13

Medical Regulation

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INTRODUCTION

Medical regulatory authorities (MRAs) around the world share similar objectives: to protect patients by employing effective regulatory tools to manage risk and ensure that doctors are fit to practise and contribute to the provision of high-quality health care. The term 'medical regulatory authority' refers to an organization recognised by the government of a specific country, state or province as being responsible for the regulation, and/or registration/licensure, of medical practitioners, whereby such practitioners are entitled to practise the profession of medicine. They are commonly referred to as Medical Boards or Medical Councils.

In 1994, the Federation of State Medical Boards of the United States (FSMB) hosted the first International Conference on Medical Regulation in Washington, DC. The conference was attended by representatives of Australia, Canada, Ireland, New Zealand, South Africa, the United Kingdom and the United States. Observers attended from Egypt, Israel, Mexico and Taiwan.

Designed to initiate dialogue among the attendees, the conference focused on the status of medical regulation in the participating nations, examined current research and identified future research needs. In September 2000, medical regulatory authorities from Australia, Canada, Ireland, New Zealand, South Africa, Sweden, the United Kingdom and the United States formed the International Association of Medical Licensing Authorities, which was formally incorporated in 2004 in the State of Texas, USA as the International Association of Medical Regulatory Authorities (IAMRA).

IAMRA's vision is that everyone around the world is treated and cared for by safe and competent doctors. Its stated purpose is to promote effective medical regulation worldwide by supporting best practice, innovation, collaboration and knowledge sharing in the interest of public safety and in support of the medical profession.

IAMRA recognises that effective regulation makes a vital contribution to patient and workplace safety. The challenge for medical regulators is to create relevant and effective systems that can respond to the rapidly changing environments in which doctors work, changes in health care and communication technologies, and evolving health care delivery systems.

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Given the mobility of the medical workforce, IAMRA recognises that the impacts of medical regulation can be felt across the world; what happens in one jurisdiction has the potential to affect another, both positively and adversely. Facilitating interconnectedness and collaboration is the mechanism by which IAMRA fosters best practice and collegiality in medical regulation.

IAMRA does not promote a particular model of medical regulation or dictate how MRAs should operate, recognising that regulatory models are influenced by cultural factors, the structure of the health care system, the legal framework in which regulatory authorities operate and the resources available. Even within IAMRA's membership, many different models of regulation and degrees of independence and autonomy are represented, including autonomous self-regulating MRAs, MRAs responsible to government, MRAs within a national or state government, and hybrid models.

In addition, the composition of Boards and Councils within MRAs is similarly variable. Some are comprised entirely of members elected by the profession. Others are appointed by their government. Many have legal members, but the involvement of community members is not universal, and even when present, community members may experience difficulty having their voices heard.

Recognising this diversity, one of IAMRA's objectives is to provide resources to assist members as they navigate the challenges and competing priorities of regulating the medical profession in their own jurisdiction.

Whatever model is employed, regulation of the medical profession generally involves the same key processes aimed at ensuring that doctors are fit to practise as outlined in Table 13.1. The processes relevant to the issue of sexual harassment of doctors by other doctors are setting and enforcing standards of practice, managing complaints and managing unsatisfactory professional conduct/behaviour.

Health care systems are complex, and patient safety requires individual doctors to be fit to practise, teams to operate effectively, and the health care system to be provided with the necessary resources and infrastructure. Not all of these factors are within the sphere of influence of MRAs, but MRAs are in the unique position of having statutory powers to set standards, manage complaints and ensure that medical practitioners practise medicine according to those standards. While an employer may take action that is applicable within a particular workplace, they probably will not have authority or influence over a doctor who moves their practice to another location. This is an important consideration in the management of all professional conduct matters, including sexual harassment.

STANDARDS OF PRACTICE

IAMRA recognises that a multitude of attributes contributes to a doctor's fit to practise. (1) In the list below, those in bold are most relevant to the topic of sexual harassment in medicine.

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TABLE 13.1 *Medical regulation authorities' common key processes*

Initial licensure – a process during which a doctor's qualifications and experience come under careful scrutiny, along with other fitness to practise considerations.
Renewal of licensure – a process requiring consideration of a doctor's continuing competence and fitness to practise.
Setting and enforcing standards of practice.
Managing complaints – a process which may highlight fitness to practise concerns.
Managing unsatisfactory professional conduct/behaviour – a process that may result in disciplinary action as well as restrictions of the doctor's practice.
Managing impairment– a process whereby impaired doctors are able to continue in practice, if the impairment does not impede their ability to provide safe and effective care.
Managing poor performance – a process generally focused on remediation, but which may require restrictions on the doctor's practice or disciplinary action, if appropriate.
Reinstatement of licensure – a process whereby the reinstatement of a doctor's licence is considered, following a period of voluntary or imposed revocation.
Establishing and maintaining relationships with stakeholders.

