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# Legal Perspectives

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## INTRODUCTION

A number of legal consequences can follow when a medical practitioner behaves in a non-consensually sexualised way towards a junior doctor or a medical student in or involving the workplace. Such conduct can result in the institution of criminal prosecution for indecent assault, battery, or rape. (1) It can also have the consequence in some jurisdictions of a civil action for damages for either sexual harassment or assault. (2) Action can be taken by the employer to remove the person from their employment, (3; 1) although there are occasions when such actions have been contested in the courts after a hospital has terminated a doctor's employment, (4) and action can be taken by the health regulator to remove the practitioner's registration or impose conditions upon it. (1) There is also the potential for the person who is the subject of a complaint to take retributive measures for defamation against a complainant. (5) In addition, there are instances where an employing institution comes to know of a medical practitioner's predatory propensities. (6; 7) If it can be proved that an employer was aware of the risks of an employee engaging in such conduct, by reason of prior behaviour or information to which the employer is otherwise privy, there is the potential for occupational health and safety litigation to be commenced against an employer, such as a hospital, for failing to provide a safe workplace.

This chapter explores the structural and other impediments to reporting of sexual assaults or harassment by doctors upon other health practitioners, particularly upon junior doctors.

## NON-REPORTING IN THE CRIMINAL CONTEXT

Reporting by women of a variety of forms of sexual assaults committed against them is low. (8) A Latin American study, for instance, estimated that only 5% of adult victims of sexual violence reported incidents to the police. (9) While figures vary internationally, the overwhelming majority of such assaults are not communicated to investigating or prosecuting authorities, and while young women and those from ethnic minorities, including First Nations women, are at particular risk of sexual



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assault, (10) they report comparatively rarely. Males also experience a high level of hesitation to report sexual assaults, (11–16) although there has been a suggestion that males do not experience as many adverse emotional sequelae from sexual harassment and are hesitant to categorise it as such. (17)

Much is known and can be learned from other contexts about the reasons for diffidence on the part of victims to report sex crimes to police and prosecutorial authorities. There are many different forms of fear that can inhibit such reporting. Among these, there is a fear of the investigative process and of court procedures; a fear of retaliation from the offender and persons associated with the offender; a fear of not being believed; and a fear of being blamed, as well as self-blame, embarrassment, shock and denial. (18–20) A culture of self-sacrifice in medicine runs the risk of normalising inappropriate behaviours in the workplace to a point where harassment can come to be considered 'part of the job'. (21) Cultural considerations which affect preparedness to make a report of assault can also be highly relevant. (22) There can be concerns too on the part of victims about the consequences of a report of sexual assault for perpetrators whose standing in the community they do not wish to imperil. (22)

Accusing perpetrators can have a range of adverse economic consequences for victims (23) should they fail to be renewed in their workplace contract or if they are assessed as unsuitable for an ongoing position. A 2021 Australian study also suggested that women must meet unrealistic expectations and engage with doubt and suspicion when they make a complaint, whereas accused mens' actions in gaining consent to their conduct are not scrutinised as rigorously. (24) Put another way, there can be complex balances between victims' needs and expectations and those of others, (25) which can militate against reporting of sexual improprieties.

In addition, there is a further noxious element to the reporting experience – when complainants are not believed, including by police, they can experience deleterious health consequences. For instance, a Canadian study, using open-ended and semi-structured interviews with twenty-three sexual assault survivors, who were sexually assaulted but not believed by police, found a number of negative health outcomes for survivors. (26) These included broken expectations which resulted in loss of trust and secondary victimisation, loss of self, and cumulative health and social effects. There can also be alienation from the workplace, shame, the emotional effects of being ostracised, depression and suicidality.

## REPORTING SEXUAL ASSAULT AND HARASSMENT IN THE WORKPLACE

Sexual harassment in the workplace generally is persistent, prevalent and under-reported to authorities. (27; 28) A component of this can be a perception of futility in making a report, which can play a role in maintaining or even deepening a 'culture of silence'. (29) A series of significant studies has been published on the issue. In 2016, for instance, the Trade Union Council (30) in the United Kingdom issued

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a report, 'Still Just a Bit of Banter?', which concluded that approximately 52% of women suffered sexual harassment in the workplace (including nearly a quarter who had experienced unwanted touching and a fifth who had experienced unwanted sexual advances) and identifying that 80% of them did not report it. The problems complained about were mostly from male colleagues, and nearly one-in-five victims stated that their direct manager or someone else with direct authority over them was the perpetrator.

