



**Regulation Matters:
a CLEAR conversation**

Episode 4: Sexual Abuse by Regulated Professionals: Achieving Zero Tolerance July 10, 2018

Line Dempsey: Welcome to another edition of our podcast, Regulation Matters: a CLEAR conversation! I'm your host, Line Dempsey. I'm the senior investigator with the North Carolina State Board of Dental Examiners, and I'm the current chair of the National Certified Investigator Training Committee with CLEAR. This podcast is a part of the Council on Licensure, Enforcement and Regulation, or CLEAR; and we are an association of individuals, agencies, and organizations that comprise the international community of professional and occupational regulation. This podcast is a chance for you to hear about the latest and greatest in our community. As a lead up to our Annual Educational Conference, which is scheduled for September 26 to 29 in Philadelphia, Pennsylvania, this is a preview of a topic that will be presented there. I'm excited about working with our speakers today as we cross multiple time zones and days to bring about this episode, which falls into the compliance and discipline track. Today, I'm joined by Melanie deLeon, Washington Medical Commission; Kim Ayscough, Australian Health Practitioner Regulatory Agency; and Debbie Tarshis, WeirFoulds LLP. Welcome everyone.

Guest speakers: Thank you.

Line: Thanks for joining me. So, today's topic is sexual abuse: achieving zero tolerance, and regulators' response to sexual abuse committed by regulatory professionals. I have a particular interest in this as our NCIT committee this year has been revamping our sexual misconduct pre-conference workshop. And it, too, will be offered in Philadelphia. So as I understand it, there have been some significant changes to the framework, policies, and procedures for handling sexual abuse cases in each of your jurisdictions. Let's start with Melanie. So, here in the States, what prompted your organization to revamp the way they process sexual misconduct cases?

Melanie deLeon: Well, in the summer of 2016, the *Atlantic Journal Constitution* published a series of articles regarding doctors and sex abuse that highlighted their national investigation into how state medical boards dealt with these types of cases. They rated each state how they protected their patients from sexual abuse of doctors based on five factors. These factors included transparency: was complete and accurate information on physician discipline provided to help patients protect themselves; a duty to report: are colleagues and institutions that are aware of potential physician

misconduct required to notify regulators; the board's composition: were there consumer members included to balance physicians' tendency to identify with their colleagues; criminal acts: were medical regulators and law enforcement made aware of doctors' criminal conduct; and discipline laws: do state laws strengthen oversight and discipline of problem physicians. Now Washington rated seventh in the nation in their investigation overall. But, in gathering information to give the *Journal*, I found some disturbing realities about how we had been dealing with sexual misconduct allegations against physicians in Washington State. The most prevalent issue that I came across was communications from the commissioners themselves, who basically said that the cases seemed to boil down to a "he said, she said" matter and that sexual allegations, because of that, were very difficult to prove. Now, Washington had recently changed their law requiring all of our investigators to take specialized training to interview victims of sexual misconduct in a manner that minimized the negative impacts on the victim's trauma. And it was because of this training that I began looking at how we could change the way we process cases regarding sexual misconduct allegations against physicians.

Line: Well, that sounds very interesting. I guess you've put some changes in place. What kind of impact have you had?

Melanie: Well, first of all, we established a new type of team. We gave it a really cool acronym - it's called the Sexual Misconduct Analysis and Review Team, or SMART Teams. And we developed a new procedure for all cases regarding sexual misconduct. Now, all sexual misconduct cases are assigned to a team of reviewing commissioners. One of those has to be a male, and one of them has to be a female. In addition to the male and female combination on the team, one of the team members has to be a clinician, and one of them has to be a public member, so we can get both sides of the aisle and their input on those particular cases. Now to be part of the SMART teams, all of the commissioners that want to participate on these teams have to complete a one-day trauma informed approach to sexual assault investigative training. So our investigators were sent to a two-day training, and now we send our commissioners to a one-day training, and the training includes an understanding of the neurobiology of trauma, the impact of trauma on victims, and how that trauma may be the best evidence in the sexual misconduct case. So those who have taken the trainings are no longer using the "he said, she said" argument, and cases that once were determined to be boundary issues are now being considered sexual misconduct, and in some cases actually sexual assault cases. So it has really increased their perception and awareness of sexual misconduct.

