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Serious misconduct of health professionals in disciplinary tribunals under the National Law 2010–17

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Abstract

Objective. There is a gap in knowledge regarding serious disciplinary matters concerning health professionals under the *Health Practitioner Regulation National Law Act 2009* (hereafter 'National Law'). The present study applies a typology of misconduct to the first 7 years of available tribunal cases under the National Law brought against the five most populous regulated health professions with the overarching goal of mapping the relationship between type of misconduct and outcome. As subquestions, the study examined whether the ostensibly uniform law is producing consistency of outcomes, both between the professions and between jurisdictions.

Methods. All publicly available Australian tribunal-level decisions concerning complaints of serious misconduct and/or impairment brought against the five most populous regulated health professions (nurses and midwives, doctors, psychologists, pharmacists, and dentists) were gathered from 1 July 2010 to 30 June 2017. Decisions were coded for case and respondent attributes, the type/s of misconduct alleged, whether proved, and the relevant disciplinary outcome. Respondent attributes were: profession, sex, legal representation, and certain identified 'risk' factors from previous studies. The type of allegation was coded based on five main categories or heads of misconduct, with subtypes within each. Outcomes for proved conduct were coded and categorised for severity. Analyses of cases was conducted using SPSS, version 21 (IBM, New York, NY, USA). Data was subject to statistical analysis using Pearson's Chi-squared test with an α value of 0.05.

Results. Major variations were identified in outcomes across the professions, with doctors being subject to less severe outcomes than other professions, in particular compared with nurses, even when the same main head of misconduct was in issue. Differences in legal representation did not completely account for such variation. Marked disparities were also identified between outcomes in different states and territories, suggesting that the National Law is not being applied in a uniform manner.

Conclusion. Tribunal cases reflected complaint data in that: (1) male practitioners were greatly over-represented as respondents; (2) outcomes were most severe for sexual misconduct and least severe for clinical care; and (3) doctors faced less severe outcomes than other professions. There were also significant variations in severity of outcome by jurisdiction. Variations were more pronounced when deregistration was the focus of analysis.

What is known about this topic? Existing research on complaints data under the National Law in place since 2010 has suggested that doctors may be receiving less severe outcomes than other professions at board level. There is a gap in knowledge concerning serious disciplinary matters heard by tribunals. Unlike data on complaints against regulated health professionals collated by AHPRA, legal tribunals, which hear only the most serious matters, do not record data on cases in a consistent or centralised form.

What does this paper add? This study is the first to compare tribunal outcomes for the five most populous professions by reference to the type of misconduct proved. The finding that different professions are receiving different outcomes for the same malfeasance is novel. Other novel findings include significant variations in severity of outcome by jurisdiction, more pronounced variations in outcomes by both profession and jurisdiction when deregistration was the focus of analysis and variations in outcome according to legal representation.

What are the implications for practitioners? There are major implications for policy makers and decision makers in terms of whether the National Law is operating consistently, with important outcomes for practitioners in terms of equitable and fair treatment when facing disciplinary charges.

Additional keywords: disciplinary decisions, *Health Practitioner Regulation National Law Act 2009*, health regulation, professional discipline.

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Introduction

Since 2010, a national scheme regulates the registration, accreditation and discipline of health professionals in Australia (*Health Practitioner Regulation National Law Act 2009*; hereafter 'National Law'). The scheme began with 10 registered health professions, expanding to 14 professions in 2012 and then 15 from 1 December 2018.[1] Although there is some jurisdictional variation in terms of which agencies undertake disciplinary investigations, and slight differences in definitions and legislative provisions in some states and territories,[2,3] the scheme is a national one with broadly uniform rules addressing unprofessional conduct and misconduct for many health professions for the first time. Bismark *et al.*[4] note that this creates 'unprecedented opportunities for researchers, policy makers and regulators to move towards evidence-based regulation', in particular through understanding complaint and disciplinary data. This study contributes to the wave of new research on the National Law by examining disciplinary action against health professionals at tribunal level.

Most formal complaints against health practitioners (which may be made as mandatory or voluntary 'notifications' under the National Law) are handled within the professional board system, in which matters are channelled into health or performance and conduct 'pathways' within each profession if found to have some basis. Practitioners with health issues are managed by an 'impaired registrants panel', whereas those with unsatisfactory professional performance or illegal, unethical or unprofessional 'conduct' face a 'performance and professional standards panel'.[1,2] Each pathway may entail the imposition of conditions on a practitioner's registration or, if assessed as a risk to the public, suspension. The most serious matters, those that are characterised as *prima facie* so significant a risk or breach as to be likely to lead to deregistration (and those involving repeated breach of conditions or failure in the above pathways) are referred to a legally headed disciplinary tribunal, the only body with the power to deregister a practitioner altogether.[3,5] As Elkin *et al.*[6] note, the number of matters that appear before tribunals are therefore the product of three interrelated elements: the rate of underlying misconduct in each profession, the rate at which it is reported and the rate at which it is referred on to tribunals. Therefore, the present study of tribunal cases is not on the prevalence of misconduct *per se*, but rather addresses regulatory responses and, in particular, the issue of consistency in outcomes of the most serious disciplinary matters determined since the advent of the National Law.