The BBC released two polls in October and November 2017; they found that 53% of women and 20% of men (37% overall) said they had experienced sexual harassment at work or a place of study, and one in ten of the women who had been harassed said they had been sexually assaulted; the second poll concluded that 40% of women and 18% of men had been sexually harassed at work, 9% in the previous year alone. Importantly, of the women who said they had been harassed, 63% said they did not report it to anyone, and 79% of male victims did not report it. (31)

More recently, a 2022 investigation by UN Women UK found that 97% of women aged 10–24 have been sexually harassed, and 96% have not made a report because of a belief that it would not change anything. (32) Of course, much depends upon definitions, as well as subjective experiences. However, it is apparent that the norm is for sexual assaults and harassment not to be reported – the dark figure of its incidence is difficult to identify, with most light on the phenomenon being shed by anonymous surveys. To a similar effect, high levels of sexual harassment have been reported among junior doctors in the United Kingdom (33; 34) and in the United States (34; 35) including among resident physicians, particularly by self-report surveys. (35–38)

When sexual assault or harassment occurs in a workplace, there are additional considerations which can deter victims from reporting. First, there are the complexities of workplace dynamics and concerns that may be experienced about ongoing vocational viability if a complaint of harassment is lodged about a colleague and, especially, about a superior. (39) Most harassment targets do not report their experience (40–44) out of a fear, with justification, that they will experience deleterious consequences in their career and ostracism and even retribution from fellow-workers and management. This is exacerbated if the person who is the subject of the complaint is organisationally powerful or senior in status to the complainant. (44) Put another way, the power imbalance in the unwanted sexual conduct can provide strong reasons not to report what has occurred. In the aftermath of the Caroline Tan case in Australia (see below), the surgeon, Dr Gabrielle McMullin, observed that Dr Tan's career had been ruined by the successful sexual harassment litigation that she initiated (see below) and that 'realistically' she would have been better off giving her supervisor 'a blow job'. (45)

There can be worries, too, about stigma and victim-blaming (46) which discourage people from disclosing sexual harassment in the workplace and perceptions that

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it is pointless to initiate a complaints process because it will not be assertively pursued or is unlikely to result in constructive changes to safety in the workplace. Kadota (39) has related being discounted as an 'emotional female' when she raised concerns about conditions for doctors and about sexual harassment in the workplace in relation to junior doctors. Too often there is little by way of support from colleagues and other medical practitioners (47; 48). Issues of confidentiality can also loom large in a workplace where leakage of information about a complaint can result in a variety of adverse consequences from colleagues.

The next sections of this chapter deal with experiences of medical practitioners who have reported sexual impropriety by other medical practitioners. The case examples selected for discussion are provided because of their being illustrative of different issues affecting the preparedness of medical practitioners to report diverse forms of sexual conduct engaged in towards them by other medical practitioners. The discussion of each is based upon publicly available information.

## THE DR XENOS LITIGATION

Dr Caroline Tan was a registrar in her third year of training in neurosurgery in 2004 at the Monash Medical Centre, in Melbourne, Australia. (49) Dr Chris Xenos was a senior neurosurgeon who worked principally in private consulting rooms but also for part of the week at the Monash Medical Centre.

From about December 2004 Dr Tan developed a supportive professional relationship with Dr Xenos and from time to time discussed her professional progress with him. From January 2005 Dr Xenos invited Dr Tan to his private rooms adjacent to the hospital for what he proposed as extra tuition. She declined these requests as they were made for times that were not convenient to her but in due course stated that at that stage she did not perceive them as other than professionally motivated. However, on 15 February 2005 she accepted an invitation from Dr Xenos to meet him at his rooms so he could review some neurosurgery topics with her as part of her training. She arrived in the early evening and, after small talk about artwork on the walls, he led her into his room by the hand and, when she turned her back to look at material on his desk, he suddenly approached her from behind, spun her around and embraced her. He kissed her on the lips, put his hand on her breast, pinning her against the desk, and as she twisted around to get out of his grasp, she saw his erect penis out of his zipper. He explicitly propositioned her but she escaped his grasp, blurted out 'how could you' and ran out of the premises to her car. She maintained that Dr Xenos followed her and suggested he drive her home. She declined his offer and drove away on her own.