Line: That's great! I really like the idea of the team approach, and certainly the demographics of that obviously will have a major impact on how cases are handled. Certainly, I know other states have been looking into how they handle these. I've been through some certain training on dealing with it, and obviously it is a very hot topic right now. Well, let me pose this question to Kym. And, I guess it's tomorrow there today, right?

Kym Ayscough: Yes, it is early morning for me.

Line: Well, we appreciate you getting up and being a part of this; we're having to cross several

different areas. So firstly, I guess, what prompted the Medical Board of Australia and AHPRA to commission a review of the use of chaperone restrictions in response to the allegations of sexual boundary violations?

Kym: So we jointly commissioned this review with the Medical Board of Australia in August of 2016, and it followed a series of really very disturbing events. So, in our legislation, the Medical Board has the power to take immediate action to protect patients and the public pending an investigation, and consistent with the practice of international health regulators, particularly medical boards, the Medical Board had been imposing chaperone restrictions as an interim protective measure on the theory that the presence of the chaperone would protect patients while the Board undertook investigations of sexual boundary misconduct allegations. So it became apparent, though, that this really needed to be more closely re-examined in the wake of allegations of indecent assault on multiple male patients by a Melbourne neurologist. The neurologist faced criminal charges following allegations of sexual assault. Initially when the criminal charges were brought to the attention of the Board, he was permitted to continue to practice for eight months with conditions that required a chaperone to be present for all consultations with male patients. Ultimately, he was suspended because we received a further notification, which is the term we use for complaints; we received a second notification from a male patient that he had been sexually assaulted behind a pulled curtain while the chaperone was present. So that set of circumstances really made it clear to us that we needed to have a close look at whether chaperone-type restrictions were appropriate and sufficient to protect patients while the Board undertook a more detailed investigation of their allegations.

Line: Gotcha. Now with the chaperone itself, was that a cost burden that the practitioner had to pay for in order to have the chaperone in their presence, or is that something that the Medical Board provided?

Kym: No, that was at a cost to the practitioner, and the Board did have a documented chaperone protocol which set out the types of people who would be considered to be suitable as chaperones of the medical practitioners. And there was the requirement that the Board had agreed to the particular person acting as a chaperone, but the costs were actually met by the practitioner.

Line: Gotcha. Now, obviously with this one scenario that you brought up, where the chaperone was present but behind the curtain, some type of sexual boundary violation occurred that prompted this review. What were your findings?

Kym: So essentially, the review found that chaperone restrictions are not sufficient to protect the public. And also that chaperone restrictions don't meet the public's expectations of the protective actions that a board would take in these sort of circumstances. So the reviewer, Professor Ron Paterson, looked at the practice of medical boards in multiple jurisdictions. He engaged directly with medical regulators in particular in New Zealand, the UK, Canada, and the USA, but he also held consumer forums and called for public submissions and received submissions from these patients who had been sexually assaulted by Dr. Churchyard, and from his mother, who is a general practitioner, and

from other members of the public making it quite clear that they really didn't believe that the chaperone restrictions were appropriate or sufficient. And so he drew a conclusion that there are better ways to protect patients and to ensure that they're properly informed when there are allegations of sexual misconduct being investigated.

Line: And so has that also changed the way you guys actually approach investigations of allegations of sexual boundary violations?