There is a serious gap in knowledge concerning tribunal outcomes because, unlike data on complaints under the National Law, tribunal data are not collated in a consistent manner and are not centralised. There is no publicly accessible data on cases and outcomes that presents complaint type, profession or other significant factors, such as sex or age. In short, the more serious the matter, the less is known about types of misconduct and ultimate outcomes imposed, or about the association between profession and outcome. Further, it is not known whether outcomes are comparable across the various state and territory tribunals applying the National Law.

Previous studies

Bismark *et al.*[4,7,8] assessed complaint data gathered by the national regulator, the Australian Health Practitioner Regulation Agency (AHPRA), and identified trends and risk factors across and within the regulated health professions. In a retrospective study of all notifications made to AHPRA during 2011 and 2012 (excluding New South Wales (NSW)) concerning the original 10 regulated professions, Spittal *et al.*[9] found that the notification rate was highest among doctors and dentists and lowest among nurses and midwives. Spittal *et al.*[9] reported that the likelihood of 'restrictive action' (a broad category that included voluntary undertakings and conditions, as well as suspension or deregistration) was higher for cases involving impairment, improper prescribing or use of medication, and sexual misconduct than for cases involving clinical care. Doctors were less likely to face restrictive action than all the other professions. Male practitioners were more than twice as likely as female practitioners to be the subject of a notification.

In a retrospective study of all notifications made to AHPRA from 2011 to 2016 inclusive concerning chiropractors, osteopaths and physiotherapists (excluding NSW), Ryan *et al.*[10] reported that the rate of notifications against chiropractors was threefold higher than for osteopaths and sixfold higher than for physiotherapists, and that there was a higher likelihood of complaints against chiropractors being referred to an external body such as a disciplinary tribunal. Again, male practitioners were more than twice as likely as female practitioners to be the subject of a notification.

Elkin *et al.*[6,11,12] conducted a major study that addressed disciplinary cases concerning doctors determined by tribunals in the 10 years prior to the National Law in NSW, Victoria, Queensland (Qld), Western Australia (WA) and New Zealand in the period 2000–09 inclusive (excluding matters in which impairment was the main issue), finding that male doctors appeared as respondents at a rate more than fourfold higher than that for female doctors. The study analysed 485 cases in which one or more complaints were proved and found that 43% resulted in removal from practice (within which deregistration was twice as common as suspension), 37% resulted in conditions and 19% resulted in non-restrictive sanctions, such as a caution, reprimand or fine.[12]

Recollecting that tribunal cases are not categorised by reference to the kind of issue alleged, Elkin *et al.*[6] developed a typology of misconduct in order to analyse the relationship between allegations and outcomes. This typology was based upon complaints categories then in use by two medical boards, refined with subcategories to draw out more textured information (e.g. by unpacking the commonly used category of 'sexual misconduct' (also frequently obscured by the catch-all 'boundary violation') to separate out sexual relationships with patients as opposed to other 'inappropriate sexual contact' such as use of the therapeutic setting to engage in unjustified touching of patients).

Millbank *et al.*[13] applied the Elkin typology to all available tribunal cases involving complementary health professions (Chinese medicine practitioners, osteopaths and chiropractors) under the first 6 years of the National Law (2010–16). That small study involved 32 cases and found that male respondents appeared at a rate more than sixfold higher than female respondents, sexual misconduct was the most common main head of misconduct and removal from practice occurred in 72% of all proved matters (in which deregistration was slightly more common than suspension).[13]

The present study applies the Elkin typology to the first 7 years of available tribunal cases under the National Law brought against members of the five most populous regulated health professions, with the overarching goal of mapping the relationship between type of misconduct and outcome. As subquestions, the study examined whether the ostensibly uniform law is producing consistency of outcomes, both between the professions and between jurisdictions.

Disciplinary tribunals

Under the National Law, unprofessional conduct (called unsatisfactory professional conduct in NSW) may rise to the higher level of professional misconduct either by reason of severity, repetition or both.

A board must refer a matter to the 'responsible tribunal' if it reasonably believes that the practitioner has behaved in a way that constitutes professional misconduct (or if the practitioner's registration was improperly obtained because of false or misleading information, or if a panel established by the board requires it to do so). Although the composition of each tribunal varies across the state and territories, in general it is chaired by a legal member and made up of one or two members of the same profession as the health practitioner whose behaviour is under review, in addition to a non-practitioner or 'community' member.

