

**CHIROPRACTORS and OSTEOPATHS
REGISTRATION BOARD (Tasmania)**

**CODE OF PROFESSIONAL
CONDUCT AND PRACTICE**

MAY 2005

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Introduction

The purpose of this policy is for the use of the Chiropractors and Osteopaths Registration Board of Tasmania to assist in administering the Chiropractors and Osteopaths Registration Act 1997 (the Act).

The standards of conduct and practices detailed in this publication are a guide to the chiropractic and osteopathic professions of the principles that will be used in future decisions relating to complaints of professional misconduct under the provisions of the Act.

The question of whether any particular course of conduct amounts to professional misconduct is a matter which is determined by the Board after considering the evidence in each individual case.

As a guide to the professions, the Board has noted the following definition of 'unprofessional conduct' which was taken from a judgement of Chief Justice Murray in *Re A Practitioner of the Supreme Court* (1927) SASR58 (Supreme Court of South Australia, page 60), and which has subsequently been considered and adopted in more recent cases:

"In our view, "unprofessional conduct" is not necessarily limited to conduct which is disgraceful or dishonourable, in the ordinary sense of those terms. It includes, we think, conduct which may reasonably be held to violate, or to fall short of, to a substantial degree, the standard of professional conduct observed or approved of by members of the profession of good repute and competency."

This document will cover the conduct of practitioners in their clinical practice and competencies, including their personal conduct; their conduct in relation to patients, other healthcare providers, third party insurers, and the public and the use of radiography. It also covers ancillary areas of professional conduct, such as use of title and advertising. An over-riding concern of the Board is that the professions should have a clear understanding that in all areas of conduct, the practitioner must act in the patient's best interests.

The Board will use these guidelines to perform its duties but is not limited solely to utilising this Code.

The Code of Conduct applies to chiropractors and osteopaths and any other entities as identified by the Board. Section 6 on radiography and the use of x-rays applies to chiropractors only.

1. Competence to Practise

1.1 Legislation

The following sections of the Act relate to the Board's role in ensuring appropriate levels of competence and standards.

Section 7

"The Board has the following functions:

(d) to monitor the standard and provision of chiropractic and osteopathic services in this State.

Section 35

"The Board may refuse to issue(a renewal)..... certificate of registration if it is not satisfied that the registered practitioner –

*(e) complies with the requirements specified in section 21(1)(b),
....."*

Section 21

"(1) an applicant is entitled to be registered as a practitioner if the Board is satisfied that the applicant -

(b) has sufficient physical capacity, mental capacity and skill to practise"

A chiropractor or osteopath must therefore maintain his/her knowledge and practise at an acceptable level of competence.

A practitioner must only perform or participate in those procedures that are within his/her competency and for which he/she is appropriately qualified, and refer those patients whose needs or requests are outside his/her competency to an appropriately qualified practitioner.

1.2 Recency of Practise

The Board will not issue a new certificate of registration to a practitioner who has not practised for a period exceeding 5 years unless it is satisfied that the person has, amongst other attributes, sufficient physical capacity, mental capacity and skill to practise.

1.3 Delegation to Others

If using the services of an assistant, the practitioner should not delegate tasks (eg. history taking, blood pressure) to the assistant unless the assistant is appropriately trained. An assistant should only take direction from the practitioner. The practitioner remains responsible for having such delegated tasks performed to the standard identified in this Code.

1.4 Continuing Professional Development

Relevant professional development should be undertaken by all practitioners to maintain competency.

2. The Consultation (The clinical encounter)

2.1 Relationship with the patient:

Practitioners must be constantly mindful of their responsibilities for the protection of the patient's welfare and rights and must always act in the best interests of the patient. Practitioners must not exploit a patient for emotional, financial or sexual gain or for any other purpose.