Note: Those particularly relevant to sexual harassment and abuse between doctors are in bold.

- They must possess a recognised and relevant qualification;
- They must always practise in accordance with their training and competence;
- They must demonstrate professionalism through their ongoing commitment to maintaining their competence throughout their working life;
- Their personal health must not adversely impact their practice;
- They must make safe and appropriate judgments, recognise when their performance is compromised and act accordingly;
- **They must always demonstrate professionalism in their interactions with patients and colleagues**;
- **Their professional conduct and behaviour must always reflect the expectations of the community and the trust placed in them**.

'Professionalism in their interactions with patients and colleagues' is recognised by IAMRA because of the potential for unprofessional conduct towards colleagues to adversely impact on clinical teams, whether that conduct occurs in the workplace or outside it. Sexual harassment, perpetrated by a doctor, falls squarely into this domain. The argument frequently put forward in the defence of a medical practitioner accused of sexual harassment of a colleague, that the conduct did not involve patients, can be refuted when the impact of such behaviour on clinical teams and on the integrity and reputation of the medical profession is recognised.

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Regulators' Expectations of Medical Practitioners

MRAs generally expect that medical practitioners will exhibit behaviours and attitudes that reflect the expectations of those with whom they interact and the society in which they work. Professional misconduct is variously named and defined in the particular legislation MRAs administer, and there is a spectrum of professional behaviour that may constitute grounds for disciplinary action against a practitioner. Universally, the sexual assault of a patient would constitute grounds for disciplinary action, but MRAs' policies and codes of conduct in relation to sexual harassment of colleagues are not always explicit. However, many MRA's have documented a clear expectation of how doctors should conduct themselves in relation to their colleagues. Some examples follow.

International Examples of Relevant Standards of Practice

Australia

The Medical Board of Australia document, Good Medical Practice: a code of conduct for doctors in Australia, (2) provides a comprehensive standard, stating:

> 1.2 Use of the code
>
> Doctors have a professional responsibility to be familiar with Good Medical Practice and to apply the guidance it contains.

This code will be used:

> to assist the Medical Board of Australia in its role of protecting the public, by setting and maintaining standards of medical practice against which a doctor's professional conduct can be evaluated. If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration.

and

> 5.4 Discrimination, bullying and sexual harassment
>
> There is no place for discrimination (including racism), bullying and sexual harassment in the medical profession or in healthcare in Australia. Respect is a cornerstone of good medical practice and of patient safety. It is a feature of constructive relationships between medical practitioners, their peers and colleagues on healthcare teams, and with patients. Discrimination, bullying and sexual harassment adversely affect individual health practitioners, increase risk to patients and compromise effective teamwork by healthcare teams.
>
> Good medical practice involves:
>
> 5.4.1 Being fair and showing respect for peers, colleagues, co-workers, students on health care teams and patients.
>
> 5.4.2 Not discriminating against, bullying or sexually harassing others.

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5.4.3 Providing constructive and respectful feedback to colleagues, trainees, international medical graduates and students, including when their performance does not meet accepted standards.
5.4.4 Being open to receiving constructive feedback.
5.4.5 Doing or saying something about discrimination, bullying or sexual harassment by others when you see it and reporting it when appropriate.

Good medical practice in the management of discrimination, bullying or sexual harassment requires a timely, proportionate and fair response, including:

5.4.6 Having zero tolerance for discrimination, bullying and sexual harassment.
5.4.7 Providing respectful and timely feedback to another medical or health practitioner about behaviour that does not meet accepted standards.
5.4.8 Early, timely, local and fair management of concerns about discrimination, bullying and sexual harassment whenever possible, including through existing employer complaints resolution processes to help minimise harm and build a culture of respect.
5.4.9 Appropriate information sharing, within the law, by all relevant parties such as employers and specialist medical colleges, to support effective resolution and remediation, when possible.
5.4.10 Referring concerns about discrimination, bullying or sexual harassment to the Medical Board when there is ongoing and/or serious risk to patients, students, trainees, colleagues or health care teams (in addition to mandatory reporting obligations).