If unprofessional conduct is proved, a tribunal may impose conditions or issue a reprimand or caution or, in certain circumstances, a fine. Removal from practice through deregistration or suspension is only available if misconduct is proved (or if the practitioner is not competent to practise or is unsuitable or, by reason of criminal conviction, unfit in the public interest to practise). Although the category 'removal from practice' is commonly used by researchers and policy makers, there is a significant difference in severity between deregistration and suspension orders. A suspension is finite; it must be limited in time and, when that time passes, registration is automatically restored. In contrast, after an order of deregistration the practitioner must reapply to the board (or in NSW to the tribunal), sometimes only after a set period, and satisfy it that they are now fit to practise. This is a heavy practical and legal burden, because the passage of time alone does not establish fitness and the practitioner bears the onus of proving they are safe to return to practice at the time of reapplication. A prohibition order, preventing the practitioner from providing one or more other health services for a period of time or permanently, is available only if the practitioner is removed from practice and poses a substantial risk to the health of members of the public.

Methods

All publicly available Australian tribunal-level decisions concerning complaints of serious misconduct and/or impairment brought against the five most populous regulated health professions were gathered from 1 July 2010 to 30 June 2017. This period was chosen to correlate with the advent of the operation of the National Law. In order from most to least populous, the professions were: nurses and midwives, doctors, psychologists, pharmacists and dentists. (Although nurses and midwives are separate professions, they are regulated by the same board and are often addressed together in research and policy literature.)

Relevant decisions were identified through a search of all previous and current tribunal sets within the Australasian Legal Information Institute (AustLII) database (https://www.austlii.edu.au), augmented by cases from the various tribunal websites (http://www.healthpractitionerstribunal.sa.gov.au/decisions; https://www.sat.justice.wa.gov.au/D/decisions.aspx; and https://www.acat.act.gov.au/decisions2). Appeal decisions and non-disciplinary cases were excluded. The dataset comprised 794 cases, of which 35% (n = 278) were determined in NSW, 20% (n = 159) were determined in WA, 17% (n = 134) were determined in Qld, 15% (n = 118) were determined in Victoria and 8% (n = 66) were determined in South Australia (SA). The over-representation of cases from WA compared with the more populous states reflects differential publication policies, because Qld and Victoria do not release all decisions. Cases determined in the Australian Capital Territory (ACT), Northern Territory (NT) and Tasmania cumulatively amounted to 5% of the dataset overall (accounting for 16, 4 and 18 cases respectively). There were approximately equal numbers of cases found across each of the 7 years.

The data was organised per respondent, as opposed to organised by decision *per se*, so any procedural or subsequent decisions flowing from the same matter were treated in the dataset as one case. Where on occasion proceedings against two or more respondents were heard together, separate entries were made for each respondent so as to record the complaints made against each professional and final outcome.

The coding instrument recorded case and respondent attributes, the type/s of misconduct alleged, whether proved and the relevant disciplinary outcome. Respondent attributes were profession, sex, legal representation and certain identified 'risk' factors from previous studies (>60 years of age, trained outside Australia, engaged in sole or isolated practice, subject to criminal proceedings, repeat incidents).[7,8,14]

The type of allegation was coded building on the 'typologies of misconduct' developed by the research of Elkin *et al*.[6] This uses five main categories or heads of misconduct, with subtypes within each, as set out in Table 1. Following Elkin *et al*.,[6] the main head of misconduct was defined as the behaviour of 'most concern' to the tribunal, ascertained through close reading of the text of the decision. Decisions ranged from 10 to over 100 pages in length, but were generally around 30 pages long; most matters involved multiple allegations.

Outcomes for proved conduct were coded and categorised for severity: (1) removal from practice (deregistration, suspension or prohibition orders); (2) conditions on practice (education or mentoring, counselling, supervision, health conditions, restricted practice, other conditions); and (3) non-restrictive sanctions (reprimand, fine or caution). Analyses of cases were conducted using SPSS version 21 (IBM, New York, NY, USA), with the investigator and research staff cross-checking coding for consistency at several junctures throughout the research. Data presented in the tables were subject to statistical analysis using Pearson's Chi-squared test with an α value of 0.05.

Respondent characteristics: professions and sex

Doctors and nurses comprised the overwhelming majority of respondents, together accounting for 75% of the dataset. The numbers of pharmacists and psychologists were near equal,

Table 1. Misconduct typologies, including subtypes

	Main head of misconduct				
	Illegal or unethical prescription or provision of drugs	Impairment	Inappropriate clinical care	Sexual misconduct	Other
Subtypes	1. To self 2. To others	1. Substance abuse 2. Mental illness 3. Physical impairment 4. Cognitive impairment	1. Treatment (inappropriate or inadequate) 2. Failure to refer to a medical practitioner, hospital or ambulance 3. Diagnosis (missed, delayed or incorrect)	1. Relationship with patient 2. Inappropriate sexual contact during treatment	1. Non-sexual misconduct 2. Inappropriate conduct not regarding patient 3. Breach of registration conditions 4. Failure to obtain informed consent 5. Failure to maintain adequate records 6. Breach of privacy 7. Supervision of others 8. Criminal offence 9. Other unethical conduct