2.2 Patient history

A health history should include the following information:

- Patient details, i.e. date that care commenced, name, date of birth, occupation, address, contact phone number, gender.
- Patient's chief complaint data.
- History of past and present health, and family history.
- Previous treatment, including chiropractic or osteopathic care.
- Past illness, surgeries and/or accidents.
- Radiographic history, particularly if recent (including all procedures utilising ionising radiation).
- Correspondence to or from a referring practitioner.
- General correspondence with lawyers, third party payers, and others.
- Copies of x-ray reports, medico legal reports or other relevant clinical information.
- Documented results of any special studies.
- Pertinent copies of health records from previous or concurrent health care providers.
- And any other information necessary for the practitioner to meet their obligations.

Where known, particular note should be made of previously made diagnoses and elements of history, observations or findings that give clues to contraindications to the practitioner's type of case management and methods of intervention.

Information gathered from a health history interview with the patient and the practitioner's own observations must be recorded.

2.3 Examination

The extent and nature of the physical examination should be based on the new or returning patient's health history, and the practitioner's observations. Examination procedures should follow a logical procedure and be related to the condition of concern, using peer-accepted methods. Relevant and necessary imaging and/or other procedures should be performed by the practitioner or by referral to other facilities when clinically justified.

2.4 Diagnosis

The diagnosis of a patient's complaint shall be based upon the examination findings with reference to the clinical history. The diagnosis should be relevant, justifiable, consistent with current peer-accepted standards, and based on sound clinical reasoning.

2.5 Informed Consent

A practitioner must inform his/her patients of reasonably foreseeable implications prior to the commencement of a course of treatment, including material risks, complications and reactions, and explain the nature and purpose of the treatment.

Informed consent requires that the patient understands the information provided.

Consent, when given, should be recorded.

A patient may withdraw consent at any time and such withdrawal should be recorded.

Where the patient is less than sixteen years of age, or where the patient has a known mental disability, it is necessary to obtain the informed consent of a parent, a legal guardian or an authorised person (eg. the patient's GP).

Informed consent is required prior to any examination and/or treatment of intimate areas (ie. PV and PR techniques).

2.6 Patient records

Clinical

For professional and legal reasons a practitioner is required to keep and maintain adequate patient records which clearly reflect the course of patient management.

An appointment book should be kept. The name of each patient and the date when seen shall be recorded in the appointment book.

In addition to the initial case history, examination findings, imaging study reports, and any other relevant reports, a practitioner should keep a record of patients' progress. Records must be capable of being interpreted by the practitioner's colleagues, and should include:

- date of consultation;
- brief notes about the subjective comments made by the patient or guardian, along with the practitioner's observations;
- examination findings;
- informed choice/consent obtained;

- all procedures performed on the patient;
- significant concerns the practitioner may have about the findings or the patient's progress;
- advice given to the patient;
- patient non-compliance with the practitioner's instructions;
- clinical impression and diagnosis,
- treatment and management plans;
- date of the next follow-up visit.

Progress notes

Records should be made and dated at each patient visit or communication, and the notes should reflect:

- the patient's response to previous treatment;
- changes in the clinical presentation;
- relevant information from every re-assessment and re-examination;
- specifics of the care given
- recommendation(s) made to the patient on self-care, referral or for any other reason.

Use of Abbreviations and Terminology

Recorded abbreviations and terminology should be internally consistent and a key for these abbreviations should be available.

Amendment of Records

Errors in the record should be corrected, observing the following:

- when an entry is to be deleted or amended it should be crossed out in such a manner that it can be read if necessary;
- record date and sign corrected entry.

Patient Access to Records

The patient has a right to see his/her records. If records are requested, copies should be made available. A reasonable charge for copying of such records may be made. The guiding principle is that patient records remain the property of the practice in which they are generated.

Transfer of Records

Health care records, excluding data and reports from external sources, that are requested by another health professional currently treating a present or former patient should be forwarded promptly, following receipt of a signed patient consent form.

Record of Discharge

When the patient is discharged there should be a record made.

Financial

An accurate financial record for each patient must be kept. It shall include:

- date and type of professional service provided (initial visit, subsequent visit, X-ray, examination and any other services provided to the patient);
- fee for service(s) or products;
- payment received and from which source; and
- balance of account to date.