Dr Tan asserted that she was distraught after the incident and spent the night crying. However, she 'decided not to make any complaint to her employer as she was concerned that it would be her word against that of a senior and respected consultant in the very area in which she was working'. (49) Further, she was conscious that

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Dr Xenos was involved in her training assessment and she did not want to be seen as a troublemaker: she 'thought that her accreditation as a neurosurgeon, and her future career, might well suffer if she made a complaint'. (49) She claimed that Dr Xenos went about his usual work in the following days and pretended that nothing had happened. She tried to confront him about the incident but he told her that she needed to 'move on' and it was clear to her that he was going to pretend the incident had not taken place. She was deeply embarrassed about what had occurred, felt in a quandary about what to do and, although at first she decided not to make an official complaint, felt profoundly affected in her capacity to work in the same environment as Dr Xenos. She did make private complaints to others. However, ultimately she took civil action alleging that Dr Xenos engaged in sexual harassment towards her in the course of her employment in contravention of section 87 of the *Equal Opportunity Act 1985* (Commonwealth). The case was assertively contested by Dr Xenos. It was heard by Judge Harbison of the Victorian Civil and Administrative Tribunal.

During the Tribunal hearing Dr Tan was extensively cross-examined about the incident. She was unable to give any evidence about the physical characteristics of Dr Xenos' penis that she claimed she had seen. Dr Xenos gave sworn evidence that the incident never took place. He said that he had fallen into a pattern of giving private tutorials to Dr Tan because she had declined to participate in tutorials with another doctor. He called extensive evidence about his good character, suggesting that it was unlikely that he would have engaged in conduct of the kind alleged by Dr Tan.

Judge Harbison confirmed that the burden of proof for the allegations lay upon the person making them, Dr Tan. She found Dr Tan to be impressive in her veracity and consistency of accounts but also found Dr Xenos largely to present in an impressive manner. Judge Harbison observed that she was 'very much aware that there is little that a person, wrongfully accused of sexual harassment can do in his own defence except to emphatically deny that the event took place'. (49) She commented that there were no witnesses who could corroborate the accounts of either Dr Tan or Dr Xenos and stated that were she faced with two equally compelling versions of events by the two parties, Dr Tan's case would have to fail.

Evidence was adduced, though, that Dr Tan complained to others and that she did so before she received an unsatisfactory assessment of her performance. Judge Harbison described Dr Tan's complaint evidence as striking in its extent and to be interlocking. (49) Dr Xenos sought to portray Dr Tan's allegations as motivated by malcontent with her assessment and contended that she would 'escape rejection by a tirade of complaints about standards of teaching, and personal complaints against other medical staff' from an early juncture in her studies. (49) Ultimately, Judge Harbison found Dr Tan's evidence as to the incident of harassment to be credible and that the evidence adduced by Dr Xenos about her poor work performance prior to her making the complaint not to be supported by documentary evidence. Thus,

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her Honour rejected the argument mounted by Dr Xenos that Dr Tan's motive in making her harassment complaint was one of disappointment at the adverse evaluation of her performance. Rather, Judge Harbison found that the conversations that took place by Dr Tan with others were consistent with her 'finding more and more difficulty with her work as a result of her emotional reaction to the incident of harassment, but not being prepared to make a formal complaint of harassment, or acknowledge her difficulty in coping as a result, because of her position as a trainee'. (49)

Judge Harbison found Dr Xenos to have 'deliberately exaggerated the timeframe during which [Dr Tan] demonstrated substandard work, to make it more closely fit his suggestion that she had fabricated her claim'. (49) Judge Harbison observed that Dr Tan had endured cross-examination that was far-ranging and repetitive: 'Throughout it her evidence remained consistent and credible. She remained courteous, even when asked the same question many times over. She showed extraordinary poise and composure under pressure.' (49)