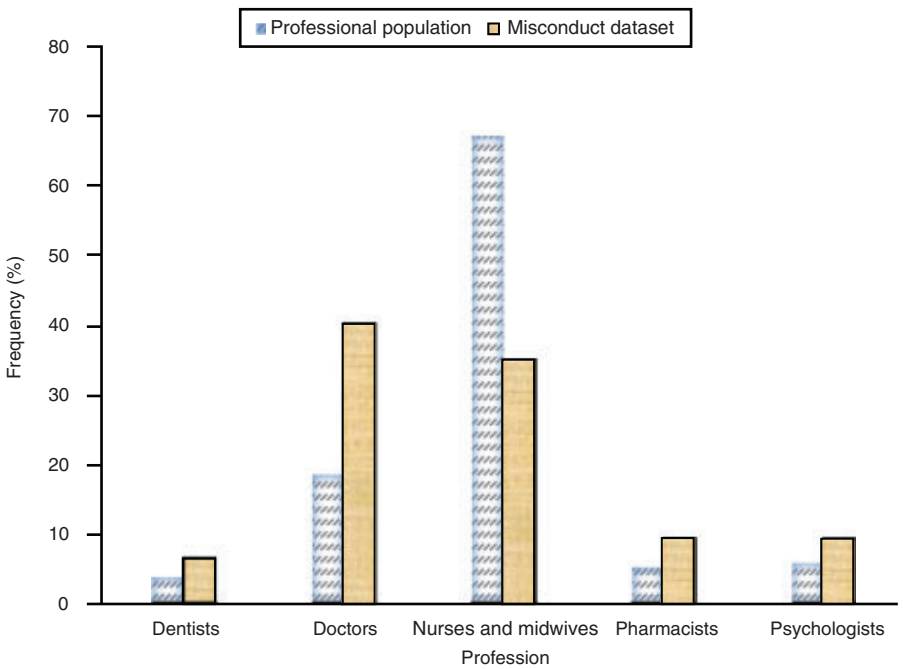

Fig. 1. Size of the five professions compared with their proportion of the disciplinary cases.

constituting 9.4% and 9.3% of cases respectively, whereas dentists comprised 6.5% (n = 52) of the dataset. When taken within the context of AHPRA data on the numbers of registered practitioners from the five professions over the corresponding 7-year period (taken from AHPRA annual reports 2010/11 to 2017/17; see https://www.ahpra.gov.au/Publications/Annual-reports/Annual-report-archive.aspx, accessed 25 July 2019), doctors were significantly over-represented in disciplinary cases, appearing at more than double their proportion of the practitioner population, whereas pharmacists, dentists and psychologists were also over-represented, appearing at almost double their proportion of practitioners. In contrast, nurses and midwives, although numerous in raw terms, were substantially under-represented (Fig. 1).

Most were male (n = 526; 66.2%). This disproportion is much starker when national data on the sex breakdown of the professions is taken into account. Based on AHPRA annual report data on registered practitioners over this 7-year period, men comprise only 23.2% of registered practitioners across these five professions. Fig. 2 disaggregates each profession to demonstrate where sex disproportions appear most starkly in the case set; for example, female dentists appear in the misconduct cases at less than one-quarter of their representation in the profession, whereas female doctors and pharmacists appear at around one-third their populations. In contrast, male nurses appear at fourfold their proportion of the professional population. (The P-value testing sex for statistical significance was 0.001.)

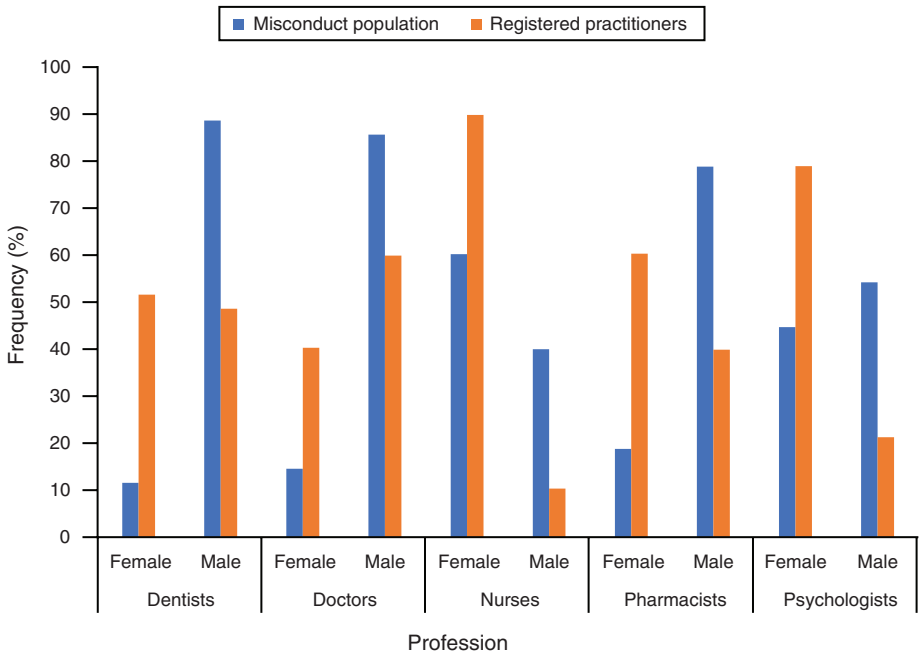

Fig. 2. Profession breakdown by sex.

