.

To incorporate the assessments or credentialing performed by other organisations, the truster must trust the institutions providing these assessments. This in turn places an additional demand on the truster patient to be performing a risk assessment view of not only their doctor, but also the institutions credentialing their doctor. Under a thin version of trustworthiness, therefore, reference to use of external credentialing compounds the burden on the prospective trustee, and further renders the model inappropriate.

The nature of the doctor – patient relationship renders a thin version of trustworthiness inappropriate because the patient cannot perform an assessment of trustworthiness, in keeping with a risk assessment view. Perhaps even more seriously, thinner versions of trustworthiness do not demand regard for the preferences of the truster, for their own sake. This is certainly discordant with modern health care consumer expectations.

These demands are excessive particularly given that the trustworthiness of a particular practitioner may vary from situation to situation. The patient is not therefore required to perform a ‘once off’ assessment of trustworthiness, but instead, to perform a dynamic, ongoing assessment.

4.5 Conclusions
The importance of trust and trustworthiness for the medical profession are beyond dispute. Both interpersonal and institutional forms of trust are dynamic over time for
individuals and communities. It is clear that levels of both interpersonal and institutional trust can be reduced by perceptions that the medical profession is not trustworthy. Perceptions of trustworthiness may be influenced interpersonally, in private, or publicly, via the media, with the observation of conduct not in keeping with the community’s expectations of trustworthiness.

I have argued that thin versions of trustworthiness are inappropriate as a standard for medical practitioners. Patients expect that their preferences for their own healthcare will be prioritised. Both healthcare consumer expectations and legal precedent demonstrate this clearly. The requirement to prioritise the preferences of the truster exceeds the minimum requirements of thin trustworthiness, to a standard of thick trustworthiness.

Additionally, thin trustworthiness requires only that the trustee be motivated by the consequences of not being seen to be trustworthy. They need not be concerned with the inherent worth of the truster, and may be concerned only by the consequences of being ‘caught’ as untrustworthy. This is a particularly flawed criteria for the doctor – patient relationship. It may be difficult for the patient to assess whether or not their doctor has behaved in a trustworthy fashion, due to the imbalance in knowledge about medical care. Moreover, the power imbalance may also be such that there may be few consequences for the trustee (doctor), even if they do behave in an untrustworthy way. This may be because it is difficult for the patient to identify when they have a clear right to protest, because the avenues of protest are unclear, or because they perceive, rightly or wrongly, that their complaints will not be responded to. There is little to suggest, therefore, that the motivations of thin trustworthiness lead to reasonable outcomes for patients as trusters.

All of these factors suggest that thin versions of trustworthiness are not reasonable expectations of doctors as trustees. Thin trustworthiness may also be rejected when considering doctors as trustees because they are excessively demanding of the patient. In a thin version of trustworthiness, described as risk-assessment views by Jones [141], the onus is on the patient to assess the trustworthiness of their doctor. They must assess their doctor’s competence and inclinations, all at a time that they
themselves are incapacitated by illness or distress. This is also clearly unreasonable.

From these arguments, alone, then, it can be seen that a model of thick trustworthiness, such as Jones’ Basic Trustworthiness, must be utilised. Jones defines Basic Trustworthiness as follows; “B is trustworthy with respect to A in domain of interaction D, if and only if she is competent with respect to that domain, and she would take the fact that A is counting on her, were A to do so in this domain, to be a compelling reason for action” [page 23, 22].

As we have considered, thicker versions of trustworthiness are more demanding of the trustee. Thicker versions of trustworthiness also place a significant burden on the prospective truster, who is attempting to evaluate the trustworthiness of their trustee. Reducing this burden on the truster seems like an imperative for the thick versions of trustworthiness to be viable.

This reduction in burden is met with the concept of Rich Trustworthiness, defined by Jones as “Trustworthiness that reliably signals its presence” [22]. In the presence of rich trustworthiness, the potentially truster can expect that the prospective trustee will assist them in their evaluation of their trustworthiness by offering “signals” about the trustee’s limitations and capacities. The presence of rich trustworthiness in a trustee is a far higher standard, in that it requires “the coordination of a sophisticated set of competences: in domains, in self-assessment, in signalling, and in the practical wisdom required to be alive to the expectations of others and the appropriate ways in which they might be met”.

The requirement for rich trustworthiness, then, introduces further demands on the doctor trustee, to be reliably signalling what their capacities and limitations are to prospective patient trusters. Initially it would seem to be placing an even greater burden on the doctor. However, rich trustworthiness is not inconsistent with modern medical practice. Doctors are credentialed for specific roles and subspecialties. They routinely indicate the limitations of their capacities by referring patients to alternate doctors with the appropriate skills or training.
I argue, therefore, that the standard of trustworthiness which may be reasonably expected by the Australian community of its doctors is that of rich trustworthiness, in combination with thick trustworthiness. With the definition of a standard of trustworthiness, there is the opportunity to define deviations from acceptable conduct according to this standard. In Chapter Five, I will argue that this standard of trustworthiness should be applied to the medical profession, and offers a framework with which professional sexual misconduct can be examined.
Chapter Five: A Moral Framework Based on the Standards of Trustworthiness

5.1 Use of a Moral Typology When Considering Doctors Who Have Committed Professional Sexual Misconduct

Thus far I have argued that professional sexual misconduct remains a serious concern for the community, and the Medical Board of Australia, charged with the protection of the community. I have expressed concern about the responses to professional sexual misconduct being based upon psychodynamic understandings of doctors who have engaged in professional sexual misconduct, as they are currently used, during Medical Board Hearings.

I have argued that professional sexual misconduct has moral implications, and therefore for the use of a moral typology in the consideration of cases of professional sexual misconduct, I have expressed concern about use of the requirements of informed consent, and the limited capacity of a framework based on the requirements of informed consent to discriminate between cases of professional sexual misconduct, or guide responses to professional sexual misconduct.

I have argued that the ethical standards of rich trustworthiness are responsive to reasonable community expectations. Before considering a typology based upon use of trustworthiness as the standard, I will consider the desiderata of a moral typology in the consideration of doctors who have committed professional sexual misconduct.

This moral typology will examine cases of professional sexual misconduct according to the moral features of these cases. A moral typology, to be useful, must be specific in being able to respond to the details of cases of professional sexual misconduct. This may, in turn, result in greater numbers of categories, but these outcomes may be more directly understandable in terms of the actions of the doctor. The categories will be directly linked with observable moral choices, with clear correlation with the category associated. This is unlike clinical typologies, in which external actions or behaviours must be interpreted through an understanding of the individual’s internal world.
A moral typology could be used in combination with psychodynamic and psychiatric assessments. This moral typology will still require some consideration of the individual’s internal world, in terms of their moral reasoning, and the factors which undermined their decision-making. The clinical impairments cited during hearings are often assumed to be temporary, reversible and underlying poor moral choices. They are often proposed as readily treatable, and in fact often treated by the time the hearing is occurring. The emphasis on their nature is therefore strongly as state phenomena, which occur for a period but are able to be reversed. This has obvious implications for the way the doctor is responded to be by a board charged with protecting the community. If the factors underlying risk to the community have resolved, and indeed there is an identified expert (treatment doctor) who is able to neatly certify their resolution, there would seem to be no persisting risk to the community.

Gabbard’s own categorisation of doctors involved in professional sexual misconduct suggests that it is only a very small minority of doctors who engage in professional sexual misconduct due to an acute, reversible mental illness [18]. Far more commonly, he suggests, there is a combination of external stressors occurring at a time when the doctor is vulnerable psychologically. Assessing the implications of these factors for the incident of professional sexual misconduct, as well as an ongoing risk to the community, is far more complex.

Consideration of conduct according to both a psychodynamic framework and a moral framework will enable a far more sophisticated understanding of the doctor’s conduct. In particular, consideration of the ways in which the doctor’s conduct has deviated from the standards expected by the community will be enhanced with an understanding of the connection between moral decision-making and character and psychodynamic factors.

In psychiatry, there is certainly an understanding that the nature of personality is stable over time, once established [145-149]. The stability of an individual’s moral character has been debated by philosophers. More recent philosophical arguments suggest that “robust character traits” are less predictive of moral conduct than the situation in which the individual is operating [150]. It has therefore been suggested
that “situational influences often appear to do their work with little regard to the character of the people in the situation” [150]. This “situationist” approach has implications for a moral typology.

According to a situationist approach, a moral typology of professional sexual misconduct would seem to assess the moral choices that an individual made in one instance of professional sexual misconduct, but these would have no significant implications for future conduct, which would be dependent upon the specific circumstances that the doctor operates. This would mean that an assessment of untrustworthy conduct could not offer any prognostic implications for the future. A situationist understanding of moral character does not preclude a moral typology from having some contribution to make to predicting future behaviour, for two reasons.

Firstly, situationists do agree that there is stability of behaviour when there is stability of circumstances. Working as a doctor does offer much structural stability in role and interactions with patients, and therefore has implications for the likelihood that similar behaviour will recur, even if a situationist approach is used.

Secondly, use of a moral typology based on trustworthiness in combination with a psychodynamic typology may enable some prediction of a tendency towards trustworthiness over time, based upon an understanding of the psychological capacities of the individual. If the doctor is understood to have antisocial personality disorder, and this is understood to be stable over time, this could readily be understood to have implications for the way that the individual behaves. However, use of a moral typology could also allow examination of the way that they may have difficulties responding to the different requirements of trustworthiness, such as response to dependence, or experiencing patient preferences as compelling, as I will describe in this chapter.

A typology based on the standards of trustworthiness promotes consideration of the need to be trustworthy to be safe to practice, and therefore, upon the needs of the community for safe medical care. This typology will in turn promote consideration of the potential for the doctor to be trustworthy in the future.
In this Chapter, I will demonstrate that the problems associated with use of informed consent when considering professional sexual misconduct are not present when trustworthiness is used as the underlying moral requirement. I define the requirements of trustworthiness for the medical profession as provision of competent, appropriate care, regard for patient preferences, regard for the patient’s dependence upon the doctor, recognition of the limitations of their own trustworthiness, including clinical competence, and communication to patients and others regarding appropriate care. I then examine the ways that trustworthy, untrustworthy, and extremely untrustworthy doctors respond to these requirements.

5.2 Expectations of a Moral Typology of Doctors Who Have Committed Professional Sexual Misconduct

How a moral typology may contribute to the understanding of professional sexual misconduct will depend on how and where that typology will be utilised. In Australia, it is the MBA, under the auspices of the Australian Health Practitioners’ Regulatory Agency, which is charged with responding to complaints by the community about the conduct of doctors. There may be responses from other bodies, such as employing health services, and specialty colleges, but these will often be heavily influenced by the response of the MBA.

A moral typology, then, to be usefully implemented, would have to be useful to the Board in achieving its stated goals. As we have seen in Chapter Two, the MBA, in enacting the Health Practitioner National Law Act 2009, states its primary role to be the protection of the public. This is the primary purpose of all ten national health practitioner boards [77]. A moral typology makes explicit the standards expected by the boards, and may promote this conduct through education. By raising the importance of trustworthiness, boards may use this typology to promote trustworthy conduct. The typology would also be helpful to the Board if it were to assist in the identification of doctors who, having committed professional sexual misconduct, were more likely to do so again in the future, or indeed, act in any way which was potentially harmful to the public.
I am going to use an established ethical understanding of the role of the doctor, including community understandings and expectations, to develop an ethical framework based upon standards of trustworthiness. There is no literature examining trustworthiness in this way, but this does not mean that this would not be invaluable in developing an understanding of trustworthiness for the medical profession.

In considering the risk of recidivism, and the prediction of this, there are two possible approaches. An empirical approach will examine what literature is available regarding the prediction of recidivist professional sexual misconduct behaviour amongst doctors. Given the limited literature available examining this area directly, an examination of relevant related literature may be of assistance. Firstly, the literature examining prediction of moral behaviour may be considered. There is a literature examining the prediction of medical misconduct of doctors more generally [151-153]. This literature has grown with pressure on medical schools to select the most appropriate candidates for training, but also with the expectation that inappropriate candidates will be recognised during that training. The prediction of recidivism amongst criminal sex offenders may also be relevant in considering persistent inappropriate sexual behaviour. Examining these areas, and the data available, may assist in identifying factors which may predict recidivism amongst doctors who have committed professional sexual misconduct.

However, there are likely to be a number of limitations associated with this literature. There are, in fact, no studies attempting to identify factors which predict recidivist professional sexual misconduct amongst doctors who are presenting to a medical regulatory board with this charge. Even if studies were available, their generalisability to the Australian context may be questioned. Similarly, the relevance of criminal sexual offending, or other forms of medical misconduct, may be disputed in terms of generalisability.

Empirical research, at this time, seems seriously deficient in terms of how it may guide development of a moral typology. An alternate approach to the use of empirical research to is to base a moral typology upon the standards that the community may reasonably expect of doctors, and consider the ways in which
conduct deviates from these standards. This approach would not itself be derived from empirical research. Instead, this approach would be based upon community expectations of doctors and the moral behaviour which may reasonably be expected of them. Empirical research could, in turn, be used to evaluate the outcomes of the typology.

Use of a moral typology would clarify how a doctor’s conduct deviated from the moral standards expected by the community. I will argue that the most appropriate expectation of doctors is that of trustworthiness. An examination of the ways and degrees to which a doctor’s conduct fell short of the standards of trustworthiness could in turn form the basis for planning about what changes are necessary for protection of the public.

5.3 Use of Trustworthiness as the Basis of a Moral Typology Classifying Doctors Who Have Committed Professional Sexual Misconduct

In Chapter Three, I argued that the most commonly used ethical argument against professional sexual misconduct was the argument that it is a failure of informed consent. That is, that professional sexual misconduct is unethical because the patient cannot make a meaningful consent to this behaviour. I argued that there are a number of concerns with use of informed consent as a moral framework for the examination of professional sexual misconduct.

Although informed consent recognises the inappropriateness of professional sexual misconduct, it does so in a paternalistic way which is unable to recognise the important antecedents of professional sexual misconduct. For these reasons, a typology based upon informed consent would be seriously limited. An alternate typology should not be limited by these concerns. A typology based upon the expectation of trustworthiness is not so limited.
5.4 Advantages of a Typology Based of Trustworthiness, Compared to Informed Consent

5.4.1 Trustworthiness is the Responsibility of the Medical Practitioner, Whilst With Informed Consent, the Responsibility is Shared by the Patient

The first concern about examining professional sexual misconduct as a failure of informed consent is that informed consent is a shared responsibility between the doctor and patient [52]. The doctor cannot ensure that a patient has made an informed consent to a medical procedure without the patient’s participation. Although the bulk of the responsibility is with the doctor, the patient also holds some responsibility in the processes of informed consent.

Consideration of professional sexual misconduct in terms of trustworthiness, in contrast, places the responsibility squarely with the doctor. This is more appropriate particularly because of the doctor – patient power imbalance described, but is also in keeping with community expectations and professional conduct standards. The trustworthy medical practitioner should therefore be able to understand that the responsibility for not engaging in sexual behaviour lies with them, and ensure that they behave accordingly, regardless of the conduct of the patient. Use of trustworthiness, as the standard which is breached in professional sexual misconduct, is more appropriate than informed consent, in placing the responsibility with the doctor.

5.4.2 Use of a Trustworthiness Framework Does Not Require That the Patient be Deemed ‘Incompetent’ In Any Way

The informed consent argument for prohibition of professional sexual misconduct requires that the impact of either the perceived power imbalance, or transference, be considered to be such that the patient’s voluntarism is undermined.

Use of the informed consent framework raises issues of paternalism. It can readily be argued that there are isolated, specific doctor - patient relationships in which there is no significant and demonstrable power imbalance. These circumstances may include situations in which the patient’s health care concern is trivial and
transient, they are aware of the nature of the complaint, and have alternate options for health care. In these circumstances, according to the informed consent framework, the professional sexual misconduct which results is not morally wrong. This argument neglects some important implications of this hypothesized relationship for the perceived trustworthiness of the medical profession. A trustworthiness framework again allows examination of these concerns.

In terms of the doctor’s trustworthiness, the doctor has, at the very least, breached the requirements of professional codes and legislation. Professional codes currently stipulate a prohibition of professional sexual misconduct with all patients, regardless of the perceived power balances between doctor and patient. If a doctor is willing to breach these codes, regardless of whether informed consent has occurred or not, it could be argued that they may not be considered trustworthy by the professional bodies expecting adherence to the codes. The community in turn could be concerned about the trustworthiness of a doctor who was willing to disregard professional codes.

Strasburger et al [70] argue that “it is not that the patient cannot consent or that consent has been improperly obtained - as through undue influence of transference or lack of information about risks. The issue is fiduciary breach and abuse of power in the fiduciary relationship.” Even if the patient’s level of power in the relationship is said to approximate the doctor’s, this does not negate the fact that the doctor is using what power they do have, and the unique nature of this power, to meet their own personal needs. This is not in keeping with an expectation of trustworthiness, and particularly not in keeping with an expectation of rich trustworthiness.

Informed consent fails to allow examination of the harm done in professional sexual misconduct when the patient is argued to be able to make an informed consent. When patients are competent to make an informed consent, harms may still result with damage to the perceived trustworthiness of the medical profession. As I described in Chapter Four, levels of institutional trust in the medical profession will have implications for the level of interpersonal trust some patients will have in their doctors. The harms will extend beyond the individual relationship in which the sexual misconduct is occurring, to the medical profession and other individual
doctor-patient relationships. By arguing that the standard should be of trustworthiness, we can see that the doctor cannot justifiably embark upon a sexual relationship with their patient, even if that individual patient is argued to be able to make an informed consent.

5.4.3 Trustworthiness Enables Consideration of Professional Sexual Misconduct and the ‘Slippery Slope’, Whilst Examination of the Slippery Slope As a Failure of Informed Consent is not Useful

Professional sexual misconduct often begins with relatively minor changes to standard clinical care. This progression down what Gabbard describes as “a slippery slope” therefore includes apparently insignificant events before overt sexual behaviour emerges. These minor changes have been described in detail in Chapter One, and are not, in themselves congruent with the requirements of informed consent. Examined in isolation, it may seem ridiculous to apply the requirements of informed consent to each minor variation, and indeed, each may readily seem to reach the standards required for an informed consent. The patient cannot anticipate the effects of individual events of the slippery slope, and therefore cannot make an informed consent.

It is the doctor’s responsibility, however, to consider all changes in context. A trustworthy doctor must have the capacity to monitor the overall care of their patient, and modify the course of that care in response to any deviations from standard clinical care. Although informed consent as a framework does not allow an examination of the “slippery slope” that importantly precedes overt professional sexual misconduct, a framework based on the standard of trustworthiness does.

5.4.4 Informed Consent is a Categorical Classification, While Trustworthiness Can be Considered on a Continuum

Informed consent offers only a categorical examination of professional sexual misconduct. Informed consent either occurs or does not, and it cannot therefore be used as part of a normative model of professional conduct without use of an additional ethical model.
Trustworthiness allows consideration of professional sexual misconduct risk on a continuum. By considering professional sexual misconduct as function of reduced trustworthiness, we can therefore consider not only failed trustworthiness, and the progression down a slippery slope of reduced trustworthiness, but also the factors in doctors which protect against professional sexual misconduct, and how these factors can be promoted. Trustworthiness as a standard leads to the opportunity to consider whether there may be preventative ‘population approaches’ to improving the conduct of the medical profession, as well as a different framework for considering those doctors who are found to have committed professional sexual misconduct.

5.4.5 Examining Professional Sexual Misconduct According to Informed Consent is Reliant Upon the Presence of Trustworthiness

Informed consent is itself reliant upon the presence of trustworthiness. Use of informed consent as an ethical standard requires trustworthiness in the doctor. Indeed, to ensure that informed consent has been provided, the doctor must be trustworthy in a number of ways. They must be trustworthy to value and enact the appropriate assessment of autonomy, disclosure of information, with consideration of potentially coercive or manipulative influences. They must also be trustworthy to consider the limits of their own capabilities. The untrustworthy doctor cannot be presumed to enable informed consent. Trustworthiness is fundamental to the informed consent process.

In this way, informed consent is secondary to the presence of trustworthiness in the medical practitioner. A doctor who is not trustworthy may inadvertently facilitate an informed consent, but this cannot be assumed. Trustworthiness is a more fundamental ethical principle.

As informed consent is a moral concept that is secondary to trustworthiness, examination of conduct according to trustworthiness is preferable to examining it according to the more derivative principles of informed consent. Use of a typology based on trustworthiness is therefore preferential to one based on informed consent, which would also inherently be based upon the presence of trustworthiness.
5.5 Trustworthiness as the Basis for a Moral Typology of Professional Sexual Misconduct

I have argued that trustworthiness is not limited in the same ways as informed consent, when applied to consider professional sexual misconduct. Is trustworthiness itself a reasonable standard to set in terms of expectations of the medical profession?

There seems little doubt that the community does hold the expectation that its doctors should be trustworthy. Trust is fundamental to all fiduciary relationships. In Chapter Four, I argued that there are unique aspects to the doctor-patient relationship which warrant not only the expectation of trustworthiness, but the expectation of rich trustworthiness.

Jones defines Basic Trustworthiness as:
“B is trustworthy with respect to A in domain of interaction D, if and only if she is competent with respect to that domain, and she would take the fact that A is counting on her, were A to do so in this domain, to be a compelling reason for action” [page 23, 22].

Jones’ version of trustworthiness is already at the end of the spectrum which is described as a thicker form of trustworthiness. The thickness (or thinness) of a definition of trustworthiness is a function of the motivating factors within the trustee which determine their response to the truster’s expectations, and Jones expects that her trustee will be motivated by the preferences of her truster. I have argued that Jones’ thicker version of trust is the only acceptable form in the doctor-patient relationship, or indeed any relationship in which there is a significant power imbalance, the trust exchange is socially sanctioned, or the truster is entrusting something with an extremely high personal value.

Beyond the expectation of trustworthiness, in Chapter Four I argued that patients not only expected trustworthiness, that the only appropriate form of trustworthiness for the doctor-patient relationship was that of rich trustworthiness. In rich trustworthiness, the trustee recognises and indicates the limitations of their basic trustworthiness. Rich trustworthiness is defined by Jones [page 26, 22], as
trustworthiness which “reliably signals its presence”. The richly trustworthy are aware of their limitations, and indicate these clearly to the prospective truster. Within the doctor-patient relationship, other forms of trustworthiness were unfeasibly demanding of patients, do not require the doctor to have regard for the patient’s preferences, and only rich trustworthiness meets community expectations about the underlying factors which motivate doctors.

I will, therefore, set the expectation of trustworthiness from doctors as the expectation of rich trustworthiness. That is, doctors should be trustworthy with respect to their patients, in the doctor-patient relationship, by maintaining their clinical competence where possible, be motivated by their patient’s preferences and experience their patient’s dependence on them as compelling. Moreover, doctors should be able to recognise the limits of their trustworthiness (including clinical competence), and reliably communicate this to their patients when necessary.