At first Dr Tan had simply sought an apology as a remedy in her sexual discrimination action but withdrew this application during the process of submissions after the conclusion of evidence on the basis of how assertively the case had been fought by Dr Xenos and the fact that any apology ordered by Judge Harbison would not be genuinely given. (49) Judge Harbison concurred, expressing the view that in a sexual harassment case the ordering of an apology should only be done rarely. She preferred to make an order for damages. However, she noted that there was no evidence to support an award of special damages or loss of earnings. By the time of the hearing Dr Tan had concluded her qualifications as a neurosurgeon and, while her period of training had been delayed, there was no evidence that that was because of the conduct of Dr Xenos.

In assessing the damages that she should award in favour of Dr Tan, Judge Harbison observed that Dr Tan had been 'terribly affected by the incident. I even venture to say that her reaction has been unusually severe and, to some extent, out of proportion with the incident itself. She has reacted to it as a gross violation of her body and her trust.' (49) She took into account that Dr Xenos was in a position of power over Dr Tan and that he knew her performance had previously been under a cloud, rendering her especially vulnerable to Dr Xenos' overtures. She found that Dr Xenos 'deliberately and falsely denied the harassment', attempting to smear the character of Dr Tan, exploring every aspect of her professional competence in a context in which neurosurgery is a speciality in Australia with only approximately 150 practitioners. A consequence is that the great majority of Australian neurosurgeons would know of Dr Tan's case and therefore that Dr Tan's 'enjoyment of her profession … will now be significantly tarnished by the sexual harassment which I have found proved'. (49) Dr Tan failed her final assessment and thus had not yet become fully qualified as a neurologist. Judge Harbison awarded her AUD100,000 in damages. (49)

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However, in important respects, aside from establishing an important precedent, Dr Tan's win proved to be a pyrrhic victory. In due course she completed her qualifications but by 2015 her experience was that she had been shunned by other surgeons who had repeatedly overlooked her in applications that she made for positions in both public and private hospitals. Dr Xenos, by contrast, remained in employment at Monash Health although he was warned that any further misconduct would have serious consequences for him, and he was not permitted to continue supervising trainees. As of 2015 Dr Tan was disillusioned and stated that she would have been better off if she had submitted to Dr Xenos' harassment. She denounced the Australasian College of Surgeons as an 'Anglo-Saxon old boys club' that favoured men (45) and drew little comfort from her litigation success.

Dr Tan's case illustrates many of the internationally recognised phenomena about the consequences of a junior doctor making a complaint about sexual harassment or discrimination against a senior colleague. Her case before the Victorian Civil and Administrative Tribunal extended for eight days and was keenly contested, with every aspect of Dr Tan's performance as a trainee being scrutinised and denigrated by the senior practitioner who, ultimately, was found to have sexually harassed Dr Tan. The whole experience was extremely high profile and, while, Dr Tan was financially successful, an outcome was that her entry into the profession was delayed, and she suffered the outcome experienced by most whistleblowers (50) in that she was marginalised in her profession and found it extremely difficult to secure employment as a specialist doctor.

## THE KAYE LITIGATION

A high profile and deeply troubling case involving a senior medical practitioner in Victoria, Australia, came before that state's medical disciplinary tribunal, the Victorian Civil and Administrative Tribunal (VCAT) in 2025. (56) It involved an allegation brought by the Medical Board of Australia that one of Australia's most highly regarded neurosurgeons, a 'world-renowned figure', Professor Andrew Kaye, had engaged in unwanted sexual conduct towards a young female medical practitioner, an unaccredited neurosurgery registrar (Dr A), whom he supervised. The allegation was that in the context of having pressured her to drink whisky in his rooms, knowing she had to return to the operating theatre, he touched her in a sexualised way and thereby breached professional boundaries. (56)

Professor Kaye was a graduate of the University of Melbourne in 1973 and was appointed Professor of Neurosurgery at the University in 1992 and the James Stewart Professor of Surgery and Head of the Department of Surgery at the Royal Melbourne Hospital in 1997. Subsequently, he chaired the Board of Examiners for the final year of Medicine at the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne for many years and was also appointed in 2010 by the New Zealand Government to Chair the Board of the New Zealand South Island

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Neurosurgery Service. He is the author of a leading neurosurgery textbook (60) and many leading scholarly articles.