Kym: Yes, it certainly has. There are a number of very specific recommendations in Professor Paterson's report, all of which were accepted by the Medical Board of Australia and by AHPRA, and subsequently, this report has been shared with the boards for the other 14 professions that we regulate in our national scheme, all of whom have similarly adopted the recommendations. As I said, the primary finding was that chaperone restrictions are generally ineffective to protect patients and that we should move away from that regulatory response in these cases and should look more to more reliable restrictive measures such as gender-based restrictions or suspension of the practitioner. We also accepted a recommendation around the need for more transparency in these matters, so that in the event that there is a chaperone (or we've moved away from that term as well, which was found to be a bit archaic, and refer now to practice monitors), so in the event that a practice monitor is used that it's now really important that that person is informed of the nature of the allegations under investigation. Previously that wasn't really done. And similarly, that patients are adequately informed, so at the time of booking an appointment that they're informed why a chaperone is required and that they're given a fuller explanation of that if they ask. And we have also recently given effect to the final of the recommendations, which is to include on our public register of practitioners a link to any published tribunal or criminal decisions in regard to a practitioner. Because that lack of information about prior history of a practitioner was found to be of significant concern, obviously, for members of the community. In terms of the investigations, and so I think very much as Melanie described in Washington, we have moved to a position - we are a national regulator, but we have state-based decision-makers; part of the review found that decision making was not entirely consistent between the states, and the Medical Board has now struck a single national committee to deal with sexual boundary notification. It has both practitioners and community members from across the country. They work now with a single team of investigators. So again, we have investigators in each of our locations, but they work as a virtual team and they have all had the same training. They trained together - the investigators and the committee members - and again, very much as Melanie's outlined in Washington, a lot of the input into the training program for us came from sexual assault and rape crisis experts to really ensure that our investigators and our decision-makers understood, from the perspective of victims of sexual assault, what was necessary in order to conduct an effective investigation.

Line: Well, that form of continuity sounds like it would probably make things a lot more efficient and better for all parties involved. Thanks, Kym. And Debbie, looking at things from a Canadian perspective, what was the Ontario legislation governing the health regulatory bodies change with respect to sexual abuse?

Debbie Tarshis: In December 2014, the Minister of Health and Long-Term Care appointed a task force on the prevention of sexual abuse of patients and the Regulated Health Professions Act. The Regulated Health Professions Act is umbrella legislation that governs the health regulatory bodies in Ontario. The purpose of the task force was to review the Regulated Health Professions Act, or the RHPA, to ensure that it's effective in preventing and dealing with sexual abuse of patients by regulated professionals. And the scope of the task force was to recommend ways that this legislation can best ensure that every interaction between patients with health regulatory professionals, in relation to issues involving sexual abuse, and colleges' processes are sensitive, accessible, and timely. The task force was also asked to identify best practices from leading jurisdictions around the world. In September 2016, the report of the task force, including its recommendations, was released by the Ministry of Health to media and health regulatory bodies, at the same time as the Ministry's response to the recommendations. And very shortly thereafter, in December of 2016, a bill was introduced which amended the RHPA, and that bill was introduced in December, late December, and then went through the legislative process, and by May 30th of 2017, the bill had been passed and received royal assent. Now, many of the provisions came into force on May 30th 2017. So some of the amendments to the RHPA included increased transparency, in other words, increased information on the public register of a health regulatory body; a power to make interim orders such as suspensions or imposing terms, conditions, and limitations at any time following the receipt of a complaint or following the appointment of an investigator. At the time, interim orders could be made, but only after an allegation of professional misconduct, incompetence, or incapacity had been referred for a hearing. Another amendment made by Bill 87 was to expand the list of acts and other conduct that would result in mandatory revocation. The list of frank acts of sexual abuse, for which there already was mandatory revocation, was expanded to include touching of a sexual nature of the patient's genitals, anus, breasts, or buttocks and other conduct of a sexual nature that could be prescribed in regulations. Another area of amendments was mandatory suspension as the new minimum penalty for sexual abuse. So if there was a finding of sexual abuse and there was not a revocation of the member's certificate of registration, then the minimum penalty would be a mandatory suspension. The last amendment that I'm going to comment on was the elimination altogether of gender-based restrictions. So the inquiries, complaints, and report committee, which is basically the screening committee, would no longer be able to make interim orders that imposed gender-based terms, conditions, or limitations. And similarly, a panel of the discipline committee would no longer be able to impose gender-based terms, conditions, or limitations as a part of its penalty orders. So those are some of the amendments that were passed as a result of the task force report.

Line: Wow, that's quite impressive. And I know a lot of that is very recent up to last year. Is the legislative landscape continuing to change in this area even though we've just gone through all this just recently?