If this is the standard that we will hold doctors to, a moral typology will be based upon the ways that this standard may be breached. Ultimately, the typology will indicate degrees of trustworthiness indicated by the doctor’s behaviour.

5.6 The Implications of Professional Sexual Misconduct for Trustworthiness

There is an enormous range of behaviour subsumed within the subject of professional sexual misconduct. Professional sexual misconduct can range from apparently consenting relationships between adults to sexual assault and rape to the involvement of children. Circumstances may vary depending on the patient’s illness and other care, its duration, and comorbid diagnoses. What key aspects of cases should be used to categorise doctors who breach their patient’s trust with professional sexual misconduct?

The requirements of trustworthiness themselves offer some guidance about the different ways that a doctor may not be trustworthy. If we expect doctors to maintain their clinical competence where possible, be motivated by their patient’s preferences, experience their patient’s dependence on them as compelling, recognise the limits of their trustworthiness (including clinical competence), and reliably communicate this
to patients, it follows that the following will comprise components of conduct necessary for trustworthiness.

5.6.1 Provision of Competent, Appropriate Care

The patient who is involved in professional sexual misconduct by their doctor has, at some stage, attended that doctor seeking healthcare of some form. Professional sexual misconduct has the potential to undermine appropriate care of that initial medical concern, as well as any subsequent concerns which may develop.

A trustworthy doctor, then, responds to any medical concerns of the patient, either by providing appropriate care themselves, or by referring the patient to a doctor who may more appropriately provide that care.

Modern care of patients will rarely occur without the doctor interacting with other professional staff. These staff may include, for example, the administrative staff at a practice or clinic, the pathology staff providing investigations necessary for diagnosis, and other specialist doctors consulted as a part of treatment. Provision of competent, appropriate care must therefore include an ability to interact competently and appropriately with other clinical staff. Care of patients, if trustworthy, must include an ability to competently and appropriately interact with others in the workplace.

The expectation of particular competencies is directly linked with the doctor’s role as a doctor. This role is most evident when they are within their workplace. Expectations of the doctor and their ability to provide competent care may be substantially lessened when they are in an environment not conducive to this. A psychiatrist may, for example, provide some medical care to a fellow traveller who experiences a cardiac event on a flight unable to be readily diverted, but the expectations of this doctor in terms of their level of competence will not be the same as an emergency department physician, specialised in this clinical area, and surrounded by equipment enabling angiography, arterial bypass and anticoagulation.

The expectations of the doctor in the provision of competent, appropriate care will also be guided by the clinical standards and guidelines established by that doctor’s
profession. These guidelines will in turn be guided by scientific research. By their nature, these guidelines will be dynamic, as research provides new recommendations, and new treatments are developed and become available. The trustworthy doctor is expected to main familiarity with current treatment guidelines as a part of their clinical competence.

There have been well-documented instances in history when doctors have provided care that has later been considered inappropriate, or not in keeping with competent practice. In the early twentieth century, patients were encouraged to smoke by their doctors, who participated in advertising for cigarettes. Initially, the adverse consequences of smoking were not known to the medical profession. The imperative is upon the profession to respond when research provides evidence for a need for change in clinical practice.

There have also been periods of time when doctors have treated patients not according to established clinical standards, but under the influence of social and political agenda. Possibly most obvious of these was during the Nazi regime in Germany, when Jewish people in particular, but also people from other ethnic minorities, received treatment from doctors that caused harm and ultimately contributed to their deaths. There were no clinical guidelines suggesting that such treatment was appropriate, and the individuals receiving this ‘care’ were forced to do so. These doctors cannot be seen to have behaved appropriately both because patient preferences were not considered, and also because of the nature of the guidelines according to which the doctors were behaving.

To legitimately guide trustworthy care as competent and appropriate, clinical guidelines must reflect the medical profession’s understanding about what is the best possible care for patients. This understanding should be based upon a considered understanding of the scientific research available, rather than social or political agenda. It is the responsibility of the doctor to translate this understanding into information which can be conveyed to patients about what options are available to them. The doctor cannot guarantee the availability of all options to all patients in all contexts. There may well be limitations imposed by resource availability. Although the trustworthy doctor may advocate for more resources, their prime responsibility is
ensuring that the patient has access to competent and appropriate care within any externally imposed limitations.

An untrustworthy doctor allows other factors, including professional sexual misconduct, to undermine optimal medical care of the patient’s presenting concern, and any subsequent medical concerns which develop, or should reasonably be detected.

An extremely untrustworthy doctor may be willing to provide inappropriate, unsafe, or illegal treatments in order to promote the professional sexual misconduct. These treatments may include inappropriate prescribing which promotes dependence, or psychotherapy, which may also promote dependence. Active deceit of the patient, in which the inappropriate prescribing, psychotherapy, or even the professional sexual misconduct are represented as optimal, or even necessary care, is extremely serious, because it undermines further the patient’s understanding of alternative care available, and consequences of not receiving this.

5.6.2 Regard for Patient Preferences
The trustworthy doctor seeks to understand their patient’s preferences, and is motivated to act according to these.

This emphasis on the patient’s preferences does not mean that the doctor must be absolutely compelled by any preferences which the patient may have. As I have described in Chapter Four, the trustworthy trustee need not experience the preferences of the truster as absolutely compelling, and may need to “deliberate about what to do” [page 23, 22]. This will be necessary if a patient’s preferences are incongruent with other commitments held by the trustworthy doctor.

In particular, the trustworthy doctor must provide competent, appropriate care. If a patient presents with preferences for care or treatments that the doctor does not consider appropriate or consistent with competent practice, then they may deliberate and decide that these preferences are not compelling.
In these circumstances, the patient may be seeking care that would be unsafe, potentially harmful, or even just not optimal. In response, the trustworthy doctor is obliged to offer information to the patient regarding the potential hazards associated with their stated preference. If the patient continues to seek care that is not congruent with the established clinical standards guiding that doctor’s practice, the doctor may reasonably decline to provide that particular care, regardless of the patient’s ongoing preferences.

For example, if a patient with a history of abusing benzodiazepine medications, such as diazepam, presents seeking prescription of diazepam, the trustworthy doctor remains obliged to provide competent, appropriate care. Part of this care will include explaining the potential risks and benefits associated with diazepam prescription to the patient, and considering these for this patient given their individual health concerns.

Prescription of benzodiazepines to someone who is abusing them may result in overdose, worsening dependence, or disinhibited, risk-taking behaviours [154]. The potential outcomes are not foreseeable, but it is clear that there is a significant likelihood of harm. Further harm may be sustained in the form of the missed opportunity to treat the underlying benzodiazepine dependence. Importantly, the standard for what care is deemed unsafe is set not only by the individual doctor, but by their peers. The medical profession itself sets standards in the form of clinical guidelines about what care may reasonably be provided, based on research and clinical standards.

If the doctor believes that the risks, including those of diazepam abuse, outweigh any potential benefits, the trustworthy doctor is not obliged to prescribe this medication by the patient’s preferences. Instead, the doctor may reasonably be expected to offer the patient information about alternatives, including treatment of their benzodiazepine dependence. Even if this care is declined, the trustworthy doctor is not obliged to provide care which they believe to be unsafe or inappropriate.

The decision about what care should be provided may become more complex when the patient’s preferences are potentially hazardous, yet they are congruent with a
social, cultural or spiritual belief that is not the doctor’s, but is recognised by the community in which the doctor practices. An example of this would be the patient who identifies themself with the Jehovah’s Witness religion, and who presents with a medical condition that would optimally be treated with blood transfusion. The patient presents with the preference that they not be treated with blood transfusion. The trustworthy doctor is obliged to ensure that he understands the basis of the patient’s preferences (in this case, their religion), but also the potential consequences of these preferences and the alternatives available and their potential consequences.

Usually, if a patient requests treatment that the doctor deems inappropriate, the doctor is obliged not to provide that care. However, if the patient’s preferences differ significantly from that which the doctor considers will lead to appropriate care, but this difference is caused by a recognised spiritual or cultural belief, then the doctor is obliged if not to provide that care, then to facilitate that care by referral to a doctor willing to provide that care.

There is a requirement that the religious or cultural belief be acknowledged and recognised by the community, and hence the medical profession. If I presented my new born child to a doctor, and claimed to be a member of a new sun worshipping sect, and demanded surgery to my child’s genitals, this may not be responded to without extensive review. In contrast, a mother of Jewish faith presenting her child for routine circumcision would require no such evaluation.

The trustworthy doctor must be able to recognise the religious or culturally influenced beliefs of their patients, then, as well as maintaining an awareness of, and commitment to, the clinical standards established to guide their clinical practice.

The preferences of the patient are always acknowledged by the trustworthy doctor. When these can be responded to with care that is safe and clinically appropriate, these preferences are compelling to the trustworthy doctor.

Consideration of the patient’s preferences must include those preferences that are less directly acknowledged or expressed by the patient. These less directly expressed preferences will include those which may be reasonably assumed. A
Other less directly expressed preferences include the preferences of the patient’s family. This does not imply that the patient’s own preferences should be voided by those of their family. There may be situations, however, where the preferences of the patient might not be available to the doctor, if the patient is so unwell that they cannot express these, or if they are unable to formulate preferences due to their cognitive status, including if they are a child. In these situations, the preferences of the patient may be formally substituted by the family, or others, with guardian status.

If regard for the preferences of family members requires disregard for the preferences of the patient and the provision of care that is neither competent nor appropriate, then the preferences of family members need not be compelling, and responding to them is not in keeping with trustworthiness. A mother with an established diagnosis of Munchausen’s By Proxy who presents seeking an inappropriate and potentially harmful investigation for her child, hoping to confirm a diagnosis which has been reliably excluded should not compel with her preferences. It may reasonably be assumed that the child does not wish to be unnecessarily harmed, particularly in the absence of any potential benefit.

Consideration of the patient’s preferences may also require consideration of the preferences of the community’s expectations of their doctors. The community in which the doctor practices will hold expectations of doctors which are universal expectations of all community members, as exemplified in criminal codes. The doctor’s role as a medical practitioner does not absolve them of the responsibility to behave in ways consistent with the laws of their community. Individual patient preferences can therefore reasonably be assumed to include the expectation of legal conduct. Beyond the doctor’s responsibility to consider the preferences of their patient, there are also responsibilities to consider the preferences of their conduct, as members of the community, by the community.
These preferences need not be absolutely compelling beyond the preferences of the patient. There are well known examples in which doctors have acted as agents of the state, and sacrificed the care of individual patients at the behest of social or political movements. The war crimes of Nazi Germany included the participation of doctors, who tortured Jewish people, as well as other ethnic minority groups and disabled people, in the name of medical research sought to promote political agendas. In these cases, the care provided to patients was neither competent, nor appropriate, and therefore not trustworthy. Disregarding the preferences of the patient for the preferences of the state cannot be acceptable when the doctor is required to disregard other principles of trustworthiness.

Similarly, the expectations of the community need not compel the doctor if these preferences are irrelevant for patient care. A patient may prefer that their doctor attend a particular church, for example. This church attendance may even be the patient’s way of ‘credentialing’ their doctor’s trustworthiness. The doctor’s attendance at church cannot determine their clinical competence, however, and is ultimately unrelated to clinical care, or trustworthiness. For these reasons, patient preferences which are unrelated to the doctor’s role and clinical care do not need to be experienced as compelling for the doctor to be trustworthy.

The community’s expectations of doctors must be considered to be preferences when they are explicitly stated in professional codes. These codes refer directly to clinical care. The expectation of adherence to these codes must be considered a preference of all patients, and the community as a whole.

An untrustworthy doctor does not seek to understand their patient’s preferences. An untrustworthy doctor allows other factors, including professional sexual misconduct, to distract from the importance of understanding the patient’s preferences, and prioritising these preferences. Similarly, an untrustworthy doctor may not seek to understand and prioritise the preferences of the family members of their patients, whether they be parents of child patients, partners or children or carers of adult patients.
In situations in which there is apparent consent by the patient to sexual activity with their doctor, or even when it is somehow argued that this sexual activity is the patient’s preference, can the doctor argue that engaging in professional sexual misconduct is compatible with trustworthiness, in that they have been responding to the patient’s preferences? In fact, this scenario is no different to the patient seeking care that is recognised by the doctor’s peers, and indeed their profession, as neither therapeutic or safe. In the same way that the doctor should not prescribe drugs of addiction for abuse, the doctor should not engage in professional sexual misconduct. Both may be expressed as the preference of the patient.

Like benzodiazepine prescription to someone who is abusing benzodiazepines, professional sexual misconduct may result in harms that are in themselves unpredictable. It has been established that these harms can be severe, however [154] and that they occur in a significant number of patients involved in professional sexual misconduct [154]. The medical profession therefore supports the prohibition of sexual conduct between doctor and patient. The doctor may not respond to the preferences of the patient, when it is known within the medical profession that to do so confers a reasonable risk of harm.

The extremely untrustworthy doctor may recognise the preferences of the patient, and be willing to disregard these only to further their own interests. This may include preferences that may be reasonably inferred (such as a parent’s preferences that their child not be unnecessarily harmed), as well as those which are stated. In the extreme, the doctor intent upon professional sexual misconduct may disregard their patient’s preferences to the extent that they are coercive, verbally pressuring their patient to agree to the sexual conduct, or manipulative, providing incorrect or inappropriate verbal information in an attempt to convince their patient to agree to the sexual conduct, or even frankly sexually assaultative of their patient, compelling the sexual conduct regardless of their patient’s lack of agreement or even refusal.

5.6.3 Regard for the Patient’s Dependence Upon the Doctor
All patients seeking healthcare from a doctor do so with some power imbalance between themselves and the doctor. This imbalance is inherent to all doctor - patient relationships, and based on the vulnerability associated with health concerns, and
the imbalance associated with the doctor’s greater knowledge and expertise about health concerns. There may be circumstances in which it could be argued that this imbalance of power is less; because the health concern is minor, the interaction with the doctor brief, or because of the patient’s own level of knowledge, or the availability of alternative healthcare providers. However, there are also factors within the patient, factors within the patient’s health, factors associated with treatment, and factors specific to the doctor, which may heighten the power imbalance between doctor and patient, and hence the potential dependence.

Factors within the patient that increase the power imbalance between doctor and patient, and therefore the potential level of dependence, do so in a range of ways. Age may increase vulnerability for patients who are children or adolescents, both because of developmental factors such as cognitive development, but also because of the community-wide power imbalance between adults and children. Children and adolescents are aware of this imbalance, and their consequent dependence upon adults for survival. They will also likely be aware of the ‘importance’ of the doctor, and be cued to this in a number of ways. The need to make an appointment to see the doctor, the intimidating clinical setting in which they are seen, and their parent’s deference to the doctor will all emphasize to the child or adolescent how different the doctor is to themselves, in terms of power and status.

Other factors within the patient which heighten the power imbalance between doctor and patient include lower intellect in the patient, with intellectual impairment, social isolation and lack of social supports, and socioeconomic disadvantage. A patient with intellectual impairment may be more readily overwhelmed, confused, or distressed. They may be unsure of how to respond to behaviour that is unfamiliar to them or unsure of what they may reasonably expect and be entitled to. Intellectually impaired patients are more likely to be socially isolated and socioeconomically disadvantaged, also, and these factors may compound their vulnerability and dependence.

Social isolation in patients heightens the degree of dependence between themselves and their doctors in a number of ways. Patients without supports will be more likely to see their doctor alone, and less likely to be able to discuss concerns about their
health or care with someone who knows them well. As a result, they may be more reliant upon the opinions of the doctor, and more likely to be influenced by these opinions. This might be particularly significant for elderly patients, at a time in their life when they are facing increasing challenges in maintaining their health.

Socioeconomically disadvantaged people may then have fewer options for alternate healthcare if they are not satisfied with what they are initially able to access. Lower levels of health literacy may mean that they are less able to assertively access appropriate alternatives, or even to be certain that this is necessary. When seeing a doctor, then, socioeconomically disadvantaged people may feel obliged to accept healthcare that they are not satisfied with, on account of not knowing whether there are alternatives.

Factors associated with the illness itself may also heighten the power imbalance between doctor and patient, and hence the level of dependence. A patient seeking care for either a life-threatening illness, or an illness which they believe may be life threatening will be more dependent upon their doctor for care. This group of patients may believe, rightly or wrongly, that their life depends on the care that their doctor can provide, with resultant extreme dependence.

Illnesses which continue to be associated with significant social stigma may also cause a greater power imbalance between doctor and patient, and resultant level of dependence. Examples of illness associated with significant social stigma include mental illness, some infectious diseases such as human immunodeficiency virus infection, or sexually transmitted infections, disorders of sexual function, and substance use disorders. The patient may be highly aware of the stigma associated with these disorders, and consequently vigilant about their confidentiality, the perceptions of their doctor, and the importance of treatment. All of these factors will contribute to a greater level of dependence of the patient on their doctor.

There may also be factors within the doctor that heighten the degree of dependence that the patient experiences. If the doctor has a high degree of expertise in an area, perhaps even compared to other specialists, and the patient is aware of this, they may be particularly willing to obtain care from this particular doctor. The doctor may
be seen, rightly or wrongly, as the only doctor who can provide care of a particular type or standard, and the patient may therefore feel dependant on the doctor to obtain this care. The doctor’s role may be established in this way either because of seniority, academic appointments, unique training or experience, or even an absence of other doctors in a particular geographic location.

Finally, factors within the healthcare that is provided may heighten the dependence between doctors and their patients. Examples of this include healthcare that is life sustaining, or perceived as life sustaining, healthcare which is provided over a prolonged period, during which dependency is likely to increase and healthcare associated with particular intimacy between doctor and patient, whether that be due to physical examinations and treatments required, or psychological disclosures required by the patient for assessment or treatment.

Factors within the patient, their illness, the doctor, or aspects of treatment may then result in heightened dependence between a doctor and their patient. The trustworthy doctor experiences the dependence of the patient as compelling, and provides healthcare that does not exploit this dependence. When the power imbalance creating the dependence can be reduced by information, assistance, or advocacy, the trustworthy doctor seeks these.

The trustworthy doctor must respond to dependence beyond that directly associated with the doctor - patient relationship, in the same way that they must respond to patient preferences beyond the direct doctor - patient relationship. In particular, the doctor is not exempt from community expectations about response to dependence of members of the community beyond his patients. Some of these expectations are legislated, including protections for the safety of children and the elderly with mandatory reporting. These legal obligations apply to all members of the community, and apply equally to doctors as members of the community, regardless of whether the child or elderly person is a patient of the doctor.

An untrustworthy doctor may not recognise or respond to the dependence of the patient. The untrustworthy doctor, when they do recognise the dependence of the
patient, does not experience this as compelling, even if the dependency is heightened by the factors described above.

An extremely untrustworthy doctor recognises the dependency created by factors within the patient, their illness, the doctor themselves, or the treatment, and actively exploits this dependence for their own gain. They are not compelled in any way by the patient’s dependence, but conversely use the dependence opportunistically. The extremely untrustworthy doctor may even seek to heighten the dependence between themselves and their patient, to ensure their own gain. Examples of this include inappropriate prescribing of drugs of dependence to a patient who is already dependent on those medications.

5.6.4 Recognition of the Limitations of Their Own Trustworthiness, Including Clinical Competence

Doctors must be able to recognise the extent to which they are trustworthy. This trustworthiness will include the degree to which they will prioritise their patient’s preferences, and experience their dependence as compelling, as above, but to respond to their patients, the doctor must also recognise the degree to which they are clinically competent or skilled to do so.

Gabbard argues that the doctor is expected to continually reflect not only on their interactions with patients, but their own motives underlying these [31]. This reflection, Gabbard argues, will enable earlier recognition of motivations which may lead to a ‘slippery slope’ towards professional sexual misconduct, as well as the slippery slope itself. Gabbard does propose a normative standard in which the doctor should be able to reflect on the limitations of their own trustworthiness. The use of a Framework according to the expectations of trustworthiness is again compatible with Gabbard’s expectations of his psychodynamic model of professional sexual misconduct.

A doctor may not respond to their patient’s preferences or dependence due to factors which are characterological. These doctors, who longitudinally are not trustworthy, may be unlikely to acknowledge, or even recognise, the limitations to their clinical practice. However, there are also doctors who become, for a period of
time, less likely to be responsive to their patient’s preferences or experience their patient’s dependence as compelling. These doctors may be expected to recognise that their level of functioning has changed, and seek assistance to both restore their level of functioning, and also ensure appropriate standards of patient care.

This change in a doctor’s ability to provide appropriate clinical care may result from factors causing distress or impairment in the doctor. Social stressors, including losses, and medical illnesses, including depression, may all contribute to a reduced ability to be appropriately responsive to patient preferences and dependence. These factors may similarly influence the clinical competence of the doctor for a time.

The trustworthy doctor, then, continually reflects upon the care they are providing to their patients, and seeks to maintain their clinical competence. The trustworthy doctor is aware of the potential for any impairment to impinge upon their clinical competence, and seeks to maintain their own physical and psychological health. With any changes in their health, the trustworthy doctor recognises the potential for this to impact upon patient care, seeks healthcare for themselves to optimise their health, and also considers whether alternate care needs to be sought for their patients.

The untrustworthy doctor does not recognise the potential for their own distress or health concerns to impinge upon patient care, and does not reflect regularly upon their patient care. As a result, they are at risk of providing care that is not appropriately responsive to patient preferences or dependence. The untrustworthy doctor also may not prioritise their own clinical competence, through measures such as continuing medical education, and may be unaware about limitations to their own clinical competence as a result.

The extremely untrustworthy doctor may have had previous incidents of professional misconduct, but these have not resulted in reflection upon their own limitations. The extremely untrustworthy doctor may be engaged in multiple ongoing cases of professional sexual misconduct that have not prompted any reflection or acknowledgement on the part of the doctor. Alternately, previous unprofessional conduct associated with professional sexual misconduct, such as other forms of
boundary violations, may not, for the extremely untrustworthy doctor, prompted reflection on the importance of avoiding further such conduct, and obtaining assistance to do so.

The extremely untrustworthy doctor may also fail to acknowledge limitations in their clinical competence, and misrepresent this competence to patients in a deliberate deception.

5.6.5 Communication to Patients Regarding Appropriate Care
A trustworthy doctor must be able to reliably communicate what the limits of their trustworthiness are, to their patients. This communication will include limits to their clinical competence, but also include acknowledgement of when the doctor will not be able to prioritise the patient’s preferences (due, for example, to external constraints such as cost), or respond to dependence.

An untrustworthy doctor may not communicate these limitations, and their patients may consequently be uncertain about what the doctor’s limitations may be, and consequently why they are receiving particular care.

An extremely untrustworthy doctor may deliberately omit communication about limitations to their trustworthiness, to meet their own needs. They may, in cases of professional sexual misconduct, actively be deceptive about the nature of professional sexual misconduct, and present it as a part of treatment. The extremely untrustworthy doctor may misrepresent their clinical skills, or the prohibition of sexual relationships between doctors and their patients.