The allegations brought by the Medical Board of Australia related to Professor Kaye's interactions with the registrar during 2019. The registrar alleged that Professor Kaye asked her in the days leading up the incident whether she was married and told her that she was 'a remarkable person'. (56) She described arrangements that he made to release her from other work commitments and a requirement from him that she come to his office and drink whisky with him, in the course of which she detailed that he made unwanted sexual overtures towards her, sitting beside her on his couch with his office door closed.

Professor Kaye assertively disputed almost all aspects of the Board's allegations and maintained that they were made after he chastised the registrar for coming to work wearing a backpack, and his having spoken to a nurse expressing concern about the registrar's having worn face-piercing jewellery to surgery. However, he accepted that he did drink whisky alone with her in a closed office, which he characterised as unwise in retrospect. Thus, his concession was as to imprudent behaviour on his part in leaving himself exposed to false allegations, but no more than that. His senior counsel accused the young practitioner of fabricating multiple aspects of her accounts and cross-examined her at some length in this regard. However, she adhered to her accusations in relation to Professor Kaye's conduct. On the issue of his credibility, the Tribunal commented in relation to his knowledge of the registrar's having consumed whisky with him that: 'it is almost unthinkable for someone of Dr Kaye's eminence and high standards to not take some action, for example, directing Dr A not to return to surgery, chastising her at a later time and/or reporting her to the hospital. Dr Kaye's failure to take any action is inconsistent with the events occurring as he states.' (56)

In 2019/2020 (after the incident) Professor Kaye left his role at the Royal Melbourne Hospital and his directorship of the prominent Hawthorn Football Club. He emigrated to Israel, with his wife, surrendering his Australian registration (56), and became the Hadassah Medical Organization's Director of Neurosurgery Resident Training, stating that: 'I wanted to contribute to Israel, and I felt guilty that I had not done it earlier.' On his departure, the former Victorian Premier, Jeff Kennett, communicated to Hawthorn's members and supporters appreciation for Professor Kaye's service, describing him as 'perhaps Australia's leading neurosurgeon, with huge leadership responsibilities'.

Ultimately, when the matter was resolved in 2025, the registrar's account was accepted by VCAT and Professor Kaye was disbelieved on his oath. The Tribunal commented that: 'people process trauma in different ways and it is not necessarily the case that Dr A would remember every detail of the events.' (56) Professor Kaye was found to have exerted pressures on the registrar and in relation to the sexualised overtures that he made towards her. It observed that 'in the context of Dr Kaye being an eminent and influential neurosurgeon, . . . Dr A felt pressured to drink the whisky

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and did drink the whisky'. (56) It accepted that he asked her a series of questions about her family and personal life, inviting her in the confines of his office to call him by his first name. The Tribunal found that Dr Kaye made physical contact with the junior doctor on a series of occasions and was in contact with her by personal text messages, which was conduct that was uncharacteristic of his normal behaviour. It expressed 'comfortable satisfaction' that Professor Kaye failed to maintain professional boundaries in inviting the junior doctor to his office for a non-clinical or non-academic purpose and that she felt pressures to drink the whisky he offered her. Similarly, it was comfortably satisfied that he:

> placed his right hand on Dr A's left leg and hands; attempted to stroke Dr A's hands; and touched Dr A's arm, left thigh, hip, back and bottom. This conduct was in the context of Dr Kaye sitting close to Dr A on the couch in his office with the door closed, suggesting to Dr A that she call him Andrew rather than Prof while they were in the office, and occurred immediately after Dr Kaye said to Dr A, in reference to the wall of another building immediately outside his office window, '. . . I prefer it that way, because it's private and no one can see inside'. Dr Kaye's demeanor to Dr A had changed the previous day when he discovered Dr A's interest and knowledge of whisky. He had immediately become more friendly to her and commenced sending personal text messages to Dr A. (56)