Any invoice or receipt should be legible, contain the date of the consultation, location of consultation, who provided the care, item number and provider number.

2.7 Treatment/Management

Management of a given condition shall be undertaken with regard to the diagnosis and with regard to patient comfort, tolerance and safety. All contraindications to treatment should be noted and taken into account when selecting techniques.

A practitioner shall not give a specific guarantee regarding the results to be obtained from treatment.

A practitioner shall not exaggerate for his/her own advantage, or for any other reason, the condition of a patient to that patient or to the patient's parents, next of kin or guardian.

2.8 Duration of treatment and frequency of care

A practitioner shall not over-service a patient. In determining what constitutes over-servicing, the Board will have regard to what a practitioner's peers of good repute and competency would consider to be therapeutically justifiable.

The Board is of the view that the frequency and duration of care of each patient should be based on the findings in each case as determined by the case history, examination and diagnosis. Care should relate to the individual patient's needs and be re-assessed periodically using peer accepted outcome measures to determine the rate and degree of progress.

2.9 Contracts and advance payments

A practitioner should not:

- contract fees for a pre-determined package of treatments;
- solicit substantial advance payments;
- offer a discount or enticement for payment in advance of treatment;
- financially exploit a patient.

A practitioner who undertakes any of these practices may be investigated by the Board. In the investigation, the Board would consider the circumstances in which these practices are implemented.

2.10 Radiography/Use of X-rays

Imaging (ionising radiation and other) undertaken or requested by a practitioner must be clinically justified with regard to the patient's circumstances.

2.11 Sexual misconduct

Practitioners should refer to the Board's Sexual Misconduct Policy, which is an appendix to this Code.

3. Practice environment (Clinic Standards)

3.1 Facilities/Amenities

Practitioners shall ensure the privacy of changing and treatment areas. There should be suitable sound barriers and visual privacy.

Patients should be asked to prepare appropriately for examination and treatment. Privacy gowns or suitable covering towels should be made available to ensure that a patient's privacy is not unduly compromised.

3.2 Chaperones

A chaperone (such as a parent, guardian, or other adult relative or suitable member of staff) should be present in the following situations, unless this is impracticable in the circumstances:

- during the examination or treatment of a child under the age of 16 years;
- during an examination or treatment which involves regions that the patient would consider intimate or an intrusion of their personal space (the definition of an intimate area in this context will not be defined in this document, however it is expected that effective communication is achieved so that the patient understands what procedure is to be undertaken);
- when treating a patient in the patient's home;
- where a patient so requests.

These conditions may be waived by mutual agreement between the patient (& their parent/guardian if patient under 16) and practitioner provided informed consent for the examination/treatment is given.

3.3 Clinical Setting

Practitioners shall ensure that the premises in which they practise are clean, suitably lit, heated, ventilated and safe.

Equipment utilised should be well maintained and professional equipment (such as treatment tables) must perform to their normal operational levels.

3.4 Employees of the Practitioner

Practitioners who employ health professionals shall ensure that they are properly qualified, and registered with the appropriate statutory or regulatory body (if any). Such employees must comply with all regulatory requirements of their Statutory Authorities and professional associations

It is a practitioner's responsibility to ensure that he/she does not authorise or permit any unregistered or unqualified person in his/her employ to make any diagnosis, prescribe any therapy or perform any part of the examination or treatment of a patient.

3.5 Privacy and Confidentiality

Practitioners and their staff must respect and maintain the privacy and confidentiality rights of patients. Practitioners should ensure appropriate patient confidentiality in creating, storing, transferring and disposing of all records under their control. Practitioners must not divulge confidential information about a patient unless:

- the patient or guardian specifically authorises in writing the release of that information; or
- the release of that information is to protect the patient or others from harm; or
- the release of that information is required by law.

The Privacy Amendment (Private Sector) Act 2000 has extended the operation of the Privacy Act 1988 to cover the private health sector throughout Australia. Practitioners must comply with the provisions of this legislation.

All records including X-ray films are to be regarded as part of a practitioner's case records and should be kept for a minimum of 7 years after the most recent date shown in the patient's health information on which care was provided to the patient, or until the patient reaches the age of 21, whichever event occurs last.

