



# SEXUAL BOUNDARIES IN THE DOCTOR-PATIENT RELATIONSHIP

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A resource for doctors

Medical Council of New Zealand

Protecting the public, promoting good medical practice

Te tiaki te iwi whānau me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

The Council continues to support touch as a crucial, healing part of the practice of medicine, when that touch is caring or nurturing, non-intrusive and not sexual or exploitative.

The Medical Council of New Zealand is the organisation in New Zealand responsible under the Health Practitioners Competence Assurance Act 2003, to protect the health and safety of the public by providing for mechanisms to ensure that doctors are competent and fit to practise medicine.

The Council's objective in this publication is to assist you by detailing and explaining your professional and ethical responsibilities to maintain sexual boundaries with patients. It gives guidance on how to do this, and what to do if you feel that you or a peer may breach sexual boundaries.

If you have any questions about the content of this publication or would like to discuss a specific situation, contact a senior staff member of the Council.

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# Introductory statement

1. The Council has a zero-tolerance position on doctors who breach sexual boundaries with a current patient<sup>1</sup>. In the Council's view it is also wrong for a doctor to enter into a relationship with a former patient or a close relative of a patient if this breaches the trust the patient placed in the doctor.
2. The Council rejects the view that changing social standards require a less stringent approach. Only the highest standard is acceptable and the professional doctor-patient relationship must be one of absolute confidence and trust.
3. As the professional, it is your responsibility to maintain sexual boundaries with your patients.
4. In summary, this position is because:
  - a breach of sexual boundaries in the doctor-patient relationship has proven to be harmful to patients and may cause emotional and/or physical harm to both the patient and the doctor
  - trust in the doctor-patient relationship is the basis of the professional relationship and a breach of boundaries is a breach of trust
  - the doctor-patient relationship is not equal. Doctors can influence and possibly manipulate some patients, so even if a patient has consented to a sexual relationship this is not a sufficient excuse and it is still considered a breach of sexual boundaries
  - sexual involvement with a patient impairs clinical judgement.

<sup>1</sup> The Council has identified the transfer of patient records as the official termination of the doctor-patient relationship. Refer to Council's statement *Ending the doctor-patient relationship*.

# Doctors' Information

## What is considered a breach of sexual boundaries?

5. A breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse or gratify sexual desires. It is not limited to genital or physical behaviour. It incorporates any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate or unprofessional.
6. A common misperception is that breaches of sexual boundaries in the doctor-patient relationship are restricted to male doctors with female patients. This is not true. A female or male doctor may breach a sexual boundary, with either a female or a male patient.
7. In the early 1990s the Council defined three levels of inappropriate sexual behaviour in the doctor-patient relationship. The purpose of categorising this behaviour into three levels is to illustrate the continuum of behaviour that is considered inappropriate, unprofessional and unethical and to show that a breach of sexual boundaries is not limited to sexual assault.
8. Sexual impropriety means any behaviours, such as gestures or expressions, that are sexually demeaning to a patient, or that demonstrate a lack of respect for the patient's privacy. Such behaviours include, but not exclusively:
  - examining the patient intimately without his or her consent
  - conducting an intimate examination of a patient in the presence of students or other parties without the patient consenting to the presence of the students
  - making inappropriate comments about, or to, the patient, such as making sexual comments about a patient's body or underclothing
  - making sexualised or sexually-demeaning comments to a patient
  - making comments about sexual performance during an examination or consultation (except where pertinent to professional issues of sexual function or dysfunction)
  - making irrelevant comments about or ridiculing a patient's sexual orientation
  - requesting details of sexual history or sexual preferences not relevant to the type of consultation
  - any conversation regarding the sexual problems, preferences or fantasies of the doctor.