British Columbia, Canada

The College of Physicians and Surgeons of British Columbia, in their practice standard on sexual misconduct, (3) states;

> Registrants must be aware of and never exploit the power imbalance in a registrant–learner or registrant–coworker relationship. Registrants must not make sexual comments or gestures toward a learner or co-worker or enter a close personal or sexual relationship with a learner or co-worker while directly or indirectly responsible for mentoring, teaching, supervising, or evaluating that individual.

New Zealand

The Medical Council of New Zealand / Te Kaunihera Rata o Aotearoa standard on unprofessional behaviour (4) states:

> As a doctor, you have an obligation to be respectful and professional as your behaviour may affect how a health team functions, how care is delivered to patients, and the public's trust and confidence in the medical profession.

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It also states:

> Unprofessional behaviour may erode trust, and create division and conflict with other members of the health care team, including all who are involved in the patient's care. It can affect the morale and mental well-being of others, as well as the inclusivity, collegiality and culture in your practice setting or workplace.

Singapore

The Singapore Medical Council (SMC) document, Ethical Code and Ethical Guidelines (ECEG), (5) states:

> The SMC takes the view that serious disregard of or persistent failure to meet the standards set out under the ECEG can potentially lead to harm to patients or bring disrepute to the profession with loss of confidence in the healthcare system and consequently may lead to disciplinary proceedings.
>
> D5. Colleagues under supervision
>
> Teaching, supervising and mentoring junior doctors and other healthcare professionals is an important part of professional life and forms part of your obligation to improve the care of patients in the community. This means:
>
> (2)You must not abuse your position as a teacher or supervisor to exploit supervisees for personal gain or gratification. You must not enter into emotionally intimate or sexual relationships with your supervisees while they are under your charge.

United Kingdom

The General Medical Council document, Good Medical Practice, (6) states:

> Good Medical Practice describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with the Good Medical Practice standards and the explanatory guidance which supports it, following the guidance they contain.

These standards require the doctor to work collaboratively with colleagues, outlining the following expectations:

> 52. You must help to create a culture that is respectful, fair, supportive, and compassionate by role modelling behaviours consistent with these values.
>
> 53. You should be aware of how your behaviour may influence others within and outside the team. . . .
>
> 56. You must not abuse, discriminate against, bully, or harass anyone based on their personal characteristics, or for any other reason. By 'personal characteristics' we mean someone's appearance, lifestyle, culture, their social or economic status, or any of the characteristics protected by legislation – age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

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> 57. You must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress. What we mean by acting 'in a sexual way' can include – but isn't limited to – verbal or written comments, displaying or sharing images, as well as unwelcome physical contact. . .
>
> 58. If you witness any of the behaviours described in paragraphs 56 or 57 you should act, taking account of the specific circumstances. . . . We recognise some people may find it harder than others to speak up4 but everyone has a responsibility – to themselves and their colleagues – to do something to prevent these behaviours continuing and contributing to a negative, unsafe environment.
>
> 59. If you have a formal leadership or management role and you witness – or are made aware of – any of the behaviours described in paragraphs 56 or 57, you must act. You must:
>
> a. make sure such behaviours are adequately addressed
>
> b. make sure people are supported where necessary, and
>
> c. make sure concerns are dealt with promptly, being escalated where necessary.

United States of America

A Federation of State Medical Boards (FSMB) paper entitled 'State Medical Board recommendations for stronger approaches to sexual misconduct by physicians' (7) primarily addresses the issue of sexual misconduct directed towards patients, but does include reference to harassment between doctors in the following statement:

> The medical profession must promote a culture in which sexual misconduct in any form is not tolerated. Such behaviour undermines professional attainment, and when that behaviour is tolerated, overtly or tacitly, it reduces the likelihood of bystander reporting and erodes professional culture in a patient-centered system. Sustaining this effort across the entire profession and in every clinical setting, both inpatient and outpatient, will be critical to maintaining the public's trust. (7)

MRAs whose codes of conduct explicitly state that sexual harassment of colleagues constitutes a breach of professional standards are in a strong position to take action against a medical practitioner who is not compliant with the code. Even if an MRA is not explicit about its expectations, there may still be mechanisms available by which it can deal with the issue. For example, laws under which MRAs operate frequently require registered/licensed medical practitioners to be 'of good character', or words to that effect. However, reliance on this inexplicit requirement alone can be problematic in the prosecution of individual cases.

REGULATORY RESPONSE TO COMPLAINTS OF SEXUAL HARASSMENT

MRAs generally become aware of departures from acceptable standards of conduct through notifications or complaints, but for the reasons explained elsewhere in this book, the victims of sexual harassment may be reluctant to come forward.