3.6 Discrimination

A practitioner must respect his/her patients' differences and not discriminate against a patient on the basis of race, disability, age, gender, sexual orientation, religion or political beliefs. The practitioner should be willing to refer patients to a more suitable practitioner should such issues seem likely to affect the professional relationship.

3.7 Complaints Procedure

The Practitioner should record all patient complaints and/or incidents that he/ she becomes aware of and endeavour to resolve these.

If an incident occurs where civil legal proceedings commence, the practitioner must notify the Board in accordance with Section 61 of the Act.

4 Practitioners Responsibilities

4.1 The Public

Personal Conduct

Practitioners must maintain high standards of personal conduct in their capacity or identity as chiropractors/osteopaths. Practitioners must not act in a false, misleading or deceptive manner. The private conduct of a practitioner is a personal matter except where such conduct compromises professional obligations or brings the practitioner's profession into disrepute.

Advertising/Promotions

The provisions governing advertising are set out in Section 60 of the Act (see below) and must be adhered to.

60.(1) A person must not advertise a chiropractic or osteopathic practice or chiropractic or osteopathic service in a manner that:

is or is intended to be false or misleading; or

offers a discount, gift or other inducement to attract patients unless the advertisement also sets out the conditions of the offer; or

refers to or cites actual or purported testimonials; or

unfavourably compares another chiropractic or osteopathic practice or other chiropractic or osteopathic services with that practice or those services.

Promotions of any description will be assessed in accordance with the above provisions.

Any advertising or promotion of services undertaken by practitioners must also comply with the Trade Practices Act 1974.

Relationship with the Public

Practitioners should clearly identify themselves as registered chiropractors or osteopaths on their practice sign, stationery, telephone directory listing and in any other advertising and must not identify themselves as any other form of health practitioner unless they are so qualified.

Use of Title

Nothing prevents the use of the title "doctor" provided it is not used in a manner which would amount to conduct that is misleading or deceptive or likely to mislead or deceive contrary to Fair Trading legislation, or used to advertise in a manner that is intended to be false or misleading contrary to

the Act. In addition, the Medical Practitioners Registration Act makes it an offence for a person who is not a medical practitioner to hold him/herself out as a registered medical practitioner, so care should therefore be exercised to ensure that the use of the title does not contravene this legislation. The context, manner and the circumstances in which the title is used should be such that no confusion is allowed. The Board has advice that it could be misleading or deceptive to use the title where a practitioner has not gained the academic qualification of a doctorate or at least gained the highest academic qualification offered by the university faculty from which his/her qualification was obtained. However this applies equally to medical practitioners, dentists and veterinarians.

Impaired Practitioners

Practitioners who have reason to believe that patients may be at risk because of their own ill health, whether mental or physical, must seek and follow proper advice as to whether or how they should modify their practice. Failure to do so may be regarded as unacceptable professional conduct.

Practitioners should report to the Board any concern that they may have about the mental or physical health of another practitioner - having first made an honest attempt to verify the facts upon which their concern is based. The safety of patients should come first at all times and override personal and professional loyalties.

Impairment of a practitioner's ability to practise as a result of the misuse of alcohol or other drugs may lead to the question of the practitioner's fitness to practice being considered by the Board.

Personal Liability

Practitioners who work in a practice run by a limited company are reminded that they remain personally liable to individual patients in respect of any treatment or advice they provide.

Seminars

Any chiropractor, osteopath or other person, entity or organisation providing conferences, seminars or workshops for practitioners who are not registered in Tasmania which will involve spinal manipulation or other prescribed procedures needs to apply to the Board for endorsement in accordance with Section 56(2)(c) of the Chiropractors and Osteopaths Registration Act 1997 and Regulation 4. For details contact the Board.

4.2 Other Health Professionals

Relationship with Health care Providers

When appropriate, a practitioner should be prepared to accept a patient on referral from another health professional and should care for the patient if,

in his or her opinion, chiropractic/osteopathic care is required. Practitioners should recognise patients' rights to co-operation and communication between their health care providers to ensure quality and continuity of care.

