Problem Doctors in Disciplinary Tribunals:

Who Do Protective Orders Protect?

An Analysis of Australian Tribunal Decisions from

2010 – 2013

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Certificate of original authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

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Abstract

This thesis questions whether the approach to 'problem' doctors adopted by medical disciplinary tribunals in Australia undermines a key objective of the Health Practitioner Regulation National Law, namely, the protection of the public. The thesis analyses medical tribunal decisions in Australia from 1 July 2010 to 1 July 2013, with a particular focus on 'impaired' doctors. It argues that the concept of the protection of the public has been undermined by protective orders (also known as disciplinary sanctions), which focus on the rehabilitation of problem and impaired doctors in the management of risk, rather than more severe protective orders, such as suspension or deregistration. The tribunal decisions create a rich database for a nuanced examination of the way in which the culture of 'the therapeutic state' has permeated disciplinary decision-making in relation to protective orders, under both the old State and Territory laws and the current Health Practitioner Regulation National Law. This culture medicalises professional misconduct that may attract negative moral judgment, and redefines it in terms of illness, in particular, psychiatric illness. The thesis critically assesses how tribunals struggle to distinguish between misconduct as a function of illness or impairment, and other misconduct, and identifies the key role played by psychiatrists in this process. The findings indicate that the most common form of risk management in medical tribunals was the use of protective orders to impose conditions upon a doctor's registration, such as supervision of a doctor's practice, psychiatric treatment, drug testing or the use of a chaperone. It is argued that in view of the paucity of research on the rationale and utility of such protective orders, tribunals show too much trust in their effectiveness. The thesis concludes that the pendulum has swung too far towards the rehabilitation of doctors at the cost of protection of the public.

CHAPTER 1 – INTRODUCTION

1.1 Introduction

In spite of important recent research in Australia involving complaints about doctors[1] and the outcomes of these complaints in disciplinary proceedings,[2] there has been little detailed analysis of the rationale or utility of the protective orders used by disciplinary tribunals in order to carry out their mandate of protecting the public.[3] This thesis addresses this research deficit by analysing medical tribunal decisions[4] dealing with 'problem' doctors in Australia from 1 July 2010 to 1 July 2013, with a particular focus on 'impaired' doctors.[5] For the purposes of this thesis a 'problem' doctor is defined as

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[*]The author of this thesis was until very recently a Hearing Member of the Medical Council of New South Wales and the former Medical Board of New South Wales. She has experience as a member of both Professional Standards Committees (which hear less serious complaints about doctors), and Medical Tribunals (which hear more serious complaints). Any tribunal decisions in which the author participated are marked with an asterisk in Appendix A and where relevant footnoted in the thesis.

[1] The term 'doctor' is used in this thesis because it is still in common use both generally and in the literature, and is more concise than the term 'medical practitioner'. Under the *Health Practitioner Regulation National Law* (Queensland) current at 1 July 2014) (the 'National Law)', the generic term 'health practitioner' is used to refer to the 14 health professions it regulates. Doctors are distinguished from the other health professions under the National Law in the Definitions section (Section 5) where the term 'medical practitioner' is defined as 'a person who is registered under this Law in the medical profession'.

[2] Katie Elkin, Matthew J Spittal, David J Elkin and David M Studdert, 'Doctors Disciplined for Professional Misconduct in Australia and New Zealand' (2011) 194 *Medical Journal of Australia* 452–456. Marie M Bismark, Matthew J Spittal and David M Studdert, 'Prevalence and Characteristics of Complaint-Prone Doctors in Private Practice in Victoria' (2012) 195 *Medical Journal of Australia* 25. Katie Elkin, Matthew J Spittal and David M Studdert, 'Risks of Complaints and Adverse Disciplinary Findings against International Medical Graduates in Victoria and Western Australia' (2012) (8) *Medical Journal of Australia* 197.

[3] As will be further discussed, whilst the National Law in most States and Territories refers to 'the protection of the public', in New South Wales and Queensland the National Law refers to 'the health and safety of the public'. In this thesis, for ease of reference the simpler term 'the protection of the public' is used to refer to both concepts. The concept is further discussed and referred to throughout the thesis. For a detailed discussion of the concept see Katie Elkin, 'Medical Practitioner Regulation: Is It All about Protecting the Public' (2014) 21 *Journal of Law and Medicine* 682–697.

[4] Disciplinary decisions made by tribunals are guided by the the National Law. Prior to the National Law, the decisions were made under former State and Territory laws. As further explained in Chapter 3, many of the earlier decisions in this study were made under the former State and Territory laws.

[5] In Australia, under Section 5 of the National Law, impairment is defined as follows: 'impairment', in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally or is likely to detrimentally affect-

> (a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or
>
> (b) for a student, the student's capacity to undertake clinical training-

one whose professional behaviour has resulted in adverse findings in disciplinary proceedings, and includes any impaired doctors in this category.[6] Such proceedings can have a significant impact on doctors' lives, both professionally and personally. The effect of a complaint upon a doctor can be profound, and exacerbate an impairment, as further discussed in Chapter 5.[7] Tribunals, aware of the potential consequences of their decisions, thus have the challenging task of balancing the rehabilitative needs of doctors against their public protection mandate.

1.2 Aim

The aim of the thesis is to examine whether the use of protective orders[8] by disciplinary tribunals,[9] which focus on the treatment and rehabilitation of doctors, undermines a key

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(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.

See Chapter 5 for discussion of the concept.

[6] Linda Hancock, 'Addressing the Problem Doctor: Professional Misconduct and Avenues of Complaint' in Peter Lens and Gerritt van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997) 452. Hancock's definition is used in this thesis. This quite narrow definition is apposite to the thesis because it neatly confines the research to only those doctors who appear in disciplinary proceedings and provides the rationale for the database of tribunal decisions as further discussed in Chapter 3. Problem doctors have also been defined as those who may 'malfunction' in their work due to impairment, incompetence, lack of experience, age, work pressure, or personality conflict. Any of these 'malfunctions' may result in disciplinary proceedings. See Marilyn Rosenthal, 'Promise and Reality: Professional Self-Regulation and 'Problem' Colleagues' in Peter Lens and Gerritt van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997).

[7] Louise Nash, *Medico-Legal Matters and Australian Doctors: An Investigation of Doctors Experience of Medico Legal Matters* (PhD, University of Sydney, 2011). Sarah Bird, 'Mandatory Reporting of Health Practitioners - Notifiable Conduct' (2010) 39 *Australian Family Physician* 593. Nick Goiran, MLC, Margaret Kay, Louise Nash and Georgie Haysom, 'Mandatory Reporting of Health Professionals: The Case for a Western Australian Style Exemption for All Australian Practitioners' (2014) 22 *Journal of Law and Medicine* 209.

[8] Also known as disciplinary sanctions, or more infrequently as disciplinary penalties *Walton v Gardiner* [1993] HCA 77 per Brennan, J at [25]. The protective orders available are set out in the legislation. See *Health Practitioner Regulation National Law* (Queensland) current at 1 July 2014 s 196 (2); *Health Practitioner Regulation National Law* (NSW) s 149A. The relevant legislation is further discussed in Chapter 2.

[9] Tribunals under the National Law are discussed in Chapter 2. According to Elkin, a tribunal is any disciplinary body with the power to remove a doctor from practice, other than on an interim basis. Katherine Jane Elkin, *Protecting the Public? An Analysis of Complaints and Disciplinary Proceedings Against Doctors in Australia and New Zealand* (PhD, The University of Melbourne, 2013) 53. JRS Forbes, *Disciplinary Tribunals* (Federation Press, Second Edition, 1996) 1, defines a disciplinary tribunal as an authority created by statute or by agreement that exercises quasi-penal functions outside the regular court system. The jurisdiction in which medical disciplinary tribunals operate is a protective jurisdiction and the caselaw rejects the idea of any penal or punitive functions in the relevant law. This issue is further discussed in Chapter 2.

purpose of the Health Practitioner Regulation National Law ('the National Law'),[10] which is the protection of the public.

Such protective orders are generally focussed on treatment and rehabilitation through the imposition of conditions upon a doctor's practice whilst s/he remains in practice, rather than more severe orders, such as suspension or deregistration, which are generally more protective of the public and are arguably more likely to have a deterrent effect.[11] Typically conditions on a doctor's registration may include psychiatric treatment, or, for doctors with addictions, regular urine or blood testing for the presence of alcohol or drugs. This thesis contends that a therapeutic culture is incorporated into the National Law through the health provisions for impaired doctors and the mechanisms of 'therapeutic jurisprudence'.[12] The thesis does not suggest that rehabilitation is not a worthwhile approach in the regulation of problem doctors, but argues that it becomes problematic when the balance tips towards the rehabilitation of problem doctors rather than the protection of the public.

In order to achieve its aim, this thesis will focus on two particular cohorts of cases; one involving impaired doctors and the other involving doctors who are not impaired. The first cohort (impaired doctors)[13] is chosen on the assumption that it is more likely to attract a therapeutic or rehabilitative approach in protective orders. In addition, there has been very little research in Australia on impaired doctors who appear in disciplinary proceedings, as discussed further below. The second cohort will comprise doctors found guilty of sexual misconduct who are not impaired, although psychiatric evidence was called in some cases.[14] This cohort is chosen because sexual misconduct was the most common form of misconduct found in the Tribunal decisions analysed in this study. By

[10] In this thesis, when references to the 'National Law' are made, they refer to those parts of the law that are consistent and binding in all States and Territories. Where there are relevant differences, they are discussed. The National Law is discussed in Chapter 2.

[11] These and other protective orders are further discussed in the following chapters of this thesis. There appears to be no empirical research available on the deterrent effect of protective orders in medical disciplinary proceedings.

[12] This concept and the health provisions are elucidated in Chapter 2.

[13] This cohort includes doctors against whom a formal complaint of impairment is made under the National Law or previous legislation, or where the doctor has been recognised as impaired although the complaint is not of impairment.

[14] These cases are discussed in Chapter 7. As noted in Chapter 3, the comparison is not intended to be a numerical comparison as the second cohort is much larger than the first.

examining the two cohorts, this thesis will explore whether a rehabilitative approach in disciplinary tribunals extends to doctors who are not impaired. This thesis will also explore how tribunals distinguish between misconduct as a function of illness or impairment, and other misconduct.[15]

It is important to note that disciplinary proceedings are in fact only a very small part of a complex system that involves the regulation of doctors. This thesis confines itself to this very small part of the regulatory system, and further confines itself to the analysis of the two cohorts of cases mentioned above, in the context of the overall findings discussed in Chapter 4.

1.3 Overview

In this chapter the concept of 'the protection of the public' is briefly discussed, and the rationale for the thesis is elucidated. This chapter briefly identifies some of the key imperatives for reform that led in 2010 to the establishment of a national system of health practitioner regulation under the National Law. It also notes the role played by scandals in identifying problems in how doctors are regulated, particularly impaired doctors. It argues that the formal recognition of the need to rehabilitate impaired doctors provides the perfect climate for the 'medicalisation' of problem doctors and a shift in the discourse on regulation. The chapter briefly reviews the existing literature on problem doctors and their management in disciplinary tribunals, and elucidates the framework used to guide the analysis of tribunal decisions that is woven throughout the subsequent chapters. It concludes by identifying a research deficit in analysis of disciplinary decision-making and problem doctors, and briefly outlines the issues to be addressed in the following chapters.

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[15] In this thesis, when the general term 'misconduct' is used it refers to both professional misconduct (the most serious form of misconduct, which may lead to deregistration) and unprofessional conduct (less serious misconduct): See s 5 of the National Law. In New South Wales 'unprofessional' conduct is referred to as 'unsatisfactory professional conduct'. *Health Practitioner Regulation National Law Act* (NSW) s 5. These definitions are further discussed in Chapter 2. In this thesis, the term 'character' is not used to distinguish other misconduct from impairment, as the cases themselves provide the rationale for the distinction and generally do not ue this terminology. Although 'other misconduct' may involve judgments about character the conceptual shortcomings of the term are well recognised, especially the simplistic dichotomy between 'good' and 'bad character'. Ian Freckelton, ''Good Character' and the Regulation of Medical Practitioners' (2008)16 *Journal of Law and Medicine* 488.

Although the regulation of health practitioners is sometimes regarded as being synonymous with disciplinary proceedings, such proceedings are clearly only a small part of the complex mosaic involving the regulation of health practitioners, which is briefly outlined below. However, in spite of the many other mechanisms of regulation, it is only in disciplinary proceedings under the National Law in all States and Territories that a doctor can be deregistered, and it is in this respect that disciplinary proceedings are so important.[16] Disciplinary tribunals can remove 'problem' doctors from practice so that they are no longer a risk to the public, or impose other protective orders, which can significantly restrict a doctor's practice. The significance of disciplinary proceedings to the medical profession, the general public and to 'problem' doctors, highlights the importance of research involving decisions made by Australian disciplinary tribunals.

1.4 Tribunal decisions

Tribunal decisions provide a rich database for a nuanced examination of the discourse used in the making of findings about misconduct and protective orders. The decisions importantly also provide information about the regulatory histories of doctors and previous attempts at rehabilitation. These regulatory histories often do not become public until a tribunal decision is published. An analysis of the discourse in tribunal decisions is undertaken in Chapters 6 and 7 and draws on what Morrow has argued to be the conceptualisation of misconduct in doctors as a medical problem,[17] what Conrad and Schneider refer to as the 'medicalization of deviance',[18] and what Nolan has argued to be the 'culture' of 'the therapeutic state',[19] as further elucidated below.

The analysis of tribunal decisions in this thesis confirms that misconduct, which may attract moral judgment or condemnation, is often redefined in terms of the symptoms or

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[16] See Judith Allsop, 'Regulation and the Medical Profession' in Judith Allsop and Mike Saks (eds) *Regulating the Health Professions* (SAGE Publications, 2002) 81. Allsop discusses the role of the General Medical Council in the United Kingdom, which has similar functions to the administration of the National Law in Australia under the Australian Health Practitioner Regulation Agency (AHPRA).

[17] Carol Klaperman Morrow, 'Sick Doctors: The Social Construction of Professional Deviance' (1982) 30 No 1 *Social Problems*.

[18] Peter Conrad and Joseph Schneider, *Deviance and Medicalization: From Badness to Sickness* (Temple University Press, 1992).

[19] James L Nolan Jr, *The Therapeutic State* (New York University Press, 1998).

outcomes of illness.[20] The Tribunal decisions reveal an interpretation of the protection of the public that includes the rehabilitation of 'problem' doctors.[21]As noted above, it is not suggested that there is anything inherently misconceived in this approach. The question tackled in this thesis is whether a rehabilitative approach is one that undermines public protection, a key objective of the National Law and therefore needs to be challenged or, at a minimum, calibrated.

1.5 Is rehabilitation inconsistent with the protection of the public?

Rehabilitation of problem doctors is clearly in the public interest given society's investment in the education and training of doctors, and the specialist skills they offer to the community. A rehabilitative approach will ideally foster the acquisition of insight and an acceptance of responsibility for the misconduct, and may be educational both personally and professionally. If successful, it may minimise the risk of re-offending. Such an approach may also improve the capacity of doctors to become 'self-regulating' at the micro level.[22] Referring to the more general concepts of redemption and remediation, which are similar to a rehabilitative approach, Case argues that a redemptive model of regulation cultivates certain desirable professional attributes, encourages personal responsibility and demonstrates a form of compassion and forgiveness.[23] The redemptive model presents 'a more realistic, multifaceted form of self-discipline pared down from the old archetype of the doctor as selfless 'paragon of virtue'.[24] However, in spite of the obvious advantages of a rehabilitative or redemptive approach, such an approach can also be inherently problematic and is based upon assumptions that need to be explored and challenged.

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[20] In most cases psychiatric illness, as is further discussed in Chapter 5.

[21] In this thesis rehabilitation is used in its ordinary English dictionary meaning to refer to the restoration of good health or fitness. See, for example, definitions of rehabilitation in the Oxford English Dictionary, and Macquarie Dictionary.

[22] Paula Case, 'The Good, the Bad and the Dishonest Doctor: The General Medical Council and the "Redemption Model" of Fitness to Practise' 31 *Legal Studies* 591.

[23] Ibid 609.

[24] Ibid.

1.6 The 'protection of the public' – an elastic concept

Conspicuous by its absence in the National Law[25] is any attempt to define the term 'protection of the public', although it is elucidated in disciplinary caselaw, as discussed below. The lack of definition in the National Law is important, as 'the protection of the public' provides the rationale for the use of protective orders in disciplinary tribunals,[26] and leaves disciplinary tribunals to determine not only who are 'the public' but what protective orders are most likely to 'protect' the public. Some of the conceptual problems in the term 'protection' are pointed out in the literature. Freckelton notes that whilst protection of the community is the overarching purpose of professional regulation, 'protection' is a 'subtle and complex concept'.[27] According to Mendelson, the protection of the public is 'a noble aim, but an amorphous one that is open to many interpretations'.[28] 'The term 'the public' is also an amorphous concept, and open to different interpretations, as discussed in the next chapter, although the thesis does not undertake a nuanced examination of either of these terms.

In Chapter 2 it will be argued that the lack of legislative definition of 'the protection of the public' allows tribunals to medicalise a doctor's conduct and can lead to a rehabilitative focus in protective orders. As noted above, this rehabilitative focus may not in itself be problematic as the rehabilitation of doctors is clearly in the public interest.[29] In an English case, the court noted that there is a particular public interest in rehabilitating doctors that does not necessarily apply in other professions, such as law,

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[25] See the next chapter for a detailed discussion of the National Law.

[26] There is limited discussion of this concept in the literature. Elkin's work, *Protecting the Public?',* above n 9, is important in this respect and is discussed further in this chapter as is Mendelson's paper: Danuta Mendelson, 'Disciplinary Powers of Medical Practice Boards and the Rule of Law' (2000) 8 *Journal of Law and Medicine* 142–151. Her later papers are also discussed in this thesis.

[27] Ian Freckelton, 'The Margins of Professional Regulation: Disjunctions, Dilemmas and Deterrence', Ian Freckelton (ed) *Regulating Health Practitioners* (Federation Press, 2006) 167. Rather than define it, he states 'It encompasses more than just dissuading health practitioners from unsafe or reckless conduct. It includes addressing public disillusionment after phenomena such as Shipman, Bristol, Bailey and Patel. It also requires maintenance within the general community of trust and well-founded confidence in the integrity and competence of health practitioners.'

[28] Mendelson, 'Disciplinary Powers of Medical Practice Boards', above n 26, 151.

[29] As further discussed in Chapter 2, the rehabilitation of doctors is not an explicit objective of the law in spite of the existence of the health provisions, which belie this omission. Whether this rehabilitation should occur under the umbrella of the National Law is further discussed in Chapters 6 and 8.

where there is no workforce shortage.[30] However supply considerations, which are enshrined in the objectives of the National Law in Australia, may also undermine public protection and give inappropriate weight to the interests of doctors.[31] In discussing the objective of ensuring the supply of doctors Elkin found in her own research that not only did the balancing of supply considerations against public protection go beyond the legislative mandate of the Tribunals (as it was at the relevant times), but it may also have provided an apparent justification for inappropriate weight to be given to the interests of the doctor concerned, potentially at the expense of public protection.[32] She concluded that Australia's urgent need for doctors in rural and remote areas was driving down registration requirements,[33] and that supply considerations may have compromised other public interest considerations, such as public protection.[34] Rehabilitation considerations may also compromise public protection and give inappropriate weight to the interests of doctors. The rehabilitative focus in tribunal decision-making clearly becomes problematic if there is a tension between protecting the public and meeting the rehabilitative needs of doctors. This thesis explores this tension.

A recent definition of the concept of the protection of the health and safety of the public was considered in a New South Wales Court of Appeal case, *Health Care Complaints Commission v Do* [2014] NSWCA 307 (4 September 2014) which involved an appeal against the protective orders imposed by a tribunal. The Court of Appeal stated that:

> The objective of protecting the health and safety of the public is not confined to protecting the patients or potential patients of a particular practitioner from the continuing risk of his or her malpractice or incompetence. It includes protecting the public from the similar misconduct

[30] *Giele v General Medical Council* (QBD) [2006] 1 WLR 942 *[20]*.

[31] See the National Law Objective (f) which provides 'to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners*'*.

[32] Elkin, *'Protecting the public?'* above n 9, 282. Elkin conducted two major empirical studies. She referred to them as her First Study and her Second Study In her First Study she described the characteristics of doctors found guilty of professional misconduct by tribunals in Australia and New Zealand. In her Second Study she also examined the effectiveness of the registration and supervision requirements of IMGs (International Medical Graduates) in protecting the public.

[33] Elkin, *'Protecting the public?'* above n 9, 282.

[34] Ibid.

> or incompetence of other practitioners and upholding public confidence by setting and maintaining those standards and, where appropriate, by cancelling the registration of practitioners who are not competent or otherwise not fit to practise, including those who have been guilty of serious misconduct. Denouncing such misconduct operates both as a deterrent to the individual concerned, as well as to the general body of practitioners. It also maintains public confidence by signalling that those whose conduct does not meet the required standards will not be permitted to practise.[35]

This definition is apposite for this thesis because it contains no reference to the rehabilitation of doctors, although it does not exclude it. It focusses on the aspect of deterrence in protective orders, which is not often considered in cases where a rehabilitative approach is taken.[36] Because the aspect of deterrence is usually associated with more severe protective orders such as suspension from practice or deregistration, it is more protective of the public, as *Do* illustrates.[37] Dr Do was removed from practice rather than being allowed to remain in practice with conditions upon her registration. As will be demonstrated in this thesis, the imposition of conditions upon a doctor's registration is not always protective of the public.

There is also little attention in the National Law to the actual concept of 'protective orders' and again it is the caselaw that provides some guidance. In a South Australian case, decided before the National Law came into existence,[38] the court referred to protective orders as follows:

> [45] While there is a fundamental difference between an order made by a professional disciplinary tribunal for the protection of the public, and a punishment imposed by a court administering the criminal law, disciplinary orders made by professional bodies may nevertheless have elements in common with criminal sanctions.

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[35] *Health Care Complaints Commission v Do* [2014] NSWCA 307 (4 September 2014) [45].

[36] One exception is the case of *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012) [33].

[37] *Health Care Complaints Commission v Do* [2014] NSWCA 307 (4 September 2014).

[38] But still frequently cited.

[39] *Craig v The Medical Board of South Australia* No. SCCIV-01-573 [2001] SASC 169 (25 May 2001), citing *New South Wales Bar Association v Evatt* [1968] HCA 20; (1968) 117 CLR 177.

> [46] In the case of a professional disciplinary tribunal, an obvious type of order protective of the public is an order cancelling the registration or recognition of a person as a member of a profession. Such an order removes the right to practise in the profession; thereby protecting the public against a person found unfit to be a practitioner. And, as Evatt[39] shows, such an order will be made even though, if punishment of the practitioner were the only consideration, considerations of mercy might lead to a less severe order.
>
> [47] In other cases the protection of the public or the public interest may justify an order intended to bring home to the practitioner the seriousness of the practitioner's departure from professional standards, and intended to deter the practitioner from any further departure.[40]

In spite of the focus on deterrence in both the early case of *Craig* and the later case of *Do*, the protective orders in some of the decisions in this thesis demonstrate that tribunals interpret the protection of the public as being almost synonymous with the rehabilitation of problem doctors. This is not problematic where rehabilitation is successful; however, the cases discussed in this thesis demonstrate that such an interpretation is seriously flawed.

1.7 Old wine in the changing bottles of regulation

It is important to locate current disciplinary proceedings within the broader context of the development of the regulation of doctors in Australia.[41] The historical discourse

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[40] The judgment at [47] continues 'A fine might well be imposed with this object. An order imposing a fine might look like a punishment imposed by a court exercising criminal jurisdiction, but in professional disciplinary proceedings it is imposed on a different basis. An order might also be made in professional disciplinary proceedings to emphasise to other members of the profession, or to reassure the public, that a certain type of conduct is not acceptable professional conduct. In the latter case the order is made in part to protect the profession, by demonstrating that the profession does not allow certain conduct. This, in the end, is also in the public interest.' As noted in Chapter 2, because they are not imposed with any degree of consistency, and the particular rationale for their imposition is not usually explained in the Tribunal decisions, fines are not discussed in this thesis.

[41] The regulation of 'problem' doctors in Australia was heavily influenced by developments in the United Kingdom where the first doctors in Australia were trained. The early history of regulation reveals the lively debates in the discourse on the regulation of doctors and the transition of the medical profession from marginal to established status in the United Kingdom, the USA and Australia (See MJD Roberts, 'The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act' 53 *Medical History* 37). Today the General Medical Council is the key registration and regulation authority for doctors in the

about the regulation of doctors reveals that many of the debates that occurred in the early days of regulation continue today. The first doctors in Australia were emigrants from the United Kingdom and arrived by ship, travelling as ship's doctors.[42] A few doctors came as prisoners in convict ships,[43] arguably some of the first 'problem' doctors in Australia.[44]

> … England transported its finest quacks and criminals to the Antipodes, creating at once an urgent need for regulation in the colonies and a less urgent need at home.[45]

Just as pioneering doctors in the first 50 years of the colony attempted to distinguish themselves from quacks and chemists, there is continuing controversy today about unorthodox medical practice and alternative medicine.[46] There are also continuing debates about the vested interests of the profession in self-regulation,[47] the boundaries of professional regulation,[48] what constitutes professional misconduct (the basis for adverse findings in disciplinary proceedings)[49] and what conduct can be described as

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UK; Michael Moran and Bruce Wood, *States, Regulation and the Medical Profession* (Open University Press, 1993). See also Mendelson's account of the early history of medical regulation in the United Kingdom and Australia, in 'Disciplinary Powers of Medical Practice Boards', above n 26. For the US see JN Thompson and LA Robin, 'State Medical Boards. Future Challenges for Regulation and Quality Enhancement of Medical Care' (2012) 33 *Journal of Legal Medicine* 95 (an American journal), and for Australia see, eg, Milton Lewis and Roy MacLeod, 'Medical Politics and the Professionalisation of Medicine in New South Wales, 1850–1901' (1988) 12 *Journal of Australian Studies* 69; David Thomas, *The Rise and Recession of Medical Autonomy and Peer Review in New South Wales 1856–1994* PhD University of Sydney (2003). Gabrielle Wolf, 'A delayed inheritance: the Medical Board of Victoria's 75-year wait to find doctors guilty of "infamous conduct in a professional respect"' (2015) 22 *Journal of Law and Medicine* 568.

[42] Stephen Due, *Australian Medical Pioneers Index* (Geelong Hospital Library) vol 2012 <http://www.medicalpioneers.com/> See Sources of Information about Pioneer Doctors.

[43] Ibid.

[44] Ibid.

[45] Alison Reid, 'To Discipline or Not to Discipline? Managing Poorly Performing Doctors', *Regulating Health Practitioners* (The Federation Press, 2006) 91.

[46] See, eg, Freckelton, 'The Margins of Professional Regulation', above n 27; and Jamal Walid, Cameron Stewart and Malcolm Parker '"CAM-Creep": Medical Practitioners, Professional Discipline and Integrative Medicine' (2014) 22 *Journal of Law and Medicine* 222.

[47] See Rob Baggott, 'Regulatory Politics and the Public Interest' in J Allsop and M Saks (eds), *Regulating the Health Professions* (SAGE Publications Ltd, 2002) 34. Daniel Klass, 'Saving Polly: Can Professional Self-Regulation Play an Ongoing Role in the Delivery of Medical Care?', *Health Workforce Governance* (Ashgate Publishing Ltd, 2012) 142-161. These debates are further discussed in Chapter 2.

[48] Freckelton, 'The Margins of Professional Regulation', above n 27.

[49] The modern version of 'infamous conduct in any professional respect', the first definition of professional <Medical Act 1858 - Legislation.gov.uk>.

conduct 'in the practice of medicine'.[50] These ongoing debates all form part of the context for this thesis and illustrate the challenges for regulators in addressing these issues. It is arguable that these debates are old wine in the changing bottles of the regulatory system.

The imperatives for reform that led to the development of the National Law have been well documented.[51] In the mid-1990s there were spirited debates in Australia in response to the proposal for a new National Law to regulate health practitioners, following the trend towards globalisation in Europe and growing mistrust in the medical profession.[52] In the United States, the medical profession was seen as professionally incompetent, insufficiently accountable, and self-interested.[53] In Australia, reflecting these overseas trends and a growing consumer movement, complaints commissions in each state known as Health Complaints Entities[54] (HCEs), now encourage patients to challenge doctors when they are unhappy with the service provided, and as Freckelton notes:

> Access to information on the internet has fundamentally empowered and informed health care consumers about health conditions, diagnoses and treatments. … In addition, a sequence of scandals and egregiously bad

[50] *Child v Walton* [1990] NSWCA <http://www.mcnsw.org.au/page/417/doctors--performance--conduct--health/professional-conduct-/hearings-and-decisions/decisions/relevant-court-decisions/nsw-court-of-appeal-/nsw-court-of-appeal-decisions-1976---1999/>.

[51] See, eg, Anne-Marie Carlton, 'National Models for Regulation of the Health Professions', in Ian Freckelton (ed) *Regulating Health Practitioners* (The Federation Press, 2006). They included a lack of sufficient mobility for practitioners who wished to work across state boundaries, the problems for practitioners, boards and health service managers arising from inconsistencies both in legislation and in the administration of registration and accreditation schemes across States and Territories, and the need for a more effective regulatory system to protect the public.

[52] Judith Allsop and Mike Saks 'Introduction: The Regulation of Health Professions' in Judith Allsop and Mike Saks (eds) *Regulating the Health Professions* (SAGE Publications Ltd, 2002) 1. Michael Moran and Bruce Wood, *States, Regulation and the Medical Profession* (Open University Press, 1993). This literature describes a decline in public trust of the professions in the UK and Europe, the impact of globalisation on the health professions, and pressure for a cross-border European legal framework to encourage the mobility of labour within the European Union. There was similar dissatisfaction in the US with a growing consumer movement in the late 1960s and mid-1970s reflecting public distrust in medicine, a sharp increase in malpractice claims and 'a flurry of reforms in professional discipline'. See Morrow 'Sick Doctors', above n 17. In 2006, when Freckelton's important book *Regulating Health Practitioners* was published in Australia there already existed a significant body of literature on health professional regulation overseas. Ian Freckelton (ed) *Regulating Health Practitioners* (Federation Press Sydney, 2006) 167.

[53] Morrow, 'Sick Doctors', above n 17, 94.

[54] <http://www.ahpra.gov.au/About-AHPRA/What-We-Do.aspx>.

> instances of professional conduct has to be acknowledged as having detracted from the status of and respect for health practitioners in the United Kingdom, Australia and New Zealand.[55]

The National Law commenced in July 2010, and was intended to address some of the criticisms of the existing system, most notably the need for consistency across the States and Territories in how health practitioners are registered and regulated. Already, however, there are now marked inconsistencies in the eastern states in terms of regulation,[56] and some of the provisions of the legislation, including those related to mandatory reporting, are controversial.[57]

In addition to the imperatives for reform identified above, as Freckelton and other writers have noted, [58] scandals about doctors have played an important role. Scandals need to be understood 'not as simple determinants of change, but as one performative element in a constellation of socially contingent forces and contexts'.[59] The Patel scandal in Australia was arguably one such 'performative element 'or 'perfect storm', which revealed flaws not only in the regulatory system, but also in the criminal justice system,[60] and involved political repercussions for the government of the day.[61] The

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[55] Ian Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' (2010) 18 *Journal of Law and Medicine* 207–219. A scathing report was published in 2005 on the role of the General Medical Council (the GMC), the key regulatory body for doctors in the United Kingdom, following an inquiry into the deaths of patients caused by Dr Harold Shipman, Britain's most prolific serial killer. The report criticised the GMC for failing in its primary task of looking after patients because it was too involved in protecting doctors. J Smith, *The Shipman Inquiry Fifth Report* Stationery Office, London (2004) <http://www.theguardian.com/society/2005/aug/25/health.shipman>. Mary Dixon-Woods, Karen Yeung and Charles L. Bosk, 'Why Is UK Medicine No Longer a Self-Regulating Profession? The Role of Scandals Involving "Bad Apple" Doctors' (2011) 73 *Social Science and Medicine* 1452.

[56] New South Wales has always had a co-regulatory system, and Queensland has also opted for its own system of regulation.

[57] The mandatory reporting provisions are at s 140 of the National Law. This issue is further discussed in Chapter 2.

[58] Deborah Lupton and Jane Mclean, 'Representing Doctors: Discourse and Images in the Australian Press' (1998) 46 *Social Science and Medicine* 947. These authors conclude that in spite of scandalous or criminal activity the medical profession in Australia as a whole appears to enjoy significant social and cultural authority 957; Fiona McDonald, 'Scandals, Public Inquiries and Health Professional Regulation', *Health Workforce Governance* (Ashgate Publishing Limited, 2012).

[59] Dixon-Woods, Yeung and Bosk, above n 55, (Abstract).

[60] The High Court of Australia overturned Dr Patel's three convictions for manslaughter and a conviction for grievous bodily harm on the basis of a miscarriage of justice after the prosecution changed its case against him. *Patel v The Queen* [2012] HCA 29 (24 August 2012). See also Margaret Cunneen, S.C. 'The Patel Case - Implications for the Medical Profession' Paper presented to the Medico-Legal Society of New South Wales Sydney (2010). A retrial for one of the manslaughter counts resulted in acquittal. Dr Patel pleaded guilty to fraud and the remaining charges were dropped.

Queensland Medical Board was strongly criticised for its handling of the Patel case.[62] Other scandals in Australia have exposed not only the hitherto hidden world of regulators and the protected world of doctors, but significantly, the protected world of impaired doctors. Because of privacy and health concerns the issue of a doctor's impairment is not usually made public. Scandals about impaired doctors have forced the issue of impairment and how it is managed by regulators into the public arena. Nevertheless many questions remain unanswered. Elkin notes that public perceptions about disciplinary proceedings are shaped by the intense media coverage that surrounds selected 'scandals',[63] and that:

> The disciplinary system is where the rubber of public protection hits the road of public expectation. … it is when things go wrong that questions are asked and answers demanded.[64]

Some recent scandals in Australia confirm that a rehabilitative or therapeutic[65] approach to doctors in a regulatory context can have disastrous consequences.[66] A 'therapeutic'

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[61] David Thomas, 'Peer Review as an Outmoded Model for Health Practitioner Regulation' in Ian Freckelton (ed) *Regulating Health Practitioners* (Federation Press, 2006). Thomas notes that the then Queensland Premier blamed the loss of safe seats in bi-elections on 'health issues' arising from allegations about Dr Patel. Dr Patel withheld information from the Queensland Medical Board that in 2001 he had agreed to surrender his New York State medical licence, and that prior to that, the scope of his surgical practice was restricted in Oregon. See Anthony P Morton, 'Reflections on the Bundaberg Hospital Failure' *Medical Journal of Australia* 183, 6 (2005) 183. Dr Patel was appointed Director of Surgery at Bundaberg Base Hospital in Queensland in 2003, and soon became known as 'Dr Death' after a number of his patients died from complications following surgery. See, eg, <http://www.theage.com.au/news/National/Queenslands-Dr-Death-linked-to-80 -deaths/2005/05/24/1116700709781.html>. His past history in the US was discovered not by the Medical Board of Queensland but by a journalist who simply Googled his name when allegations about Dr Patel became public. Following surgery on four patients at Bundaberg Base Hospital, he was convicted of three counts of manslaughter and one of inflicting grievous bodily harm. He appealed the convictions and the High Court upheld his appeal on the grounds that a miscarriage of justice had occurred when the prosecution case changed its case after the evidence showed that the surgery had been performed competently enough. The High Court referred to the 'highly emotive and prejudicial evidence that was irrelevant to the case'. A retrial for one of the manslaughter counts resulted in acquittal and led to a plea deal where Patel pleaded guilty to fraud and the remaining charges were dropped. On 15 May 2015 he was deregistered.

[62] Geoffrey Davies, Queensland Public Hospitals Commission of Inquiry, *Queensland Public Hospitals Commission of Inquiry Report* (2005) (Unpublished). There were other reviews of the Queensland Medical Board (AHPRA Annual Report 2012/2013 43) and it was eventually disbanded.

[63] Elkin, *Protecting the Public?*, above n 9. She points out that information about disciplinary cases tends to be anecdotal, an issue to be addressed by this thesis. Some of the scandals are mentioned further on in this chapter.

[64] Ibid 100.

[65] The cases involving a therapeutic approach are discussed in Chapters 6 and 7 of this thesis.

approach is generally one that is focussed on treatment and rehabilitation, rather than suspension or deregistration when an impaired doctor's conduct comes to the attention of regulators. Protective orders (which are discussed in the following chapters of this thesis), may allow an impaired doctor to remain in practice with health conditions on his/her registration. Such conditions frequently involve treatment and monitoring such as urine or blood testing for the presence of drugs. Whilst the scandalous cases represent the most extreme failures in the management of impaired doctors, this thesis will examine other less sensational cases involving impaired doctors and investigate how disciplinary tribunals carry out their mandate of protecting the public in this complex arena.

There is now a significant body of literature on different types and concepts of regulation in relation to health practitioners.[67] At its simplest, and for the purposes of this thesis, the concept of formal regulation incorporates the notion of being controlled

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[66] A Victorian doctor with an addiction problem was allowed by the Medical Board of Victoria to remain in practice as an anaesthetist, and infected 55 patients with the hepatitis C virus. *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012); *R v Peters* [2013] VSC 93. This decision made clear that the Medical Board of Victoria was regularly testing Dr Peters for the wrong drugs. The judge said in addressing Dr Peters at his sentencing hearing that 'It is a matter of singular regret that the very regular urine samples taken from you under Medical Board supervision were never once tested for the presence of Fentanyl or its metabolites, notwithstanding that this was your narcotic of choice and one to which you were exposed on a daily basis' [6]. A neurosurgeon in New South Wales with an addiction to cocaine, also known to the Medical Board of New South Wales, was convicted of the manslaughter of two young sex workers in separate cocaine binges. *R v Suresh Nair* (2010) 2010/8460 (unreported, 29 June 2010). Medical Tribunal of New South Wales 2/12/2013 <http://www.mcnsw.org.au/page/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-2013/>. Dr Nair was known to the then Medical Board of New South Wales, (which became the Medical Council of New South Wales in 2010, and had conditions upon his registration at the time the offences took place. Clearly the conditions were ineffective, and this issue is further discussed in Chapters 4 and 6.

Another New South Wales case involved a psychiatrist who shot and killed the doctor who notified the New South Wales Medical Board of her concerns about him. *Dr John Eric Gassy* Medical Tribunal of New South Wales 1/8/1997 <http://www.mcnsw.org.au/page/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-1997/>. This doctor refused treatment recommended by the Board and was deregistered. This case, in particular, powerfully demonstrated the very difficult challenges regulators face in the management of impaired doctors, as some impairments may reduce the capacity for insight and the ability to accept treatment.

[67] Regulation today has been described as having a multi-faceted nature (Baggott, above n 47, 32) and a number of different terms are used to describe various forms of health practitioner regulation, including 'light touch' regulation <http://www.professionalstandards.org.uk/policy-and-research/light-touch-regulation>; 'right touch' regulation (Council for Regulatory Excellence, UK 2010, Right Touch Regulation); 'risk-based' regulation Sally M Lloyd-Bostock and Bridget M Hutter, 'Reforming Regulation of The Medical Profession: The Risk of Risk-Based Approaches' (2008) 10 *Health, Risk and Society* 69; and 'responsive regulation' J Braithewaite, J Healy and K Dwan, 'The Governance of Health Safety and Quality A Report' (The Australian Council for Safety and Quality in Health Care) X1 <http://regnet.anu.edu.au/sites/default/files/Braithwaite-etal_governance-health-safety.pdf>.

by means of rules.[68] These rules are often enshrined in legislation, such as the National Law[69], which regulates 14 health professions, including doctors.[70] The complex and confusing bureaucratic arrangements necessary to administer the National Law[71] clearly illustrate the inherent contradictions and tensions inherent in any system of regulation.[72]

As an instrument of formal regulation, the law sets standards for registration, clearly exercising control over the membership of the medical profession. It also sets professional standards of conduct, which if breached, as discussed in Chapter 2, can result in deregistration and expulsion from the profession. Although the main purpose of health practitioner regulation is 'the protection of the public', in New South Wales and Queensland additional provisions refer to 'the protection of the health and safety of the public' as a 'paramount consideration'.[73] The rationale for the regulation of doctors is seen not only in terms of public protection but also as fundamentally protective of the profession itself and as serving the interests of the state.[74]

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[68] David Price, 'Legal Aspects of the Regulation of the Health Professions' in J Allsop and M Saks (eds) *Regulating the Health Professions* (SAGE Publications Ltd, 2002) 46. Regulation has also been described as the activity by which the rules governing the exchange of goods and services are made and implemented. See Michael Moran, and Bruce Wood, *States, Regulation and the Medical Profession* (Open University Press 1993) 17.

[69] As in force in each State and Territory.

[70] <https://www.ahpra.gov.au/>. Each health profession that is part of the National Registration and Accreditation Scheme under the Australian Health Practitioner Regulation Agency is represented by a National Board. The 14 Boards are: the Aboriginal and Torres Strait Islander Health Practice Board of Australia, the Chinese Medicine Board of Australia, the Chiropractic Board of Australia, the Dental Board of Australia, the Medical Board of Australia, the Medical Radiation Practice Board of Australia, the Nursing and Midwifery Board of Australia, the Occupational Therapy Board of Australia, the Optometry Board of Australia, the Osteopathy Board of Australia, the Pharmacy Board of Australia, the Physiotherapy Board of Australia, the Podiatry Board of Australia, and the Psychology Board of Australia.

[71] These include the relationships between AHPRA and the various complaints commissions (HCEs) and medical boards in each state. The AHPRA website states, for example that 'Different National Boards have established different structures for dealing with notifications, or have delegated some of their decision-making to their committees and AHPRA officers in state and territory offices'. See <http://www.ahpra.gov.au/Notifications/The-notifications-process.aspx>.

[72] Justin Waring, Mary Dixon-Woods, and Karen Yeung, 'Modernising Medical Regulation: Where Are We Now?' (2010) 24 *Journal of Health Organization and Management* 540. According to the authors regulation may involve 'complex multiplayer structures in a dense interactive system'.

[73] The *National Law* (NSW) No 86A s '3A Objective and guiding principle [NSW].

[74] Such as the supply of doctors in remote areas as noted earlier. See Elkin, *Protecting the Public,* above n 9, 685. Elkin refers to 'friction points' between the interests of the state and the interests of the profession.

Regulation of the health professions generally also serves other purposes, which include defining the scope of competence, ensuring high standards of practice, and promoting and maintaining professionalism and ethics.[75] Although systems of regulation are highly variable across countries, most incorporate these purposes.[76] However, as Elkin notes, 'purpose' is not necessarily a static or singular notion, and may vary according to legislative intent, who and what is regulated, which activities are being regulated and the identity of the regulator.[77] It is because 'purpose' is not a static concept that a rehabilitative purpose can be readily accommodated in the National Law, as further discussed in the next chapter.

As well as the National Law, there are also broader mechanisms of regulation for doctors and other health practitioners, including civil litigation and criminal proceedings,[78] and schemes that address problems of fraud and over-servicing, such as Medicare, the Health Insurance Act, and the Professional Standards Review Scheme.[79] Doctors are also influenced and arguably 'regulated' by 'professional indemnity insurers and 'softer' forms of regulation and by individual colleagues and consumers of [their] services'.[80]

Doctors may also be regulated by hospitals, other employers, specialist colleges and professional associations as well as by the informal mechanisms used when doctors are confronted with a problem colleague. Rosenthal refers to a 'conspiracy of silence' that operates in an informal circuit around a malfunctioning doctor,[81] along with a

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[75] Lucian L Besancon, Paul Rocky and Marta van Zanten, 'Regulation of Health Professionals: Disparate Worldwide Approaches Are a Challenge to Harmonization' (2012) 58 *World Medical Journal* 128.

[76] Ibid.

[77] Elkin, *Protecting the Public,* above n 9, 682–690.

[78] Nikita Tuckett, 'Balancing Public Health and Practitioner Accountability in Cases of Medical Manslaughter: Reconsidering the Tests for Criminal Negligence-Related Offences in Australia after R v Patel' (2011) 19 *Journal of Law and Medicine* 377. In an extensive review of these cases in Australia, Tuckett notes that only a small number of doctors in Australia have been prosecuted in criminal proceedings. Dr Patel's prosecution for manslaughter and grievous bodily harm, is noted above, and as also noted above, three of the impaired doctors mentioned were convicted of criminal charges.

[79] Fiona McDonald, 'The Regulation of Health Professionals', *Health Law in Australia* (Lawbook Co., 2010) 509.

[80] Elkin, *Protecting the Public,* above n 9, 80. Also citing Linda Haller, 'Regulating the Professions' in Peter Cane and Herbert Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2010) 217.

[81] Marilynn Rosenthal reports on the findings of a study she carried out in Britain and Sweden where she examined how 'mistake', 'error' and 'mishap' are defined by doctors themselves. She also reports on the

conspiracy of tolerance that surrounds 'problem colleagues'.[82] The mechanisms documented by Rosenthal,[83] include 'The quiet chat: personal persuasion', 'Protective support: the gentlemanly approach' (where colleagues quietly shift work away from the doctor and do it for them) and 'Diverting patient flow' from the doctor (which can be carried out by nurses or receptionists).[84]

Although Rosenthal was writing in 1997 it is arguable that the informal mechanisms that she documented have now become more significant as a consequence of the controversial mandatory reporting provisions in the National Law, where colleagues are now legally obliged to notify regulatory authorities of doctors who may be placing the public at risk. Some doctors may prefer to have a 'quiet chat' to a poorly performing or impaired colleague, than to make a formal notification, which has significant implications for both the notifier and the notified doctor. Rosenthal also argues that the criteria for entrance into medical school are potentially 'the most powerful tools for effective professional self-regulation' as the characteristics of those admitted may predict future behaviour.[85] Other studies have established a link between conduct as a student and conduct following graduation.[86]

1.8 The recognition of impairment – a significant development

As well as some of the imperatives for reform identified above, the explicit recognition of impairment in doctors was a significant development in the regulatory context. Although it had been recognised earlier, impaired doctors became of official concern to

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informal mechanisms developed for dealing with such 'mistakes'. She refers to problem doctors in general rather than specifically to impaired doctors, Marilynn Rosenthal, *The Incompetent Doctor* (Open University Press, 1995) 14. See also Andre F Tempelaar, 'The Problem Doctor as Iatrogenic Factor: Risks, Errors, Malfunctioning and Outcomes' in Peter Lens and Gerritt van der Wal (eds), *Problem Doctors A Conspiracy of Silence* (IOS Press, 1997).

[82] Ibid 15.

[83] Ibid 54–60.

[84] Ibid.

[85] Rosenthal, *The Incompetent Doctor,* above n 81. A case in point is that of *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012). Dr Howari first came to attention as a medical student. This case is further discussed in Chapter 6.

[86] Maxine A Papadakis et al, 'Disciplinary Action by Medical Boards and Prior Behaviour in Medical School' (2005) 353 *New England Journal of Medicine* 2673; Maxine A Papadakis et al, 'Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board' (2004) 79(3) *Academic Medicine* 244.

the American Medical Association in the early 1970s, when it was acknowledged that an impairment could undermine a doctor's competence.[87] The recognition of impairment in disciplinary proceedings marks a transition from a punitive to a therapeutic rehabilitative approach and also signals an extension of the meaning of the protection of the public to an interpretation involving the protection of doctors. This recognition of impairment was also accompanied by a descriptive narrative in the literature about the identification and management of impaired doctors in impairment programs.[88] In these programs, conditions suffered by doctors, such as drug addiction and alcoholism, were seen as diseases requiring treatment, rather than disciplinary action. Impaired doctors were 'sick', not 'bad', and needed medical help.[89]

Lagging somewhat behind the development of impairment programs in the US, in the late 1980s the New South Wales Medical Board developed an informal program for managing impaired doctors and medical students in a 'constructive and non-disciplinary manner'.[90] The program was soon formalised, and impairment provisions were introduced to the Medical Practice Act 1992 in New South Wales with other states soon following suit. These provisions were incorporated into the National Law in 2010,[91] creating a central tension between the health provisions under the law and other stated objectives, such as the protection of the public. The health and impairment provisions under the National Law also explicitly introduced into the discourse a therapeutic or medical approach to doctors who came to the attention of regulators.[92]

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[87] Carol Klaperman Morrow, 'Doctors Helping Doctors' (1984) 14 No 6 *Hastings Center Report* 32.

[88] This literature is further described in Chapter 5.

[89] Morrow, 'Doctors helping Doctors', above n 87.

[90] K Wilhelm and A Reid, 'Critical Decision Points in the Management of Impaired Doctors: The New South Wales Medical Board Program' (2004) 181(7) *Medical Journal of Australia* 372. Pethebridge traces the gradual recognition of impairment in the New South Wales legislation, noting that under the *Medical Practitioners Act 1938*, the Board could deregister doctors who had become incapable within the meaning of the *Lunacy Act 1898*; Dr Andrew Pethebridge, *Rehabilitation of the Impaired Doctor* (Master of Medicine by Research, University of New South Wales, 2005). According to Pethebridge within the 1938 Act was the germ of the later coined concept of the impaired practitioner. This Act covered doctors who were: psychiatrically ill; addicted, and cognitively impaired. Creation of a formally defined category of impaired registrant could wait until repeal of the 1838 Act and its replacement by the *Medical Practice Act 1992*. Wolf, above n 41, notes that Victoria took 75 years to incorporate the definition into its legislation.

[91] As defined in above n 5.

[92] Morrow, 'Doctors helping Doctors', above n 87.

1.9 A different 'take' on impairment

In contrast to the then 'mainstream' literature on impairment which focussed quite narrowly on the identification, management and rehabilitation of impaired doctors,[93] in the United States Morrow examined the development of impairment programs from a broader sociological perspective, and linked the programs to the issue of self-regulation.[94] Morrow's published work, beginning in the early 1980s, is based upon extensive research. In her paper 'Sick Doctors: The Social Construction of Professional Deviance' Morrow reported on an extensive 1979 study in which she collected data from several sources.[95] Morrow convincingly argues on the basis of her research that it was the prevailing political, social and economic climate of the 1970s that set the stage for the medicalisation of professional self-governance through impairment programs.[96] Morrow also argues that the drive to rehabilitate impaired physicians was not associated with an escalation in the incidence of addiction and alcoholism in physicians,[97] but was an 'ideologically convenient way to humanely control errant colleagues, promote public trust and strengthen professional autonomy'.[98] She explains how 'deviant' doctors, such as those with addiction or alcohol problems, are reconstructed as 'sick' doctors, with the assistance of educational campaigns promoting awareness that alcoholism, other addictive diseases and most psychiatric disorders are treatable diseases, not moral weaknesses. Morrow clearly elucidated the appeal of this medical model in the management of impaired doctors, noting that the medical model did not challenge doctors' natural reluctance to criticise fellow members, and that:

> the medical model pairs misconduct with illness and defines substandard performance as a medical problem to be treated by medical experts. It

[93] As further discussed in Chapter 5.

[94] Or what she referred to as the social and professional components of self-governance.

[95] Morrow, 'Doctors helping Doctors', above n 87, 93. These included requests for information from medical societies in the US, interviews with those familiar with peer review of the medical profession in general or physician impairment in particular, and case studies of the management of selected types of problem doctors including the drug addict, the sexual offender and the senile doctor. She analysed and reviewed some 100 published articles and various other unpublished documents that included transcripts of state disciplinary hearings, and in-house materials provided by impaired physician programs.

[96] In Australia, self-governance is usually referred to as self-regulation.

[97] Morrow, 'Doctors helping Doctors', above n 87, 96.

[98] Ibid 105.

> extends the profession's mandate as healers to include the management of problem doctors whose misconduct may be construed as an outcome or symptom of illness. Such a system of self-governance, based on the medical model, safeguards the profession's control over its members and discourages intervention by government and other would-be regulators.[99]

Morrow details the ways in which the concept of physician impairment was legitimated and institutionalised through bureaucratisation and 'sick doctor statutes'.[100] Similar developments in Australia, although on a much smaller scale, are demonstrated in the health provisions of the National Law, which are discussed in Chapter 2 of this thesis, and in other programs for impaired doctors in Australia.[101]

The argument developed in this thesis resonates with the approach adopted by Morrow. It suggests that the medical approach to problem doctors in Australia too readily ascribes misconduct to illness rather than also judging the conduct in terms of behaviour that is immoral or unethical. The failure to judge the conduct of some doctors in terms other than those that are illness-related leads to protective orders that focus on the health of the doctor rather than the protection of the public. Importantly, in this thesis a psychiatric, rather than a medical model, of misconduct is posited.

In 1984 in her paper *Doctors Helping Doctors* Morrow referred to the 'paternalistic helping ideology'[102] of impaired physician programs and identified many of their inherent tensions, noting that early identification of impaired doctors could unduly label the person, affect their reputation, and infringe on their personal rights.[103] She concluded that in medicalising the problem of addicted, alcoholic and psychiatrically disturbed doctors, impaired physician programs, with a simultaneous commitment to

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[99] Ibid 103.

[100] Ibid 100.

[101] Such as the Victorian Doctors Health Advisory Program, which is further discussed in Chapter 6.

[102] Morrow, 'Doctors helping Doctors', above n 87, 36. She notes that the nature and justification for intervention is clear in the extreme cases but that the middle ground where there is potential harm is not so clear, and that delineating pathology and normalcy is difficult. Noting that many committees approach an impaired doctor informally, Morrow questions whether a paternalistic ideology and assumed mutuality of interest justify an informal approach.

[103] Morrow argues that as they mature programs for impaired physicians will need to confront the social, legal and ethical tensions that underlie the medicalisation of professional self-governance. Morrow also queries whether these programs understate doctors' personal and professional responsibility for their own health.

physician rehabilitation and public welfare, confused the purpose of coercive intervention.[104] The simultaneous commitment to the rehabilitation of problem and impaired doctors and the protection of the public is also evident in the Australian context.

In 1992 another important work, *Deviance and Medicalization*, was published in the United States presenting an analysis of the historical transformation of definitions of deviance from badness to sickness, focusing on the medicalisation of deviance in American society.[105] In 1998, in his landmark work *The Therapeutic State*, Nolan in the same vein, argued that there is a growing tendency to define a range of human behaviours as diseases or pathologies.[106] He noted that behaviours that were formerly described at face value or interpreted in moralistic terms, such as alcoholism and drug addiction, have increasingly been portrayed as illnesses or pathologies that require treatment, rather than as crimes.[107] In the medical disciplinary context in which this thesis is located, this culture may also redefine misconduct that would normally be described as immoral or unethical, such as sexual misconduct or inappropriate prescribing, as a function of a doctor's illness and compromise the protection of the public.

1.10 The framework as a navigational device

Morrow, Conrad and Schneider, and Nolan's work all provide important sociological insights for the analysis of disciplinary decisions on impaired doctors in particular, and problem doctors in general. However, Morrow's work, because of its specific focus on problem and impaired doctors, is especially relevant for this thesis. As noted above Morrow conceptualises a medical model of misconduct based upon her extensive research on impairment programs in the United States. According to Morrow, impaired

[104] Ibid 37.

[105] Conrad and Schneider, above n 18, 1.

[106] Nolan, above n 19.

[107] Ibid.

physician programs in the United States view the problem doctor as a morally innocent patient and cast the disciplinary agent as medical diagnostician and healer.[108]

Morrow's work is important as her conceptualisation of a medical model of misconduct not only assists in identifying and explaining the development of a rehabilitative rather than a disciplinary approach to misconduct in the Australian context, but adds a third dimension by exposing how this rehabilitative approach functions to keep the control of problem doctors within the profession, and therefore fosters self-regulation. It provides a simple framework which guides the analysis of tribunal decisions in this thesis to examine whether Australian tribunals also act as 'medical diagnosticians and healers', rather than ascribing any moral culpability to doctors. [109] This thesis explores whether a medical model of misconduct in the Australian context leads to a rehabilitative or therapeutic approach in disciplinary tribunals that may undermine the protection of the public.

In addition to Morrow's framework, the thesis also draws on the sociological perspective provided by Cotterrell, who argues that disciplinary boundaries (which are encapsulated in the tribunal decisions in this thesis) should be viewed pragmatically and with a degree of scepticism, and that they should not become 'prisons of understanding'.[110] He argues that law as a discourse determines, within the terms of that discourse, what is to count as 'truth' for specifically legal purposes, and that a sociological perspective makes it possible to observe and understand the effect of legal discourse and situates it in relation to the social effects of other kinds of ideas and practices.[111] Morrow's framework helps 'situate' the discourse in tribunal decision-making in the broader social context of the development of impairment programs in Australia, and to both identify and explore the rehabilitative focus in tribunal decisions and its impact upon the regulation of doctors.

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[108] Morrow, 'Sick Doctors', above n 17, 104.

[109] Ibid. The term 'moral culpability' is used here to describe conduct by a doctor that s/he knows may create a risk to the public but continues regardless of the consequences.

[110] Roger Cotterrell, 'Why Must Legal Ideas Be Interpreted Sociologically?' 25 *Journal of Law and Society* 171- 192, 177.

[111] Ibid. According to Cotterrell, sociological interpretation both reveals law's character and is, like many other forms of knowledge, available to enrich law's debates, colour its interpretations, and strengthen or subvert the strategies of control to which legal discourse is directed.

The application of a framework developed in the United States which is based upon sociological perspectives on deviance, as well as extensive research, provides unique insight into disciplinary decision-making in Australia. Morrow's framework provides a navigational device through the 'low, swampy ground' of studies' such as the present one, which involves complex human behaviour and conduct that may or may not be caused by impairment. It invites 'multiple, relevant, complementary perspectives and methods of investigation that take into account the importance of causal mechanisms'.[112]

Any framework also has limitations. The framework may be used to exclude other possible interpretations of the tribunal decisions, or to distort relevant information. Thus in the present study, care is taken not to exclude, for example, the possibility that some conduct such as lying or stealing, may be caused primarily by the nature of a doctor's addiction, and a medical model of misconduct may be appropriate. However the thesis also recognises that whilst some misconduct by doctors may well be a function of their impairment, other conduct may not so easily be explained.

To put it colloquially, some 'mad' doctors (such as those who suffer from serious delusional disorders and refuse treatment) may also, distinct from their impairments, be 'bad' doctors because of personality flaws[113] or dishonest and manipulative behaviour.[114] Although the distinction between 'mad' and 'bad' is typical of the oversimplification of language in this complex arena[115] the simplistic distinction has been made in the mental health literature and is even used in the title of books.[116] As noted in Chapter 6, there is clearly 'a degree of slippage'[117] in the discourse about 'madness' as opposed to 'badness', and there is also a degree of slippage in the

[112] Bronwynne C. Evans, David W. Coon and Ebere Ume 'Use of Theoretical Frameworks as a Pragmatic Guide for Mixed Methods Studies: A Methodological Necessity?' (2011) 5(4) *Journal of Mixed Methods Research* 276–292.

[113] *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010). This case is discussed in Chapter 6.

[114] *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012). This case is also discussed in Chapter 6.

[115] It ignores doctors who may be also 'sad' and suffer from depression. Although these descriptors may be seen as offensive they reflect the language that is used in the media and by the public. It is used here to provide a kind of shorthand.

[116] See, eg, Deidre Greig, *Neither Bad Nor Mad* (Jessica Kingsley Publishers, 2002).

[117] Ibid 15.

discourse when a causal relationship is postulated between impairment and misconduct. As the discussions in Chapters 6 and 7 indicate, it is when conduct is extreme or repeated that tribunals are likely to attribute conduct to personality or other defects not caused by impairment.[118]

Because of the inherent complexity in tribunal decision-making in this area and the 'slippage' in the discourse, the framework guides the use of the mixed methodology chosen for this thesis (which is discussed in Chapter 3) and informs the analysis of the decisions in Chapters 6 and 7. As Denzin and Lincoln note 'the field of qualitative research is defined by a series of tensions, contradictions and hesitations'.[119] The tribunal decisions reflect both the tensions between treatment and discipline, and the 'hesitations' in decisions and protective orders when tribunals attempt to decide what risk a doctor may pose to the public if s/he remains in practice.

1.11 Recent research

There is a significant body of literature on problem doctors overseas[120] and a growing body of research in Australia.[121] A landmark study ('the ANZ study'), analysed cases adjudicated by medical disciplinary tribunals in Australia and New Zealand over a ten-year period (2000–2009) focussing on cases in which a doctor had been found guilty of misconduct.[122] According to the study, the most common offences were sexual

[118] As noted earlier, in this thesis the term 'character' is used only in general terms but not to distinguish misconduct from impairment. See Freckelton, 'Good character', above n 15. As discussed in Chapters 6 and 7 some of the cases refer to 'characterological' defects. Medical Board of Western Australia and L [2011] WASAT 98 (30 June 2011).

[119] N.K. Denzin and Y.S Lincoln, 'Introduction: Entering the field of qualitative research' in N.K. Denzin and Y.S. Lincoln (Eds.) *Handbook of qualitative research* (SAGE Thousand Oaks CA, 1994) 2.

[120] Lens and van der Wal, (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997). This book refers to problem doctors in a more general sense than the definition adopted in this thesis (see n 6 above) and contains other studies on problem doctors in different countries. Other references to problem doctors are contained in the more general literature on the regulation of health practitioners.

[121] An early Australian work on the regulation of health practitioners in general is an edited book, by Ian Freckelton, 2002 (ed) *Regulating Health Practitioners* (The Federation Press, 2006). See also the earlier United Kingdom publication by Judith Allsop and Mike Saks (eds) *Regulating the Health Professions* (SAGE Publications Ltd, 2002). Both books contain quite disparate collections of articles on topics ranging from self-regulation to new approaches to regulation in the context of a decline in public trust of the professions, and other socio-political and economic factors.

[122] Elkin, Spittal, Elkin and Studdert, 'Doctors disciplined for professional misconduct', above n 2.

misconduct, illegal or unethical prescribing and inappropriate medical care.[123] This is consistent with a much smaller and earlier study in New South Wales that found that the most common reasons for doctors being deregistered involved inappropriate prescribing and sexual misconduct.[124]

The ANZ study excluded the smaller Australian states, and most importantly, it excluded cases concerned with 'non-disciplinary' matters, such as practitioner impairment. This is quite significant, as some overseas studies have found the impaired physician to top the list in terms of the characteristics of 'malfunctioning' doctors.[125] The Annual Report of the Australian Health Practitioner Regulation Agency ('AHPRA') notes that in the year 2013–2014, mandatory notifications, based on concerns that a practitioner had an impairment that was placing the public at risk, increased slightly to 26% as a proportion of the total, compared with 21% in 2012–13.[126]

The landmark ANZ study has been followed up by other important studies in Australia. A number of these studies deal with the types and prevalence of complaints against doctors.[127] One study concluded that a small group of doctors accounts for half of all patient complaints lodged with complaints bodies in Australia,[128] and that the number of prior complaints doctors had experienced was a particularly strong predictor of their

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[123] Elkin, *Protecting the Public,* above n 9, 455. Male doctors were disciplined for misconduct at four times the rates of their female colleagues.

[124] Helen Kiel, *Doctors in Disgrace: Issues and Criteria in the De-registration and Re-registration of Doctors in New South Wales* (LLM Honours Dissertation University of Sydney 2000, Unpublished).

[125] Lens and van der Wal, above n 120, 263. However these figures must be approached with caution as definitions of impairment may vary widely as may the term 'malfunctioning'.

[126] 2013/14 Annual Report: AHPRA and National Boards, 185 <http://www.ahpra.gov.au/Publications/Corporate-publications.aspx>. These figures do not refer specifically to doctors but further details by profession are provided in the subsequent tables in the report. The figures indicate increasing numbers of impairment notifications in relation to doctors, particularly in New South Wales where the numbers jumped from 73 to 113 in the period discussed above. See Table N20 at 185 in the AHPRA report.

[127] Marie M Bismark, Matthew J Spittal, Lyle C Gurrin, Michael Ward, David M Studdert, 'Identification of Doctors at Risk of Recurrent Complaints: A National Study of Healthcare Complaints in Australia' (2013) *BMJ Quality & Safety* 1. Bismark, Spittal and Studdert, 'Prevalence and Characteristics of Complaint-Prone Doctors', above n 2. See for example Fiona Manning, 'Changing Disciplinary Responses to Sexual Misconduct by Health Practitioners in New Zealand' (2014) 21 *Journal of Law and Medicine* 508.

[128] Bismark, Spittal, Gurrin et al, Identification of Doctors at Risk of Recurrent Complaints', above n 127.

short-term risk of further complaints.[129] However this study was about complaints generally and it was not clear how many doctors ended up in disciplinary proceedings. Another study concluded that international medical graduates are more likely than Australian-trained doctors to attract complaints to medical boards and adverse disciplinary findings, but the risks differed markedly by country of training.[130] Both of these studies were focussed on complaints rather than disciplinary proceedings.

1.11.1 Disciplinary proceedings

The few studies in Australia and New Zealand that focus on disciplinary proceedings are quite disparate both in terms of their content and methodology.[131] They include topics such as the risk of recidivism in previously deregistered doctors,[132] changing disciplinary responses to sexual misconduct cases in New Zealand,[133] jurisprudential ideas underpinning modern disciplinary proceedings in cases against doctors that involved inappropriate prescribing,[134] and a very recent paper by Mendelson on disciplinary proceedings against doctors who abuse controlled substances.[135] A paper by

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[129] Ibid 5.

[130] Elkin, Spittal and Studdert, 'Risk of complaints', above n 2, 448.

[131] Many of the relevant studies are published in the *Journal of Law and Medicine*, a very useful and important interdisciplinary Australian journal that publishes both local and overseas articles. According to its publisher the *Journal of Law and Medicine* publishes contributions about issues that have a legal, medical or bioethical content arising at the interface between law and health, including the delivery of the full range of health services <http://sites.thomsonreuters.com.au/journals/>. Its focus is broad, international and cross-disciplinary.

[132] Laurie Warfe, 'Determining the Risk of Recidivism in Previously De-registered Health Practitioners' (2013) 21 *Journal of Law and Medicine* 67. Whilst Warfe's paper is apposite to this research in relation to the consideration of risk, it was not a systematic study and did not purport to be. Warfe generally reviewed the caselaw on deregistered doctors in Australia and critically examined the concept of 'fit and proper person', a criteria for re-registration.

[133] Manning, above n 127, 508.

[134] Danuta Mendelson, 'Disciplinary Proceedings for Inappropriate Prescription of Opioid Medications by Medical Practitioners in Australia (2010 to 2014)' 22 *Journal of Law and Medicine* 255. Mendelson undertook a systematic exploration of 32 disciplinary cases against medical practitioners found guilty of inappropriate prescribing in New South Wales and Victoria. The cases were reported between July 2010 and September 2014 by professional disciplinary tribunals in New South Wales and Victoria. The paper also considered the appropriateness of the use of common law theories, such as deterrence in protective sanctions in disciplinary proceedings. Mendelson argues that the borrowing of sanctions from the criminal arena raises profound jurisprudential questions regarding the nature of the disciplinary jurisdiction and its relationship with the common law.

[135] Danuta Mendelson, 'Disciplinary Proceedings Against Doctors Who Abuse Controlled Substances' (2015) 23 *Journal of Law and Medicine* 24. In this paper Mendelson argued that there was a lack of consistency in the imposition of professional sanctions and penalties by the relevant tribunals and that a test of proportionality in the form of 'reasonable necessity' should be applied when tribunals are deciding whether to deregister or suspend an addicted doctor.

this researcher examined the regulation of impaired doctors in New South Wales in 2010 and discussed the particular challenges impaired doctors posed for regulators.[136] A brief overview of these studies is provided below and they are referred to in more detail where relevant in Chapters 5, 6 and 7 of this thesis. The studies were particularly apposite to this thesis, as they focussed on aspects of tribunal decision-making and protective orders.