9. Sexual transgression includes any inappropriate touching of a patient that is of a sexual nature, short of sexual violation, including but not exclusively:
- manual internal examination without gloves
  - touching breasts or genitals, except for the purpose of appropriate physical examination or treatment
  - touching breasts or genitals when the patient has refused or withdrawn consent for the examination or treatment
  - inappropriate touching of other parts of the body which may also be construed as sexual transgression
  - propositioning a patient.
10. Sexual violation in the doctor-patient relationship<sup>2</sup> means a doctor having sexual intercourse with a patient (whether or not contact is initiated by the patient), masturbation, clitoral, penile or rectal stimulation or other forms of genital or other sexual connection (including where drugs or services are exchanged for sexual favours).

## Why does Council have a zero-tolerance position?

11. Professional boundaries are set to establish appropriate behaviour between a professional and his or her clients. The boundaries in the doctor-patient relationship are particularly important because there is a physical and intimate aspect to the relationship that does not exist with most other professionals.
12. At your request a patient will undress, allow physical touch normally limited to partners and family, and share private and personal information on the sole basis that you are a doctor. For this reason clear sexual boundaries are necessary to ensure professional and ethical behaviour is maintained throughout the professional relationship.

## Trust in the doctor-patient relationship

13. Trust is the basis of the doctor-patient relationship.
14. This trust lets a patient discuss private, confidential and personal information with you. By creating an environment of mutual respect and trust, in which your patients feel confident and safe, a patient will allow you to perform physical examinations.

<sup>2</sup> The definition's sexual violation in the doctor-patient relationship is not intended to be interchangeable with the definition of sexual violation as defined in the Crimes Act 1961.

15. The successful doctor-patient relationship may not depend solely on you, as you are only one half of the relationship, however, as the professional, it is your responsibility to maintain clear sexual boundaries.

### **Harm to the patient**

16. A breach of sexual boundaries in the doctor-patient relationship has proven to be harmful to patients and may cause emotional and/or physical harm to both the patient and the doctor.

### **Power imbalance**

17. The doctor-patient relationship is not equal. When seeking assistance, guidance and treatment, the patient is vulnerable.

18. This power imbalance is often subconscious. It is not dependent on the intelligence, education or confidence of the patient. It exists in every doctor-patient relationship, whether the patient is a child or the chief executive of a company.

19. This may be considered a paternalistic and condescending position, however, it is based on sound reasoning that has been subject to study and is supported by evidence.

20. The major reasons for an imbalance are:

- the patient shares personal information with you that he or she rarely shares with others
- you do not reciprocate with personal information and therefore it is a one-sided relationship
- the close physical contact that occurs in a consultation is based solely on your position as a doctor
- as the doctor, you determine the level of physical contact through examination
- the patient does not have an equal power status in the relationship.

### **Sexual involvement impairs clinical judgement**

21. As with other close relationships (eg, with family members) your personal involvement with a patient may impair your judgement about diagnosis or treatment because your emotions are involved.

22. Concern about personal and professional commitments may influence your decisions about seeking and providing good care to the patient.

## Doctor's responsibilities to maintain sexual boundaries

23. As the professional, the onus is always on you to behave in a professional manner. You must ensure that every interaction with a patient is conducted in an appropriate professional manner.
24. The community and the profession expect you to have integrity. The community must be confident that you will maintain professional boundaries and that no patient will be at risk.
25. It is not acceptable to blame a patient for any of your transgressions.

## Mechanisms to assist maintenance of sexual boundaries

26. You can arrange your practice in a manner that helps you to maintain boundaries. By acknowledging the patient's perceptions and feelings (eg, embarrassment at having to undress), you can create an atmosphere where the patient is confident and trusting. This will contribute to a successful doctor-patient relationship.

## The importance of open and clear communication

27. An important aspect of any consultation is communication with the patient. You must obtain informed consent before conducting a physical examination. This is not only a right of the patient but the discussion will also help to avoid miscommunication or misunderstanding about what you are asking or doing.
28. Your actions and how you communicate them to the patient influence the patient's perceptions about what you do and the treatment he or she receives. What may be an acceptable form of physical examination may appear suspicious behaviour to a patient if he or she does not understand what is happening and why it is necessary.  
  