Reflecting the fact that only the most serious matters are subject to a referral to disciplinary tribunals, the overwhelming majority of matters (96.3%; $n = 765$) involved at least one head of the complaint being proved.

Results

Main head of misconduct and outcomes

The most common type of misconduct was inappropriate clinical care (25.7%), followed by sexual misconduct and the illegal or unethical prescription or provision of drugs, which were equal in number, each amounting to 20% of matters. Impairment was the least likely to feature as the main head of complaint, appearing in only 4.8% of matters (although it was frequently a secondary complaint in prescription matters). The 'Other' head of misconduct was substantial, comprising 29.7% of cases in which the subtypes of matter were diverse and not readily categorised.

Inappropriate clinical care

Doctors and nurses were overwhelmingly the subjects of this head, constituting 45.6% ($n = 93$) and 36.8% ($n = 75$) of respondents respectively. This main head of misconduct had marginally the lowest rate of proven matters, at 94.6%, but was markedly less likely than other heads of misconduct to result in removal from practice, with a removal rate of only 36.8% in proved matters.

Within this head, 65.8% of respondents were male and 34.8% were female, broadly reflecting the sex breakdown of respondents in tribunal matters as a whole.

Illegal or unethical prescription or provision of drugs

Doctors were most likely to appear in this head (forming 51.3% of respondents; $n = 93$), followed by pharmacists ($n = 51$; 32.3%) and nurses ($n = 25$; 15.8%). Only one prescription or provision matter was found not proved, producing a proven rate of these matters of over 99%. Among proven matters, the rate of removal from practice was 53.5%.

As with inappropriate clinical care, the proportion of male and female respondents was roughly similar to their appearance in the dataset as a whole: female respondents accounted for 27.8% of respondents in prescribing or providing drugs matters.

Within this category, 70% involved provision to others ($n = 120$), whereas the remaining 30% involved the practitioner themselves ($n = 52$). The sex differential was much more marked within these subsets: 22.8% of those prescribing or providing to others were female, but women made up nearly half of those self-prescribing or -providing.

Sexual misconduct

Doctors were the largest group within sexual misconduct ($n = 67$; 42.4%), followed by psychologists ($n = 42$; 26.6%) and nurses ($n = 67$; 24.1%). Notably, psychologists were disproportionately likely to appear in sexual misconduct: 56.8% of all matters concerning psychologists were sexual misconduct (of which 88.1% involved allegations of inappropriate relationships with patients), whereas pharmacists were sharply underrepresented. These matters produced a proven rate of 94.9% and the highest removal rate from practice among proved matters (at 84.7%).

Within this category, 67% ($n = 106$) concerned sexual relationships with patients, whereas 37.9% ($n = 60$) concerned inappropriate sexual contact with patients during treatment or some form of indecent assault (eight concerned both).

Men comprised 80.4% ($n = 127$) of all respondents in sexual misconduct matters. This differential was most stark in the subset

of inappropriate sexual contact, in which 96.7% of respondents were male. In contrast, in the subset of relationship with a patient, women comprised 28.3% of respondents.

Impairment

Nurses were the main group in this category (n = 19; 50%), followed by doctors (n = 11; 29%) and pharmacists (n = 4; 10.5%), with remarkably few dentists (n = 3) or psychologists (n = 1). This category notably had a 100% proven rate and a very high level of removal from practice (71%). Impairment was the head with the highest proportion of female respondents (44.7%; n = 17).

Most cases involved substance abuse (n = 25). Mental illness was identified as the subtype of impairment in 11 cases, and cognitive impairment was identified in two cases. There was no instance where physical impairment featured as the main cause of disciplinary proceedings.

Other

This diverse category produced a proven rate of 96%. The subsets were non-sexual misconduct (n = 58; 7.3%), respondent guilty of a criminal offence (n = 44; 5.5%), breaches of pre-existing registration conditions (n = 20; 2.5%), inappropriate conduct not in relation to a patient (n = 15; 1.9%) and other matters, such as inappropriate record keeping. There were no significant relationships of these subtypes with sex or profession.

Anomalies in outcomes

Of proven cases, 55.8% (n = 427) resulted in the respondent being removed from practice. Removal from practice orders were frequently accompanied by a reprimand. Deregistration was ordered in 37.1% of proven cases (n = 284), and suspension in 18.7% (n = 143). Identified discrepancies in outcome, discussed below, were more pronounced in deregistration. A prohibition order, available only if removal from practice is ordered, occurred in 6.3% of proved cases.

Conditions were imposed on registration in just over half the proven cases (n = 395), and most (n = 218) involved multiple conditions. In order of prevalence, conditions involved education or mentoring (n = 237), restricted practice (n = 142), supervision (n = 120), counselling (n = 71) and health conditions (n = 47).

Because non-restrictive sanctions could be issued in tandem with other orders, they were counted and are shown in Fig. 3 as ‘non-restrictive’ only when they were not imposed in tandem with a restrictive sanction, such as deregistration.