Warfe reviewed the caselaw on deregistered doctors in Australia and critically examined the concept of 'fit and proper person', a criteria for re-registration in the cases he examined.[137] He questioned whether boards[138] are sufficiently skilled or resourced to perform the task of assessing whether a doctor is a fit and proper person. Warfe argued that 'one approach to improve quality and consistency of decision-making may be to define, recognise and tabulate a given set of risk factors and predictors against which more accurate clinical assessment can be made'.[139] This study is further discussed in Chapters 6 and 8. [140]

Mendelson's very useful papers are also relevant to the present research. In one paper she explores the use of protective orders in overprescribing cases. Her focus is on the borrowing of sanctions, such as deterrence from the criminal arena. This paper is an important contribution to the discourse about sanctions in the disciplinary context. [141] In her most recent paper, Mendelson's informative analysis of the conduct of doctors who abuse controlled substances is of particular relevance to this thesis. Mendelson argues that consistency in tribunal decision-making would be improved if tribunals applied the test of proportionality in the form of 'reasonable necessity' when suspension from

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[136] Helen Kiel 'Regulating Impaired Doctors: A Snapshot from New South Wales' 21 *Journal of Law and Medicine* 429.

[137] Ibid 71.

[138] The term board is often used synonymously with tribunal, which is a more recent term and usually denotes a multidisciplinary composition as discussed in Chapter 2.

[139] Warfe, above n 132, 81.

[140] Whilst Warfe was concerned with consistency of decision-making in relation to the risk posed by deregistered doctors who apply for reregistration, this research explores decision-making about the risk posed by doctors who remain in practice whilst being 'rehabilitated'. The tools suggested by Warfe would arguably also be of assistance to tribunals in the determination of protective orders when doctors are found guilty of misconduct.

[141] Mendelson, 'Disciplinary Proceedings for Inappropriate Prescription', above n 134.

practice or de-registration is being considered.[142] Although this is an interesting argument, of more direct relevance to this thesis is not only Mendelson's detailed profile of the doctors who abuse controlled substances but her analysis of the protective orders used by tribunals in these cases. Her work is further discussed in Chapter 5.

In Manning's study on sexual misconduct, she noted that a more flexible disciplinary response had evolved in relation to sexual misconduct in New Zealand. Her paper focusses on the relationship between the type of sexual misconduct and protective orders. She reports a move away from automatic deregistration or suspension in sexual misconduct cases, provided there are sufficient mitigating factors, although the risk of deregistration remains high.[143] Her paper is further discussed in Chapter 7.

The earlier study by this researcher was a small study of the regulation of impaired doctors in New South Wales in 2010.[144] It found that almost a third of the doctors appearing in disciplinary proceedings suffered some kind of impairment, and that conditions on a doctor's registration were not always effective in protecting the public. The study concluded that there was clearly a need for more research into how conditions upon a doctor's practice can be made more effective. This thesis builds upon these conclusions.

Whilst the above studies make an important contribution to the existing research on medical disciplinary tribunals, due to their disparate nature they are impossible to compare. Although some studies, including the large ANZ study, reported on the outcomes of disciplinary proceedings, none of them focussed on the rationale for the protective orders imposed.

Tempelaar, writing more generally from a European perspective, argues that a major problem in research on the regulation of problem doctors in Europe is the lack of

[142] Ibid.

[143] Manning, above n 127.

[144] Kiel, 'Regulating Impaired Doctors', above n 136, 440.

uniform description and consistent interpretation of basic concepts.[145] He also observes that many studies are not comparable.[146]

In a comprehensive review of the literature on the regulation of doctors, Elkin points out that most of the studies on disciplinary proceedings involving doctors emanate from the United States.[147] The research conducted for this thesis is consistent with this finding. For example there is a large body of literature in the United States on sexual misconduct by doctors. [148] In a separate paper Elkin et al also noted some important gaps in the literature, pointing out that the nature of misconduct has only been examined in general terms and typologies often conflated types of misconduct with the underlying reasons for the misconduct.[149] Elkin's review of the United States research does not reveal any qualitative studies of the decisions in disciplinary proceedings as is proposed in the present study, although there are a number of studies that report on protective orders imposed.[150] It is therefore not clear from the studies in the United States why tribunals chose particular protective orders or how effective they were.[151] Elkin notes that one of the major issues with this data is that reporting to the Federation of State Medical Boards[152] has not traditionally been standardised, and that lack of standardisation may account for much of the observed variation between states.[153]

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[145] Tempelaar, above n 81. This book does not focus particularly on disciplinary proceedings.

[146] For example, a Dutch study explored how Dutch medical disciplinary tribunals evaluated the 'gut feelings' of doctors in assessing patients is unique in its content; Erik Stolper, Johan Legemaate and Geert Jan Dinant, 'How Do Disciplinary Tribunals Evaluate the 'Gut' Feelings of Doctors? An Analysis of Dutch Tribunal Decisions, 2000-2008' [2010] *Journal of Law and Medicine* 68.

[147] Elkin, *Protecting the Public?* above n 9, 123. According to Elkin, those US studies concerning disciplinary action have generally been undertaken using data from the national database of 'disciplinary orders' maintained by the Federation of State Medical Boards (FSMB). FSMB data is published annually in the Summary of Board Actions.

[148] This literature is referred to in Chapter 7 of this thesis.

[149] K Elkin, M.J Spittal and D.M Studdert, 'Removal of Doctors from Practice for Professional Misconduct in Australia and New Zealand 2000–2009' (2012) 21 *BMJ Quality and Safety* 1027. Elkin, Spittal and Studdert, 'Risks of complaints' above n 2, 127.

[150] Elkin, *Protecting the Public,* above n 9, 137–138.

[151] Elkin notes that her data has been publicly available since 1986 due to the *Health Care Quality Improvement Act 1986* (US) that began to mandate public reporting of all disciplinary actions and paid malpractice claims.

[152] The Federation of State Medical Boards represents the 70 state medical and osteopathic regulatory boards — commonly referred to as state medical boards — within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in

This lack of comparability is also apparent in Australia, as illustrated by the studies discussed above. There appears to be less research emanating from the United Kingdom than the United States in relation to problem doctors and disciplinary proceedings, with the exception of the recent paper referred to above on the 'redemption model' of fitness to practise.[154] In this paper, Case analyses Fitness to Practice decisions over a year by the General Medical Council's Fitness to Practice Panels, which are similar to medical tribunals in Australia.[155] Case refers to an emphasis on 'redemption' as opposed to a 'preoccupation with punishing or sanctioning doctors', and argues that the redemptive style of regulation based upon remediation is particularly apt in the disciplinary context.[156] Case's use of the terms 'redemption' and 'remediation' are similar to the concept of rehabilitation, and her work is therefore of particular relevance to the argument in this thesis that a rehabilitative approach may undermine public protection. Case argues that a redemptive style of resolving professional disciplinary matters can bring significant benefits to doctors, patients, and societies generally. However, she also notes some 'dysfunctionalities'[157] in the redemptive model that can encourage in doctors a contrived exchange of remorse and contrition, with implications for doctors' integrity. Some of the decisions discussed in Chapters 6 and 7 of this thesis clearly support this argument.

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most jurisdictions, other health care professionals. See <http://www.fsmb.org/about-fsmb/fsmb-overview>.

[153] Elkin, *Protecting the Public,* above n 9, 137–138. Elkin, *Protecting the Public,* above n 9, 137–138. is careful to distinguish studies about complaints against doctors as opposed to those about disciplinary proceedings, and she further distinguishes between studies of disciplinary proceedings using data from the Federation of State Medical Boards and studies from narratives of disciplinary action constructed from data gathered for the Public Citizen Health Research Group's 'Questionable Doctors' series. She also distinguishes between studies about complaints as opposed to studies about disciplinary proceedings. The studies Elkin refers to are based upon the databases, and are largely descriptive demographic studies, each with their own inherent methodological complexities and limitations. As Elkin notes, these limitations include the quality of the data, the typologies used, the outcome variables, and the quality of analysis.

[154] Case, above n 22.

[155] Ibid. Although the definition of impairment in the UK is much broader than in Australia and includes professional misconduct. As Case notes, it also includes criminal conviction or caution, deficient professional performance adverse health or determination by another regulatory body to the effect that fitness to practise is impaired. The definition of impairment in the UK is further discussed in Chapter 5 of this thesis.

[156] Ibid 609. She states that an emphasis on individual redemption is an example of creative and responsive regulation that entails significant benefits for doctors, patients and society. Braithewaite's model of responsive regulation is discussed in Chapter 2.

[157] Case, above n 22, 611.

1.11.2 Impaired doctors in Australia

As well as a paucity of research on problem doctors and disciplinary tribunals overseas, there is also very little literature and research on impaired doctors in Australia, in spite of the scandals mentioned above. The literature that is publicly available focusses largely on the identification and management of impaired doctors in health programs and other contexts,[158] but does not refer to their management in disciplinary proceedings. Some unpublished research on the effectiveness of the New South Wales Impaired Registrants Program at the former New South Wales Medical Board pointed out that before the establishment of the program, a punitive approach, usually resulting in deregistration, was a likely outcome for doctors suffering from an impairment, and that the program was recognised as non-punitive and rehabilitative.[159]

1.11.3 The use and effectiveness of protective orders

There is a significant research deficit both in Australia and overseas on how and why tribunals use protective orders, with the marked exceptions of some articles by Walzer in the United States,[160] and the paper by Pauline Case in the United Kingdom referred to above.[161] Inherent in the notion of protection of the public is the prevention of future harm before it occurs. The management of risk and the concept of risk reduction underpins the use of protective orders. Although there is a growing body of literature on the concept of risk, risk management and risk theory, it is not the intention in this thesis to explore this literature. [162] As the focus of the thesis is on how tribunals infer and

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[158] Wilhelm and Reid, above n 90, 372. G Hulse, MG Sim, E Khong, 'Management of the impaired doctor'(2005) 33, 9 *Australian Family Physician* 703–707.

[159] Jacqueline Milne, *Impaired Registrants Program Evaluation* (New South Wales Medical Board, 2002). An unpublished thesis on impaired doctors also studied the outcomes for impaired doctors of their rehabilitation under the New South Wales Medical Board's Health Program. The findings of this study have not been published. A thesis on the rehabilitation of impaired doctors also studied the effect of this program, see Pethebridge, above n 90. Pethebridge's findings are discussed in more detail in Chapter 5.

[160] Robert S Walzer and Stephen Miltimore, 'Mandated Supervision, Monitoring, and Therapy of Disciplined Health Care Professionals' (1993) 14:4 *Journal of Legal Medicine* 565; Robert S Walzer and Stephen Miltimore, 'Proctoring of Disciplined Health Care Professionals: Implementation and Model Regulations' (1994) 81 *Federation Bulletin*.

[161] Case, above n 22.

[162] See, eg, the review of the literature and the problems in risk-based regulation in in Sally M Lloyd-Bostock and Bridget M Hutter, 'Reforming Regulation of The Medical Profession: The Risk of Risk-Based Approaches' (2008) 10 *Health, Risk and Society* 69. The work of Nicholas Rose, 'Governing Risky Individuals: The Role of Psychiatry in New Regimes' (1998) 5 *Psychiatry, Psychology and Law* 177, is referred to because of its particular relevance to the role of psychiatrists in the regulation of doctors.

manage risk through the use of protective orders, only the literature directly relevant to this area is considered. This literature is referred to below.

The tribunal decisions in this study indicate that the imposition of conditions upon a doctor's practice are the key risk management technique for tribunals if they do not suspend or deregister a doctor, but still remain concerned about risk to the public. Conditions upon a doctor's practice provide re-assurance to tribunals faced with the difficult task of assessing whether a doctor is likely to re-offend. Risk thinking reflected in the use of protective orders 'seems to bring the future into the present and make it manageable',[163] and to 'discipline uncertainty by bringing it under control and making it orderly and docile'.[164]

As Warfe notes[165] however, there are real problems with the assessment of the risk of recidivism in the disciplinary arena, and he calls for the clear identification of risk factors in tribunal decision-making, as noted above. In her research, Elkin notes that recidivism among disciplined doctors has been found to be high, and was likely to be even higher if a period longer than four years is reviewed.[166] A very recently published study based on the earlier ANZ study of complaints against doctors reported on a further analysis of patient complaints to create a simple predictive algorithm for the prediction of risk of further complaints against doctors.[167] This study is further discussed in Chapter 8.

Given the enormous reliance by disciplinary tribunals upon protective orders as a means of protecting the public (as discussed in the following chapters) the lack of research in this crucial area is surprising. Protective orders, as further discussed in Chapters 6 and 7, may often involve supervision of a doctor's practice by another doctor, or psychiatric treatment. One of the few articles that could be located in this area was a very

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[163] Rose, above n 162, 179.

[164] Ibid.

[165] Warfe, above n 132.

[166] Elkin, *Protecting the Public,* above n 9, citing Darren Grant and Kelly C Alfred, 'Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards', (2007) 32(5) *Journal of Health Politics, Policy and Law*, 867.

[167] Matthew J Spittal, Marie M Bismark and David M Studdert, 'The PRONE Score: An Algorithm for Predicting Doctors' Risks of Formal Patient Complaints Using Routinely Collected Administrative Data' [2015] *BMJ Quality and Safety* doi:10.1136/bmjqs-2014-003834.

informative American article that addressed some key issues.[168] According to Walzer, the author of the article:

> The selection of practice monitors, supervisors and psychotherapists for licensed health care professionals who have been ordered to submit to scrutiny in their practice is an awesome burden for the disciplinary authority. A recent survey, conducted by the authors, revealed that many state licensing agencies do not function on the basis of clear statutory or regulatory guidelines regarding the manner in which the disciplinary process is to be executed in the above regard.[169]

Walzer notes that 'vague specifications have been relied upon, often permitting the designation of a friend or officemate to serve as a therapist or practice monitor',[170] that doctors are often loath to accept the responsibility associated with the discipline of a colleague and that 'monitoring' of a doctor's practice is a particularly difficult duty to sell.[171] Some of the cases discussed in Chapters 6 and 7 of this thesis validate Walzer's views. The cases also validate the observations in an Australian paper by Wilhelm, Diamond and Williams, who note the difficulties for psychiatrists in treating impaired doctors who are 'clever, skilled verbally and can be intimidating to those who are not used to treating medical colleagues'.[172]

In a very encouraging recent development in Australia, the Health Ombudsman in Queensland recently announced that it is working with AHPRA to improve the monitoring of conditions placed on registered health practitioners, and published a review of a particular case.[173] The findings are important and are further discussed in Chapters 6, 7 and 8. The case review published in March 2015, 'Case Review by the Health Ombudsman: Managing practitioner compliance with conditions of registration' found that a doctor had breached his registration conditions at least 191 times before

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[168] Walzer and Miltimore, 'Mandated Supervision', above n 160, 565.

[169] Ibid.

[170] Ibid 566.

[171] Ibid 567.

[172] Kay Wilhelm, Michael Diamond and Anthony Williams 'Prevention and Treatment of Impairment in Doctors' (1997) 3 *Advances in Psychiatric Treatment*, 267-274.

[173] <http://www.oho.qld.gov.au/wp-content/uploads/2015/03/Health-Ombudsman-case-review-managing-practitioner-compliance-with-conditions-of-registration.pdf>.

AHPRA or the Queensland Board of the Medical Board of Australia (QBMBA) took further action and suspended the practitioner's registration.[174] The breaches of conditions involved the use of a chaperone with female patients. The Ombudsman noted that the case under review was an extreme case but also that 'Conditions imposed on a practitioner's registration are only as effective as the monitoring processes in place to ensure they are adhered to'.[175] He concluded that the processes followed by AHPRA and the QBMBA during their monitoring of the practitioner's compliance with the conditions imposed on his practice, including their decisions:

> do not meet reasonable expectations for high quality and timely compliance monitoring.
>
> It is difficult to reconcile the progression of this case with the obligation on AHPRA and the national board to protect the public by taking timely and necessary action.[176]

He made 10 key recommendations in relation to the monitoring of conditions upon a doctor's registration.[177] These recommendations are discussed in Chapters 6 and 8. It is difficult to know whether the case reviewed by the Ombudsman was an isolated case or the tip of an iceberg. In any event, the review by the Ombudsman clearly signals the need for more research into how protective orders can be operationalised most effectively when the treatment and supervision of doctors with conditions upon their registration can be so difficult. Whilst the rationale for protective orders may be considered within tribunal and Court of Appeal decisions, there has been no systematic study in Australia, other than the small studies mentioned above, of how these protective orders work in practice.[178]

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[174] Ibid.

[175] Ibid.

[176] Ibid.

[177] Ibid.

[178] A recent decision supports the need for further research in this area. In *Medical Board of Australia v Tausif* [2015] ACAT 4, a case involving inappropriate prescribing, a tribunal found that the doctor's professional misconduct was substantially contributed to by the lack of clinical supervision and mentorship the doctor experienced at the two practices where she worked. Although the doctor did not have formal supervision conditions upon her registration at the time, she had previously been suspended from practice and her prescribing rights were limited. However her prescribing was not supervised at the practices. According to Madden, the case raises significant issues about the extent to which a Tribunal

1.12 The rationale for this thesis

In sum, the literature on problem doctors in general, and disciplinary proceedings in particular, indicates a lack of comparability in the studies available, a lack of consistency in the types of research undertaken and a lack of systematic analysis of the caselaw emanating from disciplinary tribunals. As the research mentioned above indicates there has not been a nuanced examination of the discourse[179] in decisions made in disciplinary tribunals in Australia or overseas when doctors are found guilty of misconduct and protective orders are made.

The number of doctors who appear in disciplinary proceedings is in fact very small when seen in the context of the total number of doctors who safely practise medicine in each state and territory of Australia.[180] The number of impaired doctors who appear in such proceedings is even smaller, as the majority of impaired doctors who come to attention under the National Law may be 'managed' with conditions on their registration.[181] However, as the scandals mentioned above indicate, even a single doctor can create significant harm to the public. Impaired doctors pose particular challenges in disciplinary tribunals. Many impaired doctors suffer from chronic but fluctuating or overlapping psychiatric conditions that make it difficult to predict and manage the risk they may pose to the public.

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addressing public protection and safety should consider not just the conduct of a registered practitioner but also the nature of the system in which he or she practises, including that system's levels of training, supervision, mentorship and quality control <https://billmaddens.wordpress.com/2015/02/11/protective-orders-relevance-of-training-supervision-mentorship-and-quality-control/>.

[179] Greig, above n 116, 12. According to Greig 'the term discourse, whilst convenient, is false if it is only intended to refer to some highly principled intellectual endeavour designed to arrive at truth in a given social space. This denies the ebb and flow of social influences, which have the power to alter outcomes ...it is also about the choices made by individual professionals to define a problem in one way rather than another.' In this thesis the discourse generally refers to the discussion in tribunal decisions about reasons for a doctor's misconduct and the protective orders the tribunal considers relevant. It argues that tribunals often define a problem, misconduct, as a medical problem.

[180] These numbers are further elucidated in Chapter 4. The number of doctors registered in Australia at 30 June 2013 were 95,690, and the number of doctors disciplined between 1 July 2010 and 1 July 2013 were 128.

[181] Kiel, 'Regulating impaired doctors', above n 136. 18 of the 128 cases in the present study (approximately 14%) involved impaired doctors. These issues are further discussed in Chapters 5 and 6. It is difficult to know whether problems arise in the 'management' of these doctors and, apart from scandals, any difficulties do not usually become public until a tribunal decision is published.

As there has been very little research on how risk is managed in disciplinary tribunals this thesis will address this deficit by providing a unique analysis of the tensions and complexities involved in the decisions of medical tribunals to demonstrate the most common types of protective orders employed to carry out their mandate of public protection. It will explore whether the rhetoric of protecting the public is undermined by the reality of protective sanctions that protect the interests of doctors. In doing so, it will make an important evidence-based contribution to the research and literature in this area. By focussing particularly on impaired doctors the thesis will also provide important information for regulators on the risk prevention strategies employed by tribunals in the management of impaired doctors as well as information about the effectiveness of the diversionary health pathways under the Health Practitioner Regulation National Law. The research should benefit various stakeholders in the regulatory regime, including problem doctors themselves, their patients, colleagues and peers, members of disciplinary tribunals and the various other professionals, bureaucrats and administrators involved in the formal mechanisms of regulation.

1.13 Conclusion

This chapter has briefly outlined some of the imperatives for reform that led to the National Law. It argued that because the concept of 'the protection of the public' is not defined under the National Law, the concept could be extended to include the protection of doctors and embrace a therapeutic approach to misconduct. It noted that following the explicit recognition of impairment in doctors, the discourse on problem doctors now reflects a rehabilitative approach to misconduct. The chapter briefly outlined the research on problem doctors and tribunal decision-making in this important area and identified a significant deficit in the area of protective orders. It also identified the framework that will guide and inform the research.

In Chapter 2, in order to provide the background and context for the analysis of tribunal decisions that follow in subsequent chapters, some of the key concepts and inherent contradictions within the National Law are elucidated. It is noted that the law is national in name only and that there are some significant differences between the states in their adoption of the law. Chapter 2 picks up the framework elucidated in this chapter, and examines the various avenues under the National Law, which facilitate a medical approach to problem doctors both explicitly through the health pathways and more

implicitly through discretionary processes which determine these pathways following a complaint or notification. It argues that as a key objective of the law 'the protection of the public' is not defined, the culture of the therapeutic state has been transformative in extending the concept to the protection and rehabilitation of impaired doctors.

Chapter 3 outlines the key assumptions underpinning this research and explains the methodology for the thesis and the construction of the database of tribunal decisions. This database facilitates the detailed analysis in subsequent chapters of protective orders in two particular groups of problem doctors: impaired doctors, and those found guilty of sexual misconduct. The two different categories of problem doctors are chosen in order to explore whether a rehabilitative focus extends to doctors who are not impaired using the framework identified in Chapter 1 to challenge and extend the analysis of disciplinary decision-making. Chapter 3 also notes the inherent limitations of the methodology, which include the recognition that tribunal decisions represent only the 'front-stage view' of disciplinary proceedings.

Chapter 4 discusses the general research findings about problem doctors. The findings indicate that the imposition of conditions upon a doctor's registration was the most frequent protective order used by tribunals to manage the risk posed by problem doctors, and these orders often involved a rehabilitative approach to misconduct. The chapter notes that the most common form of misconduct was sexual misconduct, and the number of impaired doctors appearing in disciplinary proceedings was much higher in New South Wales than in the other states, where the numbers were very small. It also notes that the high number of older doctors appearing in disciplinary proceedings indicate that older doctors can pose a serious risk to their patients.

Chapter 5 critically examines the meaning of impairment in the regulatory context, and notes the key role played by psychiatrists in the regulation of doctors. It also notes that the medical model of misconduct may in reality be characterised as a psychiatric model. The chapter discusses the tension between the therapeutic and surveillance role played by psychiatrists. It argues that given these inherent tensions, a focus on the actual conduct of the doctor rather than his or her impairment, may better protect the public.

Chapter 6 analyses the discourse in the tribunal decisions that involve impaired doctors, and examines how the psychiatric model of misconduct, which associates misconduct with illness, is reflected in tribunal decisions. It notes that the impairment decisions

reveal moving narratives of doctors battling various psychiatric conditions and addictions whilst trying to maintain their careers. The decisions also tell stories of failed attempts at rehabilitation when these doctors, in spite, or because of their impairments, fail to comply with conditions upon their registration, and compromise the protection of the public. The chapter concludes that unless a doctor's behaviour or conduct is extreme or repeated, tribunals generally refuse to make moral judgments about doctors' conduct and impose serious sanctions that may have a deterrent effect. In some cases attempts to rehabilitate doctors have clearly put the public at risk.

Chapter 7 explores whether the medicalisation of misconduct is also apparent in decisions where doctors are not impaired, namely in sexual misconduct cases, and concludes that a therapeutic approach is also reflected in these cases. It notes that the continuing risk a doctor found guilty of sexual misconduct might pose to the public is the common theme that anchors the discourse between psychiatry and law in these decisions. In this discourse moral issues of good or bad conduct are in some cases re-defined in terms of psychiatric health or illness, and expert psychiatric evidence becomes the basis for a decision. It is argued that health and chaperone conditions on a doctor's registration ensure that these 'deviant' doctors are controlled within the profession, rather than expelled, in spite of a raft of explicit principles that condemn sexual misconduct. The question is raised as to whether 'treatment', using the principles of therapeutic jurisprudence, is the most appropriate response to unethical conduct that is not caused by illness.

Chapter 8 discusses the implications of the overall findings, and recent research on the management of risk in the disciplinary arena. It proposes some ways forward so that the regulation of doctors in disciplinary tribunals becomes more evidence-based. It draws a number of conclusions about the impact of a therapeutic approach to misconduct, the management of risk in disciplinary proceedings through the use of protective orders, and the rhetoric, as opposed to the reality of protecting the public, in disciplinary proceedings. It concludes that the pendulum has swung too far towards the rehabilitation of problem doctors. This conclusion is evidenced by the Tribunal decisions that indicate that unless a doctor's behaviour or conduct is extreme and repeated, tribunals generally refuse to make moral judgements about their conduct, and to impose severe sanctions. The impairment cases indicate that a non-judgmental position on the part of tribunal decision-makers may understate doctors' own

responsibility for maintaining their own health and well-being. The literature reveals that there is a dearth of research on how the imposition of conditions upon a doctor's practice actually 'work' in practice, both for the doctors being regulated and the doctors administering protective orders. The chapter concludes that this thesis has identified this research deficit and begins to address it.

CHAPTER 2 – THE HEALTH PRACTITIONER REGULATION NATIONAL LAW

2.1 Introduction

In the last chapter problem doctors were defined as those whose professional behaviour has resulted in adverse findings in disciplinary proceedings.[182] Adverse findings under the law mean findings of unprofessional conduct[183] or professional misconduct. In this chapter, the definitions of professional misconduct and unprofessional conduct are briefly elucidated in order to identify how adverse findings are made and doctors 'cross the line' into becoming problem doctors. The National Law is examined in order to provide the background and context for the analysis of tribunal decisions.[184] This chapter picks up the framework elucidated in Chapter 1 and describes the various avenues under the National Law that facilitate a medical approach to problem doctors both explicitly through the health pathways[185] and more implicitly through discretionary processes which determine these pathways following a complaint or notification. One avenue is through the transformation and extension of one of the key objectives of the law: the 'protection of the public', which has been extended to include the treatment and rehabilitation of doctors. Another avenue is through the exercise of discretion after a complaint is received. Finally, the medicalisation of misconduct may be reflected in protective orders that involve treatment or rehabilitation. The use of protective orders is further discussed in subsequent chapters.[186] Some differences between the states and New South Wales are noted, both in relation to the definitions of misconduct, mandatory notification, and the types of protective orders available to tribunals.

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[182] Hancock, above n 6, 153. It is this definition, which is adopted for research purposes in this thesis, as discussed in the methodology chapter below.

[183] In New South Wales referred to as unsatisfactory professional conduct, as further discussed.

[184] Although not all cases in this study were decided under the National Law, a significant number were, as explained in Chapter 3.

[185] It is important to note that the old State and Territory laws also allowed a therapeutic approach, but, as noted in Chapter 1, this approach has become far more explicit with the development of impairment programs for doctors.

[186] Any differences under the old State and Territotory laws are not significant enough to prevent exploration of the Tribunal decisions in terms of the use of protective orders.

2.2 The Health Practitioner Regulation 'National' Law – tensions and contradictions

The National Law was introduced on 1 July 2010 in all jurisdictions except Western Australia, where it commenced on 18 October 2010. The parliamentary debates surrounding the introduction of the National Law are somewhat disappointing in that they tend to simply describe the law, rather than provide a clear rationale for it.[187] The main object of the National Law was to establish a national registration and accreditation scheme for the regulation of health practitioners and students across Australia.[188] As noted in Chapter 1, the National Law was intended to address some of the criticisms of the existing system, most notably the need for consistency across the States and Territories in how health practitioners are registered and regulated.[189] However, in relation to regulation the law is now 'National' in name only.[190] The

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[187] See, eg, Carmel Tebbutt, 'Health Practitioner Regulation Bill 2009' (Speech delivered at the Legislative Assembly, New South Wales, 13 October 2010) <http://bulletin/prod/parlment/hansart.nsf/8bd91bc90780f150ca256e630010302c/52c88...>; T.A. Jennings, '*Health Practitioner Regulation National Law* (South Asutralia) Bill' (Speech delivered at the Legislative Council, South Australia, 22 June 2010).

[188] The National Law s 3. The Bill and Second Reading speeches stress how the law will address the need for consistency across the states. In New South Wales, in the Agreement in Principle Discussion of the Bill, the Minister for Health, Ms Carmel Tebbutt stressed the uniqueness of the New South Wales model for the investigation of complaints through the Health Care Complaints Commission, which is described as an independent investigator and prosecutor. <http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/>.

When the National Law commenced it regulated only ten professions across Australia. These included: chiropractors, dentists, doctors, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, and psychologists. In July 2012 four 'new' health professions, the Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation, and occupational therapy were added, implicitly granting them status and legitimation as professions. The inclusion of Chinese medicine, which is not always regarded as a 'mainstream' profession was somewhat controversial.

[189] The Hon Paul Lucas, the then Minister for Health, when he introduced the Bill into the Queensland Parliament on 6 October 2009, stated that 'The national consistency in registration and accreditation arrangements in this bill will help improve the availability and flexibility of the provision of health services and will also protect the public'.

[190] Although the website of the Australian Health Practitioner Regulation Agency ('AHPRA'), the agency that administers the law, still states that:

> AHPRA's operations are governed by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), which came into effect on 1 July 2010. This law means that for the first time in Australia, 14 health professions are regulated by nationally consistent legislation under the National Registration and Accreditation Scheme. <http://www.ahpra.gov.au/About-AHPRA/Who-We-Are.aspx>.

National Law, which was first adopted in Queensland,[191] was then adopted by Acts in the other States and Territories of Australia.[192] As it is not a Commonwealth law, the legislative powers lie with the States and Territories, which are free to amend their own laws.[193] Therein lies a problem with the title of the law. All of the state and territory Acts basically adopted the Queensland legislation,[194] nevertheless in spite of the word 'National' in the title, there are some variations between the states in the legislation itself as a result of the states making amendments for their own purposes.[195] This is particularly so in relation to New South Wales and Queensland. New South Wales from the beginning opted for its own system of regulation in relation to the management of complaints, which it argued allowed for more independent investigation of complaints,[196] and Queensland, in spite of being the first state to enact the law, has also now established its own system for managing complaints.[197] Both Queensland and New South Wales are referred to as co-regulatory jurisdictions.[198] In New South Wales the

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[191] *Health Practitioner Regulation National Law Act 2009*. This legislation is no longer current, and there have been various changes to the legislation below.

[192] These Acts were the *Health Practitioner Regulation Act 2009* (NSW) the *Health Practitioner Regulation National Law Act 2009* (ACT), *the Health Practitioner (National Uniform Legislation) Implementation Act 2010* (NT), the *Health Practitioner Regulation National Law Act 2010* (VIC), the *Health Practitioner Regulation National Law 2010* (South Australia), the *Health Practitioner Regulation National Law Act 2010* (Tasmania), and the *Health Practitioner Regulation National Law Act 2010* (WA).

[193] The Member of the Greens, The Hon T.A. Jennings, introducing the Bill into the South Australian Legislative Council on 22 June 2010, stated that 'The prerogative to regulate the health professions is held by governments of the Australian States and Territories, and this denies the possibility of any single, comprehensive legislative strike. Indeed the Parliament of Australia has felt the need to stress, with Minister Hill's second reading speech, that the National Law is agreed legislation between all health ministers. It is not Commonwealth law.' <http://hansardpublic.parliament.sa.gov.au/pages/loaddoc.aspx?i=158578http://hansardpublic.parliament.sa.gov.au/pages/loaddoc.aspx?i=158578>.

[194] Which has since become another co-regulatory jurisdiction like New South Wales as further discussed in this chapter.

[195] For example, New South Wales has a different definition of professional misconduct and Western Australia has different mandatory reporting provisions.

[196] Complaints in NSW are investigated and prosecuted by the Health Care Complaints Commission ('HCCC') <http://www.hccc.nsw.gov.au/>.

[197] The newly established Office of the Health Ombudsman is Queensland's health service complaints agency, and is an independent statutory authority, which receives and investigates complaints about health services and providers. *Health Ombudsman Act 2013* <http://www.oho.qld.gov.au/about-us/office-of-the-health-ombudsman>.

[198] Because in relation to the investigation and management of complaints they do not participate in Part 8 of the law in relation to the health, performance and conduct parts of the National Law. See s 7A Co-regulatory jurisdiction. *It is declared that this jurisdiction is not participating in the health, performance and conduct process provided by part 8, divisions 3 to 12 of the Health Practitioner Regulation National*

National Law is currently being reviewed and submissions have been invited to comment on various aspects of the law, in particular the performance and health provisions in Part 8.[199]

Despite the development of jurisdictional differences in how the National Law is applied, the law's operational arm, AHPRA retains an overarching and umbrella function. AHPRA supports the 14 National Boards that are responsible for regulating the 14 health professions. The primary role of these National Boards is to protect the public, although medical boards have been criticised for protecting the interests of the profession rather than the public. In a study of medical boards in the United States, Carl Ameringer argued that state medical boards, with their focus on remediation and rehabilitation, became 'guide dogs' not 'watchdogs'.[200] Prior to the introduction of the National Law the Medical Boards played a key role in the regulation of doctors and had significant disciplinary powers.[201] They still play a pivotal role, but in conjunction with other entities, as discussed below.

AHPRA also liaises with the relevant Health Complaints Entities (HCEs) in each state and territory. The way AHPRA administers the law is complex and confusing,[202] in part because of differences between the states referred to above, and discussed more fully below. Information about how the law is administered is readily available on the AHPRA website and through related links. Under the national scheme it is the National Board of the relevant health profession, such as the Medical Board of Australia, that delegates to a State or Territory board or council the responsibility for referring matters for disciplinary proceedings to a tribunal in accordance with the provisions of section

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Law set out in the schedule. 7B Co-regulatory authority It is declared that the health ombudsman is a co-regulatory authority for the purposes of the Health Practitioner Regulation National Law (Queensland).

[199] At <http://www.health.nsw.gov.au/legislation/Pages/Acts-under- review.aspx>.

[200] C Ameringer, *State Medical Boards and the Politics of Public Protection*, (The John Hopkins University Press Baltimore, 1999) 104.

[201] Mendelson, 'Disciplinary Powers of Medical Practice Boards', above n 26, 142.

[202] <http://www.ahpra.gov.au/Notifications/The-notifications-process.aspx>. For example, the website states that 'Different National Boards have established different structures for dealing with notifications, or have delegated some of their decision-making to their committees and AHPRA officers in state and territory offices.' The AHPRA website however has a useful diagram setting out the notification process. As noted above, and adding to the confusing picture of regulation, there is a lack of uniformity between the states in terms of how complaints are investigated and managed.

170 (1)(b) of the National Law. It is the published decisions of these tribunals that are explored in the following chapters of this thesis.[203]

2.3 Disciplinary tribunals

Disciplinary proceedings take place in state-based Civil and Administrative Tribunals[204] responsible for hearing and making decisions about complaints that have been referred for hearing following investigation.[205] Under the National Law a tribunal is referred to as a 'responsible tribunal'.[206] The composition of a tribunal is generally similar to the composition under the former State and Territory laws. In Queensland, for example, the Tribunal consists of a judicial member, an assessor from the public panel of assessors and two assessors from the professional panel of assessors.[207] In New South Wales the Tribunal composition is similar,[208] but the law does not use the word 'assessor'. As the

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[203] A Tribunal is required to give reasons for its decision: National Law, s 167F(2)(c).

[204] These are the New South Wales Civil and Administrative Tribunal; Australian Capital Territory Civil and Administrative Tribunal; Northern Territory Health Professional Review Tribunal; Queensland Civil and Administrative Tribunal; South Australia Health Practitioners Tribunal; Tasmania Health Practitioners Tribunal; Victoria Civil and Administrative Tribunal; Western Australia State Administrative Tribunal. A tribunal is generally made up of members of the same profession as the health practitioner whose behaviour is under review, a non-health practitioner member and a judicial officer. <http://www.ahpra.gov.au/Notifications/Fact-sheets/Tribunal-hearings.aspx>.

[205] Under s165H, the Tribunal is not required to conduct an inquiry if the complaint has been admitted in writing. However, Part 8 does not detail any further what the Tribunal should do in such cases. Section 163A gives a right of review, to an appropriate review body, to practitioners that are subject to a prohibition order, suspension, disqualification or an order imposing conditions. The appropriate review body will be either the Tribunal or a Health Professional Council.

[206] The *Health Practitioner Regulation National Law* provides under s 5 (Definitions) that a 'responsible tribunal' means a tribunal or court that-

> (a) is declared, by the Act applying this Law in a participating jurisdiction, to be the responsible tribunal for that jurisdiction for the purposes of this Law as applied in that jurisdiction, or
>
> (b) is declared, by a law that substantially corresponds to this Law enacted in a participating jurisdiction, to be the responsible tribunal for that jurisdiction for the purposes of the law of that jurisdiction.

As noted in Chapter 1, Elkin defined a tribunal as the disciplinary body in each jurisdiction with the power to remove a doctor from practice other than on an interim basis.

[207] <http://www.qcat.qld.gov.au/__data/assets/pdf_file/0011/101207/changes-for-hpt.pdf>.

[208] A tribunal is generally made up of members of the same profession as the health practitioner whose behaviour is under review, a non-health practitioner member and a judicial officer. <http://www.ahpra.gov.au/Notifications/Fact-sheets/Tribunal-hearings.aspx>. In New South Wales a tribunal comprises four members. The proceedings are chaired by an NCAT member who is a senior judicial officer. The Medical Council appoints the non-judicial members to sit on all NCAT hearings, appeals and review hearings, and staff of the HPCA monitor compliance with any orders and conditions that are imposed by a Tribunal. Whilst complaints before the Tribunal are prosecuted by the HCCC, the Medical Council is a party (respondent) to review hearings and certain appeals that are lodged in the

Tribunals are multi-disciplinary, they bring significant expertise to the decision-making process.[209] These decisions require the combination of legal insight with knowledge derived from other disciplines, such as psychology, neuropsychology and psychiatry.[210] When it comes to dealing with impaired doctors tribunals can rely upon their own expertise rather than that of witnesses in reaching its conclusions. Thus, in a decision that involved over-prescribing,[211] where the evidence of the peer reviewer was in dispute, the Tribunal cited a well-known case involving a veterinary surgeon, which clearly states the principle that an expert tribunal can draw upon its own expert resources.[212] As noted in Chapter 1 a tribunal decision to deregister a doctor can be seen as the apex or end-point in the regulatory system.[213]

As the Tribunals are established under various State and Territory Acts,[214] the National Law includes a provision giving itself priority in any areas in which both Acts apply and are inconsistent with one another.[215]

2.4 Becoming a problem doctor – unprofessional conduct and professional misconduct

As noted above, an adverse finding means that a doctor is guilty of unprofessional conduct[216] (which is less serious conduct, such as poor medical records), or professional

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Tribunal. Tribunal hearings are open to the public. See the Medical Council of NSW Annual Report 2014 <http://www.mcnsw.org.au/page/76/resources/publications/annual-reports/>.

[209] Jeremy Webber, 'Legal Research, the Law Schools and the Profession' (2004) 26(4) *Sydney Law Review* 565.

[210] Ibid. The term 'transdisciplinary' has been coined for this amalgam of different perspectives, to differentiate it from collaboration where the disciplines remain separate.

[211] *Health Care Complaints Commission v Gorondy-Novak* [2011] NSWMT 3 (15 April 2011).

[212] See *Kalil v Bray* [1977] 1 NSWLR 256. The Chief Justice, Street CJ observed at [261]–[262]:

> The purpose of setting up the tribunal, with its membership drawn from the ranks of veterinary surgeons, is to enable it to do the very thing that either a Bench of justices or a jury may not do, that is to say, to draw upon its own expert resources to resolve such questions of expert science as might emerge from the objective, or lay facts proved in evidence before it. In doing so it will, no doubt, give due weight to such expert evidence, if any, as may be placed before it. But the ultimate responsibility for forming an expert view upon which the disciplinary powers will be exercised or withheld is with the tribunal itself. This is a responsibility to be discharged by drawing upon its own internal resources of knowledge of veterinary science.

[213] See Allsop, above n 16.

[214] See above n 192.

[215] s 198 of the National Law The wording of this provision is somewhat obtuse.

misconduct (more serious conduct, such as sexual misconduct, which could lead to suspension or the ultimate sanction of deregistration). A finding of fact about the misconduct must be made before any determination is made about appropriate protective orders, such as the imposition of conditions on a doctor's registration. When a finding is made about misconduct, clearly the law is reactive in that it looks back and assesses the misconduct in hindsight. However it is proactive in that protective orders may take into account factors such as the doctor's insight into their conduct and their attempts to remedy it, and impose other rehabilitative measures.

There are a number of grounds for complaint or notification.[217] The grounds are broadly similar although in New South Wales a complaint may be made about a criminal conviction.[218] Section 243 of the National Law Act specifically provides that conduct may constitute both a criminal offence and professional misconduct.

As well as the mandatory notification provisions, under s144 of the National Law (Queensland) a voluntary notification may also be made, whilst in New South Wales s 144B provides that anyone can make a complaint. [219]

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[216] As already noted in New South Wales referred to as unsatisfactory professional conduct. See s 139B of the National Law (NSW).

[217] The National Law provides at s 139A that a complaint means a notification under division 2 or 3.

[218] In New South Wales the National Law provides at s 144 that:

> The following complaints may be made about a registered health practitioner-
>
> > (a) A complaint the practitioner has, either in this jurisdiction or elsewhere, been convicted of or made the subject of a criminal finding for an offence.
> >
> > (b) A complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct.
> >
> > (c) A complaint the practitioner is not competent to practise the practitioner's profession.
> >
> > (d) A complaint the practitioner has an impairment.

[219] s 144 provides that a voluntary notification may be made that

> (a) the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers
>
> (b) that the knowledge, skill or judgment possessed, or care exercised by the practitioner in the practice of the health practitioner's profession, is or may be below the standard reasonably expected;
>
> (c) that the practitioner is, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession

There are other differences between New South Wales and the other States and Territories under the National Law in the definitions of professional misconduct and unprofessional conduct.[220] As already noted, many of the cases in this study were determined under the old State and Territory laws, and whilst there are some variations in the definitions of professional misconduct under the old laws and the National Law,[221] they are not significant enough to prevent exploration of the Tribunal decisions, particularly as the focus in this thesis is mainly on the use of protective orders in managing risk. The basic rationale of the former State laws - the protection of the public - has not changed under the National Law.[222] It is important to elucidate the current definitions of professional misconduct and unsatisfactory conduct as most cases are now being decided under the National Law.

(d) that the practitioner has, or may have, an impairment;

(e) that the practitioner has, or may have contravened this Law;

(f) that the practitioner has, or may have, contravened a condition of the practitioner's registration or an undertaking given by the practitioner to a National Board;

(g) that the practitioner's registration as, or may have been, improperly obtained because the practitioner or someone else gave the National Board information or a document that was false or misleading in a material particular

(h) A complaint the practitioner is otherwise not a suitable person to hold registration in the practitioner's profession.

[220] Queensland has not adopted a different definition since it became co-regulatory.

[221] See Appendix C, which sets out the governing legislation under the former state laws. In Victoria, for example, the *Health Professions Registration Act 2005* defined professional misconduct as follows s 3 'professional misconduct' includes—

(a) unprofessional conduct of a health practitioner, where the conduct involves a substantial or consistent failure to reach or maintain a reasonable standard of competence and diligence; and

(b) conduct that violates or falls short of, to a substantial degree, the standard of professional conduct observed by members of the profession of good repute or competency; and

(c) conduct of a health practitioner, whether occurring in connection with the practice of the health practitioner's health profession or occurring otherwise than in connection with the practice of a health profession, that would, if established, justify a finding that the practitioner is not of good character or is otherwise not a fit and proper person to engage in the practice of that health profession.

[222] In Victoria for example the *Health Professions Registration Act 2005* provides as follows:

2. The main purposes of this Act are to—

(a) protect the public by providing for the registration of health practitioners and a common system of investigations into the professional conduct, professional performance and ability to practise of registered health practitioners; and

(b) protect the public by providing for the registration of students of the health professions and investigations into the suitability of those students to undertake clinical training….

The burden of proof is the civil standard of proof and the onus of proof is on the complainant, which is the relevant Medical Board or HCE in each State or Territory. The tribunal must be reasonably satisfied on the balance of probabilities that the subject matter of the complaint against the doctor is established, as stated in the commonly cited case of *Briginshaw v Briginshaw*.[223] The cases in this study generally refer to the standard of proof without further discussion, but in one case the tribunal embarked upon a lengthy discussion of some relevant caselaw and the Evidence Act 2008 in Victoria and noted

> Where disciplinary proceedings raise serious allegations of unprofessional conduct and professional misconduct clearly there are potentially serious consequences for the practitioner concerned. In determining the strength of the evidence required to attain the 'balance of probabilities' standard, the seriousness of such allegations must be taken into account.[41][224]

Clearly in cases such as those involving sexual misconduct, which are discussed in Chapter 7, where there are often no independent witnesses as to the conduct, a tribunal has to choose between the version of the patient and the version of the doctor. Here the standard of proof, which does not have the strict requirement in criminal proceedings of proof 'beyond reasonable doubt', may arguably be more protective of the public. At the same time it may compromise the interests of the doctor, who may be found guilty of sexual misconduct purely on the word of the complainant and without the standard of evidence required in a criminal trial.

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[223] *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336 at [37] The High Court said 'Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the Tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.' Briginshaw is in fact an adultery case. The standard of proof is not as high as the criminal standard of 'beyond reasonable doubt', but it is not a vague standard. As the Federal Court has observed, the principle which Briginshaw embodies is that there is a rational relationship between the seriousness of the fact to be proved and the strength of the material sufficient to prove that fact *Sullivan v Civil Aviation Authority* FCA [2013] 1362 (17 December 2013) [37]. For further comment on the standard see *Neat Domestic Trading Pty Limited v Karajan Holdings Pty Ltd* [1992] HCA 66; (1992) 110 ALR 449.

[224] *Medical Board of Australia v Jansz* (Occupational and Business Regulation) [2011] VCAT 1026 (31 May 2011).

2.4.1 Professional misconduct – judgment by peers

Both the literature and the Tribunal decisions indicate that professional misconduct can cover a range of different factual circumstances, from the more traditional forms of misconduct, such as inappropriate prescribing and sexual misconduct to conduct involving issues such as plagiarism by registered health professionals,[225] and accessing child pornography on the Internet.[226] Whilst the nature of professional misconduct may change to reflect changing social and cultural circumstances, and lay members are now included on disciplinary tribunals as noted above, the test for misconduct as judged by professional peers has not changed significantly. As well as findings of fact, the recognition of systemic error may impact upon findings of professional misconduct. This issue is discussed below.

One of the intentions of the National Law was to bring about some consistency in terms of how the health professions are regulated, and to date, the definition of professional misconduct is consistent across all States and Territories with the exception of New South Wales, as further discussed below. As the definitions below clearly illustrate, just as the earliest English case, which contained a definition of professional misconduct relied upon peer review 'the strong reprobation of professional brethren of good repute and competence',[227] the modern day test refers to a 'lesser standard than that which

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[225] Jon Wardle, 'Plagiarism and Registered Health Professionals: Navigating the Borderlands between Scholarly and Professional Misconduct' (2013) 21 *Journal of Law and Medicine* 399. Ian Freckelton, 'Plagiarism in Law and Medicine: Challenges for Scholarship, Academia, Publishers and Regulators' (2010) 17 *Journal of Law and Medicine*.

[226] *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010). In her analysis of changing disciplinary responses to sexual misconduct Manning notes that there is early indication of a stricter approach to in cases of downloading and accessing objectionable material. See Manning, above n 127, 508.

[227] The very earliest definition of professional misconduct was enunciated in *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 755. Dr Allinson had published advertisements that reflected badly upon his professional brethren and their methods of treating patients. The English Court of Appeal held that:

> If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency...

Since then the definition has undergone a number of variations but the essence of the early definition was restated by Priestley JA the New South Wales Court of Appeal in *Qidwai v Brown* (1984) 1 NSWLR 100 [105]:

> ...whether the practitioner was in such breach of the written or unwritten rules of the profession as would reasonably incur the strong reprobation of professional brethren of good repute and competence...

might reasonably be expected of the health practitioner by the public or the practitioner's professional peers'.[228]

2.4.2 Less serious conduct – Unprofessional conduct (National Law) and unsatisfactory professional conduct (New South Wales)

The current definition of professional misconduct builds upon the definition of unprofessional conduct as defined under s 5 in the Schedule of the National Law. Under s 5 of the National Law:

> Unprofessional conduct, of a registered health practitioner, means professional conduct that is of a **lesser standard** than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers.[229]

The test was again restated in *Pillai v Messiter* (No 2) [1989] 16 NSWLR 197. Dr Pillai was found guilty of professional misconduct after he made a transcribing error and overprescribed an anti-convulsant drug causing the death of a patient. The Court of Appeal recognised that it was not only Dr Pillai who had failed to recognise the signs of drug toxicity and check the dosage. Three other doctors had failed to make the connection, and the court also referred to the run-down state of the hospital. It identified understaffing and incompetence within the hospital as the key issues responsible for the transcribing error.

[228] National Law s5 To date there has been little judicial reference to the inclusion of 'the public' in the statutory test.

[229] It includes—

(a) a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and

(b) a contravention by the practitioner of—

(i) a condition to which the practitioner's registration was subject; or

(ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and

(c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession; and

(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being; and

(e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and

(f) accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider; and

(g) offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner; and

However, in New South Wales the Health Practitioner Regulation Law (NSW) provides under s 139B:

> 'Unsatisfactory professional conduct' of a registered health practitioner includes each of the following–
>
> (a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is **significantly below** the standard reasonably expected of a practitioner of an equivalent level of training or experience.[230]

(h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

Unsatisfactory professional performance, of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.

[230] The definition continues:

(b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.

(c) A contravention by the practitioner (whether by act or omission) of-

(i) a condition to which the practitioner's registration is subject; or

(ii) an undertaking given to a National Board.

(d) A contravention by the practitioner (whether by act or omission) of a decision or order made by a Committee or Tribunal in relation to the practitioner.

(e) A contravention by the practitioner of section 34A(4) of the Health Care Complaints Act 1993.

(f) Accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for-

(i) referring another person to the health service provider; or

(ii) recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter.

(g) Accepting from a person who supplies a health product (or from consideration or reward for recommending that another person use the health product), but does not include accepting a benefit that consists of ordinary retail conduct.

(h) Offering or giving a person a benefit as inducement, consideration or reward for the person-

(i) referring another person to the registered health practitioner; or

(ii) recommending to another person that the person use a health service provided by the practitioner or consult the practitioner in relation to a health matter.

The test for unsatisfactory professional conduct in New South Wales is therefore more stringent than the test for unprofessional conduct under the National Law.[231]

Under s 139C in New South Wales there are additional matters that may constitute unsatisfactory professional conduct.[232]

(i) Referring a person to, or recommending that a person use or consult-

(i) another health service provider; or

(ii) a health service; or

(iii) a health product;

if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of the interest to the person before or at the time of giving the referral or recommendation.

(j) Engaging in overservicing.

(k) Permitting an assistant employed by the practitioner (in connection with the practitioner's professional practice) who is not a registered health practitioner to attend, treat or perform operations on patients in respect of matters requiring professional discretion or skill.

(l) Any other improper or unethical conduct relating to the practice or purported practice of the practitioner's profession.

[231] Under s144 the National Law there is a separate category of 'unsatisfactory professional performance', of a registered health practitioner, which refers to 'substandard' knowledge, skill or judgment possessed, or care exercised by, the practitioner when compared to the standard reasonably expected of a health practitioner of an equivalent level of training or experience. New South Wales does not have this provision. In New South Wales the equivalent is under s144 (c) Lack of competence. These complaints may be dealt with through the performance pathways under the law.

[232] s 139C. In addition to the matters referred to in s 139B,

'unsatisfactory professional conduct' of a medical practitioner also includes each of the following-

(a) Conduct that results in the medical practitioner being convicted of or being made the subject of a criminal finding for any of the following offences-

(i) an offence under section 102 of the *Mental Health Act 2007*;

(ii) an offence under section 175 of *the Children and Young Persons (Care and Protection) Act 1998*;

(iii) an offence under section 35 of the *Guardianship Act 1987*;

(iv) an offence under section 128A, 128B, 129 or 129AA of the *Health Insurance Act 1973* of the Commonwealth;

(v) an offence under section 58 of the *Private Health Facilities Act 2007*.

(b) By the medical practitioner's presence, countenance, advice, assistance or co-operation, knowingly enable a person who is not a medical practitioner (whether or not that person is described as an assistant) or is not otherwise authorised by a National Board to-

(i) perform operative surgery (as distinct from manipulative surgery) on a patient in respect of any matter requiring professional discretion or skill; or

(ii) issue or procure the issue of a certificate, notification, report or other like document, or to engage in professional practice, as if the person were a medical practitioner.

2.4.3 More serious conduct – professional misconduct

The more serious complaint of professional misconduct is also defined under s 5 of the National Law. Professional misconduct, of a registered health practitioner, includes−

> (a) unprofessional conduct by the practitioner that amounts to conduct that is **substantially below** the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
>
> (b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
>
> (c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

The New South Wales law again is stronger in its language in referring to professional misconduct[233] as being of:

> a **sufficiently serious nature to justify suspension or cancellation of the practitioner's registration**,

than the National Law which as noted refers to 'conduct substantially below the standard…' and more obliquely to:

> (c) Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a medical practitioner if the practitioner has reasonable cause to believe the person is in need of urgent attention by a medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another medical practitioner attends instead within a reasonable time.

[233] According to the the National Law (NSW) - s 139E

> 'professional misconduct' of a registered health practitioner means-
>
> > (a) unsatisfactory professional conduct of a sufficiently serious nature to justify suspension or cancellation of the practitioner's registration; or
> >
> > (b) more than one instance of unsatisfactory professional conduct that, when the instances are considered together, amount to conduct of a sufficiently serious nature to justify suspension or cancellation of the practitioner's registration.

> conduct ⋯ inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

A tribunal may find that a doctor is guilty of both forms of conduct, and that the unsatisfactory conduct is sufficiently serious to also find that it amounts to professional misconduct. For example, in the matter of *Underwood*,[234] a New South Wales paediatrician admitted to having a sexual relationship with the mother of one of his patients, and that his conduct amounted both to unsatisfactory professional conduct and to professional misconduct. Noting his admissions, the Tribunal found that Dr Underwood's conduct demonstrated that his judgment was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience and found him guilty of unsatisfactory professional conduct.[235] It also considered that Dr Underwood's unsatisfactory professional conduct was of a sufficiently serious nature to justify suspension or cancellation of his registration and also found him guilty of professional misconduct.[236]

It can be difficult to determine the fine line between the less serious finding of unprofessional conduct and a more serious finding of professional misconduct.[237] In a recent case involving a podiatrist[238] the Tribunal reflected on the definition of professional misconduct. The Tribunal said:

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[234] *Health Care Complaints Commission v Dr Anthony Underwood* (NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012).

[235] *Health Care Complaints Commission v Dr Anthony Underwood* (NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012).

[236] *Health Care Complaints Commission v Dr Anthony Underwood* (NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012).

[237] In the case of *Pillai v Messiter* (No 2) 97, referred to above, the line was considered by Kirby, P at [200]-[201]:

> Departures from elementary and generally accepted standards of which a medical practitioner could scarcely be heard to say that he or she was ignorant could amount to such professional misconduct ... But the statutory test is not met by mere professional incompetency or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner...

[238] *Health Care Complaints Commission v Bours* (No 1) [2014] NSWCATOD 113 (13 October 2014).

> It can be a vexed question to determine what type of conduct creates a bridge from the lesser finding of unsatisfactory professional conduct to the more serious one of professional misconduct.
>
> Contemporary cases involving unsatisfactory professional conduct and professional misconduct primarily consider the wording of the relevant statute rather than the considerations of moral condemnation found in earlier decisions, expressing their views 'in terms of strong criticism'.[239]

2.4.4 Differences between New South Wales and the National Law

The language in the definitions of professional misconduct and unprofessional conduct or unsatisfactory professional conduct suggest that the more stringent tests in New South Wales may make the conduct at issue more difficult to prove, although the standard of proof remains the same. In spite of these differences in definition and allowing for the differences in the number of doctors in each State this thesis demonstrates that New South Wales still had more doctors with adverse findings against them (64 doctors) than either Victoria (31 doctors) or Queensland (17 doctors), as further discussed in Chapter 4.

However, there are different mechanisms in different states for investigating complaints, as noted in Chapter 3, and possible differences in the exercise of discretion involved in determining the pathway a complaint or notification may follow. It would therefore be speculative to make any generalisations about whether or how the different definitions of misconduct impact upon findings about misconduct that determine whether doctors become problem doctors. As well as adverse findings under the law according to the definitions of misconduct, it is important to recognise that other systemic factors may impact upon doctors becoming problem doctors.

2.4.5 Human error, misconduct and systemic error

The fine line between error and misconduct is one that has taxed many a disciplinary tribunal. The line becomes even more slippery when there is systemic error relating to the circumstances surrounding the misconduct. The importance of a systemic approach

[239] *Health Care Complaints Commission v Bours* (No 1) [2014] NSWCATOD 113 (13 October 2014).

to human error reduction, rather than a focus simply on human error, has been well documented in the literature, with aviation systems analysis being readily transported to an analysis of adverse events in healthcare systems.[240] A systems approach involves the proactive management of human error from an organisational standpoint. A former President of the General Medical Council in the United Kingdom noted that the level of harm caused by unsafe systems is in an order of magnitude higher than the harm caused by unsafe doctors.[241] However as the high profile cases referred to in Chapter 1 indicate, a single doctor can cause enormous harm. Disciplinary proceedings are the mechanism by which such doctors can be stopped.

A case under the old New South Wales Medical Practice Act 1992 provides a good example of the arbitrariness of some decisions which determine whether a doctor has an adverse finding made or how serious their conduct is. In *Daskalopoulos v HCCC* [2002] NSWCA 200 a doctor (a gastrointestinal specialist) was found guilty of unsatisfactory professional conduct after a finding that he injected the incorrect contrast medium into a number of patients causing them to suffer higher than usual rates of complications. He appealed. The Court of Appeal found that whilst some of the adverse findings could not stand because of a denial of procedural fairness, it was still open to the Tribunal to find that Dr Daskolopoulos should have ascertained what medium he was injecting into patients. The Court of Appeal considered that the conduct 'could be characterised fairly as an error of judgment' (although significantly the complaint involved more than one patient), and the doctor was found not guilty of unsatisfactory professional misconduct. A lack of adequate judgment or care was part of the definition of professional misconduct and unsatisfactory professional conduct under the *Medical Practice Act 1992* and the Court said:

> Persons who do not lack 'adequate judgment' do from time to time make errors of judgment. On the whole I am not comfortably satisfied that the appellant's error of judgment in this case demonstrated a lack of adequate

[240] D.E. Maurino, J Reason, N Johnston, R Lee, *Beyond Aviation Human Factors* (Ashgate Publishing Limited, 1995) x.

[241] Liam J Donaldson, 'Good Doctors: Safer Patients: Proposals to Strengthen the System to Assure and Improve the Performance of Doctors and to Protect the Safety of Patients' (Department of Health, 2006), 28.

> knowledge, skill, judgment or care: and I would not make a finding that the appellant has been guilty of unsatisfactory professional conduct.[242]

In this case the court unfortunately did not elaborate on how it distinguished an 'error' of judgment from a lack of adequate judgment. Some systemic issues were raised in the case in relation to the handling and labelling of the contrast medium injected into the patients. This case demonstrates not only how the line between human error and misconduct can be quite elusive, but also how the line between human error and systemic error can also be a slippery one.[243]

The consequences of a systemic approach were graphically illustrated in New South Wales in 2003 and 2004. In December 2003, the Health Care Complaints Commission of New South Wales ('HCCC'), as a result of a complaint by the Director-General of the Department of Health, produced a report after conducting an inquiry into 47 clinical incidents involving poor patient care at Campbelltown and Camden Hospitals.[244] The HCCC report identified a number of systemic factors that contributed to the poor standard of patient care at the hospitals and did not suggest that any doctors be investigated for misconduct.[245] The Health Care Complaints Commissioner was sacked in the context of considerable publicity about the issue. The HCCC approach was contrary to the traditional disciplinary procedures of professional bodies, which involve disciplining doctors for acts of omission or commission according to professional standards[246] or 'naming and shaming' these doctors.[247] It was clear that political

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[242] *Daskalopoulos v HCCC* [2002] NSWCA 200.

[243] *Daskalopoulos v HCCC* [2002] NSWCA 200 [59].

[244] *Health Care Complaints Commission Investigation Report* Campbelltown and Camden Hospitals Macarthur Health Service (December 2003). It noted that both the Commission's experience and independent research showed that many adverse events and problems which arise in the provision of health care are not merely attributable to an individual on the spot at the time of the event, but are often the result of a chain of errors or failures in the system of care that unless identified and fixed, may reoccur.

[245] Ibid.

[246] Price, above n 68.

[247] The Commissioner did not name any doctors and arguably became a political scapegoat when the report became public and received considerable attention in the media. See Thomas, *The Rise and Recession of Medical Autonomy* above n 41, 52 for an interesting discussion of this issue. Freckelton notes that the increasing awareness of health, performance and systemic issues has the potential to move regulatory bodies away from the traditional focus on whether practitioners engaged in inappropriate conduct on specific occasions, Ian Freckelton (ed), 'Disciplinary Investigations and Hearings: A Therapeutic Jurisprudence Perspective' in *Regulating Health Practitioners* (Federation Press Sydney, 2006).

imperatives, as well as systemic issues outside the National Law, may determine who becomes a problem doctor.[248] It was following the release of the Walker Report following a subsequent inquiry that the doctors were referred for investigation with a view to disciplinary proceedings being taken against them. [249]

Clearly, where systemic error is involved, the protection of the public under the National Law becomes particularly challenging for tribunals. The public may be at risk due to factors beyond the control of an individual doctor, although his or her conduct may exacerbate the risk. Turnbull illustrates the complexities involved in decision-making about professional misconduct in discussing the case of a highly regarded and well-respected Australian surgeon who performed a mastectomy on the wrong breast on a patient with dementia. According to Turnbull:

> In this case, the combination of systemic and human errors, and a departure from professional standards paradoxically resulting from professional concern to accommodate the patient's needs, created the 'perfect storm'. The result was an event which not only resulted in harm to the patient but has had major personal and professional ramifications for the surgeon involved.[250]

Turnbull importantly elucidates the complexities involved in decision-making about professional misconduct, which cannot always be simplistically reduced to either systemic issues or the individual conduct of a doctor.

Having very briefly examined how doctors 'cross the line' into becoming problem doctors with adverse findings against them in disciplinary proceedings, the 'protection of the public' can now be examined.

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[248] See Thomas, *The Rise and Recession of Medical Autonomy,* above n 41, for an interesting discussion of this issue.

[249] It is not clear whether adverse findings were made against all of these doctors as their names were suppressed at the time.

[250] Helen Turnbull, 'The Perfect Storm: A Case of Wrong-Sided Surgery', *Health Workforce Governance* (Ashgate Publisher Surrey England, 2012).

2.5 Inherent contradictions in protecting the public

The National Law is a very comprehensive piece of legislation. Objective 2 (a) of the National Law simply provides that 'the protection of the public' [251] is ensured by allowing only health practitioners who are 'suitably trained and qualified to practise in a competent and ethical manner' are registered. The National Law provides under the objectives and guiding principles that:

> *(2) The objectives of the national registration and accreditation scheme are−*
>
> > *(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.*[252]

Under the old State and Territory laws the protection of the public was also a key objective in the laws.[253] As noted in Chapter 1, in both New South Wales and Queensland under the National Law[254] the health and safety of the public are a paramount guiding principle. When the *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) was enacted it contained an additional provision, s 3A titled 'Objective and guiding principle [New South Wales]', which reads:

> *In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.*[255]

Queensland adopted this provision into the *Health Ombudsman Act 2013* (Qld). s 4(1) states that:

> The main principle for administering this Act is that the health and safety of the public are paramount.[256]

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[251] Or as noted earlier the health and safety of the public.

[252] The National Law s 3.

[253] See Appendix C.

[254] As discussed in Chapter 2 each state has its own version of the National Law.

[255] There is no mention in the Second Reading speech as to why New South Wales added this extra provision. <http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/1d4800a7a88cc2abca256e9800121f01/a7b62adad14778d5ca25765c00160664?OpenDocument>.

The Queensland Health Practitioner Regulation National Law (Queensland) also provides:

> *3A Paramount guiding principle*
>
> *The main principle for administering this Act is that the health*
>
> *and safety of the public are paramount.*

These provisions make it clear that the protection of the public takes precedence over the other objectives in the law in New South Wales and Queensland. Whilst this may be the intention of the National Law, which applies in the other States and Territories, this intention is not made explicit in their legislation. Although the National Law omits any reference to the protection of the profession, as Mendelson notes,[257] when the phrase 'the protection of the public' is discussed in the caselaw, the protection of the profession is also often mentioned, as further discussed below.

Significantly, there is no reference in the objectives of the National Law to impairment or the health of the doctor, in spite of the provisions that refer to impairment and health.[258]

The general objectives and guiding principles include:

> *3. Objectives and guiding principles*
>
> *(1) The object of this Law is to establish a national registration and accreditation scheme for−*
>
> *(a) the regulation of health practitioners; and*
>
> *(b) the registration of students undertaking−*

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256 The Act will see Queensland become a co-regulatory jurisdiction.This will not affect the national registration of health practitioners, but enables Queensland to vary how Part 8 of the National Law (Health, Performance and Conduct) applies in Queensland and the disciplinary arrangements for registered health practitioners <https://www.asapo.org.au/archives/govtPolicy/OHOQldNewHealthComplaintsManagement.pdf>.

257 Mendelson, 'Disciplinary Proceedings for Inappropriate Prescriptions', above n 134.

258 These provisions are also referred to in Chapters 5 and 6.

(i) programs of study that provide a qualification for registration in a health profession; or

(ii) clinical training in a health profession.

(2) The objectives of the national registration and accreditation scheme are–

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.[259]

As already noted, there are tensions between the explicit role of public protection and the implicit goal of rehabilitation leading Elkin to ask:

> Quite simply: is access to a doctor who represents an elevated risk to the public preferable to having no doctor at all?[260]

[259] Objective (f) is the 'supply' provision referred to in Chapter 1.

[260] Issues such as this are particularly difficult to resolve in rural and other areas poorly resourced by doctors.

The guiding principles of the scheme explicitly state that it is to operate in a fair and transparent way and that restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.[261] These restrictions usually involve the imposition of protective orders by panels or tribunals, such as supervision of a doctor's practice or attending a psychiatrist for treatment, and are further discussed throughout this thesis.

The rationale for protective orders was considered in a sexual misconduct case in New South Wales where a doctor was deregistered. The Tribunal said:

> In the exercise of its functions under the Act for the paramount purpose of protecting the health and safety of the public, the Tribunal may consider five matters bearing on protection:
>
> (1) Any need to protect the public against further misconduct by the practitioner.
> (2) The need to protect the public through general deterrence (of other practitioners).
> (3) The need to protect the public by reinforcing high professional standards and denouncing transgressions.
> (4) The maintenance of public confidence in the profession.
> (5) The desirability of making available to the public any special skills possessed by the practitioner.[262]

Just like the National Law it makes no reference to the rehabilitation of doctors as a means of protecting the public. And, as noted in Chapter 1, to state that the purpose of

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[261]s 3 (3) (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way; (b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme; (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality

[261]s 3 (3) (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way; (b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme; (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality

*Erratum. The author is aware that this footnote may appear twice but attempts to correct it or have it corrected have not been successful.

[262] *Re Dr Paraju1i* (2010) NSWMT 3.

medical professional regulation is to protect the public is somewhat simplistic, and considerations of purpose at one stage may differ at another stage. [263]

The 'slippage' in the discourse about public protection thus clearly provides one of the avenues through which a doctor's conduct may be medicalised. As noted in Chapter 1, the phrase 'the public' is not confined to just patients and potential patients. [264] It can also refer to the public at large. Elkin refers to the challenge in identifying 'the public'

> ... there is no singular public; publics have many different interests that change and compete from one situation to another. It seems that the profession's enabling legislation is the place to start when attempting to determine the public interest[265]

Although the above quotation refers to the 'public interest' it is also relevant to the determination of what is meant by 'the protection of the public'. As already noted the National Law does not assist in this respect. This thesis argues that the amorphous nature of the terms 'protection' and 'the public' and the lack of definition of what is meant by the protection of the public thus allows tribunals to interpret 'the protection of the public' to include doctors in need of rehabilitation. Whether this rehabilitation should occur under the umbrella of the National Law is an issue which is further discussed in Chapters 6 and 8.