Explain why you are asking questions or why the physical examination is necessary and what will happen in the examination. Remember that it may be obvious to you why these questions or examinations are necessary but it may not be obvious to the patient.
29. Make sure the patient is aware that he or she should voice any feelings of discomfort or pain and that he or she can ask you to stop at any time.

## Disrobing facilities

30. If the consultation involves a physical examination that requires the patient to remove his or her clothes, you should provide an appropriate place to undress. This is an area where the patient can undress in private, out of view of anyone else, including you (although someone should be able to help if necessary).
31. Disrobing facilities may be provided by a curtain or a separate changing area.
32. You should not require a patient to undress unnecessarily or stay undressed for unnecessary lengths of time. For example, the patient only needs to uncover the part of the body that is being examined, and should be allowed to cover it again once you have finished.
33. If the physical examination includes several parts of the body, you should endeavour to allow the patient to cover as much of his or her body as possible before moving on.
34. For some physical examinations it may be appropriate for you to provide a robe if the patient's own clothing makes examination difficult.

## When another person is present

35. You or your patient may want another person present. This may help you or the patient feel more comfortable in what could be an embarrassing consultation. Appendix 1, at the end of this booklet, gives more information about this.

## What to do if you feel boundaries are threatened

36. It is important to remember that doctors and patients have the same emotions and feelings as any other people. It is not uncommon for two people who meet in a professional setting to feel attracted to each other.
37. Judgement on your behaviour is not based on the attraction you feel towards a patient but how you respond to this attraction. It is important to recognise the harm that can occur when sexual boundaries are breached.

## Danger signs

38. An improper emotional or sexual relationship between you and a patient can start very easily. You need to watch for danger signs that indicate that professional boundaries are threatened. Early recognition and action can help avoid discomfort or harm to you or the patient. Danger signs include:

- seeing patients at unusual hours, especially when other staff are not there
- preferring a certain patient to have the last appointment of the day
- giving or accepting social invitations from a patient
- revealing intimate details about your life to a patient during a professional consultation, especially personal crises or sexual desires or practices.

### **What to do if you feel sexually attracted to a patient**

39. It is difficult for any professional to objectively assess the appropriate action when he or she is attracted to a client. By recognising the danger signs you can consciously avoid any improper behaviour before any damage is done.
40. The identified danger signs are documented in a number of past cases where doctors have acted sexually inappropriately with patients<sup>3</sup>. If you recognise your own behaviour in any of the above points or you feel attracted to a patient, ask for help and advice from a respected peer who can help you to decide the appropriate and ethical course of action.
41. Whether it was you or the patient who first threatened sexual boundaries in the doctor-patient relationship, as the professional you need to take action. You may still feel able to continue being the patient's doctor. However, if you believe you cannot remain objective and professional, it is important that you find alternative care for the patient.
42. You can also ask for advice from the Medical Council, the New Zealand Medical Association (NZMA), Doctors for Sexual Abuse Care (DSAC) or your college.

### **Patients acting inappropriately towards doctors**

43. If a patient is attracted to you and his or her behaviour is threatening the sexual boundaries of the doctor-patient relationship, you need to take measures that put a stop to this behaviour.
44. If possible, try to discuss the patient's feelings and attraction in a constructive and helpful manner that explains the inappropriateness of a relationship. If this is not possible, it is best to transfer the care of the patient to another doctor.

<sup>3</sup> MPDT Decision No: 28/97/16D  
 MPDT Decision No: 29/97/17D  
 MPDT Decision No: 144/00/64C  
 MPDT Decision No: 170/01/72D

45. Advice from your peers is helpful and the Council strongly recommends you speak with a peer before taking any action.
46. Consider obtaining a copy of Council's publication *The importance of clear sexual boundaries in the patient-doctor relationship* which is written for patients.

## Your duty to notify

47. If you receive or become aware of information that another doctor may have breached sexual boundaries with a patient you have certain ethical obligations.