As Fig. 4 demonstrates, there were markedly different outcomes depending on the main head of misconduct in proven matters, with inappropriate clinical care less than half as likely to result in removal from practice than a matter of proved sexual misconduct. When the relationship between head of misconduct and removal from practice was tested for statistical significance, the P-value was 0.0001.

Anomalies in outcomes across jurisdictions

There were major differences in outcomes across the various jurisdictions, with NSW removing practitioners from practice at a significantly higher rate than all other jurisdictions, whereas WA, Tasmania, the ACT and NT had very low removal rates.

Differences were far more acute when deregistration was the focus. Deregistration was ordered in NSW more than fivefold as often as in the ACT, Tasmania and NT combined, and approximately twice as often as in the other states combined. The greater severity of outcomes in NSW is underscored by its far higher rate of prohibition orders compared with SA and WA, and the fact that other jurisdictions did not issue any of these types of orders (Table 2).

Although Qld had a removal rate comparable to that of NSW, it was the only major jurisdiction in which suspension was ordered more often than deregistration. When the relationship between jurisdiction and deregistration was tested for statistical significance, the P-value was 0.0001.

Anomalies in outcomes across professions

Taking an overview of all outcomes, it appears that doctors are less likely than the other professions to be removed from practice

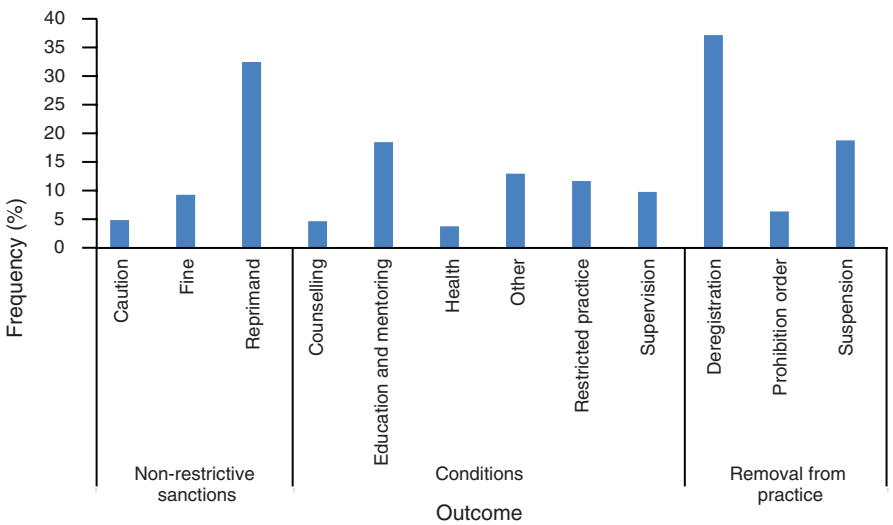

Fig. 3. Disciplinary outcomes by frequency and severity.

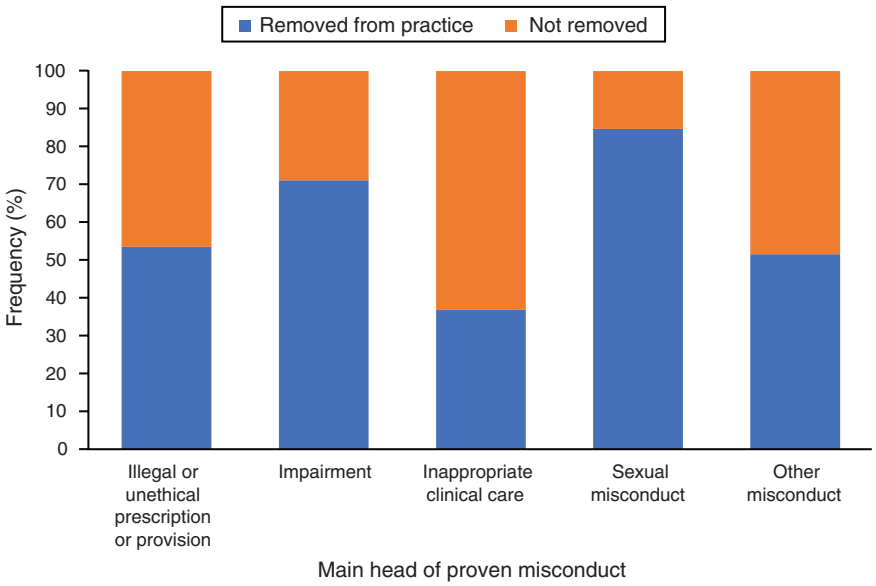

Fig. 4. Removal from practice by main head of proven misconduct.