5.7 Conclusions
The framework described in this chapter may be summarised in table form, as follows.

This Table is also attached as Appendix One.
Professional sexual misconduct is an ethical issue, and may reasonably be considered through a framework based upon an ethical standard. Use of an ethical, or moral typology, is not incompatible with concurrent use of clinical, and legal
frameworks. Use of a moral typology may be useful in addition to these frameworks by providing correlates for complex behaviours, and requiring less reliance on the doctor’s recollections of internal motivations for events, or psychiatric expert witnesses.

Trustworthiness is a fundamental and reasonable expectation that the community has of the medical profession, essential for access to useful health care. A framework based upon the standards of trustworthiness is consequently reflective of community expectations. Finally, while the clinical and legal frameworks place substantial emphasis on the experience of the doctor, and their rights to practice, this framework emphasizes their trustworthiness, and therefore, the rights of the community to safe care.

The consideration of professional sexual misconduct as a failure of trustworthiness is advantageous compared to its consideration as a failure of informed consent. While the ethical standards of informed consent are a shared responsibility, the requirement of trustworthiness in the doctor is their responsibility, and this is a more appropriate standard when considering professional sexual misconduct. Use of a trustworthiness model does not require that the patient be deemed ‘incompetent’ in any way, or their informed consent disregarded in the way that the ethical arguments associated with informed consent must. The standard of trustworthiness when set at that for rich trustworthiness is able to consider the ‘slippery slope’ which so often precedes professional sexual misconduct in a way that informed consent cannot. Finally, trustworthiness can offer a more complex classification of the ways in which the doctor’s conduct breached that expected.

The to meet the standards of rich trustworthiness, the doctor must; provide competent, appropriate care, have regard for patient preferences, have regard for the patient’s dependence upon the doctor, recognise the limitations of their own trustworthiness, including clinical competence, and communicate to patients regarding appropriate care. Professional sexual misconduct breaches the standard of trustworthiness, but individual cases of professional sexual misconduct will breach this standard in different ways, and to different degrees. The trustworthiness framework enables cases to be considered according to the ways that
trustworthiness has been breached, and the degree to which the conduct deviates from the standards of trustworthiness. In Chapters Six and Seven I will describe use of the Trustworthiness Framework when considering cases of professional sexual misconduct.
6.1 Application of the Framework for Trustworthiness in Doctors to Professional Sexual Misconduct Cases

The Framework for Trustworthiness in Doctors which has been described categorises the ways in which trustworthiness is breached when professional sexual misconduct occurs, and the degrees to which that conduct deviates from the standards of trustworthiness. I have argued that although medical regulatory bodies such as the Medical Board of Australia (MBA) are currently charged with the responsibility of protecting the public, conflicting legal principles such as the Briginshaw Principle, as well as protecting the rights of the doctor, often conflict with the role of ensuring the public's safety. An additional conflict occurs when the doctor seeks consideration of their conduct according to their own psychodynamic factors, or presents a psychiatric illness as partly causative.

These legal and psychodynamic factors have become influential in the considerations that state and territory medical boards, and from July 2010, the Medical Board of Australia (MBA) make of cases of professional sexual misconduct. This influence has occurred in the absence of other frameworks which effectively promote consideration of conduct according to other, ethical, standards.

The MBA is a statutory body created by the legislation of the Australian Health Practitioner Regulation National Law Act 2009. This legislation consequently defines the role and functions of the MBA. The MBA cannot exist without a legal framework, and additionally must operate according to the legislation of the Australian community. The MBA will, therefore, operate according to legal frameworks. The use of legal frameworks alone, or in combination with psychodynamic frameworks, is problematic, however.

Legislation will only ever offer broad standards and requirements that may be difficult to correlate with specific and complex behaviours. The legislation guiding medical regulatory boards in Australia state a requirement to protect the public. It is the task of the medical regulatory board initially to attempt to establish what the doctor's
behaviour was, and any harms done, then make inferences regarding the implications of this behaviour and any harms for the future well-being of the community. Legal principles such as the *Briginshaw Principle* and the legal rights of the doctor must also guide the outcome of the process.

Some aspects of cases of professional sexual misconduct may require less of an inference on behalf of MBA Hearing Panel members than others. A doctor who repeatedly engages in sexual misconduct with patients despite repeated disciplinary action might be considered more likely to continue to engage in this conduct than a doctor who does so once. Similarly, a doctor who fails to communicate the nature of a breast exam to a patient who experiences this as assaultative may be less likely to repeat their conduct than the doctor prepared to physically restrain a patient to enable sexual misconduct. The complexities of cases of professional sexual misconduct, however, may not have direct correlates in the law, and yet specific aspects of cases of professional sexual misconduct may have importance in terms of assessing the seriousness of the case and the consequent legal implications. In these cases, the inferences required by the medical regulatory board may be greater.

When substantial inferences are required by MBA Hearing Panel members, these inferences may be complex not only because of a lack of clear guidance by the law as to very specific aspects of cases of professional sexual misconduct, but also because these cases may be highly emotive for those charged with responding to them. The exploitative nature of professional sexual misconduct, as well as the distress which is associated with notification to a medical regulatory board, may be powerful in terms of the emotional response in those hearing details of the cases. These cases are heard by members of panels authorised by medical regulatory boards. The individual members of these panels will each have their own beliefs and values concerning sexuality, gender roles, and even the place of doctors within the community. The members of these panels must then consider a highly emotive subject, with little specific guidelines from the law in terms of the specific details of the cases. In this context it seems extremely unlikely that the values and beliefs of the individuals considering the cases will not be influential.
This influence may or may not be seen to be reasonable. If the Hearing Panel members are designated by the MBA as representative of the community, perhaps their individual beliefs and values around sexuality, gender roles and the role of the doctor within the community could also be taken to be representing those of the community. This view might be somewhat acceptable if the panels acknowledged the potential influence of the values and beliefs of their members. They do not, however, and state their role as guided only by the law.

Beyond concern about a lack of acknowledgement of the enactment of individual values and beliefs within medical regulatory group panel hearings are concerns about the impact of these personal values and beliefs on the hearings themselves. In particular, a lack of standardisation of these values, a consequent potential lack of consistency between hearings, and finally a lack of transparency not only that these values and beliefs are being enacted, but the ways in which they are being enacted. That is, it could be argued that different panel hearings will have different panel members participating, and if their individual beliefs and values are influential to an unknown degree, there may be a lack of consistency between hearings. This does, of course, have potential implications for the doctor accused of professional sexual misconduct, in terms of procedural fairness.

A framework reducing the impact of individual beliefs and values and the lack of transparency associated with these could, then, increase fairness in terms of improving consistency and overting the standards by which cases of professional sexual misconduct were being assessed.

The proposed Framework for Trustworthiness in Doctors offers an ethical structure to those considerations about how seriously a doctor has deviated from the standards of trustworthiness, in specific cases of professional sexual misconduct. It could encourage Hearing Panel members to consider the same variables for these cases, and ensure that these variables are transparent. The impact of individual biases could be recognised, and with use of the framework, minimised. The ways in which cases are assessed could then be transparent to the doctor presenting with alleged professional sexual misconduct, and also to the community.
In this Chapter, two cases of professional sexual misconduct are analysed according to the *Framework for Trustworthiness in Doctors*. The details of the cases have been obtained from publicly available *Reasons for the Decision* available from the MBA website. The two cases have been chosen on the basis that professional sexual misconduct was established by the Medical Practitioner’s Board of Victoria (MPBV). Both cases were complex in that there were multiple participants in the Hearings.

The case of the professional sexual misconduct of Dr Ian Fitzgerald, a psychiatrist, is of a prolonged sexual relationship between the doctor and a young woman with significant psychiatric disturbance. The patient was not the complainant, and during the Hearing, maintained that she did not have any concerns about Dr Fitzgerald. The Hearing was remarkable for the large number of witnesses who spoke to Dr Fitzgerald’s good character, and as psychiatrists stated that they did not believe that Dr Fitzgerald posed any further risk to the community.

The case of the professional sexual misconduct of Dr Gregory Wilks, a general practitioner, includes three complainants. One of these complainants was the husband of a woman with whom Dr Wilks maintained a sexual relationship with throughout the Hearing into his conduct. Dr Wilks refused to participate in the Hearing, as did the patient that he continued a relationship with.

I will demonstrate that examining cases of professional sexual misconduct according to the *Framework for Trustworthiness in Doctors* is consistent with the requirement that the MBA act to protect the public. Beyond this, I will also argue that the *Framework for Trustworthiness in Doctors* is more consistent with demonstrating the conditions necessary for the protection of the public than the existing guidelines. Finally, I will argue that the *Framework for Trustworthiness in Doctors* is superior to existing guidelines in its ability to meet legitimate community expectations of regulation of the medical profession.

The framework described in Chapter Six may be summarised in table form, and is attached as Appendix One.
6.2 The Case of Dr Fitzgerald

In a Formal Hearing held on November 12 and December 18 2001, the MPBV considered whether Dr Fitzgerald had engaged in “unprofessional conduct” by having a sexual relationship with a patient, Ms A, between January 1997 and December 2000.

The Reasons for the Decision, made on December 18, 2001, are publicly available online [155]. The facts of the case, as documented by the Board within the Reasons for the Decision, are documented below according to the Framework for Trustworthiness in Doctors.

6.2.1 Clinical Synopsis

Ms A was referred to see Dr Fitzgerald in 1987, when she was 25 years old. Ms A received psychiatric care from Dr Fitzgerald as an outpatient for the next ten years. During this time, Ms A saw Dr Fitzgerald at varying frequencies, although up to five times a week. Ms A experienced difficulties with depression, psychosis, and alcohol abuse. Dr Fitzgerald provided care including individual psychotherapy. Whilst Ms A was an inpatient in a psychiatric hospital in January 1997, at Dr Fitzgerald’s suggestion, Ms A and Dr Fitzgerald agreed to commence a sexual relationship [155].

Ms A and Dr Fitzgerald had a sexual relationship, including living together, from January 1997 to November 2000. During this time, Ms A continued to experience mental health difficulties including prescription benzodiazepine and prescription opiate abuse. In 1999, Ms A lost custody of her child. Dr Fitzgerald made a notification to the then MPBV in 2001, after the Medical Director of the Private Clinic in which he worked, Professor Schweitzer, became aware of his relationship with Ms A, and urged him to make a notification.

6.2.2 Provision of Competent, Appropriate Care

Ms A was referred to Dr Fitzgerald for psychiatric care of multiple difficulties. Ms A developed further diagnoses during her period of care with Dr Fitzgerald, including a diagnosis of post partum psychosis. Dr Fitzgerald is described by himself and Ms A as providing some appropriate care for Ms A over the ten years preceding their
relationship. Based on the information provided in the Reasons for the Decision, it is impossible to assess the quality of the care that was provided to Ms A. There is some information included, that suggests that even prior to commencement of the sexual relationship in January, there may have been some inappropriateness in the care provided, such as Dr Fitzgerald’s tearful disclosure during one of Ms A’s sessions in 1995 that he was [page 3, 155] “not coping at home”. Progression of boundary violations over time is well established [39], and it could be expected that even prior to commencement of their sexual relationship, that the therapeutic relationship between Ms A and Dr Fitzgerald may have included inappropriate care.

It is clear that once Ms A commenced her relationship with Dr Fitzgerald, she did not receive appropriate care. During the Hearing, Ms A emphasised that she did not believe that Dr Fitzgerald was acting as her psychiatrist whilst they were engaged in a sexual relationship. During this time, Ms A continued to experience multiple mental health difficulties, including alcohol abuse, prescription benzodiazepine abuse and prescription opiate abuse. Ms A also lost custody of her child during this time. However, despite these serious concerns, Ms A did not see another psychiatrist, or even a regular general practitioner, whilst in a sexual relationship with Dr Fitzgerald.

It is impossible to make a definitive assessment about why Ms A was without appropriate care for this time, based upon the information within the Reasons for the Decision. However, it seems likely that the relationship was an important factor, given Ms A’s history of ten years’ engagement with psychiatric care immediately prior. Many factors may have contributed to Ms A being unable or unwilling to seek alternative psychiatric care. The lack of a termination phase with her previous psychotherapist may have left many aspects of this psychotherapy unresolved. Quadrio [51] noted the difficulties that many patients engaged in professional sexual misconduct have in engaging with a subsequent therapist. Ms A may additionally have been concerned about disclosing her relationship to Dr Fitzgerald to a subsequent psychiatrist because of the potential for professional harm to Dr Fitzgerald.
Regardless of how Ms A’s care was affected, it is clear that Dr Fitzgerald did at least provide less than ideal care during a period preceding the relationship with his patient, and that Ms A did then have a prolonged period without appropriate care that coincides with the sexual relationship. Dr Fitzgerald cannot be said to have been trustworthy. There are no definite indications from the Reasons for the Decision that Dr Fitzgerald had been extremely untrustworthy, by being willing to provide inappropriate, unsafe or illegal care to promote or maintain the professional sexual misconduct. It is possible, of course, that aspects of the five-sessions-per-week intensive psychotherapy met this criteria, but based on the information provided this cannot be presumed.

6.2.3 Regard for Patient Preferences

Ms A attended Dr Fitzgerald with concerns about her mental health. Prioritising addressing these concerns could reasonably be seen as her preference, and Dr Fitzgerald’s suggestion of a relationship therefore not consistent with trustworthy care. However, during the Panel Hearing, Ms A indicated an additional preference, to have a sexual relationship with Dr Fitzgerald. Ms A indicated that this preference developed during her period of psychotherapy with Dr Fitzgerald, but that “she was aware of the meaning of “transference” and did not feel that the term was appropriate in her context” [page 4, 155].

Could, then, Dr Fitzgerald be reasonably seen to have acted according to the requirements of a trustworthy doctor by responding to Ms A’s preferences to have a sexual relationship with him? There are two reasons why this cannot be the case. Firstly, given the established literature concerning professional sexual misconduct, and its harmful effects on patients involved, doctors cannot be seen to be trustworthy if they respond to a request for a sexual relationship, even if clearly made by the patient.

Secondly, although Ms A stated that she did not believe that transference was a significant factor in contributing to her preference to have a sexual relationship, it is difficult to imagine that some transferential motivations would not have been in place, and perhaps highly significant in Ms A’s subsequent preference to have a sexual relationship with Dr A. It is also difficult to estimate the degree to which Ms A’s
testimony at the Panel Hearing was influenced by the ambivalence associated with patients involved in professional sexual misconduct [51].

Therefore, although Dr F’s behaviour meets the criteria for untrustworthy behaviour by not experiencing patient preferences as compelling and responding to inappropriate patient preferences, there is no evidence suggesting that Dr Fitzgerald was willing to force his own preferences. Some may question the effects of transference and the way that this was developed within the intensive five-sessions-a-week psychotherapy. There is no doubt that this may enable a degree of manipulation, but there is no evidence that this was the case in Ms A’s psychotherapy, and during the Hearing “Ms A said that she felt that she had been treated decently and appropriately by Dr Fitzgerald” [page 4, 155].

6.2.4 Regard for the Patient’s Dependence Upon the Doctor

Ms A presented with a high degree of dependence from her first contact with Dr Fitzgerald. This dependence was heightened further with the emergence of multiple severe psychiatric diagnoses over the ten years during which Ms A was Dr Fitzgerald’s patient, but also by the forms of treatments that were provided.

When Ms A met Dr Fitzgerald for the first time, it was as she awoke from a deliberate drug overdose, and was being admitted to a private psychiatric hospital, with Dr Fitzgerald in the role of admitting on-call psychiatrist. The power imbalance of this encounter is clear in terms of the severe impact of illness on Ms A’s life, and her need for a form of care that could only be provided by Dr Fitzgerald, as the only admitting psychiatrist to the hospital.

This power imbalance only increased over subsequent years, with Ms A noted to have developed “post partum psychosis” in 1989, to be “drinking heavily” in 1992 and to be “severely depressed” in 1994 [page 3, 155]. Ms A stated during the Panel Hearing that she had had a “nervous breakdown” requiring inpatient care in 1997, and it was during this admission that Dr Fitzgerald suggested to Ms A that they have a sexual relationship. Ms A was undoubtedly extremely vulnerable throughout her period of care by Dr Fitzgerald. It seems unlikely that Dr Fitzgerald was unable to recognise the degree of dependence associated with Ms A’s illnesses.
A trustworthy doctor must be able to recognise the patient’s dependence, and experiences this dependence as compelling. To experience the dependence as compelling, as I have described in Chapter Five, the doctor should seek to minimise the dependence if possible. The dependence which remains is experienced as *compelling* by the doctor in that the doctor is motivated to act in the patient’s interests by their dependence. Dr Fitzgerald did not experience this extreme dependence as compelling, and in fact took advantage of the patient’s extreme vulnerability, acting in with extremely untrustworthy behaviour.

This lack of regard for extreme dependency is even more concerning given Dr Fitzgerald’s management of Ms A’s difficulties using intensive psychodynamic psychotherapy, during which Ms A was seeing Dr Fitzgerald “up to five times per week” [page 3, 155]. This form of psychotherapy promotes an increased level of dependency upon the psychotherapist, and it is impossible to fully understand Dr Fitzgerald’s motives for this. It is possible that promotion of further dependency was a motivating factor, further in keeping with extreme untrustworthiness, but this cannot be established on the basis of the *Reasons for the Decision*. Regardless, Dr Fitzgerald’s behaviour in response to Ms A’s dependence is most appropriately characterised as extremely untrustworthy.

6.2.5 Recognition of the limitations of their own trustworthiness, including clinical competence

The relationship was acknowledged to have continued for more than three and a half years. During this prolonged period, it seems unlikely that Dr Fitzgerald would not have had opportunity to reflect upon his own limitations, the ongoing distress experienced by Ms A, and the consequent limitations in his own trustworthiness.

In particular, Dr Fitzgerald stated, during the Hearing, that he was aware that his relationship with Ms A was “wrong for many reasons, including because such a relationship could do her long-term harm” [page 5, 155]. His work colleague, Professor Schweitzer testified that he must have been aware of “the impropriety of a sexual relationship with a patient” [page 10, 155], on the basis of information provided through workplace-based education sessions. The lack of reflection on this
both prior to the relationship becoming overtly sexual, and then once it was overtly sexual, suggests an extreme inability to do so. This behaviour is in keeping with extreme untrustworthiness in terms of an ability to recognise and respond to the limitations of Dr Fitzgerald’s own trustworthiness.

Similarly, Dr Fitzgerald was aware that he was depressed in the time leading up to commencing a sexual relationship with Ms A. During the Hearing he stated “He said that he was aware that he had been depressed, at one time self-medicating with the antidepressant Cipramil, although he ceased it after a few months when he became concerned it was interfering with his ability for clear thought” [page 6, 155]. Despite being aware that he was unwell, and self-initiating treatment, Dr Fitzgerald did not seek his own care from another medical practitioner, to minimise the impact of his illness on his clinical practice, nor did he modify his practice to ensure that his illness did not impact upon his clinical competence. As a psychiatrist, he could reasonably be expected to be aware of the potential for depression to impact upon his functioning as a psychiatrist. His behaviour in response to this awareness is in keeping with extreme untrustworthiness.

Finally, during the Panel Hearing, Dr Fitzgerald was adamant that his relationship with Ms A was the only relationship that he had ever had with a patient, and that he would never have a sexual relationship with a patient again; “He maintained that he had never had never had a relationship with any other patient.” Dr Fitzgerald “stated that he would eventually like to practise psychiatry again and said that he would never repeat his error, explaining that “The knowledge that I have done the wrong thing, the knowledge that I have betrayed my family, the knowledge that I have betrayed my patient and therefore other patients, the knowledge that I betrayed my colleagues and the profession has been very difficult to bear” [page 6, 155].

In terms of being able to be confident that he would never have a relationship with a patient again, Dr Fitzgerald said that he could provide the following reassurance to the Panel: “I don’t intend ever to be working the hours that I was working, to have the financial pressure that I had, to be in a loveless marriage, to be constantly criticised by a wife who when I complained about finances would simply say ‘Go out and work
harder” [page 8, 155] Dr Fitzgerald does seem in this statement to be suggesting that his behaviour could be explained by pressures external to himself.

There is, however, no suggestion at this Hearing that Dr Fitzgerald’s behaviour was repeated or involving multiple patients in such a way that would be consistent with extreme untrustworthiness. Extreme untrustworthiness is confirmed by his protracted lack of reflection upon the impact of his behaviour upon the patient. Subsequent Hearings are discussed below.

6.2.6 Appropriate Communication to Patients and Others Regarding Appropriate Care

Dr Fitzgerald’s communication with Ms A was inappropriate even prior to his telephone call to her, whilst she was an inpatient in a psychiatric hospital in 1997, when he “asked her in so many words whether she had room in her life for him” [page 3, 155]. Dr Fitzgerald is described as having “cried and told Ms A (her) that he was not coping at home” [page 3, 155] in 1995, during an appointment with Ms A. This communication is clearly inappropriate for the doctor-patient relationship, and suggests a lack of trustworthiness in terms of the doctor’s responsibility to emphasize appropriate care in communication, and not communicate in such a way that misleads the patient. By expressing his own distress, Dr Fitzgerald was communicating this and also a lack of clarity about the boundaries between them. This is not trustworthy conduct in terms of the responsibility for appropriate communication.

However, Dr Fitzgerald was also not trustworthy in providing accurate or appropriate communication to the Panel Hearing. Before the Hearing, Dr Fitzgerald indicated that he began seeing Ms A as a patient at the end of 1996. This was acknowledged to be incorrect, and that he had in fact treated her as a patient for an additional nine years prior to this date. Dr Fitzgerald also acknowledged deliberately not discussing Ms A with his colleagues during their sexual relationship; “He did not discuss his overture with any peers or with Dr Braun (Ms A’s treating psychiatrist during a period of inpatient care) because he knew that it was wrong” [page 7, 155]. Dr Fitzgerald has therefore acted to conceal information from colleagues and the Panel, knowing
the consequences of his communication. This is also in keeping with extremely untrustworthy behaviour.

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<tr>
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<td></td>
<td>Dr Fitzgerald was aware of the extreme dependency, and actively exploited this for his own gain. May have even sought to increase the dependency to promote his gain.</td>
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<tr>
<td>Recognition of the limitations of their own trustworthiness, including clinical competence</td>
<td></td>
<td></td>
<td>Despite being aware of the potential for his health concerns and PSM to impinge upon patient care, did not act to maintain these. May repeatedly engage in PSM despite feedback regarding the inappropriateness of this.</td>
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<tr>
<td>Communication to Patients and Others Regarding Appropriate Care</td>
<td></td>
<td></td>
<td>Actively deceptive in his communications with his patient and others about what the limits of trustworthiness are, including the inappropriateness of PSM.</td>
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6.2.7 Hearing Outcome
Dr Fitzgerald appeared before a Panel Hearing with the support of a number of senior colleagues, as well as his treating psychiatrist. His senior colleagues all presented impassioned statements emphasizing their esteem for Dr Fitzgerald, and their strong belief that his behaviour occurred as a result of mental illness that could be treated, removing the risk of future harm to the community in the form of further professional sexual misconduct.