In the Tribunal decisions considered in this thesis the Tribunals generally did not give detailed consideration to the meaning of 'the protection of the public' and assumed that the imposition of conditions upon a doctor's registration were protective of the public. However a recent New South Wales case (referred to in Chapter 1) which considered the meaning of 'protecting the health and safety of the public' rejected the imposition of conditions upon the doctor's registration[266] The facts in the case help explain the reasoning of the Court of Appeal. In *Do*, these facts revealed that Dr Do had

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[263] Elkin, *Protecting the Public?,* above n 9, 699.

[264] *Health Care Complaints Commission v Do* [2014] NSWCA 307 refers to potential patients when referring to 'the public'.

[265] Elkin, *Protecting the Public,* above n 9, citing Jordan Max and Monique Taylor, 'Defining the Public Interest: Part I' (2006) (Sept/Oct) *Engineering Dimensions,* 50-51.

[266] *Health Care Complaints Commission v Do* [2014] NSWCA 307 (4 September 2014).

treated her drug dependent de facto partner with drugs of addiction and restricted substances and that he had died from an overdose. Dr Do was found guilty of professional misconduct, but at the time of the Tribunal hearing she was no longer registered. The Tribunal declined to disqualify her but imposed conditions including education and counselling, before she could apply for re-registration.[267] The decision was appealed. Among the issues for determination on the appeal were whether in not disqualifying Dr Do the Tribunal gave proper consideration to the full scope of the objective of protecting the health and safety of the public. The Court of Appeal found that the Tribunal did not give proper consideration to this objective and that Dr Do's departure from acceptable medical practice required her to be marked publicly as justifying cancellation of her registration and that she be disqualified from being registered for a period of time The decision was appealed, as noted in Chapter 1.

The nebulous phrase 'upholding public confidence in the standards of the profession' referred to in *Do* is also clearly protective of the profession. However, it is clear in the Court of Appeal decision that being protective of the profession does not extend to a rehabilitative approach, which was arguably reflected in the Tribunal's earlier decision that Dr Do not be deregistered but receives education and counselling before applying for re-registration.

Significantly in *Do* the Court also said:

> [39] In concluding that the public could be protected adequately by the imposition of conditions which had to be complied with before the respondent could reapply for registration, the Tribunal focused only on the protection of the public from further malpractice or misconduct of the respondent. It did not address at all the public interest in having the respondent's conduct denounced as unacceptable. Nor did it address the full implications of its finding that the respondent's conduct, although contained or confined, had revealed her 'knowledge, skill and judgment in the practice of medicine' to be significantly below the standard reasonably to be expected of a practitioner of her level of training and experience.

[267] *Health Practitioner Regulation National Law* (NSW) s 149A (3). See also s 149C (4).

> [40] In not addressing these matters the Tribunal failed to give proper consideration to the full scope of the objective of protecting the health and safety of the public, as it was required to do by ss 3A and 4 of the National Law. It follows that the Commission's principal argument should be upheld and that this Court must re-exercise the Tribunal's disciplinary power in the light of the Tribunal's earlier findings.[268]

The decision in *Do* may foreshadow a retreat from a rehabilitative approach. As it is a very recent decision it is too early to tell.

2.5.1 Conspicuous by omission – the protection of the profession

Although there is no explicit mention of the protection of the profession in the objectives of the National Law, the principle is well recognised in the caselaw. In the case of *Litchfield*, which involved sexual misconduct in relation to three women, the Tribunal had suspended the doctor from practice and placed conditions upon his registration. On appeal the HCCC successfully argued that he should be deregistered. Inter alia,[269] the Court of Appeal said:

> Disciplinary proceedings against members of a profession are intended to maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the profession.[270]

Mendelson, in her analysis of 32 cases of inappropriate prescribing, notes the differences between the caselaw and the National Law in relation to the protection of the profession.[271] She points out that the National Law omits the principles referred to in *Do*, cited above, and other cases of ‘upholding public confidence in the standards of

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[268] *Health Care Complaints Commission v Do* [2014] NSWCA 307 (4 September 2014). As the case is a New South Wales case it is important to note that it is not necessarily binding on the other states as New South Wales is not part of the national scheme in relation to regulation, as noted above, and also has a different definition of professional misconduct as discussed below. None of the decisions in this study referred to this case.

[269] The doctor had been acquitted on criminal charges arising from the same facts as the third complaint and he cross-appealed contending that the disciplinary proceedings in respect of that complaint should have been dismissed because they involved double jeopardy. See, *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297 (1997) 41 NSWLR 630 [638].

[270] *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297 (1997) 41 NSWLR 630 [638].

[271] Mendelson, ‘Disciplinary Proceedings for Inappropriate Prescription’, above n 134, 255.

the profession'.[272] Mendelson also notes that the principle of deterrence in protective orders, is omitted in the National Law:

> The omission of both from the legislative scheme raises an inference that these common law doctrines are no longer major, let alone paramount considerations. In fact, statutory developments raise doubt regarding the continuing relevance of the specific and general deterrence as rationales for disciplinary determinations.[273]

The lack of explicit reference to the protection of the profession in the objectives of the National Law thus allows considerable discretion to tribunals to interpret protection of the profession as involving the rehabilitation of problem doctors.[274]

2.5.2 Conspicuous by omission – the health of doctors

Even more conspicuous by its omission is any reference in the actual objectives of the National Law to the health of doctors, in spite of the provisions for health assessments, health programs and the mandatory reporting and impairment provisions under the law,[275] which clearly imply or state that a doctor with a health problem or an impairment may pose a risk to the public.[276] The health provisions also indicate the therapeutic intention of the law. Whilst the health and safety of the public is a

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[272] Mendelson also highlights another important inconsistency between the case law and the National Law in relation to the principles referred to in protective orders:

> …selective privileging of common law doctrines over the statutory principles in relation to disciplinary proceedings results in internal inconsistencies that profoundly impair the fairness of the National Registration and Accreditation Scheme.

[273] Mendelson, 'Disciplinary Proceedings for Inappropriate Prescription', above n 134. As Mendelson notes, the decision in *Do* refers to a sanction borrowed from the criminal jurisdiction, that of deterrence. She raises questions about the appropriateness of utilising common criminal law theories of punishment and deterrence in disciplinary tribunals. Mendelson further argues that the selective privileging of criminal law doctrines such as deterrence over the statutory principles in the law results in internal inconsistencies that profoundly impact upon the fairness of the National Registration and Accreditation Scheme. She does not elucidate this unfairness but it is arguable that a lack of consistency may also lead to unfairness in decision-making.

[274] Ibid. Mendelson also notes that the lack of explicit reference in the law to the protection of the profession results in internal inconsistencies.

[275] See Division 9 of the National Law The definition in s 5 of the law states that 'health program' means a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence.

[276] As indicated in the definition of impairment, see above n 5.

paramount consideration[277] it is arguable that the health and safety of doctors to practise medicine should also be recognised in the objectives. This omission indicates the tension in the law between its implicit objective of rehabilitating doctors and its explicit objective of protecting the public.

2.5.3 Mandatory reporting

This tension is also reflected in the mandatory reporting provisions. Section 140 of the National Law provides that a doctor must make a notification about a colleague who may be placing the public at risk because of intoxication, drugs, sexual misconduct or impairment, or a doctor who departs significantly from professional standards.[278]

In all states other than Western Australia and Queensland, the obligation to report to AHPRA under s 141 applies equally to a practitioner's treating health practitioner. In Western Australia there is a blanket exemption for treating practitioners.[279] In Queensland, there is an exemption for treating practitioners where the treating practitioner does not believe the public is at substantial risk or there is professional misconduct.[280] It is also important to recognise that the threshold for mandatory reporting is quite high. An impairment in and of itself is not grounds for a mandatory report. Rather, there needs to be a reasonable belief that the practitioner has placed the public at risk of substantial harm in the practitioner's professional practice because of their impairment.[281]

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[277] As already noted, specifically in New South Wales and Queensland.

[278] The National Law provides 140 Definition of notifiable conduct

In this Division–

notifiable conduct, in relation to a registered health practitioner, means the practitioner has –

> (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
>
> (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
>
> (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
>
> (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

[279] s 141(4)(da) of the *Health Practitioner Regulation National Law* (WA).

[280] s 141(5) of the *Health Practitioner Regulation National Law* (Qld).

[281] The mandatory notification requirement applies not only to registered health practitioners but also to employers of registered health practitioners and, in the context of students, to education providers. The

As noted in Chapter 1, mandatory reporting is a very controversial issue and there is a developing body of literature in this area.[282] A recent review of the international literature found that compulsory notification appeared to be counterproductive, even taking into account the inherent limitations of the studies.[283] The review also noted a dearth of literature supporting the opposing view, namely that such reporting 'was either beneficial to the medical practitioners who were identified through mandatory reporting or was protective of the society in which they operated.'[284] The debates and historical and legal background to mandatory reporting in Australia are carefully reviewed by Goiran et al.[285] One of the most common arguments against such reporting is that it may compromise the relationship between a treating doctor and his patient and that impaired doctors might avoid seeking treatment on the basis that they could be reported.

Parker refutes claims concerning the negative consequences of mandatory reporting, and states that they lack supporting evidence, and that the medical profession should "cease huffing and puffing and throwing its weight around" and engage in more coherent efforts to ensure the welfare and safety of patients. [286] However when the National Law was adopted in Western Australia on 18 October 2010, the Western Australian Parliament amended it to include an additional category of exemption from the requirement for mandatory notification of a fellow health practitioner or student where 'the first health practitioner forms the reasonable belief' as to the notifiable conduct or impairment 'in the course of providing health services to the second health practitioner or student'.[287] Three years later, in 2013, the *Health Practitioner National Law Act 2009* (Qld) was also amended. The amendment at s 141 states that:

National Law provides some exemptions from the requirement for mandatory notification in s 141(4). These include health practitioners who are engaged by or providing advice to a professional indemnity insurer and health practitioners who know that AHPRA has been notified.

[282] See, eg, P Komesaroff, 'Protecting the Community or Increasing the Risk?' 44 *Journal of Internal Medicine* 1154. MM Bismark, JM Morris and C Clarke, 'Mandatory Reporting of Impaired Medical Practitioners: Protecting Patients, Supporting Practitioners' (2014) 44 *Journal of Internal Medicine* 1161–1165.

[283] RG Beran, 'Mandatory notification of impaired doctors', (2014) 44, *Internal Medicine Journal,* 1161.

[284] Ibid.

[285] Goiran et al, above n 7.

[286] M Parker, 'Embracing the New Professionalism: Self-regulation, Mandatory Reporting and Their Discontents' (2011) 18 *Journal of Law and Medicine* 462 (Bioethical Issues).

[287] *Health Practitioner Regulation National Law Act 2010* (WA), s 4(7).

> The National Law does not apply in relation to a second health practitioner's notifiable conduct if the first health practitioner–
>
> (i) forms the reasonable belief as a result of providing a health service to the second health practitioner; and
> (ii) reasonably believes that the notifiable conduct -
> (iii) relates to an impairment which will not place the public at substantial risk of harm; and
> (iv) is not professional misconduct.

But, as Goiran et al note:

> While this may appear to align more closely with the Western Australian amendment, it does not have the same effect. The wording does little more than restate that a treating doctor does not need to report a doctor-patient if there is no risk of substantial harm or professional misconduct. This amendment does not give the treating doctor an exemption from the mandatory obligation to report notifiable conduct. As it stands, it will not remove concerns raised about the impact of mandatory reporting on health access.[288]

As the case of Dr Gassy, mentioned in Chapter 1, clearly demonstrates, a notification (whether mandatory or not) may exacerbate an impairment and clearly illustrates the complexity involved in managing a doctor with a delusional condition. The regulator or other doctors may become part of the delusion or of a perceived conspiracy against the doctor.

Whilst the mandatory notification provisions are clearly intended to protect the public and also the doctor, the provisions clearly embody inherent contradictions within the law which may undermine the protection of the public by driving impaired doctors 'underground' for fear of being reported. Doctors have always been under an ethical duty to report colleagues who may place the public at risk. It has been argued that doctors have a right to confidential care without being concerned that they will be

[288] Goiran et al, above n 7, 220.

reported, and that the ethical obligation (rather than a legal obligation) may provide an easier therapeutic space for this doctor-patient relationship.[289]

Komesaroff raises another important issue, which he refers to as 'ethical competency'. Ethical competency depends on the ability to engage freely in ethical discussion, to take into account relevant issues, arguments and possibilities and to arrive at uncoerced decisions to which people are prepared to commit themselves, and:

> The cultivation of such an ability, or 'ethical competency', provides an important resource by which professional practices are adapted to the specific, infinitely variable needs that arise unpredictably and idiosyncratically in the course of everyday life.[290]

Komesaroff argues that mandatory reporting threatens to erode ethical competency and 'to deplete the ability of the participants in clinical dialogues to negotiate the nuances of decisions or courses of action in relation to the peculiarities and specificity of local context and conditions'.[291] Whilst this may be an unintended consequence of the mandatory reporting provisions, it is an important consideration, as the undermining of ethical competency may also undermine the protection of the public.

Clearly the mandatory reporting provisions in the National Law provide a shield for doctors who do report concerns about colleagues. The issues are extremely complex in terms of public protection, and further research is needed to see whether the provisions are more protective of the public than simply relying upon doctors' ethical obligations. Further research is also needed to examine whether doctors make reports about their colleagues because they are required to under the National Law, or because of their own ethical and professional concerns about their colleagues irrespective of the National Law. Mandatory reporting clearly has the capacity to undermine the protection of the public in that it may drive impaired doctors underground, compromise the treating relationship between doctor and patient, and undermine the ethical competency of doctors.

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[289] Ibid 219.

[290] Komesaroff, above n 282.

[291] Ibid.

2.6 The exercise of discretion – the gatekeepers

As noted above, there are health and impairment provisions within the National Law that allow for a medical approach to misconduct. There are also a number of other avenues that achieve the same purpose. A complex and intricate network of factors interacts in bringing a matter to a tribunal, and discretion may be exercised at any point along the way. As Sparrow notes, the nature and quality of regulatory practice hinges on which law regulators choose to enforce, how they use their discretion and their choice of methods for ensuring compliance.[292] The ways in which the exercise of discretion may operate in the criminal justice system is well recognised,[293] and it also operates in a similar way in disciplinary proceedings.

> To structure or confine discretion at one point in the system without attention to the way the discretionary behaviour is shaped in response to, or in anticipation of, the behaviour of others, leads to the phenomenon of displacement. Squeeze in one place and, like toothpaste, discretion will emerge in another.[294]

As the authors note, 'discretion is not something which is logically separable from what surrounds it in the processing of cases'.[295] In the journey of a complaint or notification towards a tribunal therefore, a decision may be made, for example, to refer a matter down a health, performance or conduct pathway. It is important to note that these pathways imply clear discernible boundaries between health, performance and conduct, when in reality the boundaries are often blurred. For example, a poorly performing doctor may be suffering from an undiagnosed impairment but be referred down a performance pathway, or an incompetent doctor may be referred to an impairment program. Gatekeepers play an important role in this process, as outlined below.

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[292] Malcolm K Sparrow, *The Regulatory Craft* (Brookings Institute Press, 2000) 2.

[293] R Baldwin and K Hawkins, 'Discretionary Justice: Davis Reconsidered' (1984) Winter *Public Law*.

[294] Ibid.

[295] Ibid.

2.7 Health, performance and conduct pathways

Part 8 of the Health Practitioner Regulation National Law deals with the health, performance and conduct of doctors. The different streams are usefully described in the review of the law currently being undertaken in New South Wales.[296] In order to elucidate how and where discretion may be exercised under the National Law it is necessary to briefly outline the pathways to disciplinary proceedings, which are set out on the AHPRA website.[297] As the website notes, after a complaint or notification is received, an assessment is made to see if the concerns raised can be quickly and easily addressed and if not, to make sure they are dealt with in the most effective way possible.

The initial health assessor has an important role in the determination of how a complaint is managed. More information about a doctor may be sought through a performance

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[296] <http://www.health.nsw.gov.au/legislation/Documents/Discussion-Paper-National-Law.pdf >.

According to the review at 3.4.1 the conduct stream operates through NSW Civil and Administrative Tribunal (Tribunal) hearings for all professions; Professional Standards Committee (PSC) hearings for the medical profession and the nursing and midwifery professions; and through NSW Tribunal hearings and Council disciplinary inquiries for all professions other than medical, nursing and midwifery. The conduct stream deals with complaints against health practitioners that relate to lower level allegations of unsatisfactory professional conduct as well as higher-level allegations of professional misconduct.

The medical, nursing and midwifery professions have access to Professional Standards Committees to deal with lower level complaints relating to conduct matters. PSCs are intended to provide a less formal and legalistic alternative to Tribunal hearings to deal with lower level complaints. There are a number of differences between PSCs and Tribunal hearings, including:

- PSCs cannot make findings of professional misconduct and therefore cannot suspend or cancel a practitioner's registration (although they can make recommendations regarding suspension or cancellation);
- PSCs cannot award costs; and
- appeals are to the Tribunal rather than to the Supreme Court.

The performance stream operates through performance assessments and performance review panels in all professions. The performance program is designed to provide an environment in which individual performance deficits, not amounting to unsatisfactory professional conduct, can be identified and addressed in a supportive environment. The performance program has continued largely unchanged since its introduction and allows a Council to require a practitioner to undergo a performance assessment if a Council considers a practitioner's professional performance may be unsatisfactory. Matters that raise significant issues of public health or safety or raise a prima facie case of professional misconduct cannot be dealt with by way of a performance assessment. Following the assessment, an assessor assesses the performance of the practitioner and provides a report to the Council. The Council can then take a variety of different actions, including deciding to take no further action, refer the matter to a Performance Review Panel or order the practitioner to undertake counselling.

The health stream operates through impaired registrants panels, with conditions or suspensions being imposed (with consent) by the relevant Council, for all professions.

[297] <http://www.ahpra.gov.au/Notifications/The-notifications-process.aspx>.

assessment or a health assessment, which may lead to referral to a health or performance program. As noted above, a health program is defined under the National Law at s5 as a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence. These programs illustrate a proactive feature of the law in that they aim to support poorly performing doctors so that they do not end up in disciplinary proceedings. A matter is referred to a tribunal only when the allegations involve the most serious unprofessional conduct (professional misconduct) when a Board believes suspension or cancellation of the practitioner's registration may be warranted. Some matters may only become conduct matters when health and performance programs under the law have been unsuccessful and when, after investigation, a complaint is made of unprofessional conduct or professional misconduct. For example, a doctor with an impairment may fail to comply with conditions on his or her registration, or a doctor may not perform competently in spite of supervision, and may also breach conditions on his or her registration.

It is through the initial assessment that a doctor may be diverted from disciplinary proceedings and down a health or performance pathway.[298] A National Board may require a practitioner or student to undergo a health assessment if it believes that the practitioner or student has, or may have, an impairment that may put the public at risk because it affects their ability to practise safely. The health assessment is conducted by an experienced and appropriately qualified, independent medical practitioner or psychologist who is not a member of the National Board.[299] The Board pays for the assessment and the assessor writes a report for the Board.[300] If the Board believes a doctor may be impaired or that it is appropriate to refer the matter to a panel for any reason it may establish a health panel, which must consist of at least one member of the health profession, one member with expertise relevant to the subject matter of the hearing, and one member who is not a member of the health profession. These latter

[298] It is not intended in this thesis to focus on the performance pathway as it is quite different from the health pathway and different issues are raised, such as performance assessment and revalidation.

[299] According to s 5 of the National Law a health assessment means an assessment of a person to determine whether the person has an impairment and includes a medical, physical, psychiatric or psychological examination or test of the person.

[300]<http://www.ahpra.gov.au/Notifications/The-notifications-process/Possible-outcomes/Health-assessment.aspx>.

members are often referred to as lay members.[301] In New South Wales, the doctor will follow a different process.[302] The doctor may be referred to an Impaired Registrants Panel only after assessment by a Council appointed practitioner, and the Panel must consist of at least one doctor in the same area of medicine and one other doctor.[303] There is no lay member.

Referring to a similar process that occurs under the General Medical Council in the UK when a complaint is received, Smith refers to the preliminary screener as 'a powerful gatekeeper'.[304] He notes that the assessment process has been criticised for having so much power concentrated 'in one man'[305] whose accountability is limited, and also notes the call for more laypeople to be involved in the process. In Australia, under the National Law, as is evident above, the preliminary screening of a complaint is undertaken by one person, a doctor or a psychologist. A health panel (at the second stage of the assessment process) will have a lay member (as mentioned above), but, as noted, in New South Wales there is no lay member on an Impaired Registrants Panel. The process is thus a very medical one.[306] Once a doctor on a health pathway has been referred to a Board, (and not a tribunal which involve disciplinary proceedings) the Board may place conditions upon the doctor's registration.[307]

It is in these preliminary stages before a matter reaches a tribunal that discretion is exercised. A single doctor or a few doctors play a powerful role in determining the management of other possibly impaired doctors, demonstrating how the medical model

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[301] See Sections 181 (1) and (2).

[302] When a credible notification is received, the registrant will be assessed by a Council-appointed doctor to determine the extent and nature of their impairment. They will then meet with two or three members of the Council's Impaired Registrants Panel and the action necessary to protect the public will be agreed. The most common outcome is conditions on the registrant's registration, although on occasions, it may be necessary for the registrant to be suspended for a period of time. See <http://www.mcnsw.org.au/page/doctors--performance--conduct---health/doctors--health>.

[303] The National Law (NSW) – Section 173A.

[304] Richard Smith, 'Discipline 11: The Preliminary Screener – a Powerful Gatekeeper' (1989) 298 *British Medical Journal*, 1569.

[305] Smith notes that it was always a male until February 1989 (the year his article was published).

[306] And although in a different jurisdiction not entirely unlike the principle stated in *Bolam,* a torts case that established that a responsible body of medical opinion is needed to establish that a doctor is negligent *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

[307] This may occur in both New South Wales and under the National Law elsewhere.

of misconduct may extend the profession's mandate as healers to include the management of problem doctors. Albeit with the benign intention of rehabilitation, impairment programs under the National Law are coercive, as a doctor who breaches conditions upon their registration or fails to comply with an undertaking can be referred for disciplinary proceedings. Morrow sounds a note of warning, and referring to the development of physician impairment programs in the United States points out that:

> In expanding its focus to include early diagnosis and prevention, the profession hopes to identify increasing numbers of impaired doctors at earlier stages. And yet, early identification may unduly or prematurely label the person and harm his or her personal and professional reputation. Further, early intervention combined with coercion may infringe on personal rights; threatened with referral to the state board (or loss of a place in medical school) students and doctors are not free to reject treatment and to choose help voluntarily …[308]

As Morrow notes, cases where performance is severely affected clearly warrant constructive coercion, but delineating pathology and normalcy is difficult.[309] One of the difficulties inherent in the powerful role of the gatekeeper and in the discretionary pathways under the National Law is the judgment that must be made about the degree of impairment required to indicate the necessity of intervention. One physician cautions that:

> Everyone is occasionally forgetful, careless or mildly depressed. Toe-stubbing, bad luck and fender-bender episodes can happen to any of us.[310]

Whilst another writer comments that:

> The sick doctor is a brother physician in need of help and rehabilitation in order to stay within the fold of medicine, rather than a black sheep to be

[308] Morrow, 'Doctors Helping Doctors', above n 87, 34.

[309] Ibid 35.

[310] Ibid, citing Stanford B Rossiter *The Responsibility of Colleagues in Conference Proceedings: What You Need to Know about Impairment in Physicians* (Undated) 51.

> excluded from the flock. The challenge of external surveillance has been bought off at the price of a higher level of internal surveillance.[311]

There is little research available on how impaired doctors experience the processes under the National Law in general, or the powerful role of the gatekeeper in particular.

It is clear that the National Law provides a number of avenues for conduct to be medicalised. These same avenues also foster and enhance self-regulation, as is further discussed below.

2.8 Self- regulation under the National Law

As well as allowing for the medicalisation of misconduct, the health provisions play a key role in maintaining and sustaining self-regulation at a time when it has been the subject of considerable controversy.[312] It is important to note that there are many forms of self-regulation. These include the formal mechanisms of regulation referred to in Chapter 1, the development of clinical standards, guidelines and checklists endorsed by professional organisations, and individual self-regulation that focusses on the maintenance of personal professional standards by an individual practitioner.[313] Self-regulation also includes the informal mechanisms referred to by Rosenthal.[314]

Self-regulation has traditionally been seen as appropriate in professions or areas where knowledge is highly specialised and technical. Friedson noted in his landmark work that the medical profession possessed '… such an unusual degree of skill and knowledge … that non-professionals are not equipped to evaluate it or regulate it'[315] It has also been noted that:

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[311] Gerry V Stimson, 'Recent Developments in Professional Control: The Impaired Physician Movement in the USA' (1985) 7 *Sociology of Health and Illness* 141.

[312] Baggott, above n 47. Baggott refers to perceived bias in doctors 'protecting their own', and other arguments.

[313] Turnbull, above n 250, 261.

[314] Rosenthal, *The Incompetent Doctor,* above n 81.

[315] Eric Freidson, *Profession of Medicine A Study of the Sociology of Applied Knowledge* (Harper and Rowe, 1970). Another writer argues that 'areas of professional judgment present special problems of risk management and special problems for 'command' or rule based regimes of control. R Baldwin, B Hutter and H Rothstein, *Risk regulation, Management and Compliance: A Report to the BRI Inquiry* (Unpublished, 2001).

> … governments … face information gaps in regulating the behaviour of professional groups … Accordingly, most systems for the regulation of health care professionals rely upon self-regulation: placing the control of behaviour essentially in the hands of the professional group itself. [316]

The arguments both for and against self-regulation are well documented.[317] As noted in Chapter 1, Morrow argues convincingly that concern with physician impairment signals a change in professional self-governance.[318] This governance had previously been educationally oriented, such as in continuing education programs or focussed on disciplinary proceedings that emphasised moral weakness. According to Morrow:

> The growing tendency to interpret deviations from the rules of good medical care and professional conduct as a symptom or outcome of illness, and the establishment of programs to control these deviations by 'treating' their underlying cause, signify the medicalisation of professional social control.[319]

The powers that were enshrined in the old system of self-regulation have now been challenged, with lay members sitting on disciplinary bodies and opening up the closed shop of medicine to more public scrutiny.[320] The increased lay element on regulatory bodies helps to counter the charge that professional self-interests are being pursued

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[316] Michele Mekel, 'Emerging Issues In Health Care Regulation: Protecting Patients or Punishing Providers?' (2010) 33 *Journal of Legal Medicine.* Elkin, *Protecting the public?,* above n 9 citing Carolyn Hughes Tuohy, *Governance and Accountability in the Ontario Health Care Arena* 22-23 (2003) <http://www.law-lib.utoronto.ca/investing/eports/rp48.pdf>.

[317] Baggott, above n 47. Baggott succinctly sets out the arguments for and against self-regulation noting that in favour it is said that self-regulation is more effective because it enables 'insider knowledge' to be brought to bear on a problem, that it is felt to improve compliance because the regime is seen as more reasonable and acceptable to those being regulated, and finally because it is relatively 'low-cost' because of lower monitoring costs and greater flexibility in the application of rules. It is also believed to be less costly and more flexible in response to new problems. On the negative side it is seen to lack legitimacy because of perceived bias in doctors 'protecting their own', because of economic and other forms of self-interest and because it lacks accountability. Another concern about self-regulation is that it focusses mainly on individuals, when there should be an accompanying focus on the external influences on these individuals and the context in which they work.' Mekel, above n 316. It has also been noted that '…governments… face information gaps in regulating the behaviour of professional groups... Accordingly, most systems for the regulation of health care professionals rely upon self-regulation: placing the control of behaviour essentially in the hands of the professional group itself'.

[318] Morrow, 'Sick Doctors', above n 17, 93; that the medical control of problem doctors is compatible with professional values and interests.

[319] Ibid.

[320] Thomas, *The Rise and Recession of Medical Autonomy,* above n 41, 52.

unscrupulously at the expense of public welfare.[321] However, in spite of the argument that self-regulation is now an outmoded form of regulation,[322] inherent in the National Law is a significant degree of self-regulation, which in addition to the pathways described above, is most clearly illustrated in the predominantly medical membership of committees, panels and disciplinary tribunals involved in peer review processes under the law.

The principle of peer review underpins this model of regulation under which governments effectively delegate to select members of a profession, and give them statutory powers to 'self-regulate' the profession. The statutory self-regulation or peer review model enshrines the principle that a practitioner's peers are in the best position to judge what constitutes professional and unprofessional conduct.[323] It is not clear what impact increased lay membership in various regulatory forums such as tribunals has had on the protection of the public. Elkin points out the advantages of more external regulation of the profession, stating that what is important is what happens when the interests of the profession and the interests of the public come into conflict.[324] She notes that

> This is the friction point between self-regulation and state regulation. Suffice to say here that that the "hidden" agendas of a profession are much less likely to compromise public protection when the system is externally regulated and sufficiently prescriptive.[325]

The National Law thus sustains self-regulation. It does so through the definitions of unprofessional conduct and professional misconduct, which enshrine the peer review test, through its health and other pathways, and through the medical membership of various committees and tribunals which regulate doctors. The National Law clearly provides a mechanism by which problem doctors can be controlled from within the profession by other doctors. Health programs can use the medical model of misconduct

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[321] Ibid.

[322] Ibid.

[323] See Thomas, 'Peer Review as an Outmoded Model', above n 61, 57.

[324] Elkin, 'Medical Practitioner Regulation', above n 3, 685.

[325] Ibid.

to explain and manage problematic conduct, and divert doctors from disciplinary proceedings, and tribunals can impose protective orders that focus on rehabilitation rather than more severe protective orders, which, as demonstrated in Chapters 6 and 7, can undermine the protection of the public.

2.9 Therapeutic jurisprudence

It was argued above that the protection of the public has been extended to embrace the treatment and rehabilitation of doctors found guilty of misconduct. In this section it is argued that the concept of therapeutic jurisprudence is clearly implicit in the health provisions and pathways under the National Law. As noted in the Introduction to this thesis, Morrow, in referring to impairment programs in the United States, comments that 'the programs' simultaneous commitment to physician rehabilitation and public welfare confuses the purpose and justification for coercive intervention'.[326] The same confusion is apparent in the National Law with its simultaneous commitment to the protection of the public and the treatment and rehabilitation of doctors.

A central tenet in the management of impaired doctors is a form of therapeutic jurisprudence,[327] which has been defined as the 'study of the role of the law as a therapeutic agent'.[328] It has been successfully applied in both drug courts and mental health tribunals.[329] Some of its critics note its potential for paternalism and the extension of judicial and medical authority under the guise of benevolent therapeutic intervention.[330] However, generally the benefits are seen to outweigh any negative consequences. Freckelton argues strongly in favour of the potential for therapeutic jurisprudence for health practitioners boards, pointing out that it 'gives specific

[326] Morrow, 'Doctors Helping Doctors', above n 87, 37.

[327] Much of this discussion on therapeutic jurisprudence is drawn from a previous paper by this researcher: Kiel, 'Regulating Impaired Doctors', above n 136, 429.

[328] DB Wexler and BJ Winick, *Law in Therapeutic Key Developments in Therapeutic Jurisprudence* (Carolina Academic Press, 1996). Therapeutic jurisprudence provides a theoretical framework for an interdisciplinary approach to impairment, using social science and medical research to develop evidence–based strategies for treatment.

[329] Kate J.D. Diesfield, and Brian McKenna PhD, 'The unintended impact of the therapeutic intentions of the New Zealand Mental Health Review Tribunal?' *Therapeutic jurisprudence perspectives* <www.aija.org.au/TherapJurisp06/Papers/Diesfeld&McKenna.pdf> Accessed 12 July 2012.

[330] Ibid.

recognition to the health repercussions of each aspect of the operation of the law in practice … and offers the possibility for the law to draw creatively for both its processes and its outcomes from the insights of the mental health professions'.[331] However Freckelton also notes that:

> a therapeutic jurisprudence approach is predicated on a health practitioner being prepared to participate in remedial measures and in an assessment by the decision-making body that the practitioner is reclaimable … examples of predatory sexual misconduct or persistent lack of probity rarely give rise to much by way of the perception of potential for rehabilitation.[332]

Some of the cases in Chapters 6 and 7 of this thesis clearly demonstrate Freckelton's point that some doctors are not prepared to participate in remedial measures. The concept of therapeutic jurisprudence is clearly implicit in the health provisions of the National Law, which incorporate compliance-based strategies for the management of impairment, as well as poor performance, based upon persuasion rather than punishment. These strategies are said to be more effective than deterrence-based approaches in terms of preventing recidivism,[333] although as noted above the recent case of *Do*[334] may foreshadow a return to an emphasis on deterrence in protective orders. However, by allowing impaired doctors to continue in practice whilst receiving treatment, the law acts as a therapeutic agent. By placing conditions on a doctor's registration the law demonstrates the concept of 'creative compliance'. According to this theory, protective orders at the lower end of the scale, if breached, may attract more serious sanctions[335] If a doctor breaches his or her conditions, a complaint and the possibility of deregistration may follow. It has been argued that regulators are best able to secure compliance when they are 'benign big guns' and that 'the trick of successful

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[331] Freckelton, 'Disciplinary Investigations and Hearings', above n 247, 207–219.

[332] Freckelton, 'The Margins of Professional Regulation', above n 32, 153.

[333] R.G. Smith, (ed) *Health Care Crime and Regulatory Control,* The Australian Institute of Criminology (Hawkins Press 1998) 5.

[334] *Health Care Complaints Commission v Do* [2014] NSWCA 307.

[335] John Braithwaite, *Crime, Shame and Reintegration* (Cambridge University Press, 1989) 9. Braithewaite notes that the theory of reintegrative shaming explains compliance with the law by the moralising qualities of social control rather than by its repressive policies.

regulation is to establish a synergy between punishment and persuasion'.[336] Grabosky and Braithwaite argue that regulators are able to speak more softly when they carry big sticks but also possess a hierarchy of sanctions.[337] It is when persuasion fails, and doctors for example breach conditions upon their registration, that the 'benign big guns' become less benign and the 'big sticks' of disciplinary proceedings come into play. Whilst in theory Grabosky and Braithewaite's thesis is compelling, in practice the benign big guns may only come into play after significant delay, as noted in Chapter 4, 6 and 7 where the findings in this thesis are discussed. A small number of complaints involved breaches of conditions on a doctor's registration, and these were not infrequently health conditions.

The role of therapeutic jurisprudence under the National Law raises squarely the issue of whether the health of doctors should be a regulatory issue under the National Law at all, unless there is a formal complaint about impairment. This issue is further discussed in Chapters 5 and 6, which indicate marked differences between Victoria and New South Wales in terms of how impairment is managed.

2.10 Protective orders

As noted earlier, one of the guiding principles of the National Law states that 'restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate standard.[338] In the disciplinary context the synergy between persuasion and punishment is usually demonstrated in protective orders that place health conditions upon, for example, an impaired doctor's practice, such as regular drug testing if a doctor has an addiction, or psychiatric treatment for mental illness. As noted above, although many of the cases in this study were decided under former State and Territory laws, in this section only the protective orders available under the current National Law are examined. The factual circumstances of a case often determine the types of protective

[336] I Ayres and J Braithwaite, *Responsive regulation: Transcending the Deregulation Debate* (Oxford University Press New York, 1992) 25.

[337] P Grabosky, and J Braithwaite, *Of Manners Gentle: Enforcement Strategies of Australian Business Regulatory Agencies* (Oxford University Press, Melbourne, 1986).

[338] The *National Law* s 3 (2).

orders imposed by a tribunal. In sexual misconduct cases, for example, a not uncommon protective order may involve a doctor not examining a female patient unless a chaperone is present. Evidence may be heard in tribunals not only in relation to the facts of a particular case, but once findings have been made also in relation to protective orders. In a New South Wales case, the Court of Appeal found that the Tribunal had breached its duty of procedural fairness in ordering deregistration without giving the appellant the opportunity to adduce evidence and make submissions on the appropriate orders consequential on the Tribunal's findings.[339] In Chapter 7 some of the cases indicate that not all doctors comply with chaperone conditions and in one notable case, discussed below, it was stated that if a doctor needed a chaperone, he was not fit to practice.[340]

2.10.1 Factors taken into account

The National Law is silent as to the factors to be taken into account in determining protective orders, and tribunals routinely cite the protection of the public as the dominant rationale. However a number of principles have evolved from tribunal decisions, as the following case illustrates. The Tribunal said (at [128]):

> In determining the appropriate protective orders, the following factors are relevant to the consideration:
>
> (a) The seriousness of the misconduct;
>
> (b) The admissions made by the practitioner;
>
> (c) The expressed contrition and the responsibility taken by the practitioner;
>
> (d) The risk of re-offending;
>
> (e) The need for deterrence.[341]

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[339] *King v Health Care Complaints Commission* [2011] NSWCA 353 [202].

[340] *Health Care Complaints Commission v Bruce Litchfield* (New South Wales Court of Appeal) 8 August 1997.

[341] *Health Care Complaints Commission v Dr Saeid Saedlounia* [2013] NSWMT 13 (21 June 2013). The author of this thesis was a member of this particular tribunal. When Dr Saedlounia later did not comply with the supervision conditions after difficulty with the supervisor confirming their willngess to supervise, the Council considered s 150 proceedings which did not proceed after contact with the supervisor. Upon the receipt of another complaint relating to inappropriate touching of a patient in 2014, s 150 preoceedings were held, and further conditions upon Dr Saedlounia including a chaperone condition were imposed. On appeal in *Saedlounia v Medical Council of New South Wales* [2015] NSWCATOD 53 the Tribunal confirmed the conditions but restricted their application to a year.

Dr Saedlounia was an overseas trained doctor from Iran who breached the visa and practice conditions on his registration. The Tribunal having set out the above factors nevertheless rejected Dr Saedlounia's expression of contrition, stating that:

> Dr Saedlounia's expressions of contrition and remorse were guarded and glib. He sought to avoid the consequences of his conduct by claiming his breaches were due to inadvertence and misunderstandings, and a selective misinterpretation of what his conditions permitted him to do by way of professional work. The Tribunal considers that those explanations by Dr Saedlounia indicated he had difficulty in facing up to the consequences of his actions [at 131]. [342]

The Tribunal reprimanded Dr Saedlounia and again imposed conditions including supervision upon his registration. It also considered that a fine should be imposed as a strong signal of deterrence and fined him $5,500. Ironically in spite of its clear exposition in relation to protective orders, this case also demonstrates that the Tribunal's faith in conditions upon a doctor's registration was misplaced, as Dr Saedlounia subsequently breached the first set of conditions imposed.[343]

2.10.2 Rationale

Although the rationale for protective orders is repeatedly stated in the caselaw as being for the protection of the public rather than for the punishment of a doctor, it is well recognised both in the literature[344] and the caselaw that for some doctors, protective orders are punitive in effect, particularly when the doctor is deregistered, suspended or fined, as in the case above. As well as the protection of the public, the other commonly cited principles or rationales for the use of protective orders are the protection of the profession (discussed above), the upholding of professional standards, the maintenance of public confidence in the profession and both personal and general deterrence. The principle of deterrence is usually associated with more severe protective orders.

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[342] *Health Care Complaints Commission v Dr Saeid Saedlounia* [2013] NSWMT 13 (21 June 2013) [137].

[343] On appeal in *Saedlounia v Medical Council of New South Wales* [2015] NSWCATOD 53 the Tribunal confirmed the conditions but restricted their application to a year.

[344] Mendelson, 'Disciplinary proceedings against doctors', above n 134.

There is no actual evidence however as to whether this principle when invoked to justify a severe protective order actually does deter the errant doctor or other doctors from misconduct, although common sense would dictate that the threat of suspension or deregistration might deter many doctors from any form of misconduct likely to attract such sanctions. The lack of evidence in relation to the effectiveness of deterrence has also been noted in relation to civil litigation.[345] According to Elkin, whether the deterrent function is achieved is dependent on many factors, including whether the misconduct and the sanctions imposed are publicised to other members of the profession.[346] As noted above, if a doctor is reprimanded, the decision is published on the Internet, thereby 'naming and shaming' the doctor, but the impact of this publicity on the doctor and on the public is unknown.

In *Prakash v HCCC* [2006] NSWCA 153 at [91] the Court said:

> The purpose of any order consequent upon a finding that a complaint has been proved, is said to be protective of the interests of the public at large, but more particularly patients or potential patients of the practitioner concerned. However the public interests include indirectly, the standing of the medical profession and the maintenance of public confidence in the high standard of practitioners. There is also an element of deterrence or, to put it more positively, encouragement to other practitioners to recognise the importance of complying with professional standards and the risks of failing to do so.[347]

This rationale was recently affirmed in *Health Care Complaints Commission v Do* [2014] NSWCA 307, as noted above, and also in *HCCC Health Care Complaints Commission v Athour* [2014] NSWCATOD 28. Dr Athour was found guilty of unsatisfactory professional conduct and professional misconduct after he treated 14 heroin addicts with rapid opioid detoxification (a high risk treatment) without having adequate training, knowledge or experience. The Tribunal said:

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[345] Troyen Brennan, 'The Role of Regulation in Quality Improvement' (1998) 76 *The Milbank Quarterly* 709.

[346] Elkin, 'Medical Practitioner Regulation', above n 3, 112.

[347] This case involved an appeal against a decision to deregister Dr Prakash after he breached conditions upon his registration. He had a long history of dishonesty and other disciplinary proceedings.

> The purpose of disciplinary proceedings is to maintain proper ethical and professional standards in the protection of the community and also to protect the good standing and reputation of the profession and not to punish the practitioner. The public and professional colleagues must have confidence that a medical practitioner will properly and safely perform in his profession. The object of protecting the public includes deterring the practitioner from repeating his misconduct and deterring others who might be tempted to behave in a similar way (at [11]).

In imposing protective orders the Tribunal made it a critical compliance condition (critical compliance conditions are further discussed below) that Dr Athour should not undertake rapid opioid detoxification, imposed other conditions and, pursuant to the legislation, also fined him $10,000 on the basis that there was no other order, or combination of orders, that was appropriate in the public interest other than the imposition of a fine of $10,000.[348]

The principle of deterrence is often associated not only with severe protective orders, such as deregistration or suspension from practice, but as Mendelson notes, with punishment. In her careful and detailed analysis of the issue Mendelson states:

> There exists a logical inconsistency between the denial that protective orders are a punishment on the one hand, and inclusion of deterrence as one of the principal purposes of disciplinary proceedings. Despite the fact that there is no High Court authority for the latter proposition, the object of deterrence (as well as protection of the profession's standing in the community) has become a prominent feature in several judgments of medical disciplinary proceedings by civil and administrative tribunals.[349]

Clearly tribunals operate in a research vacuum in terms of whether the principle of deterrence that they invoke actually does deter doctors from misconduct. It is also not known what particular factors influence problem doctors themselves in terms of any future misconduct.

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[348] *Health Practitioner Regulation National Law* (NSW) s 149B.

[349] Mendelson, 'Disciplinary proceedings against doctors', above n 135, 268.

2.10.3 Types of orders under the National Law

The National Law allows a tribunal wide scope in terms of the orders it may impose upon a doctor found guilty of misconduct. Although they are broadly similar, the Health Practitioner Regulation National Law (Queensland)[350] and the other States and Territories have slightly different provisions from the New South Wales legislation in relation to protective orders. At s 196 (2) the National Law provides that if a practitioner is found guilty of unprofessional conduct, professional misconduct, an impairment or has falsely obtained registration it may:

(a) caution or reprimand the practitioner

(b) impose a condition on the practitioner's registration including for example -

(i) A condition requiring the practitioner to complete the further specified education or training, or to undergo counselling within a specified period; or
(ii) a condition requiring the practitioner to undertake a specified period of supervised practice; or
(iii) a condition requiring the practitioner to do, or refrain from doing, something in the practitioner's practice; or
(iv) a condition requiring the practitioner to manage the practitioner's practice in a specified way; or
(v) a condition require a the practitioner to report to a specified person at specified times the practitioner's practice; or
(vi) a condition requiring the practitioner not to employ, engage or recommend a specified person or class of persons

(c) require the practitioner to pay a fine of not more than $30,000 to the National Board that registered the practitioner[351]

(d) suspend the practitioner's registration for a specified period

(e) cancel the practitioner's registration.

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[350] *The Health Practitioner Regulation National Law* (Queensland) current at 1 July 2014.

[351] Because they are imposed almost always without reasons for the amount of the fine being given, their use is not discussed in this thesis. The fines that were imposed are noted in Appendix B, which shows that they are usually imposed in conjunction with other protective orders.

2.10.3.1 Deregistration

Clearly deregistration is the sanction which is most protective of the public in that the doctor is removed from practice. The cases involving deregistration are discussed in Chapters 6 and 7. When a doctor is de-registered a period of time is specified before the doctor can apply for re-registration. The period of time generally indicates how seriously tribunals regard the misconduct, but the precise rationale for the period chosen is rarely indicated.

2.10.3.2 Suspension from practice

Suspension from practice can be used as a severe sanction or as an interim measure to protect the public. When used as a severe sanction, although the doctor cannot practise during the period of suspension, suspension is different from deregistration. As the Tribunal noted in a sexual misconduct case which is further discussed in Chapter 7:

> The distinction between cancellation and suspension is an important one. A practitioner whose registration is cancelled must reapply to be registered and, in doing so, must satisfy the Board of their competence and fitness to practice at the time of registration. If a practitioner's registration is suspended, their status is restored once the suspension term has been served.[352]

Suspension orders are often made as an interim measure to immediately protect the public, usually after an urgent notification has been made, for example, that a doctor has been drinking or using drugs in the workplace, whilst the complaint is properly investigated.[353] There is a tension in the law when doctors are suspended from practice, as a decision to suspend a doctor involves weighing up whatever evidence is

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[352] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011).

[353] Section 150(1) of the *Health Practitioner Regulation National Law* (NSW) provides:

> 150 Suspension or conditions of registration to protect public [NSW]
>
> A Council must, if at any time it is satisfied it is appropriate to do so for the protection of the health or safety of any person or persons (whether or not a particular person or persons) or if satisfied the action is otherwise in the public interest- (a) by order suspend a registered health practitioner's or student's registration; or (b) by order impose on a registered health practitioner's registration the conditions relating to the practitioner's practising the health profession the Council considers appropriate; or (c) by order impose on a student's registration the conditions the Council considers appropriate.
>
> See also Sections 155-159 of the National Law.

immediately available that the doctor is a risk to the public against the doctor's right to remain in practice. Under the National Law, a doctor may 'show cause' as to why s/he should not be suspended[354] but in New South Wales the situation is slightly different and the doctor may apply for a review of the decision to suspend him or her from practice,[355] or appeal the decision.[356] A doctor for whom suspension is an issue is still entitled to procedural fairness. According to a recent review of the legislation in New South Wales:

> The rules of procedural fairness are flexible and adaptable to the circumstances of each individual case. Therefore while some instances may warrant a face-to-face meeting with the practitioner others may appropriately and efficiently proceed on the papers.
>
> In the National Board jurisdictions, the issue of procedural fairness is in large measure addressed by the inclusion in the National Law of a 'show cause' process whereby practitioners or students are given an opportunity to make submission.[357]

The cases involving suspension are discussed in Chapters 6 and 7.

2.10.3.3 The imposition of conditions upon a doctor's registration

As noted in Chapter 4, the imposition of conditions upon a doctor's registration was the most frequent protective order made in the Tribunal decisions in this study. This protective order is further discussed in Chapters 6 and 7, and as noted below, there are

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[354] Ibid.

[355] s 150(1) of the *Health Practitioner Regulation National Law* (NSW) provides:

> 150 Suspension or conditions of registration to protect public [NSW]
>
> A Council must, if at any time it is satisfied it is appropriate to do so for the protection of the health or safety of any person or persons (whether or not a particular person or persons) or if satisfied the action is otherwise in the public interest- (a) by order suspend a registered health practitioner's or student's registration; or (b) by order impose on a registered health practitioner's registration the conditions relating to the practitioner's practising the health profession the Council considers appropriate; or (c) by order impose on a student's registration the conditions the Council considers appropriate.

[356] s 158 *Health Practitioner Regulation National Law* (NSW).

[357] New South Wales *Health Practitioner Regulation National Law* (NSW) Statutory Review Discussion Paper. Undated but the paper states that the review is to commence five years after assent of the Act, being 19 November 2014 and the closing date for submissions was 7 August 2015.

some differences between New South Wales and the National Law in terms of the types of conditions that can be imposed.

2.10.3.4 Caution or reprimand

It is important to note that if a doctor has been reprimanded the law requires that the reprimand be recorded on the National register.[358] A caution is not recorded, and is therefore regarded as less serious than a reprimand. The reprimand remains on the register unless the National Board affirmatively decides to remove it in accordance with s 226 (3) of the National Law. Under s 226 a National Board may decide not to include or to remove certain information in the register.[359] This provision explicitly refers to impaired doctors, and reflects a tension in the law between protecting the privacy of an impaired doctor, and the public interest in knowing a doctor has been the subject of a reprimand.[360] It is arguable that this public shaming of an impaired doctor may

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[358] s 225 provides (j) if the practitioner has been reprimanded, the fact that the:

practitioner has been reprimanded;

(k) if a condition has been imposed on the practitioner's registration or the National Board has entered into an undertaking with the practitioner—

(i) if section 226(1) applies, the fact that a condition

has been imposed or an undertaking accepted; or

(ii) otherwise, details of the condition or undertaking;

(l) if the practitioner's registration is suspended, the fact that the practitioner's registration has been suspended and, if the suspension is for a specified period, the period during which the suspension applies;

[359] (1) A National Board may decide that a condition imposed on a registered health practitioner's registration, or the details of an undertaking accepted from a registered health practitioner, because the practitioner has an impairment is not to be recorded in its National Register or Specialists Register if—

(a) it is necessary to protect the practitioner's privacy; and

(b) there is no overriding public interest for the condition or the details of the undertaking to be recorded.

(2) A National Board may decide that information relating to a registered health practitioner is not to be recorded in its National Register or Specialists Register if—

(a) the practitioner asks the Board not to include the information in the register; and

(b) the Board reasonably believes the inclusion of the information in the register would present a serious risk to the health or safety of the practitioner.

(3) A National Board may decide to remove information that a registered health practitioner has been reprimanded from the National Register or Specialists Register if it considers it is no longer necessary or appropriate for the information to be recorded on the Register.

[360] It is arguable that the public shaming of an impaired doctor by the placement of his/her name on the register may also exacerbate their impairment, like mandatory notification, as discussed above.

exacerbate an impairment, in the same way as a mandatory notification might do, as discussed above.

2.10.3.5 Fines

Fines are not a common protective order. The fines that were imposed in this study are noted in Appendix B, which shows that they are usually imposed in conjunction with other protective orders, such as a reprimand, without reasons for the amount of the fine being given. It is difficult to discern why fines are imposed in some cases and not others if they are intended to have a deterrent effect. As Mendelson notes in her study, the 'tenuous connection between the statutory objectives and the imposition of fines on doctors who abuse controlled drugs may explain why such measures are relatively rare'.[361] The imposition of fines would be more consonant with the objective of protecting the public if there were a more explicit statement in the Tribunal decisions both in relation to the rationale for the fines imposed and the amounts of the fine, which appear to be chosen quite arbitrarily.

2.10.3.6 Some differences in New South Wales

The Health Practitioner Regulation National Law in New South Wales has slightly different provisions to the National Law in two other important respects, in that firstly, it specifically refers to psychiatric treatment, and secondly, it also has provision for 'critical compliance conditions'.

Section 149A provides

> 149A General powers to caution, reprimand, counsel etc. [NSW]
>
> (1) The Tribunal may do any one or more of the following in relation to the registered health practitioner-
>
> (a) caution or reprimand the practitioner;
>
> (b) impose the conditions it considers appropriate on the practitioner's registration;
>
> (c) order the practitioner to seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

[361] Mendelson, 'Disciplinary proceedings for inappropriate prescription', above n 134, 39.

(d) order the practitioner to complete an educational course specified by the Tribunal;

(e) order the practitioner to report on the practitioner's practice at the times, in the way and to the persons specified by the Tribunal;

(f) order the practitioner to seek and take advice, in relation to the management of the practitioner's practice, from persons specified by the Tribunal.[362]

Quite clearly where the National Law refers to 'counselling', the New South Wales Law has a more explicit focus on treatment, as it specifically refers to psychiatric treatment. As noted in Chapter 4, New South Wales has more impaired doctors than the other states, even when the numerical differences between the states are taken into account. This issue will be further discussed in Chapters 5 and 6, but the New South Wales National Law clearly indicates a more therapeutic focus in its protective orders.

In an earlier New South Wales sexual misconduct case (not part of this study) the Court of Appeal made a significant comment about protective orders.[363] In *Litchfield* the doctor had been the subject of complaints before the Medical Tribunal that he had engaged in inappropriate sexual conduct towards three female patients. He was suspended from practice for nine months and ordered to submit to a psychiatric assessment.[364] On appeal the Commission sought an order that the doctor's name be removed from the Register.[365] It was argued that the court should overrule a previous decision in *Richter v Walton,* another sexual misconduct case,[366] where the Court of Appeal by majority had set aside the Tribunal's deregistration order and substituted an order imposing conditions prohibiting the appellant, except in the case of an emergency,

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[362] Both the National Law and the NSW law also make provisions for students as follows:

(2) The Tribunal may do any one or more of the following in relation to the student-

(a) caution or reprimand the student;

(b) impose the conditions it considers appropriate on the student's registration;

(c) order the student to seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

(d) order the student to complete an educational course specified by the Tribunal.

[363] *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297; (1997) 41 NSWLR 630 [638]. This decision is further discussed in Chapter 7.

[364] For 12 months after his suspension the doctor was to practise in a position approved by the Board.

[365] *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297; (1997) 41 NSWLR 630.

[366] *Richter v Walton* [1993] NSWCA 234.

from seeing a female patient except in the continuous presence of a female chaperone. Priestley JA had dissented. The Court in *Litchfield*, referring to *Richter*, stated that:

> The majority thus found that the appellant could not be trusted to observe proper professional standards in his conduct towards female patients unless a female chaperone was present throughout. With the greatest of respect the necessity for imposing such conditions on the appellant's registration demonstrated that he was unfit to practice medicine and in those circumstances the only appropriate order was one dismissing his appeal. The dissenting judgment of Priestley JA was entirely correct, and the majority decision should be overruled.[367]

This case is interesting because the imposition of conditions upon a doctor's registration clearly are protective of the profession as well as the public,[368] in that they allow a doctor to remain in practice. Although it is difficult to generalise, it is arguable that in other cases the necessity for imposing conditions on the doctor's registration may also demonstrate that they may be unfit to practice medicine. Mendelson notes in her study that in almost every case, except for when the doctor was deregistered, conditions and limitations on the doctor's practice were imposed.[369] These issues are further discussed in Chapters 5, 6 and 7.

2.10.4 Critical compliance conditions

Significantly the law in New South Wales also provides at s 149A that:

> (3) If the health practitioner is no longer registered, an order or direction may still be given under this section but has effect only-
>
> (a) to prevent the practitioner being registered unless the order is complied with; or
>
> (b) to require the conditions concerned to be imposed when the practitioner is registered.

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[367] *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297; (1997) 41 NSWLR 630.

[368] And continue to be a common sanction, as discussed in Chapter 5.

[369] Mendelson, 'Disciplinary Powers of Medical Practice Boards', above n 26, 260.

(4) If the Tribunal makes an order or imposes a condition on the registered health practitioner's or student's registration, the Tribunal may order that a contravention of the order or condition will result in the practitioner's or student's registration being cancelled.

(5) The order or condition concerned is then a **'critical compliance order or condition'.**

Although this condition was imposed in the case of *Athour* mentioned above,[370] in the cases discussed in this thesis this condition was not invoked, although it could arguably be used in cases where impaired doctors suffer from chronic relapsing conditions, so that if they relapse their registration is cancelled immediately, thereby protecting the public. In one impairment case involving a doctor who had an addiction, a critical compliance condition was suggested, but the Tribunal rejected it, as is further discussed in Chapter 6.[371]

2.11 How protective are protective orders?

Although protective orders are imposed by tribunals, how they are carried out is left to the discretion of bodies, such as AHPRA, and in New South Wales, the Medical Council of New South Wales. Clearly a protective order is only effective if the terms and conditions of the order are complied with. According to the AHPRA website, monitoring practitioners is one of the important ways that AHPRA helps National Boards to protect the public and manage risk to patients.[372] The website provides detailed information on a new proposed drug and alcohol screening protocol to take

[370] *HCCC Health Care Complaints Commission v Athour* [2014] NSWCATOD 28.

[371] *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012).

[372] <http://www.ahpra.gov.au/Publications/Monitoring-and-compliance.aspx>. The website states that AHPRA's monitoring and compliance team monitors health practitioners and students with limitations on their registration, or whose registration has been suspended or cancelled. This is one of the important ways that AHPRA helps National Boards to protect the public and manage risk to patients. This is consistent with our regulatory principles and is one of our responsibilities under the National Law.

Our monitoring and compliance program is designed to ensure that practitioners are complying with restrictions on their registration, or identify if they are not so we can manage any risk to patients. The program also confirms that the health practitioner or student whose registration has been suspended or cancelled is not practising their profession.

effect in mid-2015 and what may occur if the protocol is breached.[373] Drug screening and some of its inherent problems are further discussed in Chapter 5 in relation to the difficulties in monitoring impaired doctors.[374] As noted in Chapter 1, an important new initiative has commenced in relation to the monitoring of conditions. On 25 March 2015 it was announced that the Queensland Health Ombudsman and the Australian Health Practitioner Regulation Agency (AHPRA) are working together to improve the monitoring of conditions placed on registered health practitioners, according to a case review published by the Health Ombudsman.[375] The Health Professions Council of Australia[376] has also just produced a Conditions Handbook, which it states is to assist decision makers, including Tribunals, Professional Standards Committees, Performance Review Panels, Impaired Registrants Panels, and Councils to draft conditions that are clear and easy to understand, can be monitored and enforced, and are effective in protecting the public and promoting public interest.[377] Whilst this handbook has made the use of conditions more 'user-friendly' for tribunal members, it is a largely descriptive document that does not pretend to address issues such as quality and

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[373] Proposed Drug and Alcohol Screening Protocol 12 <http://www.ahpra.gov.au/Publications/Monitoring-and-compliance.aspx> The possible consequences of a confirmed breach of the requirements in the protocol include action from the Board to:

- take immediate action to protect the public, such as suspension of registration or imposition of more stringent conditions
- increase in the frequency or duration of drug and/or alcohol screening
- undertake an additional early hair test to confirm compliance
- caution the registrant
- seek cancellation of registration by the tribunal, and/or
- take any other action permissible under Part 8 of the National Law.

[374] It is not clear from the AHPRA website what time delays are involved when conditions are breached. In some cases a doctor may immediately be suspended from practice or have further conditions imposed, when the breach comes to attention, but in others the breach of conditions complaint must make its way through the system until it reaches a tribunal whilst the doctor is still practising. The website is also not particularly informative about conditions such as supervision, although there is information about this process for International Medical Graduates (known as IMGs).

[375] <http://www.oho.qld.gov.au/wp-content/uploads/2015/03/Health-Ombudsman-case-review-managing-practitioner-compliance-with-conditions-of-registration.pdf>.

[376] The HPCA provides the administrative and secretarial support to each of the 14 New South Wales Councils in their primary role to protect the public. The HPCA is self-funded from the regulatory proportion of the annual registration fees paid by health practitioners practising in NSW. The Director of the HPCA reports to the NSW Ministry of Health, and HPCA staff are employed by the Director-General of the NSW Ministry of Health. <http://www.hpca.nsw.gov.au/About-Us/default.aspx>.

[377] Seminar Medical Council of New South Wales, 1 July 2015 <http://www.mcnsw.org.au/page/resources/publications/>.

standards of supervision, which are clearly relevant to the protection of the public. These issues are clearly elucidated by Walzer, who, as noted in Chapter 1, identifies some of the pitfalls of supervision and monitoring of problem doctors by friends or colleagues.[378]

However, the Conditions Handbook referred to above, in its guide template for mentor conditions,[379] explicitly states that the doctor is:

> To nominate a registered experienced [type of specialist] to act as his/her professional mentor for approval by Medical Council of NSW's Compliance Policy – Mentoring (as varied from time to time) and as subsequently determined by the appropriate review body.[380]

Thus a doctor can nominate a friend or colleague to be his/her mentor, which may not always be in the best interest of either the doctor with conditions on their registration, the mentor who may have a conflict of interest if the doctor does not practise safely or most importantly, the public. In one of the cases in this thesis, an impaired doctor with conditions upon her registration was allowed to choose her supervisor, who was to be approved by the Medical Council of New South Wales.[381] The doctor suffered from severe depressive episodes and had inappropriately prescribed drugs to numerous

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[378] Walzer and Miltimore, 'Mandated supervision', above n 160, 565–566.

[379] As opposed to supervision conditions, which are more rigorous.

[380] <http://www.mcnsw.org.au/page/resources/publications/>. Current as at 16 June 2015, 28.

[381] *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012) [66] the conditions are set out and include:

> The practitioner is to nominate a supervisor within the next 21 days, to be approved by the Medical Council of NSW, to monitor and review her clinical practice and compliance with *(Practice)* Conditions in accordance with Level 3 Supervision as contained in the Medical Council of NSW's Guidelines for Supervision (Policy PCH 7.2). The supervisor is to be provided with a copy of the Medical Council of NSW's Policy PCH 7.2 and a copy of the any reports the Medical Council of NSW deems appropriate. To be responsible for all costs associated with the supervision arrangement. To ensure that:
>
> She and the supervisor meet on a monthly basis for at least one hour, the first meeting to occur within one month of being advised by the Medical Council of NSW that her nominated supervisor has been approved.
>
> At each meeting they address medical record reviews, workload, clinical outcomes, patient follow up, boundary issues, communication skills, overall patient care and management, substance abuse and appropriate prescribing practices.

It is not clear from the Council website how supervising doctors are approved. Anecdotal information suggests that a check is made to ensure that the supervisors themselves have not been the subjects of complaints or disciplinary proceedings.

patients with addiction; however, when conditions were placed upon her registration she was allowed to nominate her own supervisor. Although the supervisor must be approved by the relevant regulatory authority, it is arguable that allowing a doctor to choose a supervisor could undermine the nature of the supervisory relationship and compromise the protection of the public. Whilst it is not clear how supervisors and monitors are actually screened by regulatory authorities, it is clear that supervision and monitoring of doctors with conditions upon their registration play a critical role in protecting the public; hence, more research is needed in this vital area.

2.12 Conclusion

Health professional regulation has been described as a proactive approach to risk and misconduct,[382] and also as reactive in that it only deals with practitioners when they come to the attention of disciplinary bodies.[383] Elements of both approaches, which are contained in the National Law, have been examined in this chapter. Disciplining doctors for misconduct is clearly reactive, whilst treating them in a diversionary health program under the law for example, can be seen as proactive. The law plays both a disciplinary and a therapeutic role and these roles may at times be in conflict with each other, and undermine the protection of the public. This chapter has shown how the concept of therapeutic jurisprudence is clearly implicit in the health provisions and pathways under the National Law and reflects a movement away from 'a prosecutory/disciplinary model of regulation where a few bad doctors are identified and blamed and then punitive sanctions are applied'.[384] Whilst the move away from a disciplinary model of regulation is well intentioned, it has been argued in this chapter that the National Law facilitates a medical model of misconduct through the health pathways, discretionary processes and the use of protective orders. Chapters 6 and 7 examine how this model may undermine the protection of the public.

[382] Thomas, *The Rise and Recession of Medical Autonomy,* above n 41, 52.

[383] Allsop, above n 17, 84.

[384] Ibid 91.

CHAPTER 3 – METHODOLOGY

3.1 Introduction

In this chapter key assumptions underpinning this research are identified and the rationale for the employment of a mixed methodology, using both quantitative and qualitative approaches, is explained. The chapter also elaborates how the framework elucidated in Chapter 1, which posits that misconduct by doctors is seen as a function of illness, can be used to inform and guide the exploration of tribunal decisions. It is argued that in spite of some inherent limitations or 'situational constraints' in the methodology and the database, the examination of impairment and sexual misconduct decisions will still reveal the extent of a therapeutic approach to misconduct.

3.2 Rationale

This research is underpinned by three key assumptions: firstly, that there is a need for a systematic analysis of disciplinary decisions in medical tribunals in order to explore how protective orders are used in the management of risk to the public, particularly in relation to impaired doctors; secondly, that a mixed methodology guided by the framework elucidated in Chapter 1 is the most appropriate way to address the research aims; and finally, that the medical model of misconduct provides an informative perspective on disciplinary decision-making which helps to identify and explain the development of impairment programs and how they function to maintain self-regulation.

Each of these assumptions will now be elucidated.

3.2.1 The need for systematic analysis of disciplinary decisions in medical tribunals

The literature on the regulation of health practitioners in general and doctors in particular is fundamental to the thesis in that it forms part of the rationale for the research, and also provides the context for it.[385] As the studies referred to in Chapter 1 indicate, there is a lack of systematic research on disciplinary tribunals across Australia.

[385] Terry Hutchinson, *Researching and Writing in Law* (Law Book Company/Thomas Reuters, 3rd Edition, 2010), 182.

The studies both justify the rationale for the present research and enrich it. Whilst these studies make an important contribution to the existing research on medical disciplinary tribunals, they also indicate the disparate nature of research in this area and are impossible to compare. In Chapter 1 it became clear that there have been no studies of how and why disciplinary tribunals utilise protective orders to manage the risk problem doctors pose to the public. An assumption underlying this research is therefore that a systematic analysis of tribunal decisions will provide new insights into this important area.

As also noted in Chapter 1, this study will in part replicate an earlier landmark study of professional misconduct by doctors, the ANZ study,[386] but with some significant differences. This study will exclude New Zealand, but include the smaller states of Australia as well as the ACT and Northern Territory. It will therefore be a national study which takes as a starting date the commencement of the National Law on 1 July 2010, although because of the delays in matters reaching a hearing, many of the cases in this study are considered complaints made under the previous State and Territory laws, as discussed below. The study will also include impairment cases that were excluded in the ANZ study, and will specifically explore the impact of a rehabilitative approach and the medicalisation of misconduct upon tribunal decision-making. The ANZ study focussed on empirical information that could be gleaned from both the decisions and other sources, such as complaints data by the use of a coding system. Unlike the intention of the present study, however, it did not closely analyse the rationale for the decisions or the protective sanctions imposed, although it reported the type of sanction, such as deregistration.

This study will also build upon a previous study by this researcher, [387] as noted in Chapter 1 which concluded that the law might contradict its own purpose of public protection when the balance tips towards the treatment and management of the doctor, rather than the impact of the doctor's conduct that may put the public at risk.[388] This conclusion is followed up in the present study in the examination of how and why

[386] Elkin et al, 'Doctors disciplined for professional misconduct' above n 2.

[387] Kiel, 'Regulating Impaired Doctors', above n 136, 429. The study concluded that it could be difficult to determine misconduct with the shadow of mental illness clouding not only an impaired doctor's judgment but the judgment of a disciplinary body as well.

[388] Ibid 435.

protective sanctions are used, and the exploration of how tribunals distinguish between misconduct and impairment.

3.2.2 A mixed methodology

The studies referred to in Chapter 1,[389] and other kinds of research discussed below inform the methodology chosen for this thesis, which will consist of different or mixed methods.[390] The different methodologies of qualitative and quantitive research were traditionally seen as being very different forms of research and the rift between the two approaches was described in terms of 'paradigm wars'.[391] Now however the two happily coexist and some writers also refer to mixed methodology as an 'integrative methodology'. This methodology is consonant with a worldview or paradigm of pragmatism, where the focus is on the problem in its social and historical context, and different forms of data collection are used to answer the research questions.[392] This methodology is therefore particularly apt for this thesis that uses different forms of data collection and where the analysis of the data is guided by Morrow's framework. There is growing recognition of the utility of mixed methods research, particularly in the health sciences.[393]

As Onwuegbuzie et al note:

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purposes of breadth and depth of understanding and corroboration.[394]

Tashakkori and Creswell define mixed methods research quite simply as follows:

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[389] Mendelson's systematic analysis, Warfe's discussion of caselaw and concepts, Stolper's mixed methodology to analyse Dutch tribunal decisions, and Manning's review of selected cases to analysis changes in decision-making in sexual misconduct cases.

