SRS accommodation. SRSs, for these Victorians, offer an important option in housing and care when choice is severely limited.

The SRS industry has a low profile in the community and residents in the lower end of the market find it difficult to access services like Home and Community Care (HACC) services. Barriers such as social isolation, few family networks and poverty limit the residents' ability to achieve good quality care for themselves.

Staff of SRSs are largely untrained carers although many do have some nursing background. This has led to discrepancies in care between facilities and difficulties for external providers of care, like medical practitioners and others, in knowing what level of care to expect from an SRS. Currently there is no requirement to have trained staff in SRSs but the regulations provide for a minimum ratio (1:30) of staff to residents. A report has been prepared for the Minister for Health and the Minister for Aged Care recommending a minimum qualification for a key staff member in each SRS.

The Review

The purpose of this Review is to determine whether residents of SRSs are receiving appropriate quality medical services, have their own choice of medical practitioner and have an informed choice of appropriate treatment.

Healthcare International, an independent consulting company, has been conducting the Review which is due to report at the end of November 1998. It reports to a Steering Committee which consists of personnel representing numerous sections of the Aged, Community and Mental Health Division of the Department of Human Services as well as the Health Services Commissioner, the Public Advocate and the President of the Association of Supportive Care Homes (the peak industry body). This committee will decide on the distribution of the final report and subsequent actions to be taken on the recommendations issuing from the report.

The methodology for conducting the review has included a literature review, a survey of the proprietors of SRSs, extensive interviewing of residents and staff, consultations with medical bodies, structured interviews with individual doctors, other health care providers, community services workers and other interested people. There have also been consultations with the industry peak body, the Health Services Commissioner, the Public Advocate, the Community Visitors Board and Department of Human Services regional and central office staff. Wide publicity has been sought through the newsletters of the industry peak body and the Divisions of General Practice.

There has been general support of the Review within the industry and from stakeholders. Many Divisions of General Practice have expressed an interest in a structured approach to an ongoing involvement aimed at improving the medical services offered to residents of SRSs.

Emerging issues from the Review include a combination of structural, systemic and process problems from within and outside the immediate industry. Many problems relate to the socially marginalised and disempowered groups and individuals the industry strives to serve. Other issues identify concerns with lack of education and fragmentation and the apparent complexity and inaccessibility of health and community services.

The Review will endeavour to identify issues that can be addressed in a systematic and cost effective way to improve the quality of life of the residents of supported residential services.

The Review will be presented to the Department of Human Services through the Steering Committee on 30 November 1998. It is the expectation of the Steering Committee that the Review will be published. Publication, distribution of the final report and action on the recommendations within the report will be at discretion of the Department.

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PROFESSIONALS

Sexual abuse by lawyers

BILL GLASER discusses sexual exploitation by professionals of their clients specifically comparing the law and health disciplines.

One of the standard jokes about legal ethics is that you can murder the client but you cannot run away with the trust funds. This certainly seems to apply to sexual relationships between lawyers and clients. In Australia, with the notable exception of the Family Court jurisdiction, there appears to be little or no disapproval of a legal practitioner who engages in sexual activity with even the most vulnerable client, provided that criminal or sexual harassment laws are not infringed. At a recent meeting of the Australian and New Zealand Association for Psychiatry Psychology and Law, the chairperson of the Victorian Bar Council Ethics Committee remarked that, during a period of several years he had encountered only one case of alleged sexual misconduct.

Sexual abuse by health practitioners

Sexual abuse by health practitioners, by contrast, is recognised as being both common and harmful. Between 7–10% of male mental health therapists and 1–3% of female therapists sexually abuse their clients. The perpetrators themselves are often experienced and well-respected members of professions such as medicine and psychology; to add insult to injury, they may compound their hypocritical claims that sex is 'therapy' by charging fees to the patient or third party such as Medicare. The victims themselves are usually intensely vulnerable. Many have experienced sexual and physical abuse in childhood and the effects of therapist abuse can often be devastating. Not only do victims receive inadequate or inappropriate treatment for the problems for which they first sought help, they also encounter disbelief and denial when they complain about their abuse to subsequent therapists or investigating authorities.[1]

The societal response to health professional abuse, although somewhat tardy, has nevertheless been significant.

Registration authorities (such as the medical practitioner boards of various State jurisdictions) and professional codes of ethics (such as those adopted by the Royal Australian and New Zealand College of Psychiatrists, the AMA and the Australian Psychological Society) all now unequivocally condemn sexual activity involving current (and, in many cases, former) clients. The sanctions for such behaviour may include deregistration from professional practice, expulsion from relevant professional associations and various forms of civil action based on breaches of professional standards. In some Australian jurisdictions, criminal sanctions can also be applied. For example, s.51 of the *Crimes Act 1958* (Vic.), provides that a 'person who provides medical or therapeutic services to a person with impaired mental functioning' must not take part in an act of sexual penetration or an indecent act with that person. Notwithstanding the limitations of this legislation ('person with impaired mental functioning' has been held to include only those with severe disabilities), its intention is clear: most forms of sexual activity with a mentally impaired client, whether consensual or not, are criminal offences resulting in substantial terms of imprisonment for the offending professional.[2]

Sexual abuse by legal practitioners

On the other hand, there are no clear rules regarding lawyer–client sexual relationships. Section 64 of the *Legal Practice Act 1996* (Vic.), for example, requires the legal practitioner to 'act honestly and fairly in the client's best interests', specifically, by acting with skill, diligence and reasonable promptness, maintaining a client's confidences, avoiding a conflict of interest, refraining from charging excessive fees and conforming with a number of obligations to the courts, the profession and the community. These very specific guidelines governing lawyer–client communications and financial relationships contrast with the Act's silence about sexual misconduct. In Australia, lawyer–client sexual relationships either do not exist or (as is more likely) are regarded as far less harmful than those involving health professionals.