At the time of the Panel Hearing, Dr Fitzgerald’s treating psychiatrist was Dr Conron. Dr Conron testified at the Panel Hearing regarding his assessment of Dr Fitzgerald’s
diagnosis: “Dr Conron concluded that Dr Fitzgerald was markedly depressed” [page 8, 155].

Dr Conron additionally offered statements about what he believed to be the likelihood that Dr Fitzgerald would cause future harm to the community, based both on his psychiatric assessment, but also on stated expertise regarding professional sexual misconduct. “Dr Conron concluded that it was extremely unlikely that Dr Fitzgerald would have any further relationships with patients.” “He expressed the opinion, based on his clinical experience that psychiatrists who have sexual affairs with their patients fall into two groups: “The smaller group are best described as predators who may have repeated or concurrent sexual relationships with a number of patients. The larger group of practitioners who have sexual relationships with patients are depressed and are often very busy and competent clinicians who have major marital problems.” He concluded that Dr Fitzgerald fell into the latter group and clearly understood that his behaviour was seriously unethical” [page 9, 155].

With these statements, Dr Conron’s role as treating psychiatrist was extended to expert witness, in the way that Kiel suggests is not infrequent, but can be potentially problematic [15]. The roles of other witnesses at the Panel Hearing were often similarly complex.

Dr Stocky provided a statement and also gave “oral evidence” to the Hearing. Dr Stocky was a colleague of Dr Fitzgerald’s, serving “on various committees with him”. However, at the Hearing he was also described as having “a particular interest in sexual malpractice by psychiatrists” [page 11, 155]. Dr Stocky’s role at the Hearing therefore spanned that of professional colleague providing a character witness to an expert witness making an assessment of Dr Fitzgerald’s forensic risk: Dr Stocky “expressed the view that Dr Fitzgerald’s entry into a relationship with his patient was not indicative of his being a psychopath or a sexual predator” [page 11, 155]. Beyond this appraisal, Dr Stocky offered recommendations to the Hearing about appropriate responses to Dr Fitzgerald’s professional sexual misconduct: Dr Stocky “recommended that the Panel explore mechanisms for combating (Dr Fitzgerald’s) vulnerability” [page 12, 155].
Similarly, Dr Scott’s statement to the Panel Hearing suggested that he held multiple potential roles. He stated that he had known Dr Fitzgerald socially and as a part of his peer review group for 23 years. In this way his role seems to be as a psychiatrist who has a social relationship with Dr Fitzgerald. However, he then went on to give a statement that implied both a psychiatric assessment of Dr Fitzgerald, and also some expertise in the relationship between mental illness and professional sexual misconduct; “He said that it was evident to him that the relationship in which Dr Fitzgerald engaged took place in the setting of marital separation and depression from which by the time of the hearing he was making a good recovery” [page 13, 155]. Again, the role of psychiatric expert witness is present to some degree in the testimony of a witness not overtly declared to be such.

In fact, multiple witnesses presented to the Panel Hearing and acknowledged that although professional sexual misconduct had occurred, that they believed that it had only occurred because Dr Fitzgerald was depressed [155]. They suggested that once his depression was treated, there would be no further risk of professional sexual misconduct, and therefore no reason for deregistration.

The Panel representing the MPBV deliberated, and in its Reasons for the Decision noted that there were a number of factors which increased the seriousness of this case of professional sexual misconduct. The Panel noted that Ms A was Dr Fitzgerald’s patient for “a lengthy period”, that “her therapeutic relationship was lengthy and intense”, and that Ms A was “an extremely vulnerable person, requiring hospitalisation on a number of occasions for mental illness and in the context of ongoing substance dependencies” [155]. Additionally, the Panel noted that the sexual relationship continued for almost three years, and that Dr Fitzgerald provided some information to the Panel which was later demonstrated to be false.

In the context of finding that Dr Fitzgerald’s conduct was serious enough to meet the standard of “infamous conduct of a professional respect”, the Panel did nonetheless state that it accepted “that Dr Fitzgerald’s behaviour arose out of his personal needs and his inability to take a strong position in relation to boundary issues, rather than out of predatoriness or psychopathy. It also accepts that his intentions were not consciously exploitative” [page 29, 155]. The Panel did therefore state that “although
Dr Fitzgerald’s misconduct has been at a very high level of seriousness, there are reasons to anticipate that in due course, should his rehabilitation continue, he may be able to resume a place amongst registered practitioners” [page 30, 155]. Dr Fitzgerald’s registration as a medical practitioner was cancelled, but the option to reapply was clearly available.

6.2.8 Comparison Between Hearing Outcome and Application of the Framework for Trustworthiness in Doctors

The outcome of the Hearing was clearly a serious one for Dr Fitzgerald, with loss of his registration. Cancellation rather than suspension of registration meant that he would have to reapply to obtain registration. However, despite the seriousness of this response, the Medical Practitioners’ Board does foreshadow a return to practice. This anticipated return is associated with the Board’s understanding of Dr Fitzgerald’s behaviour according to its psychodynamic motivation, which was not “predatoriness or psychopathy” [page 29, 155].

This understanding is in contrast with Dr Fitzgerald’s behaviour according to the Framework for Trustworthiness in Doctors. Dr Fitzgerald’s behaviour was consistent with untrustworthy conduct in terms of his provision of competent, appropriate care and regard for patient preferences, and extremely untrustworthy in terms of regard for the patient’s dependence upon the doctor, recognition of the limitations of their own trustworthiness, including clinical competence, and communication to patients and others regarding appropriate care. His behaviour did not meet any of the standards for trustworthiness. Dr Fitzgerald’s behaviour is recognised as significantly morally inadequate by the Framework for Trustworthiness in Doctors, and it could be reasonably inferred that this might have implications for his future practice.

However, as the MPBV foreshadowed, Dr Fitzgerald successfully reapplied for registration in May 2003, and was re-registered in March 2004. Dr Fitzgerald was the subject of a second Formal Hearing in November 2006. This Hearing was in response to a second complaint of professional sexual misconduct, which was found, and Dr Fitzgerald’s registration was again cancelled for a period of five years.
A third Formal Hearing was held in March 2009, in response to a third allegation of professional sexual misconduct. This complaint was found also, and Dr Fitzgerald was disqualified from applying for registration for five years from the date of that Hearing. Notably, the sexual relationships which were the subject of the second and third Formal Hearings were established and continuing at the time of the first Formal Hearing. He continued with this behaviour whilst his clinicians and colleagues testified on his behalf that he would never engage in professional sexual misconduct again, at the Hearing held in 2001 [156].

Dr Fitzgerald’s case illustrates the problems associated with using a psychodynamic or illness model in cases of professional sexual misconduct. The doctor will be both motivated to present with an illness and equipped to do so by both their medical background and the access to resources to maintain this diagnosis.

The Framework for Trustworthiness in Doctors, by comparison, examines behaviour and categorises that behaviour independent of (declared) causal factors. In the case of Dr Fitzgerald, the very extreme untrustworthy behaviour foreshadowed ongoing untrustworthiness, and could not be attenuated by the testimonies of friends, colleagues and clinicians.

6.3 The Case of Dr Wilks
In a Formal Hearing held on May 21 and 22, 2007, the MPBV considered whether Dr Wilks had engaged in “unprofessional conduct” by having made inappropriate sexual comments to two patients, Ms N and Ms R, and engaging in a sexual relationship with a third patient, Ms T.

The Reasons for the Decision, made on May 22, 2007, are publicly available online [157]. The facts of the case, as documented by the Board within the Reasons for the Decision, are documented below according to the Framework for Trustworthiness in Doctors.

6.3.1 Clinical Synopsis
At the time of the notifications, Dr Wilks was working as a general practitioner with the bulk of his clinical practice being obstetrics. Two of Dr Wilks’ female patients,
and the husband of a third of Dr Wilks’ female patients, made complaints about Dr Wilks’ behaviour towards them, with five complaints of professional sexual misconduct.

The first complaints were by a patient, Ms N, who at age 35 years had received medical care from Dr Wilks for 7 years, including obstetric care for her three children. Ms N’s marriage had broken down in 2002 and she had discussed this with Dr Wilks. Ms N consulted Dr Wilks on 5 August 2004 to obtain a repeat prescription for the oral contraceptive pill. Ms N alleged that, during this consultation;

1. Dr Wilks ‘told Ms N in words to the effect of “that you prefer to examine young women and that older women do nothing for you’” [page 8, 157] and
2. Dr Wilks “confided to Ms N inappropriate information of a personal sexual nature including your internet dating, sexual relationships with your wife and/or extra marital sexual liaisons” [page 8, 157]

Following this consultation, Dr Wilks sent a text to Ms N suggesting that they could engage in a sexual relationship.

A second patient, Ms R, made the third complaint. Ms R saw Dr Wilks for the first time on November 26, 2007. At that time she was 26 years old, seven weeks pregnant and seeking obstetric care, including for her pregnancy and delivery. Ms R underwent breast examination, abdominal examination and an internal pelvic examination. Ms R alleged that, during this consultation;

1. Dr Wilks “made inappropriate comments regarding her breasts, including how they had grown, and/or how you bet her husband loves that” [page 13, 157], and
2. Dr Wilks “asked Ms R whether she had seen a scene in movie where a man said, in words to the effect of, ‘She can’t come to the phone right now, she’s got my dick in her mouth’” [page 13, 157], and
3. Dr Wilks had “failed to provide appropriate privacy for Ms R (such as a screen around the examination couch for disrobing and/or a gown and/or cover sheet for an examination) when conducting a physical examination while she was in a state of undress from the waist” [page 13, 157], and
4. Dr Wilks “failed to adequately communicate and/or explain to Ms R the purpose of an internal examination” [page 13, 157]
The husband of a third patient, Ms T, made the fourth and fifth complaints. Ms T first consulted Dr Wilks in July 2003, at aged 32 years, for obstetric care for her pregnancy and delivery. Ms T's baby was delivered by Dr Wilks in March 2004. In September 2004, Ms T consulted Dr Wilks as to whether she may have post natal depression, marital concerns, and with concerns about her low libido. Dr Wilks treated Ms T’s low libido with a testosterone implant, and prescribed the oral contraceptive pill. Ms T and Dr Wilks’ sexual relationship commenced within three weeks of commencement of testosterone, in October 2004. During the Hearing, Dr Wilks stated that he told Ms T that he could not continue to see her as a patient because they were engaged in a sexual relationship. However, Medicare documentation showed continued medical consultations until January 2005 [157].

At the same time, Ms T’s husband, Mr T was a patient of Dr Wilks’. In late October 2004, Mr T consulted Dr Wilks. At this time, Mr T was unaware that Dr Wilks had commenced a sexual relationship with his wife, and sought advice from Dr Wilks about how to manage the mismatch between his wife’s low libido and his own. In particular, Mr T asked Dr Wilks about whether having either a vasectomy or chemical castration might be appropriate. During this consultation, Dr Wilks sent a message to Ms T via an internet chat site about consulting her husband [157].

Mr T consulted Dr Wilks a further seven times over five months before becoming aware that his wife was having an affair with Dr Wilks, in April 2005.

6.3.2 Provision of Competent, Appropriate Care

In considering Dr Wilks’ trustworthiness according to whether he was providing competent and appropriate care, there are a number of ways in which his sexual behaviour directly impinged upon the care of his patients. His sexual comments towards Ms N and Ms R caused such distress that both women elected to not seek further care from Dr Wilks. Ms N had attended him for medical care for seven years prior to the incidents which resulted in a notification to the MPBV. Ms R had attended Dr Wilks with the intent of seeking antenatal care from him. Dr Wilks did not prioritise responding to his patients’ concerns, but rather used the consultations with patients for his own purposes. He did not meet the standards necessary for
trustworthiness according to whether he provided competent and appropriate care, and allowed the professional sexual misconduct to undermine the patient’s care.

Beyond this untrustworthy conduct, however, it must be considered whether Dr Wilks was “willing to provide inappropriate, unsafe, or even illegal care to promote or maintain professional sexual misconduct” [157] including inappropriate prescribing. Dr Wilks’ conduct with Ms T was particularly remarkable. Dr Wilks initiated prescription of implanted testosterone as management for her concerns about lowered libido, at the same time that Ms T was describing marital difficulties and concern that she may have post natal depression. Implantable testosterone is not a first line treatment for low libido, particularly when there are comorbid mood or relationship difficulties [157]. As noted by the Board “If a medical practitioner provides treatment to increase libido, he must be extra vigilant to ensure no personal or intimate relationship develops”. Although it could not be established that Ms T’s libido increased after this treatment, and that this increase contributed to her willingness to engage in a sexual relationship with Dr Wilks, the timing of this relationship raises serious concern.

It is clear that Dr Wilks’ treatment of Ms T’s libido was, at least to some degree, inappropriate, and that this treatment had at least the potential to promote Ms T’s willingness to have a sexual relationship with Dr Wilks. It is also clear that Dr Wilks would have been aware of the potential for this to occur, as he was prescribing the testosterone with the intention of increasing Ms T’s libido. Dr Wilks’ willingness to engage in a sexual relationship with his patient under these circumstances is therefore in keeping with extremely untrustworthy behaviour.

Dr Wilks’ ongoing care of Mr T could not be trustworthy in the context of his sexual relationship with Mr T’s wife. No evidence was presented suggesting that Mr T received care that was physically harmful to him. However, it was clear that he had been extremely distressed to realise that he had continued to confide in a man who was having a sexual relationship with his wife. Dr Wilks’ breach of Mr T’s confidentiality, via an email to Ms T during a consultation with Mr T, is clearly inappropriate. His behaviour was untrustworthy in terms of the provision of appropriate, competent care.
6.3.3 Regard for Patient Preferences

Dr Wilks disregarded patient preferences in a number of ways. Ms N, Ms R and Ms T presented seeking health care, and this preference was disregarded by Dr Wilks, who prioritised his own sexual behaviour over provision of his patients’ healthcare. In this way, Dr Wilks could be seen to have behaved in ways that were not in keeping with trustworthy conduct.

Beyond this conduct with his female patients, Dr Wilks also acted in ways that directly contradicted the preferences of his patient Mr T. Mr T attended Dr Wilks seeking advice as to how to manage difficulties in his sexual relationship with his wife, Ms T. During this consultation, Dr Wilks breached Mr T’s confidentiality by communicating with Ms T about the consultation. The tone of Dr Wilks’ communication could at best be described as disparaging, and there could be no doubt that this behaviour occurred in disregard to Mr T’s preferences, and occurred with deceit. This behaviour was therefore in keeping with the criteria for extremely untrustworthy behaviour, in which the doctor “Is willing to disregard the preferences of patients to further their own interests. This includes patient preferences which may be reasonably inferred (such as a parent’s preference that their child not be harmed). Extremely untrustworthy doctors may be willing to force their own preferences by manipulation, coercion, deceit or frank assault”. Dr Wilks’ sexual relationship with Ms T was contrary to Mr T’s preferences, and these preferences were evident to Dr Wilks. Mr T did not have the opportunity to change his healthcare to another doctor to avoid continued contact with his wife’s sexual partner, as this information was not provided to him. Dr Wilks did, instead, act as if he was trustworthy whilst actually being extremely untrustworthy.

6.3.4 Regard for the Patient’s Dependence Upon the Doctor

Dr Wilks made sexually inappropriate comments to two of his female patients, and engaged in a sexual relationship with a third female patient while continuing to see that patient’s (unknowing) husband as a patient. Dr Wilks disregarded the dependence of his patients in a number of ways.
Ms N had been Dr Wilks’ patient for seven years, including receiving the obstetric care for her three children, at the time that he made sexually inappropriate comments during a consultation, then suggested that they could have a sexual relationship. The length of this relationship, as well as the fact that Ms N had consulted Dr Wilks for obstetric care and discussed her concerns about finding a sexual partner, suggest a high degree of dependence. Ms R sought obstetric care from Dr Wilks and was pregnant at the time of her consultation, during which Dr Wilks made sexually inappropriate comments. Ms R was particularly vulnerable because of her pregnancy, and additionally because she underwent a pelvic examination during the consultation. There is no evidence presented in the Reasons for the Decision which suggest that Dr Wilks attempted to respond appropriately to this dependency.

Ms T and her husband, Mr T, sought medical assistance from Dr Wilks after her delivered their baby. This medical assistance included Ms T seeking assistance for mood difficulties, concerns about her libido being lower than her husband’s, and Mr T’s concern that his libido was higher than that of Ms T’s, and exploring options for chemical castration. There is no doubt that both patients were extremely vulnerable, and that this vulnerability was exploited in the extreme by Dr Wilks. The standard for extreme untrustworthiness in terms of responding to a patient’s dependency is “Is aware of the dependency, and actively exploits this for their own gain. Do not recognise extreme dependency, due to serious illnesses. May even seek to increase the dependency to promote their own gain.” Three female patients with substantial dependency sought care from Dr Wilks, and he either did not recognise this dependency, or did recognise it, and sought to exploit it. For this reason, his behaviour meets criteria for extremely untrustworthy according to the expectation that he have regard for his patients’ dependency.

6.3.5 Recognition of the limitations of their own trustworthiness, including clinical competence

Dr Wilks repeatedly engaged in inappropriate conduct with his patients. There is no information to suggest that he was concerned about his conduct, nor that he attempted to manage it in any way. His refusal to participate in the MPBV Hearing in person limits the information available about his perceptions about his own
behaviour. It can be established that he did not recognise the potential for his conduct to impact upon his clinical care, or that he was not influenced by this. His behaviour was not trustworthy in that he repeatedly behaved inappropriately, but it may be that further information would confirm attitudes in keeping with extreme untrustworthiness.

6.3.6 Appropriate Communication to Patients and Others Regarding Appropriate Care
Dr Wilks did not communicate to his patients what the limits of his trustworthiness were. In particular, in his interactions with Mr T, Dr Wilks was overtly deceptive. He acted as though he was continuing to provide appropriate medical care to Mr T when he could not have considered that this was appropriate, given his relationship with Ms T, and the nature of the care that Mr T was seeking (sexual counselling with regard to his relationship with his wife). The standard for extreme untrustworthiness is “May be actively deceptive in their communications with patients about what the limits of trustworthiness are, including the inappropriateness of boundary crossings or violations, including PSM.” Dr Wilks’ conduct was therefore in keeping with extreme untrustworthiness according to communicating his own limitations to his patients.
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</tr>
<tr>
<td>Recognition of the limitations of their own trustworthiness, including clinical competence</td>
<td></td>
<td>Do not recognise the potential for their health concerns or lack of clinical competence to cause harm, and consequently does not maintain these, nor refer patients appropriately.</td>
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6.3.7 Hearing Outcome

Dr Wilks elected not to appear at the Hearing, and withdrew his instructions to his solicitors on the first day of the Hearing. Dr Wilks’ previous statements to the Board, during the investigation for the Hearing, were inconsistent with other evidence obtained, such as Medicare billing records.
The Panel determined that Dr Wilks had engaged in unprofessional conduct of a serious nature, and cancelled his registration. The Panel also disqualified Dr Wilks from applying for registration for a period of five years. The Panel commented that Dr Wilks had “given no indication of insight into or remorse for his behaviour”, and was therefore “unsuitable for medical practice” [page 38, 157].

6.3.8 Comparison Between Hearing Outcome and Application of the Framework for Trustworthiness in Doctors

The outcome of the Hearing was clearly a very serious one for Dr Wilks, who was prevented from practicing for a minimum period of five years. By cancelling his registration, rather than suspending it, the MPBV placed the impetus upon Dr Wilks to demonstrate his fitness to practice from five years after the Hearing. By making the statement that that Dr Wilks had “given no indication of insight into or remorse for his behaviour”, and was therefore “unsuitable for medical practice” [page 38, 157], the Board suggested that there might be serious concerns about allowing Dr Wilks to return to practice.

The application of the Framework for Trustworthiness in Doctors to this case gives clear explanation about how Dr Wilks’ behaviour deviates from a reasonable community standard of trustworthiness. It makes clear why his behaviour was unacceptable and indeed how unacceptable it was. This framework is advantageous in a number of ways.

For the doctor, the process is transparent and clear in terms of the deviation from acceptable standards, and what those standards are. This clarity is vital for procedural fairness, but may also be used to guide the rehabilitation of the doctor. If the doctor is to return safely to practice they will benefit from understanding not only that their conduct was wrong, but how and why their behaviour deviates from the required community standard. When there is additional misconduct that is not sexual in nature, this behaviour can also be seen according to the ways in which it deviates from reasonable community standards.

In response to the outcomes of this Hearing, Dr Wilks appealed to the Victorian Civil and Administrative Tribunal regarding the finding of misconduct of a serious nature
and the cancellation of his registration. A Hearing was held between October 29 2007 and October 31 2007. The facts of the cases were reviewed in detail, and Dr Wilks gave evidence as well as being cross-examined. Dr Wilks also “relied on the evidence of” Mr Foenander, a clinical psychologist. The Reasons for the Decision for this Hearing are also available online [158]

In the Reasons for the Decision [158] the Board stated that during the Hearing it was “satisfied that Mr Wilks did intend to mislead the Board”. In Mr Foenander’s statement, it was clear that Dr Wilks had told him that he had only commenced a relationship with Ms T after her marriage had ended, and that Mr Foenander had therefore based his statement on false information. The Board stated that they were “seriously troubled” that Mr Foenander was misled, and therefore indicated that they had “no confidence” in Mr Foenander’s “opinion that there is very little risk of Dr Wilks reoffending”. The Board additionally stated that “we were troubled by his tendency to be loose with the truth, to excuse his behaviour and to shift blame onto others”. Consequently, the Board concluded “We are not satisfied that Mr Wilks has any true insight into his conduct, nor that he understands fundamental doctor/patient relationships, boundary issues or the essence of the doctor-patient relationship in terms of the need for medical practitioners to avoid any conduct which might be seen to or actually abuse the trust of their patients”.

At this Hearing, the decision to cancel his registration was upheld. The Board clearly referred to the expectation that the trust of patients be maintained. Without reference to trustworthiness, or what this trustworthiness might require, however, there is little clarity about how Dr Wilks’ behaviour must change. The requirement to indicate remorse is readily met by the doctor seeking to recommence clinical practice, but there is little correlation between a statement of remorse and future trustworthiness.

In this context, Dr Wilks recommenced practice in December 2010. The process by which he demonstrated that he posed no further risk to the public is not publicly available. Dr Wilks was allowed to recommenced practice with extensive conditions on his registration, including having a female chaperone with him at all times when he consults with female patients above the age of sixteen years. Other
recommendations including not being allowed to work in solitary practice, having another doctor present on site at all times and receiving ongoing supervision suggest that the Board was not confident of Dr Wilks’ trustworthiness, despite a statement of remorse.