[390] R.B. Onwuegbuzie, A.J Johnson and L.A Turner, 'Towards a definition of mixed methods research' (2007) 1 *Journal of Mixed Methods Research* 112.

[391] Hutchinson, above n 385, 106.

[392] Evans et al, above n 112, 276-292.

[393] Ibid.

[394] Onwuegbuzie et al, above n 390, 123.

> Research in which the investigator collects and analyses the data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry.[395]

These approaches allow for the collection of data as a springboard for a more nuanced analysis of tribunal decisions. In addition, a mixed methods way of thinking is, according to Green 'an orientation toward social inquiry that actively invites us to participate in dialogue about multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and cherished'.[396] A mixed methodology also allows a quantitative finding to generate a smaller data set for qualitative analysis. For example, an unexpected finding in this study was the number of doctors aged over 65 appearing in disciplinary proceedings. These 'older doctor' cases were analysed further, with two significant themes emerging, as discussed in the next chapter.

3.2.3 The framework as a golden thread

A framework is a useful and pragmatic guide in mixed methods studies. It assists in conceptualising the study, making design decisions and interpreting the data. [397] As noted in Chapter 1, the framework offered in the work of Morrow that is adopted in this thesis also challenges and extends analysis of disciplinary decision-making by locating it in the broader social context of the formal recognition of impairment in doctors and how this functions to keep 'deviant' doctors within the profession. It facilitates examination and interpretation of both the intended and unintended consequences of the medical model of misconduct. One of the unintended consequences of the medical model is that the rehabilitation of doctors may undermine the protection of the public.

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[395] A Tashakkori and J.W. Creswell, 'Exploring the nature of research questions in mixed methods research' (2007) *1*(3), *Journal of Mixed Methods Research*, 207–211, 10 cited in Evans, Coon and Ume, above n 117, 278.

[396] J Greene, 'Is mixed methods social inquiry a distinctive methodology?' (2008) *2*(1), *Journal of Mixed Methods Research*, 7–22. Green also states that mixed methods can nourish research 'through acknowledgment of the importance of context, recognition of both the particular and the general, identification of recurring patterns, development of insight into variation, seeking of multidimensional results that encompass both magnitude and lived experience, and achievement of neutrality balanced by advocacy.

[397] Evans et al, above n 112, 276.

Morrow provides a lens through which to make sense of tribunal decision-making not provided by a more conventional legal analysis.

3.3 A demographic profile

The construction of a database of 128 tribunal decisions over a three-year period provides not only data but also context for the systematic analysis of tribunal decisions, which follows and is further discussed below. The database facilitates the construction of a broad profile of problem doctors and also identifies the number of impaired doctors who have adverse findings made against them. A number of tables and case lists are generated from the data (see the Appendices at the end of this thesis) and are further discussed in subsequent chapters. It is important to note that only the tribunal decisions are included in the database, but where relevant any subsequent appeals from these decisions are discussed, and relevant caselaw is also referred to more generally throughout the thesis.

3.4 A qualitative methodology

Having constructed the database, a qualitative methodology is then used to facilitate a more nuanced examination of the way in which the concept of the protection of the public is diluted and transformed to embrace a therapeutic approach to problem doctors. In Denzin and Lincoln's compelling argument for qualitative research they state that:

> It is a springboard for new thought and new work, work that is fresh and sensitive and that blurs the boundaries of our disciplines, but always sharpens our understanding of the larger human project.[398]

Denzin and Lincoln talk about qualitative research in terms of 'construction' and describe their own comprehensive *Handbook of Qualitative Research* as 'a social construction, a socially enacted, co-created entity' and not a final statement on qualitative research.[399] The authors argue that 'qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter … qualitative

[398] Denzin and Lincoln, above n 119, ix.

[399] Ibid.

researchers deploy a wide range of interconnected methods, hoping always to get a better fix on the subject matter at hand'.[400] In addition to the research deficit identified in Chapter 1, it is noteworthy that there has been no research on the relationship between impairment and misconduct, and the distinction in itself is simplistic, as the boundaries between the two concepts may often be blurred. Therefore, this area particularly lends itself to an exploration of possible diversity through a qualitative analysis of relevant decisions to examine how tribunals 'draw the line' in this complex area.

McBarnet clearly demonstrates the utility of a qualitative approach in her compelling analysis of the operation of magistrates' courts. She distinguishes between the rhetoric of justice and the actual procedures and rules by which justice or legality are operationalised.[401] In a similar vein, a qualitative approach involving a close reading of each tribunal decision to identify both consistencies and inconsistencies in the findings and reasons for protective orders will allow examination of the distinction between the rhetoric of public protection and how the rhetoric is operationalised in tribunal decisions.

3.5 Doctrinal legal research

Academic legal scholars make a distinction between qualitative research and doctrinal legal research,[402] although they both involve very similar processes. The Council of Australian Law Deans stated that

> Doctrinal research, at its best, involves rigorous analysis and creative synthesis, the making of connections between seemingly disparate doctrinal strands, and

[400] Ibid 4. Denzin and Lincoln describe a qualitative researcher as a 'bricoleur' that is 'A Jack of all trades or a professional do it yourself person' and the solution 'bricolage' is a an emergent construction that changes and takes new forms as different, tools, methods and techniques are added to the puzzle'.

[401] Doreen J McBarnet, *Conviction: Law, the State and the Construction of Justice* (Macmillan Press, 1983) 163. McBarnet is speaking about the criminal justice system.

[402] Denzin and Lincoln are not legal scholars. Their backgrounds are in education, sociology and other related areas.

> the challenge of extracting general principles from an inchoate mass of primary materials.[403]

In this thesis the 128 tribunal decisions comprise the 'inchoate mass of primary materials'.

Doctrinal method according to Hutchinson, is a two-part process because it involves both finding the law and interpreting or analysing the text.[404] According to Susan Bartie, the aim of such doctrinal research is to examine the 'internal puzzles raised by the judge's reasoning process' and to 'unveil uniform principles'.[405] Clearly in this thesis it is the reasoning process of a multidisciplinary tribunal that is under scrutiny, rather than that of a single judge, but the description of the requisite process is nevertheless apposite. Doctrinal legal research can be classified as qualitative research because it is 'a process of selecting and weighing materials taking into account hierarchy and authority as well as understanding social context and interpretation'.[406] It draws on the tribunal decisions as the 'main supplier of concepts, categories and criteria'[407] but in addition it also draws upon a Morrow's work, which consists of 'concepts, categories and criteria that are not primarily borrowed from the legal system itself'.[408]

Precedents for the use of doctrinal analysis can be found in the areas of torts and corporations law, as well as in cases decided by the High Court of Australia. These precedents provide examples of how doctrinal analysis might be useful for disciplinary tribunals. For example, a study by Emma Armson reviewed 148 decisions of the first five years of the Takeovers Panel and coded the data so that a number of significant

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[403] Council of Australian Law Deans, *CALD Statement on the Nature of Research* (May and October 2005), 3.

[404] Hutchinson, above n 385, 37.

[405] Susan Bartie, 'The Lingering Core of Legal Scholarship' (2010) 30 *Legal Studies* 345–348.

[406] Ian Dobinson and Francis Johns, 'Qualitative Legal Research', in Mike McConville and Wing Hong Chui (eds) *Research Methods for Law* (Edinburgh University Press, First Indian Reprint 2013, 2007) 22.

[407] Pauline Westerman, 'Open or Autonomous? The Debate on Legal Methodology as a Reflection of the Debate on Law 94' in Mark Van Hoecke (ed), *Methodologies of Legal Research Which Kind of Method for What Kind of Discipline?* (Hart Publishing, 2011).

[408] Ibid.

trends became apparent.[409] A recent paper on High Court negligence cases analysed decisions between 2000 and 2010 and established a shift towards the imposition of greater personal responsibility on plaintiffs in most circumstances, and a substantial level of protection for public authority defendants at common law.[410] The paper clearly demonstrates how systematic analysis of cases can generate important findings for the various stakeholders involved in these cases. The authors sound a note of caution however:

> This form of study, which examines a large number of cases systematically, remains relatively rare in Australian legal research. However its novelty should not obscure its limitations. While inference and implications are drawn from the data throughout this article, the overall aim is for the data presented to stimulate discussion. As such, the statistical information presented in this article is not intended as an end in itself, but rather is provided as a foundation for more detailed consideration.[411]

Neither in the present study is the statistical information presented in the demographic profile intended as an end in itself. Rather this information, as well as providing some demographic data, is used to provide context for the detailed analysis that follows and to identify any trends in the data that may indicate the need for further research.

McBarnet notes that caselaw is discretionary and particularistic,[412] and that although there are precedents to constrain judgments, the 'open texture of law' allows wide scope in the use and application of precedent.[413] In disciplinary proceedings, the lack of definition of the key concept of 'protection of the public' reinforces the 'open texture of the law' and arguably promotes inconsistency in decision-making. A qualitative methodology, however, will allow exploration of this inconsistency and diversity, rather

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[409] Emma Armson, 'An Empirical Study of the First Five Years of the Takeovers Panel' (2005) 27 *Sydney Law Review* 665. Harold Luntz analysed High Court cases in 2003, Harold Luntz, 'Round-up of High Court of Australia in 2003' (2004) 12 *Torts Law Journal* 1. Andrew Lynch developed a methodology for measuring judicial disagreement in the High Court. See A Lynch, 'Dissent: Towards a Methodology for Measuring Judicial Disagreement in the High Court of Australia' (2002) 24 *Sydney Law Review* 471–504.

[410] Pam Stewart and Anita Stuhmcke, 'High Court Negligence Cases 2000–2010' (2014) 36 *Sydney Law Review* 585–618, 586.

[411] Ibid.

[412] McBarnet, above n 401, 163.

[413] Ibid.

than seeking standardisation. By exploring diversity in decision-making, the thesis may provide new insights into the interpretation and application of the National Law.

3.6 The database

The outcomes of tribunal decisions are readily available on the AHPRA,[414] Austlii[415] and other websites, and in published research, such as the ANZ study referred to in Chapter 1, but the rationale for the decisions can only be gleaned from a complete reading of each decision. This thesis undertakes this task in its review of 128 cases, which is further explained below.

As noted in Chapter 1 the 128 reported cases that form the database for this study comprise the reported decisions of disciplinary tribunals in which doctors have been found guilty of professional misconduct, and/or unprofessional conduct (Appendix A). Cases involving unprofessional conduct or unsatisfactory professional conduct are included as sometimes findings were made of both professional misconduct, and/or unprofessional conduct or unsatisfactory professional conduct and protective orders were considered in relation to both forms of conduct. A table was developed from this data which included the number of doctors with adverse findings against them in each State and Territory, the date of the case, where possible the delay in the case coming to hearing, the name of the doctor, the sex, age, and speciality of the doctor where provided, the nature of the complaint, whether it involved formal impairment as defined in the legislation, whether it involved psychiatric evidence, discussion about risk, and the findings and protective orders (see Appendix B).

The number of doctors who appear in disciplinary proceedings is small when seen in the context of the number of doctors registered in Australia, as noted in Chapter 1, but the database consists of all doctors with adverse findings against them in the three year period selected. Although unprofessional conduct, if proved, is a less serious finding than that of professional misconduct, which can attract the ultimate sanctions of suspension or deregistration, it is included in the present study as the less serious finding but may still attract sanctions such as conditions upon a doctor's registration

[414] Australian Health Practitioner Regulation Agency <https://www.ahpra.gov.au/>.

[415] <http://www.austlii.edu.au/>.

which are particularly relevant in impairment cases, and which are designed to protect the public. Appendix B indicates that, in a number of cases findings are made of both professional misconduct and unsatisfactory professional conduct.[416] Unprofessional conduct may involve less serious complaints such as deficiencies in record-keeping[417] whilst professional misconduct may involve more serious complaints, such as sexual misconduct or inappropriate prescribing.[418]

The three-year period from 1 July 2010 to 1 July 2013 was selected to allow as many cases as possible to be examined under the National Law and to ensure, as far as possible, a degree of consistency in exploring the application of the law. However, because of the time delay in the cases coming to hearing, 78 of the 128 cases had to be considered under the old State and Territory laws.[419] These cases are referred to by AHPRA as 'archival' cases.[420] Only 54 of the cases, less than half, were heard under the National Law (Appendix D).[421] In spite of these inconsistencies, the basic rationale of the former state laws, the protection of the public, has not changed under the National Law,[422] although as noted in Chapter 2 there are some variations in the definitions of professional misconduct under the old laws and the National Law.[423]

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[416] See Appendix A.

[417] *Health Care Complaints Commission v Woods* [2010] (15 October 2010); *Health Care Complaints Commission v Halder* [2011] NSWMT 8 (26 August 2011).

[418] *Health Care Complaints Commission v Howe* [2010] NSWMT 12 (30 September 2010); *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010).

[419] See Appendix C, which identifies the relevant legislation.

[420] *AHPRA Annual Report 2010* http://www.ahpra.gov.au/Publications.aspx.

[421] As noted in Chapter 2, the National Law itself has not achieved its goal of consistency in how doctors are regulated, with both New South Wales and now Queensland having independent mechanisms for the investigation and management of complaints. New South Wales has a different definition of professional misconduct. At the time of the cases under discussion, Queensland was operating under the old system.

[422] In Victoria, for example, the *Health Professions Registration Act 2005* provides as follows:

> 2. The main purposes of this Act are to—
>
> > (a) protect the public by providing for the registration of health practitioners and a common system of investigations into the professional conduct, professional performance and ability to practise of registered health practitioners; and
> >
> > (b) protect the public by providing for the registration of students of the health professions and investigations into the suitability of those students to undertake clinical training…

[423] See Appendix C and, eg, s 3 of the Victorian *Health Professions Registration Act 2005*.

The data was collected through the Austlii Health Practitioner Law Library website and its links to the Health Practitioner Tribunals within each Australian state, which also report cases on their own websites.[424] The cases were checked for accuracy by cross-referencing websites in each State and Territory to make sure no cases had been missed. The Medical Council of New South Wales sometimes reported cases not reported by Austlii. Some New South Wales cases were therefore accessed from that website.

3.6.1 Applying the mixed methodology

3.6.1.1 Demographic analysis

Both demographic data as well as more qualitative information about the content of the decisions reviewed was extracted both from the database and other sources. The

[424] However depending upon the State, a further search is required on the Austlii website to get to the actual decisions. Some New South Wales cases were not reported on the Austlii website but on the website of the Medical Council of New South Wales. Medical tribunal decisions can now also be accessed on the New South Wales Civil and Administrative Tribunal site <http://www.ncat.nsw.gov.au/ncat/index.html> but it is necessary to search for the Occupational Division on the main website via 'view all matter types' and then access Professional Discipline. There is also a link to the NSW caselaw website for recent NCAT decisions.

New South Wales Cases Medical Tribunal decisions for the years 2010, 2011, 2012 and 2013 were accessed on the Medical Council of NSW website <http://www.mcnsw.org.au/page/117/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/>.

Victorian Cases Decisions for the years 2010, 2011, 2012 and 2013 were accessed via the Victorian Civil and Administrative Tribunal decisions on the Austlii website: <http://www.austlii.edu.au/au/cases/vic/VCAT/>. The word 'medical' was used to scroll through the display page of cases for each year to identify relevant decisions.

Western Australian Cases Accessed Western Australia State Administrative Tribunal decisions on the Tribunal website: <http://decisions.justice.wa.gov.au/SAT/SATdcsn.nsf>. Accessed decisions for the years 2010, 2011, 2012 and 2013. Used the word 'medical' to scroll through the display page of cases for each year to identify relevant decisions.

ACT Accessed ACT Civil and Administrative Tribunal decisions on the Austlii website: <http://www.austlii.edu.au/au/cases/act/ACAT/>. Accessed decisions for the years 2010, 2011, 2012 and 2013. Used the word 'medical' to scroll through the display page of cases for each year to identify relevant decisions.

Tasmania Accessed Tasmanian Health Practitioners Tribunal decisions on the Austlii website: <http://www.austlii.edu.au/au/cases/tas/TASHPT/>. Accessed decisions for the years 2011, 2012 and 2013. Used the word 'medical' to scroll through the display page of cases for each year to identify relevant decisions. No< decisions for 2010 were available on the tribunal website: <http://www.healthpractitionerstribunal.tas.gov.au/legal_representation>.

South Australia Accessed Health Practitioners Tribunal of South Australia decisions on the Austlii website: <http://www.austlii.edu.au/au/cases/sa/SAHPT/2011/>. Accessed decisions for the years 2011, 2012 and 2013. Used the word 'medical' to scroll through the display page of cases for each year to identify relevant decisions. No decisions for 2010 were available on the tribunal website: <http://www.healthpractitionerstribunal.sa.gov.au/>.

There were no cases in the Northern Territory.

AHPRA Annual Report [425] for example, provided information about the numbers of doctors registered in each state on 30 June 2013, whilst the database table (Appendix B Master Case Table) indicated how many doctors in each state appeared in disciplinary tribunals over the three preceding years.[426] This table also provided information at a glance, which facilitated further analysis, and was also used as a check for the other tables that were generated,[427] and which are discussed in Chapter 4, which reports the main findings, and in subsequent chapters. A number of cases lists were also generated from the data and are shown in Appendix B**.**

The cases were coded according to the formal primary complaint, as well as other criteria described below. A coding system for the types of complaint was developed by a preliminary examination of the cases themselves as well as perusal of reports, such as the Annual Reports of the Australian Health Practitioner Regulation Agency, Medical Council of New South Wales, and the Health Complaints Commission, which refer to categories of complaints. Other relevant research, such as the ANZ study and a study of impairment cases in New South Wales in 2010 by this researcher were also consulted.[428] Elkin notes in her research some of the difficulties she experienced in other studies she reviewed, which included a limited recording of case and doctor characteristics, and vague and non-specific misconduct types.[429] She also noted that the specificity with which misconduct was categorised varied greatly and was typically fairly crude. An example of this was an approach to categorisation that confuses misconduct types (the actual misconduct), such as inappropriate prescribing, with the underlying reason for that misconduct, such as incompetence.[430] With these caveats in mind the data about professional misconduct and unsatisfactory conduct in the present

[425] <http://www.ahpra.gov.au/Publications/Corporate-publications/Annual-reports.aspx>.

[426] These figures are intended merely to show the very small number of doctors appearing in disciplinary proceedings.

[427] As well as Appendix B the Master Case Table, the other tables included the number of registered doctors in each state on 30 June 2013, the number of doctors disciplined in each state and territory between 1 July 2010 and 1 July 2013, the most common types of misconduct, the differences between the states in terms of common types of misconduct, and other tables and data as shown in the Appendices to this thesis.

[428] Kiel, 'Regulating Impaired Doctors', above n 136. This study indicated an important category of misconduct 'breach of conditions' frequently related to impairment. See also Helen Kiel, 'Drugs, Sex and the Risk of Recidivism' 13 *Psychiatry, Psychology and Law* 132.

[429] Elkin, *Protecting the Public,* above n 9, 133.

[430] Ibid.

study was coded according to sexual misconduct, inappropriate prescribing, inappropriate medical care, breach of conditions, impairment, and other misconduct.[431] These categories include four out of Elkin's five categories but added in breach of conditions and impairment, as the thesis aimed to explore the impairment cases and a preliminary reading of the cases indicated that a number of impaired doctors had breached conditions upon their registration. These conditions often involved health conditions, as demonstrated in Chapter 6.

There were 18 cases where the complaint actually alleged that the doctor suffered from an impairment,[432] or the doctor had been previously classified as impaired under the National Law, although the complaint itself was usually about conduct rather than impairment[433] **(**Appendix E). These cases were coded according to the main type of impairment recorded in the judgment (although a number of cases involved more than one kind of impairment) and then further explored in terms of the therapeutic approach to impairment, the use of protective orders in managing risk and how the tribunals drew the fine line between impairment and misconduct. A profile was constructed of the most common forms of misconduct by doctors and of the most common forms of impairment. The impairment profile is further discussed in Chapter 6.

In order to enable consideration of whether a therapeutic approach was also used in cases involving doctors who were not impaired, the research method was calibrated to facilitate the detailed examination of cases involving non-impaired doctors. Sexual misconduct was the most common form of misconduct (there were 34 cases Appendix F), so these cases were also extracted for exploration. Given that there were almost twice as many cases involving sexual misconduct, it was not intended to compare the two groups statistically but rather to explore the rationale for protective orders in the two groups.

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[431] This coding system differed only slightly from that used in the ANZ study which included a category 'Misconduct not in relation to a patient', which in the present study was subsumed under 'Other misconduct'. However the present study included the categories of Impairment and Breach of Conditions, which were indicated by a preliminary reading of the cases.

[432] See Chapter 6 for further discussion of thse cases.

[433] See, eg, *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010).

3.6.1.2 A qualitative and doctrinal methodology

As noted above, the analysis of the impairment and sexual misconduct cases necessitated a shift from a demographic approach, which noted some key characteristics of the cases, to an approach that was more qualitative in nature. The rationale for the use of this methodology is also elucidated above. In the present study the application of this approach meant that each case was carefully read and analysed, frequently several times, to identify any discussion of the concept of the protection of the public and the rationale for protective orders in the management of risk. This analysis and discussion is set out in the following chapters; however, any conclusions drawn must be seen in the context of the limitations of this research.

3.7 Research limitations

Denzin refers to qualitative research as the 'socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints which shape inquiry'.[434] Some of these situational constraints are described below.

3.7.1 Cases as constructions

Every case or disciplinary decision contains facts that tell an important story about a problem doctor, but does not tell the whole story. The facts of any case are 'the end-product of a process which organises and selects the available "facts" and constructs cases for and in the court room'.[435] As Charmaz notes, as a discourse, a text follows certain conventions and assumes embedded meanings[436] and '…such texts may provide useful statements about an organisation's professed images and claimed objectives - the front stage view aimed to shape its public reputation.'[437] Cases can be seen as 'dominant and elite voices in the public conversation about a social problem…[and thus] important sites of reality construction.'[438] In a similar vein, Hutchinson notes that doctrinal

[434] Denzin and Lincoln, above n 119, xi.

[435] McBarnet, above n 401, 3.

[436] Kathy Charmaz, *Constructing Grounded Theory* (SAGE Publications Ltd, 2006) 169.

[437] Ibid 38. She further notes that grounded theories of textual material can address form as well as content, audiences as well as authors, and production of the text as well as presentation of it.

[438] Ibid 39.

research focusses for the most part on privileged voices, and in relation to caselaw, the voices or versions of the truth are those of judges,[439] who in disciplinary decisions, as noted above, speak in one voice for other members of the Tribunal.

The cases that form the database for this research clearly represent the 'front stage view' of disciplinary proceedings in that they involve a selection of evidence that was before the Tribunal, but not all of the evidence. Behind the facts of each case lives a process of construction,[440] which is of necessity confined and defined by the requirements of the law. The cases rarely reveal how doctors themselves experience the regulatory system, although their experiences could provide telling insights into the strengths and limitations of the National Law. In disciplinary tribunals the 'facts' of the cases are those that are most relevant to the definition of professional misconduct or unsatisfactory conduct.[441] As McBarnet notes:

> Far from being 'the truth, the whole truth and nothing but the truth' a case is a biased construct, manipulating and editing the raw material of the witnesses' perceptions of an incident, not so much an exhaustively accurate version of what happened as one which is advantageous to one side.[442]

Thus, construction or writing of the disciplinary decisions, as well as the discussion that emerges from them in this thesis, will be like the making of a quilt in that 'the quilter stitches, edits, and puts slices of reality together'.[443] This is similar to Denzin's idea of a bricolage, which is 'an emergent construction that changes and takes new forms as different tools, methods and techniques are added to the puzzle.'[444] The analysis of the decisions therefore is limited by the facts available in the decisions and as noted below,

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[439] T Hutchinson citing WK Storey, *Writing History: A Guide for Students* (Oxford University Press, 2nd ed, 2004). In disciplinary tribunals other than New South Wales where, as noted earlier, medical tribunals are chaired by judges, the 'judges' would be the presiding members who chair the proceedings and write the decisions

[440] McBarnet, above n 401.

[441] Although the rules of evidence do not apply in disciplinary proceedings and the standard of proof is 'on the balance of probability' generally as matter of procedural fairness only evidence that is relevant to the complaint will be allowed.

[442] McBarnet, above n 401, 17.

[443] Denzin and Lincoln, above n 119, 5.

[444] Ibid.

the decisions vary in quality, degree of analysis and rationale for the findings and protective orders.

3.7.2 Inconsistencies in the data

Inconsistencies in tribunal decisions include the ways in which professional misconduct is determined, as discussed in Chapter 2. The line between error and misconduct may in some cases be a very fine one. As noted in Chapter 5, psychiatry and the law, for example, may both compete and collaborate in the discourse on risk and how it should be managed. Tribunals may fear stigmatising doctors on the basis of sex, or age or mental health issues, but vary in the extent to which this fear is reflected in decision-making. Contributing to this possible inconsistency in decision-making is the fact that the Tribunals are multi-disciplinary and their composition varies in almost every case, as does the nature of the reporting of the decisions themselves. Some decisions are more detailed and informative than others. Although most judgments are written according to a reasonably standard format, in that they set out the complaint, the background to the complaint, the evidence, some discussion of the evidence and the reasons for the findings and protective orders, there was nevertheless considerable variation in the decisions. There was also considerable variation in the inclusion of demographic information, such as the age of the doctor, and in the analysis of the conduct and various concepts within the legislation. However notwithstanding these limitations, the tribunal decisions still contain important information about how misconduct is medicalised and the use of protective orders.

3.7.3 Inconsistencies in the management of complaints

Walton reports that the tremendous variance in statutory, funding, judicial, administrative and geographic environments from state to state, along with widely divergent methods for gathering and classifying categories of disciplinary activities, preclude meaningful state-by-state comparative reporting of disciplinary statistics.[445] In this study, it is not the statistics that are the focus, but the decision-making. Valid conclusions can still be drawn. However these conclusions must be seen in the context of the variance between the states described by Walton.

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[445] Merrilyn Walton, Dr Jennifer Smith-Merry, Dr Judith Healy, and Dr Fiona McDonald 'Health Complaint Commissions in Australia: Time for a National Approach to Data Collection' (2012) 11 *Australian Review of Public Affairs* 1.

As noted above, Queensland recently followed New South Wales in developing its own system for the independent investigation of complaints. As yet there is no detailed information available as to how this variation affects which complaints are prosecuted and which are not. Because of these differences, a potential problem doctor in one state may not be referred for disciplinary proceedings when s/he might be referred in another state. This thesis does not explore this issue.

3.8 Conclusion

This chapter has identified the assumptions underpinning this research and argued that a mixed methodology guided by Morrow's framework was the most appropriate research tool for addressing the aim of the thesis. The limitations of the methodology were also elucidated. It was noted although the Tribunal decisions represent only the 'front stage' view of disciplinary proceedings, the discussion of tribunal decisions in this thesis was like the making of a quilt in that 'the quilter stitches, edits, and puts slices of reality together'.[446] In spite of the limitations in the data it was argued that the tribunal decisions could still provide important information about the extent to which a doctor's misconduct is medicalised, and how and why protective orders are used in tribunal decisions.

[446] Denzin and Lincoln, above n 119, 21.

CHAPTER 4 – FINDINGS

4.1 Introduction

In this chapter the data is analysed to identify the type of misconduct and protective orders, and relevant characteristics of the doctors disciplined in tribunals between 1 July 2010 and 1 July 2013. It also identifies any significant differences between the States and Territories in terms of the types of misconduct referred to tribunals under the National Law and former State and Territory laws. Although there are much fewer cases in the smaller States and Territories, these cases nevertheless contribute to the overall profile of misconduct that is constructed from the data. When the cases in the more populated eastern states are broken down into different types of conduct, the numbers are also small. However the information that can be gleaned from all of the cases over the three-year period nevertheless provides important information about the doctors found guilty of misconduct, and how protection of the public is managed through the use of protective orders. The fact situations behind the misconduct are extremely varied, even within particular categories. For example, as discussed in the following chapters the sexual misconduct cases reveal not only the stereotypical cases of doctors exploiting vulnerable patients, but also instances of powerful patients blackmailing doctors with the threat of disciplinary proceedings if the doctor attempts to terminate the sexual relationship. The impairment cases reveal both the loneliness and pathos that may accompany mental illness and addiction, as well as the quite devious conduct that these doctors sometimes manifest in order to support their addiction.[447] Just as the Tribunals try to manage the risk these doctors pose, the decisions reveal that many doctors end up in tribunals because they are poor risk managers themselves.

The first part of this chapter sets out the key findings from the data and the second part analyses these findings. A more detailed analysis of the findings in relation to sexual misconduct and impairment is undertaken in the following chapters in order to explore the impact of a therapeutic approach to misconduct. Because of the unexpectedly large

[447] See, eg, *Health Care Complaints Commission v Sims* [2010] NSWMT17 (30 November 2010); *Health Care Complaints Commission v Dr Roland Von Marburg* [2012] NSWMT 5 (8 May 2012).

number of cases involving older doctors, some of these cases are discussed in this chapter.

4.2 The data

The data below should be seen in the general context of the population of doctors in Australia. According to the AHPRA Annual Report 2012/2013 there were 95,690 registered medical practitioners in Australia on 30 June 2013.[448] There is significant variation in the number of registered doctors in each state and territory, making generalisations and comparisons difficult when it comes to analysing the data. When seen in the context of the number of registered doctors in each state, the number of doctors appearing in disciplinary tribunals is extremely small. Table 4.1 shows that, quite predictably, the highly populated eastern states (New South Wales, Victoria and Queensland) have significantly more doctors than the other states, with New South Wales having the highest number of doctors.[449]

Table 4.1: Number of registered doctors in each state on 30 June 2013

New South Wales	30,333
Victoria	23,402
Queensland	18,413
Western Australia	9,426
South Australia	7,403
ACT	1,894
Tasmania	2,128
Northern Territory	992
No PPP (No principal place of residence)	1,699
TOTAL	**95,690**

[448] <http://www.ahpra.gov.au/Publications/Corporate-publications/Annual-reports.aspx>.

[449] The smaller tables generated from the data are included in the body of this chapter but the longer tables and lists are appendices at the end of the thesis.

Table 4.2: Number of Doctors Disciplined in each state and territory[450]

	Number of registered doctors in each state on 30 June 2013	No disciplined between 1 July 2010 and 1 July 2013
New South Wales	30,333	64
Victoria	23,402	31
Queensland	18,413	17
Western Australia	9,426	8
South Australia	7,403	2
ACT	1,894	2
Tasmania	2,128	4
Northern Territory	992	0
TOTAL		**128**

Table 4.2 makes it clear that the numbers of doctors disciplined in tribunals in each state are a tiny proportion of the total number of doctors registered at any one time. However, as some of the scandalous cases referred to in Chapter 1 illustrate,[451] even one doctor engaging in professional misconduct can pose a serious risk to the health and safety of patients. As discussed in the previous chapter,[452] the coding was of necessity

[450] This information is taken from the AHPRA Annual Report 2012–2013, 27. This data must be interpreted cautiously as the second column refers to the number of doctors disciplined over a three-year period but it indicates that on a yearly basis the number of doctors disciplined would be even smaller.

[451] See above n 66.

[452] Chapter 3. As noted in the Methodology chapter, the cases were coded according to the date of the Tribunal decision, the name of the doctor, the sex, age and specialty of the doctor when these factors are indicated in the decisions, the type of complaint, whether there is a formal complaint of impairment, psychiatric evidence, discussion about risk, the findings and protective orders.

limited by the information available in the cases, and there was considerable variation in this respect. For example, there were differences between the cases in the inclusion of demographic information, such as the age of the doctor, and in the analysis of the conduct and various concepts within the legislation. Appendix B shows how the cases were coded initially. This table shows that 128 doctors across Australia had findings of professional misconduct or unprofessional or unsatisfactory professional conduct made against them over the three-year period between 1 July 2010 and 1 July 2013.[453] The following general information was extracted from this table. This information provides context for the more detailed analysis of the decisions that follow.

4.2.1 Age of doctor

Appendix B shows that in only 44 or approximately 34% of the 128 cases was the age of the doctor indicated. The average age was 56. According to the AHPRA Annual Report 2012/2013 the highest number of registered doctors in Australia are aged between 50 and 65. Thirty-eight per cent of registered practitioners are aged under 40, while 10% are aged over 65.[454] The ANZ study noted that on average disciplined doctors gained their medical qualification 21 years before they committed the misconduct. Thus although precise comparisons cannot be made because of the significant differences between the two studies, both in the present study and the ANZ study, the majority of doctors who appeared in disciplinary proceedings were quite experienced in terms of their years in practice. It is notable that of the 44 doctors in the present study where the age of the doctor was indicated, 14 doctors (almost a third) were aged 65 or over. Of this group, seven doctors were over 70, the oldest being 90.[455] The significance of this finding about older doctors is further discussed below.

4.2.2 Sex of doctor

19 of the 128 doctors, or almost 15%, were women, a higher number than the ANZ study in which only 9% were women and 91% were men. Of the 19 women doctors in the present study (see Appendix G) six complaints involved sexual misconduct, five

[453] A list of these cases is provided in Appendix A.

[454] In the period 2012‑2013 according to the AHPRA Annual Report 2012‑2013 the following numbers of doctors were registered between ages 65–69: 5,128; between ages 70–74: 3,071; between ages 75–79: 1,387; and 80+: 1,686 doctors were registered.

[455] *Health Care Complaints Commission v Smith* [2012] (14 September 2012).

involved inappropriate treatment, and four involved inappropriate prescribing.[456] The other four complaints involved practising without insurance, competence, breach of conditions and self-administration. These figures are similar to the most common forms of complaint in the total population of doctors as described below. As Table 4.3 indicates the proportion of male/female doctors in Australia is 40% female and 60% male.[457]

[456] See Appendix G Women doctors found guilty of misconduct.

[457] <http://www.medicalboard.gov.au/News/Statistics.aspx>. As at June 2014. Published July 2014.

Table 4.3: Medical practitioners – percentage by gender[458]

Medical practitioners – percentage by gender										
Gender	**ACT**	**NSW**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**	**No PPP**	**Total**
Female	44.64%	39.97%	48.89%	39.39%	39.03%	40.60%	41.21%	40.55%	34.10%	**40.21%**
Male	55.36%	60.03%	51.11%	60.61%	60.97%	59.40%	58.79%	59.45%	65.90%	**59.79%**

[458] <http://www.medicalboard.gov.au/News/Statistics.aspx>. As at June 2014. Published July 2014.

The findings in this study, namely that there are fewer successful complaints against women doctors, echoed the ANZ study and other studies in the US.[459] The ANZ study notes that there is no reason to assume that these overseas findings are not applicable in the present research and that women doctors in Australia, like their overseas counterparts, display more of the attributes that 'underpin a good doctor-patient relationship' leading to fewer complaints against women doctors, as noted above.

4.2.3 GP or specialist

As Appendix B shows, consistent with the ANZ study, GPs are the most frequently disciplined doctors. This is not surprising given that they are the highest occupational group of doctors. There were 94 general practitioners and 34 specialists. Of the specialists, 10 were surgeons (three of the 10 surgeons were plastic surgeons), seven were anaesthetists, five were obstetricians,[460] four were psychiatrists, and the others had a variety of specialisations. These included two paediatricians, two physicians, a urologist, a geriatrician, a neonatologist, and a cardiologist (Appendix H**)**.

These findings are somewhat different from the ANZ study, which reported obstetrics and gynaecology, and psychiatry as specialties with the highest rate of misconduct. However both of these specialties are also featured within the present study and it is important to note that the ANZ study included 485 doctors over a much longer time span (between 2000 and 2009). The high number of anaesthetists in the present study is unsurprising, and is consistent with the literature. According to Elkin in her review of overseas studies:

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[459] Elkin, 'Medical Practitioner Regulation', above n 3, 6; J Firth-Cozens, 'Doctors with Difficulties: Why so Few Women?' (2008) 84 *Journal of Postgraduate Medicine* 318. Firth-Cozens cites and summarises a number of overseas studies which include J Morrison and T Morrison, 'Psychiatrists disciplined by a State Medical Board' (2001) 158 *American Journal of Psychiatry* 474–8; LJ Donaldson, 'Doctors with problems in an NHS workforce' (1994) 308 *British Medical Journal* 1277–82. MI Taragin, AP Wilczek, E Karns et al, 'Physician demographics and the risk of medical malpractice' (1992) 93 *American Journal of Medicine* 537–42; SZ Bratland and S Hunsk˚ar, 'Medico-legal assessments of complaints against general practitioners' (2006) 126 *Tidsskr Nor Laegeforen* 166–9; P Lusilla, A Gual, B Navarro, et al, 'Gender differences among impaired doctors' International Conference on Physician Health, Ottawa, 2006; M Gallanter, D Talbott, K Gallegos, et al, 'Combined alcoholics and professional care for addicted physicians' (1990) 147 *American Journal of Psychiatry* 64–8; including a study by an Australian psychiatrist C Quadrio, 'Sex and gender and the impaired therapist' (1992) 26 *Australian and New Zealand Journal of Psychiatry* 346–63.

[460] Some decisions refer to obstetricians as obstetricians and gynaecologists as can be seen from Table 3. In fact they could also be generally classified as surgeons as obstetricians surgically deliver babies. They are classified here according to the way their occupation is described in the Tribunal decisions.

> Specialty of the doctors disciplined is not consistent across studies but psychiatrists (especially child psychiatrists), anaesthetists, obstetricians and gynaecologists, and general practitioners have all been found to be overrepresented across multiple studies.[461]

The findings in this study are therefore broadly consistent with overseas studies. However the present study did feature a higher number of surgeons. Referring in their study to the higher number of psychiatrists, obstetricians and gynaecologists, which echo findings from the US, Elkin et al argue that provider factors may play a role with, disproportionate selection into these specialties by individuals with personal characteristics that put them at elevated risk of disciplinary action.[462] They also note that:

> A rival explanation underlines the distinctive aspects of the clinical activities these specialists perform and the patient populations they serve, as independent risk factors. Although such patient factors may play a role, they are unlikely to tell the whole story.[463]

It is therefore likely that the high number of surgeons amongst the specialists disciplined for misconduct in the present study reflect to some degree both personal characteristics of the surgeons, as well as the high-risk nature of their specialties. From the decisions in this study it is impossible to identify the role each of the above factors may play, including the role of patients, in the number of surgeons found guilty of misconduct. This is an area that warrants further research.

4.3 General findings

Overall the most common form of misconduct involved sexual misconduct and inappropriate medical care. Inappropriate prescribing was also common. Appendix B indicates that between 1 July 2010 and 1 July 2013, of the 128 doctors who had findings of unprofessional conduct or professional misconduct made against them, the majority

[461] Elkin, *Protecting the Public,* above n 9, 129.

[462] Elkin, 'Medical Practitioner Regulation', above n 3, 452–456.

[463] Ibid.

involved sexual misconduct,[464] and the next largest was inappropriate medical care. These findings are consistent with the ANZ study.[465] Although the cases in this thesis are categorised according to the principal type of misconduct, there was overlap in many cases with other complaints, such as record-keeping, which are classified as 'other misconduct'. This is also consistent with the findings of the ANZ study which found that misconduct regarding medical certificates and records frequently coexisted with other forms of misconduct, and that professional misconduct was often multi-layered, rather than confined to a single breach.[466]

4.4 The most common forms of misconduct

Appendix B displays the way the cases were coded, and forms the basis of the information provided in the tables presented in this thesis. It shows (when the information was available): the date of the Tribunal decision; the delay in cases reaching a hearing; the age, sex, and specialisation of the doctor; the type of complaint in terms of the facts; whether the doctor was impaired; whether there was psychiatric evidence; discussion of risk; the findings; and the protective orders.

[464] See Appendix F for a list of cases.

[465] These results are also consistent across the most highly populated Eastern states. The smaller numbers of cases in the other states do not allow any such conclusions.

[466] Elkin, 'Medical Practitioner Regulation', above n 3, 7.

Table 4.4: Differences between the most populated states[467]

	Sexual misconduct	Inappropriate prescribing	Inappropriate medical care	Breach of conditions
NSW	28%	23%	14%	14%
Victoria	34%	23%	40%	3%
Queensland	35%	24%	35%	0%

4.5 State differences

4.5.1 Sexual misconduct

Table 4.4 shows that sexual misconduct is a more frequent finding in disciplinary proceedings in Queensland (comprising 35% of all cases) than in the other states. Sexual misconduct is also the most frequent finding in New South Wales (28%), but in Victoria it comes second, with 34% involving sexual misconduct, and 40% inappropriate medical care. It is not clear why these differences exist, but as noted in Chapter 3, there are widely divergent methods for gathering and classifying categories of disciplinary activities which preclude meaningful state-by-state comparative reporting of disciplinary statistics,[468] and it is not clear how this variation affects which complaints are prosecuted and which are not. It is also not clear how the 'gatekeepers' referred to in Chapter 2 exercise their discretion. The differences may also reflect political and ideological tensions between the states in relation to various forms of misconduct. These differences however do not undermine the findings.

[467] This table only includes the eastern states as the numbers in the other states are too small for comparative purposes. The percentages are calculated according to the number of doctors disciplined for each type of misconduct in each state against the total number of doctors disciplined in each state. The percentages are rounded out to the nearest whole number.

[468] Walton et al, above n 445.

The sexual misconduct cases raise an important question as to why this particular form of conduct is the most common in disciplinary proceedings. There are a number of possible explanations. One writer suggests that character defects may be considered less remediable than problems involving competence or inappropriate medical care.[469] Elkin et al also note that tribunals in Australia and New Zealand tend to remove doctors from practice for behaviours indicative of character flaws and lack of insight, rather than behaviours exhibiting errors in care delivery, poor clinical judgment or lack of knowledge.[470] The findings in this study support Elkin's conclusions. It may also be difficult to obtain expert evidence in relation to complaints about clinical care, as such evidence is more challenging than judgments about ethical issues.[471] In addition, allegations about inappropriate or inadequate treatment are often dealt with in medical negligence claims, which, if successful, have the added benefit for the patient of financial compensation, unlike disciplinary proceedings. It is clear that the protective orders for inappropriate care are much less stringent than the protective orders for sexual misconduct.

4.5.2 Inappropriate medical care

Appendix B indicates that 33 of the 128 cases involved inappropriate medical care.[472] Victoria had the highest number of cases, 10 (40% of cases) as opposed to nine (14%) in New South Wales. As New South Wales has approximately 7,000 more doctors than Victoria the number is significant. It appears that Victoria is far more concerned with matters involving inappropriate medical care than sexual misconduct or impairment. In Queensland six cases involved inappropriate medical care.

However both the AHPRA Annual Reports and other sources, such as the HCCC Annual Reports,[473] indicate patients complain more often about their treatment than sexual misconduct or inappropriate prescribing. This apparent anomaly between matters complained about to investigatory bodies and those that proceed to a tribunal raises the

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[469] Robert M Wachter, 'Disciplining Doctors for Misconduct: Character Matters, but so Does Competence' (2012) 21 *BMJ Quality and Safety* 976.

[470] Elkin, Spittal, Elkin and Studdert, 'Doctors Disciplined for Professional Misconduct', above n 2.

[471] Robert M Wachter, 'Disciplining Doctors for Misconduct' above n 469.

[472] See Appendix I.

[473] <http://www.hccc.nsw.gov.au/Publications/Annual-Reports>.

question of what happens to the complaints of inappropriate medical care that do not proceed to a tribunal hearing. Some of these types of complaints, if not considered serious enough to refer for disciplinary proceedings, may be referred to a health or performance pathway.[474]

4.5.3 Inappropriate prescribing

Although inappropriate prescribing[475] inevitably involves inappropriate treatment, it is considered here as a separate category of complaint because the complaints which proceed to disciplinary tribunals are framed in this way, and it is often the principal complaint. Pharmaceutical services officers often pick up these complaints when a pattern of prescribing by a particular doctor is detected by computer-generated reports.

Appendix I lists the 31 cases in all states where inappropriate prescribing was the first complaint, but inappropriate prescribing frequently co-existed with other forms of complaint. In New South Wales there are almost as many inappropriate prescribing complaints as there are sexual misconduct, where there were 34 complaints. Some complaints involve not only inappropriate prescribing to patients who are often addicts, but also self-prescribing when doctors may be impaired. These cases are discussed in Chapter 6.

Appendix M indicates that although seven doctors were deregistered for inappropriate prescribing, most had conditions placed upon their registration, five with conditions only and 15 with conditions and a reprimand. So 20 out of 31 doctors found guilty of inappropriate prescribing had conditions imposed upon their registration.

A very typical condition in the inappropriate prescribing cases is worded as follows:

> For a period of two years from this decision, the practitioner must not prescribe, supply or administer any Schedule 4D or Schedule 8 drug of addiction.[476]

In *Health Care Complaints Commission v Dr Stamatios Ktenas* (NSW Medical Tribunal, Deputy Chairperson Balla J, 21 April 2011) the Tribunal stated that the

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[474] As noted in Chapter 2 where these pathways are elucidated.

[475] In the ANZ study this is described as illegal or unethical prescribing.

[476] *Health Care Complaints Commission v Dr Ly* [2010] NSWMT 20 (15 December 2010) [23].

misprescribing of drugs of addiction is serious misconduct (at page 11) and referred to a case which is frequently cited in inappropriate prescribing cases, *Spicer v the New South Wales Medical Board* (NSW Court of Appeal Unreported 19 February 1981), where Hope J, speaking for the court, said,

> Strict adherence to the statutory requirement relating to the use of drugs of addiction is required of medical practitioners and the breadth and depth of the illicit drug problem in this community has reached alarming proportions and any medical practitioner who prescribes drugs of addiction other than in accordance with the law is seriously misconducting himself in a professional respect.

His Honour also said that,

> It is clear beyond argument that the proper handling and prescribing of drugs by medical practitioners are of the greatest importance to the community. If a medical practitioner handles or carries out that very great responsibility in a way which is reckless and which shows disregard to the law, it cannot be said that he is fit at such a time to be a medical practitioner.

However in terms of public protection, clearly in this study tribunals felt that the protection of the public was achieved by restricting a doctor's prescribing rights, consistent with the finding in Mendelson's recent study, as further discussed in the following chapter.[477] The principle espoused in Spicer is undermined by the reality that most doctors who inappropriately prescribe remain in practice.

4.5.4 Breach of conditions

Seven New South Wales cases involved complaints of breaches of conditions, with one such case in Victoria and one in Tasmania (See Appendix K). The cases in New South Wales can be explained in part by the fact that some impaired doctors breach conditions placed upon their registration,[478] and New South Wales has a high number of impaired doctors. This issue is further discussed in Chapter 6. It is important to note that there

[477] Mendelson, 'Disciplinary Proceedings for Inappropriate Prescriptions', above n 134.

[478] See, for example, *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011); *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012).

were other cases that indicated that doctors had breached conditions upon their registration in the past, but these were not pleaded as such, but rather in terms of other misconduct.[479]

Conditions upon a doctor's registration are commonly imposed in order to protect the public. Breaches of conditions therefore may fail to protect the public. In an early case outside this study the Tribunal found a doctor guilty of sexual misconduct and also guilty of breaches of conditions upon his registration that he not conduct certain surgical procedures and that he not use a scalpel.[480] He was deregistered. The Tribunal commented on the breaches of conditions as follows:

> Particularly when imposed in a disciplinary context, such restrictions are not lightly imposed nor may they be treated lightly. Any practitioner whose registration is subject to conditions could not reasonably hold any view of those conditions other than that they must be scrupulously observed. Repeated wilful breaches of conditions are treated by the Medical Tribunal as a most serious finding against a practitioner.[481]

In view of the above statement, it is surprising that 'breaches of conditions' cases are not more frequent. The histories revealed in the impairment and sexual misconduct

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[479] In a recent case involving an impaired nurse the Tribunal commented on the confusing wording in the New South Wales legislation in relation to breaches of conditions and orders. See *Health Care Complaints Commission v Perceval* [2014] NSWCATOD 38; (29 April 2014).

> 122. Section 139B (c) (i) provides that contravention of a condition, if proved, constitutes unsatisfactory professional conduct. Section 139B (d) separately provides contravention of an order of a Committee or a Tribunal, if proved, also constitutes unsatisfactory professional conduct. 'Contravene' is defined in Schedule 7 Part 3 Cl 12 as 'includes fail to comply with'. Thus, although it is necessary for the HCCC to particularise with care whether a contravention of s 139B (c) (i) is alleged, or a breach of s 139B (d), the consequences for the practitioner may not necessarily be substantially different. But we note the comments of the Court of Appeal in Prakash about the serious consequences of breach of conditions. Further, contravention of a critical compliance condition or order, if proved, it may lead to cancellation of the practitioner's registration (see 149A (4)).
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> 123. The question of whether a Tribunal imposes a condition on a practitioner's registration, or orders a practitioner to undergo medical treatment or to comply with other requirements becomes important if the practitioner seeks a review of the Tribunal's orders under s 163A (again a NSW provision of the National Law). The Tribunal has the power to review a 'relevant order' (see s 163A (b)) or an order made under Division 8. A 'relevant order' is defined as an order suspending or cancelling a practitioner's registration, or 'an order that conditions be placed on a practitioner's registration'. This wording may be considered confusing. It may be the draftsperson intended to limit a review to a review of an order imposing conditions under s 150.

[480] *Re Dr Than Le* (Medical Tribunal decision, 20 September 2001) 46 [95].

[481] *Re Dr Than Le* (Medical Tribunal decision, 20 September 2001) 46 [95].

cases in Chapters 6 and 7 indicate that doctors who breach their conditions are often given a second chance when a therapeutic approach is taken to their misconduct. Further conditions may have been placed upon their registration before they are eventually referred for disciplinary proceedings. Referral to disciplinary proceedings indicates the failure of these conditions and that public protection is being compromised.

4.5.5 Impairment

Appendix B indicates that 18 of the 128 cases (approximately 14%) involved impaired doctors and that in New South Wales significantly more impaired doctors became the subject of disciplinary proceedings than in the other states, even allowing for the higher population of doctors in this state. This finding is confirmed by the very recent study by Mendelson mentioned in Chapter 1 in relation to doctors who abuse controlled substances.[482] As Appendix E shows, in five out of 12 cases in New South Wales, there was a formal complaint of impairment, with a further seven cases involving evidence of impairment.[483] In Victoria, there were only three cases, or 8%, which involved impairment, and these cases all indicated the doctor's involvement with the Victorian Doctors Health Program, which is run independently of AHPRA and the Medical Board of Victoria. In Queensland, Western Australia[484] and South Australia there was only one case of impairment. These cases, and the differences between the states in the management of impaired doctors, are further discussed in Chapter 6. Many impaired doctors had a previous regulatory history. These cases are also discussed in Chapter 6.

4.5.6 Other misconduct

As in the ANZ study noted above, in many cases poor record-keeping co-existed with other complaints, although this was rarely the main complaint. Many of the older

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[482] Mendelson, 'Disciplinary proceedings for inappropriate prescription', above n 134. The study involved 27 doctors, 14 of whom came from New South Wales. Mendelson comments that given that Victoria is the second largest jurisdiction in Australia, the discrepancy of 10 reports between New South Wales and Victoria is puzzling. This issue is further discussed in Chapter 6.

[483] Whether 'officially' according to the definition in the legislation, or 'unofficially' in that the evidence was that their condition detrimentally affected their ability to practice medicine.

[484] *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011). In this case a formal complaint of impairment was added after the evidence had been heard.

doctors were criticised for their poor medical records.[485] Other misconduct involved a wide range of circumstances, including for example, providing a false statement,[486] being involved in a business relationship with a patient,[487] practising without insurance,[488] past criminal convictions,[489] Medicare fraud, and failure to disclose convictions,[490] a criminal conviction for accessing child pornography,[491] and running a website with information about medication termination of pregnancy without medical supervision.[492]

4.6 Protective orders

Appendix M shows that the ultimate sanction of deregistration after a finding of professional misconduct was used in 30 of the 128 cases, about 23%. These figures are lower than the ANZ study, where 43% were deregistered, but very much in line with Pauline Case's study of Fitness to Practice hearings in the UK, where 'erasure' or deregistration was used in 22% of cases.[493] As Appendix B shows, 14 doctors were deregistered for sexual misconduct, eight for inappropriate prescribing, and three (all in New South Wales) for impairment, two for inappropriate medical care, one for breach of conditions and two for other misconduct.

Twenty-two doctors were suspended and 56 doctors had conditions imposed upon their registration. 13 of the 56 had conditions only imposed, whilst 43 had conditions with a reprimand. Any appeals from these decisions where relevant are noted.[494]

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[459] *Medical Board of Australia v Van Opdenbosch* [2012] QCAT 703 (12 November 2012).

[486] *Health Care Complaints Commission v Allen* [2010] NSWMT 8 (2 July 2010).

[487] *Heath Care Complaints Commission v Dr Joseph Nicholas* [2011] NSWMT 2 (30 March 2011).

[488] *Health Care Complaints Commission v Dr Peng Seng Chan* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 9 September 2011).

[489] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012).

[490] *Medical Board of Australia v Bajpe* (Occupational and Business Regulation) [2010] VCAT 1439 (25 August 2010).

[491] *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010).

[492] *Medical Board of Australia v Dr FA* (No 2) [2012] QCAT 288 (6 July 2012).

[493] Case, above n 22, 594.

[494] However, interestingly in the UK there were a string of appeals from cases where doctors had been suspended from practice soon after the independent Medical Practitioners Tribunal Service was set up in June 2012. The cases had previously been run by the GMC, which still investigates and presents cases to

The findings show that the most common protective order was the imposition of conditions upon a doctor's registration. Appendix M shows the protective orders made in each state for the type of misconduct. It shows that deregistration is a common protective order for sexual misconduct but that, as noted above, conditions upon a doctors practice, frequently with a reprimand, are the most frequent protective order for all types of misconduct. As discussed in the following chapters, many of the conditions indicated a rehabilitative approach to misconduct. As the findings indicate that relatively few 'bad apples' in the medical profession are actually weeded out by deregistering them, much more evidence is needed to support decision-making as to the most effective and appropriate protective orders. The protective orders made in the impairment and sexual misconduct chapters are discussed in more detail in Chapters 6 and 7.

As noted in Chapters 1 and 3, there is a dearth of research on protective orders, and Walzer, an American writer, has pointed out the inherent difficulties in relation to the imposition of conditions on a doctor's practice, and that 'monitoring' of a doctor's practice is a particularly difficult duty to sell.[495] It is arguable that the imposition of conditions on a doctor's registration, such as chaperone conditions, may also undermine a doctor's 'ethical competence'[496] by imposing external constraints on conduct rather than encouraging the development of personal internal constraints.

4.6.1 Older doctors

As noted above, of the 128 doctors, 14 doctors (almost 10%) were aged 65 or over. Of this group, seven doctors were over 70, the oldest being 90.[497] Two key repeating themes become evident from these cases, a lack of insight into the misconduct and a

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the Tribunal, which are headed by a judge, and are similar to disciplinary tribunals in Australia. According to Clare Dyer, 'GMC and Vulnerable Doctors: Too Blunt an Instrument?' [2013] *British Medical Journal 347*, 'When doctors do challenge decisions in the courts, judges are holding the regulator to account, as their rulings are influencing future decisions. Interim orders panels have been issued with new guidance after a string of high court cases last year in which judges found them too ready to suspend doctors, depriving them of their livelihood when no findings had yet been made against them, at [5].This is an important area warranting much more detailed research in Australia.

[495] Walzer and Miltimore, 'Mandated supervision', above n 160, 176. As also noted in Chapter 1.

[496] As Komesaroff, above n 282, argues in relation to mandatory reporting.

[497] *Health Care Complaints Commission v Dr Robert Darlow Smith* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 September 2012) <http://www.mcnsw.org.au/page/421/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-2012/>.

certain intellectual rigidity in the doctor's approach to practice. Whilst these characteristics may be seen in any age group, they were particularly evident in the cases discussed below. Some of the doctors were well known to the relevant National Boards but were allowed to remain in practice for a long time. These cases clearly raise the issue of revalidation, which has recently been the subject of a research report commissioned by the Medical Board of Australia.[498] Generally, revalidation refers to programs or tools designed to assist doctors in keeping their knowledge and skills up-to-date.[499] Bismark[500] warns against a 'one size fits all approach' to revalidation, noting that a targeted approach based upon risk factors, such as age, practice type or complaint history, may improve the performance of certain revalidation tools. The following cases demonstrate that revalidation would be a proactive form of public protection in relation to older doctors.

In one case involving a 78-year-old doctor in NSW,[501] the doctor was qualified as an ophthalmic surgeon but also practiced as a general practitioner with a special interest in forceful manipulation of the cervical spine. He had been known to the Medical Board of New South Wales since the mid-1980s.

He believed that virtually all medical conditions could be successfully treated by this kind of manipulation. He described his medical philosophy to the Tribunal in 2011 (at [15]) as follows:

> I have developed a medical philosophy (which is repugnant to orthodox medicine) ... which has formed the basis of my life in medical practice...I have strongly and repeatedly recommended that this new medical

[498] Dr Julian Archer, Miss Rebecca Pitt, Dr Suzanne Nunn, Dr Sam Regan de Bere, *The evidence and options for medical revalidation in the Australian context final report.* Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA). Plymouth University Peninsula School of Medicine and Dentistry United Kingdom 10 July 2015.

[499]<http://www.medicalboard.gov.au/News/2015-09-15-media-statement.aspx>. The report that was commissioned found positive evidence that revalidation is worthwhile in managing risk to patients and recommended three alternative models for the Board to consider. According to its website the Board has set a 12-month timeline for the Expert Advisory Group to recommend one or more models for Australia and provide advice on how these can be piloted.

[500] Marie Bismark, 'Gauging revalidation', (2015) 5, *Medical Journal of Australia InSight.*

[501] *Health Care Complaints Commission v Gorman* [2011] NSWMT 7 (17 August 2011).

> philosophy should supersede orthodox medical practice where appropriate to do so.[502]

The Tribunal found that the doctor had:

> … rigid and firmly-held held views that nearly every illness, whatever it is, will be better after spinal manipulation, such that it is virtually always appropriate.[503]

However in spite of a very complex history before the Board, including a number of suspensions from practice, it was not until 2011 that he was deregistered. The Court of Appeal noted that one Tribunal took a more liberal view of Dr Gorman's practice than a Professional Standards Committee had done,[504] the differences clearly demonstrating that how the public should be protected in such a case is one where there may be competing views.

In 2011 the Tribunal found that he showed a disdain for the general principles and framework of general practice and that in his opinion conventional general practice was

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[502] According to the Tribunal:

> In his view, the medical philosophy that he espouses has been deliberately suppressed by an 'arch-villain', the Royal Australian and New Zealand College of Ophthalmologists (RANZCO): see Exhibit 2 at p 240.

Accordingly, he regards himself as a whistleblower, seeking to alert the community to aspects of orthodox medicine, which, he alleges, damage New South Wales citizens, and their fellow citizens worldwide, on a daily basis:

> 'The failure of this Tribunal to take its place in the history of mankind is augured by his Honour's legal inability or disinclination to publicly acknowledge that I am a whistleblower of the major travesty in health care since homosapiens appeared on earth.'

[503] Ibid [407].

[504] Ibid [20]. On 6 May 1988, the Professional Standards Committee made a finding of professional misconduct (as it was then termed) against Dr Gorman 'on the basis that Dr Gorman [had] demonstrated a serious lack of judgment in performing a potentially dangerous procedure, namely manipulation of the cervical spine under anaesthesia'. The Committee further imposed a condition on Dr Gorman's registration, namely, that he refrain from manipulation of the cervical spine under anaesthesia. Dr Gorman appealed to the Tribunal. An amended complaint was filed in the Tribunal asserting that, as depicted in a 60 Minutes programme shown in 1986, Dr Gorman demonstrated a lack of adequate knowledge and/or judgment and/ or care in his practice of cervical manipulation of patients. The video depicted cervical manipulation under anaesthetic of two teenage girls.

inferior, incompetent and involved 'the lowest common denominator',[505] and that his rigidity 'inhibited his ability to take on new information'.[506]

It also found numerous examples of a lack of insight. The Tribunal noted that the doctor's philosophy was that:

> … there is a universal illness, for which there is a single, standard, effective cure, namely forceful spinal manipulation therapy. The procedure is not dangerous, and is cheaper and more effective than conventional medical treatment. His therapy, consisting of forceful spinal manipulation is a 'rough procedure' designed to break any 'rigid end fields' encountered in the neck (Transcript 555.37).

He was deregistered. It is difficult to understand why this took so long, particularly in view of the risk this doctor posed to the public.

As Skowronski and Peisah note:

> In terms of performance, older doctors are more likely to be investigated and disciplined by licensing bodies, more likely to be represented among those referred for competency assessments (specifically associated with cognitive impairment) and, according to most studies, perform worse than younger doctors in many areas. Years of clinical experience were negatively related to performance attributed to a lack of responsiveness in older physicians to new therapies, standards of care, and practice innovations that involve theoretical shifts.[507]

This decision illustrates that the protection of the public is particularly challenging when it comes to older doctors, and it is arguable that the issue of impairment should be considered more often with these doctors. The cognitive rigidity referred to above could clearly interfere with a doctor's capacity to practice medicine safely and put the public at risk. This issue is further discussed in the next chapter in relation to the definition of

[505]Ibid [97].

[506] Ibid [412].

[507] George Skowronski and Carmelle Peisah, 'The Greying Intensivist: Ageing and Medical Practice-Everyone's Problem' (2012) 196 *Medical Journal of Australia* 505–507.

impairment, where it is noted that the American definition includes a reference to age in relation to impairment. In the present case, Dr Gorman's intellectual rigidity in relation to spinal manipulation was not considered in terms of impairment, although in the next case it was.

This case involved an 83-year-old psychiatrist,[508] and the issue of intellectual rigidity was also raised in the Tribunal decision. The doctor had been the subject of an adverse finding in the Tribunal on 30 June 2010[509] in relation to inadequate communication with a patient. There was also a finding of unsatisfactory professional performance in his approach to Attention Deficit Hyperactivity Disorder (ADHD) . The Tribunal found that Dr Orchard over-diagnosed ADHD and/or Bipolar Spectrum Disorder, did not properly supervise the taking of dexamphetamine, which he prescribed for his patients, failed to submit his unusual diagnostic and treatment regime for peer review, and rarely recommended alternative therapies.[510] Following these findings he retired from practice for a while but then applied for re-registration. His application for re-registration was refused, and Dr Orchard appealed. There was conflicting psychiatric evidence as to whether he was impaired, and one expert neuropsychiatrist considered that the doctor's narrowing of his practice to predominantly patients with ADD[511] to be an impairment to practice.[512] All experts, the neuropsychiatrist, a neuropsychologist and an old age psychiatrist, found no convincing evidence of cognitive impairment but all expressed reservations about his 'cognitive rigidity' and a narrowness in his approach to diagnosis and treatment, which the Tribunal said could also be referred to as 'tunnel vision'.[513] However the Tribunal found that Dr Orchard's lack of preparedness to consider

[508] *Orchard v Medical Board of Australia* (Review and Regulation) [2013] VCAT 1729 (9 October 2013). This case is not included in the database for this study as it was decided after 1 July 2013.

[509] *Orchard v Medical Board of Australia* (Review and Regulation) [2013] VCAT 1729 (9 October 2013).

[510] *Orchard v Medical Board of Australia* (Review and Regulation) [2013] VCAT 1729 (9 October 2013) [5]. He retired but later regretted his decision and in June 2011 applied for re-registration after sending a number of long and intemperately worded letters to the Board, as well as two letters to VCAT and one to the Premier of Victoria.

[511] Attention Deficit Disorder.

[512] *Orchard v Medical Board of Australia* (Review and Regulation) [2013] VCAT 1729 (9 October 2013) [62].

[513] *Orchard v Medical Board of Australia* (Review and Regulation) [2013] VCAT 1729 (9 October 2013) [65].

alternative diagnoses to be a matter of 'attitude', rather than impairment and placed conditions upon his registration.

In view of the Tribunal's findings it is difficult to explain this decision. It is arguable that someone with cognitive rigidity may not be able to comply with registration conditions. Possible concern about age discrimination may have influenced the Tribunal.

Given the quite similar findings about possible impairment and cognitive rigidity in the cases discussed above, the inconsistency in the Tribunals decisions in relation to protective orders is quite marked. It shows that protection of the public from older doctors is a fraught area for tribunal decision makers, no doubt because of individual differences both in the ageing process itself and doctors responses to it.

In another case, a 70-year-old doctor was deregistered for inappropriate prescribing to 20 patients over a significant period of time.[514] He prescribed multiple benzodiazepines in excessive doses repeatedly for sleep purposes because he believed that benzodiazepines were safe.[515] The Tribunal found that he still lacked insight as to the conduct that led to the complaint, that he had an incomplete understanding of the legal requirements of Schedule 8 drugs, that he had had difficulties using a computer programme, and an audit showed only some improvement. The Tribunal was not persuaded that there had been any real changes to the way he practised and he was deregistered.[516] Computer illiteracy in older doctors may in itself be a risk to the public if doctors cannot readily access important medical information. Anecdotal evidence suggests that computer illiteracy in older doctors is not uncommon.[517]

In a case against an 88-year-old general practitioner in a small country town in Queensland, the complaint raised issues of general competency including concerns

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[514] *Health Care Complaints Commission v Fiay* [2012] Medical Tribunal of New South Wales (31 August 2012) <http://www.mcnsw.org.au/page/421/doctors--health/professional-conduct-/hearings-and-decisions/medical-tribunal -decisions-index/medical-tribunal-decisions-2012/>.

[515] *Health Care Complaints Commission v Fiay* [2012] Medical Tribunal of New South Wales (31 August 2012) 58.

[516] *Health Care Complaints Commission v Fiay* [2012] Medical Tribunal of New South Wales (31 August 2012) 62–63.

[517] Seminar on 'Older Doctors' Medical Council of New South Wales 21 October 2015. Proceedings unpublished at time of writing.

about his age and cognitive function and his relationship with a woman, 50 years younger than himself, whom he was teaching water polo and prescribing drugs. The doctor was found guilty of unsatisfactory professional conduct and had conditions placed upon his registration. Although there were concerns about his age and cognitive function he was found by a psychiatrist not to be impaired.[518] The case was heard 'on the papers'.[519] Again this case is difficult to explain. In some cases however, tribunals may place such stringent conditions on a doctor's registration that they make it difficult for a doctor to remain in practice. S/he is then forced to retire without the disgrace of deregistration at the end of their career. It is not clear whether this form of de-facto deregistration occurred here.

The oldest case involved a 90-year-old doctor who practised as an urologist from 1958 to 1996. He first came to the attention of the then New South Wales Medical Board in 2003. In 1996 he began to undertake medico-legal consultations on patients (claimants) referred to him by lawyers or insurance companies. In 2007 he had conditions placed upon his registration after complaints were received from nine patients. The Medical Tribunal stated then that:

> Dr Smith exhibited a considerable degree of rigidity in his thinking. He was unable to accept that the patients who had complained had honestly felt aggrieved and ascribed their complaints to them being 'put up' to bringing the allegations ... He would not concede that he may have been at fault or that the complaints would lead him to reflect on this manner.[520]

Dr Smith unsuccessfully appealed the conditions. He was suspended from practice in 2010, when he failed to comply with the conditions on his registration, and a complaint was again referred to the Medical Tribunal. The delegates to the inquiry, which suspended him from practice, noted his '...complete disregard for and lack of insight

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[518] *Medical Board of Australia v Van Opdenbosch* [2012] QCAT 703 (12 November 2012).

[519] Pursuant to the *Queensland Civil and Administrative Tribunal Act 2009* - sect 32 which provides that (2) the tribunal may, if appropriate, conduct all or a part of a proceeding entirely on the basis of documents, without the parties, their representatives or witnesses appearing at a hearing.

[520] Robert Darlow Smith, <http://www.mcnsw.org.au/page/421/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-2012/> [3].

into the benefit that the conditions were intended to give his patients'.[521] In 2012 the Medical Tribunal found that Dr Smith deliberately failed to comply with the conditions on his registration and showed no insight into the behaviour that led to the imposition of conditions. Although he was still suspended from practice and suffering from health problems he was deregistered.