### Notification by a patient

48. If a patient discloses an alleged breach of sexual boundaries by another doctor, or any person, you should try to help the patient by explaining his or her options, ie, tell the police, contact a patient advocate and/or make a complaint to the Health and Disability Commissioner.

It is important to remember that this may be the first time the patient has disclosed the alleged breach and your reaction may influence the patient's future disclosures.

49. The Council has an information pamphlet for patients on breaches of sexual boundaries in the doctor-patient relationship and the local advocacy service may be able to help (refer to the end of this document for contact details).
50. As the patient's doctor you are obligated to try and answer any questions the patient raises about sexual behaviour in a professional relationship, or help him or her to find another source of assistance.
51. If the patient wants to make a complaint you should direct the patient to the advocacy service, the Health and Disability Commissioner, and in the matter of sexual violation, the police.
52. If the patient does not want his or her name revealed, but still wants to report the situation, you have a professional and ethical obligation to notify the Registrar of the Council about the alleged behaviour, even if the information is limited. Initially this may be done by phone, email or in writing, and should include your name and contact details, the name of the doctor involved, and the details of the incident(s).
53. Even if you have not witnessed, or have no evidence of the alleged breach of sexual boundaries, you should still tell the Registrar. The Registrar will identify these matters when your notification is considered.

54. If the patient says he or she does not want to file a report, but you believe there is a serious and imminent threat to the patient's safety or that of another person, you should tell the police immediately. Under the Health Information Privacy Code 1994, you are not liable for this notification if the threat is 'serious and imminent'<sup>4</sup>.
55. In each of the above scenarios you have an ethical obligation to discuss the issue and offer to help the patient to make a complaint, or find more help for the patient.

### **Notification by a peer**

56. If you are approached and asked for advice from a peer who feels attracted to a patient but has not acted inappropriately, you do not have an ethical duty to inform anyone. You may counsel and advise the doctor without worrying that you must then tell the Council.

However, if you feel that the doctor or the patient may be at risk of harm or if you feel that you need help in advising your peer, the Council strongly recommends that you ask for help.

57. If you are approached by a doctor who has breached sexual boundaries with a patient, your first priority must be the patient's safety. You may ask a senior staff member of the Council for confidential advice.
58. The Registrar will discuss the situation with you and explain the range of options that are available. Together you and the Registrar can explore what safeguards are necessary and how the situation can be addressed.

### **What happens when you notify the Council—is this a formal complaint?**

59. When you contact the Council to notify that a peer may have breached sexual boundaries the matter will be referred to the Registrar.
60. The Registrar will accept your notification and discuss with you the facts of the situation and what information is available.
61. Your notification will not be considered a formal complaint about the peer without your cooperation. The Council does not accept anonymous complaints or concerns.

<sup>4</sup> Please refer to the Council's statement *Confidentiality and public safety* for more details or contact the Registrar of the Council if you are unsure about the level of seriousness.

## Disciplinary action

62. The Council is not a disciplinary body. Any complaints are referred to the Health and Disability Commissioner.
63. If the Commissioner decides that it may be a disciplinary matter, the doctor will be referred to the Director of Proceedings who decides whether to begin disciplinary proceedings by laying a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal process is a legal hearing with lawyers and a panel of Tribunal members that consists of a legal chair, three doctors and a member of the public, all appointed by the Minister of Health. Detailed information about the Tribunal process is available from the Tribunal office (phone: 04 381 6816) or the Tribunal website ([www.hpdt.org.nz](http://www.hpdt.org.nz)).
64. If a doctor is found guilty of breaching sexual boundaries, he or she may be fined, have to pay some of the costs of the hearing, be suspended, have conditions placed on his or her registration, or be removed from the medical register.
65. The Tribunal does not have the power to remove a doctor from the medical register for life, but can specify a minimum time before the doctor can reapply for registration.