The MBA requires that doctors seeking registration be demonstrably “of good character”. The Framework for Trustworthiness in Doctors offers a potential structure and standards for defining aspects of character. Doctors reapplying for registration could reasonably be asked to demonstrate that they held the knowledge, attitudes and skills necessary to meet the standards of trustworthiness. This may well mean demands beyond demonstrating that the circumstances which predisposed to untrustworthy behaviour have resolved.

6.4 Conclusions

Two cases of professional sexual misconduct, chosen for their diversity in terms of the ways in which the professional sexual misconduct occurred, have been examined according to a framework which describes ways of deviating from the standards of rich trustworthiness.

The Framework for Trustworthiness in Doctors offers structure when considering the doctor who has committed professional sexual misconduct, according to how they have breached the standards of trustworthiness expected by society, rather than according to the internal motivations of the doctor. This framework is therefore appropriately used by a medical board charged with protecting the public from unacceptable conduct. In the two cases above, untrustworthy conduct is recognised and categorised without influence from remorse expressed in the spotlight of potential deregistration, nor testimonies from friends, colleagues and clinicians.

This Framework may be applied when considering the doctor’s conduct, and the seriousness of professional sexual misconduct, but may also hold value in considering the rehabilitation required if the doctor is able to seek re-registration. Different forms of breaches may warrant different approaches to rehabilitation, to minimise the likelihood of professional sexual misconduct.
This framework does, by contrast to the existing approaches, make clear the variables which are to be considered in terms of the detailed facts of each case, and place these in terms of the community’s reasonable expectations of a doctor. In this way, the expectations of the community are prioritised and overted when cases of professional sexual misconduct are considered.

The Australian communities expectations of the medical profession extend beyond just that the doctor will not harm patients directly in their care. These expectations are entirely consistent with those of trustworthiness. In Chapter Eight I will demonstrate the use of the *Framework for Trustworthiness in Doctors* in cases of professional sexual misconduct which are not associated with a direct risk of harm to patients.
Chapter Seven: Application of the Framework for Trustworthiness in Doctors to Sexual Misconduct Occurring Without Apparent Direct Risk to Patients

7.1 Application of the Framework for Trustworthiness in Doctors to Sexual Misconduct Occurring Without Apparent Direct Risk to Patients

Chapter Six demonstrates that the Framework for Trustworthiness in Doctors proposed can be applied to cases of professional sexual misconduct, and when so applied, reflects the expectations and values of the community more than existing legal and psychodynamic frameworks. The Framework for Trustworthiness in Doctors is consequently argued to have utility in the consideration of cases of professional sexual misconduct, and in the planning of appropriate responses to professional sexual misconduct.

In the two cases of professional sexual misconduct described in Chapter Six, the Framework for Trustworthiness in Doctors suggested differing levels of wrong doing than those suggested by the response of the Medical Practitioners' Board of Victoria (MPBV), or the Victorian Civil and Administrative Tribunal. The Framework enables identification of extreme untrustworthiness within the doctors' conduct, when that conduct is associated with professional sexual misconduct. Identifying and documenting extreme untrustworthiness consequently has some explanatory power in term of understanding the discordance between the recommendations made by the MPBV, and the reasonable expectations of the community.

This discordance is even greater in cases in which there is inappropriate, and even illegal, sexual conduct by a doctor, but when this conduct cannot be linked with posing direct harm to patients, according to the MPBV, and now the MBA’s mandates. I will describe two such cases, in which a doctor has behaved illegally in their sexual conduct. Both of these cases came before the MPBV after the criminal proceedings were finalised. I will note that the MPBV was limited by its mandate to protect the public in its findings and recommendations in these cases, as well as other legal standards including the Briginshaw Principle. I will argue that the Framework for Trustworthiness in Doctors would have very different findings, and that these findings would be more congruent with reasonable community expectations.
The community’s expectations of doctors cannot be assumed to be the gold standard which determines best practice. There are well documented examples of doctors acting in morally unacceptable ways which were affirmed by their communities at the time. This is not to say that doctors, and the regulatory bodies which monitor their conduct, must not be accountable to the communities in which they practice. Rather, standards of conduct cannot be said to be reasonable on the sole basis that this conduct is sought by a community, or members of a community, at a point in time. As I have argued in Chapter Five, the preferences of individual patients or the community as a whole need not be compelling to the trustworthy doctor if they are not consistent with other commitments of the trustworthy doctor, including provision of competent and appropriate care.

In this Chapter I will demonstrate the application of the Framework for Trustworthiness in Doctors to two cases of sexual misconduct. These cases are distinctive because although in both cases the conduct of the doctor was illegal, the misconduct did not directly involve patients. These two cases do not suggest that harm is directly posed to patients, yet were of interest to the MPBV. The involvement of the MPBV might suggest that although patients were not directly harmed by the conduct of the doctors, and criminal courts had responded to the illegal conduct, there was a risk of additional harms to patients. This risk compelled the Board to act according to its stated principle of protection of the public.

In both cases, the conduct of the doctors occurred within their roles as doctors. Dr Abraham Stephanopoulos downloaded large amounts of child pornography within his workplace, whilst working as a neurosurgical registrar [159]. Dr Sabi Lal sexually harassed and assaulted two female pharmaceutical representatives who had contact with him only because of his role as a doctor. His conduct with both these women occurred in his consulting room in the private practice where he worked as a general practitioner. Although Dr Stephanopoulos’ and Dr Lal’s conduct did not involve their patients, its occurrence whilst they were in the role of doctor held significance for the Board [159, 160].
This significance could be argued to be consistent with the Board’s role of protecting the public if future potential harms to patients could be extrapolated from the conduct of the doctors. However, it could also be argued that the fact that the conduct occurred whilst the doctors were in their role as a doctor had an additional moral significance that the Board found compelling. The Board raised the question of harm to the profession explicitly with both Dr Stephanopoulos and Dr Lal [159, 160], when considering the implications of their conduct. This seems to acknowledge the additional moral imperative associated with actions whilst in the role of doctor. Other than an inferred risk to the public or damage to the reputation of the medical profession and secondary consequences of this, it seems difficult to understand how these concerns can be addressed under the Board’s direct remit of protection of the public.

The Framework for Trustworthiness in Doctors, by contrast, enables an understanding of the ways that these cases not associated with direct risk to the public remain clearly within the remit of the Board. With its guiding principle that doctors behave in a manner that is consistent with rich trustworthiness, the Framework for Trustworthiness in Doctors is able to be used to examine conduct associated with being in the role of a doctor, even if this conduct does not directly pose a risk of harm to the community. I will apply the Framework to these cases and argue that the ability of the Framework to describe untrustworthy conduct is consistent with the Board’s remit. In particular, I will argue that the Framework can be used to demonstrate the ways that the conduct of an individual doctor, even if not directly harmful to patients, may be harmful to the community by damaging the perceived trustworthiness of the medical profession. This potential harm is certainly within the remit of the Board.

The framework described in Chapter Five may be summarised in table form, and is attached as Appendix One.

7.2 The Case of Dr Stephanopoulos

In a Formal Hearing held on December 9 and 16 in 2005, and April 29, May 3 and June 14 2006, the MPBV considered whether Dr Stephanopoulos had engaged in “unprofessional conduct of a serious nature” [159] by having been convicted by the
The Magistrates’ Court of Victoria of three indictable offences of knowingly possessing child pornography.

The *Reasons for the Decision*, made on August 16 2006, are publicly available online [159]. The facts of the case, as documented by the Board within the *Reasons for the Decision*, are documented below according to the *Framework for Trustworthiness in Doctors*.

7.2.1 Clinical Synopsis

At the time of the offences, Dr Stephanopoulos was a senior registrar, completing neurosurgical specialty training. After a complaint was made about pornographic images on a computer in Dr Stephanopoulos’ workplace, the police were contacted and seized this computer. Child pornography images were found on this computer by the police. A search warrant for Dr Stephanopoulos’ home was obtained on the basis that he was the only individual to have consistent access to the workplace computer from the period March 7 to 21 June 2003 [159].

At Dr Stephanopoulos’ home, the police seized his home computer and a variety of computer discs. When the police examined the computer and discs, many more child pornography images were found. These had been downloaded between 26 May 2002 and 11 July 2003. The police also search Dr Stephanopoulos’ car and found a CD Rom containing further child pornographic images. In total, the police found a total of 27,000 pornographic images, including 1405 pictures, 175 web pages and 5 movie files containing child pornography [159].

On 26 July 2005, Dr Stephanopoulos was convicted of three counts of knowingly possessing child pornography contrary to section 70 of the *Crimes Act 1958 (Victoria)* [159]. Dr Stephanopoulos was sentenced to five months imprisonment, which was suspended for 15 months, and fined $5000. On 15 September 2005, Dr Stephanopoulos was notified by the MPBV that his registration was suspended, and that a Formal Hearing would be held regarding his conduct [159].

The child pornography images were extremely graphic, showing the children’s genitals. Some of the children were as young as four years of age, and some of the
children were engaged in sexual behaviour with other children, as well as sexual bondage. There was no evidence that Dr Stephanopoulos had created any of the images. The concerns were, then, the downloading of child pornography, which was obviously illegal, as well as the downloading of any pornography in the workplace. The downloading of adult pornography, although not illegal, was also considered within the Panel Hearing because of its extreme nature (the number of images downloaded) [159].

7.2.2 Provision of Competent, Appropriate Care

In considering Dr Stephanopoulos' trustworthiness according to whether he was providing competent and appropriate care, there was no suggestion that his care to patients was not competent or appropriate. His illegal behaviour did not directly involve patients, and there was no testimony suggesting that his clinical care of patients at the time of the illegal behaviour was not competent and appropriate. Whether his preoccupation with pornography may have distracted him from his work may be speculated upon, but there is no material within the Reasons for the Decision supporting this.

It is important to note that Dr Stephanopoulos’ conduct did occur at least in part within a workplace setting. Although it could be argued that there was no evidence that his conduct impinged upon the care he provided to his patients, it is also clear that his conduct is not appropriate for the workplace. As I have argued in Chapter Five, trustworthiness as a doctor in the workplace includes competent and appropriate behaviour beyond direct patient care. Doctors are expected to be competent and appropriate with other professionals with whom they interact in their role as doctors. His colleagues were exposed to Dr Stephanopoulos’ illegal behaviour in a way that could not be considered competent or appropriate. It was certainly not consistent with shared norms and expectations of workplace behaviour. Dr Stephanopoulos’ behaviour with patients may have been competent and appropriate, but his workplace behaviour, in his role as a doctor, could not be seen as appropriate in a way that is congruent with trustworthiness.

Dr Stephanopoulos’ behaviour met the criteria for untrustworthiness in that his conduct was not in keeping with the appropriate, competent conduct of a doctor.
There was no evidence presented within the *Reasons for the Decision*, however, that suggest that he was willing to compromise care to maintain his conduct. He did not, therefore, meet the criteria for extreme untrustworthiness.

### 7.2.3 Regard for Patient Preferences

None of the children in the pornographic images were patients of Dr Stephanopoulos’. If patients were directly involved, and Dr Stephanopoulos had been involved in the creation of child pornography, this would clearly be demonstrably extremely untrustworthy. Children involved in child pornography do so at the instigation of adults, under the effects of manipulation at the least, or more probably, frank coercion. Manipulative or coercive behaviour is in complete disregard for patient preferences, and overtly contrary to them. This places the behaviour in the realms of extremely untrustworthiness.

Dr Stephanopoulos’ illegal behaviour did not directly involve patients. Despite this, as I have argued in Chapter Five, the preferences of patients extend beyond those directly involved in care, and must include the established preferences of the community in which the doctor practices. These include those stipulated by law, which the doctor is not exempt from. It could be reasonably inferred that Dr Stephanopoulos’ patients’ preferences would reflect those of the general community, in terms of preferring that he not be engaged in illegal activities, and certainly not illegal activities that necessitated the exploitation of children. Dr Stephanopoulos’ illegal behaviour, although not directly involving patients, can therefore be seen to be contrary to patient preferences.

### 7.2.4 Regard for the Patient’s Dependence Upon the Doctor

Once again, because Dr Stephanopoulos’ illegal behaviour did not involve patients, it might initially appear that there was no failure of trustworthiness in terms of holding regard for the patient’s dependence upon the doctor. However, I have argued that the requirement for trustworthiness in terms of regard for patient dependence must be considered more broadly than merely governing direct interactions with specific patients.
In the same way that the expectation of regard for patient preference extends beyond behaviour conducted with patients for a doctor to be trustworthy, a regard for dependence might also be reasonably expected to extend beyond direct doctor-patient relationships. The dependence of a child on adults is violated when that child is used for the sexual gratification of adults. Child pornography is an example of this, and therefore an example of a failure of trustworthiness.

I have argued in Chapter Five, the doctor’s role within the community does not excuse the doctor from the expectations of all members of the community, as stipulated by criminal codes. The laws of a community concerning child abuse and child protection stipulate that community’s expectations of its members according to the dependence of children on adults. These expectations are held of all members of the community, regardless of their professional roles.

By accessing and downloading child pornography, even without payment, Dr Stephanopoulos was promoting the creation of child pornography, and the disregard for the dependence of children exploited in the pornography. This behaviour is contrary to community expectations of all citizens, as stipulated by criminal codes, about responses to the dependency of children. Although the children in the pornography were not in Dr Stephanopoulos’ care, the role of a doctor as trustworthy is not compatible with the extreme disregard of dependence warranted by child pornography. Dr Stephanopoulos’ conduct was therefore untrustworthy according to the expectation that he hold regard for dependence.

In terms of whether his conduct was extremely untrustworthy, there was no evidence that Dr Stephanopoulos himself acted in a coercive or manipulative manner. He did not, he argued, pay for the child pornography. By accessing and downloading child pornography Dr Stephanopoulos was participating in creating demand for child pornography, and the disregard for the wellbeing of the children involved that occurs with child pornography. It would be difficult to quantify Dr Stephanopoulos’ contribution to this, however, and consequently difficult to argue that his behaviour met the criteria for extreme untrustworthiness.
7.2.5 Recognition of the limitations of their own trustworthiness, including clinical competence

Much of Dr Stephanopoulos’ defence before the Panel Hearing was based in the argument that his illegal behaviour (the downloading of child pornography) as well as the downloading of adult pornography, occurred in the context of an extreme workload and lack of support. This was the testimony of several witnesses, as well as Dr Stephanopoulos himself.

The Hearing Panel received a report and verbal statement from Mr Ridley, who had provided Dr Stephanopoulos with care as a “counselling psychologist” from August 2003. Mr R stated that “prior to the police intervention Dr Stephanopoulos had lived a driven life, accepting an excessive workload, being constantly on call, giving up sport and much of his social life, neglecting his personal relationships and concentrating solely on his professional pursuits”, and that the internet pornography acted as a “diversion from work”, and then an “addiction” [pages 10-11, 159].

Professor Ogloff provided an assessing forensic psychologist statement that Dr Stephanopoulos “had essentially no functional mode of coping with his work circumstances” and “appears to have engaged in the possession of Internet pornography partly as a release from his then stressful and anxious life as a busy neurosurgical registrar” [page 12, 159]. Dr Glaser provided written reports and verbal testimony to the Panel as Dr Stephanopoulos’ treating psychiatrist. Dr Glaser observed that Dr Stephanopoulos had been “working between 180 and 200 hours per fortnight” at the time of the illegal behaviours. In the context of increasing work related distress, Dr Stephanopoulos was described as feeling “really helpless”, and having “lost the capacity to manage distress in more conventional and socially acceptable ways” [page 13, 159].

Dr Stephanopoulos’ own statement was that his workload had been “ridiculous”, and that at the time of the offences he “had been trying to be too good a doctor” [page 9, 159], and that this led to his interest in pornography. A number of additional statements were heard from other witnesses, ranging from ex-work colleagues to friends, also suggesting that Dr Stephanopoulos had been placed in unacceptable circumstances in terms of workload and lack of support.
The basis of Dr Stephanopoulos’ defence to the Panel was that his behaviour was caused by workplace stress, but that no patients had been harmed. If able to return to work as a doctor, he argued that he would not allow himself to become so overloaded, and also that he would receive support from his treating psychiatrist to manage his stress more appropriately. There is an acknowledgement that he was not, at the time of the offences, trustworthy, describing his behaviour as “despicable”. He was not able to recognise that his stated level of stress had overwhelmed him to the degree that he was making use of inappropriate, and in fact illegal, coping strategies. In this context, he could not be considered able to recognise the limitations of his own trustworthiness. He argued that he would be trustworthy in the future, with ongoing professional care, and that there was consequently no future risk to patients.

Dr Stephanopoulos was therefore untrustworthy in terms of being able to reflect on his own limitations and impairments, and the potential impact of these on patient care. No patients were evidenced to be harmed as a result of Dr Stephanopoulos’ distress, but the nature of his work as a neurosurgery registrar does emphasize the potential hazards associated with impairment. Dr Stephanopoulos does not meet the framework’s criteria for extreme untrustworthiness, as there is no evidence in the Reasons for the Decision that Dr Stephanopoulos’ behaviour was repeated after discipline, education or healthcare enabled him to understand the potential impact of his own distress.

7.2.6 Appropriate Communication to Patients and Others Regarding Appropriate Care

Dr Stephanopoulos’ illegal and inappropriate behaviour did not directly involve patients, according to the information available. He deliberately concealed his illegal and inappropriate behaviour from everyone, including patients. In terms of expectations of a doctor, Dr Stephanopoulos described level of distress and preoccupation that would have warranted withdrawal from work and attention to his own health. A trustworthy doctor would be expected to be able to recognise when they are unable to provide safe patient care, or when they are at risk of providing sub-optimal care because of impairment. This may not result in ceasing all practice,
but might, for example, have implications for more complex work or more acute work undertaken as a part of the after-hours duties.

In the eighteen months preceding having to cease work due to his legal charges, Dr Stephanopoulos is stated to have participated in approximately 950 neurosurgical procedures, with approximately 750 of these being undertaken without another doctor present. It seems unlikely, given the levels of distress, exhaustion and preoccupation described in the Panel Hearing, that the care that Dr Stephanopoulos provided in all these procedures was optimal or even acceptable. Dr Stephanopoulos is not stated to have ever excused himself from patient care in the interest of the patient, however. This may have been for a number of reasons; concerns about being seen as less capable, stigma associated with expressing psychological distress, or even financial implications.

Dr Stephanopoulos does not meet the expectations of a trustworthy doctor in terms of being able to communicate his own limitations to those around him, in the interests of patient care. There is no evidence, however, that Dr Stephanopoulos actively deceived patients about his misconduct, nor presented inappropriate sexual conduct to patients as an aspect of their care. He therefore does not meet the criteria for the extremely untrustworthy doctor. Within the expectations of being able to communicate his limitations in terms of trustworthiness, Dr Stephanopoulos is an untrustworthy doctor.
### Components of Trustworthiness

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<tr>
<th>Provision of Competent, Appropriate Care</th>
<th>The Trustworthy Doctor</th>
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<td></td>
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<td>Allows PSM to undermine care of presenting or subsequent health concerns</td>
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<th>Regard for Patient Preferences</th>
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<td></td>
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<td>Is willing to disregard the preferences of patients to further their own interests. This includes patient preferences which may be reasonably inferred (such as a parent’s preference that their child not be harmed). May be willing to force their own preferences by manipulation, coercion, deceit or frank assault.</td>
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<th>Regard for the Patient’s Dependence Upon the Doctor</th>
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<td></td>
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<td>Does not recognise or respond to this dependence, and does not experience it as compelling, even if there are factors contributing to a marked power imbalance.</td>
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<th>Recognition of the limitations of their own trustworthiness, including clinical competence</th>
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<td></td>
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<td>Do not recognise the potential for their health concerns or lack of clinical competence to cause harm, and consequently does not maintain these, nor refer patients appropriately.</td>
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<th>Communication to Patients and Others Regarding Appropriate Care</th>
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<td></td>
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<td>Does not communicate to patients what the limits of their trustworthiness are.</td>
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### 7.2.7 Hearing Outcome

In this context, Mr Ridley’s role initially seemed to be that of a treating practitioner. Although Mr Ridley stated that he “had not treated Dr Stephanopoulos specifically in relation to matters related to his addiction to pornography” [page 10, 159], he did state that “the trauma of the last two years would make it unlikely that he (Dr Stephanopoulos) would return to pornography as a habit” [page 10, 159]. Mr Ridley does seem to offer some testimony as an expert witness, as well as a treating practitioner. His expertise in terms of predicting recidivist sexual misconduct is not stated. His ability to evaluate the likelihood of further sexual misconduct is also unclear given his acknowledgement that he had not evaluated or treated Dr Stephanopoulos for his “addiction to pornography” [159].
Testimony from expert witness Professor Ogloff was that Dr Stephanopouloos may be able to recommence work as a doctor in the future, and that he was not sexually attracted to children. Dr Glaser testified as “a psychiatrist with particular expertise in sex offending and in diagnosing and treating sexual disorders” [159], as well as Dr Stephanopouloos’ treating psychiatrist. Although he was less categorical about whether Dr Stephanopouloos had ever been sexually attracted to children, Dr Glaser did testify that he believed that the risk of Dr Stephanopouloos accessing child pornography again would be “very low” [page 16, 159], based on his willingness to engage in a cognitive behavioural treatment program.

During the Hearing there was also testimony from Dr Stephanopouloos’ colleagues regarding his technical competence as a neurosurgical trainee, and apparent high standards of professional conduct during his training.

The Panel acknowledged in its ruling that “there is a real possibility that at the time of his offending Dr Stephanopouloos may have had some level of sexual attraction toward children” [page 41, 159], but also “the proposition (put forward by expert witnesses) that he is not a paedophile”. The Panel responded by concluding that “exceptional circumstances exist which justify his being permitted in due course to return to practice, subject to rigorous long term conditions” [page 42, 159]. Dr Stephanopouloos’ registration was consequently suspended until March 1 2007, with conditions including not being able to work with children, and psychiatric follow up, being imposed from his return to practice at that time.

7.2.8 Comparison Between Hearing Outcome and Application of the Framework for Trustworthiness in Doctors

The outcome of the Hearing was clearly a serious one for Dr Stephanopouloos. At the time of Dr Stephanopouloos’ Formal Hearing, there was enormous public interest in what conduct had occurred, what criminal charges had been found, and the consequent findings and recommendations of the MPBV [159, 161-163]. Dr Stephanopouloos’ conduct had not directly involved any patients, and it was never suggested that any patients had ever been harmed by him. The issue of whether he was sexually attracted to children, and therefore at risk of harming child patients in
the future, became a major focus of the Hearing, in the absence of any established conduct harmful to children.