These cases raise significant issues about how doctors of all ages maintain their competence in view of considerable variations in the ageing process. Some older doctors keep up their skills and are valuable teachers and mentors for more junior doctors and colleagues. Their experience and wisdom is an asset both to their patients and the community as a whole. Other older doctors are unable to keep up with the demands of modern medicine and the increased use of technology. It has been argued that older doctors are more at risk of the 'fours Ds' – depression, drink, drugs, and dementia, as well as increased risk of chronic disease.[522] Ageing doctors are also affected by a number of age-related sensory and neuro-cognitive processes. The regulation of ageing doctors is particularly tricky, given the enormous range of individual differences in the ageing process, and the possibility that an adverse decision against an older doctor could be seen as age discrimination. The nature of work for a procedural specialist is distinct from that of a non-procedural physician or a psychiatrist, and distinct demographics, environmental and skill bases mean that there are different demands on and priorities for the ageing doctor in different specialties.[523] The important article by Skowronski et al referred to above makes a number of suggestions in relation to the management of the ageing doctor, including competency assessment and retirement planning. They conclude that:

> The wisdom and experience of older doctors is of great value. However, work adaptations may need to be considered. For intensivists, these could include part-time work towards retirement, reduced after-hours call and shift

[521] Robert Darlow Smith, <http://www.mcnsw.org.au/page/421/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-2012/> [13].

[522] Skowronski and Peisah, above n 508, 505.

[523] Ibid.

> work, and reduced exposure to acute crisis intervention, with an increased focus on mentoring, teaching, administration and research.[524]

Tribunals dealing with complaints about older doctors may fear accusations of age discrimination if they order harsh protective sanctions. Sympathy for older doctors who have devoted their lives to medicine may also explain why older doctors are allowed to remain in practice relatively unfettered by demanding conditions upon their registration. Clearly the cases above however are a warning sign for tribunals that stringent protective orders such as deregistration may be the best way of protecting the public when older doctors lack the insight to recognise that the ageing process may impact upon their professional conduct as doctors.

4.7 Conclusion

Whilst suspension and deregistration may clearly be the orders that are most protective of the public, this chapter shows that the most common protective orders are the imposition of conditions upon a doctors' registration, allowing doctors found guilty of misconduct to remain in practice. These orders aim to manage the risk a problem doctor may pose in terms of the likelihood of future re-offending. As noted in Chapter 1, according to Rose, risk thinking disciplines uncertainty 'by bringing it under control and making it orderly and docile'.[525] This description is very apt for describing, for example, the conditions imposed on a doctor's registration, as they are often detailed and specific, and in this sense impose a sense of order upon the future uncertainty of a doctor's conduct. The finding, in relation to protective orders, is important as the imposition of conditions provides the mechanism for a therapeutic approach to misconduct, as the following chapters will demonstrate.

Overall the most common form of misconduct involved issues such as sexual misconduct, followed closely by cases relating to inappropriate medical care, and inappropriate prescribing. There were differences between the states in relation to the most common forms of misconduct. It is difficult to identify the cause of these differences. As noted in Chapter 2 a degree of discretion is exercised in determining

[524] Ibid.

[525] Rose, above n 162.

which matters are serious enough to be prosecuted in a tribunal. Even allowing for differences in the number of doctors in each state, a significantly higher number of impaired doctors appeared in disciplinary proceedings in New South Wales. This seems to indicate a different philosophy in relation to impaired doctors in New South Wales. This issue is further discussed in Chapter 5.

The number of older doctors appearing in disciplinary proceedings indicates that older doctors can pose a serious risk to their patients, and may indicate the need for more targeted and stringent revalidation requirements as doctor's age although many older doctors continue to make a valuable contribution to medical practice. In this chapter as the Appendices show, the database has generated a number of tables not only about sexual misconduct, impairment and protective orders, but in addition tables about inappropriate prescribing and inappropriate medical care, women doctors and specialists found guilty of misconduct. Each of these tables in themselves provide the basis for further investigation and enrich our existing knowledge base about problem doctors, although they cannot be considered in detail in this thesis. The findings on impairment and sexual misconduct will now be considered in the following chapters.

CHAPTER 5 – IMPAIRMENT

5.1 Introduction

Impairment in a doctor can have a devastating impact on a doctor's life, both professionally and personally. The emotional, legal, and other consequences of a doctor practising medicine whilst suffering from an impairment can also be far-reaching for patients, the public and the profession, as the scandals in Australia about impaired doctors noted in Chapter 1 have graphically demonstrated. The issue of whether a doctor is, to put it colloquially, sad, mad and/or bad[526] is squarely raised in the impairment cases in this study. As Grieg notes, 'many voices and many different understandings surface about where badness ends and where madness begins …'.[527] The impairment cases in the next chapter illustrate some of these tensions and resulting complexities involved in the regulation of impaired doctors, especially when attempts are made to keep doctors in practice by placing conditions upon their registration. This chapter provides the context for that discussion by exploring some of these complexities through a brief review of the literature on impairment in the context of the regulation of doctors, and a discussion of the definition of impairment. It also examines the impact of complaints and notifications upon doctors, which is similar to the impact of mandatory reporting discussed in Chapter 2. It picks up the framework of the medical model of misconduct noting that the medical model is in reality a psychiatric model of misconduct, and that psychiatrists play a key surveillance role in the regulation of impaired doctors. The chapter argues that the public might be better protected by a focus on the actual conduct of the doctor that placed the public at risk, rather than their impairment.

5.2 Background

5.2.1 An overview

In Chapter 1 it was noted that the recognition of impairment was a significant development in the regulatory context and that the first formal impairment programs for

[526] As discussed in Chapter 1.

[527] Greig, above n 116, 15.

doctors were initiated in the United States.[528] By 1981, 47 states in the United States had passed 'sick doctor' amendments allowing boards to examine doctors suspected of being impaired, restrict their practice, and impose rehabilitative measures.[529] Impairment programs are now an established part of the regulatory landscape in the United States, the United Kingdom and Australia.

Generally, impairment programs have been seen as meeting the challenge of balancing the desire to help physicians with substance use disorders against the need to safeguard public welfare.[530] According to Morrow such programs have attempted to use one solution to address both problems and been described as 'a kind of professional self-help movement' based upon the assumption that doctors should help 'sick' doctor colleagues and rehabilitate them, rather than expel them from the profession.[531] Historically, in the UK doctors accessed treatment through the 'old boy network' or used informal channels through colleagues. Changes in the National Health Service meant that it became increasingly difficult for addicted doctors to access confidential specialist treatment directly.[532] Now the General Medical Council in the UK operates a health program for impaired doctors similar to impairment programs in Australia and the United States.[533]

In Australia in the early years of the 20th century a doctor could be removed from the register for 'problematic alcohol use' but there was no power then to impose any other sort of penalty.[534] By 1938, following legislative amendments, the Medical Practitioners Act 1938 also referred to doctors who were psychiatrically ill, addicted, and cognitively impaired.[535] However this early legislation did not include the health pathways aimed at treatment and rehabilitation,[536] which now exist under the National Law, and

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[528] Morrow, 'Sick Doctors', above n 17.

[529] Morrow, 'Doctors Helping Doctors', above n 87, 32.

[530] Linda Andrews, 'Substance-Impaired Physicians: Treating Doctors Protecting Patients' (2005) 91 *Journal of Medical Licensure and Discipline* 7.

[531] Morrow, 'Sick Doctors', above n 17.

[532] E Jan Marshall, 'Doctors Health and Fitness to Practise: Treating Addicted Doctors' (2008) 58 *Occupational medicine* 334–336.

[533] <http://www.gmc-uk.org/concerns/11551.asp>.

[534] Pethebridge, above n 90, 60.

[535] Ibid.

[536] Which promoted a therapeutic culture in the National Law, as discussed in Chapter 2.

impairment was seen as a disciplinary matter.[537] The, impairment provisions which were introduced into the Medical Practice Act 1992 in New South Wales are an important development in the regulation of doctors, and clearly facilitated a change in the discourse from a disciplinary approach towards a rehabilitative approach to misconduct. As noted in Chapter 1, these provisions were incorporated into the National Law in 2010.[538]

Much of the early literature on impaired doctors in Australia and overseas, particularly the United States, focussed on research which reveals the nature and extent of impairment in doctors.[539] Current literature also deals with these issues. A report by *beyondblue*, an Australian, independent non-profit organisation set up to raise awareness about issues associated with depression, anxiety disorders and related mental disorders, found that doctors in Australia reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals. The report also noted high numbers of anxiety disorders, substance abuse and self-prescribing within the profession as well as a number of barriers that prevent doctors seeking treatment. These include perceptions of stigmatising attitudes toward mental health conditions, lack of confidentiality and privacy, concerns about career progression, potential impact on patients and colleagues, and embarrassment and concerns about professional integrity.[540]

The literature also focusses on how impaired doctors can best be rehabilitated and reintegrated into the profession.[541] However, there are only a few studies that focus on the complex issues different types of impairments in doctors, such as addiction and

[537] In a more recent analysis of how Medical Boards and various governments in Victoria have responded to impairment in doctors, Gabrielle Wolf examines the powers to manage unwell doctors that the legislature has granted to Boards that have regulated the medical profession in Victoria from 1844 to the present day. See Gabrielle Wolf, *From Cancelling the Registration of the 'Inebriate' to Suspending the Registration of the 'Impaired': Powers granted to Victorian Medical Boards to Regulate Unwell Doctors between 1844 and 2015*. Apart from those by Wolf and Pethebridge, there do not appear to be any other studies of the development of impairment programs in the other States and Territories of Australia.

[538] The National Law Part 8.

[539] Marshall, above n 532, 334.

[540] beyondblue National Mental Health Survey of Doctors and Medical Students October 2013, 2.

[541] Ibid.

psychiatric disorders, pose for regulators.[542] The recent study by Mendelson of doctors who abuse controlled substances[543] makes an important contribution in this respect and is discussed below.

A common assumption in the literature is that society's investment in the education and training of doctors should not be lost, and that rehabilitation of 'problem' doctors is preferable to professional excommunication on economic, social and humanitarian grounds.[544] Rarely acknowledged in the literature is the challenge that this assumption poses for regulators in general and members of disciplinary tribunals in particular, not to mention those delegated to treat or supervise impaired doctors whilst they remain in practice.[545] Also rarely acknowledged in the literature is the associated cost of impairment programs, or the fact that disciplinary proceedings are also costly in terms of time, money and lives.[546] There is little or no research available that compares the cost of educating and training doctors, and keeping them in practice through impairment programs, to the costs involved in cumbersome investigations and the prosecution of these doctors in disciplinary proceedings, which not infrequently involve significant delay, and may not always protect the public, as some of the cases demonstrate. Appendix B indicates significant delays of two to three years in many cases.

5.2.2 Impairment or illness

The policy statement of the Federation of State Medical Boards in the United States notes the critical distinction between impairment and illness.[547] According to the policy, illness does not equate with impairment and typically predates impairment, often by many years. Whereas illness is the existence of a disease, impairment is a functional classification and implies the inability of the person affected by disease to perform

[542] Wilhelm, Diamond and Williams, above n 172, 267; Carol E Fletcher, 'Michigan's Unique Approach to Treating Impaired Health Care Professionals' (2001) 4 *Journal of Addictive Diseases* 101.

[543] Ibid 7.

[544] Morrow, 'Doctors Helping Doctors', above n 87, 33.

[545] Wilhelm, Diamond and Williams, above n 172, 267-274.

[546] Fletcher, above n 543, 105.

[547] FSMB Working Group, 'Policy on Physician Impairment from the Federation of State Medical Boards of the United States, Inc' (2011) 97 *Journal of Medical Regulation* 10.

specific activities.[548] Impairment exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon.[549]

The most common forms of impairment in doctors are substance abuse disorders, which include both alcohol and drugs, and various psychiatric conditions, including depression, adjustment disorders, paranoid and other personality disorders and mood disorders.[550] Doctors may also be cognitively impaired or simply too old to keep up with the requirements of modern medicine.[551]

Pethebridge sounds a note of warning regarding the use of terminology:

> When referring to alcohol or substance use the literature employs various terms including categories of use, abuse, dependence and hazardous use, and within the literature, the meaning ascribed to these terms has altered over time and over geography.[552]

In one of the few studies of impaired doctors and how they are managed in Australia, Pethebridge reviewed 181 impaired doctors who had participated in the Health Programme of the then Medical Board of New South Wales between 1 July 1993 and 30 April 2001.[553] The largest source of impairment was psychiatric illness (45.3%), and 77% of the doctors were male. The average age of the cohort was 41.6 years. Impaired doctors were more likely to be working in emergency medicine or psychiatry and be based in a rural area. Of those who had finished their involvement in the programme, successful graduates participated for a mean of 38.2 months. In general, outcomes of involvement were positive, and 64 of 113 (56.6%) doctors successfully graduated from the programme. 110 of 168 (65.5%) improved during the period of their involvement and 111 of 126 (88.1%) were working in medicine. Five, 2.8% of the participants died during the period of this study.

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[548] Ibid.

[549] Ibid 11.

[550] Robert S Walzer, 'Impaired Physicians' (1990) 11 *Journal of Legal Medicine* 131; Pethebridge, above n 90; Marshall, above n 532.

[551] Skowronski and Peisah, above n 508, 505–507.

[552] Pethebridge, above n 90, 1.

[553] Ibid.

Measures of registrant insight and support tended to increase during the period of involvement with the Health Program.[554] Pethebridge concluded that future studies will need to establish evidence for the most appropriate interventions with impaired doctors, and this process would be strengthened by the collection of standardised data across intervention programmes, supplemented with functional assessments and the collection of qualitative data.[555] Although AHPRA provides numerical information about impaired doctors and types of impairment on its website there does not appear to be any ongoing national research about impaired doctors in Australia, although the Medical Council of New South Wales is currently reviewing its own impairment program.[556] Since Pethebridge's study, only two papers, which relate to the Health Program of the New South Wales Medical Board (now Council), have been published, one of them by this researcher, and they address quite different issues.[557] There is also little research available on the effectiveness of supervision, monitoring and treatment of impaired doctors, although as noted in Chapter 1, Walzer in the United States has addressed this issue.[558] He argues that overseeing disciplined health care practitioners' clinical performance or rehabilitation is 'flawed by a weak or cavalier system for selecting and guiding monitors and therapists'.[559] These issues are further addressed in the discussion of the cases in the following chapters.

5.2.3 Impairment in the regulatory context

Within the context of the regulation of doctors both in Australia and overseas, there are a number of differing definitions of impairment. The definition is crucial because of the consequences that may follow if a doctor meets the criteria of impairment under the National Law. A classification of impairment after the doctor comes to attention and has been assessed according to the provisions of the law,[560] generally means that s/he will

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[554] Pethebridge, above n 90, ii.

[555] Ibid.

[556] <http://www.mcnsw.org.au/page/resources/publications/newsletters/> Medical Council of NSW e-newsletter - February 2015.

[557] Wilhelm and Reid, above n 90; Kiel, 'Regulating Impaired Doctors', above n 136. Kiel's paper examines tribunal decisions in New South Wales about impaired doctors in 2010, whilst Wilhelm and Reid examine critical decision points in the management of impaired doctors.

[558] Walzer and Miltimore, 'Mandated supervision', above n 160, 565.

[559] Walzer and Miltimore, 'Proctoring of Disciplined Health Care Professionals', above n 160, 79.

[560] The National Law Division 9.

be directed down a health pathway under the Law, and wherever possible, kept in practice during the rehabilitation process. If the doctor's conduct is not seen as a function of impairment s/he is more likely to be sent down a performance or conduct pathway and could incur protective orders, such as suspension or deregistration, and consequential loss of livelihood and career, either temporarily or permanently.

These draconian consequences may provide an incentive for regulators who determine the complaint pathways, or for sympathetic members of disciplinary tribunals, to identify conduct as a function of impairment. Significantly, as noted in Chapter 2, the objectives described in the National Law do not clearly specify the treatment of impaired doctors, although the health provisions under the law clearly assume this goal.

In Australia under Section 5 of the National Law[561] impairment is defined as follows:

> 'impairment', in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally or is likely to detrimentally affect-
>
> (a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or
>
> (b) for a student, the student's capacity to undertake clinical training-
>
> (i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.

When the definition of impairment was introduced into the New South Wales Medical Practice Act 1992 on 24 September 1992, in the Second Reading speech for the Medical Practice Bill, it was noted that the new provisions would allow action to be taken regarding medical practitioners who could be suffering from an impairment, before matters deteriorate to the stage where a complaint may be made against a practitioner. The impairment provisions were designed to pre-empt problems before difficulties arose and to assist the impaired doctor or student in dealing with his or her impairment. According to the Second Reading speech 'the provisions operate as an alternative to the

[561] The same definition is used in all States and Territories.

disciplinary mechanisms contained in the legislation. Nevertheless, they are not intended to provide a means whereby disciplinary action may be avoided'.[562] As the cases in the following chapter show, however, some impaired doctors do end up in disciplinary tribunals in spite of the parliamentary intention of the legislation.

In the United Kingdom the concept of impairment is very broadly defined under the Medical Act 1983, which governs the regulation of doctors.[563] The definition of impairment includes misconduct and deficient professional performance as well as adverse physical or mental health.[564] This broader definition removes the focus purely on health to a more all-embracing concept of impairment, which includes performance and conduct. The Australian definition, by focusing on physical or mental conditions, which are broadly defined, clearly facilitates the use of the health pathways under the law/s and the 'medical control of problem doctors'[565] as discussed above.

The United States definition is closer to the Australian definition in focusing on physical or mental disabilities. In its 'sick doctor' statute the American Medical Association defines impairment as 'the inability to practice medicine with reasonable

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[562] <http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LA19920924029>.

[563] This Act also governs the General Medical Council <http://www.gmc-uk.org/about/legislation/medical_act.asp>.

[564] As noted in Chapter 1, s 35C of the Act refers to the functions of the Investigation Committee in investigating fitness to practise as follows:

> (1) This section applies where an allegation is made to the General Council against -
>
> (a) a fully registered person; or
>
> (b) a person who is provisionally registered, that his fitness to practise is impaired.
>
> (2) A person's fitness to practise shall be regarded as 'impaired' for the purposes of this Act by reason only of -
>
> (a) misconduct;
>
> (b) deficient professional performance;
>
> (c) a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;
>
> (d) adverse physical or mental health;
>
> (e) not having the necessary knowledge of English (but see section 2(4));
>
> (f) a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect.

[565] Morrow, 'Sick Doctors', above n 17.

skill and safety due to physical or mental disabilities, including deterioration through the ageing process, loss of motor skill, or abuse of drugs and alcohol'.[566] This definition is interesting in that it explicitly focusses on the ageing process, which the Australian definition does not. The ageing medical workforce in Australia has however, prompted concerns about competence, health and impairment in older doctors, and age related sensory and cognitive changes that may affect performance, as noted in Chapter 4 above.[567] Evidence at a parliamentary review of health-related complaints in New South Wales identified ageing male doctors as a 'cohort of concern'.[568] The Health Care Complaints Commissioner stated that many older doctors did not 'appreciate that their practice is out of date… or realise that they were becoming impaired.'[569] Whilst the Australian definition of impairment under the law is broad enough to encapsulate the ageing process, given recent concerns, it arguably should include ageing more specifically, particularly in light of some of the cases in Chapter 4.

In an extensive review of the legal issues surrounding impaired physicians in the United States, Walzer (himself an attorney and a former psychiatrist) defines impairment in physicians very simply, stating that impairment generally arises from an illness or disorder that compromises professional judgment and abilities.[570] He notes that substance abuse and addictive disorders comprise the largest and most significant group of underlying causes of impairment.[571] These conditions have been classified as a disease or disorder by the American Psychiatric Association in its definitive codification of diagnoses and nomenclatures.[572] This classification therefore fits neatly with the therapeutic rather than disciplinary approach to substance abuse disorders in doctors.

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[566] Robert A Mines et al, 'The Organizational Impact of Impaired Health Care Executives or Physicians: A Review and Recommendations' (2013) 28 *Journal of Workplace Behavioural Health* 1.

[567] Skowronski and Peisah, above n 508, 506.

[568] Nicole Hasham, *Sydney Morning Herald* 26 June 2014, 3. *Parliament of New South Wales Committee on the Health Care Complaints Commission Report* 4/55 – June 2014 www.smh.com.au/nsw/half-of-all-health-complaints-in-nsw-not-followed.

[569] Ibid.

[570] Walzer, above n 550, 131–143.

[571] Ibid.

[572] Ibid.

The Australian definition also refers to substance abuse, which is also classified as a disease in Australia.[573]

As well as the differences already noted, the Australian definition of impairment found in s 5 of the National Law noted above, differs from both the UK and the American definition in another important aspect. Although 'the person's capacity to practice the profession is not defined' the definition clearly contemplates not only present capacity, but also future capacity, in the use of the phrase '**is likely to** detrimentally affect'. However when a Medical Tribunal deregistered a New South Wales impaired doctor she successfully appealed the decision. The Court of Appeal in *Tung v Health Care Complaints Commission*[574] found that an impaired doctor with a paranoid personality disorder could not be deregistered merely on the possibility of the doctor's capacity to practice being detrimentally affected.[575] Giles JA stated (at [56]):

> A physical or mental impairment, disability, condition or disorder which *detrimentally affects* the person's physical or mental capacity to practice medicine may mean that the person does not have sufficient physical capacity, mental capacity or skill to practice medicine. But that is not necessarily so, and particularly it is not necessarily so in the case of a physical or mental impairment, disability, condition or disorder which *is likely to detrimentally affect* the person's physical or mental capacity to practice medicine.[576]

Giles JA went on to cite an important impairment case that further considered the definition of impairment, and linked impairment to competence. In the case of *Lindsay v Health Care Complaints Commission* [2010] NSWCA 194, Sackville AJA noted in the Court of Appeal (at [170]) that:

> … Even a serious psychiatric condition does not necessarily lead to the conclusion that the medical practitioner concerned lacks competence in the relevant sense. Whether it does or not will depend on such considerations as

[573] Jack Warhaft, 'Addicted Doctors: Finding a Path to Recovery' (2011) 9 *Of Substance*.

[574] *Tung v Health Care Complaints Commission* [2011] NSWCA 143.

[575] *Tung v Health Care Complaints Commission* [2011] NSWCA 143.

[576] *Tung v Health Care Complaints Commission* [2011] NSWCA 143.

> the nature and likely duration of the impairment, the kind of practice carried on by the medical practitioner, the extent to which the impairment interferes with the practitioner's judgment, communication skills and clinical ability, and other relevant circumstances.

In another case a Tribunal also discussed the link between impairment and competence:

> A person is 'competent to practise medicine' only if he or she has, relevantly, sufficient mental capacity to practise medicine and has sufficient communication skills to do so (cl 2). There is clearly a close relationship between a finding of impairment, based on the existence of a disorder which is likely to detrimentally affect a practitioner's mental capacity to practise medicine, and a finding of lack of competence to practise medicine based on a want of sufficient mental capacity to practise medicine. Accordingly, a finding of impairment of that sort may very well lead to a finding that the medical practitioner is not competent to practise medicine within the meaning of s 64(1)(a) of the Act.[577]

5.2.4 Impairment or misconduct

The above cases recognise that a doctor can be impaired and still competent to practice medicine cases but there has been also been judicial consideration of the relationship between impairment and misconduct. In a case in New South Wales *Reimers v Health Care Complaints Commission* [2012] NSWCA 317 (25 September 2012) [578] the Court of Appeal made clear the distinction.

Dr Reimers was an anaesthetist who had been deregistered for 10 years after a finding that he was addicted to narcotics. He appealed in part on the basis that a miscarriage of justice had occurred because if impairment was established, as the Tribunal found, he could not be guilty of professional misconduct.[579]

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[577] *Health Care Complaints Commission v Philipiah* [2012] NSWMT 14 [50] (28 June 2012), citing *Lindsay v Health Care Complaints Commission* [2010] NSWCA 194 [168] per Sackville AJA, with whom Giles and Young JJA relevantly agreed and citing the *Medical Practice Act 1992* s 64(1) (a).

[578] This case was not part of this study as the original Tribunal decision was made in 2003.

[579] *Reimers v Health Care Complaints Commission* [2012] NSWCA 317 (25 September 2012).

The Court of Appeal was unequivocal in its finding about the relationship between impairment and misconduct and is cited at length below because of the clarity with which it draws the distinction:

> [12] So understood, the first proposition is untenable. Gross, repeated, incompetent medical practice does not cease to be such because it is caused by an addiction to alcohol, heroin or other drugs. This was not a case where the practitioner was held to be unaware of his condition or its consequences. That he continued to practice as an anaesthetist whilst unable to exercise the necessary care, skill and judgment, could reasonably be found to constitute professional misconduct. The conclusion of the Tribunal that there was professional misconduct was, at least, unsurprising.
>
> [13] The second proposition is also untenable. There is no doubt that addiction is a condition which may, perhaps should, evoke sympathy. The degree to which a criminal offence is caused by a mental illness, including addiction, may properly be reflected in the sentence imposed. Nevertheless, 'protection of the community' is a relevant sentencing principle and may, within limits of proportionality identified by reference to the seriousness of the offence, extend rather than restrict the sentence: *The Queen v Veen [No 2]* [1988] HCA 14; 164 CLR 465. But the underlying purpose of a disciplinary order of deregistration is not primarily punitive, but protective. That is not to impose some artificial dichotomy of punitive and protective orders, contrary to *Rich v Australian Securities and Investments Commission* [2004] HCA 42; 220 CLR 129. Rather, it is to recognise the primary object of the *Medical Practice Act,* which was 'to protect the health and safety of the public by providing mechanisms designed to ensure that ... medical practitioners are fit to practise medicine': s 2A(1). Misconduct which could be classified as professional misconduct may properly lead to deregistration.
>
> [14] In short, the applicant's submission that impairment cannot be professional misconduct is true, but only in the sense that an impairment is not conduct. An impairment may manifest itself in conduct or, to

> reverse the relationship, an impairment may explain particular conduct in part or in whole. There is no substance in the complaint that the decisions of the Tribunal on the various complaints were manifestly unreasonable. That being so, the challenges to the deregistration order must also fail.

Hopefully, more attention will be paid to *Reimers* in future tribunal decisions, although none of the cases in the present study referred to it. As there were only two impairment cases following Reimers, [580] this is not altogether surprising. The *Reimers* decision clearly focusses on the protective nature of the jurisdiction in arguing that protection of the community is 'a relevant sentencing principle'. Some decisions in the next chapter demonstrate that like Dr Reimers, the doctors were both aware of their conditions and the consequences but continued to practice regardless.

In spite of the broad definition under the National Law, the diagnosis of impairment may be problematic as there is no 'one size fits all' and many impairments are by nature, fluctuating conditions,[581] as the cases to be discussed in the next chapter clearly demonstrate. Addiction, for example, has been defined as a chronic relapsing disease[582] and according to Dr Kym Jenkins anxiety and depression are intimately associated with substance abuse.[583] Mental illness also often fluctuates,[584] and some disorders are particularly difficult to treat, with symptoms waxing and waning at different periods of a person's life and in response to different triggers and vulnerabilities.[585] According to Marshall, the relationship between stress at work and substance misuse in doctors is

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[580] See *Health Care Complaints Commission v Snell* [2013] (30 November 2012; *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013)

[581] Kiel, 'Regulating Impaired Doctors', above n 136, 431.

[582] Jack Warhaft, *'From Addiction to Recovery – A Personal Journey'* with a Public Message Address to Medico-Legal Society of Victoria 15 November 2008 <http://www.mlsv.org.au/past_meetings.htm> Accessed 4 November 2012.

[583] Ranjana Srivastava, 'Child Pornography, Sex with Patients, Drug Abuse – Why Do Doctors Fall?' <http:www. theguardian.com.commentisfree/2015/may13/>. According to Jenkins 'Propofol is becoming the hypnotic of choice amongst anaesthetists'.

[584] Kiel, 'Regulating Impaired Doctors', above n 136.

[585] Ian Freckelton and G Mendelsohn, 'Psychiatric disorders and referral obligations' (2011) (2)1 *Medical Journal of Australia* 1.

mediated by individual vulnerability, privileged access to drugs and the ability to self-prescribe and thus facilitate their own polydrug use.[586]

Although the definition of impairment as defined under the National Law includes physical as well as mental conditions, the discourse above about impaired doctors largely focusses on various forms of addiction and psychiatric conditions, which are largely managed by psychiatrists The cases discussed in the next chapter also indicate the key role played by psychiatrists in the management of impaired doctors. Hence Morrow's medical model may be more accurately described as a psychiatric model of misconduct.

5.3 The medical or psychiatric model of misconduct

Morrow refers to the organised concern for impaired doctors, which developed in the 1970s in the United States, and to social, political and legal pressures for professional accountability. [587] Some of these pressures for accountability in the Australian context are described in Chapter 1 of this thesis. As also noted in Chapter 1, Morrow argues that it was these contextual factors which led to an extension of the boundaries of professional self-regulation from continuing medical education and the discipline of 'deviant' doctors, into the management and control of impaired doctors.[588] Although Morrow refers to a medical model of misconduct in the United States, in Australia the literature referred to above and the tribunal decisions indicate that the illness or medical condition related to the misconduct is usually a psychiatric condition. According to Wilhelm et al, the treatment of impaired doctors predominantly involves disorders that are psychiatric or have psychiatric implications.[589] Psychiatrists manage this treatment when health conditions are placed upon the registration of an impaired doctor.[590] It is

[586] Marshall, above n 532, 335.

[587] Morrow, 'Sick Doctors', above n 17, 94.

[588] Ibid 92.

[589] Wilhelm, Diamond and Williams, above n 172.

[590] They are also placed upon other doctors who are not impaired as indicated in Chapter 7.

assumed that appropriate handling and treatment of his (sic) disorder will lead to amelioration of his other difficulties'.[591]

The psychiatric model, by treating rather than disciplining 'sick' doctors, also neatly complements the ideals and goals of the medical profession to heal people. This model also ensures that 'deviant' doctors who breach codes of professional conduct are controlled within the profession, often by psychiatrists. One writer notes that efforts to control impairment in doctors simply constitute a new approach to an old problem of substandard performance.[592]

The cases in this study indicate that there is considerable overlap between psychiatric problems and substance abuse disorders and the two often co-exist. Psychiatrists usually treat them.[593] The 'medical model' of misconduct could thus more accurately be called a 'psychiatric model',[594] as psychiatrists play a key role in the diagnosis, treatment and management of impaired doctors in Australia.

5.4 'Managing' impaired doctors – the psychiatric model of misconduct

The treatment of impaired doctors is acknowledged to be challenging:

> Those who are impaired are clever, skilled verbally and can be intimidating to those who are not used to treating medical colleagues. They are knowledgeable and can easily slip into the use of medical jargon. They can use their knowledge to mask symptoms by self-medicating (either appropriately or inappropriately). They know which of their colleagues may be a 'soft option' when seeking treatment for themselves, and do not easily engage in psychotherapy. They can be dishonest with the treating

[591] Emanuel M Steindler, 'The Impaired Physician: An Interpretive Summary of the AMA Conference on The Disabled Doctor: Challenge to the Profession' (American Medical Association, 1975).

[592] George S Palmer, 'The Sick Doctor Statute: A New Approach to an Old Problem', *The Disabled Doctor: Challenge to the Profession* (1975).

[593] Psychiatrists played a dominant role in the development of the 'impaired physician campaign' in the United States.

[594] It is the American Medical Association's position that 'the impaired physician requires psychiatric intervention'.

psychiatrist and themselves, and can collude with the treating psychiatrist to lose sight of the fact that the impaired doctor is the patient.[595]

Mendelson categorised the problematic conduct of doctors who abuse controlled substances as follows:

1. fabricating consultations and injuries in patients' clinical notes to justify prescribing Sch 8 opioids (morphine and oxycodone) and Sch 4 benzodiazepines intended for the doctor's own use;
2. forging prescriptions for controlled substance drugs; 'prescribing' them in the name of family members, of patients, and of other doctors (or on prescription pads belonging to other doctors);
3. creating false records (mostly for pethidine prescribing); accessing pethidine, propofol, Panadeine Forte, oxycodone, fentanyl, midazolam, morphine and other opioid medications from hospitals and clinics for their own use; and
4. systematically lying to their colleagues, employers, treating and supervising clinicians as well as medical authorities.[596]

She also noted that in one case drug addiction led the medical practitioner to commit armed robbery on a pharmacy;[597] one doctor was convicted of 'common assault' and 'obtaining money, valuable thing/financial advantage by deception';[598] and one of a shoplifting offence.[599] These cases clearly portray the desperate nature of drug addiction and the extreme risks that doctors will take to satisfy their addictions. Clearly this group of doctors would be challenging for anyone required to monitor, supervise or to treat.

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[595] Wilhelm, Diamond and Williams, above n 172, 73.

[596] Mendelson, 'Disciplinary proceedings against doctors who abuse controlled substances', above n 135, 30.

[544] Ibid citing *Medical Board of Australia v Eldred* (unreported) WASAT, VR:119/2014, 10 December 2014) [23]–[24]. In 2013, Eldred pleaded guilty to, and was convicted of five charges of armed robbery; four charges of robbery; and one charge of attempted robbery involved stealing oxycodone 'and/or money from pharmacies with threats of violence'. He was sentenced to a custodial sentence of four years and six months, with eligibility for parole.

[598] Mendelson, 'Disciplinary proceedings against doctors who abuse controlled substances', above n 135, citing *Health Care Complaints Commission v Hasil* [2012] NSWMT 1. This case is further discussed in Chapter 6.

[599] Ibid citing *Health Care Complaints Commission v XC* [2015] NSWCATOD 9.

Mendelson's study is a valuable evidence-based contribution to the literature in this area. The specific identification of particular conduct means that protective orders can be more closely tailored to the conduct. Significantly in her study, all doctors facing disciplinary proceedings had a documented history of drug abuse that at one stage or another resulted in the imposition of conditions upon their registration. Mendelson noted that in the period under review new or additional conditions were imposed upon 10 of the suspended and/or reprimanded doctors. She stated that:

> While imposition of health conditions (including limitations on practice), combined with support provided by the doctors' health programs enabled rehabilitation of some doctors, others repeatedly breached or were non-complaint with their orders. Several addicted doctors had a history of periods of compliance that resulted in lifting of conditions, subsequent relapse and imposition of new conditions; periods of non-compliance followed by periods of abstinence from drugs, return of addiction and the concomitant breach of prohibitions, invariably accompanied by failure to comply with urine screening and hair analysis tests.[600]

These findings support those in the present study, which are reported in the next chapter.

A Sydney psychiatrist has also classified the problematic conduct of doctors more generally. He refers to three categories of doctors where there is what he refers to 'a degree of resoluteness and indignation' at a diagnosis of impairment and notes that such cases are almost invariably covered by a small number of diagnostic entities.[601] Firstly, the substance-abusing or drug-addicted practitioners who insist that they do not have a problem, deny their addiction, and refuse to comply with treatment. Secondly, doctors with personality disorders that cause them to be viewed in their workplace as disruptive practitioners. These are often difficult people who go about life experiencing interactions with those around them, which are frequently in conflict and which

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[600] Mendelson, 'Disciplinary proceedings against doctors who abuse controlled substances', above n 135, 34.

[601] Michael Diamond, "Inside Madness: The Murder of a Psychiatrist", paper presented to the Medico-Legal Society of New South Wales (September 2006), <http://www.medicolegal.org.au/resources/publications-archive/p2006/inside-madness-the-murder-of-a-psychiatrist> viewed 12 December 2012.

invariably create negative outcomes or problems.[602] The third category is those doctors with an impaired appreciation of reality, which Dr Diamond refers to as a spectrum disorder. He says that these are individuals who are insecure, unduly suspicious, quick to take offence and who interpret the behaviour of those around them as persecutory.[603]

Psychiatrists perform much of the challenging work of treating and supervising impaired doctors who have conditions upon their registration, and failures in treatment usually only become public when the impaired doctor is referred for disciplinary proceedings, or their conduct attracts notoriety, as demonstrated by the scandals referred to in Chapter 1. According to Marshall, developing a relationship with an addicted doctor can be difficult, particularly if the psychiatrist takes on a supervision role.[604] She states that 'Doctor-patients can be tetchy, irascible and arrogant and tend to use a number of ploys to avoid contact', and that 'the treating psychiatrist must be meticulous and maintain an attitude of compassionate skepticism throughout.'[605] In spite of these problems, according to one writer, the quality and quantity of the treatment provided to impaired physicians in the United States is far superior to that which the average person with an alcohol or drug problem receives. Post treatment monitoring is much more rigorous and the consequences for non-compliance are often severe.[606]

There is little research available on how impaired doctors experience treatment in Australia,[607] or on how psychiatrists manage the sometimes very difficult issues raised in the management and treatment of impaired doctors. Andrews in her discussion of impairment programs in the United States refers to the 'seemingly straightforward' issue of how frequently to conduct random drug tests and which drugs to include, noting that one recent study found the frequency of drug testing required by different state monitoring programs ranged from 15 per month to fewer than one per month.[608] In one

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[602] Ibid.

[603] Ibid.

[604] Marshall, above n 532, 337-338.

[605] Ibid.

[606] Andrews, above n 530.

[607] Other than the studies undertaken by the Medical Board of New South Wales referred to in Chapter 1.

[608] Andrews, above n 530, 10.

of the impairment case scandals referred to in the introduction to this thesis, a doctor injected 55 women with a needle he had used himself, so that they all contracted hepatitis C. It was discovered that the Medical Board of Victoria had been testing for the wrong drug.[609] According to Andrews, physicians 'are savvy enough to know which drugs have short detection windows and calculate the odds of getting caught if they use a given drug at a particular time'.[610] Psychiatrists treating impaired doctors are necessarily dependent upon the results of drug testing but also upon the self-report of the doctor, even though as noted above, doctor-patients can be dishonest with their treating psychiatrists.

Michael Diamond's contention that to argue about impairment is really a diversion and that the behaviour of an impaired doctor may more realistically be dealt with as a conduct issue in relation to specific alleged complaints is compelling.[611] It is supported by the decision of *Reimers* above. [612] Although many impaired doctors do practise safely, a focus on conduct rather than impairment may lead to the imposition of more stringent protective orders such as suspension from practice and the use of critical compliance conditions (only available in New South Wales) on the registration of those doctors who do place the public at risk.

Clearly one of the problems in managing impaired doctors is that chronic relapsing and fluctuating conditions such as addiction, paranoid disorders, and cognitive impairment are hard to treat and hard to manage at any time, and particularly so in the context of medical regulation.[613] As noted in an earlier study by this writer addiction was the most common form of impairment and because denial is a common feature of most forms of addiction, intervention and treatment poses difficult problems for regulators.[614] Doctors are a high-risk population for addiction, and it is now recognised that anaesthetists are a particularly high-risk group.[615] Also

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[609] *Peters v The Queen* [2013] VSCA 222 (16 August 2013).

[610] Andrews, above n 530, 10.

[611] Diamond, above n 601, referred to in Kiel, 'Regulating Impaired Doctors', above n 136.

[612] *Reimers v Health Care Complaints Commission* [2012] NSWCA 317 (25 September 2012)[12].

[613] Kiel, 'Regulating Impaired Doctors', above n 136, 427.

[614] Ibid citing Keith J Degi, D Talbott and D.G. Warren, 'The Chemically Impaired Physician' in P Lens and G van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 2006) 66–67.

[615] Ibid citing K Hagan, 'When Doctors Become Addicts', *Saturday Age* (2 June 2012) 15.

noted as difficult to manage in the earlier study were doctors with paranoid personality disorders whose conditions sometimes fluctuate markedly, and who may become convinced that regulators are conspiring against them. These doctors may develop problems in the workplace although they may not be subject to episodes of overt mental illness in so far as psychosis and mood disorder is concerned.[616]

The important role played by psychiatrists involved in the management of impaired doctors under the National Law must be seen in the context of continuing debates about the role of psychiatry as a profession in a wider social context, and the role of psychiatric diagnosis in converting, in the regulatory context, misconduct into illness which can be treated and monitored whilst keeping impaired doctors in practice.

Significantly, in the cases discussed in the next chapter, although the Tribunal may have rejected psychiatric evidence in relation to the impact of a particular impairment upon a doctor's conduct, in very few cases was a diagnosis challenged per se, although the cases did discuss the nature and impact of a particular impairment on a doctor's practice.[617]

5.5 Psychiatry and its critics

As Grieg notes, psychiatry has been increasingly co-opted to assist in the governmental task of identifying and containing risky persons:

> It is a role which is both disciplinary and political, and because the state is dependent upon technologies possessed by experts, the relationship is intrinsically symbiotic. There is a mutual interest in developing the definition of a problem in such a way as to satisfy both political and professional understandings.[618]

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[616] Diamond, above n 601.

[617] *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010); *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

[618] Greig, above n 116, 25.

A significant body of literature emanated from the anti-psychiatry movement in the 1970s,[619] one writer noting that:

> Psychiatry takes on itself the responsibility for people's pain and frustration; it confiscates their problems, redefines them as 'illnesses', and (with luck) exterminates the symptoms.[620]

Some of the critiques of psychiatry, which emerged in the 1970s, continue today. The most recent classification of psychiatric disorders in the United States, the DSM-V,[621] which replaces the DSM-IV, is controversial, as recently noted in one critique:

> The prejudices and fallacies behind psychiatric diagnoses, and even the interests they serve, are as invisible to all of us, doctors and patients alike, as they were … to all those doctors who 'treated' homosexuals. The desire to relieve suffering can pull a veil over our eyes ...[622]

An eminent Sydney psychiatrist, Dr Gordon Parker, was also scathing of the DSM-V, pointing out that one of its critics had noted that:

> Anyone who is lightly old and forgets things occasionally will now have a neurocognitive disorder. There is a fad for adult ADHD. Gluttony has become a formalized eating disorder … and the changed criteria to post-traumatic stress disorder will increase the prevalence of that condition inappropriately.[623]

According to Parker, DSM-V is essentially a political document used in the United States to ensure that a person will be covered for hospitalisation, medical benefits, and

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[619] See, eg, Thomas Szasz, *The Myth of Mental Illness* (Dell Publishing Company, 1961); David Cooper, *Psychiatry and Anti-Psychiatry* (Granada, 1970); David Cooper, *The Grammar of Living* (Penguin Books, 1976).

[620] D Ingleby, 'Understanding Mental Illness', in D Ingleby (ed) *Critical Psychiatry The Politics of Mental Health* (Penguin Books, 1981).

[621] *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders Fifth* (APA Arlington VA, 2013).

[622] Gary Greenberg, *The Book of Woe: The DSM and the Unmaking of Psychiatry* (Scribe, 2013) 7 referring to when homosexuality was regarded as a mental illness.

[623] Dr Gordon Parker, *Diagnostic Systems Manual (DMS5) Diagnostic Systems Manual (DMS5) – Is Everybody Diagnosable?* Address to Medico-Legal Society of New South Wales 13 November 2013 <http://www.medicolegal.org.au/resources/publications/>.

their children's schooling.[624] There will of necessity, therefore, be some reliance upon it, but he warns that it is 'a house of cards'.[625]

The above criticisms and considerable research demonstrate that psychiatric disorders remain conspicuously difficult to define or categorise, whether by symptoms or signs, prognosis, aetiological factors or response to treatment'.[626] Sullivan notes that there is a dearth of tests or other diagnostic strategies that can clearly define the presence or absence of a disorder, and diagnosis has consequently relied on diagnostic acumen, and increasingly, the influence of structured criterion checklists.[627]

However the DSM-V remains as an authority for psychiatric diagnosis in Australia and in spite of its critics, psychiatry is a well-recognised specialty within the medical profession today. Psychiatrists undertake really challenging work with people who can be very difficult people to treat and manage, and psychiatry is therefore almost inherently controversial. In the context of the regulation of doctors, psychiatric diagnoses, however flawed or speculative, provide the rationale for both treatment and protective orders under the National Law. The articles by Diamond and Marshall are an important contribution in recognising that protection of the public is not simple in the psychiatric context.

The cases discussed in the next chapter demonstrate that on the one hand, psychiatrists actively participate in a psychiatric model of misconduct that may put the public at risk. On the other hand, they also play an important supportive role by successfully treating and managing many impaired doctors who are able to remain in practice without being referred to disciplinary proceedings. In a regulatory context, psychiatrists demonstrate one of the basic contradictions of psychiatry in 'hovering between care of the sick and protection of the community, between medicine and law and order'.[628]

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[624] Ibid.

[625] Ibid.

[626] Danny Sullivan, 'Disorders, Sublime Menu: The DSM-5' (2013) 21 *Journal of Law and Medicine* 39.

[627] Ibid.

[628] F Basaglia, 'Problems of Law and Psychiatry: The Italian Experience' (1980) 3 *International Journal of Law and Psychiatry* 17.

5.6 Risk factors for impaired doctors

An impairment may develop in response to a number of risk factors, which for doctors include easy access to prescription drugs, the demands and stresses of professional life, interpersonal conflict at home or at work, self-treatment, and the reluctance of colleagues to identify and manage early warning signs of impairment. As one writer notes:

> Once they arrive medical students are put through a gruelling course, and exposed much younger than their non-medical friends to death, pain, sickness, and the perplexity of the soul. And all this within an environment where 'real doctors' get on with the job and only the weak weep or feel distressed. After qualification, doctors work absurdly hard, are encouraged to tackle horrible problems with inadequate support, and then face a lifetime of pretending that they have more powers than they actually do. And all this within an environment where narcotics are readily available.[629]

Doctors are indeed subject to a unique range of stressors in their lives. These stressors may or may not lead to impairment. One classification in the literature divides these stressors into three different categories: structural factors, attitudinal factors, and intrapsychic personality and coping styles.[630] This classification appears to be generally borne out by the impairment cases in this study. Structural factors include the work environment, long working hours,[631] the increasing possibility of malpractice litigation and, more frequently, complex ethical dilemmas to name just a few.[632] Attitudinal factors may include denial of symptoms, failure to seek help, and a sense of shame associated with a psychiatric illness. Personality factors may include competitive, obsessive and perfectionist behaviour.[633] Dr Kym Jenkins, a psychiatrist who heads the

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[629] R Smith, Preface in P Lens and G van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997) ix.

[630] H Freudenberger, *The Health Professionals in Treatment: Symptoms, Dynamics and Issues* (Brunner/Mazel, 1986).

[631] See *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012) [29]. Dr Nemeth was an impaired general practitioner who admitted to inappropriate prescribing to large numbers of patients. Between 2007 and 2008 she worked up to 70 hours per week and saw 200–300 patients per week.

[632] Freudenberger, above n 630, 8–42.

[633] Ibid 43–54.

Victorian Doctors Health Program has noted two personality traits as red flags for doctors who come to the attention of regulators: an obsession with the notion of being perfect at everything, and lack of the capacity to self-correct.[634] This lack of ability to 'self-correct' was clearly evident in some of the decisions discussed in the next chapter, and is often referred to as lack of insight.[635] In a Victorian decision *Williams v Medical Practitioners Board of* Victoria, [2008] VCAT 1784) citing an earlier case[636] the concept of insight was referred to in the following way:

> (a) an understanding of the nature of the conduct;
> (b) an acceptance that the conduct was seriously wrong;
> (c) an appreciation of why the practitioner engaged in that conduct;
> (d) empathy with the consequences; and
> (e) a willingness to take measures to identify risk factors and to avoid similar behaviour [99]

As well as the above issues, a number of other factors have also been identified as increasing the risk of relapse. These include a family history of substance use disorder, using major opioids and having a coexisting psychiatric disorder.[637] Certain personality traits can be selective in determining the choice of medicine as a career, and also predictably lead to disruptive behaviours.[638] In the case of Howari, for example, who was working with supervision conditions upon her registration, the judgment notes her disruptive behaviour in a report from her supervisor that stated:

> [4] … Dr Howari had fallen asleep, displayed bizarre behaviours, had been very demanding and authoritarian, when she mixed up patients she insisted she was right so that her behaviour was unsafe and she had poor time management skills.[639]

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[634] Srivastava, above n 583.

[635] *Medical Board of Australia v Hrstic* (Occupational and Business Regulation) [2011] VCAT 707 (20 April 2011).

[636] *Medical Practitioners Board of Victoria v Kaur* [2010] VCAT 364.

[637] Andrews, above n 530, 8.

[638] Charles V Ford, MD, and Gerald L Summer, MD, 'The Disruptive Physician: The Role of Personality Disorders' (1998) 85 *Federation Bulletin* 28.

[639] *Health Care Complaints Commission v Howari* [2012] (unreported, 14 December 2012) 10.

Dr Howari was diagnosed with a narcissistic personality disorder and deregistered. Her case is further discussed in the next chapter.

The risk factors mentioned above may be compounded when a complaint or notification is received about a doctor, particularly if the doctor has an impairment. Although complaints mechanisms and mandatory reporting are aimed at the protection of the public, they also have unintended consequences, as discussed below.

5.7 The impact of complaints and notifications

As noted in Chapters 1 and 2, the National Law makes it mandatory for a doctor to report another doctor if the reporting doctor suspects a colleague may be impaired.[640] Mandatory reporting can be stressful for the notifier as well as for the notified,[641] and as noted in Chapter 2, may undermine the 'ethical competency' of a reporting doctor, drive impaired doctors 'underground' and compromise the treating relationship between an impaired doctor and his treating doctor. Complaints, also referred to as notifications under the National Law, can also have a devastating effect. A recent study in the United Kingdom of doctors facing complaints found that they suffered from severe depression and suicidal thoughts.[642] An earlier UK study on doctors while under GMC investigation over the past decade raised serious questions about the stress and fear associated with the process.[643]

Tempelaar notes the profound effect of a patient complaint on a doctor:

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[640] The National Law at s 140.

[641] Freckelton, 'Disciplinary Investigations and Hearings', above n 247, 142.

[642] Zosia Kmietowicz, 'Doctors Facing Complaints' (2015) 350 *British Medical Journal* 244 [3]. This study found that doctors who were referred to the professional regulator in the UK, the General Medical Council, seemed to be the most at risk of mental health. The study noted that 'a (complaints) system associated with high levels of morbidity among those going through it is not appropriate'.

[643] Dyer, above n 514, 1. It was not clear how many had actually committed suicide but the issue was under investigation. The study cited one case where an impaired doctor who suffered from a number of conditions, including recurrent depressive episodes, and was declared by three psychiatrists to be unfit to take part in the proceedings, was not allowed by the GMC to remove himself from the register voluntarily, a decision the High Court later branded 'irrational'.

In Australia a report in 2011, tabled in a Senate inquiry, noted that a doctor took his own life after a treating psychiatrist reported him to the Australian Health Practitioner Regulation Agency in line with new mandatory reporting laws <http://www.psychiatryupdate.com.au/news/doctor-takes-his-life-after-mandatory-reporting?t=635363626217764535> accessed 19 May 2011. A senate inquiry completed in 2012 focussed on AHPRA's failings in transferring practitioners over to the new national registration system.

> A complaint is an emotional event for a doctor, and it may lead to a vicious circle of physical problems, burnout and subsequent malfunctioning. Doctors who have experienced a malpractice claim or disciplinary proceedings are often more prone to depression, psychosomatic problems, insomnia and feelings of anger and frustration. This creates also a vicious circle, in which not only errors of malfunctioning can lead to malpractice claims, but in which these claims cause even worse functioning.[644]

In one study in New Zealand it was found that the most pervasive finding about the disciplinary process was a 'feeling of being engulfed by a system about which the respondents had no experience and no control',[645] and 'there was a profound, negative, and sustained impact on the doctor-patient relationship, and on the doctor's practice of medicine'.[646] Another study found that the complaints process was perceived as a negative, disempowering, and damaging process for both medical practitioner and patient.[647] Dr Louise Nash examined the impact of medico-legal matters on doctors in Australia, medico-legal matters being not only the investigation of complaints, but negligence claims and other inquiries, such as coronial inquests.[648] According to Nash, over half of Australian doctors will experience some kind of medico-legal matter during their career. Approximately 14% will have a current matter at any time, the most common of which are claims for compensation and a complaint to a complaints body. Nash found that male doctors working in high intervention areas and long hours are more likely to experience a medico-legal matter, and that most doctors find this an emotionally difficult time, with anxiety and depressive symptoms common. The cases of impairment identified in the study undertaken for this thesis support this finding. Most doctors are male and a significant number of doctors suffered from depression, as

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[644] Tempelaar, above n 81, 43; See also Nash, above n 7.

[645] W Cunningham and S Dovey, 'The effect on medical practice of disciplinary complaints: potentially negative for patient care', (2000) 113 *NZ Medical Journal* 464–7.

[646] Ibid.

[647] Richard Tapper, Laurence Malcolm and Frank Frizell, 'Surgeons' experiences of complaints to the Health and Disability Commissioner' 117(1198) *Journal of the New Zealand Medical Association*, 23 July 2004, (referring to past regimes of complaints processes).

[648] Nash, above n 7.

discussed below. In some cases the nature of the doctor's impairment undermines the effectiveness of treatment, as the following 1997 case demonstrates.[649]

In 1997 a quite sympathetic tribunal deregistered an impaired doctor[650] who refused to comply with conditions on his registration, leading to disastrous consequences.[651] Dr Gassy had been diagnosed with a delusional disorder, although it had been difficult for psychiatrists to reach a diagnosis. The complaint alleged that he had breached conditions on his registration, was not competent to practice medicine, and that he suffered from an impairment.[652] He had been placed on the Impaired Registrants Program but then refused to see the psychiatrist he had agreed to see, claiming that the psychiatrist had limited his intervention to history taking and support, with no active treatment. Dr Gassy also claimed that he no longer needed treatment, and that any psychiatrist nominated by the Board would be unfavourably disposed toward him. The Tribunal was not satisfied that Dr Gassy was or had ever been totally unfit to practise, although it suspected that he had been for some years an impaired practitioner.[653] It could not conclude that he was at present impaired or incompetent to an extent that would prevent him from practising medicine as a psychiatrist or at all.[654] Although expressing its disapproval of Dr Gassy's attempt to veto the Board's choice of psychiatrist, the Tribunal stated that it reached the decision to deregister Dr Gassy with considerable regret. However, because he refused to comply with the conditions upon his registration, which involved psychiatric treatment, the Tribunal felt that this was the only way in which the public could be properly protected.[655]

Dr Gassy subsequently travelled to Adelaide in a chillingly calculated plan and shot and killed the doctor whom he felt had initiated the deregistration process by reporting her

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[649] This case is mentioned briefly in Chapter 1 and was not a case in the database for this study. It however powerfully demonstrates the complexities involved in the management of impaired doctors.

[650] This case is briefly mentioned in Chapter 1. See *Re Dr JE Gassy* (NSWMT, 1 August 1997), <http://www.mcnsw.org.au/page/117/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index>

[651] This case is briefly referred to in Chapter 1.

[652] Ibid.

[653] Ibid.

[654] Ibid.

[655] *Dr John Eric Gassy* Medical Tribunal of New South Wales 1 August 1997 <http://www.mcnsw.org.au/page/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-1997/>.

concerns to the New South Wales Medical Board.[656] Dr Gassy was later found to possess a 'hit list' of other doctors whom he felt were involved in his deregistration, as well as an HIV specialist who refused to treat him after the delusional former doctor became convinced he had contracted HIV. As noted in Chapter 1, this case, whilst clearly atypical of most impairment cases, clearly illustrates the complexity involved in managing a doctor with a delusional condition when the regulator or other doctors become part of the delusion or of a perceived conspiracy against the doctor.

There are no easy solutions in cases such as these. Ironically complaints mechanisms and processes which exist to protect the public can have devastating consequences for doctors and defeat the very purpose for which they are intended.

5.8 Conclusion

This chapter has exposed some of the tensions involved in the regulation of impaired doctors, particularly when a complaint or notification is made. It has argued that a medical model of misconduct is in reality a psychiatric model. The chapter has highlighted the peripatetic and powerful role played by psychiatrists in the context of the regulation of doctors, and the tension between their therapeutic and surveillance roles. It argued that the public would be better protected by a focus on the conduct of the doctor rather than their impairment. Such a focus on the specific and problematic nature of the conduct that is described in this chapter might ensure that tribunals specifically addressed the conduct through more stringent protective orders, such as critical compliance conditions (only available in New South Wales), or suspension or deregistration from practice in the other States and Territories when a doctor's misconduct is repeated. This chapter lays the foundation for these issues to be discussed in more detail in the next chapter in the context of the tribunal decisions on impaired doctors.

[656] Dr Margaret Tobin, his former boss in New South Wales. Dr Tobin was shot four times as she was walking away from the lift that she had taken to the eighth floor of the office in which she worked after moving to Adelaide. For a very well researched and compellingly documented account of this case and the context in which it occurred see Melissa Sweet, *Inside Madness* (Pan Macmillan 2006). The book highlights the inadequacy of professional responses to mental illness and the attempts at reform of the mental health system in Australia by Dr Tobin.

CHAPTER 6 – IMPAIRMENT FINDINGS

6.1 Introduction

In this chapter, the findings on impairment are reviewed. They indicate that although very few impaired doctors end up in disciplinary proceedings, the therapeutic culture and psychiatric model of misconduct is clearly demonstrated in tribunal decisions. These decisions usually involve doctors who have repeatedly breached conditions on their registration or have serious substance abuse or psychiatric problems. The cases encapsulate the inherent tensions in reconciling concepts about moral culpability with the psychiatric model of misconduct. They also encapsulate the tensions between public protection and protection of the profession and its impaired members. These tensions are played out in protective orders, which largely focus on rehabilitation, rather than other protective sanctions that are more protective of the public. The importance of adequately monitoring conditions on a doctor's practice is noted. It is argued that a more nuanced approach to the relationship between impairment and misconduct is needed. Such an approach, whilst acknowledging a doctor's impairment, would also focus explicitly on the doctor's misconduct that poses a risk to the public.

6.2 Findings

Appendix E indicates that only a very small number of impaired doctors (six doctors) had formal complaints of impairment made against them.[657] As noted in Chapter 2, the National Law provides that a complaint may be made about impairment as well as misconduct. Another 12 doctors suffered from an impairment although it was not a formal complaint, and the primary complaint was about misconduct.[658] Thus 18 impaired doctors out of a total of 128 doctors had adverse findings against them in disciplinary proceedings during the three-year period of this study. There were other cases where the evidence indicated that the doctor was suffering from a psychiatric

[657] See for example Health Care Complaints Commission v McKenzie [2011] NSWMT 6 (27 July 2011); Health Care Complaints Commission v Philipiah [2012] NSWMT 14 (28 June 2012); Health Care Complaints Commission v Howari [2012] (14 December 2012).

[658] See, eg, *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010).

condition at the time of the misconduct, but there was no official classification or recognition of impairment as defined under the National Law in the decisions.[659] In these cases the doctor's psychiatric condition was used to mitigate or explain the conduct. None of the cases in this study involved purely physical impairment, although one doctor suffered from Lyme's disease as well as depression,[660] and one older doctor, aged 90 (mentioned in Chapter 4), suffered from a number of physical conditions.[661]

The small number of cases resonates with experience in the United States where the low numbers are explained by the fact that most impaired doctors comply with rehabilitation programs, and are treated confidentially.[662] In New South Wales, for example, there are many more doctors in the health program under the National Law than appear in disciplinary proceedings.[663] As noted in Chapter 2, impaired doctors who come to notice are usually diverted into a health pathway for treatment rather than a conduct pathway to be disciplined, although they may come to notice because of conduct or performance issues. The small number of impaired doctors appearing in disciplinary proceedings can be seen in two ways, either as demonstrating the therapeutic focus of the law working successfully, or the failure of the health pathways if the impaired doctors found guilty of misconduct were previously known to regulators. If the health pathways are not working successfully even in only a few cases, the protection of the public is jeopardised.

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[659] *Health Care Complaints Commission v Allen* [2010] NSWMT 8 (2 July 2010). Dr Allen had made a false statement and there was evidence [72] that he had however '…experienced occasional perturbations of mood, usually related to life stresses and he is prone to anxiety'; *Health Care Complaints Commission v Dr Ray Woods* (NSW Medical Tribunal, Deputy Chairperson Balla J, 15 October 2010).

[660] *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012).

[661] *Health Care Complaints Commission v Dr Robert Darlow Smith* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 September 2012).

[662] Walzer, above n 550.

[663] For example in the period 2012–2013 there were 118 participants in the Health Program of the Medical Council of New South Wales <http://www.mcnsw.org.au/page/76/resources/publications/annual-reports/> but as noted earlier only 18 impaired doctors appeared in disciplinary proceedings between 1 July 2010 and 1 July 2013; See also Kiel, 'Regulating Impaired Doctors', above n 136, 429.

6.2.1 Demographic data

Of the 18 impairment cases in Appendix E**,** 14 doctors were male, and four were female. Only five cases reported the age of the doctor.[664] The average age of these five doctors was 46, indicating that the doctors had been in practice for a significant period of time when they appeared before a disciplinary tribunal.[665] One exception was the case of a young female doctor aged 31 who first came to attention when she was a medical student. She suffered from anorexia bulimia, a depressive disorder, and a narcissistic personality disorder. After a lengthy history on the Impaired Registrants Program in New South Wales, she was eventually deregistered.[666] As noted in Chapter 1 it has been argued that the criteria for entrance into medical school are potentially 'the most powerful tools for effective professional self-regulation', as the characteristics of those admitted may predict future behaviour.[667]

Two-thirds of impaired doctors came from New South Wales, where 12 impaired doctors became the subject of disciplinary proceedings out of a total of 64 found guilty of misconduct (18.7% were impaired). In Victoria, there were only three cases of impairment out of 31 cases of misconduct (9.6% were impaired). Therefore, on a percentage basis, twice the number of impaired doctors appeared in disciplinary proceedings in New South Wales as appeared in Victoria between 1 July 2010 and 1 July 2013. This indicates a different approach to the management of impairment in New South Wales, which is further discussed below.

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[664] *Health Care Complaints Commission v Hasil* [2012] NSWMT 1 (15 February 2012); *Health Care Complaints Commission v Howari* [2012] (14 December 2012); *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013); *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010); *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010).

[665] In Mendelson's study the average age was 42, Danuta Mendelson, 'Disciplinary Proceedings Against Doctors Who Abuse Controlled Substances', above n 135. According to Mendelson her findings correlate with previous research in this field. The average age in the present study involved all forms of impairment, whereas Mendelson's only involved doctors who abuse controlled substances

[666] As demonstrated in *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012).

[667] *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012).

In Queensland, Western Australia and South Australia there was only one case of impairment in each state, and there were none in the Australian Capital Territory or the Northern Territory.

6.3 Types of impairment

Table 6.1: Types of impairment and protective orders

State	Drugs	Alcohol	Psychiatric Condition	Cognitive impairment	Protective Orders
NSW					
1. Mukherjee (Conditions breached)	Cocaine, methamphetamine	Alcohol Abuse	Bipolar disorder, depression		Deregistration 2 years
2. Chowdury (Conditions breached)			Depression adjustment disorder		Already deregistered, reprimand and conditions when reregistered
3. McKenzie (Conditions breached)			Depression adjustment disorder	Cognitive impairment	Deregistration
4. Pembroke (Conditions breached)	Self-administer propofol, diazepam, cocaine				Conditions imposed
5. Hasil		Alcohol abuse		Cognitive impairment	Deregistered
6. Nemeth (Conditions imposed)			Depression,		Practice and prescribing conditions
7. Von Marburg (Conditions breached and also imposed)	Self-administer pethidine				Conditions imposed
8. Philipiah			Depression, bipolar disorder		Suspension continued then conditions on practice
9. Woolcock (Conditions breached)		Alcohol abuse			Conditions imposed
10. Snell		Alcohol abuse	Depression		Deregistered
11. Howari (Conditions breached)			Eating disorder, depression, narcissistic personality disorder		Deregistered
12. Ramraka	Cannabis, ecstasy, amphetamines				Conditions
Victoria					
13. Poon	Benzodiazepine dependence		Undiagnosed ADHD, anxiety, bipolar mentation		Conditions and reprimand
14. Young			Narcissistic, risk-taking personality		Deregistered
15. DRP	Pethidine				Conditions and reprimand
Queensland					
16. Dr FA (No 2 and 3)			Bipolar disorder		Suspension
Western Australia					
17. L			Significant difficulties with emotional understanding, empathy and social judgment		Conditions
South Australia					
18. Dr C	Morphine, diazepam, endone				Conditions

Table 6.1 shows the overlapping nature of many impairments. The table also shows that of the 12 doctors from New South Wales, four suffered drug abuse problems and four doctors had alcohol abuse problems. Many had psychiatric conditions, all of them involving depression, usually coexistent with other disorders, including bipolar disorder,[668] adjustment disorder,[669] and, in one case, an eating disorder.[670] Two cases reported cognitive impairment.[671]

In Victoria, of the three doctors with impairments, one case involved drug abuse,[672] one involved alcohol abuse,[673] and both of these involved coexisting psychiatric conditions. The third doctor, although he had no formal psychiatric diagnosis, had 'significant problems with emotional understanding', other psychological problems, and a long complex history with the then Victorian Medical Board, including health conditions upon his registration that he regularly see a psychiatrist.[674]

In Queensland, the only impaired doctor suffered from bipolar disorder; in Western Australia, the impairment was a 'mental disability';[675] and in South Australia the impaired doctor had an addiction to drugs.[676]

Table 6.1 indicates that of the 18 impairment cases across Australia between 1 July 2010 and I July 2013, six doctors were deregistered; five in New South Wales (one doctor was already deregistered so is not counted as a typical deregistration case)[677] and

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[668] *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010); *Health Care Complaints Commission v Philipiah* [2012] NSWMT 14 (28 June 2012).

[669] *Health Care Complaints Commission v Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010); *Health Care Complaints Commission v McKenzie* [2011] NSWMT 6 (27 July 2011).

[670] *Health Care Complaints Commission v Howari* [2012] (14 December 2012).

[671] *Health Care Complaints Commission v McKenzie* [2011] NSWMT 6 (27 July 2011); and *Health Care Complaints Commission v Hasil* [2012] NSWMT 1 (15 February 2012).

[672] *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012).

[673] *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010).

[674] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

[638] *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011).

[676] *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012).

[677] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010).

one in Victoria,[678] three were suspended from practice (one each from New South Wales, Queensland and South Australia), and eight had conditions placed upon their registration[679] (five in New South Wales, two in Victoria, and one in Western Australia). Eight of the doctors had previously breached conditions upon their registration,[680] and whilst four of these doctors were deregistered,[681] four were allowed to remain in practice, in spite of their previous breaches, with further conditions upon their registration.[682]

These figures indicate not only the rehabilitative focus of the law even when conditions on practice have been breached, but the huge confidence that tribunals place in conditions on a doctor's registration being an effective mechanism for protecting the public. In her own research Elkin noted that:

> The approach of tribunals to date has been to take account of the overriding need to protect the public first and foremost but to allow that assessment to be tempered by other considerations (such as rehabilitation and ensuring supply) where doing so will not result in a unacceptable risk. The danger

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[678] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

[679] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011); *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012); *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012); *Health Care Complaints Commission v Woolcock* [2012] (unreported, 17 September 2012); *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013); *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010); *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012); *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011).

[680] *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010); *Health Care Complaints Commission v Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010); *Health Care Complaints Commission v McKenzie* [2011] NSWMT 6 (27 July 2011); *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011); *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012); *Health Care Complaints Commission v Howari* [2012] (unreported, 14 December 2012); *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013); *Health Care Complaints Commission v Woolcock* [2012] (unreported, 17 September 2012).

[681] *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010); *Health Care Complaints Commission v Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010); *Health Care Complaints Commission v McKenzie* [2011] NSWMT 6 (27 July 2011); *Health Care Complaints Commission v Howari* [2012] (unreported, 14 December 2012).

[682] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011); *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012); *Health Care Complaints Commission v Woolcock* [2012] (unreported, 17 September 2012); *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013).

> with this is that "unacceptable risk" is a moving target that can easily be influenced by the wider public interest, such as doctor shortage.[683]

In this thesis, the moving target of unacceptable risk is demonstrated in the cases discussed below which attempt to balance the protection of the public with the rehabilitation of doctors.

Although in some of the deregistration cases psychiatric evidence was rejected,[684] these cases also illustrate the Tribunals' heavy reliance upon such evidence in predicting when the conduct of a doctor may pose a risk to the public. They also indicate the reliance on psychiatrists' abilities to effectively treat and monitor doctors with conditions upon their registration. Some of the challenges in treating impaired doctors have been referred to in Chapter 5. The protective orders placed upon impaired doctors are further discussed below.