## Applications for re-registration

66. A doctor may be re-registered after he or she has been removed from the register because of disciplinary action.
67. The principal purpose of the Council is to ensure doctors are competent and fit to practise, therefore protecting the health and safety of the public. For that reason the Council is cautious in approving applications for re-registration from doctors who have been removed from the register as a penalty for breaching sexual boundaries.
68. The Council expects that, for an application to be successful, the doctor will have to provide evidence of his or her successful therapy and rehabilitation, supported by an independent assessment by a person appointed for that purpose by the Council.

## Conditions on practice

69. Doctors who have been removed for a breach of sexual boundaries may apply for re-registration. If this is granted, the doctor will probably have to practise with certain conditions. These may include:

- supervision
- use of a chaperone
- restricted practice, ie, the doctor's practice may be limited to a certain type of medicine or to working in a specific medical practice.

70. Conditions ordered by the Council are not subject to time limits. However, natural justice requires the Council to regularly revisit any conditions on a doctor to be sure they are still appropriate, relevant and justifiable.

## Sexual relationships with former patients

71. There are times when two people, such as a doctor and a patient who meet through a professional service, want to start a personal relationship.

72. However, research shows that a former patient may still be harmed by having a relationship with his or her former doctor even if he or she has been transferred to another doctor. Although not definitive, the research indicates that harm is often linked to the intensity of the doctor-patient relationship. For example, the length of the professional relationship, the frequency of contact and the type of care provided.

73. Because each doctor-patient relationship is individual, and because everyone reacts differently to circumstances, it is difficult to have clear rules on when it is or is not acceptable for a doctor to have a relationship with a former patient.

74. Council's zero-tolerance position on sexual relationships in the doctor-patient relationship has not expanded to include doctors and former patients. The Council recognises that where a former doctor-patient relationship was very minor or temporary a total ban on any subsequent relationship is unfair and unrealistic. An example could be where a doctor treats a minor condition such as a sprained ankle in a one-off situation.

75. The Council also recognises that in some situations a doctor has to practise and socialise within a small community. The doctor will then find it difficult to socialise with individuals who are not, or have not been, a patient at some stage. For example, rural areas or doctors with a certain sexual orientation or who live within a cultural community.

76. However, there are some situations where it would never be acceptable for a doctor to have a relationship with a former patient.

### **When a sexual relationship is never acceptable**

77. A sexual relationship between you and a former patient is never acceptable if:

- the doctor-patient relationship involved psychotherapy, or long-term counselling (informal or formal) or emotional support
- the patient has had, or has, a condition or impairment likely to confuse his or her judgement or thinking about what he or she may want to do
- the patient has been sexually abused in the past
- the doctor-patient relationship is ended for the sole purpose of initiating a sexual relationship.

78. A sexual relationship between you and a former patient will always be regarded as unethical if it can be shown that you have used any power imbalance, knowledge or influence obtained while you were the patient's doctor.

79. It is important that you recognise the influence you have had as the patient's doctor, and that the resulting power imbalance from the professional relationship may continue for some time after the patient stops consulting you.

80. If you are thinking about developing a relationship with a former patient, it requires serious consideration. Make sure you consider any possible future harm to the patient before making a decision.

### **Things to consider**

81. The Council strongly recommends that you make this decision in consultation with respected peers. Issues to consider include:

- The length of the doctor-patient relationship. The longer the relationship the less appropriate a personal relationship is, because the power imbalance from the doctor-patient relationship is more firmly entrenched.

- When did the doctor-patient relationship finish and what interaction have you had with the patient since? As discussed in sections 17-20, the power imbalance is often not immediately recognised. If the patient has only recently adopted the 'former' status, sufficient time may not have passed for the emotional connection as a patient to abate.
- What was the context of your relationship with the former patient? Did your professional relationship include a supportive, advisory or informal counselling role? Was there formal counselling? Are there privacy issues to consider? In these circumstances, developing a relationship with a former patient is not acceptable.
- The type of doctor-patient relationship. Were you a family doctor and if so will you still be caring for other family members? Were you a surgeon and, if so, what impact did the surgery have on the patient, ie was it minor or life changing? Overall, what impact has your care had on the former patient?
- Your understanding of the dynamics of the doctor-patient relationship and your knowledge of the concept of transference. Refer to the literature to check that you fully understand the dynamics of your relationship with the former patient reference annotated bibliography.
- The patient's understanding about the dynamics of the doctor-patient relationship and his or her knowledge of the concept of transference. If you are considering having a relationship with a former patient, the Council expects you to tell the patient about the issues to do with possible harm from a doctor-patient relationship. It may be appropriate to help the patient get independent counselling.
- The circumstances surrounding ending of the doctor-patient relationship. The Council does not believe it is acceptable to end a doctor-patient relationship for the sole purpose of starting a sexual relationship.
- The patient's degree of vulnerability. For example, patients undergoing psychotherapy may be particularly vulnerable, as may those with certain psychological, physical or character traits.