The practitioner should obtain permission from the patient to discuss the patient's case notes with the patient's other relevant health care providers, in the interest of providing high quality care to the patient.

Relationship with Colleagues

A practitioner must refrain from criticising colleagues in public or in a clinical setting in a manner which casts doubt on the colleague's professional competence. This does not apply to the critical evaluation of published works, or to expert testimony in court, or to the provision of an opinion as an expert for any legitimate purpose.

4.3 Third Parties

Referrals

The referral of a patient to any other health professional should have the sole intent of being in the best interests of the patient. There should be no financial or personal gain to the practitioner from the referral.

The practitioner should work in conjunction with other treating health professionals to maintain the best outcome for the patient.

Relationship with Third-party Payers

A practitioner is legally required to be fair and honest when reporting to, and claiming from, third-party payers. Such reports and claims should be a true and accurate record taken from the patient's records and accounts as filed in the practitioner's office.

Mandatory Reporting

Should any practitioner suspect on reasonable grounds that a child has been or is being abused or neglected they have a responsibility to take steps to prevent the occurrence or further occurrence of the abuse or neglect, as required by Section 13 of the *Children, Young Persons and Their Families Act 1997*.

Obligation to Advise the Board of Professional Misconduct

If a practitioner has suspicion of a colleague behaving unprofessionally or being a risk to his / her patients, the correct procedure is to attempt to verify the situation firstly and if necessary, the matter should be reported in confidence to the Chiropractors and Osteopaths Registration Board.

5. Professional Indemnity Insurance

In accordance with Section 21(2) of the Act, practising chiropractors and osteopaths are required to have the level of professional indemnity insurance specified by the Board

6. Radiography/Use of X-rays (Chiropractors Only)

Chiropractors possessing and using X-ray facilities must comply with the conditions of their licence issued by the Minister for Health and Human Services under the Radiation Control Act 1977 and the Radiation Control Regulations 1994.

Indications for taking an X-ray must be clear and based upon clinical history and examination findings and should be carried out only where the results of such imaging will assist in the diagnosis, prognosis and management of the patient and where potential benefit outweighs the risks of ionising radiation. A patient should never be exposed to unnecessary radiation.

The need for, and nature of, the recommended X-rays must be discussed with the patient and informed consent obtained. In the case of minors or the mentally incompetent consent must be obtained from a parent or legal guardian.

Children in the 0-18 year age group generally have low justification for X-rays due to the high sensitivity of many body tissues. Exceptions include but are not limited to marked idiopathic scoliosis, developmental or congenital defects producing aberrant spinal curvatures, marked locomotor disturbances of the spine and pelvis, suspicion of pathology or significant trauma.

Routine X-ray screening of patients and the routine or time contingent re-evaluation of biomechanical/postural disorders other than for scoliosis or in cases of exceptional circumstance is not appropriate.

A written interpretation of any imaging study performed by a chiropractor must be completed and included as part of the patient's permanent record.

CHIROPRACTORS AND OSTEOPATHS REGISTRATION BOARD, TASMANIA

SEXUAL MISCONDUCT POLICY

Making Complaints

1. Sections 40(1), (2) and (3) of the Chiropractors and Osteopaths Registration Act 1997 states the following:

“(1) A person who is aggrieved by the conduct of a registered practitioner may complain to the Board.”

“(2) A complaint may be made and dealt with under this Part even though the person who is the subject of the complaint has ceased to be a registered practitioner and, for that purpose, a reference in this Act to a registered practitioner includes a reference to a person who has ceased to be registered or whose registration is suspended.”

“(3) A complaint may be made or dealt with under this Part even though the registration of the person who is the subject of the complaint was suspended at the time of the matter complained of.”

2. Sections 41 (1)(e) of the Chiropractors and Osteopaths Registration Act states the following:

“**41. (1)** Without limiting the matters in respect of which a complaint may be made, a person may complain that a registered practitioner –

(e) is guilty of professional misconduct.”