Interprofessional distinctions

Is there a good reason for this distinction? There is very little in the pronouncements of the courts and policy agencies on the issue. One US case tried to emphasise that, for some health professionals (psychotherapists), the relationship becomes part of the treatment (the phenomenon of transference). Client-therapist sexual activity compared to (say) lawyer–client sex, is poor treatment and hence a form of negligence:

> The crucial factor in the therapist–patient relationship which leads to the imposition of legal liability for conduct which arguably is no more exploitative of a patient than sexual involvement of a lawyer with a client, a priest or minister with a parishioner, or a gynaecologist with a patient is that lawyers, ministers and gynaecologists do not offer a course of treatment and counselling predicated upon handling the transference phenomenon.[3]

The mishandling of transference phenomena, however, although clinically important, is probably of only marginal relevance from the victim's point of view. This case recognises (as do various recent studies) that clergy–parishioner sexual activity can be just as exploitative as that involving health practitioners and their clients. The real issue is that of the abuse of trust (the fiduciary relationship) inherent in all professional–client relationships. The professional is nearly always more powerful and certainly more knowledgeable than the client and it is the misuse of this knowledge and power to further the interests of the professional rather than the client that does the damage. The mental health practitioner whose main line of treatment makes little use of transference (for example prescription of medications) should still be subjected to the same legal sanctions as the psychotherapist who spends many hours developing and analysing the therapeutic relationship.[4]

Another distinction might be that clients of health practitioners are more vulnerable than those of lawyers. Those seeing doctors, psychologists, nurses and social workers are usually sick, disabled, distressed and powerless. At least until economic rationalism and managerialism completely take over the health care system, they deserve a healing relationship which, as far as possible, avoids any exploitation of their vulnerability. On the other hand, those consulting with a lawyer can be simply seen to be purchasing a service, in the same way as one would hire a plumber, car mechanic or real estate sales person. On this reasoning, the power differential between lawyer and client is much less, approaching more that of a purchaser–seller relationship rather than that of a healer–patient.

This is a somewhat naïve view of things. It may apply (for example) to a sexual relationship between a female company director and the lawyer she retains for a commercial matter. However, it is far more difficult for an impoverished female defendant facing criminal charges to resist suggestions for a sexual relationship from her legal representative, funded by legal aid, on which she is obviously heavily dependent. As noted above, similar considerations involving at least emotional vulnerability, apply to the family court jurisdiction.

Power and gender issues

There thus appears to be a good case for abandoning interprofessional distinctions of types of sexual abuse and focusing on wider societal issues which inevitably beset any professional–client relationship. The outstanding feature of all cases of sexual abuse by health practitioners is that the majority of the practitioners are male, whereas most victims are female. In our society, the reasons are not hard to find: sexist assumptions pervade all areas of health care practice and support the power differential between practitioner and client:

> Both psychopathology and treatment of the female patient are thus re-enactments of the overall feminine fantasy that an idealized relationship with a powerful male is the most desirable — and acceptable — solutions to one's problems.[5].

Given the male domination of the legal profession, similar structural problems will be encountered. In our society, the stereotypes still persist: men are independent and assertive, women are dependent and passive. The male lawyer who 'rescues' his female client in court may unfortunately be the same professional who exploits her sexually. In that sort of relationship, the victim is just as vulnerable and just as likely to suffer serious harm as any

victim of abuse by the clergy, health practitioners or other professional groups.

There have been critics of gender-based justifications for sanctions on professional–client sex. The emphasis on the vulnerability of women clients may simply reinforce Victorian-era notions of women being inherently fragile and asexual. Women may freely and knowingly choose to lust after even the most domineering and power-hungry male.

Even allowing for such criticisms, the relative immunity of lawyers who engage in sexual activity with their clients may not last too much longer. There are now at least three States in the US which specifically ban 'attorney–client sex'. More jurisdictions are sure to follow. The depressing fact is that the law does not solve the problem of lawyer–client sex any more than it does for abuse by health professionals. A review of California's 'sex ban' laws for lawyers, carried out one year after the legislation was passed, revealed that most cases were still in the 'investigatory' stage, many were dropped due to insufficient evidence and others could not even be investigated because the complaints were mounted by third parties.[6] It seems likely, therefore, that sexual exploitation by professionals, whatever their discipline will continue to produce many more victims, for a long time to come.

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the first stage of public consultation. Given that AHEC has the responsibility of co-ordinating and assisting institutional ethics committees in reviewing research, and its functions involve promoting community debate and monitoring international developments in health and ethical issues, it is reasonable to expect that the issue of women in clinical trials would at least be debated. To date, AHEC's decision in this matter seems to be at odds with its role and its functions.

These issues may yet be addressed in the final revised statement or in the operating manual for institutional ethics committees. The NHMRC is currently preparing an operating manual for institutional ethics committees which should be available in late 1998. It is being developed by a consultant in consultation with AHEC and 'key stakeholders'. With regard to the *Statement on Human Experimentation,* there has been a second stage of public consultation and submissions on the *Draft Statement* were received up until 14 August 1998. The new statement should be released in the new year.

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