82. The doctor-patient relationship is often very intense. Even though it may not be thought so by either you or your patient, by considering the above points you can more accurately assess the intensity.

Remember that the more intense the doctor-patient relationship, the more likely it is you and your patient may find yourselves in a situation where feelings towards each other are more likely to become confused between professional care and personal feelings.

## **Sexual relationships with family members of patients**

83. It is important for you to be aware of the influence you have as the doctor of a family member. This influence may be similar to the influence you develop with a patient.
84. You should think carefully before developing a relationship with a family member of a patient. If you do develop a relationship, ensure that there is no harm to the patient.
85. A sexual relationship between you and a family member of a patient will always be regarded as unethical if it can be shown that you have used any power imbalance, knowledge or influence obtained as the patient's doctor.
86. If you are unsure, ask for advice from a respected peer, the Medical Council, the New Zealand Medical Association (NZMA), Doctors for Sexual Abuse Care (DSAC) or your college.

# Appendix 1

## When another person is present during a consultation

**For some or all consultations, a doctor or patient may want another person present. When a third person attends a consultation, the doctor and the patient should understand their rights to grant or withhold consent and when the attendance of a third person is mandatory. The role and function of the third person should be clearly understood by all parties.**

1. The use of a third person is not restricted to consultations between male doctors and female patients or when conducting physical or intimate examinations. Male and female patients may wish to have a third person present for any number of reasons and doctors, whether they are male or female, may also have this preference.

## Definition and role of the third person

2. The individual circumstances of the consultation, the doctor and the patient, will determine the role of the third person in a consultation. A third person may be present to participate in one of the following five roles as defined in this statement:
  - a support person for the patient
  - an interpreter for the patient
  - an observer for the doctor
  - a student or trainee
  - the doctor's chaperone.

## Support person for the patient

3. Right 8 of the Code of Health and Disability Services Consumers' Rights states that "every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed".

4. The support person(s) may be present in all or part of the consultation to provide support for the patient. Any aspect of a consultation, not just a physical examination, may cause discomfort or confusion and the patient has a right to request one or more support people in attendance. The function and role of the support person(s) focuses on the needs of the patient, whether it be holding the patient's hand, observing the consultation or asking questions on behalf of the patient.
5. Some reasons a patient may request the presence of a support person(s) are:
  - he or she feels more comfortable with the presence of a support person(s)
  - it is the first consultation in a new doctor-patient relationship
  - the patient's cultural expectations include the presence of a third person
  - the patient's age (either young or old)
  - the patient would like assistance to understand what happens in the consultation
  - the patient has some form of mental or physical disability.

## Interpreter

6. In some circumstances an interpreter may be present to assist in the communication between the doctor and patient. An interpreter may assist with translating a different language (ie a foreign language) or with the communication or understanding of someone with a disability or alternative form of communication (ie, sign language). This is the patient's right under Right 5(1) of the Code of Health and Disability Services Consumers' Rights.

## Observer for the doctor

7. This person is present at the doctor's request. A doctor may request an observer for a number of reasons:
  - it is the policy of the organisation or practice to have an observer in attendance. Some employers have a practice policy that a third person should be in attendance for certain types of examinations or consultations (eg, internal examinations)
  - an observer may be used in continual professional development (CPD) to assess the doctor, with the intention of providing advice and guidance on how the doctor can improve his or her skills.