Table 2. Removal from practice by jurisdiction

ACT, Australian Capital Territory; Tas., Tasmania; NT, Northern Territory; SA, South Australia; Qld, Queensland; WA, Western Australia; Vic., Victoria; NSW, New South Wales

	% Removed from practice						
	ACT, Tas. and NT combined (*n* = 37)	SA (*n* = 65)	Qld (*n* = 130)	WA (*n* = 154)	Vic. (*n* = 112)	NSW (*n* = 267)	Overall proved (*n* = 765)
Removed from practice	37.8	58.5	59.2	40.9	52.6	65.9	55.8
Deregistration	10.8	30.8	25.4	25.3	30.3	57.7	37.1
Suspension	27.0	27.7	33.8	15.6	22.3	8.2	18.7
Prohibition order	0.0	7.7	0.0	3.2	0.0	14.2	6.3

Table 3. Outcomes in proved matters (*n* = 765) by profession

	% Cases					
	Dentists (*n* = 51)	Doctors (*n* = 301)	Nurses and midwives (*n* = 267)	Pharmacists (*n* = 75)	Psychologists (*n* = 71)	Overall outcomes
Removed from practice	49.0	46.1	61.0	60	77.5	55.8
Deregistration	37.2	27.9	45.7	30.7	50.7	37.1
Suspension	11.8	18.2	15.3	29.3	26.8	18.7
Conditions	58.8	53.5	43.8	66.7	52.1	51.6
Supervision	9.8	17.6	10.5	12.0	35.2	15.7
Restricted practice	3.9	25.9	13.1	22.7	14.1	18.6

by tribunals. This discrepancy is noticeably more pronounced when deregistration is the outcome, with both nurses and psychologists being deregistered at considerably higher rates than doctors. When the relationship between profession and deregistration was tested for statistical significance, the *P*-value was 0.0001.

Examining removal from practice across the professions by reference to the type of proved misconduct, the trend of less severe outcomes for doctors was consistent, particularly concerning deregistration (Table 3). Within the main head of inappropriate clinical care, deregistration rates were 15.9%, 28.6% and 36.2% for doctors, dentists and nurses respectively. Only three pharmacists had matters proved under this head and five psychologists (no pharmacists were removed from practice, and four psychologists were deregistered). Within the main head of the prescription or provision of drugs, deregistration rates were closer: 30%, 32% and 37.3% for doctors, nurses and pharmacists respectively, with no proven matters concerning dentists. Within impairment, the numbers were small but the difference in deregistration continued: 45.5% of doctors compared with 68% of nurses.

Recollecting that sexual misconduct had by far the highest rate of removal from practice, it could be regarded as the most 'serious' main head within the tribunal setting. Within sexual misconduct, nurses were almost twice as likely as doctors to be deregistered, although the smaller numbers in this subset meant that statistical significance could not be established (P = 0.2052; eight dentists and three pharmacists excluded from Table 4).

Notably, although, on average, deregistration was ordered twice as often as suspension in proved sexual misconduct matters, and all professions were more likely to be deregistered than suspended for sexual misconduct, nurses were sevenfold more likely to be deregistered than suspended in the context of sexual misconduct.

Discussion

The findings of the present study were broadly consistent with previous research on complaint data under the National Law and tribunal cases prior to the National Law in that doctors were over-represented as respondents, nurses and midwives were underrepresented as respondents, male practitioners were greatly over-represented as respondents, failures in clinical care were the least likely type of matter to lead to restrictive action and doctors faced less severe outcomes than other professions. This is significant in demonstrating that differential outcomes between professions under the National Law are occurring both at the level of boards, which are dominated by each profession, and in external tribunals, which are chaired by a legal or judicial member. The study also found significant variation in outcomes across jurisdictions.

Variations in practice, institutional structure and culture, referral patterns and legislation may account for some of the differences between different states and territories, although it is difficult to identify any coherent pattern.

Qld and NSW have unique legislative features in that their versions of the National Law, namely the *Health Practitioner Regulation National Law 2009* (Queensland) and *Health Practitioner Regulation National Law 2009* (NSW) *No 86a* respectively, place protection of the public as a paramount objective. Although this could contribute to higher levels of removal from practice in those two jurisdictions compared with other jurisdictions, it cannot account for the differences between them, notably that deregistration is ordered twice as often in NSW than in Qld, or the markedly different rates of suspension and prohibition orders.

Table 4. Sexual misconduct outcomes by profession in proved cases (n = 150)

	% Cases			
	Doctors (n = 62)	Nurses and midwives (n = 37)	Psychologists (n = 40)	Overall outcomes
Removed from practice	79	83.8	95.0	84.6
Deregistration	48.4	73.0	57.5	58.0
Suspension	30.6	10.8	37.5	26.6

NSW maintained its own well-established complaint investigation and referral disciplinary system within which to apply the National Law. Thus, NSW was thus designated a 'coregulatory' jurisdiction, and Qld followed this approach in 2014 with the creation of the Health Ombudsman to investigate complaints in Qld. If the higher proportion of deregistration orders and prohibition orders in NSW were found to be associated with this coregulatory feature, one would expect Qld outcomes to become closer to those of NSW as time passes.

A possible factor contributing to both the high number of finalised cases and the low rate of removal from practice in WA is that state tribunal's practice of recording 'consent outcomes'. Elsewhere, once a complaint is serious enough to be filed, and is not withdrawn, it is not determined by consent. It appears that the WA tribunal is releasing decisions involving practitioner undertakings and agreed conditions that would likely be finalised at board level in other jurisdictions.