Thus, it rejected Dr Kaye's accounts generally, finding key parts of his answers to be internally inconsistent and also inconsistent with other evidence. It rejected his assertion that any physical contact he had with the registrar was accidental and non-sexual in intent. It concluded that Professor Kaye failed to maintain professional boundaries in that he engaged in uninvited conduct of a sexual nature towards his registrar. (56: at [164])

There have been few more internationally eminent specialist medical practitioners in Australia than Professor Kaye. The degree to which his stature and position in the medical profession and also within the general community must have been intimidating for the young neurosurgery registrar at the time of his misconduct and in the course of the hearing before VCAT cannot be understated. Notably, through very experienced senior counsel, he sought to impugn all aspects of the registrar's credibility and reliability. Nonetheless, it is apparent that the Tribunal engaged in a close analysis of the evidence and found the registrar, albeit 'softly spoken and 'somewhat nervous', to be 'honest and credible' in her evidence, (56) while Professor Kaye was not.

## THE KEARSLEY LITIGATION

Another outcome that can follow as a matter of law from sexual harassment of a junior doctor, a registrar, by a more senior practitioner is the preferring of criminal charges. It was this that occurred in relation to Dr John Kearsley, who, at the time of

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the commission of criminal offences against a junior doctor, was a Professor and Director of Radiation Oncology at the Cancer Care Centre at St George Hospital in Sydney, New South Wales, in Australia. He was aged sixty. He pleaded guilty to administering an intoxicating substance, Lorazepam, a benzodiazepine, to enable him to assault the Registrar indecently at a private dinner at his apartment after which he perpetrated a further indecent assault. The victim was a Fellow of the Royal Australian and New Zealand College of Radiologists and a registrar at Liverpool Hospital on secondment from St George Hospital. At the relevant time she was subject to supervision by Dr Kearsley. She informed him that she had failed her Fellowship examinations, and he invited her for dinner. The offending took place in the course of the dinner which took place to enable discussions about her career.

Initially Dr Kearsley denied the Registrar's allegations but ultimately pleaded guilty to the two charges in the District Court of New South Wales (51). Judge Hock noted that Dr Kearsley stated that he was very apologetic to the Registrar and expressed shock and disbelief at the suggestion that he had touched her inappropriately, asserting that his conduct was inconsistent with everything that he believed in: 'He explained that he had been under significant pressure and had experienced alcohol blackouts and would undertake treatment to deal with his problem. He was devastated that he had put her in this predicament and offered any third party assistance he could give her, including counselling and mediation with health professionals for both of them.' (51)

A victim impact statement was tendered to the District Court, explaining that the Registrar suffered 'constant intrusive thoughts and questions about why I was chosen to be the victim of such a despicable crime'. She said that she had experienced adverse consequences for her mental health from what had occurred – she had been robbed of her confidence and self-worth and had been treated for two years for post-traumatic stress disorder. Somewhat surprisingly, Judge Hock stated that she was not satisfied that Dr Kearsley's offending was premeditated. She received a large volume of testimonials on behalf of Dr Kearsley, reports from forensic psychiatrists which suggested that at the relevant time Dr Kearsley was suffering from a major depressive disorder, and an apology from Dr Kearsley. A psychiatrist commissioned by the prosecution expressed the view that Dr Kearsley had an adjustment disorder with depressed and anxious mood and an alcohol-use disorder at the time of committing the offences. Judge Hock accepted that Dr Kearsley's intoxication and psychiatric conditions at the time of the offences provided a context for his conduct, although they did not excuse it, and that there was only a tenuous link between his psychiatric conditions and his putting a drug in the registrar's drink and his sexually assaulting her. She accepted that Dr Kearsley was genuinely remorseful and unlikely to reoffend. She sentenced Dr Kearsley to an aggregate sentence of imprisonment of four years and three months' imprisonment with a non-parole period of two years and three months.