General Comments

3. It is a general rule that a chiropractor or osteopath who engages in sexual activity with a current patient or a person who was a current patient at the time of the alleged sexual misconduct, is guilty of professional misconduct.

4. While not detracting from the fundamental impropriety of such activity, the sanction applied, as a result of a finding of misconduct, may vary according to the circumstances of each case.

5. Factors to be considered include the degree of dependence in the practitioner/patient relationship, evidence of exploitation, the duration of the professional relationship and the nature of the service provided.

6. The rule refers to current patients or a person who was a current patient at the time of the alleged sexual misconduct. The termination of the practitioner/patient relationship prior to sexual activity may be raised as a defence, but its strength will be dictated by consideration of the factors referred to in paragraph 5, as well as by the time lapse after the end of the professional relationship.

7. A practitioner who provides appropriate treatment for a spouse, de facto or partner would not be engaging in conduct considered to be professional misconduct.

8. The rationale for the Board's position has been supported in many contexts by medical disciplinary authorities. The reasons for the rule include the following:

(a) The practitioner/patient relationship depends upon the ability of the patient to have absolute confidence and trust in the practitioner.

(b) The practitioner is in a unique position regarding physical and emotional proximity. Patients are expected to disrobe and to allow practitioners to examine them intimately.

(c) The practitioner/patient relationship is not one of equality. In seeking treatment, the patient is vulnerable. Exploitation of the patient is an abuse of power.

(d) The practitioner's role is one of authority, by virtue of the patient seeking assistance and guidance.

(e) Breaches of the practitioner/patient relationship may cause severe psychological damage to the patient.

(f) The community expectation of the chiropractic and osteopathic professions is one of utmost integrity. The community must be confident that personal boundaries will be maintained and that patients are not at risk.

(g) Improper sexual conduct by practitioners brings community censure and damages the credibility of the profession as a whole.

(h) The onus is on the practitioner to behave in a professional manner. It is unacceptable to seek to blame the patient if a sexual relationship develops.

(i) Personal involvement with the patient may lead to a clouding of clinical judgment.

Definitions

9. For the purposes of disciplinary action, the Board has defined sexual abuse under three categories:

1. Sexual impropriety;
2. Sexual transgression; and
3. Sexual violation.

10. Sexual impropriety means any behaviour such as gesture or expressions that are sexually demeaning to a patient, or which demonstrate a lack of respect for the patient's privacy, including but not exclusively:

- inappropriate disrobing or inadequate draping practices;
- examining the patient intimately without their consent;
- conducting an intimate examination of a patient in the presence of students or other parties without the patient consenting to their presence;
- inappropriate comments about, or to, the patient, such as the making of sexual comments about a patient's body or underclothing;
- making sexualised or sexually demeaning comments to a patient;
- ridicule of a patient's sexual orientation;
- making comments about sexual performance during an examination or consultation (except where pertinent to professional issues of sexual function or dysfunction);
- requesting details of sexual history or sexual preferences not relevant to the type of consultation; and
- any conversation regarding the sexual problems, preferences or fantasies of the practitioner.

11. 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 of breasts or genitals, except for the purpose of appropriate physical examination or treatment;
- the touching of breasts or genitals when the patient has refused or withdrawn consent for the examination or treatment;
- inappropriate touching of other parts of the body can also be construed as sexual transgression; and
- propositioning a patient.

12. Sexual violation means practitioner/patient sexual activity, whether or not initiated by the patient. This includes, but not exclusively:

- sexual intercourse;
- masturbation or clitoral stimulation; and
- other forms of genital or other sexual connection.

Procedures

13. The Board will consider any complaints regarding allegations of sexual misconduct as serious and will appoint a disciplinary committee to investigate the complaint.

The Board may determine not to provide a copy of the complaint to the practitioner in the first instance.

Disclaimer

14. In the case of any conflict or discrepancy between this document and the applicable legislation, the legislation prevails.

This policy is adapted from the Medical Council of Tasmania, Policy Paper No 4: Medical Practitioners and Sexual Misconduct. 2001.