Lack of legal representation was considered a factor that could be associated with more severe outcomes. There was considerable variation in the proportion of legally represented respondents across the states: from a high of 96% in WA to a low of 73% in NSW. The other jurisdictions were clustered closer to the average (83%), with 87% of practitioners legally represented in Qld and Victoria, and 79% represented in SA and in the NT, ACT and Tasmania combined. However, these variations in legal representation did not correlate with outcomes: some of the lowest levels of deregistration appeared in jurisdictions with low levels of legal representation (SA, ACT, Tasmania and NT), and WA and Qld had almost identical rates of deregistration despite having different levels of legal representation. Only NSW appeared to have a clear correlation between a high rate of deregistration and low rate of legal representation.

In a study of the New Zealand disciplinary tribunal addressing 288 decisions concerning 21 health professions between 2004 and 2014, Surgenor *et al*.[15] identified that nurses were removed from practice at a higher rate than doctors (72.2% vs 55.8%), a disparity more acute in deregistration (43.5% of nurses vs 23% of doctors). However, that study did not compare removal rates for other professions and did not categorise cases in order to analyse whether outcomes were for the same type of misconduct. Surgenor *et al*.[15] suggested that the presence of legal representation may be a factor in less severe outcomes, because doctors were more likely than nurses to be legally represented at the hearing. Accordingly, the present study examined the relationship between legal representation, profession and outcome.

First, there was a major differential in legal representation by profession: 93.4% of doctors had legal representation, as did 84.6% of dentists, 84% of pharmacists and 83% of psychologists, but only 69.2% of nurses and midwives had legal representation.

There was a strong correlation between the presence of legal representation at a hearing and less severe outcomes. Among those with no legal representation there was an overall removal rate from practice among proved matters of 77.7%, compared with 52.9% for those with lawyers (analysed for statistical significance and producing a P-value of 0.001). This differential was again more acute when the comparator was deregistration: 69.8% of proved matters leading to deregistration for those without lawyers compared with 30% for those with legal representation.

Yet, even among those without legal representation, doctors were still removed from practice at a lower rate (66.7%) than nurses and midwives (77.6%), dentists (87.5%) and psychologists (100%). The exception was pharmacists without lawyers, who had a comparable removal rate to doctors (66.6%).

Thus, although different levels of legal representation may go some way towards explaining divergent outcomes across the professions, they cannot account for them entirely.

Limitations

The limitations of this study include that it addresses released cases only, with a disproportionate presence of cases from WA compared with Qld and Victoria. The study does not report on the incidence of misconduct *per se*, but rather on outcomes from determined tribunal cases. The appearance of matters before a tribunal is itself an incidence of the referral policies and practices of the various professional boards. The findings are suggestive of variations in the approach to referral to tribunals taking place in different jurisdictions and professional boards, but the study cannot determine whether that is the case.

Conclusion

The present research adds to what is known from recent studies of complaint data by focusing on serious misconduct cases referred to external legal tribunals since the inception of the National Law.

The findings of this study are consistent with current research on complaint data in that: (1) doctors were over-represented as respondents; (2) nurses and midwives were under-represented as respondents; (3) male practitioners were greatly over-represented as respondents; (4) failures in clinical care were the least likely type of matter to lead to restrictive action; and (5) doctors faced less severe outcomes than other professions. This is significant in demonstrating that differential outcomes between professions under the National Law are occurring both at the level of boards, which are dominated by each profession, and in external tribunals, which are chaired by a legal or judicial member.

The findings of this study are also broadly consistent with previous research on doctors in tribunal outcomes before the National Law, and previous New Zealand research on Tribunal outcomes in that: (1) male practitioners were greatly over-represented as respondents; (2) outcomes were most severe for sexual misconduct and least severe for clinical care; and (3) doctors faced less severe outcomes than other professions.

This study is the first to compare outcomes for the five most populous professions by reference to the type of misconduct proved. Comparing outcomes for professions across the main types of misconduct allows one to consider whether, in effect, different professions are receiving different outcomes for the same malfeasance, and the answer is ‘yes’. Other novel findings include significant variations in severity of outcome by jurisdiction, more pronounced variations in outcomes by both profession and jurisdiction when deregistration was the focus of analysis and variations in outcome according to legal representation.

Although the number of cases is small in overall terms (794 in total over the 7-year period addressed), this study indicates that there are variations in outcomes under the National Law that cannot be completely explained by differences in legislation or the presence of legal representation. Further work undertaking qualitative analysis of decisions under each head of misconduct will help better understand what other factors may explain variations in outcomes.

Competing interests

The author has been a part-time member of the NSW Civil and Administrative Tribunal (NCAT), Occupational Division, since 2015. This role involves presiding in health disciplinary matters, including seven cases that ultimately comprised part of the dataset. To ensure integrity of the coding, the author did not undertake any coding of those seven cases nor discuss them with research assistants. The views expressed in this article are those of the author alone and do not represent NCAT. NCAT had no role in the design or conduct of this research.

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