Debbie: Well, yes, it is. Some of the provisions that were not brought into force on royal assent were actually brought into force on May 1st 2018. In addition to some of the additional provisions that were brought into force, there have also been made some regulations which support the provisions that

have recently come into force. One of the provisions that came into force on May 1st 2018 was the addition of a definition of patient. Now, sexual abuse of a patient was always defined in the RHPA, but the meaning of patient wasn't defined. As a result of the provision that was brought into force combined with the regulation that was made May 1st 2018, there is now a definition of patient included in the RHPA. So then there's more information that is required to be posted on the public register as a result of a new regulation that came into force May 1st 2018, and that has increased the transparency beyond the transparency that was already enacted by the amendments to the RHPA that came into force May 30th of 2017. In addition to this increased transparency, provisions that relate to mandatory reporting were also brought into force on May 1st. So, now, members must report to their professional regulatory bodies additional information that relates to charges that have been made against them and bail conditions, and also their licenses and registration in other jurisdictions. So at the same time as there is this mandatory reporting, the regulatory bodies are now required to add some of this information to the register through a regulation that came into force on May 1st 2018. And the last that I'm going to comment on is that the regulation was passed on May 1, 2018 that requires a discipline committee to revoke a member's certificate of registration under additional circumstances, and those relate to offenses under the Criminal Code where if a member is found guilty of that offense and it's listed in the regulation, then that member must have their certificate of registration revoked.

Line: Wow, well, certainly it sounds like you guys made some significant headway in just the last two years. Can we expect to see this continue in the future as far as more changes?

Debbie: Well, there is an elephant in the room, and the elephant in the room relates back to one of the recommendations - one of the controversial recommendations - of the sexual abuse task force. And that was that a new authority that's independent of regulators be established to investigate sexual abuse and that a tribunal that's independent of regulators adjudicate sexual abuse complaints. Now, in May of 2017, the Ministry engaged a consultant to undertake work relating to the recommendations of a sexual abuse task force and among other things, the consultant was requested to review and analyze the task force's recommendations to establish independent bodies responsible for the investigation and adjudication of sexual abuse matters. Now, the other piece of this puzzle is that amendments were made by Bill 87 that relate to governance matters and give the Minister powers to determine the composition of the committees of the regulatory bodies. Those provisions are not yet in force and no regulations have been proposed yet. We're still waiting for the advice of the consultant to the Ministry, which has not yet been made publicly available. And so we've got this big question mark as to whether or not the government is going to establish independent bodies to be responsible for the investigation and adjudication of sexual abuse matters.

Line: Wow, that's also a loaded gun waiting. Now, as I understand it, all three of you will be presenting information together at the annual conference. Any homework our listeners should be doing before the presentation in September?

Kym: Line, it's Kym. My view is that we would be really welcoming of people bringing to this session

their own experiences as they touch these matters, because I think what is evident from the fact that there is so much work being done in this area, is that we're all looking for leading practice. And whilst we'll be able to share our experiences from our organizations and local perspectives, it will be great to engage with others in that conversation about what leading practice looks like.

Melanie: Hi, this is Melanie. To piggyback off of Kym's presentation, the Medical Commission in Washington had a lunch-and-learn regarding the use of chaperones, and that was always our go-to sanction when there was sexual misconduct allegations or boundary violations - to throw a chaperone in the room. And we have learned through cases, Larry Nassar was one of those, that chaperones don't work. And so, they, based on what Kym's organization has done, have discontinued the use of chaperones as a sanction. And I would be very much interested to hear what other states are doing and how they're reacting to the chaperone question.

Line: Sure, we actually have used a practice monitor in the past, although it's been probably 12 or 13 years since we last had one, a pretty substantial case that we had in North Carolina. But yes, it'd be certainly interesting to hear what other agencies and regulatory bodies are doing. Well, thank you, Melanie, Kym, and Debbie, for your time and being a part of CLEAR's podcast. This was quite the undertaking with different time zones, and I want to thank each of you for making this happen. As we said earlier, you'll be presenting on this topic in more depth at the CLEAR Annual Educational Conference in Philadelphia in September. So we look forward to hearing from you guys then. Thank you again for speaking with us today.

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