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In general, MRAs would expect that sexual harassment would, in the first instance, be dealt with in the workplace, supporting the victim/s and addressing the perpetrator's behaviour. However, in more egregious cases, for example, sexual assault or repeat harassment, should, in addition, be referred to the MRA so that the conduct can be viewed through the lens of professional standards, public protection and community expectations. Importantly, the MRA can deal with the issue at the level of the practitioner's registration/licensure, unlike the employer, whose remit may only relate to their employment in a specific location.

In some jurisdictions, practitioners and the courts are required to notify the MRA when a medical practitioner is subject to criminal charges or convictions in relation to certain offences, and this is a valuable intersection between the criminal justice system and the medical regulatory system. It may be possible for both processes to proceed in parallel, the MRA dealing with the practitioner's fitness to practise medicine and the courts determining if a criminal act has been perpetrated.

In addition, mandatory notification legislation, present in some jurisdictions, may place an obligation on registered health practitioners to notify the MRA of concerns about the conduct or fitness to practise of another registered practitioner. This obligation may also apply to medical practitioners who are colleagues or employers of the alleged perpetrator.

Important in this discussion is the realisation that MRAs are wholly reliant on receiving notifications or complaints about sexual harassment and sexual assault; they are not in the business of workplace surveillance. In the case of sexual harassment, it is often preferable for a complaint to be made by an employer, rather than the victim, so as not to place the victim in direct opposition to the perpetrator.

When made aware of sexual harassment or sexual assault perpetrated by a medical practitioner against another medical practitioner (or indeed, any other colleague), MRAs are generally well placed to deal with the issue with legislated and effective tools; this is even more so when the decision-making board/council has a good gender balance, community representation and a clear understanding of contemporary professional and community standards.

When an MRA becomes aware of an issue of sexual harassment or sexual assault, a typical response would involve some or all of the following steps:

- Seeking the practitioner's response, unless the complainant does not wish their identity to be disclosed. This can be an impediment to an individual complaint going further, as the principles of procedural fairness are such that in order to provide a full response, the practitioner needs to know the details of the accusation. It is often helpful for there to have already been a workplace-based investigation, particularly if multiple victims have come forward;
- Reviewing past notifications and complaints about the practitioner, looking for a pattern of similar or other relevant behaviour;

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- Low level intervention, if appropriate, such as a warning letter or counselling interview;
- Consideration of urgent, interim action. Depending on the legislative framework, this action may be taken for the health and safety of the public, or more generally, in the public interest. In the most egregious cases, interim action may include actions such as suspension of the practitioner's registration or imposition of conditions on their registration pending further investigation;
- Full and detailed investigation, possibly including multidisciplinary assessment of the practitioner to consider the risk of recidivism;
- Prosecution by the MRA or their agent when the investigation points to unsatisfactory professional conduct or professional misconduct.

When findings are made against a medical practitioner, action by the MRA or its agent may take a variety of forms, including:

- Reprimand or censure, placed on the practitioner's record;
- Suspension of their registration/license for a specified period of time;
- Restricted or conditional registration/licensure;
- Monetary fine;
- Deregistration, erasure, license revocation;
- Notification of other jurisdictions in which the medical practitioner is known to be registered;
- Inclusion of relevant information on certificates of registration/licensure status in circumstances where the medical practitioner seeks registration/licensure in another jurisdiction.

CONCLUSION

From the regulatory perspective, most, if not all, medical regulatory authorities view sexual harassment of a medical practitioner by another medical practitioner to be unsatisfactory professional conduct or professional misconduct, because the distress caused to the victim of sexual harassment and the potential for the clinical team to be disrupted as a result are detrimental to public health and safety, and contrary to the reasonable expectations of the medical and non-medical community about standards of behaviour of medical practitioners.

While it is usually appropriate for lower-level instances of sexual harassment of colleagues to be dealt with in the workplace in the first instance, consideration should be given to referring more egregious cases and repeat offenders to the medical regulatory authority, which can, in all likelihood, take action, including urgent action, applicable in all locations in which the medical practitioner practises. If the medical practitioner is known to be registered/licensed in another jurisdiction, that jurisdiction can be notified. Similarly, if the medical practitioner seeks

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registration/licensure in another jurisdiction, the medical regulatory authority can provide relevant information on a certificate of registration/licensure status, or similar, ensuring that the practitioner is held accountable wherever they choose or seek to practise.

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