6.4 State differences

A significant issue emerging from the data is the difference between New South Wales and Victoria in the number of doctors with impairments who became the subject of disciplinary proceedings, 12 in New South Wales, and three in Victoria where two of the three impaired doctors in this study were involved in the Victorian Doctors Health Program (VDHP).[685] As already noted, it is clear that New South Wales appears to have a greater focus on impaired doctors than the other States and Territories. As a co-regulatory jurisdiction it has an independent mechanism for the investigation and management of complaints.[686] The Medical Council of New South Wales uses the health pathways under the National Law (New South Wales) to manage impaired doctors. The Victorian program (VDHP) however is independent of the Medical Board of Victoria and AHPRA. Its focus is on treatment and rehabilitation and it does not have disciplinary functions. It therefore does not have to balance the rehabilitation of doctors

[683] Elkin 'Medical practitioner regulation', above n 3, 699.

[684] *Health Care Complaints Commission v Howari* [2012] (unreported, 14 December 2012).

[685] <http://www.vdhp.org.au/website/home.html>. The program was established in November 2000 to provide a confidential and compassionate service for doctors and medical students with health concerns, including alcohol, and other drug and mental health problems.

[686] As discussed in Chapter 2.

with the legal mandate of protecting the public. Its treatment focus is non-judgmental unless or until doctors fail to comply with their treatment regime. The VDHP is required to notify the Board only of participants who breach the National Law, that is, those doctors with an illness or condition that has seriously impaired, or may seriously impair, their ability to practice medicine and may put the public at risk.[687] According to its website it is a confidential service for doctors and medical students who have health concerns, such as stress, mental health problems, substance use problems, or any other health issues.[688] Although funded by the Medical Practitioners Board of Victoria (now known as the Medical Board of Victoria), the VDHP is completely independent of the Board and (since 2010) of AHPRA,[689] and is very much in step with developments in the United States, where programs, known as PHPs (Physicians Help Programs),[690] also operate independently of regulatory authorities.

This independence from a regulatory authority arguably contributes to the success of the program.[691] A report on this program[692] and other external programs, which is further discussed in Chapter 8, noted the good clinical outcomes reported by the VDHP as well as the clear support in comparable international settings for case management approaches for medical professionals with drug, alcohol or mental health problems.[693] Under the National Law in Australia, however, an impairment program has a dual focus and must balance the needs of an impaired doctor against the protection of the public.

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[687] In the case of DRP, (one of the notorious cases mentioned in Chapter 1, see above n 75) a condition was placed upon his registration that he participate in a treatment program with the VDHP who were to notify the Board if he failed to comply. The condition stated that he was '(iii) to participate in the Victorian Doctors Health Program (VDHP) including in counselling, monitoring and support groups for a period of not less than five years as directed by the medical director of the VDHP of his or her nominee and to authorise the VDHP to communicate with the Medical Board of Australia about his ability to work and his adherence to programs'. It is not clear whether and when the VDHP notified the Board of any concerns.

[688] <http://www.vdhp.org.au/website/home.html>. The program was established in November 2000 to provide a confidential and compassionate service for doctors and medical students with health concerns, including alcohol, and other drug and mental health problems.

[689] Jack Warhaft, 'The Victorian Doctors Health Program: The First 3 Years' 81 *Medical Journal of Australia* 376. But after the National Law commenced the various state Medical Boards and Councils now consult with AHPRA.

[690] Walzer, above n 550.

[691] Warhaft, 'The Victorian Doctors Health Program', above n 689.

[692] DLA Piper Australia, 'Governance of External Doctors' Health Programs' Melbourne (April 2014). DLA Piper is a global law and consultancy firm <http://www.medicalboard.gov.au/News/2014-04-10-media-release.aspx>.

[693] Ibid.

Impaired doctors whose conduct has come to attention are thus seen as 'both victims and malefactors'.[694] Significantly, consistent with the United States experience, former addicted doctors have been involved in the VDHP and a doctor who was a 'recovered' addict was appointed as medical director when the program was set up.[695]

6.5 Protective orders

There is a range of protective orders available to a tribunal under the National Law, as noted in Chapter 2. These include: the power to caution or reprimand, to impose conditions on a doctor's registration, to order counselling,[696] and to order suspension or deregistration.[697] A fine may be imposed if no other order seems appropriate.[698] As

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[694] Ibid.

[695] Warhaft, *From Addiction to Recovery*, above n 582.

[696] As noted in Chapter 2, New South Wales is the only state to specifically mention psychiatric treatment as a protective order.

[697] The *Health Practitioner Regulation National Law* (NSW) provides Section 149 A General powers to caution, reprimand, counsel etc. [NSW] 149A General powers to caution, reprimand, counsel etc. [NSW]

> (1) The Tribunal may do any one or more of the following in relation to the registered health practitioner—
>
> > (a) caution or reprimand the practitioner;
> >
> > (b) impose the conditions it considers appropriate on the practitioner's registration;
> >
> > (c) order the practitioner to seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);
> >
> > (d) order the practitioner to complete an educational course specified by the Tribunal;
> >
> > (e) order the practitioner to report on the practitioner's practice at the times, in the way and to the persons specified by the Tribunal;
> >
> > (f) order the practitioner to seek and take advice, in relation to the management of the practitioner's practice, from persons specified by the Tribunal.
>
> (2) The Tribunal may do any one or more of the following in relation to the student.
>
> (3) If the health practitioner is no longer registered, an order or direction may still be given under this section but has effect only—
>
> > (a) to prevent the practitioner being registered unless the order is complied with; or
> >
> > (b) to require the conditions concerned to be imposed when the practitioner is registered.
>
> (4) If the Tribunal makes an order or imposes a condition on the registered health practitioner's or student's registration, the Tribunal may order that a contravention of the order or condition will result in the practitioner's or student's registration being cancelled.
>
> (5) The order or condition concerned is then a 'critical compliance order or condition'.

[698] s 149B Power to fine registered health practitioner in certain cases [NSW].

discussed in Chapter 2, there are two protective orders that are unique to New South Wales. A tribunal may impose a 'critical compliance' condition upon a doctor's registration as follows at s 149A (5):

> (4) If the Tribunal makes an order or imposes a condition on the registered health practitioner's or student's registration, the Tribunal may order that a contravention of the order or condition will result in the practitioner's or student's registration being cancelled.
>
> (5) The order or condition concerned is then a 'critical compliance order or condition'[699]

and a tribunal in New South Wales may also specifically order psychiatric treatment under s 149 (a) as follows:

> (c) order the practitioner to seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling).

Interestingly, the zero-tolerance condition on a doctor's practice is used only very sparingly, and is not part of the National Law in the other States and Territories. In one New South Wales addiction case, in which there had been previous breaches of conditions, the Tribunal declined to impose a critical compliance condition because the

---

> (1) The Tribunal may by order impose a fine on the registered health practitioner of an amount of not more than 250 penalty units.
>
> (2) A fine is not to be imposed unless—
>
> > (a) the Tribunal finds the registered health practitioner to have been guilty of unsatisfactory professional conduct or professional misconduct; and
> >
> > (b) the Tribunal is satisfied there is no other order, or combination of orders, that is appropriate in the public interest.
>
> (3) A fine is not to be imposed if a fine or other penalty has already been imposed by a court in respect of the conduct.
>
> (4) A fine must be paid within the time specified in the order imposing the fine and must be paid to the Council for the health profession.

As noted in Chapter 2, because they are usually imposed without reasons for the amount of the fine being given, their use is not discussed in this thesis. The fines that were imposed are noted in Appendix B, which shows that they are usually imposed in conjunction with other protective orders.

[699] Ibid.

doctor had been drug-free for three and a half years.[700] Bureaucratic delay in this case thus allowed the doctor to present a stronger case for more lenient protective orders and avoid more stringent protective orders that may have a more deterrent function. In determining protective orders tribunals must take into account a doctor's current 'fitness to practice'. A tribunal must assess the doctor's fitness to practice not on his or her past misconduct, but their fitness as at the date of the hearing, as discussed below.[701] The delay in the above case was also evident in other cases, as already noted in Chapter 4. (See Appendix B which indicates the delay in cases where it was possible to glean this information from the Tribunal decision).

6.6 The concept of 'fitness to practice' and bureaucratic delay

The concept of 'present fitness to practice'[702] is very relevant in impairment cases. 'Fitness to practice' is often associated with being of 'good character'[703] but in many cases the Tribunals also refer to current 'fitness to practice' when determining protective orders. The term 'capacity to practice' is a part of the definition of impairment (referred to in Chapter 5) and states that:

> 'impairment', in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally or is likely to detrimentally affect-

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[700] *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012). The Tribunal at [32] stated that:

> Further, the critical compliance condition (under s 149 of the National Law) asked for by the HCCC has the effect the doctor would be automatically deregistered, without a hearing, if there is a breach of condition … namely, a relapse by Dr Von Marburg. The Tribunal is of the view the doctor should be given some credit for the three and a half years he has practiced without relapse. Further, the doctor continues to practice without the right to prescribe Schedule 8 and does not seek to have this right restored.

[701] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011) [19]. The author of this thesis was a hearing member of this Tribunal.

[702] The term 'fitness to practice' is often used synonymously with 'fit and proper person'. See Freckelton, 'Good Character', above n 15, 488.

[703] Ibid. As pointed out in Chapter 1, see above n 15, Freckelton notes the simplistic dichotomy between 'good' and bad' character. He reviews the concepts of 'character 'and 'fit and proper person'. He argues that the legitimate public expectation that doctors adhere to high standards of ethical conduct justifies and requires that they not diminish confidence in the profession and suggests replacing the concept of character with the requirement that a medical practitioner be a 'fit and proper person' to be registered.

> (a) for a registered health practitioner or an applicant for registration in a health profession, the person's **capacity to practise** the profession…

However the term 'capacity to practise' is not defined, and the terms 'capacity to practise' and 'fitness to practise' tend to be used synonymously. Mendelson notes in her study of doctors who abuse controlled substances:

> the Tribunal has to consider not only whether the doctor has truly overcome the problem, but also whether the past addictive behaviour has reduced his or her present cognitive and intellectual capacity with adverse consequences for practise.[704]

The principle of current fitness to practice is aided and abetted by the bureaucratic delays referred to above in the hearing of tribunal cases that allow doctors to gather evidence of rehabilitation, such as reports from psychiatrists. When evidence of rehabilitation is provided the more draconian sanctions of suspension and deregistration are avoided. Appendix B indicates that many cases were delayed in reaching a hearing. Paradoxically whilst bureaucratic delay may provide the opportunity for rehabilitation, bureaucratic delays may also put the public at risk. Not all doctors take advantage of delay to rehabilitate themselves and some doctors breach the conditions on their registration pending disciplinary proceedings, or continue the conduct that has brought them to the attention of regulators. Bureaucratic delay may also undermine public confidence not only in the profession but also in the whole system of regulation. The rhetoric of public protection is betrayed by the reality of bureaucratic delay if the public remains at risk for two or more years until the time of a tribunal hearing.

6.7 Doctors deregistered – sad or mad, but also bad

Deregistration is the most serious disciplinary sanction a tribunal can impose. It removes a doctor's livelihood and possibly means the end of their career. Although tribunal and court decisions repeatedly stress that the jurisdiction is protective rather

[704] Mendelson, 'Disciplinary Proceedings Against Doctors Who Abuse Controlled Substances', above n 135, 26.

than punitive,[705] the outcomes for doctors who are deregistered or have other serious sanctions imposed are also clearly punitive for the individual doctor concerned. It is in the deregistration cases that involve impaired doctors that the Tribunals most explicitly make judgments about the moral culpability[706] of a doctor which they tend to suspend in other cases where the rehabilitative focus of the law influences the making of protective orders. The deregistration cases discussed below indicate clearly the tension between impairment and misconduct. The doctors are 'sad' or 'mad', but also 'bad'. The histories in the cases indicate that most doctors who were deregistered had had health conditions placed upon their registration in the past because of their conduct. They had then breached these conditions, and in the worst cases repeatedly.[707]

When the cases involving breaches of conditions did eventually reach a tribunal, the Tribunals found that repeated breaches of conditions could not be adequately explained by the psychiatric model of misconduct. They considered that character flaws and personality factors also contributed to the misconduct, as the following tribunal decisions demonstrate.

The case of Dr Mukherjee involved Medicare fraud, inappropriate and dangerous prescribing, and numerous breaches of conditions.[708] Dr Mukherjee was also a cocaine and methamphetamine user.[709] The cocaine use exacerbated his bipolar disorder.[710] He first came to the attention of the Pharmaceutical Services Branch in 2002. On 24 July 2006 the Board held an inquiry and considered suspending Dr Mukherjee from practice. In spite of 'numerous complaints alleging inappropriate and/or dangerous prescribing of benzodiazepines and drugs of addiction', that 'he demonstrated little insight by continuing to claim that he had acted in the best interests of his patients' and that 'He was evasive in his responses to a number of questions and in some instances the

[705] See *Reimers v Health Care Complaints Commission* [2012] NSWCA 317 per Basten JA at [13], with whom Campbell and Hoeben JJA agreed ('the underlying purpose of a disciplinary order of deregistration is not primarily punitive, but protective').

[706] The term 'moral culpability' is used here to describe conduct by a doctor that s/he knows may create a risk to the public but continues regardless of the consequences.

[707] *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010); *Health Care Complaints Commission v Howari* [2012] (14 December 2012).

[708] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11.

[709] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 34.

[710] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 41.

evidence he gave was self-contradictory',[711] conditions were imposed upon his registration. According to the Tribunal's decision in 2010, between 2006 and 2009 he repeatedly breached the conditions that restricted his prescribing rights and lied to his psychiatrist about possessing cocaine, pethidine and other restricted substances.[712]
The Tribunal found that Dr Mukherjee had used cocaine whilst he was on the Impaired Registrants Program under the auspices of the Board.[713] In reaching the decision to deregister Dr Mukherjee the Tribunal declined to place more conditions upon his registration, commenting (at [87]) that it 'could not be satisfied that protective orders of the type sought would adequately address the need for the protection of the public, as well as maintain the standards of the medical profession'.

Whilst the doctor sought to explain his behaviour on the basis of his bipolar disorder, the Tribunal commented on the extent to which his prescribing behaviour was due to aspects of his personality unrelated to his mental health condition. In the same case, the Tribunal noted that the doctor's non-compliance with his conditions was also not adequately explained by the depression from which he suffered, and said that 'there was a significant component of wilfulness' in his conduct.[714] This case clearly demonstrates a failure in the attempts to rehabilitate the doctor, and in view of his history, it is arguable that he could have been deregistered sooner in order to protect the public. The case also demonstrates the faith of the Board at the time in conditions on a doctor's practice being an adequate means of protecting the public, and the psychiatric model of misconduct being used over many years, rather than more severe protective sanctions. This model and the attempts at rehabilitation arguably protected Dr Mukherjee rather than the public, and it was assumed that he could be 'controlled' from within the

[711] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11 [19].

[712] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11. The particular in relation to the possession of cocaine at [6] stated that:

> On 15 July 2009, while his registration was subject to practice conditions relating to his prescription of Schedule 8 drugs of addiction and Schedule 4D prescribed restricted substances, and health conditions relating to his mood disorder, alcohol dependence and other health problems, the practitioner failed to inform the Board appointed psychiatrist Dr Anthony Samuels that between June 2009 and 15 July 2009 he had — in contravention of a practice condition to which his registration was subject from 24 July 2006 to 21 December 2009 that he not possess, supply, administer or prescribe any Schedule 8 drugs of addiction — possessed a Schedule 8 drug of addiction, namely cocaine.

[713] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 33.

[714] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11.

profession. This control from within the profession and by the profession was obviously a failure and put the public at risk. A focus on the nature of his serious misconduct, which included numerous complaints, including inappropriate prescribing and breaches of conditions, rather than his impairment and attempts to rehabilitate him may have better protected the public.

Another deregistration case mentioned previously involved a young female doctor who had an eating disorder, a narcissistic personality disorder, and also suffered from depression.[715] She had repeatedly breached conditions upon her registration. The Tribunal found that her history illustrated that her dishonesty and manipulative behaviour had been evident for many years.[716] However two psychologists who gave evidence were supportive of her return to practice with more conditions upon her registration, demonstrating a rehabilitative focus on the doctor which may well have undermined the protection of the public in view of the doctor's history of breaching conditions. The Tribunal rejected their evidence and was scathing about the doctor's conduct. The Tribunal accepted the diagnosis of the treating psychiatrist that the doctor had a narcissistic personality disorder which tended to be an enduring and lifelong condition. It noted that personality disorders are one of the most difficult conditions to treat successfully, and said:

> In deciding not to accept (that) evidence from Dr Howari, the Tribunal takes into account that Dr Howari has given repeated assurances over many years that she would comply with the conditions on her registration and then has failed to do so.[717]

This case also clearly exposes the psychiatric model of misconduct and how the concept of the protection of the public embraced the rehabilitation of an impaired doctor and protected her from serious disciplinary sanction for many years. She first came to attention as a student in 2003 but was not finally deregistered until 2012. As in the case above, a focus on the doctor's conduct in breaching the conditions on her registration

[715] *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012).

[716] *Health Care Complaints Commission v Howari* [2012] (14 December 2012) 25.

[717] *Health Care Complaints Commission v Howari* [2012] (14 December 2012) 25–27.

would have arguably been more protective of the public rather than a focus on her impairment over many years.

The case of McKenzie was also one in which the doctor had breached conditions upon his registration.[718] Dr McKenzie had both medical and psychological problems and first came to attention in 2002. He had a long and complex history with the Medical Board of New South Wales involving not only breaches of conditions but suspension from practice.[719] He became engaged in what the Tribunal described as the unethical and unprofessional practice of overseas prescribing on the Internet. This case also demonstrates how a rehabilitative approach over many years took precedence over other sanctions that were arguably more protective of the public.

The character flaws in the above cases, such as wilfulness, dishonesty, and manipulative behaviour that led to the deregistration of the doctors, is consistent with other research on deregistered doctors not involving impairment,[720] which showed that they tended to be removed from practice for character flaws and lack of insight, rather than for medical errors, poor clinical judgment or lack of knowledge.[721] In the impairment cases, it appears that character flaws, such as those indicated in the case of Howari discussed above, were seen as a function of the impairment or excused because of it.

In the above cases the doctors expressed remorse for their conduct, but clearly these expressions were unconvincing to the tribunals, and validated Case's contention that a

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[718] *Health Care Complaints Commission v Dr McKenzie* [2011] NSWMT 6 (27 July 2011).

[719] *Health Care Complaints Commission v Dr McKenzie* [2011] NSWMT 6 (27 July 2011). According to the decision at [10]–[11]:

> 10. In December 2000, Dr McKenzie was suspended from practice by the NSW Medical Board. In May 2001 his suspension was lifted, with conditions. He was again suspended on 28 August 2001 and that suspension was lifted in October 2001, again with conditions.
>
> 11. Throughout 2002/2003, as a result of further complaints, Dr McKenzie was sent, by the NSW Medical Board, for a psychiatric examination by Dr Bruce Westmore. Dr Westmore assessed Dr McKenzie and recommended: urine drug screening; Dr McKenzie to obtain a treating psychiatrist, Dr McKenzie not work in isolation. The Board and Dr McKenzie accepted these recommendations. Dr McKenzie was required to undertake six monthly reviews by the Board.

[720] Elkin, Spittal and Studdert, 'Removal of Doctors from Practice', above n 149, 1027.

[721] Elkin, 'Medical Practitioner Regulation', above n 3, 452; Warfe, above n 132, 67.

redemptive approach to misconduct may encourage dishonesty in doctors at the expense of their professional integrity.[722]

The case histories demonstrate both the faith of the respective Boards or Councils in the psychiatric model of misconduct, but also the failure of the model in that the deregistered doctors had not been successfully treated or rehabilitated. Six out of 18 impaired doctors who appeared in disciplinary proceedings were deregistered. The most serious disciplinary sanction of deregistration was only exercised in the most extreme cases where previous protective orders had failed.The goal of protecting the public at an earlier stage was arguably subverted in these cases by the goal of rehabilitating the impaired doctor through the imposition of conditions upon the doctor's registration designed to protect the public during the process of rehabilitation. When conditions were breached the public was at risk. These cases raise the question not only as to whether more serious protective orders could or should have been considered earlier in order to protect the public but the question as to whether the conditions on a doctor's practice could or should have been more adequately monitored. Whilst it is difficult to glean specific information about the failure of monitoring processes from the tribunal decisions, it is clear from the recommendations made by the Queensland Ombudsman (discussed below) that there is room for significant improvement in this important area.

In the deregistration cohort of impairment cases, tribunals were assisted in their decision-making by being able to make findings of fact regarding breaches of conditions, and other factual findings about conduct relating to lack of compliance with treating doctors.[723] These findings of fact, as well as predictions about future risk, based upon the past failures of the doctors to comply with health conditions upon their registration, facilitated the imposition of the most serious disciplinary sanction of deregistration. It is arguable that in some of the above cases, such as *Mukherjee* and *Howari*,[724] this sanction should have been imposed sooner in order to protect the public. These cases indicate that the pendulum tipped too far in favour of rehabilitating the impaired doctor.

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[722] Case, above n 22.

[723] Unlike the less serious cases where a doctor may not have acquired a history of repeatedly breaching conditions upon their registration.

[724] *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010); *Health Care Complaints Commission v Howari* [2012] (14 December 2012).

6.8 Doctors suspended

In only two of the 18 impairment cases were doctors suspended from practice by the Tribunals, although in some of the cases the doctors had been suspended in the past.[725] Both cases involved the imposition of conditions upon a doctor's registration following the period of suspension.

In one such case a doctor had been found guilty of professional misconduct in relation to his management of five patients.[726] The doctor's competence had been challenged as he had failed to properly diagnose patients in an emergency department, failed to properly take a history and failed to recognise symptoms. A second complaint alleged that he suffered from impairment in the form of a bipolar affective disorder. As he was currently practising in New Zealand with conditions upon his registration the Tribunal ordered that his registration in New South Wales be suspended until he returned to New South Wales, and that he obtain an updated medical report from his treating psychiatrist confirming his fitness to practise medicine before his suspension was lifted. The Tribunal also said:

> [60] The Tribunal is of the view conditions should then be placed on the doctor's registration after the Medical Council lifts the suspension. The supervision and mentoring conditions are to ensure the doctor is given full professional support. The health related conditions[727] are to ensure the doctor continues to gain the support provided by a treating Psychiatrist.[728]

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[725] *Health Care Complaints Commission v Philipiah* [2012] NSWMT 14 (28 June 2012); *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012).

[726] *Health Care Complaints Commission v Philipiah* [2012] NSWMT 14 (28 June 2012).

[727] The Health Conditions to be imposed when Dr Philipiah resumed practice included:

> 1. To attend for treatment by a general practitioner of his choice, at a frequency to be determined by him and the treating practitioner. He is to notify the Medical Council of NSW of the name of his treating general practitioner within 2 weeks and is to authorise the treating practitioner to inform the Council of failure to attend for treatment, termination of treatment or if there is a significant change in health status. He is to be responsible for any costs associated with consulting the general practitioner.
>
> 2. Attend for treatment by a psychiatrist of his choice, once a month or at a frequency to be determined by the treating psychiatrist. Dr Philipiah is to notify the Council of the name of his treating psychiatrist within eight weeks of registration in NSW and is to authorise the treating psychiatrist to inform the Council of failure to attend for treatment, termination of treatment or if there is a significant change in health status. He is to be responsible for any costs associated with consulting a psychiatrist.

In this case the protective orders quoted above clearly embrace a rehabilitative focus with reference to 'full professional support' and 'the support provided by a treating Psychiatrist'. The Tribunal's decision was appealed on a point of law in relation to the indefinite nature of the suspension.[729] The point remains however that the language of the Tribunal was clearly focussed on the rehabilitative needs of the doctor, although practice as well as health conditions were imposed upon the doctors' registration in order to protect the public.

In the other suspension case a doctor established a website on which she provided instruction on how a woman might terminate her pregnancy using a drug regime at home, and without medical supervision.[730] Dr FA had been disciplined previously for unprofessional conduct for her role in an out-of-hospital drug-induced abortion.[731]

> 3. To attend for treatment by a psychologist of his choice, fortnightly. The sessions with the psychologist is to deal with issues relating to improving his insight to matters raised in the Tribunal hearing including resolving past trauma and dealing with stress management. To authorise the treating practitioner to inform the Council of failure to attend for treatment, termination of treatment or if there is a significant change in health status. He is to be responsible for any costs associated with consulting a psychologist.
>
> 4. To continue taking any medication prescribed by his treating psychiatrist including mood stabilising medications. Any change to medication should be at the psychiatrist's request.
>
> 5. On obtaining re-registration in NSW to attend for review by the Board-nominated psychiatrist as directed by the Council, at the Council's expense.
>
> 6. To authorise the Council to forward copies of this Decision and any subsequent Board Review Interview or other reports and any other information relevant to his health and treatment, to the Council-nominated practitioners and his treating practitioners, supervisor and mentor.
>
> 7. The practitioner is to notify the Council immediately of any change in treating practitioner so that copies of the decision may be provide to them.
>
> However, should Dr Philipiah seek to change or remove any of the conditions imposed as a result of this Tribunal's orders when his principal place of practice is anywhere in Australia other than in New South Wales, s 125 to s 127 inclusive of the Health Practitioner National Law are to apply, so that a review of these conditions can be conducted by the Medical Board of Australia.

[728] Ibid [60].

[729] Ibid. The Commission's essential complaint was that that suspension was indefinite, despite the Tribunal only having power, under s 149C(1) of the National Law, to suspend for a specified period. The Tribunal imposed the indefinite suspension despite the parties' consensus as to the Agreed Conditions and the Court of Appeal at [29] held that the Tribunal exceeded its powers and set aside the orders. In lieu of those orders, conditions were imposed on the registration of the doctor in terms similar to the Agreed Conditions put forward by the parties.

[730] *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012).

[731] *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012) [4]; Between the finding of professional misconduct and the hearing on protective orders, psychiatric evidence was presented at an interim directions hearing which included evidence from a psychiatrist, who diagnosed Dr FA as having suffered from a bipolar 1 disorder that had been present for much of her adult life, as well

The Tribunal said:

> [6] The more difficult question is whether the conduct which is the subject of these proceedings also occurred at a time when Dr FA was impaired. Tentatively, Dr Slaughter[732] suggested her conduct over a number of years may have been affected by her condition. He acknowledged the difficulty in reflecting back and assessing the impact of a present condition in the past. Dr FA has been disciplined previously for unprofessional conduct for her role in an out of hospital drug induced abortion. Dr Slaughter has raised the suggestion that Dr FA might have been labouring under her illness at that time too.[733]
>
> [7] Perhaps because, as Dr Slaughter noted, Dr FA could be very convincing, both these and the earlier disciplinary proceedings were premised on Dr FA's conduct alone, not on an allegation that it evidenced she was impaired then or now.

The above quotation from the judgment encapsulates the tension in applying the psychiatric model of misconduct to past conduct where there was no evidence of impairment at the time. Whilst tribunals routinely make judgments about a doctor's past conduct, in this case the Tribunal had to examine the possibility of an underlying psychiatric condition at the time of the misconduct through the lens of a retroscope making the task of determining appropriate protective orders even more difficult. As the Tribunal noted:

> [18] The question of what sanction is most appropriate to protect the public interest depends on what risk Dr FA presents. If her conduct in establishing the website was deliberate and not affected by an underlying and untreated psychiatric condition, a sanction that involves an element of personal deterrence might be called for, particularly given the earlier disciplinary proceedings.

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as a chronic pain disorder associated with both psychological factors and a general medical condition. He considered she was unwell when she appeared in the Tribunal.

[732] The unfortunate name of the psychiatrist.

[733] *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012).

> [19] On the other hand, if her conduct was indeed affected by an active psychiatric condition, the public will be best protected by a regime that provides a high level of satisfaction that Dr FA is fit to return to work and will maintain appropriate treatment.[734]

It is not clear in this decision exactly how the doctor's illness impacted upon her establishment of a website about the termination of pregnancy. The rather 'black and white' approach indicated above does not seem to contemplate the more nuanced view that the doctor could be both impaired and morally culpable. In either case, in view of the doctor's history, it is also not clear why an element of personal deterrence in which a tribunal aims to deter the doctor from such conduct in the future might not be called for in the consideration of protective orders, even if the doctor was impaired. The decision represents a classic example of the suspension of judgment about moral culpability once the impairment issue is raised and a failure to more explicitly recognise the protection of the public as a pivotal objective in protective orders.

6.9 Conditions on registration

The cases below clearly demonstrate the use of protective orders as a means of 'containing' deviant doctors within the profession.[735] The imposition of conditions upon a doctor's registration neatly demonstrates Rose's theory that risk strategies seek to 'identify, classify and if possible neutralise the riskiness of the individual pathological person'.[736] Risk thinking breaks up the risk by making it manageable. The cases in this study show that there is usually more than one condition when conditions are placed upon a doctor's registration, indicating how risk is compartmentalised in order to be managed. It is arguable that the decision to impose conditions upon a doctor's registration may divert tribunals to the task of considering which conditions should be imposed and why, rather than considering the protection of the public more broadly, and weighing up whether other protective orders such as suspension or de-registration would more adequately protect the public.

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[734] *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012).

[735] Morrow, 'Sick Doctors', above n 17.

[736] Rose, above n 162, 177.

A very common health condition on a doctor's practice involves regular meetings with a psychiatrist. In the case of a doctor with an addiction problem the health condition was typically worded as follows:

> To attend for treatment by a psychiatrist of his choice, experienced in the treatment of drug addiction, at a frequency to be determined by Dr Von Marburg and the treating psychiatrist. The doctor is to authorise his treating practitioner to inform the Medical Council of New South Wales of failure to attend for treatment, termination of treatment or if there is a significant change in health status (including a significant temporary change).[737]

It is significant that the psychiatrist is authorised to inform the Medical Council of any significant changes in health status as described in the condition. As noted in Chapter 5, Rose argues that the role of psychiatrists is more administrative than therapeutic[738] and it is clear in many of the cases in this thesis that psychiatrists certainly play an administrative role in the regulation of impaired doctors.

Little research is available on how an impaired doctor experiences treatment knowing that their treating psychiatrist is authorised to report them to the relevant authority if they disclose anything that might be against their interest, such as a slight relapse. Although impaired doctors may be responsive to treatment by psychiatrists with whom they develop a therapeutic relationship, it is also natural that 'there is a chronic mutual distrust between the regulatory body and those regulated'.[739] Whilst such a condition as the one referred to above may be argued to be protective of the public, clearly there is a tension in the dual roles played by a psychiatrist in this situation, which is similar to the tension discussed in Chapters 2 and 5 in relation to mandatory reporting.

In one case, the Tribunal was quite prepared to consider the issue of both specific and general deterrence irrespective of the doctor's impairment, and in the context of the Tribunal's considerable sympathy for the doctor. In this case, a doctor had self-administered morphine for a period of almost two years, had falsified prescriptions and

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[737] *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012) [43](7).

[738] Rose, above n 162, 179.

[739] Walzer, above n 550, 139.

drug registers, and written prescriptions for herself in her former married name.[740] Considerable evidence was presented in relation to her recovery from her addiction, and to her valuable community work when she was in practice.

The Tribunal in considering what protective orders to impose said:

> [33] In dealing with this matter the Tribunal has taken into account all of the foregoing in determining how best to protect the public whilst facilitating the return of Dr C to practice. The Tribunal particularly notes that she is a valued member of the medical profession and that the behaviour complained of was generally atypical and unlikely to be repeated, particularly if appropriate conditions on practice are put in place. The Tribunal also considers it important that appropriate sanctions are applied in order to send a message to others in potentially similar positions. It is our view that, whilst Dr C is deserving of leniency because of all the mitigatory factors we have discussed above, the essential elements of misuse of drugs of dependence and the falsification of prescriptions and register entries are particularly serious and must be regarded and treated as such by this Tribunal so that any sanctions imposed must be sufficient to provide both specific and general deterrence to her and to health providers at large.
>
> [34] Accordingly the Tribunal determines as follows:
>
> > (1) The practitioner, Dr C, is hereby reprimanded with respect to her behaviour detailed in the complaint.
> >
> > (2) The practitioner is to pay a fine of $5,000. That fine is to be paid directly to AHPRA in five equal instalments over a period of six months commencing in July 2012 and payable by the last day of each month.
> >
> > (3) The Practitioner is able to return to practice on the following conditions…[741]

[740] *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012).

[741] Ibid.

This case again demonstrates the faith, which it is argued in this thesis is misplaced, by tribunals on the imposition of conditions upon a doctor's registration as a means of protecting the public. It presumably imposed the fine as a deterrence, but the relatively small amount of the fine seems to contradict what the Tribunal found to be serious misconduct in the doctor's drug misuse of drugs and falsifying of prescriptions.

6.10 Conditions imposed in spite of previous breaches

The cases where the doctors have previously breached conditions indicate the faith of tribunals in a therapeutic approach to misconduct even in the face of non-compliance with conditions. As noted above there were four such cases where further conditions were imposed upon the doctor's registration in spite of their previous breaches. In one such case of an ENT surgeon who self-administered pethidine, the Tribunal found that the surgeon had been free of addictive behaviour for three and a half years (with one possible lapse),[742] and the psychiatrist stated that:

> As best I can ascertain, Dr Von Marburg expresses full commitment to remaining abstinent from self-administration of prohibited substances, and he says that his life situation is less stressful and that he is not troubled by headache as much as he was previously.
>
> All these factors could be seen to reduce the risk of lapsing into Pethidine or other prohibited substance abuse.
>
> I do not believe it is possible for anyone to quantify the likelihood of Dr Von Marburg suffering a lapse.
>
> I believe that, as long as Dr Von Marburg desists from self-administration of Pethidine or any other prohibitive substances, and complies with the usual standards of medical practice and of his specialty ENT practice, he does not pose any risk to the community.[743]

[742] *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012)[35]. Although the Tribunal noted that '…there seems to have been evidence of some access to pethidine in early October 2008'.

[743] *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012), 35.

The language used by the psychiatrist here is tentative. The phrases 'As best I can ascertain' and 'All these factors could be seen to reduce the risk' indicate an understandable lack of certainty about the future conduct of the doctor, given that he practices in a high-risk area and has breached conditions in the past. The psychiatrist here in part relies upon the self-report of the doctor, which, particularly in addiction cases, is not always reliable. Faced with cautious psychiatric evidence regarding the risk of relapse, the Tribunal manages the risk and its own uncertainty by placing conditions on the doctor's registration, by compartmentalising the risk and making it manageable.[744] As noted above, there is little available research in Australia upon the effectiveness of conditions upon a doctor's registration.

This case clearly demonstrates the tension between rehabilitation of the doctor and protection of the public. It also demonstrates one of the earlier mentioned assumptions frequently made by psychiatrists, that there is a causal relationship between a stressful situation which may cause impairment, and particular conduct. However, in fact there may or may not be a connection, and if such a connection is thought to exist, then, as Shea argues, its nature needs to be demonstrated, not simply assumed.[745] There is no such demonstration in the text of this decision, although typically the cases cite only selected passages of the psychiatric reports. However the reference to a 'less stressful' life situation and the fact that the doctor is 'not troubled by headache as much as he was previously' implies that the psychiatrist sees a causal relationship between impairment and misconduct, and may understate the doctor's responsibility for his own well-being.

In another such case where a doctor had breached conditions upon his registration and further conditions were imposed, the Tribunal accepted the evidence of two psychiatrists that Dr Pembroke was fit to practice and stated:

> In relation to the likelihood of the repetition of misconduct the Tribunal is firmly of the opinion that Dr Pembroke will not repeat his past misconduct. The Tribunal has arrived at this opinion as it considers that Dr Pembroke

[744] Rose, above n 162, 180.

[745] Peter Shea, *Psychiatry in Court* (Hawkins Press, Second Edition, 1996) xiii.

> committed the misconduct at a time when he was suffering emotional trauma.[746]

In spite of the evidence of the previous breaches the 'firm' opinion of the Tribunal is somewhat surprising, particularly when addiction has been described as a chronic relapsing condition. Like the case above, this case also demonstrates the tendency of psychiatrists to assume that stress, or in this case 'emotional trauma',[747] has a causal relationship to the misconduct of the doctor[748] and arguably understates the doctor's own personal responsibility for his conduct. It also demonstrates a psychiatric model of misconduct which keeps 'deviant' doctors within the profession.

However, it is important to recognise that many of these cases pose difficult problems for tribunals when there is strong evidence of rehabilitation over a considerable period of time and no apparent or immediate risk to the public. In these circumstances conditions may protect the public if properly monitored. The Report of the Queensland Ombusdman referred to in Chapter 1 is very timely in this respect.

The Tribunal also referred to the element of deterrence in the above case stating that:

> The Tribunal is mindful that an element of deterrence is required to assure the public that serious lapses in the conduct of practitioners will not be passed over or put aside. Taking into account the circumstances of this matter, the Tribunal considers that this deterrence can be achieved by means of imposing conditions upon Dr Pembroke's registration.[749]

It is arguable that a stronger message of deterrence would involve suspension from practice for example, and that this case also demonstrates the Tribunal protecting the interests of the doctor rather than the public by imposing conditions.

In another case where further conditions were imposed after previous breaches, draft protective orders were agreed by the parties and no reasons are given for the

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[746] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011). The author of this thesis was a member of this tribunal.

[747] In Von Marburg 'his life situation is less stressful' and in Pembroke the 'emotional trauma'.

[748] Shea, above n 745.

[749] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011) [23].

continuation of conditions upon the doctor's registration.[750] The doctor had problems with alcohol and had admitted to failing to notify the Medical Board of contravening an apprehended violence order, of driving with a mid-range prescribed concentration of alcohol, and driving while disqualified.[751] It is not clear therefore why further conditions were imposed or whether other protective orders were considered which might have been more protective of the public.

In the case of Ramraka where there were multiple complaints, conditions had been imposed and breached, but were imposed again.[752] One of the complaints involved inappropriate prescribing to nine patients between 2005 and 2008 and the doctor admitted the complaint. The Tribunal said:

> [32] The respondent prescribed serious drugs to each of them and he did so, over an extended period of time. There was an actual risk to each patient as a result of the drugs prescribed by the respondent and as a result of the period over which the drugs were prescribed. The respondent should have been aware of the dangers to the patients, including the potential for addiction or misuse of the drugs, or in which the prescriptions were contraindicated. The conduct involved nine patients in a period spanning 3 years and 10 months between January 2005 and November 2008. In these circumstances, the conduct cannot be characterised as an isolated lapse of judgment especially as the respondent was previously counselled for prescribing problems and his conduct took place after having done remedial courses.
>
> [33].The Tribunal accepts the further contention that the respondent did not provide a satisfactory explanation as to why he prescribed medication to the patients in the ways described, but we have formed the view that the effect of his excessive alcohol intake and his psychological problems together, contributed to his extended lack of judgment in acting as he did.[753]

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[750] *Health Care Complaints Commission v Woolcock* [2012] (17 September 2012).

[751] *Health Care Complaints Commission v Woolcock* [2012] (17 September 2012).

[752] *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013).

[753] *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013).

Also particularised was conduct which included not only alcohol use, but using illicit substances at his surgery during consulting hours, inappropriate comments of a sexual nature in the presence of patients, behaving violently, aggressively or threateningly to staff and/or patients, failure to observe professional boundaries, inappropriate sexual comments to staff, abusive or offensive language in the presence of patients or to staff, consulting with patients whilst under the influence of drugs/alcohol and accessing adult websites.[754] The Tribunal took into account that almost five years had passed since the conduct last occurred and said:

> Without diminishing the seriousness of the conduct in the complaints particularised in paragraphs 34 to 36, the Tribunal considers that in most cases, they were manifestations of the underlying psychological and alcohol/drug abuse problems suffered by the respondent. We consider that if the underlying causes are effectively dealt with, a repetition of conduct of this kind by the respondent is unlikely.
>
> [104] The evidence establishes that the respondent has undergone personal and professional assistance to address the underlying precipitating causes of his behaviour and according to the professional opinions of Drs Samuel and Smith; he has been successful in so doing.[755]

This case, although acknowledging the seriousness of the doctor's conduct, clearly demonstrates the Tribunal's reluctance to make any judgment about the moral culpability of the doctor, which covered numerous areas of his practice and at the relevant time clearly posed a risk to the public. It arguably understates his own responsibility both for his alcohol abuse and his misconduct in numerous areas. It was another illustration of how delay in bringing the matter before a tribunal can benefit the doctor. If a doctor is sufficiently rehabilitated, protective orders, such as suspension or deregistration, are unlikely to be imposed.

[754] *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013) [34]–[36].

[755] *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013) [104].

6.11 Conditions imposed where no previous breaches

Other cases involved doctors who had not formally breached conditions upon their registration but had come to the attention of authorities before being referred for disciplinary proceedings. In one such case, a doctor admitted to inappropriate prescribing for numerous patients with addiction problems,[756] and also admitted overservicing patients to help pay off her substantial debts. She was on the Impaired Registrants Program for a number of years. The Tribunal took into account the fact that she had no complaint against her for the past three and a half years and placed further conditions upon her registration. The Tribunal also said:

> [56].All these breaches we accept were committed in the context of her being not in good health and at a time when she was under personal stress. We also accept she did not have, in her past practices, great experience as a general practitioner with drug dependent patients (in the relevant period).
>
> [60] As to penalty, Dr Clark and Dr Schloeffel have opined the doctor is now much more physically and mentally stable than she was during the relevant period. Dr Clark has specifically opined that she is fit for practice. He concluded the way she conducts her medical practice is 'more peaceful'; that she had 'found her metier' with a 'positive way of looking ahead' and 'avoiding different aspects that got her into trouble in the past'. Significantly he opined that her way of thinking is 'very valuable' and noted her 'empathic' nature and that her 'intelligence' makes her 'a good doctor'.

This case also indicates the reluctance of the Tribunal to judge the conduct in moral terms. The overprescribing conduct involved numerous patients and serious dishonesty, and the doctor had been warned about her conduct. The decision appeared to minimise the serious nature of this conduct and its impact upon the public. The psychiatric evidence meant the doctor was allowed to continue in practice with limited prescribing rights. Given her serious dishonesty, this case and its emphasis on rehabilitation also raises the question of whether the public was adequately protected by the conditions

[756] *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012). She had been warned in the past about her prescribing practices and had also come to the attention of the Professional Services Review Board for overservicing. She was fined and had Medicare restrictions placed upon her practice that were eventually lifted.

imposed upon the doctor's practice. The decision protects the doctor from suspension or deregistration and arguably understates her own responsibility for her conduct.

In another case where conditions were imposed the Tribunal stated that:

> The Tribunal is of the opinion that the respondent's conduct was influenced by her own undiagnosed health conditions, especially adult ADHD and benzodiazepine dependency. Each of these matters affected her judgment. That being so, the tribunal is of the view that the orders it makes must protect the public whilst the respondent works towards full recovery under supervision.[757]

There were two other cases where conditions were imposed on the doctor's practice. One was the case of DRP mentioned in Chapter 1,[758] where the doctor had an addiction but was allowed to continue in practice with conditions upon his registration, and infected 55 patients with hepatitis C. The other case involved a doctor with a history of sexual misconduct, who had been deregistered in the past. In this case there was discussion as to whether his misconduct, which involved placing a post-it note under the bra strap of a patient, was due to 'characterological faults' or a 'mental disability'.[759] The Tribunal said:

> [46] Impulse control, emotional understanding, empathy and judgment are matters of the mind. The inability to adequately control impulse can, in our view, be properly described as an 'incapacity', and in that sense a disability.
>
> [47] If a practitioner possesses a condition of the mind which is likely to adversely affect their ability to practise medicine, then an impairment matter will arise.

[757] *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010).

[758] Above n 66.

[759] *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011). This case and the relevant law are discussed in Chapter 7 on sexual misconduct.

> [48] In our view, L's difficulty with impulse control within the sexual realm is such a condition of mind.[760]

As discussed in the following chapter on sexual misconduct, in many sexual misconduct cases, psychiatric evidence was used to explain or mitigate conduct, and psychiatric treatment was mandated by conditions placed upon the doctor's practice. However in none of the cases was 'impulse control within the sexual realm' seen as a condition of the mind. This case arguably also demonstrates the tendency of tribunals to pair misconduct with impairment, resulting in more lenient protective orders, such as the imposition of conditions rather than suspension or deregistration.

In the case of DRP mentioned above,[761] the doctor who infected 55 women with hepatitis C was an anaesthetist who admitted to obtaining pethidine by false representation in 2008–2009, self-administering a Schedule 8 Poison, creating false records relating to his Schedule 8 Poisons prescribing, and submitting these records to the Drugs and Poisons Regulations Group.[762] He also admitted that none of the pethidine he obtained was used on patients. At the commencement of the hearing, the parties (DRP and the Medical Board of Victoria) filed a Statement of Agreed Facts and a joint submission as to findings and determination. The doctor was cautioned and reprimanded, and conditions were placed upon his registration. There was no discussion in the judgment as to the reasons for the orders made or of the conduct itself.[763]

This tribunal decision, from the orders made, is clearly sympathetic to the doctor, as in spite of his addiction he was allowed to remain in practice as an anaesthetist, potentially putting the public at risk if he did not comply with his conditions.[764] It clearly demonstrates that a rehabilitative focus took precedence over orders which would have more adequately protected the public. However in March 2013, a sentencing decision in

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[760] *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011).

[761] Referred to in this way because the name of the doctor was suppressed at the time of the hearing after evidence was heard from a psychiatrist.

[762] *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012).

[763] *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012).

[764] It is arguable that doctors with addictions, which are still being actively treated, should not be in practice until they have demonstrated compliance with conditions upon their practice for a considerable period of time, as in the case of Pembroke, discussed above.

the Supreme Court of Victoria relating to the same doctor, named the doctor[765] and was scathing both of his conduct and that of the Medical Board of Victoria. Dr Peters was convicted on 55 charges of negligently causing serious injury after he infected 55 patients with hepatitis C. The judgment indicates that he would remove a Fentanyl syringe from an operating theatre, take it to a private place, attach a needle and inject himself. He then used the same syringe on his patients knowing that he carried the hepatitis C virus. At the time Dr Peters was under the supervision of the Board until he was finally deregistered in 2010 when the cluster of hepatitis C cases were traced to him. The judge found that from at least 2008 onwards he was not only addicted to narcotics but using them on a regular basis.[766] Both the prosecutor and the doctor's counsel made highly critical observations of the Medical Board of Victoria. The judge noted that the very regular urine samples taken from him under Medical Board supervision were never once tested for the presence of Fentanyl or its metabolites, notwithstanding that this was his narcotic of choice, and one to which Dr Peters was exposed on a daily basis.[767] In relation to the criticisms of the Board, the judge told Dr Peters that at [11]:

> By and large, these criticisms were justified. The Board relied on your honesty and their urine screening program failed… Whatever the failings of the Board may have been …It was you who infected your patients, not the Board. It was you who failed to notify the Board of your hepatitis C status, it was you who misled them as to the true state of your addiction, and it was you who made the decision to continue practising even when you knew that your addiction was hopeless. I do not regard the shortcomings of your supervision as diminishing your moral culpability in any material respect.[768]

Dr Peters was sentenced to 14 years in prison with a minimum term of 10 years before he was eligible for parole. He appealed the sentence on the basis that it was manifestly excessive. The appeal was rejected, Osborne JA noting that the negligence in issue was gross negligence by a specialist medical practitioner in a position of trust who acted

[765] *Peters v The Queen* [2013] VSCA 222 (16 August 2013).

[766] *Peters v The Queen* [2013] VSCA 222 (16 August 2013) [5].

[767] *Peters v The Queen* [2013] VSCA 222 (16 August 2013) [6].

[768] *Peters v The Queen* [2013] VSCA 222 (16 August 2013).

negligently towards a totally vulnerable class of persons who he knew were reliant upon his professional skill in managing the syringes he used for anaesthetic procedures.[769] According to Osborne JA:

> The further submission that the cumulation imposed was excessive is also not reasonably arguable. Any lesser cumulation would, in my view, have reduced the individual victims to mere ciphers, and some substantial cumulation was necessary to reflect the moral culpability inherent in the repeated practice of grossly negligent acts.[770]

The discourse in criminal cases is in sharp contrast to the discourse in most of the disciplinary cases in this study that involve addicted doctors, as it is clearly judgmental, and insists that doctors should be responsible for the consequences of their actions. This issue is further discussed below.

6.12 Psychiatrists in a surveillance role

The powerful and ubiquitous role of psychiatrists in the regulation of doctors is rarely recognised explicitly in the literature on the regulation of doctors. Reference has already been made in Chapter 5 to the inherent tensions in the roles of psychiatrists in a regulatory context, between therapeutic roles (which involve the treatment of impaired doctors), and administrative roles, which involve monitoring their rehabilitation.[771] As noted above, the tensions are also described as being between 'care of the sick and protection of the community'.[772]

The legal responsibility of a psychiatrist to report an impaired doctor for breach of a condition is more blurred than the responsibility to make a mandatory notification about a colleague, as the impaired doctor has to authorise the reporting in the first place by agreeing to the conditions upon his practice. As noted in the addiction case discussed above, the doctor had to authorise his treating practitioner to inform the Medical Council of New South Wales of failure to attend for treatment, termination of treatment,

[769] *Peters v The Queen* [2013] VSCA 222 (16 August 2013) [20].

[770] *Peters v The Queen* [2013] VSCA 222 (16 August 2013) [21].

[771] Rose, above n 162.

[772] Basaglia, above n 628.

or if there is a significant change in health status (including a significant temporary change).[773]

Effectively, however, the psychiatrist 'polices' the doctor, and may be required to notify the relevant Board (or to put it more colloquially, to be a whistleblower) if conditions are breached), although the discourse is never framed quite this bluntly. This policing role may have a negative effect on the trust between doctor and patient, which is vital for developing beneficial interpersonal working relationships and positive patient outcomes.[774] It is arguably a form of mandatory reporting, which is known to have an impact on both the reporting and reported doctor, and can be a difficult and stressful experience,[775] as also noted above. Despite its well-intentioned premise, mandatory reporting has 'the potential to reduce, rather than enhance, levels of trust across stakeholder relationships at many levels'.[776] This may also be the case when a psychiatrist has to notify a regulatory authority if a doctor breaches treatment conditions on their registration. Whilst there is now some research available on the impact of mandatory reporting, the specific impact of the reporting role of a psychiatrist in a different disciplinary context is not yet known. The issue did not arise in any of the cases discussed below.

The discourse in the cases about diagnosis, management and risk assessment is dominated by psychiatrists.[777] In spite of quite serious misconduct, almost half of the impaired doctors were kept in practice with conditions upon their registration, usually involving psychiatric treatment.[778] Thus psychiatrists play a key role in the protection of the public, which has not been explicitly recognised, and is a fruitful area for further research. For example, it was not clear from the Tribunal decisions in this study when

[773] *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012) [43](7).

[774] Jayne Hewitt 'Is Whistleblowing Now Mandatory? The Impact of Mandatory Reporting Law on Trust Relationships in Health Care' (2013) 21 *Journal of Law and Medicine* 82–83.

[775] Ibid 98.

[776] Ibid 101.

[777] Greig, above n 116, 15. Greig states that during the latter part of the nineteenth century, psychiatrists and psychologists, 'became the holders of special knowledge about 'dangerous persons' and developed a number of explanatory models with quite diverse bases and a degree of slippage between madness and badness.'

[778] See, eg, *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012).

doctors breached conditions upon their registration what role was played by psychiatrists in bringing the breaches to attention.

Although the concept of therapeutic jurisprudence to some extent blurs the boundaries between law and psychiatry, the legal role in disciplinary proceedings is still quite clearly defined, that is, to make findings of fact in relation to complaints and to impose appropriate protective orders. The psychiatrist's role is however, multifaceted. A psychiatrist may sit as a member of a tribunal, and participate in decisions in relation to findings of fact and protective orders. It is also a psychiatrist who, as an expert witness in a tribunal, may describe misconduct in terms of a psychiatric condition, often removing any question of moral judgment. It is a psychiatrist who often predicts the risk of future misconduct and 'tames uncertainty'[779] by recommending conditions upon a doctor's practice. And, it is a psychiatrist who then manages the misconduct by simultaneously treating the impaired doctor and playing a surveillance role if conditions are breached, as noted above. In some cases, when psychiatric evidence was accepted, the Tribunals appeared to merely 'rubber stamp' the conclusions and evidence of psychiatrists, and the law and psychiatry formed a collaborative relationship.[780] At other times, when findings of fact, such as previous breaches of conditions, were available to tribunals, as in some of the deregistration cases, the tribunals rejected psychiatric evidence that the doctor was unlikely to reoffend, and the relationship between law and psychiatry was more competitive.[781] The policing role of psychiatrists only ceased when a doctor was deregistered.

6.13 Psychiatry and law – the benign big stick

Because the law seeks 'facts' upon which to make findings about the relationship between impairment and misconduct, it is often dependent upon psychiatric evidence, which although often overtly speculative, assumes the status of 'fact'. Psychiatry however is dependent upon the law to legitimise this causal relationship between impairment and misconduct, which once established, provides the basis for consequent

[779] Rose, above n 162.

[780] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011).

[781] *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012).

protective orders. The law mandates the compliance strategies, discussed in Chapter 2, which are an integral part of therapeutic jurisprudence, the 'benign big stick'. The imposition of conditions upon a doctor's registration is a compliance strategy that the law imposes and psychiatrists may suggest and monitor.

The discourse and mutual dependence between psychiatry and law is also anchored by two key themes, the classification of conduct, and the consideration of future risk, as discussed below.

6.14 Sad, mad or bad – impairment or misconduct

As noted above the discourse about a doctor's conduct is quite different in the criminal arena to that in the disciplinary arena. The rationale for disciplinary proceedings is consistently stated in the caselaw as being the protection of the public, but as noted in Chapter 2 some protective orders can clearly be seen as punitive. Within the protective jurisdiction the cases discussed above also clearly indicate 'a degree of slippage'[782] in the discourse about 'madness' as opposed to 'badness', or between impairment and misconduct. Some impaired doctors are partly bad, and partly mad and/or sad. The law, with little evidence to assist it in its task of how best to protect the public, converts the 'educated guess' of a psychiatrist into facts upon which to make findings and to determine protective orders. The cases such as *Mukherjee* discussed above clearly show that tribunals favour ascribing conduct to 'madness' in preference to 'badness' initially, and a psychiatric model of misconduct which keeps doctors within the profession, until repeated breaches of conditions or other misconduct forces them towards an approach more focussed on the moral culpability of the doctor. They demonstrate that ascribing conduct to impairment when a doctor first comes to attention may seriously undermine the protection of the public. The cases of *Chowdury, Nemeth*, and *Marburg* discussed below indicate that imposition of conditions upon the doctor's conduct may not protect the public.

Hopefully the recent decision in *Reimers*,[783] (discussed in Chapter 5) which made clear the distinction and is repeated here for emphasis, 'Gross, repeated, incompetent medical

[782] Greig, above n 116, 15.

[783] *Reimers v Health Care Complaints Commission* [2012] NSWCA 317 (25 September 2012).

practice does not cease to be such because it is caused by an addiction to alcohol, heroin or other drugs',[784] will provide more guidance to tribunals in the future, as it is more protective of the public than cases with a therapeutic focus.

The deregistration cases above clearly indicated that some conduct may be related to impairment and some may not. The task in identifying the precise nature of the relationship is not an easy one. As Shea notes:

> Because human behaviour and human motivation are so complex, the end result of this process will be a list of possible contributory factors, some related to the mental disorder, some not. At this point there is no scientific way of determining the relative importance of the various factors. Science gives way to educated guesses …[785]

The case of Dr Chowdury illustrates this point. It involved a breach of conditions on the doctor's registration and impairment. Dr Chowdury failed to comply with his conditions for 14 months, which the Tribunal regarded as extremely serious.[786] The Tribunal said that the doctor's non-compliance with registration conditions was not adequately explained by the depression from which he suffered.[787] It said that '*There was a significant component of 'wilfulness*'.[788] The respondent himself described his behaviour as *'passive – aggressive*'.[789] According to a psychiatrist who gave evidence, both depression and personality factors contributed to Dr Chowdury's non-compliant conduct.[790] This case demonstrates the complexity involved in determining when conduct can be attributed to an impairment and when it is caused by factors unrelated to a doctor's impairment. The Tribunal said:

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[784] *Reimers v Health Care Complaints Commission* [2012] NSWCA 317 (25 September 2012) at [12].

[785] Shea, above n 745, 135.

[786] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010).

[787] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010).

[788] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010) [20].

[789] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010) [20].

[790] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010) [21].

> The respondent's non-compliance with registration conditions was governed by two factors: his underlying psychological condition and personality factors. The factors are not entirely independent. Depression may exacerbate a pre-morbid tendency to passive aggressive behaviour …
>
> On the evidence before the Tribunal the underlying psychological condition has resolved with treatment. The respondent cannot change his fundamental personality. He is likely to remain proud and somewhat inflexible, reluctant to display 'weakness' by accepting help, and inclined to resist direction. However the respondent has gained significant insight …[791]

This case also indicates that the causal relationship postulated between impairment and misconduct can be too simplistic. Doctors can be, as the above case demonstrates, be 'sad' 'mad' and 'bad', and in such cases, in spite of impairment, a rehabilitative focus in protective orders can easily undermine the protection of the public.

In the case of Dr Nemeth referred to above the doctor conceded that she was in her treatment of the patients, all of whom were drug-addicted 'both foolish and unprofessional' but was always motivated by her care and compassion for their 'pain'.[792] Although the Tribunal said that it accepted the breaches were committed when Dr Nemeth was unwell and under personal stress', it also said that these circumstances did not abrogate her from her responsibility to conduct her practice under professional guidelines'.[793] Conspicuous by its absence is any detailed discussion by the Tribunal as to the risk to the public when a doctor such as Dr Nemeth breaches the conditions imposed upon their registration. When doctors have previously breached conditions upon their registration, more serious sanctions could be imposed. The use of the 'critical compliance' conditions where doctors are automatically suspended from practice if they breach their conditions would better protect the public if tribunals are minded to keep doctors in practice whilst they are in the process of rehabilitation.

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[791] *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010) [27].

[792] *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 38 [54].

[793] *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 38 [57].

In the case of *Marburg* referred to above, the doctor hid his addiction by overprescribing for patients and collecting the prescribed medication himself.[794] He falsely entered patients' doses of the drug in both their clinical records and by falsifying his drug diary. The doctor also denied originally his professional misconduct when questioned by the Pharmaceutical Services Branch (PSB).[795] This conduct is clearly 'bad'. However, because he was about to 'graduate' from the Impaired Registrants Program after some three years he was allowed to continue in practice with conditions on his registration. It is clear that although the behaviour in this case involved serious professional misconduct, because, according to the evidence of his psychiatrist, he had recovered from his addiction he was not deregistered. This case clearly illustrates the slippage in the discourse between 'madness' and 'badness' referred to above.

In the matter of *Ramraka* discussed above,[796] which involved alcohol abuse, and numerous other forms of misconduct, the Tribunal accepted evidence from the doctor's treating practitioners that he was no longer using alcohol, although it was somewhat sceptical about his evidence before the Tribunal, and conditions were placed upon his registration. Again, the faith in conditions as a means of public protection is arguably not justified in view of the Tribunal's scepticism about the doctor's evidence before the Tribunal and his serious misconduct. It is possible that the issue of impairment and the medical evidence made the Tribunal more sympathetic to the doctor than otherwise might have been the case.

In one of the three Victorian cases, the doctor had been known to the Board since 2001. A panel of the Medical Practitioners Board of Victoria found that the doctor had engaged in unprofessional conduct of a serious nature by engaging in sexual relationships with two female patients in 1999.[797] The Tribunal rejected the evidence of a psychiatrist that the doctor's traits of a risk-taking personality and narcissism were now under control and deregistered the doctor. The Tribunal (at [92]) stated, in relation to the evidence of the psychiatrist, that:

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[794] *Health Care Complaints Commission v Dr Roland Marburg* [2012] NSWMT 5.

[795] *Health Care Complaints Commission v Dr Roland Marburg* [2012] NSWMT 5 [10].

[796] *Health Care Complaints Commission v Dr Riju Ramrakha* [2013] NSWMT 8 (12 April 2013).

[797] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

> While we have regard to the fact that Professor Burrows said that he was 95% to 99% certain there would not be a relapse, we feel that that statement is somewhat extravagant. Particularly, in light of the fact that social factors in the respondent's life are good at the moment but if things do change, the respondent may relapse into his previous conduct. Professor Burrows denied this but, in our view, it is very difficult to determine.[798]

The above cases demonstrate that tribunals are quite inconsistent in their determinations as to how the public should be protected when impairment is involved. The cases also demonstrate the moving target of unacceptable risk in the evidence of psychiatrists which is sometimes accepted and sometimes greeted with a degree of scepticism.

In a Queensland case, which demonstrates the fine line between 'sad' and 'mad', a general practitioner pleaded guilty to accessing child pornography and was given a suspended sentence of 12 months imprisonment.[799] The doctor suffered from moderate depression in response at least in part to relationship issues, and developed a compulsively driven usage of Internet sites, including those displaying pornographic images. The Tribunal accepted evidence of a psychologist that he presented a minimal risk of recidivism, and placed stringent conditions upon the doctor's registration including a condition that requires him to be chaperoned when consulting with children.[800] Manning notes that there is an early indication of a stricter approach in this relatively new category of cases of downloading and accessing objectionable material but also points out that too few cases have emerged to enable the establishment of an appropriate disciplinary benchmark.[801]

However, in a sexual misconduct case discussed in Chapter 2 where there was no suggestion of impairment but a doctor had chaperone conditions placed upon his registration, the question was raised as to whether the necessity for conditions meant a

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[798] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

[799] *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010).

[800] *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010).

[801] Manning, above n 127.

doctor should be practising at all.[802] It is interesting that the same issue regarding the necessity of conditions has not arisen directly in the impairment cases in this study. It could be argued that if a doctor cannot be trusted to practise without regular drug testing or other conditions, s/he is also unfit to practice. This issue is important because it highlights the complexity of regulating doctors with conditions on their registration when as noted earlier, clearly one size does not fit all.

6.15 Managing risk with conditions on practice

Conditions are imposed in widely differing circumstances. Chaperone conditions may reflect a lack of trust in the doctor's ability to observe proper professional standards. The need for regular urine and drug testing arguably reflects a lack of confidence in a doctor's ability to exercise the necessary self-discipline to abstain from drugs or alcohol. As noted above, the imposition of conditions could be seen to mean a doctor should not be in practice at all. In Chapter 2 it was noted that one writer had argued that mandatory reporting could undermine a doctor's 'ethical competency'.[804] Similarly, it could be argued that conditions upon a doctor's registration may undermine a doctor's own personal capacity to self-regulate. Clearly however protection of the public must take precedence over other considerations that relate to the doctor, and the imposition of conditions help tribunals manage future risk.

Risk thinking supports the psychiatric model of misconduct because it lacks 'pejorative connotations' and 'invites more objective and robust analysis'.[805] Rose notes that risk thinking has become central to the practice of contemporary psychiatry,[806] and Greig, referring to the criminal arena, points out that the more professionally acceptable notion of 'risk' has replaced the concept of 'dangerous'.[807] It is rare that doctors are described as 'dangerous' even though in some of the more high-profile cases mentioned at the

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[802] *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297 [Last paragraph]. See above n367

[804] Komesaroff, above n 282, defined ethical competency as 'The cultivation of such an ability, or 'ethical competency', provides an important resource by which professional practices are adapted to the specific, infinitely variable needs that arise unpredictably and idiosyncratically in the course of everyday life'.

[805] Rose, above n 162, 178.

[806] Ibid 177.

[807] Greig, above n 116, 18, in her fascinating discussion of a Melbourne case where a personality-disordered prisoner made threats of violence, and engaged in extreme acts of self-mutilation.

beginning of this thesis, their conduct, which included both murder[808] and manslaughter[809] was clearly dangerous. According to Greig, the term risk 'suggests a fluidity and adaptiveness denied dangerousness'.[810] Greig's discussion, although referring to the criminal and mental health arenas, is pertinent in the protective jurisdiction, which is heavily dependent upon risk assessment. In the discourse on risk disclosed in the cases the 'risk to the public', the 'risk of recidivism' and 'the risk of re-offending' are commonly used terms when discussing potentially dangerous conduct.

In the criminal arena, risk assessment in relation to future violence involves the consideration of risk factors, harm and likelihood of violence.[811] A number of risk predictor variables have been identified from the literature including past violence, pre-existing vulnerabilities, social and interpersonal factors, mental illness, substance abuse, state of mind, situational triggers, and personality constructs.[812]

In contrast, the risk assessment in tribunals dealing with impaired doctors appears to be more limited and ad hoc, relying largely upon psychiatric evidence and past conduct, including breaches of conditions, to predict future conduct. An analysis of how the risk of recidivism is assessed in doctors applying for reregistration elucidates the practical difficulties in risk assessment in the protective jurisdiction.[813] Noting the difficulties inherent in both clinical and actuarial risk assessments, Warfe, as noted earlier, proposes a clinical approach to improving the accuracy and consistency of risk assessment by using a given set of risk factors and predictors, derived from both the literature and decided cases against which a clinical assessment can be made.[814] Warfe noted that identification of aberrant behaviours and exploration of character flaws appear to be more predictive of repeated misconduct than assessment of clinical competence.[815]

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[808] *Dr JE Gassy* (NSWMT, 1 August 1997).

[809] *R v Suresh Nair* (2010) 2010/8460 (unreported, 29 June 2010).

[810] Greig, above n 116, 18.

[811] Bernadette McSherry, 'Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour' [2004] *Trends and Issues in Crime and Criminal Justice* 2.

[812] Ibid.

[813] Warfe, above n 132, 78.

[814] Ibid 79.

[815] In the disciplinary context factors relevant to the determination of 'good character' are set out in *McBride v Walton* [1994] NSWCA, and as noted earlier Freckelton considers the simplistic dichotomy between good and bad character at length in Freckelton, 'Good Character', above n 15, 501.

However the cases discussed in this chapter indicate that when character flaws are seen as a function of impairment, and may therefore be amenable to treatment, the prediction of risk is dependent upon the likely success of treatment. It is also dependent upon psychiatrists' assessment of risk, which may or may not be flawed.[816]

As noted in Chapter 1, conditions imposed on a practitioner's registration are only effective if they are adequately monitored. The dearth of literature and research on protective orders in general, and the effectiveness of conditions upon a doctor's registration as a means of protecting the public, in particular, is remarkable. The difficulty of supervising and monitoring impaired doctors was noted in Chapter 5. The review and recommendations by the Ombudsman in Queensland referred to in Chapter 1 is a very positive step. The Ombudsman's recommendations were that:

1. AHPRA develop and document a clear, detailed compliance monitoring plan for each practitioner that has conditions imposed on their registration. Where practicable, this plan should be progressed in parallel with the development of the conditions to be applied to the practitioner's registration.
2. AHPRA provide the practitioner with a documented compliance plan at the commencement of monitoring that includes specific information on what will be monitored and how frequently (full list of requirements can be found in Section 6.2 Recommendations of this report).
3. AHPRA work with Medicare to establish processes that provide AHPRA with more timely access to data for compliance monitoring purposes.
4. AHPRA develop and adopt a clear, risk-based compliance monitoring framework that provides a consistent set of principles and directions.
5. AHPRA's compliance monitoring framework ensures that:
   a. self-reported data is assessed at intervals that allow for the early identification of noncompliance
   b. independent data for verification of the accuracy of self-reported data is obtained and assessed at intervals that allow for early identification of non-compliance.

[816] Shea, above n 745.

6. AHPRA review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance.
7. AHPRA adopt a clear, transparent pyramid approach to regulating compliance that clearly outlines the hierarchy of responses from least restrictive to most restrictive for particular categories of noncompliance.
8. AHPRA outline in their hierarchy of responses clear sanctions for the late submission and non-submission of self-reported compliance data by practitioners.
9. AHPRA and the QBMBA, including its committees, consider changes to their decision making processes to streamline decision making, including establishing timelines.
10. Decisions by AHPRA and the QBMBA to take no further action in response to non-compliance with conditions should be accompanied by clear documented reasons for the decision and a plan to manage any outstanding risk associated with continuing non-compliance.[817]

The specificity of the Ombudsman's recommendations are encouraging,[818] although they do not embrace some of the concerns raised by Walzer, for example, in relation to doctors being able to nominate friends as practice supervisors or monitors.[819]At the time of writing it is too soon to report on their impact. The recommendations, if implemented, would certainly address some of the issues raised by the cases in this study, particularly the cases in this chapter where it was clear that doctors had breached conditions upon their registration more than once.