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However, Dr Kearsley appealed his sentence to the New South Wales Court of Criminal Appeal. (52) He was successful. The court resentenced Mr Kearsley, taking into account that by that stage he had 'lost his profession and position of good standing in the community and has been the subject of adverse media publicity. This has had a detrimental effect upon his mental health.' (52) The Court of Criminal Appeal found that the sentencing judge had erred in failing to address explicitly in her reasons the objective gravity of the offence, which in respect of the drugging was 'moderate' and in respect of the indecent assault was 'low to moderate'. The Court did not regard the principles of general deterrence as of particular significance in the case by reason of Dr Kearsley's psychiatric conditions but that his 'subjective case' was very strong. (52) The Court did note that the offences were aggravated by the relationship between Dr Kearsley and the registrar 'generated by his position as a senior medical practitioner and her position as a junior medical practitioner seeking his professional guidance'. (52) The outcome was that Dr Kearsley's appeal was allowed, and he was resentenced to a reduced term of eighteen months' imprisonment, with an immediate release, and his entering into a good behaviour bond for the balance of his sentence.

The fact that sexual impropriety is rarely a one-off form of conduct (53) was illustrated by Dr Kearsley. He was later convicted of indecently assaulting the daughter of an elderly prostate cancer patient. His modus operandi was familiar. He invited the victim to lunch at his office at St George Hospital, including giving her champagne, and then took her for a tour of the facilities. During the tour, he said: 'Your mother died of breast cancer didn't she?' and then offered to give her an impromptu breast examination. She agreed but he then proceeded to touch her naked breasts inappropriately and to squeeze her nipples. On this occasion he received a wholly non-custodial sentence. The magistrate ordered Dr Kearsley to carry out 340 hours of community service. (54)

A number of issues emerge from the Kearsley case where Dr Kearsley's victim was a medical practitioner. Although there was a manifestly predatory component to the conduct of the practitioner, and he occupied a supervisory role over his victim, a registrar, the appellate criminal court reduced his jail sentence as a result of taking into account the seriousness of his conduct and the fact that the perpetrator was able to assemble an impressive body of good character evidence and evidence from mental health professionals that he was unlikely to re-offend. Although he was later convicted a second time of sexual assault on the relative of a patient, he came before the court dealing with his indecent assault on the registrar as a person with no prior convictions and the sentence of imprisonment that he received was significantly reduced. Given the conduct in which he engaged, whether the sentence ultimately imposed was such as to acknowledge the egregious breach of trust involved in his criminal conduct and is such as to deter others minded to behave in a similar way is open to grave question.

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## THE HANDSJUK LITIGATION

Dr AB, a general practitioner, was referred to Dr Handsjuk, a psychiatrist, for treatment for symptoms of social anxiety, low self-esteem, disordered eating and depression. (55) She was treated by him for some fifteen years. The question placed before the Victorian Civil and Administrative Tribunal by the Medical Board of Australia was whether it was proved on the balance of probabilities that between approximately 1998 and 2003 Dr Handsjuk had engaged in professional misconduct in the form of intimate physical contact and/or sexualised conduct with Dr AB. After a four-day hearing, much of which involved Dr AB being rigorously cross-examined, the Tribunal concluded that Dr Handsjuk had no case to answer.

Dr AB provided extensive detail of many of her allegations but said that there were limits to what she could recall given how frequently the intimate contact took place between her and her psychiatrist. In explaining the delay in her lodging a formal notification against her psychiatrist, Dr AB said it took a long time for her to realise how devastating and damaging the interaction with Dr Handsjuk had been for her and until she became strong enough to report the conduct.

Ultimately, the Tribunal found that Dr AB had misconstrued objective facts (55) and took into account that at no time did Dr AB accuse Dr Handsjuk of sexual impropriety in her written communications with him, although she did verbalise a range of other aggrievements. The Tribunal found that Dr AB's credibility was frequently undermined and observed that 'Serious allegations with career and reputation ending repercussions require precise evidence which can survive careful scrutiny'. (55)

Thus the outcome was that Dr AB was disbelieved on her oath and the Tribunal was not satisfied that Dr Handsjuk engaged in the professional misconduct alleged against him by Dr AB. A few weeks after the Tribunal handed down its decision, Dr AB committed suicide.