The Board had to balance the possibility that Dr Stephanopoulos was sexually attracted to children at the time of his charges with the possibility that he was not, as well as the possibility that he had an enduring sexual attraction to children. An attraction to children in the past, which may recur, as well as an enduring sexual attraction towards children, would both be associated with risk to the public. The Board did seem to acknowledge this risk by imposing “rigorous long term conditions” [page 42, 159]. The Board did, however, also have to consider the rights of Dr Stephanopoulos to practice, and an elevated standard of proof required according to *Briginshaw*, in the context of the very serious consequences for Dr Stephanopoulos of either having his registration suspended, or being de-registered. It is likely that these factors contributed to the recommendations of the Board. If the Board’s only concern was the protection of the public, de-registration would seem necessary.

The Board acknowledged that Dr Stephanopoulos had agreed to cease clinical practice in November 2004, prior to his criminal trial and the Hearing with the MPBV. At the Formal Hearing decision in August 2006, the Board took into consideration this voluntary period of suspension, and extended his suspension until March 2007. The extension was therefore for a period of under nine months from the Formal Hearing decision, and under two years and four months in total [159].

A public outcry followed. The case was extensively reported in the media [161-163], and the Board’s comment that Dr Stephanopoulos was “not a paedophile” received much attention, and was contrasted with the offences found. The Royal Australian and New Zealand College of Surgeons responded by making a public statement that Dr Stephanopoulos would never hold Fellowship of their College [164], and therefore could never qualify as a surgeon in Australia [161].

There was a clear mismatch between the public’s perception of what the Board’s role was, and the Board’s perception. This may well have been due to a perception that the Board’s role was to punish doctors. However, the *Framework for Trustworthiness in Doctors* suggests an additional mismatch. According to the
Framework for Trustworthiness in Doctors, Dr Stephanopoulos’ behaviour was untrustworthy according to four out of five standards of trustworthiness, and extreme untrustworthy according to the fifth criterion of regard for patient preferences.

The public’s perception that Dr Stephanopoulos received a minimal response from the MPBV may be due to public concerns about whether Dr Stephanopoulos was trustworthy, regardless of any further appraisal of direct risk to the community. The Framework for Trustworthiness in Doctors describes reasonable expectations of the community, and is more able to do so in this case than the MPBV’s framework of protection of the public. The community’s expectations of doctors certainly include the expectation that they be trustworthy in terms of the safety of the public, but there are expectations of trustworthiness beyond direct doctor-patient interactions. The doctor is expected to be trustworthy in their role as a doctor.

Dr Stephanopoulos’ registration was automatically reinstated in 2007. At that time he commenced practice as a general practitioner in a rural community, and changed his surname. Dr Stephanopoulos’ return to practice was not publicised, and the process by which he demonstrated his “good character”, as required by the Board, is not on the public record. As I argued with Dr Wilks’ return to practice, the Framework for Trustworthiness in Doctors could offer some clarity in establishing what is required by the doctor for trustworthy character to be established.

7.3 The Case of Dr Lal

In a Formal Hearing held on September 24 and November 17 in 2003, the MPBV considered whether Dr Lal had engaged in “unprofessional conduct” by having been convicted by the County’ Court of Victoria of two offences of common law assault [160].

The Reasons for the Decision, made on December 8 2003, are publicly available online [160]. The facts of the case, as documented by the Board within the Reasons for the Decision, are documented below according to the Framework for Trustworthiness in Doctors.
7.3.1 Clinical Synopsis

At the time of the offences, Dr Lal was working as a general practitioner in a group suburban general practice. Dr Lal owned the practice, where 25 practitioners were employed [page 13, 160].

There were two complaints within this Hearing, from two different pharmaceutical company representatives, Ms Q and Ms E.

On April 23 2001, Ms Q visited Dr Lal’s practice in her capacity as a pharmaceutical company representative. After meeting with doctors at that practice about the drug product she was representing, Ms Q had a conversation with the practice receptionist in the practice lunchroom. In this conversation, Ms Q disclosed that she had separated from her husband. Dr Lal joined this conversation then asked Ms Q into his consulting room to discuss a scientific article [160].

Once they were in Dr Lal’s consulting room, Dr Lal asked Ms Q further about her marriage then asked her on a date. She declined this offer, and Dr Lal’s request that Ms Q accompany him on a “drive” [page 3, 160]. When Ms Q stood up to leave, Dr Lal grabbed her around her waist or upper arms, and repeated his request that she accompany him on a “drive”. Ms Q left and went to her car in the car park outside, with Dr Lal following her until she got into her car and drove away.

Ms Q reported the above interaction to police and Dr Lal was charged with Common law assault. This charge was heard in the County Court of Victoria on December 20 2002, and Dr Lal pleaded guilty. The MPBV received Ms Q’s complaint on February 26 2002, with the Hearing proceeding following resolution of the criminal matters [160].

On March 16 2001, Ms E visited Dr Lal’s practice in her capacity as a pharmaceutical company representative. Ms E met with Dr Lal in his consulting room and initially they discussed the drug product that Ms E was representing. Dr Lal then began to describe his marital breakdown and subsequent loneliness, before asking whether Ms E whether she would like to go out with him. Ms E stood to leave
the room, and Dr E grabbed her right hand with both of his, asking that she not tell anyone that he had asked her out.

Dr Lal then grabbed both of Ms E’s shoulders, and kissed her on the cheek. Ms E attempted to leave the room and Dr Lal held his hand against the door, preventing the door from opening. Ms E became frightened and forced the door open, then left.

Ms E reported the above interaction to police and Dr Lal was charged with Common law assault. This charge was heard in the County Court of Victoria on December 20 2002, and Dr Lal pleaded guilty. The MPBV received Ms E’s complaint on January 21 2002, with the Hearing proceeding following resolution of the criminal matters.

Dr Lal’s legal counsel stated that Dr Lal did not contest the statements of the cases, but wanted to emphasize that Dr Lal had not been charged with a sexual assault charge, and that he believed that the Common law assault charges were “at the very minor end of the spectrum” [160]. On these grounds, Dr Lal’s counsel argued that Dr Lal’s conduct met the criteria for “unprofessional conduct”, but not “unprofessional conduct of a serious nature” according to the Medical Practice Act 1994 [160].

7.3.2 Provision of Competent, Appropriate Care

In considering Dr Lal’s trustworthiness according to whether he was providing competent and appropriate care, there was no suggestion that his care to patients was not competent or appropriate. His illegal behaviour did not directly involve patients, and there was no testimony suggesting that his clinical care of patients at the time of the illegal behaviour was not competent and appropriate. While it could be hypothesized that his behaviour with patients may have been inappropriate in the same way that the complaints from the pharmaceutical representatives was, the complaints in question were not about this.

It is important to note that Dr Lal’s conduct occurred within a workplace setting, and in fact, in the consulting room where he saw patients. Although it could be argued that there was no evidence that his conduct impinged upon the care he provided to his patients, it is also clear that his conduct is not appropriate for the workplace. As I have argued in Chapter Five, competent and appropriate patient care includes
competent and appropriate interactions with other professional staff with whom the doctor must interact in their role as a doctor.

In this Hearing, Dr Lal’s behaviour with patients was not suggested to be less than competent and appropriate. In his interactions with two pharmaceutical company representatives, however, in his role as a doctor, his interactions were neither competent nor appropriate in terms of workplace norms and expectations. These interactions were not, therefore, congruent with trustworthiness.

Dr Lal’s behaviour met the criteria for untrustworthiness in that his conduct was not in keeping with the appropriate, competent conduct of a doctor. There was no evidence presented within the Reasons for the Decision, regarding the two complainants mentioned, that suggested that he was willing to compromise care to maintain his conduct. He did not, therefore, meet the criteria for extreme untrustworthiness, according to these requirements.

Counsel assisting the MPBV, did, however, raise Dr Lal’s previous history of misconduct, and previous Formal Hearing, during this Formal Hearing. It was disclosed that “between 1996 and 1999 Dr Lal had engaged in conduct with seven patients, which brought him to the attention of the Board and culminated in a formal hearing” [page 18, 160]. In summarising the conduct, the Board’s counsel noted that “Dr Lal’s conduct involved inappropriate comments of a social, personal and sexual nature during consultations, inappropriate personal contact outside the consultations and misuse of information during the consultations, attending a patient’s home uninvited and a breach of undertaking to the Board as well as convictions of indecent assault, rape and an attempt to pervert the course of justice in December 2002 in the county court” [page 20, 160].

Dr Lal’s medical registration was subsequently suspended on 6 June 1999, and reinstated with conditions in March 2000. It was under these conditions that Dr Lal was practicing at the time that Ms Q and Ms E made their complaints.

The Board’s counsel stated [page 19, 160] “that there was no dispute that Dr Lal’s conduct was attributable to a medical condition from which he was suffering”. The
Hearing was closed in part at the request of Dr Lal, on “the basis that the evidence included intimate and personal information relating to Dr Lal” [page 7, 160]. This medical condition not named or described during the formal hearing, although expert witness Professor Singh, treating psychiatrist Professor Ball and treating psychologist Professor Kyrios all stated the presence of the medical condition. Professor Singh also referred to “psychosexual immaturity inappropriate for his age and stage of life”, and Professor Kyrios stated [page 9, 160] that “Dr Lal’s social interactive skills often have a lot to be desired and his communication skills are far from adequate”.

7.3.3 Regard for Patient Preferences
Neither of the complainants in this Hearing were patients of Dr Lal’s. If either complainant was a patient it would be obvious that Dr Lal had deliberately disregarded their expressed preferences, and acted in a way that was extremely untrustworthy. Assault is one of the most obvious ways of disregarding the preferences of another, who could generally be assumed to not wish to be harmed. The attempt to detain Ms E against her will was also an obvious demonstration of disregard for her preferences, and if she was a patient, this would be demonstrably extremely untrustworthy.

However, Dr Lal’s behaviour did not directly involve patients. Despite this, it could be reasonably inferred that Dr Lal’s patients’ preferences would reflect those of the general community, which has expectations around adhering to laws, and being a ‘good citizen’. Breaking laws that are associated with protection of the members of the community is clearly contrary to the preferences of the community. Dr Lal’s illegal behaviour, although not directly involving patients, can therefore be seen to be contrary to patient preferences.

For a doctor to behave in such a way that they may be considered untrustworthy according to the Framework for Trustworthiness in Doctors, there must be evidence that the doctor did not seek to understand the preferences of the patient or their family, or did not experience the patient’s expressed preferences as compelling or responded to inappropriate requests, or any combination of these three. Dr Lal
disregarded expressed and reasonable preferences, and therefore acted in a way that was untrustworthy according to the Framework’s expectations.

In considering whether Dr Lal’s behaviour met the standards for extreme untrustworthiness according to the framework, the requirements for this standard are that he disregarded expressed preferences to further his own interests, or attempted to force his own interests. Dr Lal both disregarded the preferences of both complainants, and attempted to both verbally and physically coerce them to further his own interests. This behaviour therefore met the standards for extreme untrustworthiness.

7.3.4 Regard for the Patient’s Dependence Upon the Doctor

Once again, because Dr Lal’s illegal behaviour did not involve patients, it might initially appear that there was no failure of trustworthiness in terms of holding regard for the patient’s dependence upon the doctor. However, as I have argued, the requirement for trustworthiness in terms of regard for patient dependence must considered more broadly than only direct interactions with specific patients. In the same way that the expectation of regard for patient preference extends beyond behaviour conducted with patients for a doctor to be trustworthy, a regard for dependence might also be reasonably expected to extend beyond direct doctor-patient relationships.

The doctor’s role within the community does not excuse the doctor from the expectations of all members of the community, as stipulated by criminal codes. Dr Lal was charged with assaulting the two pharmaceutical representatives. He was able to perpetrate these assaults because he saw them both in his consulting room, where the power imbalance between he and the representatives would have been at its greatest. Dr Lal’s behaviour was not consistent with community expectations of all members in terms of responding to dependence, and he was therefore not trustworthy.

There are some aspects of Dr Lal’s behaviour that could be argued to be extremely untrustworthy. Dr Lal attempted to use his position as a doctor to pressure both Ms Q and Ms E to engage in a sexual relationship with him. Dr Lal arranged for both
women complainants to see him alone in his consulting room. He particularly asked Ms Q to leave the clinic lunch room, where other staff were present, and join him alone in his consulting room. The fact that this behaviour occurred in his consulting room emphasizes the significance of his role as a doctor. Both complainants met with Dr Lal in their capacities as pharmaceutical representatives. Their employment and income was dependent upon being able to establish and maintain positive relationships with doctors. They were both, then, in a relationship where some power imbalance with Dr Lal could be hypothesized.

Dr Lal made physical contact with both Ms Q and Ms E after they refused his advances. These physical contacts resulted in both women being unable to leave Dr Lal’s consulting room as they had indicated that they wished to. By actively physically detaining Ms Q and Ms E in his office, Dr Lal sought to increase the dependence Ms Q and Ms E had upon him. Dr Lal made both women further dependent upon him for their physical safety.

Although Ms Q and Ms E were not Dr Lal’s patients, and were not in a fiduciary relationship with him, it can nonetheless be seen that they are to some degree dependent on him, both in terms of their role as employees of a pharmaceutical company, and then physically, when he acted in a way that was intimidating. Although it would be hoped that both Ms Q and Ms E’s employers would not have unreasonable expectations of them in terms of behaviour that they should have to tolerate from doctors, and they have protection by the laws of the society in which they live, there was some dependence, and an unknown amount of perceived dependence, that Dr Lal should have been aware of.

Dr Lal did not recognise or respond to dependence, or did not experience any dependence as compelling, meeting the standard for untrustworthy conduct. The standard of extreme untrustworthiness requires the doctor to actively exploit dependence for their own gain, not recognise extreme dependency or promote dependency. Dr Lal clearly attempted to further his own interests with no regard for any dependence present. Beyond this, by attempting to coerce both women to accede to his wishes by using physical intimidation, Dr Lal has acted in a way that meets the standards of extreme untrustworthiness.
7.3.5 Recognition of the limitations of their own trustworthiness, including clinical competence

Dr Lal’s illegal and inappropriate behaviour did not directly involve patients. He attempted to conceal his inappropriate behaviour, asking Ms Q and Ms E not to reveal his behaviour to anyone. In addition to this, during his Formal Hearing, his psychologist, Professor Kyrios, acknowledged that Dr Lal had not disclosed any information about the interactions with Ms Q or Ms E. This seems particularly remarkable given Dr Lal’s previous sexual misconduct, and his previous contact with the MPBV.

During the Formal Hearing it was acknowledged that Dr Lal had a mental illness, and this was suggested to have some causative role in both his conduct associated with this Hearing, but also conduct which led to a previous Formal Hearing in 2000. As a result of the Formal Hearing in 2000, in which it was found that Dr Lal had had inappropriate sexual relationships with seven female patients, comprehensive conditions reflecting Dr Lal’s health condition were put in place. Dr Lal was consequently undoubtedly aware of the limitations of his own trustworthiness, including clinical competence.

A trustworthy doctor would be expected to be able to recognise when they are unable to provide safe patient care, or when they are at risk of providing sub-optimal care because of impairment. An untrustworthy doctor does not recognise the potential for their health concerns or lack of clinical competence to cause harm. Dr Lal’s conduct was not trustworthy. Dr Lal claimed retrospectively to be experiencing a relapse of his health condition, but stated that he had not recognised this at the time. This therefore meets the standard for untrustworthy conduct.

Dr Lal’s conduct occurred in the context of previous professional sexual misconduct, however, which was partially attributed to a medical condition. The standard for extreme untrustworthiness includes not recognising the potential for their health condition or lack of clinical competence to impact upon patient care, despite previously having been informed about this, or repeatedly engaging in professional sexual misconduct despite feedback regarding the inappropriateness of this.
7.3.6 Appropriate Communication to Patients and Others Regarding Appropriate Care

Dr Lal does not meet the expectations of a trustworthy doctor in terms of being able to communicate his own limitations to those around him, in the interests of patient care. Dr Lal actively sought to persuade both women not to disclose his behaviour to others, and acted deceptively by asking both women to meet with him under the pretext of discussing their sales product.

There is no evidence, however, that Dr Lal actively deceived patients about his misconduct, nor presented inappropriate sexual conduct to patients as an aspect of their care. He therefore does not meet the criteria for the extremely untrustworthy doctor. Within the expectations of being able to communicate his limitations in terms of trustworthiness, Dr Lal is an untrustworthy doctor.
<table>
<thead>
<tr>
<th>Components of Trustworthiness</th>
<th>The Trustworthy Doctor</th>
<th>The Untrustworthy Doctor</th>
<th>The Extremely Untrustworthy Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of Competent, Appropriate Care</td>
<td></td>
<td>Allows PSM to undermine care of presenting or subsequent health concerns</td>
<td></td>
</tr>
<tr>
<td>Regard for Patient Preferences</td>
<td></td>
<td>Is willing to disregard the preferences of patients to further their own interests. This includes patient preferences which may be reasonably inferred (such as a parent’s preference that their child not be harmed). May be willing to force their own preferences by manipulation, coercion, deceit or frank assault.</td>
<td></td>
</tr>
<tr>
<td>Regard for the Patient’s Dependence Upon the Doctor</td>
<td></td>
<td>Is aware of the dependency, and actively exploits this for their own gain. Do not recognise extreme dependency, due to serious illnesses. May even seek to increase the dependency to promote their own gain. For example, inappropriate prescription of drugs of dependency.</td>
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<tr>
<td>Recognition of the limitations of their own trustworthiness, including clinical competence</td>
<td></td>
<td>Despite being informed about the potential for their health concerns or lack of clinical competence to impinge upon patient care, do not act to maintain these. May misrepresent their competence to promote PSM, or repeatedly engage in PSM despite feedback regarding the ineffectiveness of this.</td>
<td></td>
</tr>
<tr>
<td>Communication to Patients and Others Regarding Appropriate Care</td>
<td>Does not communicate to patients what the limits of their trustworthiness are.</td>
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### 7.3.7 Hearing Outcome

The MPBV noted the expert evidence that Dr Lal’s acts of misconduct were “to a significant extent attributable to his medical condition and that his conduct might have been beyond his control” [page 19, 160]. Despite Dr Lal’s arguments to the contrary, the Board stated that “the incidents were not trivial in that they involved restraint of the two women, engaging in a (sic) conduct of sexual kind that was not
welcome and not consented to and constituted assaults which the County Court treated as serious” [page 20, 160].

The final section of the Reasons for the Decision, the Determination of the Panel, describes Dr Lal also having been found guilty in the County Court on 20 December 2002 of indecent assault, digital rape and attempting to pervert the course of justice. These charges were related to conduct that had occurred six years previously with a female patient.

The Board cancelled Dr Lal’s registration, but noted his engagement in attempts at rehabilitation, and in this context did not set a minimum period of time prohibiting Dr Lal from reapplying for re-registration.

In September 2006 Dr Lal applied to the MPBV for re-registration. This application was declined on the grounds that “Dr Lal’s character is such that it would not be in the public interest to allow him to practise as a registered medical practitioner; and Mr Lal has been found guilty of offences where his suitability to practise as a medical practitioner is likely to be affected or where it is not in the public interest to allow him to practise because of the finding of guilt” [page 2, 164].

Mr Lal appealed this decision through the Victorian Civil and Administrative Tribunal and was subsequently granted registration with conditions including those intended to “reduce the risk of a relapse (by limiting contact hours, and hence the associated stress, and providing for appropriate and ongoing professional support)” and those intended to “protect the public in the event of a relapse (by active monitoring and supervision, and by restricting Mr Lal’s clinical contact to male patients, aged sixteen years and over)” [page 32, 164].

A public outcry ensued [165-168].

7.3.8 Comparison Between Hearing Outcome and Application of the Framework for Trustworthiness in Doctors

The outcome of the Hearing was clearly a serious one for Dr Lal. At the time of Dr Lal’s Formal Hearing, there was enormous public interest in what conduct had
occurred, what criminal charges had been found, and the consequent findings and recommendations of the MPBV [165-168]. Following his re-registration on appeal to the Victorian Civil and Administrative Tribunal, the publicity was enormous. The focus was particularly upon his history of being found guilty of rape, as evidenced by newspaper headings such as “Rape doctor Sabi Lal allowed to practise” [165].

The split between the MPBV and the Victorian Civil and Administrative Tribunal was in the public eye, with the MPBV stating that it believed that the Victorian Civil and Administrative Tribunal had “failed to take into account the effect re-registering Dr Lal would have on public confidence in the medical profession” [164] to which the Victorian Civil and Administrative Tribunal responded “Public confidence is not turned on and off like a switch” [166].

Again, this case demonstrates the limitations of the MPBV’s role in terms of acting “to protect the public” under the Health Professions Registration Act 2005, and the discordance of these limitations with reasonable community expectations. The public were clearly concerned that a doctor found guilty of rape could continue to practise, regardless of what measures were put in place to protect the public.

This discordance is highlighted by the examination of Dr Lal’s conduct using the Framework for Trustworthiness in Doctors. Dr Lal’s conduct met the standards for extreme untrustworthiness in three of the five requirements, and untrustworthy conduct in the remaining two. His conduct was not trustworthy, regardless of the potential underlying causes, and in a number of ways it was extremely untrustworthy. Without this framework, the MPBV was reliant upon demonstrating a potential harm to the community to justify not re-registering Dr Lal. Although protecting the public was obviously in the community’s interest, the community clearly sought a higher moral standard of their doctors beyond not being dangerous. The Framework for Trustworthiness in Doctors is consistent with this reasonable expectation.

7.4 Conclusions

In Chapter Six, the Framework for Trustworthiness in Doctors was applied to two cases of professional sexual misconduct involving patients. The ability of the Framework for Trustworthiness in Doctors to describe cases of professional sexual
misconduct according to the ways that trustworthiness had been breached was documented. By demonstrating the ways that reasonable community expectations of trustworthiness have been breached, the Framework for Trustworthiness in Doctors demonstrates harms to individual patients and the community, consistent with the requirements of the MBA’s mandate to protect the public.

In this Chapter, the Framework for Trustworthiness in Doctors has been used to examine the cases of two doctors found guilty of criminal conduct by criminal courts. The conduct was sexual in nature, but did not directly involve patients in either of the Formal Hearings described. Dr Lal had previously been charged with multiple charges of professional sexual misconduct involving patients, and a criminal charge of rape in association with one of these charges, but the charges dealt with in the Formal Hearing described did not pertain to patients.

In the Hearings of Dr Stephanopoulos and Dr Lal, the MPBV responded according to its mandate to protect the public. For Dr Stephanopoulos, a potential risk of harm to patients was difficult to establish given the nature of his offences. Removal of risk if doubt persisted as to whether he was sexually attracted to children could readily be managed by preventing him from having any contact with child patients. When the MPBV made recommendations accordingly, however, these recommendations were inconsistent with community expectations.

The community’s reasonable expectation of its doctors is that they be trustworthy. Trustworthiness in doctors guarantees the MBA’s current standard that the public be protected. Some doctors who are argued to pose no direct risk to the community, in contrast, do not meet the standards of trustworthiness. The Framework for Trustworthiness in Doctors enables a broader understanding of the ways that these doctors may cause harm to the community by damaging the trustworthiness of the medical profession.