The frequent reference to compliance plans in the recommendations above suggests that lack of compliance has been a significant issue. Recommendation 6 that AHPRA review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance is also notable in view of the frequent breaches of conditions in cases such as

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[817] <http://www.oho.qld.gov.au/case-review-managing-practitioner-compliance-with-conditions-of-registration/>.

[818] It is not clear at the time of writing whether New South Wales will adopt the recommendations.

[819] Walzer, above n 550.

Mukherjee[820] discussed above. Recommendations 9 and 10 relate specifically to Queensland and it is not clear whether these recommendations are to be implemented in the other states. It is also not clear what additional resources would be required by AHPRA to implement the above recommendations.

Most importantly however, the Report by the Ombudsman explicitly recognises that the proper and adequate monitoring of conditions upon a doctor's registration plays a key role in the protection of the public. As the review by the Ombudsman was based upon a single case involving numerous breaches, the cases discussed in this thesis provide powerful support for the recommendations made by the Ombudsman. It is important to note that the Ombudsman did not specifically address the issue of health as opposed to other practice conditions on a doctor's registration as the focus was on the broader issue of how conditions generally should be monitored. However, a particular focus on different types of conditions and how they are monitored is an important area for further research.

6.16 The discourse in criminal cases

As noted above, the discourse on doctors in the criminal arena stands in sharp contrast with cases where there have also been disciplinary proceedings. The case of DRP (or Peters v The Queen in the criminal jurisdiction)[821] has already been mentioned and it is clear that the language in the criminal arena is both pejorative and judgmental. Whilst criminal jurisdiction is punitive, and disciplinary jurisdiction is protective, it appears from the discourse in tribunal decisions that tribunals rely upon the protective nature of the jurisdiction, and a rehabilitative focus in protective orders, to avoid condemnation of conduct that involves moral culpability except in the most serious cases. It is arguable that criminal proceedings may be more protective of the public than disciplinary proceedings in some cases.

In another case, which involved criminal proceedings, a cocaine-addicted neurosurgeon was convicted of the manslaughter of two young women during cocaine induced sexual encounters. The judge noted cynically during the application for bail that:

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[820] *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11.

[821] *Peters v The Queen* [2013] VSCA 222 (16 August 2013).

> It is abundantly clear from the terms of the conditions … that the applicant has been afflicted by a long-standing addiction to drugs, that he is prone to excessive consumption of alcohol and that there are other features of his mental health that have required the services of a treating psychiatrist. In spite of this history, the applicant seems to enjoy the confidence and support of his peers in neurosurgery. I can only conclude that the applicant is a gifted practitioner whose skills were so much in demand that suspension was a remedy of last resort.[822]

The judge also regarded with some scepticism the report of a psychiatrist that Dr Nair would not abuse bail and that he had experienced 'significant regret and remorse' noting that what emerged from the contents of the psychiatrist's report was that the doctor's expressions of resolve had been triggered by his experience in custody. Significantly, the judge said:

> I cannot accept that the applicant was able to deny the effects of his addiction throughout his working life or that he failed to appreciate the impact of his addiction upon the maintenance of his registration as a practising surgeon.[823]

The scepticism in these cases stands in marked contrast to the non-judgmental tone more typical in the Tribunal decisions about addicted doctors, which it is argued can undermine the protection of the public. Because addiction is classified as a disease, consistent with the psychiatric model of misconduct judgment is suspended, although there are a few notable exceptions, as the *Reimers* decision indicates.

6.17 Should impairment be managed under the National Law?

The impairment cases also raise the question as to whether impaired doctors are best managed within a legal context or outside the shadow of the law. It has been noted in the United States that licensing boards and agencies generally are resistant to attempts to erode any of their regulatory activity and authority.[824] In a comprehensive review of

[822] *R v Nair* (2010) 707 (unreported, 29 June 2010).

[823] *R v Nair* (2010) 707 (unreported, 29 June 2010) 8.

[824] Walzer, above n 550, 139.

impairment programs in the United States where there is 'a crazy quilt pattern' of statutes and treatment provisions for impaired doctors, many boards however, refer impaired doctors for treatment to medical societies who only disclose to the Boards the identities of doctors who do not cooperate with or succeed in treatment.[825]

In Victoria, as noted above, after the first three years of operation of the VDHP no Board notifications had been necessary as impaired participants who entered the program were asked to leave their practice until they had achieved a stable recovery and could safely return to work. The doctors in the program had either complied with this requirement or had already been suspended from practice. This meant the public were not at risk whilst lengthy investigations were undertaken into the doctor's conduct.

In spite of the apparent success of the Impaired Registrants Program under the auspices of the Medical Council of New South Wales,[826] little is known about the impact of being treated within the regulatory system as opposed to being treated in a doctor's health program independent of the system, and which does not have at its disposal the range of sanctions available under the law. NSW also has a confidential Doctors Advisory Service[827] but there is no reference to it in the cases in this study. This issue is further discussed in Chapter 8.

6.18 A conspiracy of silence?

In the examples cited of high-profile impairment cases at the beginning of this thesis, efforts to rehabilitate these doctors were not disclosed until the cases became public. Generally, the confidential nature of the management and treatment of impaired doctors means that publication of a Medical Tribunal or Professional Standards Committee decision is the first time that failures in the management of the doctor are disclosed to the public. In the United States the trend has been to emphasise the full confidentiality of records and investigations of impaired doctors, although there are some variations between the states. In Massachusetts, for example, once an investigation is complete the

[825] Ibid 141.

[826] Wilhelm and Reid, above n 90, 372.

[827] <http://dhas.org.au/>.

record is not kept confidential.[828] It has been argued that as long as confidentiality cannot be assured the medical profession will continue to view the policy of the Boards toward impairment as punitive and humiliating rather than rehabilitative, and impaired doctors will be discouraged from seeking treatment.[829]

Clearly the issue of privacy is controversial and there are no easy answers. If it became known that a doctor was impaired, it could be stigmatising and damaging to the doctor's reputation. However, withholding of information about an impaired doctor could clearly put the public at risk, as the case of Dr Nair, cited at the beginning of this chapter, demonstrates.[830]

The website of the Medical Board of Australia contains an information sheet on the management of impaired doctors and students. Although it acknowledges that health practitioners may have concerns about privacy, and fear that their private health information may be made public, there is nothing on the site to allay their concerns, as it simply notes that the Board and AHPRA can seem formal and bureaucratic.[831] There is an obvious tension between confidentiality and transparency and the balance is not easy to find. It is arguable that the protection of the public should be the dominant consideration even if it means sacrificing the privacy of the doctor.

6.19 The rhetoric and reality of protecting the public

As noted in Chapter 2, in the case of *Litchfield*[832] the Court commented on the imposition of conditions upon a doctor's registration as indicating that a doctor may be unfit to practise,[833] and rejected the imposition of conditions.[834] The principles in

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[828] Walzer, above n 550, 147.

[829] Ibid.

[830] *R v Nair* (2010) 707 (unreported, 29 June 2010).

[831] <http://www.ahpra.gov.au/Search.aspx?q=impairment>.

[832] *Health Care Complaints Commission v Bruce Litchfield* [1997] NSWSC 297; (1997) 41 NSWLR 630 [638].

[833] *Health Care Complaints Commission v Litchfield* [1997] NSWSC 297 (1997) 41 NSWLR 630See above n 367.

[834] *Health Care Complaints Commission v Litchfield* [1997] NSWSC 297 (1997) 41 NSWLR 630.

relation to protective orders were stated in the New South Wales case of *Do*, and did not mention rehabilitation.[835]

Although the decision in *Litchfield* did not suggest that conditions should never be imposed, it raised important questions about what the imposition of conditions may imply, in terms of a doctor's fitness to practise. In this study the decisions in the impairment cases indicate that the Tribunals did not consider the need for conditions as indicating a doctor's unfitness to practise, but rather the imposition of conditions indicated a need for rehabilitation. As Elkin notes, 'each of the elements of the regulatory system can also be interpreted as fundamentally protective of the profession itself',[836] and the Court in *Litchfield*, also espoused the protection of the profession'.[837] However the cases above also demonstrate that the interest of the profession may be in tension with the objective of public protection.[838] The significant interest of the profession in rehabilitating impaired doctors is evidenced, in particular, in some of the cases discussed where even doctors who had breached conditions upon their registration were nevertheless allowed to remain in practice.[839] The cases demonstrate that the rhetoric of 'the protection of the public' in reality involves the rehabilitation of impaired members of the profession, and arguably extends to the rehabilitation of other non-impaired doctors found guilty of misconduct, as discussed in the next chapter.

6.20 Conclusion

There are three themes running through the cases discussed above. Firstly, the tensions between public protection and protection of the profession and its impaired members, even when previous attempts at rehabilitation have failed. Secondly, the cases also illustrate tensions between moral judgments about misconduct and the psychiatric

[835] *Health Care Complaints Commission v Do* [2014] NSWCA 307.

[836] Elkin, 'Medical Practitioner Regulation', above n 3, 682.

[837] *Health Care Complaints Commission v Litchfield* [1997] NSWSC 297, 12.

[838] Elkin, *Protecting the Public,* above n 9, also argues that 'the 'hidden' agendas of a profession are much less likely to compromise public protection when the system concerned is externally regulated and sufficiently prescriptive'. This issue is discussed in Chapter x (on regulation).

[839] *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011); *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012); *Health Care Complaints Commission v Woolcock* [2012] (unreported, 17 September 2012); *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013).

model of misconduct. Finally, the cases demonstrate the powerful role of psychiatrists in the management of impaired doctors generally, both in relation to findings about impaired doctors in general, and in relation to the management of risk through protective orders in particular. The culture of the therapeutic state is evident in the focus upon rehabilitation rather than the more serious protective orders based upon principles of deterrence.

The impairment cases tell sad stories of doctors battling various psychiatric conditions and addictions whilst trying to maintain their careers. They also tell the stories of failed attempts at rehabilitation when these doctors, in spite or because of their impairments, fail to comply with conditions upon their registration. It was not clear what role a lack of adequate monitoring of the conditions played in the repeated breaches, although it is clearly the doctor's responsibility to comply with conditions imposed. The report of the Ombudsman in Queensland makes it clear that the monitoring of conditions upon a doctor's registration is a significant issue that needs to be addressed by regulators if the public is to be protected.

In some instances, the Tribunals were rescued from the difficulty of imposing a serious disciplinary sanction upon an impaired doctor by bureaucratic delay in bringing the matter to hearing. Whilst rehabilitation of a doctor is clearly in the public interest, bureaucratic delays can undermine public confidence and raise questions about the protection of the public in relation to those doctors who remain in practice without rehabilitating themselves prior to their disciplinary proceedings.

The impairment cases reflect a particular discourse between the disciplines of law and psychiatry, and central themes of the 'protection of the public' and 'risk of re-offending'. The literature on dangerousness offers some insight into how the tensions between law and psychiatry are played out in the cases. As one writer notes 'dangerousness has always acted as a powerful metaphor to establish society's boundaries and justify the expulsion of those who do not appear to conform'.[840] As noted earlier, the discourse in this jurisdiction refers to risk, rather than danger and it is when doctors are perceived as posing a serious risk to the public that they are deregistered. The cases in this chapter indicate the difficulties of reconciling ordinary

[840] Greig, above n 116, 15.

concepts about moral culpability with psychiatric discourse. The psychiatric model of impairment associates misconduct with illness and defines substandard performance as a medical problem to be treated by medical experts,[841] and a non-judgmental approach means that doctors may acknowledge substandard performance as undesirable, while retaining faith in colleagues' basic trustworthiness and integrity.[842]

The cases also indicate that, as Morrrow argues, a non-judgmental position on the part or regulators may understate doctors' personal responsibility for maintaining their own wellbeing.[843] It is clear from the cases that unless a doctor's behaviour or conduct is extreme or repeated, tribunals generally refuse to make moral judgements about their conduct and impose sanctions that have a deterrent effect. In some cases attempts to rehabilitate doctors may put the public at risk. A more nuanced approach to the relationship between impairment and misconduct which focusses on conduct and breaches of conditions may better protect the public.

[841] Morrow, 'Sick Doctors', above n 17, 103.

[842] Ibid.

[843] Ibid.

CHAPTER 7 – SEXUAL MISCONDUCT

7.1 Introduction

In this chapter the decisions on sexual misconduct are examined in order to explore whether tribunals adopt a rehabilitative approach to problem doctors who are not impaired. Although, as pointed out in Chapter 6, Morrow states that 'undue sympathy' for problem doctors rather than professional ex-communication may be a small price to pay for their successful rehabilitation and reintegration,[844] in this thesis it is argued that the price may be too high when a rehabilitative approach to problem doctors compromises the protection of the public. In spite of the significant body of literature and caselaw on sexual misconduct there appears to be little reported research on the effectiveness of various protective orders in protecting the public, as also noted in Chapter 1.[845] The findings and protective orders in the sexual misconduct cases are reviewed, and it is argued that the health and/or chaperone conditions on some doctors' registration ensure that these 'deviant' doctors are controlled within the profession, rather than expelled, in spite of a raft of explicit principles which condemn sexual misconduct. Like the impairment cases, the cases in this chapter also demonstrate the peripatetic and powerful role of psychiatrists, and a similar discourse between psychiatry and law in the management of future risk. The chapter concludes that the Tribunal decisions show that a rehabilitative approach to misconduct is evident in sexual misconduct cases.

7.2 Background

According to the consensual model of the doctor-patient relationship popular in the 1950s and early 1960s, 'The doctor was expected to remain objective and emotionally detached in return for being allowed free access to highly guarded spheres of the

[844] Morrow, 'Doctors Helping Doctors', above n 87, 33.

[845] This is particularly significant in relation to doctors found guilty of sexual misconduct as it is the most frequent finding in disciplinary proceedings, as noted in Chapter 4.

patient's body or life story'.[846] However sexual misconduct by doctors has been a significant part of the regulatory landscape since the 1990s in the United States,[847] the UK,[848] Europe,[849] Australia, and New Zealand,[850] with a significant body of literature, research and media coverage emerging on the topic.[851] Since then, medical sociologists have developed more critical models that mirror the cultural and political changes that have placed the doctor-patient relationship under increasing pressure and public scrutiny.[852]

One analysis of the tabloid press coverage of the Professional Conduct Committee hearings of the General Medical Council in England revealed that the press gave undue attention to hearings involving sexual misconduct by general practitioners.[853] Most of the press focus was on male GPs who succumbed to their natural sexual urges while

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[846] Hannah Bradby, Jonathan Gabe, and Michael Bury, ''Sexy Docs' and 'Busty Blondes': Press Coverage of Professional Misconduct Cases Brought before the General Medical Council' (1995) 17 *Sociology of Health and Illness* 458-476.

[847] Randolph Reaves, 'Sexual Intimacies with Patients: The Regulatory Issue of the Nineties' *Federation Bulletin Summer* 83; Thomas Gutheil and Glen Gabbard, 'The concept of boundaries in clinical practice' (1993) 150(2) *The American Journal of Psychiatry* 186. According to *Australian Doctor* (March 1992) sexual misconduct ranked near the top of professional practice litigation in the USA.

[848] Fiona Subotsky, Susan Bewley, and Michael Crowe, *Abuse of the Doctor-Patient Relationship* (RCPsych Publications, 2010).

[849] Doaitse Wilbers, C.M. Willibrod, Weijmar Schultz, and Harry van der Weil, 'Sexual Contact between Doctors and Patients in Peter Lens, Peter and Gerritt van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997) 75–86.

[850] Elkin, Spittal, Elkin and Studdert, 'Doctors Disciplined for Professional Misconduct', above n 2, 452–456; Eleanor M Dawson, 'Professional Misconduct in Psychiatry: Sexual Behaviour with Patients. A Report of Recent New South Wales Findings' 28 *Australian and New Zealand Journal of Psychiatry* 197.

[851] The literature however is quite dated, and there appears to be little recent research, although more general studies on regulation report on sexual misconduct. See, eg, Elkin, 'Medical Practitioner Regulation', above n 3. In Australia in an interesting twist on the sexual relationships between doctors and patients, sexual harassment of general practitioners by patients has also been reported in Australia. The Australian study was also reported in the UK. See LE Forrest, PM Herath, IS McRae and RM Parker, 'A national survey of general practitioners' experiences of patient-initiated aggression in Australia' (2011) 194 *Medical Journal of Australia* 605–608; and Lorraine Baker, 'Sexual harassment by patients forces doctors to alter their practice' (2014) 348 *British Medical Journal* 118. The representative survey of 600 female Australian general practitioners (GPs) found that more than half (54.5%; 97) of the 180 who responded had experienced sexual harassment during their careers. Of those 97 respondents, nine had experienced harassment more than eight times. Behaviours reported ranged from inappropriate gifts or sexual remarks to requests for inappropriate examination or inappropriate exposure of body parts to touching or grabbing.

[852] Bradby, Gabe and Bury, above n 845 459.

[853] Ibid 458.

[853] Ibid 459.

treating 'busty blonde' female patients.[854] Such patients were in turn compared with the doctor's wives who were described as 'prim and proper', although wives were not always presented in a virtuous light.[855] Stacy argues that the 'siren myth' stories about doctors being 'lured onto the rocks' by patients may influence formal proceedings when cases come before the General Medical Council,[856] with the risk of reducing the chance of objective judgment in such hearings.[857]

The prevalence of sexual misconduct, the ethical issues involved, and the necessity for the enforcement of boundaries are common themes in the literature[858] which elucidates the 'slippery slope' towards breaches of professional boundaries when doctors and patients give and receive gifts, when a doctor shares personal information, socialises with patients, enters into business relationships with patients, or inappropriately touches a patient.[859] An Australian study which examined seven complaints about sexual misconduct by psychiatrists in the period 1989–1991 in the Medical Tribunal of New South Wales, confirms these themes.[860] According to this study:

> Specific non-sexual behaviours mentioned at the outset in complaints or emerging in more detail in hearings involved developing an inappropriate close relationship and social association with a patient: sharing activities, outings and holidays and sleeping in each other's homes; inappropriate revealing of a therapist's own difficulties or sexual experience to a patient; conducting psychotherapy sessions in coffee shops and restaurants; revealing confidential material about a number of identified or identifiable patients to an intimate patient; and illegally prescribing drugs of addiction to

[854] Ibid 464.

[855] Ibid 464–470.

[856] M Stacy, *Regulating British Medicine: The General Medical Council* (John Wiley, 1992) Chichester, UK, 225.

[857] Ibid.

[858] Subotsky et al. above n 847, 2; Sameer P. Sarkar, 'Boundary Violation and Sexual Exploitation in Psychiatry and Psychotherapy: a Review' (2004) 10 *Advances in Psychiatric Treatment* 312.

[859] Ibid.

[860] Dawson, above n 850.

> a known addict without authority. All of these aspects of conduct were found to be misconduct.[861]

In this study, five of the seven were members of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).[862] They included six men and one woman. Some occupied positions of leadership and influence. Two had become prominent in the field of psychodynamic psychotherapy. One male psychiatrist and one female psychiatrist became involved with a patient of the same sex.[863]

Some of the characteristics of doctors who engage in sexual misconduct are described in the literature, and the cases are conceptualised on a spectrum in order to reflect their complexity and diversity, with 'lovesickness' at one end, and 'masochistic surrender' at the other, and many cases between these extremes showing elements of both.[864] Whilst the literature tends to focus on the cases involving consensual sexual relationships, serious criminal behaviour, such as rape and sexual assault, is discussed in some of the caselaw.[865] Manning notes three categories of sexual misconduct: sexual assault cases where there is no consent, 'exploitation' cases where the doctor in a position of dominance exploits a vulnerable patient, and romantic attachment cases where a genuine romance develops between the doctor and patient. Manning argues that in New Zealand, the moral absolutist position of 'zero tolerance' has waned, and that a more nuanced approach with a focus on the particular circumstances of each case has emerged, with a range of factors both aggravating and mitigating, being taken into account.[866]

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[861] Ibid 198.

[862] One of the seven was a trainee psychiatrist under supervision by another psychiatrist in the study, and another was a consultant physician in psychiatry.

[863] Dawson, above n 849, 198.

[864] Andrea Celenza and Glen O Gabbard, 'Analysts Who Commit Boundary Violations: A Lost Cause?' (2007) V *FOCUS*. Although this paper focussed on analysts and therapists it is apposite to doctors generally. According to the authors, for the lovesick group, the sexual relationship is experienced by both participants, at least for a time, as a true love affair, 'They usually share a fantasy that each is rescuing the other and that they are soul mates who understand each other's need like no-one else. Rationalizations are employed, especially by the analyst or therapist, to support the therapeutic nature of the relationship'.

[865] *Health Care Complaints Commission v Sudath* [2013] NSWMT 2 (22 February 2013).

[866] Manning, above n 127.

In an unusual departure from the 'high moral ground' usually taken to sexual misconduct in the literature, Yarborough notes that not all patients are vulnerable; and that there are at least some patients, who, given a previously existing relationship, such as friendship, can relate to the physician in ways other than as a typical patient who is trusting, vulnerable, and relatively powerless in the sexual as well as other arenas.[867] Banks points out that there are grey areas and complications in 'charting the choppy waters of sexual misconduct' and that not all boundary violations are created equal.[868] It is clear from some of the cases discussed below that the maintenance of appropriate professional boundaries is more difficult for doctors in country areas, where they may often meet their patients in social situations.[869]

Whilst the cases clearly elucidate the distress and damage sexual misconduct may cause patients, they also portray the devastating consequences for doctors that these cases may involve. As well as both the private and personal consequences for the doctor, and the public shame and humiliation of disciplinary proceedings, some doctors never regain their professional livelihood.[870] Tribunals are aware of these consequences and this awareness may lead to less stringent sanctions which can compromise the protection of the public.

7.3 Findings

Appendix F indicates that between 1 July 2010 and 1 July 2013, of the 128 doctors who had findings of unprofessional conduct or professional misconduct made against them, the most common category of misconduct was sexual misconduct, of which there were 34 such cases.[871] Most doctors were general practitioners, and seven were specialists,

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[867] M Yarborough, 'The reluctant retained witness: alleged sexual misconduct in the doctor/patient relationship' August 1997 22(4) *Journal of Medicine and Philosophy* 345–364.

[868] Wendy Banks, 'Charting the choppy waters of sexual misconduct' 2(5) *National Review of Medicine.*

[869] *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010) [21]. Dr Holmes told the Tribunal that he worked in a small rural area where it was almost impossible to maintain absolutely strict boundaries, and that it was inevitable that friends become patients and patients become friends and associates.

[870] Russell G Smith, (Ed) *Health Care, Crime and Regulatory Control: An Introduction,* in Health Care, Crime and Regulatory Control (Hawkins Press, Sydney, 1998) 6.

[871] As noted above, other significant categories were inappropriate prescribing and inadequate treatment.

three of whom were psychiatrists.[872] As Appendix G shows, three of the doctors were women,[873] and the average age of the doctors was 52.[874]

Thirteen doctors found guilty of sexual misconduct were deregistered, 11 were suspended from practice, all with conditions upon their registration when they resumed practice, and another 10 doctors had conditions placed upon their registration. Of the 21 cases with conditions, more than half (12 cases) involved psychiatric treatment; and it is in these cases that the medicalisation of misconduct described in Chapter 1 becomes most apparent.

7.3.1 What constitutes sexual misconduct

Sexual misconduct by a doctor is not specifically defined under the National Law, but falls within the definitions of 'professional misconduct' or 'unprofessional conduct'.[875] Very few cases are prosecuted as only unprofessional conduct,[876] and the cases indicate that the Tribunals are generally quite prepared to consider sexual misconduct as serious enough to warrant the most serious disciplinary sanction of deregistration. Sexual misconduct covers a wide range of behaviour, from a single episode of inappropriate touching during a consultation,[877] to a long-term relationship with a patient,[878] and in spite of a number of official policy documents on the subject,[879] there is still some discussion in tribunal decisions about what actually constitutes sexual misconduct.

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[872] *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012); *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011); *Medical Board of Australia & Veness* (Occupational Discipline) [2012] ACAT 36 (8 June 2012).

[873] *Health Care Complaints Commission v Amigo* [2012] NSWMT 13 (22 June 2012); *Health Care Complaints Commission v Millard* [2011] (unreported, 24 February 2011); *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010).

[874] Less than half of the sexual misconduct cases (16) indicated the age of the doctor.

[875] *Health Practitioner Regulation National Law Act 2009* s 5; *Health Practitioner Regulation National Law* (NSW) No 86a s139E and S139B.

[876] For an example see *Health Care Complaints Commission v Vastrad* [2011] NSWMT 1 (15 February 2011).

[877] See, eg, *Health Care Complaints Commission v Vastrad* [2011] NSWMT 1 (15 February 2011) which is pleaded as unsatisfactory professional conduct and/or professional misconduct.

[878] *Health Care Complaints Commission v Sims* [2010] NSWMT 17 (30 November 2010).

[879] <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>. According to these guidelines a sexual relationship is forbidden with a current or former patient, or a person closely related to the patient. The guidelines provide information about defining and understanding sexual boundaries and other related issues.

The official policies and case law make it clear that a sexual relationship between a doctor and a patient is strictly forbidden, not only for ethical reasons but also because such a relationship is likely to compromise the standard of care to the patient.[880] According to the Medical Board of Australia sexual misconduct involves a doctor engaging in a sexual relationship with a current patient, regardless of whether the patient consented to the activity or not; engaging in sexual activity with a person who is closely related to a patient under the doctors care, or with a person formerly under a doctor's care.[881] The policy states that sexual misconduct also includes making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient.[882] Inappropriate prescribing is often a characteristic of the sexual misconduct cases.[883] The Medical Board policy is clearly very broad, and as the cases discussed below indicate, this may be of necessity given the wide range of situations that come under the umbrella of sexual misconduct.

Other definitions of sexual misconduct abound in the literature, including two- and three-tiered definitions,[884] which grade the conduct according to severity.[885] One definition simply defined sexual misconduct as an exploitation of the physician-patient relationship in a sexual way by the physician's words or actions.[886]

7.3.2 The distinction between personal and professional misconduct

The distinction between personal and professional misconduct is important as it raises the whole issue of professional 'boundaries', which as one writer notes, are now more difficult to delineate in the context of decreasing formality in medicine, with the use of

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[880] *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010. The Tribunal also noted that as well as patient care being compromised, a more informal approach would be taken to the patient's clinical notes.

[881] *Medical Board of Australia v Skehan* (Occupational and Business Regulation) [2011] VCAT 2424 (15 April 2011).

[882] <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>.

[883] See, eg, *Health Care Complaints Commission v Sims* [2010] (NSWMT 17 (30 November 2010); *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012); *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010); *Medical Board of Australia v Van Opdenbosch* [2012] QCAT 703 (12 November 2012).

[884] James R Winn, 'Medical Boards and Sexual Misconduct: An Overview of Federation Data' (Summer 1993) *Federation Bulletin*, 90-97.

[885] Ibid 91.

[886] Ibid.

first names with doctors, and relaxed and more collaborative relationships with patients.[887] As one American writer notes:

> Physicians are never just physicians. They are people with personal desires, needs, interests and lives who develop various kinds of relationship with others through the courses of their lives, lives defined in part by their personal rather than professional presence at their workplace.[888]

A very early landmark case in New South Wales considered the line between personal and professional conduct. A female psychiatrist engaged in a sexual relationship with a female patient in order to explore her own sexuality after the doctor-patient relationship had ended.[889] She was deregistered. On appeal it was argued that the conduct occurred outside 'the practice of medicine'. The New South Wales Court of Appeal considered the phrase 'in the practice of medicine' (a term used in the then definition of professional misconduct)[890] and found that the act or omission need not be conduct that occurs in the course of treating a patient.[891] The principle that a doctor should not engage in conduct with a former patient is now well enshrined.

The line between personal and professional misconduct has also been considered in more recent cases, including one where a doctor had been convicted of criminal offences some 13 years before qualification as a medical practitioner and eight years before he became a medical student.[892] The doctor pleaded guilty and was convicted of six offences of indecent assault on a male.[893] In this case, although there were no patient

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[887] Cherrie A Galletly, 'Crossing Professional Boundaries in Medicine: The Slippery Slope to Patient Sexual Exploitation' (2004) *Medical Journal of Australia* 181.

[888] Yarborough, above n 866.

[889] *Childs v Walton* [1990] NSWCA.

[890] Then part of the definition of professional misconduct under the *Medical Practitioners Act 1938*.

[891] *Childs v Walton* (New South Wales Court of Appeal) 17 September 1992 [4].

[892] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012).

[893] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [13]. Dr A spent his childhood in Sydney and the Blue Mountains. His home life was chaotic. The home was occupied by his parents and seven natural siblings and four adopted siblings. Both parents had mental health issues: his father also had episodic heavy drinking with accompanying violence. The doctor, for approximately four years, studied for the priesthood and then worked for the Police Service and Ambulance Service before, in 1983, enrolling at university in the School of Architecture. He then transferred to Medicine the following year. He graduated in 1989 and served his hospital residency. He practised as a general practitioner in the Blue Mountains. He married, had a family then moved his own family, for health

complaints against the doctor, the complaints followed from the criminal proceedings after being referred to the Medical Board. Evidence established that the first victim had, throughout his life, been given considerable support, including financial support, by the doctor. When that financial support ceased, the allegation was brought to the attention of the authorities and criminal charges were laid.[894] The doctor's conduct in the practice of medicine after he qualified was unblemished, and he had practised medicine as a general practitioner for some 23 years without complaint.[895] Because the doctor admitted the conduct which was the subject of the criminal charges, the Tribunal, having made the finding that:

> … the nature of the conduct was most serious and disgraceful of him personally, ... balancing his unblemished reputation post the conduct with his proven clinical skills and qualities as a most caring General Practitioner, the Tribunal finds there has not been revealed any quality of character which could attract a finding the doctor is not suitable to practise medicine.[896]

Nevertheless, in view of the admitted conduct and evidence that the doctor was at very low risk of re-offending, the Tribunal placed conditions on his registration, stressing that 'all conditions were aimed at supporting and assisting the doctor in his clinical practice'.[897]

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reasons, to a northern districts inland community where he set up a general practice. He has practised medicine as a general practitioner for some 23 years without complaint.

[894] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [12].

[895] The Tribunal in *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) cited by C J Spigelman in *NSW Bar Association v Cummins* [2001] NSWCA 284 [56] discussing the extent to which personal conduct could be said to reflect on professional conduct:

> That is not to say that any form of personal conduct may be regarded as professional misconduct. The authorities appear to me to suggest two kinds of relationships that justify applying the terminology in this broader way. First, acts may be sufficiently closely connected with actual practice, albeit not occurring in the course of such practice. Secondly, conduct outside the course of practice may manifest the presence or absence of qualities which are incompatible with, or essential for, the conduct of practice. In this second case, the terminology of 'professional misconduct' overlaps with and, usually it is not necessary to distinguish it from, the terminology of 'good fame and character' or 'fit and proper person'.

[896] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [49].

[897] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [55].

This case indicates that the 'boundaries' between personal and professional conduct need not be based upon conduct 'in the practice of medicine' as elucidated in the case above, and that the boundary between personal and professional conduct can easily be blurred.[898] The cases in this study also make clear that an allegation of sexual misconduct may apply not only to former patients,[899] but also to the relatives of a patient, particularly if the patient is a child.[900]

In fact as noted in Chapter 2 the National Law now provides in the definition of professional misconduct at s5 (c) that:

> Conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

This provision was not considered in in any of the tribunal decisions discussed in this thesis. The National Law (NSW) does not contain this provision. This provision arguably strengthens the objective of the protection of the public under the National Law. The provision can encapsulate all of the grey areas both in the area of sexual misconduct specifically and professional misconduct more generally.

The factual scenarios in the cases in this study are many and varied, posing some unique challenges for tribunals in determining whether the conduct is sexual misconduct and the most appropriate protective orders. In one instance, the doctor was a plastic and reconstructive surgeon who had performed a breast implant upon his patient. The doctor admitted to developing a personal and intimate relationship with the patient.[901] A plastic surgeon called on behalf of the doctor argued that the conduct was not sexual

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[898] This case also clearly indicates that the conditions can be used as a risk prevention strategy in circumstances where criminal convictions alone may be seen as a risk factor.

[912] *Medical Board of Australia v Skehan* (Occupational and Business Regulation [2011] VCAT 2424 (15 April 2011).

[900] In one such case, a consultant paediatrician admitted to having a sexual relationship with the mother of two children he was treating: *Health Care Complaints Commission v Underwood* 22 August 2012 <http://www.mcnsw.org.au/page/421/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-2012/>.

[901] *Health Care Complaints Commission v Howe* [2010] NSWMT 12. He also admitted attempting sexual intercourse on one occasion but was unsuccessful.

misconduct as actual sexual intercourse had not taken place.[902] The Tribunal however was not persuaded, and stated that each case would turn on its own facts in terms of how a relationship between a doctor and patient should be characterised.[903]

The variety of potential factual scenarios gives tribunals a wide discretion, and they sometimes appear to be shy of labelling conduct in some cases as sexual misconduct, illustrating how blurred the boundaries can be in these cases. In a Queensland case, where an 88-year-old doctor twice had a 'personal' relationship with a woman to whom he was inappropriately prescribing drugs, the judgment did not clarify the exact nature of the relationship.[904] In a Western Australian case, the misconduct was described as 'improper' conduct, but not sexual misconduct.[905] The Tribunal found that the doctor acted 'improperly'[906] in that he embraced a female patient whilst she was under hypnosis, and without seeking permission to touch her, hugged her, and in the course of so doing, rubbed his erect penis against her body in circumstances where he did not have her consent.[907] In such a case, it is difficult to see how the Tribunal distinguished between improper conduct and sexual misconduct. Another Western Australian case involved a similar issue, although there were sexual connotations in the conduct and the doctor had a previous history of sexual misconduct.[908]

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[902] Another plastic surgeon in the same case argued on the doctor's behalf that the conduct was not inappropriate and needed to be seen in the 'in the context of the exceeding potential complexity of all interpersonal relationships'.

[903] See also *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010) [60] where the Court considered a number of sexual misconduct cases and concluded that a reading of these cases confirms that each complaint must be determined on its own particular facts and circumstances.

[904] *Medical Board of Australia v Van Opdenbosch* [2012] QCAT 703 (12 November 2012).

[905] *Medical Board of Western Australia and Wolman* [2011] WASAT 69 (21 April 2011).[1]

[906] Within the meaning of s 76(1)(b)(iii) of the *Medical Practitioners Act 2008* (WA) (MP Act).

[907] *Medical Board of Western Australia and Wolman* [2011] WASAT 69 (24 June 2011).[260] At the same time, it did not find the respondent guilty in relation to two other allegations involving the same patient, one of sexual misconduct and one of improper conduct.

[908] *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011). The doctor had been previously disciplined for sexual misconduct more than once and the Tribunal was called upon to decide whether conduct by a medical practitioner, namely attaching a post-it note to a patient's shoulder underneath her exposed bra strap, constituted improper conduct. It concluded that, in the absence of invitation or consent, the conduct was improper.

7.3.3 Principles derived from the cases – the rhetoric and reality

Not all of the cases typify the stereotypical sexual misconduct cases where the patient is vulnerable and the doctor all-powerful, although the principles in the caselaw assume the patient is always vulnerable. A more nuanced picture emerges from the tribunal decisions in this study, which may explain why the rhetoric about the unethical nature of sexual misconduct is not matched by the reality of stringent protective orders such as suspension or de-registration.

In a Victorian case in which a general practitioner had a relationship with the wife of a family he had been treating for 20 years, the Tribunal set out no less than 18 principles outlining the traditional approach to sexual misconduct by medical practitioners.[909] These principles have been relied upon in other Victorian cases,[910] and are typical of the principles spelled out in cases in other states. The gravamen of sexual misconduct is said to be the breach of trust by the doctor, the misuse of power, and the exploitation of the patient's vulnerability.[911] The vulnerability 'principle' is repeatedly stressed in the caselaw on sexual misconduct. However, as one writer notes, the conventional principles assume that whenever therapeutic actions are performed 'a therapeutic relationship, with all the commitments and power inequity that the relationship entails, begins'.[912] In fact, some of the cases discussed below indicate that the dynamics in terms of trust, power and vulnerability can shift dramatically once a sexual relationship

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[909] *Medical Board of Australia v Skehan* (Occupational and Business Regulation) [2011] VCAT 2424 (15 April 2011) [73]. See, eg, from the ruling: [14] 'As with all misconduct, individual examples may vary in severity. The more serious the misconduct, the more likely it will be that the interests of the public will dictate removal from the register. It cannot be said that every case of misconduct of this kind will dictate such removal. [15] These comments apply to male and female medical practitioners, both general practitioners and specialists. The nature of a particular speciality may render the misconduct more serious (e.g. psychiatrists and gynaecologists). [16] These observations apply to both heterosexual and homosexual relationships and conduct. [17] Whilst these observations generally refer to relationships with a patient, they also apply to relationships with persons closely associated with patients, particularly parents of infant patients and spouses of patients. [18] The gravamen of this misconduct is breach of trust, misuse of power and exploitation of vulnerability. Sexual misconduct is only an example of such misconduct.'

[910] *Medical Board of Australia v Erhardt* (Occupational and Business Regulation) [2011] VCAT 1702 (9 September 2011) [18].

[911] In one case the Tribunal noted that there was a disproportionate power imbalance in the relationship on two levels: that of doctor-patient and that of an adult and minor. See *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013).

[912] Yarborough, above n 866, 359. In one case the Tribunal noted that there was a disproportionate power imbalance in the relationship on two levels: that of doctor-patient and that of an adult and minor. See *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013).

commences. The patient may become powerful and the doctor vulnerable. The patient can use this power to blackmail the doctor both emotionally and financially,[913] and to force doctors to disclose their conduct to regulatory authorities before the patient does.

In one case, a cosmetic surgeon, in the words of the Tribunal '… transformed a patient from a 21 year old woman working in a pet shop to a model whose photographs appeared on the front cover of a popular men's magazine and in other well-known such magazines'.[914] The Tribunal found that the doctor participated in negotiations, including with his solicitor, whereby he proposed to pay a sum of money to the patient, on condition that she sign formal documentation that she would refrain from taking action in relation to, or otherwise disclosing, that he had engaged in a sexual relationship with the patient, and on condition that she delete material relevant to that relationship from her laptop computer and mobile telephone.[915] The patient had wanted the doctor to pay her $50,000 and he had offered only $20,000. Although she had threatened to report him to the Board and tell his wife of their relationship, she never did so. Her threat was enough to make him report himself. In this case although the doctor was a perpetrator, he also became a victim, and he also became vulnerable. Although the Tribunal noted that

> In our view, Dr Topchian made grave errors of ethical judgment in having the relationship and trying to prevent his conduct being exposed. A cosmetic surgeon operates in one of the most sensitive fields in medical practice, akin to psychiatrists and psychologists. They alter people's appearance to which self worth is often inextricably linked, perhaps particularly to the people who consult them.[47][916]

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[913] *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010); *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013).

[914] *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013).

[915] *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013).

[916] *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013).

Dr Topchian was suspended for a year, reprimanded and required to consult a mentor for two years. In view of the patient's age and initial vulnerability about her appearance, and the doctor's attempts to conceal his misconduct, it is arguable that the public could also have been protected by the doctor being de-registered, irrespective of the patient's attempts to blackmail the doctor.

In another case, after trying to end a quite lengthy sexual relationship with a patient, the doctor commenced a new relationship whilst travelling overseas.[917] The patient threatened to report their relationship to the Medical Board of New South Wales and demanded $100,000 for her silence. When the doctor refused to pay, the patient reported him to the Board. The patient then said she would drop the complaint if the doctor paid her $150,000. The doctor then reported himself to the HCCC and was ultimately suspended from practice for 12 months, had health conditions placed upon his registration and was ordered to pay the costs of the proceedings.[918] Clearly money is not the only factor in these blackmail cases, as the threat of reporting to the relevant Board gives the patient enormous power.[919]

Emotional blackmail can also emanate from the doctors who engage in sexual misconduct. In a Victorian case, when a doctor told her colleague she was going to report him for sexual misconduct, the doctor threatened suicide if the notification went ahead. He subsequently agreed to see a psychiatrist if it did.[920] He had a lengthy history with the Board and had twice been the subject of disciplinary proceedings with adverse findings against him. The doctor was deregistered for a year and reprimanded. In view of his history it is not clear why he was only deregistered for a year.

The cases involving blackmail challenge the established principles in relation to sexual misconduct set out in some of the cases in terms of the power relationship between a

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[917] *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010).

[918] *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010) [18]. The health conditions referred to psychiatric treatment, [72].The doctor had already been seeing a psychiatrist.

[919] One doctor stated that he continued elements of the relationship with his patient because she threatened to report him to the Medical Board. *Health Care Complaints Commission v Small* [2012] NSWMT 18 (19 July 2012).

[920] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010) [11].

doctor and patient.[921] In two of the blackmail cases above the doctors were suspended when deregistration was also an option. It is not clear how the issue of blackmail influenced the Tribunal's determinations in relation to protective orders.

Occasionally a tribunal will also adopt a more nuanced approach to these complex and difficult situations. In one case, the patient described her three-year sexual relationship with her doctor as 'a fling'.[922] The Tribunal determined sanction on the basis that the relationship, although inappropriate, was consensual, genuine and did not involve actual exploitation of the patient.[923] There was no evidence that she was particularly vulnerable. The Tribunal stated however, that there must be a sanction that recognises the clear breach of professional boundaries and, also, the doctor's attempt to deceive the Board in its investigations. The doctor was reprimanded and suspended for three months but the suspension was reduced to one month if the doctor complied with orders, which included boundary violation counselling. The complaint was not made by the patient but by the doctor's ex-wife.[924] This case demonstrates the tension between protection of the public and the individual interests of the doctor when there was no evidence of exploitation of the patient.

One principle, as noted above, states that it is professional misconduct to exploit even a discontinued professional relationship.[925] In an early 2007 Victorian case a psychiatrist commenced a relationship with a patient only a month after he had ceased treating her.[926] The relationship continued for some nine years and involved a financial payment to the patient.[927] The psychiatrist did not disclose it to his professional peer review group with whom he met regularly. The Tribunal said:

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[921] As noted, these principles involve the breach of trust, misuse of power and exploitation of vulnerability. *Medical Board of Australia v Skehan* (Occupational and Business Regulation) [2011] VCAT 2424 (15 April 2011) [73].

[922] *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012) [16].

[923] *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012) [16].

[924] *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012) [16].

[925] *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012) [8]. 'Thus a medical practitioner should only commence or continue an association with a former patient if there can be no suggestion that he or she is exploiting a dependency created in the course of the professional relationship'.

[926] *Honey v Medical Practitioners Board of Victoria* (Occupational and Business Regulation) [2007] VCAT 526 (30 March 2007) is not part of this study but discusses many of the relevant principles.

[927] The psychiatrist also paid the patient the sum of $100,000 as part settlement for her undertaking not to lodge a complaint with the Medical Board.

> [17] It is particularly pertinent that the medical practitioner involved in this case is a consultant psychiatrist … The risk of development of an inappropriate sexual relationship between a patient and a psychiatrist is a well-recognised hazard of psychiatric practice, so well known, that it is the subject of scientific literature, referred to as 'transference' and 'counter transference', and taught to psychiatrists as part of their routine psychiatric training.
>
> [18] It is covered extensively in information provided to psychiatrists by the Royal Australian and New Zealand College of Psychiatrists (RANZCP).
>
> [48] In this case we do not accept that Dr Honey made a mere error of judgment. His conduct over the lengthy time during which the affair took place is reprehensible and calculated.

In spite of the damning findings by the Tribunal and the principle that the nature of a particular speciality may render the misconduct more serious (e.g. psychiatrists and gynaecologists),[928] the psychiatrist successfully appealed his deregistration and was suspended instead for 18 months.[929] The Tribunal took into account the effect of the disciplinary proceedings upon him, his services to patients in the western suburbs of Melbourne and considered that he was unlikely to re-offend.[930] It also took into account that his peer review group was now aware of his relationship with the patient, although he had consistently concealed it from them over a number of years. Interestingly, of the two persons sitting on the appeal, one was a judge and the other a psychiatrist, who may well have been sympathetic to the plight of another psychiatrist. As discussed in Chapter 2 above, the concept of peer review has come under increasing critical scrutiny, particularly on the basis that doctors are seen to protect their own. Although this was a comparatively early case, recent cases indicate that tribunals are still quite lenient in

[928] *Honey v Medical Practitioners Board of Victoria* (Occupational and Business Regulation) [2007] VCAT 526 (30 March 2007).

[929] *Honey v Medical Practitioners Board of Victoria* (Occupational and Business Regulation) [2007] VCAT 526 (30 March 2007).

[930] *Honey v Medical Practitioners Board of Victoria* (Occupational and Business Regulation) [2007] VCAT 526 (30 March 2007).

spite of the principles espoused in the cases.[931] In some cases the protection of the public is sacrificed in favour of the interests of the doctor.

The traditional principles referred to earlier and the ethical rules spelt out by the Medical Board of Australia,[932] which strictly forbid sexual misconduct, are easily undermined, not only by the shift in the power relationship between doctor and patient, but also by the pervasive theme of remediation and 'treatment' of sexual misconduct. In a recent case, very reminiscent of the early case of Honey described above, a psychiatrist commenced a sexual relationship with a patient whom he knew to be very vulnerable.[933] The doctor had been a psychiatrist for fourteen years and was treating the patient for bi-polar affective disorder when he developed a sexual relationship with her. He stated that he continued 'elements' of the relationship because he was concerned about the impact on the patient's condition if he brought it to an end.[934] The Tribunal noted his degree of cooperation in the proceedings and he was suspended for two years, but the suspension was to be lifted after a year if he complied with the conditions imposed upon his registration and not face further disciplinary proceedings for three years. His conditions involved the completion of an ethics course related to boundary violation and 12 months supervision with a psychologist or psychiatrist also focussing on boundary violation. It is difficult to reconcile the principles about sexual misconduct and public protection in this case with the protective orders imposed. The case was clearly protective of interests of the doctor in not imposing the more serious sanction of deregistration given that he was an experienced psychiatrist, and that the patient suffered from a serious psychiatric condition.

In another case, a doctor with a previous history of self-injecting pethidine had a lengthy sexual relationship with a patient whilst continuing to treat her and her family. He also had health conditions placed upon his registration.[935] In spite of mitigating factors referred to by the Tribunal, this case is also difficult to reconcile with the

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[931] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011).

[932] <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>.

[933] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011).

[934] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011) [13].

[935] *Health Care Complaints Commission v Dr Guy Herron* (NSW Medical Tribunal, Deputy Chairperson Balla J, 1 March 2013).

principles espoused in the caselaw as the doctor was well aware that he was breaching professional boundaries and continued for some time to do so.

7.3.4 Protective Orders

In New South Wales, where the majority of sexual misconduct cases in this study occur, tribunals may consider a range of protective orders when a complaint is found proved. These are set out in Chapter 2. In sexual misconduct cases, the protective orders may involve chaperone or other practice conditions, whilst the health conditions usually involve psychiatric treatment,[936] particularly when the misconduct is seen as a symptom of an underlying condition, which may mitigate the conduct. The discourse on risk in these cases is invariably couched in psychiatric terminology; and as noted in some of the impairment cases, psychiatry and the law both collaborate and compete when it comes to protective orders.[937] The case of Schultz, for example, demonstrates how they compete, when the evidence of the psychiatrist is rejected:

> The recognition of the conduct in failing to keep proper boundaries is strong evidence that the respondent did not learn from his earlier unsatisfactory professional conduct in having a relationship with a patient. Under pressure he abandoned the high standards of conduct required of a medical practitioner. This is despite a report from Dr Michael Diamond, Consultant Psychiatrist, dated 17 March 2004 (which addressed the respondent's misconduct at that time) that the respondent: 'fully and clearly understands those issues pertaining to preservation of professional boundaries by psychiatrists with their patients.
>
> There was limited evidence that the respondent had addressed the character defects that led to his misconduct. The respondent's statements that he still considers himself a risk if he were allowed to continue to treat patients is a matter of serious concern for the Tribunal. The respondent believed a return to medico-legal practice was 'the safest option'. It would, he said,

[936] The conditions on a doctor's practice are often broken up into 'Employment conditions' or 'Practice Conditions' and 'Health conditions'.

[937] *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012); *Health Care Complaints Commission v Ristevski* [2012] NSWMT 23 (14 December 2012); in these cases, psychiatric evidence was rejected by the tribunals.

> 'completely remove any risk of any boundary issues developing'. However, this would still bring him in contact with patients. The respondent's lack of confidence has led this Tribunal to conclude that it is comfortably satisfied that there has been no reformation of his character.[938]

The doctor was de-registered. Psychiatry and the law collaborate when psychiatric evidence is accepted and used as the basis for protective orders. Steps towards rehabilitation appear to be almost preconditions for a doctor who has been found guilty of sexual misconduct, being allowed to continue practising, although such steps do not guarantee that they will not be de-registered. Where there are clear contraindications of rehabilitation, de-registration is more likely. One such contraindication, aside from expressing no contrition or appreciation of wrongdoing, is where the doctor is found to have lied to the Tribunal, or to his or her own treating clinician, about the conduct.[939] Elkin distinguished between conduct involving a sexual relationship with a patient from other inappropriate sexual conduct with patients, suggesting that:

> The ongoing and typically clandestine nature of sexual relationships, often combined with a lack of insight and remorse, elevates the seriousness of this conduct from a public protection perspective. By contrast, in cases involving sexual misconduct that occurs outside a relationship, the misconduct is often an isolated incident, which may be judged to have occurred due to misunderstandings or one-off indiscretions.[940]

It is in the protective orders that the medicalisation of sexual misconduct becomes most apparent, as in the impairment cases. As already noted the cases constantly reiterate the protective nature of the jurisdiction when making orders,[941] although they also

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[938] *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012) Dr Diamond's report also stated that 'I am confident that with ongoing treatment, regular supervision with an appropriate practitioner, being part of a group practice and avoiding intense psychotherapeutic work with patients that Dr Schultz could re-enter the workforce as a safe and effective medical practitioner'.

[939] Elkin, *Protecting the Public,* above n 9, 271.

[940] Elkin, Spittal and Studdert, 'Risk of complaints', above n 2, 1031.

[941] Dr A [20] citing Basten JA in Director-General, Department of Ageing, Disability and *Home Care v Lambert* [2009] NSWCA 102; (2009) 74 NSWLR 523 [83] (not a sexual misconduct case).

recognise that the effects of protective orders may be punitive.[942] The case of Dr A referred to above[943] cited *Director-General, Department of Ageing, Disability and Home Care v Lambert* [2009] NSWCA 102; (2009) 74 NSWLR 523 [83] (not a sexual misconduct case) where Basten JA in the Court of Appeal said

> 1. The specific purpose for which orders are made is protective in the public interest and is not punitive with respect to the individual.
>
> 2. That is not to deny that such orders may be punitive in effect and that punitive effects may be relevant in formulating a protective order.
>
> 3. The punitive effects may be directly relevant to the need for protection so that, in a particular case, there may be a factual finding that the harrowing experience of disciplinary proceedings, together with the real threat of loss of a livelihood, may have opened the eyes of the individual concerned to the seriousness of his or her conduct so as to diminish significantly the likelihood of its repetition and to produce a level of insight into his or her own character or misconduct which did not previously exist. [83]

A number of cases demonstrate that when the effects of protective orders become punitive of the doctor, a tribunal may take this into account.[944] Other principles in relation to protective orders include minimising the risk of recurrence, deterrence and maintaining public confidence in the profession.[945] As noted in Chapter 6, fitness to practice at the date of the hearing rather than when the conduct occurred is also an oft-stated principle in the cases, [946] and, this principle often works to the advantage of doctors. Delays in matters coming to hearing allows doctors time to gather evidence of insight and reformation of character prior to the hearing.

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[942] Basten JA in Director-General, Department of Ageing, Disability and *Home Care v Lambert* [2009] NSWCA 102; (2009) 74 NSWLR 523.

[943] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [20].

[944] See, eg, *Health Care Complaints Commission v Herron* [2013] (unreported, 1 March 2013) and the older case of *Honey v Medical Practitioners Board of Victoria* (Occupational and Business Regulation) [2007] VCAT 526 (30 March 2007) also referred to above, which discusses the impact of disciplinary proceedings in some detail.

[945] *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010) [36].

[946] *Gad v Health Care Complaints Commission* [2002] NSWCA 111 [55].

7.3.5 Deregistration

It is clear from Appendix M that tribunals consider that the imposition of conditions upon a doctor's registration is effective in protecting the public, and deregistration is reserved only for the most serious cases, usually involving repeated misconduct or criminal charges.[947]

As Appendix M indicates, during the period 1 July 2010–1 July 2013, 14 doctors across Australia were deregistered for sexual misconduct.[948] These cases often involved repeated sexual misconduct or criminal conduct. Many of the deregistration decisions indicate a period of deregistration before which the doctor may not apply for re-registration.[949] The longest period of deregistration was for eight years.[950]

One case involved a doctor who had sexual relationships with two patients, both of whom he had subsequently married.[951] He had been treating his second wife since she was 17 and she had multiple significant medical and emotional problems.[952] He also inappropriately prescribed to twelve drug dependent patients. He was deregistered for nine months. The Tribunal gives no reason for this comparatively short period of

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[947] In *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011) a case which involved sexual misconduct with two patients and breach of chaperone conditions, in considering the appropriate protective orders the tribunal refers to earlier cases in Queensland where doctors have been deregistered for sexual misconduct. These cases provide further insight as to the types of cases which attract the most serious protective order of deregistration. See *Medical Board of Queensland v Alroe* [2005] QHPT 4 (sexual intercourse with a former patient on four occasions, exploited the former professional relationship – cancelled for four years); *Medical Board of Queensland v Doolan* [2001] QHPT 003 (sexual relationship with a patient, previous offence of the same nature – cancelled for three years); *Lasrado v Medical Board of Queensland* [2005] QHPT 5 (sexual harassment and sexual behaviour towards five female patients, breaches of chaperone requirement including dishonestly altering records – cancelled for three years six months).

[948] As noted above, nine doctors were suspended from practice with conditions when they resumed practice, and another 11 had conditions placed upon their registration.

[949] See Appendix A.

[950] *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013).

[951] *Health Care Complaints Commission v Sims* [2010] NSWMT17 (30 November 2010). He did not attend the proceedings and removed himself from the register prior to the proceedings. His second wife gave the following evidence [28]: 'Bob would give me a handful of tablets to take and I wouldn't know what they were. During the last few years of our marriage I was doped out all the time. I was in bed every night from 8pm until 10am in the morning. My kids are witnesses to how doped up I was and they have since discussed it with me. In the last few months of our marriage Bob would just give me needles and would say I needed them. I wouldn't remember anything until the next morning after the first injection and tablets at 8 o'clock at night.'

[952] *Health Care Complaints Commission v Sims* [2010] NSWMT17 (30 November 2010) [99].

deregistration.[953] Other deregistration cases involved much longer periods of deregistration and involved criminal convictions for rape and assault,[954] criminal convictions for indecent assault on patients,[955] and a conviction for assault occasioning actual bodily harm on a patient with whom the doctor was having a sexual relationship.[956] Another deregistration case involved a psychiatrist who had developed a sexual relationship with a patient.[957]

As noted above, the longest period of deregistration was for eight years. It is not clear why this period was chosen. The case involved a complaint of indecent assault on 17 female patients, mainly young women (including one aged 14 and one 16) that involved '... the interference with the breasts and genitalia of the patients, usually the most spurious excuses for the need for examination'.[958] The doctor had been convicted on criminal charges and was still in prison at the time of the Tribunal hearing, although he gave evidence. The Tribunal took into account the fact that the conduct had occurred over a long period of time, that some of the conduct was repeated and involved assaults and acts of violence, the vulnerability of the patients, the continuing pattern of offending behaviour, and the lack of insight of the doctor, who denied he was a sexual offender. In this case, there was no psychiatric evidence explaining the doctor's conduct. The Tribunal clearly considered that because there was no evidence of any reformation of the defects of character, which were evident in the offences, it had no

[953] *Health Care Complaints Commission v Sims* [2010] NSWMT17 (30 November 2010) [109]. The Tribunal stated that 'Given the time that has elapsed from the date when the respondent removed his name from the Register (1 June 2010), it is the Tribunal's view that a period of nine months to take affect from the date of the decision, represents a sufficient period of time during which the respondent may not apply for re-registration'.

[954] *Health Care Complaints Commission v Dr Sudath* [2013] NSWMT 2 (22 February 2013).

[955] *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013). The Tribunal noted [19] that while most of the victims, who were patients, 'could be described as young women there were two, respectively aged fourteen and sixteen, who might be described as children. They were certainly no more than teenagers, as were three other victims, respectively aged seventeen, eighteen and nineteen'. The offences involved '...the interference with the breasts and genitalia of the patients, usually under the most spurious excuses for the need for examination. The agreed facts also contain an acknowledgement by the respondent of the absence of any need for his actions in the proper treatment of the patients' [20].

[956] *Health Care Complaints Commission v Ristevski* [2012] NSWMT 23 (14 December 2012).

[957] *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012); In this case, the psychiatrist had also married a former patient (a trainee physician) with whom he had developed a sexual relationship soon after he finished treating her, although this was not part of the complaint [11].

[958] *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013).

option but to deregister the doctor in order to protect the public. Given the nature of the offences and the lack of evidence of reformation the Tribunal could have chosen a longer period of de-registration in order to protect the public.

In a Victorian case discussed above, involving a 21-year-old patient and a cosmetic surgeon, the Tribunal noted that the common principle running through the cases where a medical practitioner's registration is cancelled are aggravating factors such as:

> (a) lack of admissions about and insight of the practitioner as to the wrong done, leading to concern that the practitioner may repeat the conduct; and
>
> (b) disputing allegations in the face of overwhelming evidence [1].[959]

These cases where doctors were deregistered usually involved repeat offences and breaches of conditions. Cases involving psychiatrists, for example, where the patients may be particularly emotionally unstable and vulnerable, may involve deregistration,[960] but not always.[961] The de-registration cases demonstrate that the most severe protective orders are only imposed in the very serious cases. The rhetoric in the principles about sexual misconduct is undermined by the reality of protective orders which only resort to the most severe protective sanctions when the conduct is extreme.

7.3.6 Suspension from practice

When a doctor is still considered fit to practice, suspension is considered an appropriate sanction. In a case referred to above, a psychiatrist who had been in practice for 14 years had a relationship with a patient who had bipolar disorder.[962] He would have been deregistered had he contested the allegations.[963] However the decision did not refer to the RANZCP policy, which states that the College has a zero tolerance policy in relation

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[959] *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013) citing *Wilks v Medical Practitioners Board of Victoria* (Occupational and Business Regulation) [2007] VCAT 2439 (17 December 2007); *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010); *Medical Board of Australia v Skehan* (Occupational and Business Regulation List) (No 2) [2011] VCAT 1935 (12 October 2011).

[960] See, eg, *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012).

[961] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011).

[962] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011).

[963] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011) [16].

to proven sexual misconduct.[964] This policy implies that even if a psychiatrist is permitted by a tribunal to practice with conditions or resume practice after a period of suspension or deregistration, they may not be readmitted to the College and their specialty in psychiatry.[965] These conflicting approaches to the regulation of psychiatrists clearly demonstrate that the College itself does not embrace the 'therapeutic culture' when it comes to its own members and allow them to be 'rehabilitated' to re-enter the profession. In all suspension cases, the suspension was coupled with conditions on the doctor's registration when the doctor resumed practice.[966]

7.4 Differences between the states in terms of conditions imposed upon a doctor's registration

As noted above, in 20 of the 34 sexual misconduct cases, conditions were imposed upon the doctor's practice, in nine cases after a period of suspension from practice. In 12 of the 20 'conditions' cases, health conditions were imposed and doctors were required to undergo psychiatric treatment. Of these 12 cases, eight were from New South Wales. In Queensland, where there were six cases of sexual misconduct, and four were suspended with conditions, the suspension was shortened if the doctor complied with the conditions.[967] For example, in the case of Nandam[968] the Tribunal made the following orders:

> Dr Nandam's registration is suspended for 3 months. That order is suspended after 1 month subject to the requirement that Dr Nandam comply with the following conditions for a period of 2 years. If he fails to do so, the

[964] <https://www.ranzcp.org/News-policy/Policy-and-advocacy/Ethics.aspx>.

[965] Ibid. According to the Guidelines on the website 'The RANZCP Ethical Guideline #8 states that sexual relationships between psychiatrists and their current and former patients are always unethical. On that basis, a zero tolerance policy on proven sexual boundary violations was approved by General Council, the RANZCP's governing body, in August 2008.'

[966] *Health Care Complaints Commission v Millard* [2011] (24 February 2011). The tribunal at [64] stated that 'Dr Millard's conduct was so serious that the Tribunal is bound to ensure, at the very least, that conditions remain in force for a set period into the future. The Tribunal has also concluded that conditions alone do not provide a sufficient formula to ensure the protection of the public. There should be added to the conditions an initial suspension of six months.'

[967] See, eg, *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011); *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012); *Medical Board of Australia v Jones* [2012] QCAT 362 (25 July 2012).

[968] *Medical Board of Australia v Nandam* [2011] QCAT 65 (25 February 2011).

> remaining 2 months suspension will be activated upon order of the Tribunal.[969]

In another Queensland case similar orders were made.[970] In fact, in only one of the suspension cases in Queensland was psychiatric treatment made a condition of registration.[971] In the only other Queensland conditions case, psychological or psychiatric treatment was specified.[972] Notwithstanding the small number of sexual misconduct cases in Queensland (six cases) compared to New South Wales (18 cases), it appears that in Queensland this particular type of misconduct was seen as an issue requiring counselling rather than psychiatric treatment. The counselling, and in one case supervision as well,[973] related to boundary violation.

In Victoria, there were eight sexual misconduct cases, three involving deregistration, two suspensions with conditions and three cases involved just conditions. One suspension case involved counselling in relation to boundary violation condition[974] and two other cases involved similar conditions.[975] In only one sexual misconduct case in Victoria was psychiatric treatment a condition of the doctor's registration.[976]

It appears therefore that the culture of the therapeutic state and a psychiatric model of misconduct is more alive in New South Wales notwithstanding that it has many more doctors than the other States. Any boundary violation counselling as ordered in

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[969] *Medical Board of Australia v Nandam* [2011] QCAT 65 (25 February 2011).

[970] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011); Dr Yasin's registration is suspended for a period of two years. That sanction is suspended after a period of 12 months provided that Dr Yasin complies with the following conditions and does not face further disciplinary proceedings for a period of three years from the date of this order.

[971] *Medical Board of Australia v Nandam* [2011] QCAT 65 (25 February 2011) (and conditions: Health condition – psychiatric treatment); *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011) (and conditions: supervision re boundary violation); *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012) (and conditions: boundary violation counselling); *Medical Board of Australia v Jones* [2012] QCAT 362 (25 July 2012) (and conditions: counselling re boundary violation).

[972] *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010).

[973] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011).

[974] *Medical Board of Australia v Erhardt* (Occupational and Business Regulation) [2011] VCAT 1702 (9 September 2011).

[975] *Medical Board of Australia v Laska* (Occupational and Business Regulation) [2011] VCAT 1888 (28 July 2011); *Medical Board of Australia v Petrovic* (Occupational and Business Regulation) [2011] VCAT 795 (6 May 2011).

[976] *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010).

Victoria and Queensland, occurs in the context of psychiatric treatment in New South Wales. However in one New South Wales case the Tribunal had found that:

> [56] The established particulars of complaint show that, over a period of seven months from October 2007 to April 2008, the practitioner engaged in inappropriate sexual conduct towards three young female patients. The behaviour included inappropriate questioning about the patients' sexual behaviour, stroking the arm of patient C in an intimate way and offering to perform pap smears. The most serious misconduct involved the practitioner moving his finger in and out of the vaginas of two patients. Apart from sexual impropriety, the practitioner demonstrated a low level of competence in relation to treatment of patient C's right wrist injury, and kept inadequate records in relation to patients B and C.[977]

Dr King was deregistered. He appealed and was successful in part. The Court of Appeal determined that, in relation to the penalty of deregistration, Dr King had been denied procedural fairness.[978] The Court held that the Tribunal should have followed a two stage procedure, first publishing its findings on the issue of misconduct, and then giving the parties an opportunity to adduce evidence in relation to the appropriate consequential orders.[979] The Court of Appeal set aside the consequential orders of the Tribunal and remitted the matter back to the Tribunal to determine what consequential orders should be made. The Tribunal found that:

> 59. The practitioner continues to deny the most serious departures (those involving sexual impropriety). He has demonstrated neither insight nor remorse, and has advanced no evidence that he has addressed the underlying problems.[980]

Dr King was again deregistered the Tribunal noting that:

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[977] *Health Care Complaints Commission v Dr Victor King* [2011] NSWMT 5 (5 May 2011).

[978] *King v Health Care Complaints Commission* [2011] NSWCA 353 (22 November 2011).

[979] per Handley AJA at [202]–[205], McColl JA agreeing, Macfarlane JA not deciding.

[980] *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013) [18]–[19].

> …it was inappropriate to impose a condition requiring ongoing psychiatric treatment as part of a final order because a condition that requires a practitioner to submit to psychiatric assessment indicates that the Tribunal has misgivings about the practitioner's future behaviour.[981]

This is similar to the argument made in cases where chaperone conditions are imposed, which is discussed below, and where the Court of Appeal stated that the necessity for imposing such conditions on the appellant's registration demonstrated that he was unfit to practice medicine.[982]

7.4.1 'Frequent flyers' and the discourse on risk

The sexual misconduct cases include cases where doctors have breached conditions on their registration,[983] as well as cases where doctors have been the subject of disciplinary proceedings in the past.[984] These doctors are sometimes referred to colloquially as 'frequent flyers'. The cases in which doctors have breached the conditions on their registration most clearly indicate how the law both competes and collaborates with psychiatry in the discourse on risk. Generally, the competition is in relation to the appropriate sanction. In one case, the Tribunal, referring to the evidence of an eminent psychiatrist, said:

> Although Dr Phillips referred to the practitioner's insight into his inappropriate conduct, the Tribunal, after carefully analysing the practitioner's oral evidence, is unable to share Dr Phillips' opinion at this time.[985]

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[981] *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013) [18]–[19] citing *HCCC v Litchfield* [1997] NSWSC 297; (1997) 41 NSWLR 630 [639].

[982] *Health Care Complaints Commission v Bruce Litchfield* (New South Wales Court of Appeal) 8 August 1997.

[983] See, eg, *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011).

[984] See, eg, *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

[985] *Health Care Complaints Commission v Howe* [2010] NSWMT 12 [63].

Ironically, the Tribunal went on to impose further conditions on the doctor's registration, including more sessions with the same psychiatrist whose evidence it had rejected.

In another case, referred to above, the Tribunal noted that the doctor had not learnt from an earlier finding of unsatisfactory professional conduct after he had a sexual relationship with a patient, despite a report from a psychiatrist at the time, which said:

> The recognition of the conduct in failing to keep proper boundaries is strong evidence that the respondent did not learn from his earlier unsatisfactory professional conduct in having a relationship with a patient. Under pressure he abandoned the high standards of conduct required of a medical practitioner. This is despite a report from Dr Michael Diamond, Consultant Psychiatrist, dated 17 March 2004 (which addressed the respondent's misconduct at that time) that the respondent: 'fully and clearly understands those issues pertaining to preservation of professional boundaries by psychiatrists with their patients.[986]

A Victorian doctor had conditions imposed after he was found to have had inappropriate relationships with two patients who were sex workers.[987] Only three months later he had oral sex in his consulting room with a patient who was also a sex worker. The Tribunal was sceptical of the psychiatric evidence that the respondent would not have a relapse, noting that even though the psychiatrist who gave evidence in favour of the doctor was an eminent and well-respected authority in his field, it was difficult to accept that he could be 95% to 99% certain the respondent would not relapse.[988] The Tribunal

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[986] *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012) [58]. The report continued 'I am confident that with ongoing treatment, regular supervision with an appropriate practitioner, being part of a group practice and avoiding intense psychotherapeutic work with patients that Dr Schultz could re-enter the workforce as a safe and effective medical practitioner'.