The case involving Dr AB as a complainant illustrates the vulnerability of many medical practitioner complainants when they make serious allegations against professional colleagues and how difficult it is for many of them to make the hard decision to report such conduct to the investigative authorities. In addition, the interaction between the psychiatric pathology that motivates them to seek therapeutic assistance in the first place renders a medical practitioner who is a patient of another doctor very vulnerable. It can intersect in a complex way with the therapy with which they are provided, whether that therapy be orthodox or iconoclastic, proper or predatory. These considerations make resolution of complaints of sexual impropriety by a practitioner who is the alleged assailant's patient particularly complex and sensitive. However, for the complainant (as well as the practitioner accused of professional misconduct) the proceedings are extremely stressful.

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## CONCLUSION

This chapter has identified a range of considerations that tend to dissuade most persons who are the victims of sexual assault or sexual harassment from reporting what has happened to them and from initiating litigation – whether it be criminal, civil or disciplinary. However, although sexual assaults and harassment tend to be recidivist forms of behaviour, when the victim is a medical practitioner and it is another doctor who has been responsible for the conduct, additional considerations at a structural level tend to deter reporting. There is the fear about how the report will be dealt with in the workplace – in particular, whether there will be a rigorous and fair investigation – and whether embarrassing details will seep out or be leaked by the person who is the subject of the complaint. Structurally, most victims are junior doctors and most perpetrators are senior practitioners who are highly valued by the establishment, often a hospital. This imbalance of power is very confronting for most victims and, save if there is independent corroboration of what has taken place, raises challenging issues of proof, and requires determination and great courage on the part of the victim.

Junior doctors also fear reprisals and secondary victimisation from the institution and, more particularly, the perpetrator and persons associated with them. In addition, becoming known as a 'complainant' tends to be an adverse step in terms of employability, as shown by the experience of Dr Tan, who was successful in her sexual harassment claim but unable to secure the employment she aspired to in the aftermath of the litigation that she initiated and in which her allegations were accepted as well-founded. In addition, perpetrators who are senior in their profession often fight accusations very determinedly (not unusually with the de facto support of their institution and colleagues) and impugn many aspects of junior doctors' assessments, achievements and conduct, turning the focus of decision-makers onto the victim, away from the perpetrator. Dr Tan's case, as well as the case involving Professor Kaye, exemplify this.

Too often the ultimate sanction imposed on a senior practitioner is relatively benign, because highly paid legal representation can muster arguments that denigrate the complainant, as occurred with Professor Kaye, and suggest there were mitigating factors for what occurred, emphasising the high regard in which the perpetrator is held, and assembling multiple testimonials as to their good character. This is not generally an option for the victim. Dr Kearsley's case is exemplary of these dynamics.

Finally, as shown by the Dr Handsjuk case, the experience of making any kind of a serious complaint by a doctor who is another practitioner's patient is extraordinarily stressful and can be perceived as stigmatising and deeply confronting, especially for a practitioner who has 'gone out on a limb', given sworn evidence and been rigorously cross-examined. If the complaint is ultimately not believed, and frequently complainants are fearful that their account will not be accepted as against the account of a senior practitioner, who is much valued by an institution, the

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impact upon the complainant can be devastating. Psychiatric vulnerability for a complainant, because of pre-existing pathology or because of the sequelae from assaults or harassment, can be highly counter-therapeutic and may constitute a rational reason for a decision not to report unethical sexualised conduct.

Thus, there are many practical impediments to doctors who are other practitioners' patients junior doctors and medical students disclosing sexual assaults and harassment in the workplace. It is important for investigation of such matters to be efficient, independent and professional, and it is fundamental that processes should be set in place to do as much as can be done to avoid secondary victimisation of a complainant. It is vital that complainants be afforded as much practical and psychological support as possible, too, during and in the aftermath of the legal and complaints processes. However, the 'real world' experience of whistleblowers tends to be that there are multiple and enduring adverse consequences to becoming a complainant against professional colleagues. This phenomenon is not easily addressed, given the power disparities within institutions such as hospitals between medical students and junior doctors on the one hand and senior medical staff on the other. It is for this reason that potential complainants are often discouraged from proceeding with their complaints and that relatively few such cases proceed to a criminal, civil or disciplinary hearing.

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