8. The role of the observer is to observe the consultation or part of a consultation on the doctor's behalf, including the communication between the doctor and patient and any examination that takes place. The level of the observer's interaction in the consultation should be agreed to before the consultation is initiated, both between the doctor and observer, and between the doctor and patient.
9. Consent for the presence of the observer should be obtained from the patient prior to the start of the consultation.

## Students or trainees

10. As part of their education, health professional students and trainees need to have the opportunity to access and learn from senior doctors with on-the-job training. This means attending actual patient consultations. Participation in teaching is covered by the Code of Health and Disability Services Consumers' Rights.
11. If a doctor would like to have one or more students or trainees attend a consultation the patient should be provided with an explanation prior to the consultation about the role that the student or trainee may take in the consultation and asked whether he or she consents to the student or trainee being present.
12. If a student or trainee is present during a consultation, he or she should be formally introduced to the patient.

## Chaperones

13. Some doctors have conditions on their registration or annual practising certificate that require a chaperone to be present at certain types of consultations. This condition is usually as a result of past disciplinary action and is intended to provide protection for patients. It requires a notice to be put up in the waiting and examination areas to inform patients.
14. The doctor who has this condition on his or her practice should inform any employer of the conditions.
15. The presence of a chaperone is not optional and if a patient does not feel comfortable with this requirement the patient will need to see another doctor. A doctor with a chaperone condition should disclose the reason behind the requirement if questioned why by a patient.

16. The only exception to the chaperone condition is in an emergency situation. A doctor with a chaperone condition may attend an emergency, even when a chaperone cannot be located.

## Principles of the process

17. Third person policies should be displayed in the practice waiting and examination areas. Arrangements for the presence of a third person should be in place prior to the start of the consultation.
18. All parties involved in the consultation must understand the role of the third person. The patient must give informed consent for a third person to be present and the role they will take.
19. The Council advises that the doctor speak with the patient about the presence of a third person in private, away from the nominated third person. This is to ensure that the patient does not feel obligated to accept someone due to the discomfort of saying 'no' in front of the third person.
20. The Council recommends to doctors that if they require a third person to attend a consultation the third person should preferably be another health professional.
21. If a third person attends all or part of a consultation or procedure you need to ensure that the third person is aware of its confidential nature and that the patient's personal information and physical privacy must be respected.

## What if the patient or doctor refuses to have the nominated third person?

22. Not every patient will want to have a third person in attendance, especially if there is an intimate aspect to the consultation that includes a physical examination for which the patient may have to undress. Some patients have indicated that a third person makes them feel an audience is present. A patient has the right to decline a third person being present.
23. If there is no agreement on the attendance of a third person, or who that third person should be, either the doctor or the patient has the right to withdraw from the consultation until a mutually acceptable third person is available. Alternatively, the patient may be referred to another doctor. This should not have any adverse effect on the care that is provided.

March 2004

## The Medical Council of New Zealand

The Council is the statutory body for registering doctors. Our principal purpose is:

*'to protect the health and safety of the public by providing for mechanisms to ensure that medical practitioners are competent to practise medicine.'*

Our many functions include promoting medical education and training and reviewing doctors' competence.

We have written guidelines and statements on specific medical treatment issues. See our website for further information on:

- complementary and alternative medicine
- drug treatment for professional sportspeople
- internet medicine
- cosmetic procedures
- sexual boundaries in the patient-doctor relationship.

## **Complaints**

To make a complaint about your doctor, contact:

The Health and Disability Commissioner  
P O Box 1791  
Auckland  
Freephone 0800 11 22 33  
Fax 09 373 1061  
Email [hdc@hdc.org.nz](mailto:hdc@hdc.org.nz)  
Website [www.hdc.org.nz](http://www.hdc.org.nz)

**Note:** The Medical Council and the Health and Disability Commissioner are responsible only for the standards of doctors who practise in New Zealand



**Contact details**

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