The case of Dr Lal further demonstrates the dilemma faced by the MPBV. Dr Lal’s successful appeal to the Victorian Civil and Administrative Tribunal was justified on the basis that conditions could be put in place to ensure that he posed no further risk to the public. The requirement to protect the public was therefore able to be met.
Despite this, the MPBV expressed concern about Dr Lal’s re-registration, citing the impact of his registration upon the public’s perception of the medical profession.

The MPBV anticipated the discomfort of the community in response to Dr Lal’s re-registration, and expressed this in terms of the way the profession as a whole may be viewed. The community’s response indicated that the standard of “being protected” was inadequate. The community’s expectation of their doctors is of trustworthiness. It could be argued, as the MPBV did, that being protected includes the standard of trustworthiness, and that harms may result if the community perceives the medical profession to be untrustworthy. In the absence of standards defining what trustworthiness is, this argument is likely to remain unsuccessful.

The Framework for Trustworthiness in Doctors provides both a standard for conduct that is consistent with current reasonable community expectations, and a classificatory system for considering the ways in which unacceptable conduct deviates from the standards of trustworthiness.
Chapter Eight: Implications and Conclusions of the Framework for Trustworthiness in Doctors

8.1 The Framework for Trustworthiness in Doctors

In this project I have expressed concern about current responses to professional sexual misconduct, in the absence of a cogent ethical framework. I have argued that use of such a framework, which reflects reasonable community expectations, is essential for consideration of the ethical dimension of professional sexual misconduct. My concerns, and this project, are not intended as criticism of the Medical Board of Australia, nor previous state and territory medical boards. Rather, I suggest that there are parallels in the delay in developing an ethical framework for considering professional sexual misconduct by the medical profession, and the relatively late interest in trust and trustworthiness by philosophy academics.

Professional sexual misconduct is ethically problematic because of the power imbalance inherent to the doctor-patient relationship and the medical profession’s sanctioned role in the community. It has been suggested that philosophy’s relatively late interest in trust and trustworthiness may be due to its emphasis on contractual relationships between equals [22, 23] with trust and trustworthiness having greater significance for those relationships characterised by power imbalance. Both professional sexual misconduct and trustworthiness have particular significance for those who are most likely to experience a power imbalance, the most vulnerable members of our community.

I have argued that professional sexual misconduct remains a major concern for the medical profession. The prohibition of professional sexual misconduct is now well established, but the available research into reporting rates suggests that professional sexual misconduct is not only persisting, but that it may be persisting at rates unaltered by the prohibition, or even increasing. Research into the incidence of professional sexual misconduct is complex, with under-reporting suspected in reporting studies and surveys of doctors. The persisting rates of professional sexual misconduct before medical regulatory bodies have therefore been argued to be likely underestimates of the community prevalence. Professional sexual misconduct is
demonstrably persisting in Australian and international settings which have processes established for its detection through reporting.

Professional sexual misconduct has been shown to be harmful to patients. Patients are potentially harmed by not receiving the healthcare for which they have presented to a doctor, and also in terms of their mental health, with a well described syndrome of distress characterised by ambivalence.

The harms which result from professional sexual misconduct are not limited to those sustained by patients directly involved in professional sexual misconduct. I have argued that cases of professional sexual misconduct, once reported, have implications for the community’s perceptions of the medical profession. The community is subsequently harmed, in terms of its ability to seek health care with confidence regarding the medical profession’s professionalism. The medical profession is harmed in terms of the community’s perceptions of it.

These later harms occur once the professional sexual misconduct has been reported to a medical regulatory body. Within Australian communities, the Medical Board of Australia, previously state and territory medical boards, have been charged with the responsibility of protecting the public. In situations of professional sexual misconduct, this includes considering the suitability of the doctor to continue practicing, or if not suitable for practice at that time, when they may reapply to practice. I have argued that the responses of medical regulatory bodies have been strongly influenced by illness models in their considerations of individual cases of professional sexual misconduct. The use of illness models is partly driven by the doctors about whom the complaints of professional sexual misconduct are made, who are understandably motivated to maintain their right to practice, and therefore present an explanation for their conduct that includes a treatable, reversible cause.

However, the use of illness models by medical regulatory bodies is also driven by the prominence of these models in contemporary understandings of professional sexual misconduct. Glen Gabbard’s classification of doctors who violate boundaries with patients has been enormously influential in promoting a psychodynamic understanding of the motivating factors for doctors who do violate boundaries with
their patients. However, this model was only ever presented by Gabbard for use after the evaluation of professional sexual misconduct by a medical regulatory body, and in planning the potential rehabilitation of the doctor.

In Australian medical regulatory board hearings, at least fifty percent of doctors accused of professional sexual misconduct make use of a psychiatrist in consideration of their conduct [15]. Use of an illness model in considering professional sexual misconduct is associated with two main concerns. Firstly, use of a psychodynamic consideration of the professional sexual misconduct while the conduct is being considered has never been shown to predict recidivism or non-recidivism. Gabbard argued that his model of boundary violating doctors did suggest higher and lower risk of recidivism amongst the different sub-types of doctors, but not that the model could be used during the evaluation of cases of professional sexual misconduct to do this. Doctors appearing before medical regulatory boards, accused of professional sexual misconduct, will be highly motivated to ensure their ability to continue practice. Assessment by a treating doctor or expert witness who is attempting to understand the doctor’s conduct in terms of their psychodynamic motivation is highly likely to be biased by the doctor’s preference to maintain practice. There are no cases reported by Australian medical boards in which a doctor has disclosed their own psychopathy, nor inclination to recidivist behaviour, even though both have been repeatedly demonstrated retrospectively.

In addition to being ineffective in predicting recidivism, I have argued that the use of illness models is inappropriate during the consideration of cases of professional sexual misconduct as these models promote an appearance of cronyism. For an illness model to be employed in the considerations of medical regulatory bodies, there must be testimony by doctors to this effect. The effect of doctors providing testimony for other doctors which results in an appearance of reduced responsibility is potentially to undermine either the public's perception of the medical profession, or the medical profession’s prohibition on professional sexual misconduct. An illness model defines the performance of doctors according to their own health, rather than according to the expectations of the community.
I have consequently argued that professional sexual misconduct must also be considered according to an ethical model. The most widely used established ethical model of professional sexual misconduct is that which argues that professional sexual misconduct violates the requirement of informed consent. I criticise the capacity of this ethical framework to examine professional sexual misconduct for the medical profession.

In particular, the requirements of informed consent; disclosure of appropriate information, competence in decision-making, and voluntarism, imply a decision making process in which the responsibility is shared. That is, although it is the doctor’s responsibility to provide appropriate information, and ensure that the patient has competent decision-making ability and is free from coercion, the patient also has responsibilities to ensure that they ask questions as required to understand and clarify the information provided, and to indicate any preferences or concerns that they may have. Patients have responsibilities in all interactions with their doctors. These responsibilities associated with “the sick role”, and include the provision of correct information about their health, and the expectation of recovery. This model of shared responsibilities is appropriate in informed consent decisions in health care.

Professional sexual misconduct occurs in the setting of health care, but a model implying shared responsibilities is not appropriate. The responsibility for professional conduct lies with the doctor, and cannot be shared with the patient. The doctor is responsible for their conduct regardless of the conduct of the patient. This is in contrast with the expectations of informed consent, when, for example, the doctor cannot unilaterally obtain informed consent if the patient does not take up their responsibilities to express any difficulties understanding the information being provided, or ask questions to express their concerns, or even to refuse the procedure. The model of shared responsibility cannot apply to professional sexual misconduct, because regardless of the patient’s conduct, the doctor is responsible for maintaining the prohibition on sexual conduct.

An informed consent framework is also inappropriate for understanding the prohibition on professional sexual misconduct because it implies some impairment on behalf of the patient if they are unable to provide a voluntary consent to a sexual
relationship with their doctor. That is, the tenet of the informed consent framework and its justification of the prohibition on sexual relationships between doctors and their patients is the argument that there is an inherent power imbalance that is present in all doctor-patient relationships, and that this power imbalance renders the patient unable to make a free consent (or refusal) to the sexual relationship proposed by their doctor. In response to this argument, some patients have suggested that this position is both paternalistic and inappropriate in the more modern age of consumer-driven health care.

The use of an informed consent framework in the ethical description of professional sexual misconduct does, then, imply that the patient is somehow incompetent to make an informed consent or refusal. As well as leading to contrary arguments about the actual competence of the patient, this framework has also led many authors to explore situations where no such power imbalance may exist (when the patient is themselves a doctor, or when the doctor-patient relationship was brief and superficial and past). I argue that whether the patient can consent or not, sexual relationships between doctors and their patients are significantly problematic to the extent that the prohibition is justified. The informed consent framework does not allow an understanding of the ways in which this conduct is problematic, and in fact suggests a level of coercion that is discordant with both the subjective experience of patients, and also the community’s expectations of health care based on partnership between doctors and their patients.

The informed consent framework is also problematic in that it does not allow consideration of the ‘slippery slope’ of conduct which often precedes, and contributes to professional sexual misconduct. Informed consent, as an ethical framework, may be applied to an individual treatment or procedure. It is able to be usefully applied to treatments which are distinct from other care, and in which the potential risks and benefits can be anticipated and even estimated in likelihood.

The distinction between what the patient experiences as their standard care, and the professional sexual misconduct, may be impossible for the patient to understand. Certainly, in some cases, the professional sexual misconduct may be abrupt in onset and very separate from care. Often, however, the professional sexual misconduct is
preceded by progressive deviations from standard care that are so subtle that the distinction between these and the professional sexual misconduct may be imperceptible to the patient, as well as to other doctors.

Similarly, it may be impossible to predict and understand the risks associated with professional sexual misconduct, particularly during the period of progressive deviations from standard care. Although the majority of patients are harmed by professional sexual misconduct, it has never been demonstrated that all are, and there are no risk factors established suggesting which patients may be more likely to be at risk of substantive harms. It could be hypothesized that those patients described by Quadrio [46], with earlier developmental experiences of sexual abuse, may be more prone to be harmed by professional sexual misconduct. Quadrio has suggested very high rates of serious harms in this group following professional sexual misconduct. However, patients with these risk factors may be particularly unable to anticipate the harms associated with professional sexual misconduct. Similarly, patients who believe that that they are “in love” with their doctor may totally disregard any potential risks to this relationship. Loss of the treatment usually associated with the doctor - patient relationship, may be associated with totally unpredictable sequelae for all, and this also undermines the ability of informed consent to be used as an ethical framework in considering professional sexual misconduct.

Use of an informed consent framework in considerations of professional sexual misconduct offers only a categorical classification of professional sexual misconduct. Informed consent has either occurred, or not. This framework does not offer guidance in terms of the severity of professional sexual misconduct. Given that the central argument against professional sexual misconduct according to the informed consent framework is the power imbalance inherent to all doctor - patient relationships, the informed consent framework does not offer guidance in terms of classifying differing ways in which the professional sexual misconduct occurred. Identifying the ways that the professional sexual misconduct occurred, according to this framework, cannot be used as a subsequent tool to guide interventions to either prevent or respond to professional sexual misconduct.
Finally, informed consent is itself reliant upon the presence of trustworthiness in the doctor. The untrustworthy doctor may not offer adequate or accurate information, or respond appropriately to the patient’s requests for information, prioritising their preferences. Informed consent is therefore a secondary ethical framework, dependent upon the presence of that of trustworthiness. Similarly, if informed consent is to be used as a framework in considering professional sexual misconduct, it assumes the presence of trustworthiness in the doctor. Professional sexual misconduct assessed as failures of informed consent may well be failures of trustworthiness, with the lack of trustworthiness the primary ethical concern, and the failure of informed consent only a consequence of this. Use of a framework which identifies the primary ethical concerns is preferable to one dependant on others.

I argue that professional sexual misconduct is appropriately and usefully considered according to an ethical framework, in comparison to a psychodynamic one, when being assessed and responded to by medical regulatory bodies. The ethical principle most frequently used in considerations of professional sexual misconduct is that of informed consent, and I am critical of this in terms of its ability to guide an ethical framework for consideration of cases of professional sexual misconduct.

I acknowledge that it is not unreasonable to base a prohibition on the ethical argument that professional sexual misconduct is a failure of informed consent. Social prohibitions can be based on the social implications of conduct, and do not require the conduct to be unethical for all concerned. The informed consent argument is problematic as an ethical justification for all instances of professional sexual misconduct, as it does not illustrate the wrongfulness in all cases of professional sexual misconduct, is paternalistic in some instances by suggesting that patients are in some way incompetent, cannot be used to examine antecedents to professional sexual misconduct, can offer only a categorical framework of professional sexual misconduct, and is based upon the principle of trustworthiness. Consequent to these weaknesses, I propose an alternate ethical framework, based on the expectation of rich trustworthiness in doctors.

Although the importance of trust within the doctor-patient relationship is almost universally acknowledged for good medical care, substantially less consideration has
been given to what the expectations must consequently be for trustworthiness. I argue that only thicker versions of trustworthiness are appropriate for doctor-patient relationships, are consistent with modern health care consumer expectations, and also the ways that the medical profession presents itself.

I do not disagree that thinner definitions of trust, and correspondingly trustworthiness, certainly have some validity for particular trust exchanges, and that trust might reasonably be described as *trusts*, with variation between trust expectations, and trustworthiness requirements, depending on the context. *For situations in which there is a significant power imbalance, the trust exchange is socially sanctioned, or the truster is entrusting X which has high personal value, the most appropriate definition of trust is a thicker version of trustworthiness.*

With the argument that thicker trustworthiness, with its expectations of the trustee to prioritise the preferences of the truster, is most appropriate when considering the doctor-patient relationship, there are significant implications for both the trustee and truster. Thicker versions of trustworthiness place higher demands on the trustee doctor, whilst at the same time raising substantial challenges for the potential truster patient, who seeks to assess whether thick trustworthiness is present. Thicker trustworthiness is the only appropriate model of trustworthiness for the doctor-patient relationship, but the requirement for thick trustworthiness raises challenges for both doctor and patient.

Rich trustworthiness appropriately has expectations of the trustee (doctor) to be able to indicate their own limitations to the truster. In this way, the burden of assessing the trustworthiness of the doctor lies not only with the patient. The moral responsibility lies with the doctor, as the prospective trustee, to be able to correctly signal their own trustworthiness. Thinner or risk assessment views of trustworthiness are incompatible with the patient’s capacity to perform a risk assessment of the doctor’s trustworthiness and are excessively demanding of the patient.

Thin versions of trustworthiness do not require respect for the patient’s preferences. Thicker versions of trustworthiness require prioritisation of the patient’s preferences,
and this is most in keeping with modern standards of informed consent, and their prioritisation of the Subjective Standard in informed consent.

Thinner versions of trust are incompatible with the expectations that patients have not only of their doctors’ trustworthiness, but of the underlying factors which motivate this. That is, that the patient’s expectations of their doctor are not only that they will not act according to very thin definitions of trustworthiness, but also that they will be motivated by more than the minimal factors required in these definitions of trustworthiness. I therefore argue that patients not only expect that their doctors act in keeping with thicker versions of trustworthiness, but that they have underlying motivations in keeping with thicker trustworthiness.

Rich trustworthiness extends beyond the requirements of more established versions of thick trustworthiness and demands that the trustee be able to signal the limitations of their own trustworthiness. Application of the standards of rich trustworthiness to the doctor-patient relationship results in the following requirements of the doctor.

1. The doctor must provide competent and appropriate care
2. The doctor must have regard for the patient’s preferences
3. The doctor must have regard for the patient’s dependence upon the doctor
4. The doctor must recognise the limitations of their own trustworthiness, including the limitations of their own clinical competence
5. The doctor must be able to make appropriate communication to patients and others regarding appropriate care

I compare use of a trustworthiness framework with an informed consent framework when considering professional sexual misconduct. I argue that the trustworthiness framework is able to address many of the deficits of the informed consent framework. I argue that according to a trustworthiness framework, trustworthiness is the responsibility of the medical practitioner, whilst within an informed consent framework, the responsibility is inappropriately shared by the patient.

I also argue that use of a trustworthiness framework does not require that the patient be deemed ‘incompetent’ in any way. As a result, arguments for the competing perspective that some patients may indeed be able to make an informed consent to
a sexual relationship with their doctor cannot be used to demonstrate that professional sexual misconduct is ethically acceptable. In the theoretical cases in which a patient is able to make an informed consent to a sexual relationship with their doctor, the use of a trustworthiness framework will still enable consideration of the ways in which that doctors who engage in professional sexual misconduct are deviating from the standards of trustworthiness.

A framework based upon the expectation of trustworthiness enables consideration of professional sexual misconduct and the ‘slippery slope’, whilst examination of the slippery slope as a failure of informed consent is not useful. The standards of rich trustworthiness require that the doctor be able to reflect on the limits of their own trustworthiness, and communicate this to their patients. Any progression towards the ‘slippery slope’, even if well short of professional sexual misconduct, should then be able to be identified by trustworthy doctors, and responded to appropriately.

Examination of professional sexual misconduct according to informed consent will only ever offer a categorical classification. In contrast, a framework based upon the standards of trustworthiness enables examination on a continuum, with attention to particular conduct. Informed consent either occurs, or does not. Trustworthiness may be present to different degrees, and breaches may occur in a greater number of ways. A framework based upon the standards of trustworthiness can then offer a richer consideration of the ways and degrees to which the conduct of the doctor deviated from that expected, than a framework based upon the expectation of informed consent. This richer understanding may in turn have implications for the complexity of cases which can be considered, and the range of implications which may be drawn from the framework.

A framework based upon the expectation of informed consent will itself be based upon the expectations of trustworthiness. Use of trustworthiness, then, becomes the preferred ethical framework as it is not secondary to another. Professional sexual misconduct may be considered, then, according to one framework, rather than needing to be considered firstly according to one framework, then additional underlying ethical frameworks.
The Framework for Trustworthiness in Doctors defines standards of trustworthy conduct, untrustworthy conduct, and extremely untrustworthy conduct for doctors according to the five requirements for trustworthiness; the doctor must provide competent and appropriate care, the doctor must have regard for the patient’s preferences, the doctor must have regard for the patient’s dependence upon the doctor, the doctor must recognise the limitations of their own trustworthiness, including the limitations of their own clinical competence, and the doctor must be able to make appropriate communication to patients and others regarding appropriate care. I describe the ways that requirements are breached in professional sexual misconduct, and the different degrees these breaches may occur to.

I have examined four cases of professional sexual misconduct according to the Framework for Trustworthiness in Doctors. Two of these cases were associated with a direct risk to patients, and for two there was established criminal behaviour with a less readily demonstrated direct risk to patients. I have argued that these examinations demonstrate the framework’s consistency with both the Medical Board of Australia’s mandate to protect the public, and also reasonable community expectations of the medical profession. I have argued that the framework is particularly valuable as a tool which demonstrates risk to the community in cases of professional sexual misconduct which do not directly involve patients.

8.2 Functions of the Framework

I propose five potential uses of the Framework for Trustworthiness in Doctors.

8.2.1 Framework for Trustworthiness in Doctors as a Normative Standard

The first potential use of the Framework is as a normative standard for expected competencies for all doctors. The expectation of trustworthiness in doctors is consistent with reasonable community expectations and the expressed expectations of the MBA. The most appropriate definition of trustworthiness has been debated in the philosophical literature, with many different definitions in operation within philosophy. It is likely that at least as many understandings of what trustworthiness is are operating in the community which receives healthcare, as well as the medical profession which participates in the provision of healthcare.
Although there may be many different understandings of trustworthiness in the philosophical literature, I have argued that the standards of rich trustworthiness are the only ones appropriately applied to the medical profession. By establishing what these standards are, there are opportunities for a greater shared understanding of what conduct is expected of doctors, with an emphasis on what competencies must be valued and maintained. Communication of these competencies could assist in both undergraduate and post graduate medical education around professional standards. This Framework may assist doctors to understand the underlying principles which justify the expectations of professional codes. The Framework for Trustworthiness in Doctors could be used in education to explain the principles underlying the prohibition of professional sexual misconduct, as well as other forms of misconduct.

At the current time, medical education about ethics tends to be dichotomised into two forms of teaching; either a focus on very general ethical principles and concepts, or a focus on very specific examinations of ethical dilemmas, and the associated professional codes.

One of the more prominent examples of general ethical principles and frameworks is that of Beauchamp and Childress [102]. According to this framework, four ethical principles (beneficence, non-maleficence, respect for autonomy and justice) are prioritised, and students are encouraged to use these principles to respond to ethical dilemmas. This framework has been invaluable for medical education as an introduction both to ethical principles, and the challenges associated with application of ethical frameworks to ethical dilemmas. This framework encourages medical students or doctors considering an ethical dilemma to consider the dilemma from different ethical perspectives.

The Beauchamp and Childress ethical framework does not claim to offer definitive answers for ethical dilemmas, and therefore no level of inter-rater reliability. Four different individuals, all using the Beauchamp and Childress framework, may arrive at different ethical ‘solutions’ to the same dilemma, depending the combinations of beneficence, non-maleficence, respect for autonomy and justice which are
prioritised. Indeed, it could be argued that, depending on the number of potential outcomes available to the ethical dilemma, that any one of these could be recommended using the Beauchamp and Childress framework. Teaching based on this framework may, nonetheless, be very effective in promoting an awareness of ethical principles, and awareness in the individual participants of the ways that they apply these to dilemmas.

In contrast to ethics education based on such a framework is education based upon examination of very specific dilemmas unique to the profession, with reflection on the associated professional guidelines and codes. An example would be the range of training programs developed for medical students and doctors regarding preventing sexual misconduct [169-172]. These training programs contrast with the above teaching in that there is a defined outcome that is the assumed desirable one by the program. For individuals who have considered professional sexual misconduct and are in agreement that it is unacceptable, these training programs may aid in development of their understanding of the area, and skills for prevention.

Use of the Framework for Trustworthiness in Doctors offers a connection between general ethical principles such as not doing harm, and particular ethical dilemmas that the student or doctor not wishing to do harm may face. The Framework explicitly describes the ways that the student or doctor may avoid doing harm, for example, by describing the standards of trustworthiness. The Framework for Trustworthiness in Doctors offers greater guidance concerning the implications of the doctor’s role for their ethical conduct. It will usefully guide considerations of ethical dilemmas in a way that general ethical principles may not, through an emphasis on trustworthiness.

### 8.2.2 Examination of the Ways and Degrees to Which the Standards of Trustworthiness Have Been Breached in Cases of Professional Sexual Misconduct

I have, in the body of this project, described my concerns about the ways in which cases of professional sexual misconduct are currently responded to. In particular, I have argued that the Medical Board of Australia’s declared role of protecting the public is congruent with a Consequentialism ethical framework. I suggest that in
practice, the frequent use of a psychiatric illness defence alone is inconsistent with the initially proposed use of the frameworks developed to promote an understanding of doctors engaged in professional sexual misconduct, and that use of these frameworks is associated with at least the appearance of cronyism.

These frameworks have never been shown to predict recidivism, and are therefore not consistent with the Medical Board of Australia’s declared role of protecting the public. Use of illness models in considering doctors engaged in professional sexual misconduct is consistent with a rights-based approach for the doctor, with emphasis on their right to practise. The *Briginshaw Principle* is also in use in all Medical Board of Australia Hearings, and this legal requirement emphasizes the seriousness of deregistration for doctors found guilty of professional sexual misconduct. The *Briginshaw Principle* is again consistent with a rights-based approach for the doctor.

I have consequently argued that there is potential conflict between the declared Consequentialism framework of the MBA and the rights-based approaches in place. I have also argued that the ethical frameworks currently in use regarding professional sexual misconduct offer little guidance regarding how to resolve this conflict. I have therefore proposed the *Framework for Trustworthiness in Doctors* as a tool for examining the moral conduct of doctors who have engaged in professional sexual misconduct.

Ultimately, the value of the framework will be determined by the direction in which medical regulatory boards move in their responsiveness to community expectations, as well as how community expectations change over time in terms of expectations of the medical profession. The age of self-regulation is over for the medical profession. The medical profession must engage in both setting appropriate standards of conduct for its members, as well as the appropriate responses when those standards are breached. Failure to engage with these processes will leave their development to other groups, and communicate to the community that doctors truly cannot be trusted.
8.2.3 Examination of the Ways and Degrees to Which the Standards of Trustworthiness Have Been Breached in Cases of Non-Sexual Professional Misconduct

In this project I have examined the ways in which professional sexual misconduct breaches the standards of trustworthiness, and demonstrated that these breaches can be demonstrated on the Framework for Trustworthiness in Doctors. If the Framework is able to form a normative standard, it may also be used for the examination of non-sexual professional misconduct.

Other forms of professional misconduct may occur either separately from professional sexual misconduct, or in association with it. Although examining this conduct according to the Framework for Trustworthiness in Doctors is beyond the scope of this project, I suggest that if professional conduct of any form deviates from the standards of trustworthiness, it may be examined according to the Framework described. In the cases I have described, the case of Dr Fitzgerald included reference to inappropriate prescribing, and the case of Dr Wilks included reference to a breach of confidentiality. Both of these cases of non sexual professional misconduct were able to be considered using the Framework for Trustworthiness in Doctors, according to the ways that the standards of trustworthiness were breached.

8.2.4 A Framework to Assist in Useful Responses for the Rehabilitation of Doctors Who Have Engaged in Professional Sexual Misconduct

The Framework for Trustworthiness in Doctors could be used, as above, to enable examinations of cases of professional sexual misconduct when these cases are being considered by a medical regulatory body. In these examinations, the Framework will enable consideration of the ways that specific cases of professional sexual misconduct have deviated from the standards of trustworthiness.

The Framework’s different categories result from different ways that the standards of trustworthiness have been breached, and the degrees to which these standards have been breached. The different ways, and degrees, of deviating from these standards will have implications for any rehabilitation being considered for the doctor. This rehabilitation may be mandated by the medical regulatory body to be
confident that the doctor may maintain their right to practise, or alternately, that they may regain their right to practise in the future, if their registration has been cancelled.

For doctors found untrustworthy on the basis that they have not provided competent or appropriate care, there will need to be an understanding reached on that doctor's behalf, that sexual relationships between doctors and patients may never form a part of appropriate and competent care, and that these relationships undermine such care. There may be instances of professional sexual misconduct in which specific skills or knowledge deficits are coincidental. Given the now established understanding that professional sexual misconduct is prohibited, it is unlikely that a deficit in knowledge could be causative of the inappropriate relationship.

Doctors found to have been extremely untrustworthy on this standard, and willing to provide inappropriate, unsafe, or even illegal care to maintain professional sexual misconduct must be regarded more cautiously.

Doctors who have been found untrustworthy by holding inadequate regard for patient preferences may have attitudes which do not prioritise understanding these preferences, skills deficits in terms of obtaining an understanding of these preferences, or attitudes of disregarding these preferences, or any combination of these. Skills deficits involving communication may more readily be overcome than competencies based on attitudes.

Doctors who are extremely untrustworthy are willing to disregard patient preferences to further their own interests, and they may be willing to force their own preferences by manipulation, coercion, deceit or frank assault. There may be criminal consequences for this group of doctors, who lack an attitudinal competency.

Doctors who have been found untrustworthy with a lack of regard for the patient's dependence upon them are unlikely to lack this competency because of a lack of knowledge. It must be ascertained whether the attitude that they have demonstrated is specific to a particular patient, or perhaps more likely, particular groups of patients or all patients. The importance of ongoing supervision may be significant for this group of doctors, if there is an ongoing deficit in this area. The prognosis for the
extremely untrustworthy doctor, who actively exploits the patient’s dependence for their own gain must be even more guarded. Again, this is unlikely to ever be conduct attributable to a lack of knowledge or skills, and much more likely be linked with particular attitudes. These attitudes may not be amenable to intervention. Assessing change in attitudes may be particularly complex for the doctor who is highly motivated to either maintain, or regain, their registration and ability to practise.

Doctors found to have been untrustworthy in terms of being able to recognise the limits of their own trustworthiness may have such difficulties in part due to personality style. Management of this by insight-directed psychotherapy is likely to require longer term intervention, and the ultimate response to this intervention may be limited. The improvement may be limited by the severity of the difficulties and the implications of these for insight and willingness to participate in psychotherapy. Forms of personality disorder which are poorly responsive to psychotherapy, such as narcissistic personality disorder and antisocial personality disorder, may be unable to make significant changes with psychotherapy, and consequently require interventions other than psychotherapy for safe practice.

There may be a degree of change possible with education for some of these doctors, who overlap with the group of doctors who have not provided appropriate or safe care. Some doctors who have limited experience working with very disorganised patients with diagnoses such as borderline personality disorder, may benefit from education regarding the nature of boundaries and the importance of these particularly when working with patients with mental health difficulties, in particular. It is unlikely that education and improvement in knowledge and skills in this way will be the entire solution, however.

If the doctor is untrustworthy because they are unable to recognise the limits of their own trustworthiness due a health condition, their rehabilitation may be similarly complex. Depending on the nature of the illness, insight may be able to be restored if the illness and its effects can be reversed. As Gabbard noted, however, relatively small numbers of doctors involved in professional sexual misconduct are so involved because of an acute reversible illness [18]. Much more frequently involved are doctors with complex personality and coping styles. Again, this group may benefit
from longer term insight-directed psychotherapy, but this response is likely to be long
term, and the degree to which the doctor achieves insight and motivated to change
their behaviour is impossible predict at the commencement of the psychotherapy.

For doctors who have been found extremely untrustworthy because they are unable
to recognise the limitations of their own trustworthiness despite being informed of
these limitations, due to deficits in clinical competence or health concerns, are again
more alarming. The lack of response to previous interventions may well suggest that
the doctor is not amenable to change. With this lack of change there must be an
associated ongoing risk to the community. Ongoing registration must therefore be
considered carefully, and the need for additional supervision and monitoring
considered as a minimum.

Doctors who are found not trustworthy because they have not communicated with
patients or others about appropriate care may not have done so for a number of
reasons. If the lack of communication is based on communication difficulties, efforts
to address these may be helpful to the doctor’s entire practise. This may respond to
some education if communication difficulties are occurring as a result of a deficit in
language skills or understanding. Again, if the failure in communication is caused by
attitudinal factors which only partially respond to education, this may mean that the
doctor will need to be managed with ongoing supervision/monitoring/restrictions in
clinical practise due to an ongoing vulnerability.

If the doctor has been found to be extremely untrustworthy because they were
deliberately deceptive with their patient, including deceiving the patient about the
inappropriateness of the professional sexual misconduct, the prognosis must remain
extremely guarded. This group of doctors are aware of the inappropriateness of their
conduct, and willing to provide false information to the patient to promote the
professional sexual misconduct. This category may well overlap with other
untrustworthy conduct, including a willingness to prioritise their preferences over the
patient’s. There may be associated criminal conduct. The prognosis for this group
must be extremely guarded, and there will need to be consideration of ongoing
supervision/monitoring/restrictions in clinical practise as a minimum.
In considering rehabilitation, of course each of these standards should not be considered in isolation. There will be overlap between the different standards for some conduct. Doctors with fewer and less extreme breaches of these standards could reasonably be expected to have a different prognosis to those who have breached multiple standards, and done so more extremely.

8.2.5 A Framework to Assist in Useful Responses for the Rehabilitation of Doctors Who Have Engaged in Non Sexual Professional Misconduct

As I have suggested above, if any form of professional misconduct deviates from the standards of trustworthiness, it may be examined according to the Framework for Trustworthiness in Doctors. With this examination, the ways in which the doctor’s conduct has deviated from the standards of trustworthiness, and the degrees to which the conduct has deviated from the standards of trustworthiness can be demonstrated.

Once examined in this way, the doctor’s conduct will consequently be able to be considered in terms of what responses might be most usefully required for rehabilitation of the doctor. In some cases there may be the need to address competencies based upon knowledge or skills. Competencies based upon in appropriate attitudes may be far more difficult to address, and care must be taken to ensure that these attitudes are appropriate before unsupervised practise resumes, if these attitudes can contribute to harm to the public.

Although all cases should be considered individually, the prognosis for doctors who have been found to be extremely untrustworthy must be considered as extremely guarded. For this group of doctors, the risks to the community may well outweigh their right to resume practise.

8.2.6 A Framework to Offer Structure for Future Research into Professional Sexual Misconduct.

Implementation of the Framework for Trustworthiness in Doctors should be associated with a plan to research the outcomes of its application. In particular, this Framework offers opportunities to examine the correlation between the moral aspects of a doctor’s conduct, and other parameters, including the detected rates of
recidivism. If this Framework was to be implanted by a Medical Regulatory Body, there would be opportunity to apply the Framework prospectively, during Hearings into professional sexual misconduct, and in combination with other Frameworks, such as clinical information provided by the doctor’s treating practitioners and expert witnesses.

The correlation between the findings of the Framework when considering doctors, and the community’s reasonable expectations of the Medical Regulatory Body would require ongoing reflection. If the role of the Framework is to provide a standard reflecting reasonable community reflections, this must remain current, and will require ongoing research.

In addition to examining the outcomes of examinations of cases of professional sexual misconduct and rates of recidivism and congruence with reasonable community expectations, opportunities to examine for congruence with other frameworks, whether they are clinical, moral or legal, may also arise as these are developed.

Finally, if the Framework is applied to cases of non-sexual professional misconduct, the correlation between the outcomes of the Framework’s application and rates or recidivism, congruence with reasonable community expectations and congruence with other available frameworks should be sought as these become available.

8.3 Limitations of the Framework for Trustworthiness in Doctors
Potential limitations of the Framework for Trustworthiness in Doctors may be categorised as due to three main factors. The first group of potential limitations is due to the nature of professional sexual misconduct, and the way that this conduct polarises the medical profession, as well as the community. The second group of potential limitations is due to the newness of this Framework, and the need for further testing of its application. The third and final group of potential limitations is those due to the nature of trustworthiness. I will discuss the potential limitations due to the nature of professional sexual misconduct first.
8.3.1 Potential Limitations of the Framework for Trustworthiness in Doctors Due to the Nature of Professional Sexual Misconduct, and the Medical Profession’s Responses to This

Professional sexual misconduct remains highly controversial within the medical profession. Many members of the medical profession believe that although the prohibition is generally warranted, there may be exceptions that are less problematic. This is hardly surprising given the likely ongoing prevalence of professional sexual misconduct, and the relatively recent prohibition. Although there are many doctors in Australia who have never practised in times when sexual behaviour between doctors and their patients was not prohibited, there are still a great number who practised when the doctors engaged in such conduct were referred to as “erotic practitioners” [page 1324, 16]. Doctors who themselves have engaged in sexual relationships with their patients, or whom have a colleague who has, even prior to the prohibition, may find it particularly difficult to accept the requirement for an absolute prohibition.

This group of doctors may be consequently reluctant to consider an ethical framework that can be applied to all doctors who have engaged in professional sexual misconduct, in part because of the reluctance to acknowledge this behaviour as misconduct. Those who can to some degree acknowledge that it is misconduct because it is prohibited may not see the conduct as problematic in all cases. The application of an ethical, or moral framework may consequently be alarming for this group.

This section of the medical profession may ultimately prefer the use of informed consent as an ethical framework when considering professional sexual misconduct. Informed consent does not, as I have argued, suggest that professional sexual misconduct is unacceptable if the patient can be argued to have made an informed consent to the relationship. For doctors inclined to justify specific cases of professional sexual misconduct as ‘different’, the informed consent framework offers opportunity to do so in ways in which the Framework for Trustworthiness in Doctors does not.
8.3.2 Potential Limitations of the Framework for Trustworthiness in Doctors
Due to the Need for Further Testing of the Framework

The Framework for Trustworthiness in Doctors is based upon sound ethical theory and argument. The framework was developed from an examination of the standards of trustworthiness that the community may reasonably expect from the medical profession. I have emphasized the consistency of this framework with the mandate of the Medical Board of Australia, as well as current reasonable community expectations, by application of the framework to four diverse cases of professional sexual misconduct. I have argued that the Framework does, in fact, give greater transparency to consideration of individual cases of professional sexual misconduct, and also the ways that these cases may impact upon perceptions of trustworthiness of the medical profession. Nonetheless, this Framework has not yet been subjected to rigorous quantitative or qualitative research establishing its validity.

In particular, the standards that I have set differentiating untrustworthy conduct from extremely untrustworthy conduct may be the most vulnerable to criticism and debate. The standards, I have argued, reflect appropriate professional standards for the medical profession, but the establishment of consistency with the medical profession's and reasonable community expectations will be optimal with empirical research.

The framework will benefit from testing which correlates its outcomes with established examinations, whether these are clinical or legal. There are currently no published ethical frameworks in use for doctors specifically. As these are developed and become available, comparison with the Framework for Trustworthiness in Doctors will also be valuable.

Although inter-rater reliability has not been established for the Framework for Trustworthiness in Doctors, this will only be possible with larger scale use of the framework. Given the relatively small numbers of cases of professional sexual misconduct heard by the Medical Board of Australia, this may take some years to achieve.
8.3.3 Potential Limitations of the Framework for Trustworthiness in Doctors Due to the Nature of Trustworthiness

The consideration of whether trustworthiness is itself a part of character is significant for this project because of the debate about the ability of character to change over time, and the implications of this for doctors assessed as not trustworthy.

I have described the standards of trustworthiness as;

1. The doctor must provide competent and appropriate care
2. The doctor must have regard for the patient’s preferences
3. The doctor must have regard for the patient’s dependence upon the doctor
4. The doctor must recognise the limitations of their own trustworthiness, including the limitations of their own clinical competence
5. The doctor must be able to make appropriate communication to patients and others regarding appropriate care

I have described these standards as a set of competencies, which may be present or lacking in almost any combination and degree. I have emphasised that the ways that deficiencies in these competencies may be responded to will vary according to whether the breach in trustworthiness occurs due to lack of knowledge or skills, or due to attitudes. I express reservations about the changeability of attitudes, particularly when there is wide deviation from the standards of trustworthiness. I suggest that these may take longer to address, and that insight directed psychotherapy may not be completely successful.

It is, then, when attitudes are based in personality that they may be most challenging to address. If trustworthiness is argued to be within character, assumptions about character will have implications for the application of this framework. If it is believed that character is fixed over time, and trustworthiness is a part of character, detection of untrustworthiness will have implications for whether the untrustworthy doctor may ever be able to safely practise independently. More recent research does suggest that “robust character traits” are less predictive of moral conduct than the situation in which the individual finds themselves, leading to converse arguments that “situational influences often appear to do their work with little regard to the character of the people in the situation” [150]. Even this “situationist” approach is compatible
with the description of the standards of trustworthiness as a series of competencies which may be, to at least some degree, developed over time.

According to a situationist approach, a moral typology of professional sexual misconduct would seem to assess the moral choices that an individual made in one instance of professional sexual misconduct, with the implication that these would have no significant implications for future conduct. This future conduct would seem to be dependent upon the specific circumstances that are the doctor’s circumstances. This would mean that an assessment of untrustworthy conduct could not offer any prognostic implications for the future. However, in Chapter Five I argued that even a situationist understanding of moral character does not preclude a moral typology based upon the standards of trustworthiness from having some contribution to make to predicting future behaviour.

Firstly, situationists do agree that there is stability of behaviour when there is stability of circumstances. Working as a doctor does offer much structural stability in role and interactions, and therefore has implications for the likelihood that similar behaviour will recur, even if a situationist approach is understood to guide moral choices.

Secondly, use of a moral typology based on trustworthiness in combination with a psychodynamic typology may enable an understanding of tendencies towards trustworthiness over time, based upon an understanding of the psychological capacities of the individual. For example, if the doctor is understood to have antisocial personality disorder, and this is understood to be stable over time, this could readily be understood to have implications for the way that the individual behaves. However, use of a moral typology could also allow examination of the way that they may have difficulties responding to the different requirements of trustworthiness, such as response to dependence, or experiencing patient preferences as compelling.

The literature regarding moral psychology will continue to hold relevance for the Framework for Trustworthiness in Doctors. Arguments that moral character is fixed
imply that trustworthiness cannot be improved. These implications will be present for all ethical frameworks reliant upon moral conduct.

8.4 Recommendations for the Development and Implementation of the Framework for Trustworthiness in Doctors

The Framework for Trustworthiness in Doctors is being proposed as a standard for conduct in doctors, a tool for educating doctors in training, a tool for facilitating the moral examination of the conduct of doctors who have engaged in professional sexual misconduct, a tool to guide the rehabilitation of doctors who have engaged in professional sexual misconduct, and a potential framework to further research into this area. Its implementation depends upon engagement, then, of a number of groups.

The Framework for Trustworthiness in Doctors includes reference to a number of ethical arguments that have not previously been published. Firstly, the argument that the only appropriate definition of trustworthiness for doctors is that of rich trustworthiness, has not been made in the literature. Similarly, although concerns have been expressed about use of consent as the ethical basis for a prohibition of professional sexual misconduct, the arguments that I have described have not been published. The comparative argument that the standards of trustworthiness offer an improved ethical basis for the prohibition of professional sexual misconduct has consequently not been made. Finally, the description of the ethical Framework for Trustworthiness in Doctors is unique to this project.

Publication on each of these areas may have a number of benefits. Firstly, ongoing consideration of the standards of conduct expected of doctors, and the underlying ethical basis of these standards, is worthwhile. Advancing interest in these standards may result. There may also be criticisms made which result in some review, and even improvement, of the arguments made.

The readership of academic publications is of course the medical profession. Defining such a standard may be useful for individual practitioners to reflect upon in their own clinical work. For those with different standards or ethical positions, the Framework for Trustworthiness in Doctors may prompt some consideration of
whether the standards under which they are presently operating are consistent with reasonable community expectations.

Beyond the medical community in general, if this Framework is to be of use to medical regulatory bodies, such as the Medical Board of Australia, it must be communicated to these bodies. I have undertaken to provide a copy of this project to the Medical Board of Australia, and am committed to seeking feedback from the Board regarding the Framework for Trustworthiness in Doctors. Engagement with this body will be my ultimate goal.

Ultimately, the Framework for Trustworthiness in Doctors may have the most value for the community by communicating what the community agrees may reasonably be expected from the medical profession. These expectations are far from clear, and likely to remain so when a television news program, which reports upon a doctor’s disgraceful fall from grace after being found guilty of a sexual relationship with a patient, can be followed by an Australian soap opera which romanticises such a relationship. It is the most vulnerable members of the community, with their potentially high levels of dependence upon their doctor, who require this certainty more than any other. Education and certainty for this group about what they may reasonably expect is imperative. It is the most vulnerable members of our community who stand to benefit most from measures which promote trustworthiness, and the prevention of professional misconduct of any form.
## Appendix One: The Framework for Trustworthiness in Doctors

<table>
<thead>
<tr>
<th>Components of Trustworthiness</th>
<th>The Trustworthy Doctor</th>
<th>The Untrustworthy Doctor</th>
<th>The Extremely Untrustworthy Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of Competent, Appropriate Care</td>
<td>Competent to respond to patients' concerns or refers if unable to themselves</td>
<td>Allows PSM to undermine care of presenting or subsequent health concerns</td>
<td>Willing to provide inappropriate, unsafe, or even illegal care to promote or maintain PSM. For example, inappropriate prescribing.</td>
</tr>
<tr>
<td>Regard for Patient Preferences</td>
<td>Seeks to understand the preferences of patients and their families, and acknowledges them. Finds these preferences compelling when they are appropriate and safe.</td>
<td>Does not seek to understand the preferences of patients and their families. Does not experience patient preferences as compelling, and may respond to inappropriate requests, such as requests for a sexual relationship.</td>
<td>Is willing to disregard the preferences of patients to further their own interests. This includes patient preferences which may be reasonably inferred (such as a parent’s preference that their child not be harmed). May be willing to force their own preferences by manipulation, coercion, deceit or frank assault.</td>
</tr>
<tr>
<td>Regard for the Patient’s Dependence Upon the Doctor</td>
<td>Experiences the dependence of the patient as compelling. Seeks to reduce or minimise any power imbalance by providing information, assistance, or advocacy.</td>
<td>Does not recognise or respond to this dependence, and does not experience it as compelling, even if there are factors contributing to a marked power imbalance</td>
<td>Is aware of the dependency, and actively exploits this for their own gain. Do not recognise extreme dependency, due to serious illnesses. May even seek to increase the dependency to promote their own gain. For example, inappropriate prescription of drugs of dependency.</td>
</tr>
<tr>
<td>Recognition of the limitations of their own trustworthiness, including clinical competence</td>
<td>Maintain ongoing reflection on the care they are providing. Are aware of the potential for their own impairment to impinge on this care, and seeks to optimise both their own health and competence. Refer their patients for care that they cannot provide.</td>
<td>Do not recognise the potential for their health concerns or lack of clinical competence to cause harm, and consequently does not maintain these, nor refer patients appropriately.</td>
<td>Despite being informed about the potential for their health concerns or lack of clinical competence to impinge upon patient care, do not act to maintain these. May misrepresent their competence to promote PSM, or repeatedly engage in PSM despite feedback regarding the inappropriateness of this.</td>
</tr>
<tr>
<td>Communication to Patients and Others Regarding Appropriate Care</td>
<td>Must communicate to patients what the limits of their trustworthiness are.</td>
<td>Does not communicate to patients what the limits of their trustworthiness are.</td>
<td>May be actively deceptive in their communications with patients about what the limits of trustworthiness are, including the inappropriateness of boundary crossings or violations, including PSM.</td>
</tr>
</tbody>
</table>
References


2. Chekhov A. Unknown.


22. Jones K. From Trust to Trustworthiness (and Back), Ethics n.d.


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