[987] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010). He breached conditions that he not have any sexual or personal relationship with a current or former patient, and have a nurse chaperone present during consultations with female patients.

[988] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010) [88].

commented that the psychiatric evidence presented during the hearing was less than satisfactory.[989]

The cases thus demonstrate that tribunals tend to reject psychiatric evidence when conduct is repeated, and the findings of fact about repeated misconduct provide a clear rationale for the rejection of psychiatric evidence.

7.4.2 Health conditions

As already noted, in many cases health conditions are placed upon a doctor's practice, particularly in New South Wales,[990] and it is in these cases that psychiatry and the law collaborate in the framing of conditions and the discourse on risk. The conditions are typically worded as noted in Chapter 6 that the doctor should attend a psychiatrist of their own choosing at a frequency determined by the psychiatrist who will report any failures to attend or changes in health status.[991] In this wording, it is clear that as with the impaired cases, the psychiatrist plays a surveillance role, even though s/he may be simultaneously treating the doctor.[992]

In one case where conditions were imposed, , the doctor's sexual misconduct in having a relationship with a patient was explained on the basis that he was suffering from a major depressive disorder at the time of the misconduct, but according to the psychiatrist who gave evidence, as he was no longer suffering from any disorder he was unlikely to put the public at risk.[993] The Tribunal nevertheless placed conditions on his

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[989] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010) [84]; At the first hearing, evidence was given by two psychiatrists: Dr Horgan who had treated the respondent and Professor Ball who had examined the respondent and wrote a report. In its decision relating to the first hearing, the Board summarised Dr Horgan's evidence. At [81] it is stated: 'He believed that boundary violations that occurred were quite inappropriate and having unprotected sexual intercourse was an expression of Dr Young's risk-taking personality. He does not have a formal psychiatric illness but he became involved in two sub-cultures of society simultaneously, the conservative successful professional one where high standards of performance and behaviour were expected and an opposite one where immediate gratification and exhibitionism were hailed as virtues' [27].

[989] *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011).

[990] See, eg, *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012); *Health Care Complaints Commission v Small* [2012] NSWMT 18 (19 July 2012); *Health Care Complaints Commission v Herron* [2013] (unreported, 1 March 2013).

[991] *Health Care Complaints Commission v Small* [2012] NSWMT 18 (19 July 2012).

[992] The role played by psychiatrists in New South Wales is explained in the Health Handbook available on the Medical Council of New South Wales website at <http://www.mcnsw.org.au/page/316/resources/publications/>.

[993] *Health Care Complaints Commission v Howe* [2010] NSWMT 12 (30 September 2010).

registration, including that he see the psychiatrist who was to report to the Board any concerns about the doctor. The Tribunal also ordered that an adult person be present whenever he saw a female patient.[994] This case is an example of how 'deviant' doctors are controlled within the profession, rather than being expelled, through the imposition of health conditions that include psychiatric treatment. In terms of the facts of the sexual misconduct and the stated principles, suspension or deregistration was an alternative for the Tribunal to consider.

In another case where a female doctor had a relationship with a female patient, both the general practitioner and the psychiatrist or psychologist nominated by the doctor were authorised to report to the Board any concerns, as the woman, who in spite of her having married and 'matured', remained vulnerable.[995] In other cases, where the doctors had admitted the conduct and seen psychiatrists prior to the proceedings, the Tribunal imposed the usual health conditions upon their registration.[996]

The impositions of such conditions in the cases above clearly demonstrate the rehabilitative focus of the law. As noted in the introduction to this thesis, rehabilitation is a worthwhile goal. However protective orders that focus on the rehabilitation of the doctor as a means of protecting the public are not always effective, as the cases demonstrate. Such orders may also undermine not only the stated principles about sexual misconduct discussed above, but also the protection of the public. It is arguable that more severe protective sanctions are warranted in these cases if the public is to be more adequately protected. The rhetoric of public protection is undermined by the reality of protective orders that attempt to rehabilitate doctors whose conduct has put patients at risk.

7.4.3 Chaperone conditions – how protective are they?

Chaperone conditions have been the subject of some controversy in the caselaw. As one Tribunal has noted,[997] chaperone conditions may be imposed in varying circumstances

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[994] *Health Care Complaints Commission v Howe* [2010] NSWMT 12 (30 September 2010).

[995] *Health Care Complaints Commission v Dr Elizabeth Millard* (NSW Medical Tribunal, Deputy Chairperson Balla J, 24 February 2011).

[996] *Health Care Complaints Commission v Dr Anthony Underwood* (NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012)*Health Care Complaints Commission v Dr Guy Herron* (NSW Medical Tribunal, Deputy Chairperson Balla J, 1 March 2013).

[997] *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013).

and for various purposes, and the circumstances and purposes will always be important, in part because of the need for the Tribunal to be satisfied that the condition will be effective.[998] As noted in Chapter 1, the Health Ombudsman and AHPRA in Queensland reviewed a case where a doctor had breached conditions on his registration 191 times.[999] The conditions involved the use of a chaperone. The review clearly raised questions about how such conditions are monitored so that they protect the public.

In an early landmark case referred to in Chapter 2, the New South Wales Court of Appeal referred to a decision where a doctor who had been found guilty of sexual misconduct successfully appealed.[1000] On appeal he had conditions placed upon his registration, one of them being that he only see female patients in the continuous presence of a female chaperone. However, the Court of Appeal in a later case was scathing about the chaperone condition stating that 'the necessity for imposing such conditions on the appellant's registration demonstrated that he was unfit to practice medicine'.[1001]

In spite of this decision, tribunals continue to place chaperone conditions upon a doctor's practice, even though two cases in this study indicate that some doctors routinely flout the conditions. In a Queensland case, a doctor who breached the chaperone conditions on his registration had been found in 2001 to have acted inappropriately towards a female patient.[1002] He questioned her about sexual matters, told her he was aroused by her and said he wanted to perform oral sex on her. His registration was suspended for three months and a chaperone requirement was imposed for two years.[1003] He later sought to mislead the Board by trying to draw others into falsifying his chaperone records.[1004] In the Victorian case mentioned above, the doctor

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[998] *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013) [62].

[999] <http://www.oho.qld.gov.au/wp-content/uploads/2015/03/Health-Ombudsman-case-review-managing-practitioner-compliance-with-conditions-of-registration.pdf>.

[1000] *Richter v Walton* (Unreported, 15 July 1993).

[1001] *Health Care Complaints Commission v Bruce Litchfield* (New South Wales Court of Appeal) 8 August 1997.

[1002] *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011). *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011).

[1003] *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011). *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011).

[1003] *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011). *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011).

had previously breached chaperone conditions on his registration. The doctor was deregistered.[1005]

The cases above clearly demonstrate that chaperone conditions are not always effective in protecting the public and can be abused.[1006] The Tribunal in King sounded a note of warning stating that:

> The imposition of an indefinite chaperone condition may well protect individual women patients against further misconduct by the practitioner. However, public confidence in the profession would be seriously undermined if the Tribunal permitted the practitioner to continue practicing despite the fact that he has little insight and the reasons for the misconduct remain unknown.[1007]

In one rather odd and confusing Victorian case a chaperone condition applied only to female patients under 18 years old, and there was discussion about whether the conditions should specify female patients over 18 who were pre-menopausal. The final draft condition removed the 'pre-menopausal' requirement.[1008]

Chaperone conditions are sometimes imposed almost for symbolic reasons. In the case of Dr A referred to above, the Tribunal said:

> The Tribunal is of the view such conditions should be continued to give assurance to the public, if there was a perception of concern or expressed concern based upon his long past conduct, of the absolute ethical manner in which the doctor conducts a skilled practice.[1009]

In the same case a consultant psychiatrist said that he would see the risk of offending in the context of medical practice as being very low, particularly if the doctor was

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[1005] *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010).

[1006] *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011); The Tribunal said [26] that in this case, the chaperone regime was inadequate to protect female patients.

[1007] The decision was appealed and is discussed above n 976 *King v Health Care Complaints Commission* [2011] NSWCA 353 [33].

[1008] *Medical Board of Australia v Kemp* (Occupational and Business Regulation) [2011] VCAT 2271 (30 November 2011) [20]–[22].

[1009] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [52].

chaperoned.[1010] In another matter where a doctor was found to have inappropriately touched a female patient, chaperone conditions were imposed until such time as he completed a communications course.[1011]

In King, the doctor attempted to explain the breach of chaperone conditions on his registration. According to the decision:

> The respondent accepted that he was in breach of his conditions. However, he expressed complete surprise as he had thought that he had already put in place the 'necessary controls'. The respondent however, stated that all patients had been properly chaperoned and that the only errors were in the paperwork. He was unable to explain why there had been so many errors in the relevant period. Furthermore, the respondent asserted that in some cases … these had been honest mistakes.[1012]

The Tribunal stated however that Dr King's behaviour amounted to a flagrant disregard of the intent of the conditions on his registration, as well as the specific reporting requirements.[1013] In another case where chaperone conditions were breached, the Tribunal stated that the doctor had demonstrated that the chaperone regime was inadequate to protect female patients, and that the doctor had 'exploited the trust inherent in the relationship between doctor and patient and did so at a time he was subject to a regime intended to protect female patients from this very conduct'.[1014]

It is clear that although chaperone conditions may provide a degree of reassurance to tribunals who are attempting to manage risk, little or no research on the use of chaperones in a regulatory context is available to assist tribunals in their decision-making capacity. Like health conditions, chaperone conditions may allow 'deviant' doctors to remain in practice when there may be grounds for more severe sanctions. The review initiated by the Ombudsman in Queensland may make the monitoring of such conditions upon a doctor's practice more effective. Significantly there is a dearth of

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[1010] *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012) [17].

[1011] *Health Care Complaints Commission v Vastrad* [2011] NSWMT 1 (15 February 2011).

[1012] *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013) [17].

[1013] *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013) [17].

[1014] *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011) [26].

comment in the Tribunals of the effect of chaperone conditions upon patients, who may arguably feel self-conscious when having an intimate examination not only in front of a doctor but also another person, even if they have been given the opportunity to nominate the person.

7.5 The role of psychiatrists

Although the traditional role of psychiatrists has been to treat people with mental health problems, this role has changed significantly. Psychiatrists now are involved not only in the treatment of patients, but also in the treatment and supervision of doctors in a regulatory context. This supervisory role has been referred to by scholarly writers, such as Foucault who refers to the role of psychiatrists in terms of strategies of 'discipline and surveillance', [1015] and as noted above by Rose.[1016]

Greig also elucidates the way in which the role of psychiatry has changed in the discourses of psychiatry, law and politics. She notes the ways in which the criminal law has gradually extended its ambit beyond an interest in the factual elements of an offence, and how in the criminal arena there was an important shift which transformed the 'power to punish' into one requiring an expert technology.[1017] Greig argues that during the latter part of the nineteenth century, psychiatrists and psychologists became the holders of special knowledge about 'dangerous persons' and developed a number of explanatory models with quite diverse bases and a degree of slippage between madness and badness.[1018] In the arena of sexual misconduct 'bad' conduct is seen as requiring psychiatric treatment and a therapeutic approach to sexual misconduct is adopted by many tribunals. The cases also demonstrate how psychiatrists demonstrate the 'special knowledge' Greig refers to when they give expert evidence about the psychiatric state of a doctor and predict the risk to the public if a doctor remains in practice.

[1015] M Foucault, *Discipline and Punish* (Pantheon Books, 1975). These terms are used by Foucault in his book.

[1016] Rose, above n 162, 177–195.

[1017] Greig above n 116, 16.

[1018] Greig, above n 116, 16.

As well as giving expert evidence, psychiatrists play a number of other roles in the regulation of doctors found guilty of sexual misconduct.[1019] As noted above, in the present study, three psychiatrists were found guilty of sexual misconduct.[1020] Two were deregistered and one had conditions placed upon his registration.[1021]

Psychiatry is one of the few professions that engage in the task of risk prediction when it comes to individual behaviour. The tribunal decisions discussed above are replete with evidence about the 'risk of re-offending', and taken-for-granted assumptions about how psychiatric treatment will reduce the risk of future misconduct. However, as noted in Chapter 6, it is arguable that the effectiveness of treatment is undermined by both the doctor's reporting obligations, and the patient's consciousness of these obligations. The reporting obligations are invariably noted in the conditions upon a doctor's practice, as noted above, and for example, in, for example the Medical Council of New South Wales Health Handbook for doctors.[1022]

These reporting obligations clearly demonstrate the way in which the role of the treating doctor may become more administrative than therapeutic, and the logic of prediction comes to replace the logic of diagnosis.[1023] Although tribunals impose conditions with the intention of treatment, it is arguable that the effectiveness of treatment may be undermined by the reporting role, in spite of the attempt by the Medical Council of New South Wales to distinguish between a treating psychiatrist and a Board-appointed psychiatrist, who reports on the doctor's progress, and the treating psychiatrist who focusses purely on testament.[1024] Little is known about the impact of dual treatment/reporting obligations both on the doctor and the patient.

[1019] Ibid, and as discussed in Chapter 6.

[1020] *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012); *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011); *Medical Board of Australia & Veness* (Occupational Discipline) [2012] ACAT 36 (8 June 2012).

[1021] *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011); Dr Yasin had conditions placed upon his registration.

[1022] <http://www.mcnsw.org.au/page/316/resources/publications/> 14.

[1023] Rose, above n 162, 185.

[1024] <http://www.mcnsw.org.au/page/316/resources/publications/>. See the Health Program Handbook for further discussion on the role of the treating doctor.

7.6 Discussion

As noted above, in spite of the significant body of literature and caselaw on sexual misconduct, there appears to be little reported research on the effectiveness of various protective orders in protecting the public from doctors found guilty of sexual misconduct. The cases indicate that it is only when conditions upon a doctor's registration are breached that any insight can be gained as to their effectiveness or otherwise. There is little or no reported research on how the doctors themselves experience these kinds of protective orders or indeed on how their patients experience them, or on the experience of doctors involved in the treatment and supervision of doctors with conditions on their practice. A private program in the US, which supervised doctors with conditions on their registration,[1025] attracted negative publicity because of the 'off the books' nature of its work and its lack of accountability.[1026] In Canada, a 1991 Task Force reported that where doctors are involved in the sexual violation or abuse of patients, the rehabilitation programs are still insufficiently developed or refined to ensure complete rehabilitation or to predict recidivism.[1027] In the United States other writers note that recidivism is a frequent problem, and rehabilitation is still merely experimental.[1028] In spite of the trend towards evidence-based medicine, there is little sign yet of evidence-based regulation in this difficult arena.[1029]

The cases discussed in this chapter demonstrate that sexual misconduct by doctors clearly poses difficult issues for regulators. When sexual misconduct is exposed, other personal, social and psychiatric problems of the doctor may also be revealed. Some of the problems may relate to the misconduct and some may not. Some doctors are more

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[1025] The Illinois Professionals Health Program, according to its website, the Illinois Professionals Health Program (IPHP) is a statewide program of Advocate Medical Group providing support and earned advocacy for healthcare professionals throughout Illinois. <http://www.advocatehealth.com/illinoisprofessionalshealthprogram> 'The mission of the Illinois Professionals Health Program is to support and guide Illinois healthcare professionals to wellness and healing, thereby promoting safe professional practice and enriching the lives of healers and their patients'.

[1026] *Chicago Breaking News* 27 December 2010 <http://articles.chicagobreakingnews.com/2010-12-27/news/28520860_1_sexual-misconduct-medical-prosecutor-venkatesan-deenadayalu>.

[1027] Walzer and Miltimore, 'Mandated supervision', above n 160, 585.

[1028] Ibid citing A Pope, 'Unanswered Questions about Rehabilitating Therapist-Patient Sex Offenders' (1991) 18 *American Psychologist* A.5.

[1029] Although Manning, above n 127, reports that in New Zealand tribunals appear to be taking a more lenient approach than they did in the past.

'treatable' than others. It is therefore unsurprising that regulators attempt to simultaneously both discipline and treat sexual misconduct. The culture of the therapeutic state and the medicalisation of misconduct appears to be alive and well in sexual misconduct cases, particularly in New South Wales. When doctors are found guilty of sexual misconduct, the pendulum between discipline and treatment in New South Wales tends to swing towards treatment, with a relatively non-judgmental approach being taken, with occasional exceptions, where a tribunal will focus on the moral culpability of a doctor.[1030]

7.7 Conclusion

The continuing risk a doctor found guilty of sexual misconduct might pose to the public is the common theme that anchors the discourse between psychiatry and law in these cases. In this discourse moral issues of good or bad conduct are in some cases re-defined in terms of psychiatric health or illness, and expert medical evidence becomes the basis for a decision. The cases indicate that conditions upon a doctor's practice are the most common mechanism for regulating sexual misconduct in Australia, and these conditions often involve psychiatric treatment, particularly in New South Wales. The conditions on a doctor's registration contain 'deviant' doctors within the profession and promote the psychiatric model of misconduct and self-regulation of the profession. The literature reveals that there is a dearth of research on how conditions, such as chaperone conditions, actually 'work' in practice, although the Ombudsman's report is a promising initiative in this area.

[1030] In *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010) the following exchange took place [47]:

> Q. And what about the selfish side of the relationship, what do you think about that, the selfish side of the personal and sexual relationship? What have you got to say about that?
>
> A. Well, there's truth in that, I wanted to see her. I don't say I was totally altruistic in wanting to help her. I loved her, I wanted to be with her. I wanted to see her so, of course, there was a selfish side to it.

CHAPTER 8 – CONCLUSION

8.1 Introduction

The aim of this thesis was to explore whether the protection of the public has been undermined by protective orders that focus on the rehabilitation of problem doctors. In order to achieve this aim, this research has explored the rationale and use of protective orders in disciplinary tribunals, guided by the framework elucidated in Chapter 1. The thesis concludes that the pendulum has swung too far towards the rehabilitation of problem doctors. Whilst it is acknowledged that many doctors may benefit from rehabilitation and do not breach conditions placed upon their registration, nevertheless the cases discussed in Chapters 6 and 7 indicate that attempts at rehabilitation can place the public at risk. The thesis thus also concludes that the rehabilitative approach in protective orders needs to be calibrated. Although only the worst cases end up in disciplinary tribunals, this thesis demonstrates that members of the public have been placed at risk by a small number of doctors who in many cases were already known to regulators, and failed to comply with conditions on their registration. The cases also demonstrate that the reliance on the imposition of conditions to protect the public is misplaced. This thesis has found that tribunals operate in a research vacuum when it comes to empirically based evidence on the effectiveness of protective orders.

The analysis of tribunal decisions from 2010 to 2013 has generated a nuanced and empirically based understanding of how tribunals carry out their mandate of public protection. The decisions paint a compelling portrait of the varying struggles doctors have in their professional lives when they are sexually attracted to patients, or suffer from mental health and/or addiction problems. The tribunal decisions also portray the struggles tribunal decision-makers have in balancing public protection and the rehabilitation needs of doctors. In this concluding chapter, after a brief overview, the key findings in the thesis are reviewed and some ways forward are proposed.

8.2 Overview

In Chapter 1 the aim of the thesis was explained and it was argued that the recognition in the 1970s of the need to rehabilitate impaired doctors provided the perfect climate for the 'medicalisation' of problem doctors and for the culture of 'the therapeutic state' to

be infused into current regulatory discourse and practice. A framework, which identified a medical model of misconduct, was elucidated to both guide and enrich the interpretation of tribunal decisions.

In Chapter 2 this framework was used to explore how the medical model of misconduct has transformed the concept of the protection of the public to include the protection and rehabilitation of problem doctors. Chapter 2 demonstrated how the National Law institutionalises and legitimates a medical approach to problem doctors both explicitly through the health pathways and more implicitly through discretionary processes, which determine these pathways following a complaint or notification. Some of the inherent contradictions in the National Law, which may undermine the protection of the public, including the mandatory reporting provisions, were identified.

In Chapter 3, the key assumptions underpinning this research were outlined. The use of Morrow's framework to guide the use of a mixed methodology was explained and the construction of the database was described. Some of the inherent limitations both in the database and in the research methodology were identified. The choice of two particular groups of problem doctors for close analysis, impaired doctors and those found guilty of sexual misconduct, were identified in order to explore whether a medical approach to problem doctors extended to both impaired and non-impaired doctors.

In Chapter 4 the main findings were reviewed. The most common protective orders were the imposition of conditions upon a doctor's registration, many of them health conditions that demonstrated a rehabilitative approach to misconduct. An unexpected finding was the number of older doctors appearing in disciplinary proceedings. The findings also indicated that the most common form of misconduct was sexual misconduct, closely followed by inappropriate medical care, and that there were significantly more impaired doctors in New South Wales, even taking into account the higher number of doctors in that state. Given the reliance upon the imposition of conditions upon a doctor's registration as the most common protective order, the chapter concluded that much more evidence is needed to support decision-making in this crucial area of public protection.

In Chapter 5 the definition of impairment under the National Law was discussed in order to provide the context for the analysis of tribunal decisions in Chapter 6. It was argued that the medical model of misconduct is in fact a psychiatric model and that

psychiatrists play a key surveillance role in the regulation of problem doctors, which may undermine their treating role. The chapter argued that a focus on the conduct of the doctor rather than impairment might lead to sanctions that are more protective of the public.

In Chapter 6 the findings on impairment were reviewed and the psychiatric model of misconduct was clearly illustrated in the decisions involving impaired doctors. The tensions between the protection of the public and the protection of the profession were played out in protective orders that largely focussed on the rehabilitation of impaired doctors. The importance of monitoring compliance with protective orders to ensure protection of the public was discussed.

Chapter 7 explored whether the psychiatric model of misconduct extended to doctors who were not impaired by reviewing the sexual misconduct cases and the protective orders made in these cases. The findings indicated that a rehabilitative approach is taken with doctors found guilty of sexual misconduct, betraying the rhetoric espoused in principles about sexual misconduct. It was argued that the imposition of health and chaperone conditions upon a doctor's registration ensured that these 'deviant' doctors were controlled within the profession rather than being expelled, at the risk of compromising the protection of the public.

This chapter now examines the key findings and draws out the implications of these findings.

8.3 Tensions between the rehabilitation of doctors and protection of the public – key findings

The analysis of tribunal decisions has challenged some important assumptions. The expectation that, for example, protective orders focussed on rehabilitation will protect the public has been challenged by the findings that conditions upon a doctor's practice can be quite inadequate in this respect. The rhetoric of public protection is betrayed by the reality of doctors breaching their conditions, or repeating their misconduct in a few notable cases, as demonstrated in Chapters 6 and 7. Through an examination in these chapters of both the cases involving impairment and those involving sexual misconduct, the thesis has also clearly demonstrated that a therapeutic approach is taken to problem

doctors in disciplinary tribunals, irrespective of whether or not they are impaired. The most commonly used sanction for doctors who appear in disciplinary proceedings is the imposition of conditions upon their registration. A total of 56 doctors out of 128 in this study had conditions imposed, whilst 30 were deregistered[1031] and 24 were suspended.[1032] Other protective orders included reprimands and fines.

This study has also shown that the conditions imposed were frequently aimed at the rehabilitation of doctors. Of the two groups chosen for detailed examination, 10 out of the 18 impaired doctors had health conditions involving psychiatric treatment imposed, and of the 20 doctors found guilty of sexual misconduct who had conditions imposed, 12 of these involved health conditions, all of which involved psychiatric treatment. These cases also demonstrated the key surveillance role played by psychiatrists in the regulation of problem doctors.

It is important to stress that the results of this thesis do not demonstrate that the rehabilitation of problem doctors always undermines the protection of the public. As only two groups of cases were analysed in detail, the numbers are small, making generalisation difficult. However the histories revealed in these cases clearly show that health and other conditions for some doctors are ineffective as a means of public protection. In a small number of cases some doctors repeated their misconduct and/or repeatedly breached conditions upon their registration. The almost evangelical zeal with which rehabilitation was attempted in these cases prior to their tribunal hearings, as demonstrated by their regulatory histories, is difficult to comprehend. However, as Morrow notes, in spite of the problems with impairment programs, undue sympathy for problem doctors may be a small price to pay for their successful rehabilitation and reintegration, compared to professional excommunication on economic, social and humanitarian grounds.[1033] The price is obviously a high one, however, when attempts at rehabilitation fail, as the cases in this thesis demonstrate, and the public is put at risk. Elkin notes that care must be taken to ensure that the assessment of the risk posed by a doctor is not unduly influenced by a desire to rehabilitate at all costs, or by the

[1031] Doctors were usually deregistered for repeated misconduct, or when the conduct was ascribed to misconduct rather than impairment, as elucidated in Chapter 6.

[1032] Reprimands and fines were not discussed in detail in this thesis.

[1033] Morrow, 'Doctors Helping Doctors', above n 87, 33.

temptation to use disciplinary decision-making to address broader issues of workforce supply, as noted in Chapter 1. [1034] This thesis has confirmed that Elkin's note of caution is well-founded, and that the rehabilitative focus in tribunal decision-making extends not only to impaired doctors but also to doctors found guilty of sexual misconduct.

The small number of doctors who do put the public at risk should not be a justification for the continued use of a rehabilitative approach to misconduct without some attempt to address the reasons for its failure in some cases, and to calibrate the approach. The Tribunal decisions showed that tribunals only make findings about the moral culpability of a doctor and impose stringent protective orders when the misconduct of impaired doctors, in particular, is extreme or repeated.

8.4 Protective orders – a research vacuum

As noted in earlier chapters, disciplinary processes can in some cases exacerbate an impairment, and the Tribunal decisions reflect 'tensions, contradictions and hesitations'[1035] in their attempts to manage the future risk to the public posed by problem doctors. The imposition of conditions upon a doctor's registration appeared to provide reassurance to tribunals that the risk of re-offending was minimised. However, whilst the most common form of protective orders in tribunals was the imposition of conditions, there is a conspicuous lack of research in this area, as noted in Chapter 1. Paterson points out that regulators in the health arena face all sorts of subtle pressures to take a lenient approach, particularly when the community is short of health practitioners.[1036] Placing conditions on a doctor's registration allows tribunals to take a more lenient approach and to tread a fine line between discipline and treatment. In effect, they have a 'bet each way', but no way of knowing how effective the conditions they impose will be. In imposing conditions on a doctor's registration, tribunals effectively transfer their own regulatory function to those involved in administering the conditions, namely supervising doctors, treating psychiatrists, doctors monitoring other

[1034] Elkin, *Protecting the Public,* above n 9, 278.

[1035] Denzin and Lincoln, above n 119, 1–17. The term is used by Denzin and Lincoln to describe qualitative research but apposite here.

[1036] Ron Paterson, *The Good Doctor* (Auckland University Press, 2012) 79. The slogan 'Learning not lynching, Resolution not retribution' was adopted by the former Health and Disability Commissioner in New Zealand.

doctors, and regulators involved in the reporting and other administrative processes involved in ensuring compliance with conditions. Problem doctors are 'contained' within the profession, although the voices of those doctors involved in these important regulatory functions are rarely heard in the public domain.

Not only is there a dearth of research on protective orders in general but specifically also a dearth in relation to particular kinds of orders such as the supervision of doctors by other doctors. Supervision of a surgeon may involve quite different supervisory processes to those involved in the the supervision of a general practitioner. Clearly there is an urgent need for research in this important area if tribunal decision-makers are to carry out their mandate of public protection more effectively. It is not apparent from the cases analysed in this study how long it is after a doctor has breached conditions on their registration before the matter comes to the attention of a regulator, and how long this breach takes before it becomes a formal complaint before a tribunal. Although a breach of conditions may warrant or result in immediate suspension from practice, the nine breaches of conditions cases identified in Chapter 4 indicate that this does not always occur.[1037] Some supervisors may be more diligent than others in bringing breaches of conditions to the attention of regulators. More information is needed regarding these important aspects of public protection.

8.5 Protection of the public – changing hindsight into foresight

8.5.1 The National Law

In Chapters 1 and 2 of this thesis, the lack of definition of the phrase 'the protection of the public' was noted and it was argued that some of the inherent contradictions in the National Law between this concept and an implicit rehabilitative approach undermined the protection of the public. One way of addressing this issue could be to argue for changes to the National Law to incorporate a definition of what is meant by 'the protection of the public', such as the one enunciated in Chapter 2 in the decision of *Do,* which focusses on deterrence rather than rehabilitation. The rehabilitative focus of the law could be made explicit, as are supply considerations, but not as part of the definition

[1037] There were other cases that indicated breaches of conditions but the breaches were not pleaded as the primary complaint.

of the protection of the public. Changes to the National Law could also incorporate guidelines as to how the purpose of protective orders should be construed.

It could also be argued that the critical compliance condition under the National Law in New South Wales (s149A) could be adopted in all states so that doctors who breach particular conditions on their registration, such as testing for drugs, are immediately suspended from practice, unless they, notify as soon as possible, a relevant authority of their breach, and can provide an appropriate explanation for the breach.

8.5.2 Ensuring appropriate and timely monitoring of conditions on a doctor's registration

The importance of the recommendations by the Ombudsman in Queensland discussed in Chapter 6 cannot be overstated. As noted in that Chapter, his review was based upon only one case but the cases discussed in this thesis, particularly Chapter 6, but also Chapter 7, which document breaches of conditions, provide ample support for his recommendations. As noted in Chapter 1, it is not clear whether the recent report by the Ombudsman in Queensland in relation to a doctor's repeated breaches of conditions represents the tip of an iceberg or is an isolated case. The tribunal decisions considered in this thesis suggest that the case considered by the Ombudsman is not an isolated case. The Report of the Ombudsman could be used to generate further consideration of the monitoring of health conditions upon a doctor's registration and the particular problems involved. In particular, Recommendation 5 that self-reported data should be independently checked is very relevant. As was demonstrated in Chapter 6, in a number of the impairment cases it became clear that problem doctors lied to their psychiatrists, for example. It is very difficult for psychiatrists to independently verify what they are told but the explicit recognition of this problem is an important start in addressing it. Also, as noted in Chapter 6, Recommendation 6 which proposes that AHPRA should review its processes for counting and categorising breaches of conditions would also provide a 'red flag' for regulators as to when a doctor's conduct may be compromising the protection of the public.

Existing data collection systems should be calibrated to include the building of an evidence base which specifically indicates which conditions are most effective, which are most frequently breached, and why.

8.5.3 Expanding the range of tools available to predict future risk to the public

As noted in Chapter 1 this thesis did not focus on risk management and theory, but recent research referred to briefly in Chapter 1 is directly relevant to the protection of the public by disciplinary tribunals. The study based on the earlier ANZ study of complaints against doctors reported on a further analysis of complaints to create a simple predictive algorithm for the prediction of risk of more complaints against doctors.[1038] The PRONE (Predicted Risk Of New Event) score is a 22-point scoring system that indicates a doctor's future complaint risk based on four variables: a doctor's specialty, their gender, the number of previous complaints, and the time since the last complaint. According to the authors, the PRONE score performed well in predicting subsequent complaints, exhibiting strong validity and reliability and reasonable 'goodness of fit'.[1039]

> The PRONE score appears to be a valid method for assessing individual doctors' risks of attracting recurrent complaints. Regulators could harness such information to target quality improvement interventions, and prevent substandard care and patient dissatisfaction. The approach we describe should be replicable in other agencies that handle large numbers of patient complaints or malpractice claims.[1040]

Although tribunals currently take into account a doctor's past conduct, the use of a more structured and consistent approach using the PRONE score could better equip tribunals to manage the risk to the public a doctor may pose, and decrease the reliance upon only psychiatric evidence to predict risk. There is no reason why the use of such a risk assessment tool could not be further explored by policy and tribunal decision-makers in determining protective orders when doctors are found guilty of misconduct.

As noted in Chapters 1 and 7, Warfe also proposes a clinical approach to improving the accuracy and consistency of risk assessment by using a given set of risk factors and predictors, derived from both the literature and decided cases against which a clinical

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[1038] Spittal, Bismark and Studdert, above n 167.

[1039] Ibid.

[1040] Ibid.

assessment can be made.[1041] Warfe's clinical approach would also provide a useful tool for tribunals as it draws on existing knowledge and research and would reduce the ad hoc nature of decision-making in this complex area. Like the PRONE score above it would also reduce the sometimes total dependence on psychiatrists to predict risk, which, as noted some of the tribunal decisions, can be problematic.

8.5.4 Educational programs

Clearly, if tribunal decision-makers are to make effective use of the risk assessment tools mentioned above, there would need to be educational programs for decision makers specifically focussed on the protection of the public and risk assessment. Such programs would arguably lead to more consistency in decision-making, and a more proactive approach to risk assessment. Such programs could also focus on issues which arise in relation to older doctors, as discussed in Chapter 4. Mendelson found in her study of inappropriate prescribing, that it was sometimes difficult to discern a pattern of clear correlation between the practitioner's conduct and the severity of sanction.[1042] Mendelson also noted that the determinations of each tribunal reflected the way it construed the purpose of disciplinary sanctions.[1043] In this thesis it was clear that many tribunals construed the purpose as rehabilitative, rather than deterrent, so that softer sanctions were imposed. These are issues that could be usefully explored in educational programs for decision-makers and policy makers.

As Grieg has pointed out, the notion of risk is more acceptable than that of 'dangerousness'.[1044] In this thesis it is the management of risk that has underpinned the legal-psychiatric dialogue in the Tribunal decisions, even though 'each discipline approaches its task quite differently, and the law appears to have an unrealistic expectation of what psychiatry can offer.'[1045] Careful use of tools, such as PRONE mentioned by Spittal et al and by Warfe, will arguably foster existing collaboration

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[1041] Ibid 79.

[1042] Mendelson, 'Disciplinary proceedings against doctors', above n 135, 260.

[1043] Ibid.

[1044] Greig, above n 116, 18. In her study of a famous prisoner, Gary David, she notes that the discourse in the Victorian Parliament at the time centred on whether he posed a danger to society, not the degree of risk that he posed.

[1045] Ibid.

between psychiatry and the law and lead to more informed decision-making based upon these tools.

8.6 The rehabilitative focus – can it be calibrated?

The rehabilitative focus of the law, as discussed in Chapter 2, is a proactive approach to risk management. As pointed out above, it was Elkin's view that the focus on rehabilitation may have gone too far.[1046] The cases squarely raise the issue of whether the National Law can or should be a therapeutic agent, and whether impaired doctors should be dealt with by independent bodies, such as the Victorian Doctors Health Program ('VDHP') mentioned in Chapter 6. Given the tensions created by the management of impaired doctors under the National Law, it is arguable that this tension can be addressed by shifting the health programs under the law to external programs, such as the VDHP, as discussed in Chapter 6. The National Law would become relevant only when an impaired doctors' conduct clearly placed the public at risk and warranted disciplinary proceedings. The focus would then be on the conduct rather than the impairment of the doctor, and the conduct would determine the protective orders.

The issue of how doctors should be rehabilitated has been an issue of concern to the Medical Board of Australia. In March 2013, the Board commissioned a report to advise on possible governance arrangements for external doctors health programs, including services to be provided, funding models and contractual arrangements.[1047] It emphasised the need for clear delineation between the regulatory role of the Board in managing impaired medical professionals and the role of external doctors' health programs in supporting medical professionals and promoting their health. In preparing the report, DLA Piper undertook a broad consultation and review process of external doctors health programs in Australia. As reported in Chapter 6, the report noted the good clinical outcomes reported by the VDHP as well as the clear support in comparable

[1046] Elkin, *Protecting the Public,* above n 9, 282. Elkin also noted that sensitivity to doctor shortages in Australia and New Zealand also appeared to be apparent in disciplinary decision-making. She stated that not only did the balancing of supply considerations against public protection go beyond the legislative mandate of the Tribunals (as it was at the relevant times), but it may also have provided an apparent justification for inappropriate weight to be given to the interests of the doctor concerned, potentially at the expense of public protection.

[1047] DLA Piper Australia, above n 692. The Board confirmed that the program would be funded from within existing Board resources and complement the regulatory focus of the Board and AHPRA in their management of doctors with impairment that may place the public at risk.

international settings for case management approaches for medical professionals with drug, alcohol or mental health problems.[1048] Under the program at the VDHP a doctor can enter into a case management agreement to comply with a comprehensive range of therapeutic measures.[1049] These may include primary monitoring by a VDHP clinician, attendance at a support group for doctors with a substance abuse condition, workplace monitoring, and chemical monitoring. The aim of the agreement is to restore a doctor to optimal health.[1050] As noted earlier in this thesis it is arguable that the independence of the VDHP from regulatory authority and its confidential nature may produce better outcomes for doctors and the public than for those being treated under the shadow of the law.

Support for this approach can also be found in the literature on regulation. Although not writing specifically about health practitioner regulation, Sparrow argues convincingly for the involvement of non-governmental entities in the regulatory process, referring to such involvement as tri-partism.[1051] He notes that various methods of involving third parties bring additional resources to bear on regulatory problems and that external parties can observe regulatory decision-making processes, monitor regulatory treatment and disposition of complaints, and force the hand of regulators.[1052]

More concretely, there are a number of more immediate changes which might calibrate a rehabilitative approach to make it more effective in protecting the public.

Firstly, consideration should be given to whether doctors should be allowed to nominate their own supervisors and practice monitors, as this may undermine the independence of the regulatory process.

Secondly, clear policies should be developed in all States and Territories as recommended by the Ombudsman in relation to ensuring compliance with conditions on a doctor's practice and monitoring breaches of conditions.

[1048] Ibid.

[1049] <http://www.vdhp.org.au/website/services.html>.

[1050] Ibid.

[1051] Sparrow, above n 292.

[1052] Ibid.

Thirdly, guidelines for tribunals for managing particular forms of impairment such as addiction, should be developed. These guidelines could draw on the significant body of existing knowledge in this area, so that if conditions are imposed, they are capable of being monitored effectively.

8.7 Conclusion

The Tribunal decisions in this study reveal the struggles of decision-makers to manage the almost impossible contradiction between a doctor's need for rehabilitation and society's need for protection. It is unsurprising therefore that the imposition of conditions upon a doctor's practice are the most attractive sanction to decision-makers because conditions can be both disciplinary and therapeutic. The decisions demonstrate that some doctors lack the 'ethical compass to navigate the all too human frailties of workplace attraction, sexual appetites and abuse of privilege'.[1053] The cases involving impaired doctors, as well as revealing the loneliness and pathos of mental illness and addiction, reveal that impaired doctors can simultaneously be both victims and malefactors. The sexual misconduct cases also demonstrate that doctors can be both malefactors and victims when they are blackmailed by patients. These cases tell powerful stories about the sometimes fatal attraction between doctors and patients that can end a doctor's career.

The analysis of decisions in Chapters 6 and 7 reveals that the medical model of misconduct referred to in the introduction to this thesis (more accurately described as a psychiatric model) has been transformative in extending the concept of the protection of the public to the protection and rehabilitation of both impaired and non-impaired doctors. Disciplinary tribunals in a number of cases acted as 'medical diagnosticians and healers.'[1054] Through the mechanisms of therapeutic jurisprudence, psychiatrists were often co-opted to assist in the process of identifying and containing doctors who may place the public at risk. This thesis has identified and made explicit the peripatetic and powerful role played by psychiatrists in the regulation of doctors, and the tension between their therapeutic and surveillance roles. The National Law itself illustrates

[1053] Srivastava, above n 583.

[1054] Morrow, 'Sick Doctors', above n 17, 104

these tensions in its exemptions from mandatory reporting for treating doctors in both Western Australia and now Queensland, where clearly different views are held about this important issue.

This thesis has demonstrated some of the complex processes involved in the regulation of problem doctors, particularly impaired doctors, and identified how doctors may become a risk both to themselves and their patients when rehabilitation fails. It has also raised questions about the adequacy of the diversionary health programs under the National Law. The impairment cases indicate that a non-judgmental position on the part of tribunal decision-makers may understate doctors' own responsibility for maintaining their own health and well-being. Although conditions on a doctor's practice were the most frequent protective order made by the disciplinary tribunals in this study, the literature reveals that there is a dearth of research on how these conditions actually 'work' in practice. More research in this pivotal area of public protection would provide important information for all stakeholders involved in the regulation of doctors. This thesis identifies the research deficit and begins to address it, as well as providing a rich data base as a springboard for further research.

Appendix A: Master case list

* Any cases below marked with an asterisk are those in which this researcher sat as a member of the Tribunal.

** How the cases were accessed is described in Chapter 3.

NEW SOUTH WALES*

1. *Health Care Complaints Commission v Allen* [2010] NSWMT 8 (2 July 2010)
2. In *Re Dr Yolande Lucire* and the Medical Practice Act (NSW Medical Tribunal, Deputy Chairperson Puckeridge J, 24 August 2010) For protective orders see: *Health Care Complaints Commission v Dr Yolande Lucire* (NSW Medical Tribunal, Deputy Chairperson Puckeridge J, 27 August 2010)
3. *Health Care Complaints Commission v Howe* [2010] NSWMT 12 (30 September 2010)
4. *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11 (7 October 2010)
5. *Health Care Complaints Commission v Dr Ray Woods* (NSW Medical Tribunal, Deputy Chairperson Balla J, 15 October 2010)
6. *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010)
7. *Health Care Complaints Commission v Dr Satya Pal Bhatia* (NSW Medical Tribunal, Deputy Chairperson Johnstone J, 2 November 2010)
8. *Health Care Complaints Commission v Robert Sims* [2010] NSWMT 17 (30 November 2010)*
9. *Health Care Complaints Commission v Dr Bao-Quy Nguyen-Phuoc* [2010] (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2010)

10. *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010)
11. *Health Care Complaints Commission v Dr Ly* [2010] NSWMT 20 (15 December 2010)
12. *Health Care Complaints Commission v Dr Timothy Tristan Tang-Tat Wong* [2010] NSWMT 21 (17 December 2010)
13. *Health Care Complaints Commission v Dr Basavaraj Vastrad* [2011] NSWMT 1 (15 February 2011)
14. *Health Care Complaints Commission v Dr Elizabeth Millard* (NSW Medical Tribunal, Deputy Chairperson Balla J, 24 February 2011)
15. *Health Care Complaints Commission v Dr Joseph Nicholas* [2011] NSWMT 2 (30 March 2011)
16. *Health Care Complaints Commission v Gorondy-Novak* [2011] NSWMT 3 (15 April 2011)
17. *Health Care Complaints Commission v Dr Stamatios Ktenas* (NSW Medical Tribunal, Deputy Chairperson Balla J, 21 April 2011)
18. *Health Care Complaints Commission v Dr McKenzie* [2011] NSWMT 6 (27 July 2011)
19. *Health Care Complaints Commission v Dr Denise Perroux* [2011] NSWDC 99 (16 August 11)

    For protective orders see: *Health Care Complaints Commission v Dr Perroux* (No. 2) [2011] NSWMT 15 (9 December 2011)
20. *Health Care Complaints Commission v Gorman* [2011] NSWMT 7 (17 August 2011)
21. *Health Care Complaints Commission v Halder* [2011] NSWMT 8 (26 August 2011)

22. *Health Care Complaints Commission v Dr Mazzaferro* [2011] NSWMT 9 (31 August 2011)*
23. *Health Care Complaints Commission v Dr Peng Seng Chan* (NSW Medical Tribunal, Deputy Chairperson Balla J, 9 September 2011)
24. *Health Care Complaints Commission v Dr John Edwards* [2011] NSWMT 10 (14 September 2011)
25. *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011)*
26. *Health Care Complaints Commission v Dr Il-Song Lee* [2011] NSWMT 12 (6 October 2011)
27. *Health Care Complaints Commission v Dr Hameiri* [2011] NSWMT 13 (11 November 2011)
28. *Health Care Complaints Commission v Dr Michael William Zacharia* (NSW Medical Tribunal, Deputy Chairperson Sidis J, 20 December 2011)
29. *Health Care Complaints Commission v Hasil* [2012] NSWMT 1 (15 February 2012) For protective orders see: *Health Care Complaints Commission v Hasil* (No 2) [2012] NSWMT 21 (7 November 2012)
30. *Health Care Complaints Commission v Tsouroutis* [2012] NSWMT 2 (12 March 2012)*
31. *Health Care Complaints Commission v Dr Nemeth* [2012] NSWMT 4 (5 April 2012)
32. *Health Care Complaints Commission v Dr Tat Kong Joseph Tiong* [2012] NSWMT 6 (5 April 2012)
33. *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012)

34. *Health Care Complaints Commission v Dr Roland Von Marburg* [2012] NSWMT 5 (8 May 2012)
35. *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012)
36. *Health Care Complaints Commission v Dr Anne Amigo* [2012] NSWMT 13 (22 June 2012)
37. *Health Care Complaints Commission v Dr Carolyn Cooke* [2012] NSWMT 12 (28 June 2012)
38. *Health Care Complaints Commission v Dr A Esin Dalat Ozme* [2012] NSWMT 15 (28 June 2012)
39. *Health Care Complaints Commission v Dr Leonard Philipiah* [2012] NSWMT 14 (28 June 2012)
40. *Health Care Complaints Commission v Dr Anthony Bosnich* (NSW Medical Tribunal, Deputy Chairperson, Elkaim J, 3 July 2012)*
41. *Health Care Complaints Commission v Dr Small* [2012] NSWMT 18 (19 July 2012)
42. *Health Care Complaints Commission v Dr Jones* [2012] NSWMT 19 (1 August 2012)
43. *Health Care Complaints Commission v Dr Anthony Underwood* (NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012)
44. *Health Care Complaints Commission v Dr Thomas Fiay* (NSW Medical Tribunal, Deputy Chairperson Balla J, 31 August 2012)
45. *Health Care Complaints Commission v Dr Robert Darlow Smith* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 September 2012)
46. In *Re Dr James Woolcock* and the Medical Practice Act (NSW Medical Tribunal, Deputy Chairperson Colefax J, 17 September 2012)

47. *Health Care Complaints Commission v Dr Renato Di Mascio* (NSW Medical Tribunal, Deputy Chairperson Balla J, 18 October 2012)
48. *Health Care Complaints Commission v Dr Andrew Snell* (NSW Medical Tribunal, Deputy Chairperson Balla J, 30 November 2012) For protective orders see: *Health Care Complaints Commission v Dr Andrew Snell* (NSW Medical Tribunal, Deputy Chairperson Balla J, 25 January 2013)
49. *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012)
50. *Health Care Complaints Commission v Dr Ristevski* [2012] NSWMT 23 (14 December 2012)
51. *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013)[1055]
52. *Health Care Complaints Commission v Dr Leslie* [2013] NSWMT 1 (22 February 2013)
53. *Health Care Complaints Commission v Dr Sudath* [2013] NSWMT 2 (22 February 2013)
54. *Health Care Complaints Commission v Dr Guy Herron* (NSW Medical Tribunal, Deputy Chairperson Balla J, 1 March 2013)
55. *Health Care Complaints Commission v Dr Maendel* [2013] NSWMT 3 (8 March 2013 For protective orders see: *Health Care Complaints Commission v Dr Maendel* (No 2) [2013] NSWMT 10 (22 May 2013)
56. In *Re Dr Peter Chang and the Medical Practice Act* (NSW Medical Tribunal, Deputy Chairperson Colefax J, 11 March 2013) (GP Anaesthetist)

[1055] See also *Health Care Complaints Commission v Dr Victor King* [2011] NSWMT 5 (5 May 2011).

57. *In the matter of Dr Robyn Lesley Pogmore* (NSW Medical Tribunal, Deputy Chairperson Mahony J, 15 March 2013). For protective orders see: *In the matter of Dr Robyn Lesley Pogmore* (NSW Medical Tribunal, Deputy Chairperson Mahony J, 6 June 2013)*
58. *Health Care Complaints Commission v Dr Riju Ramrakha* [2013] NSWMT 8 (12 April 2013)
59. *Health Care Complaints Commission v Dr David Moss* (NSW Medical Tribunal, Deputy Chairperson Walmsley J, 18 April 2013)
60. *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013)
61. *Health Care Complaints Commission v Dr Annette Dao Quynh Do* [2013] NSWMT 7 (29 April 2013)

    For protective orders see: *Health Care Complaints Commission v Dr Annette Dao Quynh Do* (No. 3) (,NSW Medical Tribunal, Deputy Chairperson Colefax J, 2 August 2013)
62. In the matter of Dr Ian Robert Hutchins (NSW Medical Tribunal, Deputy Chairperson Mahony J, 15 May 2013)
63. *Health Care Complaints Commission v Rolleston* [2013] NSWMT 12 (17 May 2013)
64. *Health Care Complaints Commission v Dr Saeid Saedlounia* [2013] NSWMT 13 (21 June 2013)*

VICTORIA

65. *Medical Practitioners Board of Victoria v Williams & Anor* (Occupational and Business Regulation) [2010] VCAT 1277 (5 August 2010)[1056]

[1056] Adjourned for protective orders. No judgment available.

66. Dr Lichter[1057]

67. *Medical Board of Australia v Bajpe* (Occupational and Business Regulation) [2010] VCAT 1439 (25 August 2010)

68. *Medical Practitioners Board of Victoria v Hafizullah* (Occupational and Business Regulation) (Correction) [2010] VCAT 2126 (9 September 2010)[1058]

69. *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010)

70. *Medical Board of Australia v Jabbar* (Occupational and Business Regulation) [2010] VCAT 1772 (5 November 2010)

71. *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010)

72. *Medical Practitioners Board v White* (Occupational and Business Regulation) [2011] VCAT 592 (7 April 2011)

73. *Medical Board of Australia v Skehan* (Occupational and Business Regulation) [2011] VCAT 2424 (15 April 2011)

    For protective orders see: *Medical Board of Australia v Skehan* (Occupational and Business Regulation List) (No 2) [2011] VCAT 1935 (12 October 2011)

74. *Medical Board of Australia v Hrstic* (Occupational and Business Regulation) [2011] VCAT 707 (20 April 2011)

75. *Medical Board of Australia v Petrovic* (Occupational and Business Regulation) [2011] VCAT 795 (6 May 2011)

[1057] Joint proceedings. See above *Medical Practitioners Board of Victoria v Williams & Anor* (Occupational and Business Regulation) [2010] VCAT 1277 (5 August 2010).

[1058] Adjourned for protective orders. No judgment available.

76. *Medical Board of Australia v Venkataraman* (Occupational and Business Regulation) [2011] VCAT 751 (12 May 2011)

77. *Medical Board of Australia v Piesse* (Occupational and Business Regulation) [2011] VCAT 859 (23 May 2011)

78. *Medical Board of Australia v Jansz* (Occupational and Business Regulation) [2011] VCAT 1026 (31 May 2011)

79. *Medical Board of Australia v Freeman* (Occupational and Business Regulation) [2011] VCAT 1166 (24 June 2011)

80. *Medical Board of Australia v Saykao* (Occupational and Business Regulation) [2011] VCAT 1338 (13 July 2011)

81. *Medical Board of Australia v Ballard* (Occupational and Business Regulation) [2011] VCAT 1386 (21 July 2011)

82. *Medical Board of Australia v Laska* (Occupational and Business Regulation) [2011] VCAT 1888 (28 July 2011)

83. *Medical Board of Australia v Erhard*t (Occupational and Business Regulation) [2011] VCAT 1702 (9 September 2011)

84. *Medical Board of Australia v Lai* (Occupational and Business Regulation) [2011] VCAT 1754 (14 September 2011)

85. *Medical Board of Australia v Kemp* (Occupational and Business Regulation) [2011] VCAT 2271 (30 November 2011)[1059]

86. *Medical Board of Australia v Mak* (Occupational and Business Regulation) [2012] VCAT 315 (5 January 2012)

[1059] Adjourned for protective orders. No judgment available.

87. *Medical Board of Australia v Steinberg* (Occupational and Business Regulation) [2012] VCAT 218 (13 February 2012)

88. *Dewan v Medical Board of Australia* (Occupational and Business Regulation) [2012] VCAT 1327 (31 August 2012)

    For orders see: *Dewan v Medical Board of Australia* (Occupational and Business Regulation) [2012] VCAT 1840 (10 December 2012)

89. *Medical Board of Victoria v Myers* (Occupational and Business Regulation) [2012] VCAT 1470 (27 September 2012)

90. *Medical Board of Australia v Scarff & Anor* (Occupational and Business Regulation) [2012] VCAT 1732 (2 November 2012)

91. *Medical Board of Australia v Christian* (Occupational and Business Regulation) [2012] VCAT 1647 (5 November 2012)

92. *Medical Board of Australia v Schulberg* (Occupational and Business Regulation) [2012] VCAT 1879 (7 December 2012). For protective orders see: *Medical Board of Australia v Schulberg* (Review and Regulation) [2013] VCAT 823 (24 May 2013)

93. *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012)

94. *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013)

95. *Medical Board of Australia v Naim* (Review and Regulation) [2013] VCAT 329 (21 March 2013)[1060]

[1060] Orders were made on 5 June 2013 but the orders were stayed on 12 June 2013: *Medical Board of Australia v Naim* (Review and Regulation) [2013] VCAT 1006. On 29 August 2013 Dr Naim's appeal against the orders was dismissed *Naim v Medical Board of Australia* [2013] VSCA 205 (29 August 2013).

QUEENSLAND

96. *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010)

97. *Medical Board of Australia v Nandam* [2011] QCAT 65 (25 February 2011)

98. *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011) For judgment on orders see: *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011)

99. *Medical Board of Australia v O'Sullivan* [2011] QCAT 135 (14 April 2011)

100. *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011)

101. *Medical Board of Australia v Lockie* [2012] QCAT 34 (20 January 2012)

102. *Medical Board of Australia v Karam* [2012] QCAT 198 (11 May 2012)

103. *Medical Board of Australia v Dolar* [2012] QCAT 271 (16 May 2012)

104. *Medical Board of Australia v Grant* [2012] QCAT 285 (2 July 2012)

105. *Medical Board of Australia v Dr FA* (No 2) [2012] QCAT 288 (6 July 2012); For judgment on orders see: *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012)

106. *Medical Board of Australia v Sykes* [2012] QCAT 293 (10 July 2012)

107. *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012)

108. *Medical Board of Australia v. Jones* [2012] QCAT 362 (25 July 2012)

109. *Medical Board of Australia v Van Opdenbosch* [2012] QCAT 703 (12 November 2012)

110. *Medical Board of Australia v Smith* [2013] QCAT 52 (4 February 2013)

111. *Medical Board of Australia v Evans* [2013] QCAT 217 (30 April 2013)

112. *Medical Board of Australia v Gallery* [2013] QCAT 334 (19 June 2013)

WESTERN AUSTRALIA

113. *Medical Board of Western Australia and Wolman* [2011] WASAT 69 (21 April 2011). For judgment on orders see: Medical Board of Western Australia and Wolman [2011] WASAT 69 (24 June 2011)

114. *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011)

115. *Medical Board of Australia and Kierath* [2011] WASAT 193 (9 December 2011)

116. *Medical Board of Australia and Wild* [2012] WASAT 37 (27 February 2012)

117. *Medical Board of Australia and McClure* [2012] WASAT 69 (13 April 2012) For judgment on orders see: *Medical Board of Australia and McClure* [2012] WASAT 69 (22 August 2012)

118. *Medical Board of Australia and Bernadt* [2012] WASAT 108 (25 May 2012)

119. *Medical Board of Australia and Woollard* [2012] WASAT 209 (19 December 2012)

120. *Medical Board of Australia and Costley* [2013] WASAT 2 (8 January 2013)

TASMANIAN CASES

121. *The Tasmanian Board of the Medical Board of Australia v Ian Martin* (Ref No. 4/2011) [2011] TASHPT 1 (11 July 2011)

122. *The Tasmanian Board of the Medical Board of Australia v Dr Ross Whittaker* (Ref No. 3/2011) [2011] TASHPT 3 (15 September 2011)

123. *The Tasmanian Board of the Medical Board of Australia v Dr Amol Daware* (Ref No. 6/2011) [2012] TASHPT 3 (25 June 2012)

124. *The Tasmanian Board of the Medical Board of Australia v Dr Paul McGinity* (Ref No. 1-7/2010 & 5/2011) [2012] TASHPT 4 (3 July 2012)

SOUTH AUSTRALIAN CASES

125. *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012)

126. *Medical Board of Australia v Ochnik* [2012] SAHPT 7 (11 December 2012)

AUSTRALIAN CAPITAL TERRITORY CASES

127. *Medical Board of Australia & Veness* (Occupational Discipline) [2012] ACAT 36 (8 June 2012)

128. *ACT Medical Board of the Medical Board of Australia & Newcombe* (Occupational Discipline) [2012] ACAT 43 (28 June 2012)

Appendix B: Master case table

Table B1: Master table of tribunal decisions

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
1	2/07/10	-	Allen	M	65	GP	Provide false statement	No	Mental illness: memory (recall) problems & anxiety	No (see [88]	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Reprimand
2	24/08/10; 27/08/10	-	Lucire	F	-	Psychiatrist	Inappropriate treatment and management; failure to document a proper and adequate management plan; failed to keep proper, adequate and legible records; failure to properly inform family, patient & GP	No	No	No discussion	Unsatisfactory Professional Conduct, s 36 *Medical Practice Act 1992*	Conditions on registration
3	30/09/10	1 Year 3 Months	Howe	M	67	Plastic and reconstructive surgeon	Sexual Misconduct; inappropriate prescribing	Yes	Yes	Yes - counselling, neuropsychometric assessment, chaperone (with female patients)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Severe reprimand; conditions on practice

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
4	7/10/10	2 Years 3 Months	Mukherjee	M	-	GP	Inappropriate prescribing; inadequate record-keeping; breach of conditions; Medicare fraud	Yes - Impaired Registrant's Programme 2008	Bipolar II disorder (depression and hypomania); substance abuse; gambling	Yes (see [117])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Deregistration 2 years
5	15/10/10	3 Years 6 Months	Woods	M	-	GP (Sole Practice); Specialist in hair transplants	Deficiencies in record keeping and prescriptions in relation to drugs; Using Endone for a period in excess of 7 days; Failing to make contemporaneous records of treatment	No	Narcissistic personality	No (see 12). However, does not p 13 and the imposition of conditions indicate a view that there is some?	Unsatisfactory Professional Conduct, s 36 Medical Practice Act 1992	Reprimand; conditions on practice
6	20/10/10	-	Chowdhury	M	-	GP	Breach of registration conditions re. performance assessments (prior history)	Yes [7, 30]	Depression; adjustment disorder	Y ([2], pages, 9 & 11)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Not on register; Reprimand; conditions on registration

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
7	2/11/10	1 Year	Bhatia	M	-	Plastic and reconstructive surgeon	Deficiencies in record keeping; clinical skills; care; knowledge and competence(for patients)	No	No	Nodiscussion	Unsatisfactory Professional Conduct, s 36 Medical Practice Act1992	Reprimand; conditions on registration
8	30/11/10	-	Sims	M	-	GP	Sexual Misconduct; inappropriate prescribing; failure to give written noticeto Department that his drug register lostor destroyed	No	No	Yes (see [105-107])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Not currently registered; maynot re-registration 9 months

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
9	7/12/10	4 Years 4 Months	Nguyen-Phuoc	M	-	GP	Inappropriate prescribing; self administration; failing to keep proper records; administering treatment withoutnecessary knowledge of background	No	No	No (See p 18)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Reprimand; conditions on registration
10	14/12/10	1 Year 9 Months	Holmes	M	55	GP	Sexual misconduct	No	Yes	No (see [51, 67])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992* (admission)	Suspended 12 months; conditions on registration

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
11	15/12/10	3 Years 2 Months	Ly	M	-	GP (sole practitioner)	Inappropriate prescribing	No	No	Yes (see protective conditions)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992* (admission)	Reprimand; conditions on registration
12	17/12/10	-	Wong	M	-	GP	Sexual Misconduct	No	No	Yes (see [61, 65])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Not currently on register; not tobe re-registered for 2 years; prohibited from providing acupuncture until 1.7.12
13	15/02/11	2 Years 11 Months	Vastrad	M	57	GP	Sexual misconduct	No	No	Yes -chaperone, CCP (see p 52, 53)	Unsatisfactory Professional Conduct, s36 Medical Practice Act1992	Reprimand; conditions on practice

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
14	24/02/11	1 Year 3 Months	Millard	F	64	GP	Sexual misconduct	No	Yes	No - see [57]	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992* (admission)	Reprimand; suspension for 6 months; conditions on practice
15	30/03/11	2 Years 3 Months	Nicholas	M	-	GP (sole practitioner)	Business relationship between doctorand patient - ethical issues; record keeping	No	No	No	Unsatisfactory Professional Conduct, s36 Medical Practice Act1992	Reprimand; conditions on practice
16	15/04/11	-	Gorondy-Novak	F	66	GP	Inappropriate Prescribing; RecordKeeping	No	No	No (see[211], [220-1])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Reprimand; conditions on registration

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
17	21/04/11	3 Years 4 Months	Ktenas	M	-	GP (sole practitioner attime of hearing; principal previous to that)	Inappropriate Prescribing; Record Keeping; issuance of false medical certificates; prescribing without authority	No	No	Yes (see p 15)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Reprimand; conditions on registration
18	27/07/11	1 Year 9 Months	McKenzie	M	-	GP	Issuing prescriptions for USA patients over the internet; breaching conditions on his registration; impairment; medicalrecords	Yes: s 3	Adjustment disorder; depression - Impaired registrants program from 1992 to 1997; impaired intellectual and cognitive functioning	Nodiscussion	Professional Misconduct, s 37 M*edical Practice Act1992*	Already suspended (since 2008); Deregistration 3 years

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
19	16/08/11; 09/12/11	10 months	Perroux	F	-	GP	Practising without insurance s 19 HCLAct	No	No	No (see [22]-[23] 9/12/11)	Unsatisfactory Professional Conduct, s139B *Health Practitioner Regulation National Law*	Not currently registered; Reprimand; conditions on re-registration
20	17/08/11	1 Year 2 Months	Gorman	M	78	GP	Incompetent Practice - Spinal Manipulation; inadequate assessmentand note taking; failure to obtain informed consent; inappropriate prescribing	No	No	Yes (see[411], [414] [415], [420], [422])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992* (admission to USP only)	Deregistration minimum 3 years; prohibited from performing spinal manipulations(s 123 *National Law)*
21	26/08/11	-	Halder	M	48	Obstetrician & Gynaecologist	Breach of undertaking; failure to advisepatient properly; Failure to keep properrecords	No	No	No (see [56])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992* (admission)	Caution

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
22	31/08/11	3 Years 1 Month	Mazzaferro	M	-	GP	Inappropriate Prescribing; RecordKeeping	No	No	No (see[64]); butsupervisor and [63]	Unsatisfactory Professional Conduct, s36 Medical Practice Act1992	Conditions on registration and practice
23	9/09/11	1 Year 10 Months	Chan	M	-	GP	Practising without insurance s 19(1) *Health Care Liability Act 2001* ; madefalse statements to the NSW MedicalBoard	No	Yes - no specific psychiatric explanationfor Dr Chan's actions	Yes (not convinced he will not reoffend, see p. 5)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Suspended 3 months; condition on registration
24	14/09/11	-	Edwards	M	-	GP	Inappropriate Prescribing; RecordKeeping	No	No	Nodiscussion	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Reprimand; conditions on registration

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
25	19/09/11	1 Year 11 Months	Pembroke	M	-	Anaesthetist	Breach of conditions	Yes	Yes	No (see [22]	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992* (admission to USP only)	Conditions
26	6/10/11	-	Il-Song-Lee	M	48	GP (sole practitioner)	Practising without insurance; Inappropriate Treatment; records	No	No	Yes (see [80])	Unsatisfactory Professional Conduct, s139B *Health Practitioner Regulation National Law*	10 weeks suspension; Reprimand; Conditions
27	11/11/11	4 Years 9 Months	Hameiri	M	-	GP	Inappropriate injections of vitamin supplements - patients acquiring Hep C;Records	No	No	Nodiscussion	Professional Misconduct & Unsatisfactory Professional Conduct, ss 36 & 37 *Medical Practice Act 1992*	Severe reprimand; fine $25,000; records audit

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
28	20/12/11	3 Years 6 Months	Zacharia	M	47	Cosmetic and plasticsurgeon; ENT	Breaches of Medical Practice and Poisonsand Therapeutic Goods Act Regulations; Inappropriate Prescribing (Anti-Ageing Practitioner_	No	No	Yes [240]-[243], [249]	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Reprimand; fine $15,000;Conditions
29	15/2/12; 7/11/12	-	Hasil	M	57	Obs & Gynae Registrar	Records; inappropriate communicationwith patients; failure to disclose conviction; not of good character	Yes: see [187]	Yes - brain injury following accident; depression	Yes -conditional (see [151])	*Impaired Medical Practice Act 1992*	Not currently registered; Deregistered; conditions on re-registration; Reprimand
30	12/03/12	-	Tsourourtis	M	-	GP	Breach of Conditions	No	Yes - personality disorder	No (See [27], [36])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*(admission)	Reprimand

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
31	5/04/12	7 Months	Tiong	M	-	GP; Cosmetic Surgeon	Records; Failure to obtain informed consent; inappropriate management; failure to ensure that aseptic techniqueswere maintained	No	No	Yes (see p. 28)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission to USP only)	Reprimand; restriction from practice of plastic surgery for 6 months; conditions
32	5/04/12	-	Nemeth	F	-	GP	Inappropriate Prescribing; RecordKeeping	Yes - Impaired Doctors Program in1999	Yes - Suffering from Lyme's disease during relevant period; also see [39]	No (but restrictions on prescribing)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission to USP only)	Conditions on practice (and prescribing)
33	26/04/12	1 Year 1 Month	Schultz	M	-	Psychiatrist	Sexual Misconduct; inappropriate prescribing; failure to refer to alternative psychiatrist; self-prescribing	No	Yes - Depression	Yes (see [59], [61], [64])	Professional Misconduct, s 139E *Health Practitioner Regulation National Law*	Not currently registered; Deregistration - 18 months

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
34	8/05/12	-	Von Marburg	M	-	ENT Surgeon	Self administration; records; destroying drugs; inappropriate prescribing; make false statement to Department of Health	Yes - Impaired Registrar's programme since 2008	Yes - addiction	Some (see [38] and restriction on prescribing)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Conditions on practice (andhealth)
35	22/06/12	-	Dr A (non-pub order)	M	62	GP	Criminal convictions - 6 x indecentassault on a male	No	Yes - tendered at sentence - homosexual paedophilia	Yes (chaperone see [52])	Convictions of Criminal Offence: s 144 *Health Practitioner Regulation National Law (NSW)*	Conditions
36	22/06/12	-	Amigo	F	-	GP (sole practitioner)	Sexual misconduct; failed to exercise responsible medical judgment; records	No - but see [39]?	Yes - Depression	No (see [47]; [52])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Reprimand; conditions

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
37	28/06/12	-	Cooke	F	56	GP	Incompetent management of patients; alternative medicine; altering patient records; making false statements	No	Lack of insight, risk of re-offending	Yes (see [50-1])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Already suspended 2.5 years; reprimand; conditions regarding re-training
38	28/06/12	-	Ozme	F	63	GP	Inappropriate treatment and management; records	No	No	No (see [48])	Unsatisfactory Professional Conduct, s 139B *Health Practitioner Regulation National Law*	Reprimand; audit of records
39	28/06/12	3 Years 1 Month	Philipiah	M	-	GP	Records; Inappropriate Management of patients	Yes	Yes - depression; bipolar disorder; cluster B personality traits (narcissism and histrionic)	Yes (see conditions under Order 5, p 25)	Professional Misconduct, s 139E *Health Practitioner Regulation National Law*	Reprimand; suspension for 3 months; conditions on registration

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
40	3/07/12	1 Year but hearing s66 hearing in September 2007	Bosnich	M	49	GP	Inappropriate Prescribing; Record Keeping; inappropriate management	No	Yes - naiveté, lack of insight; overly compliant individual	Yes (see [32])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission to some particulars)	Reprimand; fine $10,000; conditions
41	19/07/12	11 Months	Small	M	66	GP	Sexual misconduct	No	Depression	No (But see [31] conditions to protect the public)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Reprimand; conditions
42	1/08/12	1 Year	Jones	M	63	GP	Inappropriate prescribing; post-dating prescriptions; records	No	Yes - re. re-offending	No (see [47-8]), but [42]	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Reprimand; fine $10,000; conditions

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
43	22/08/12	-	Underwood	M	-	Paediatrician	Sexual misconduct with patient's mother	No	Yes - isolation, emotional gratification from care of children	No (see p 6)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Reprimand; conditions; psychiatric treatment; monitoring
44	31/08/12	3 Years 5 Months	Fiay	M	70	GP	Inappropriate prescribing; inappropriate management; minimal clinical coordination his patients' other practitioners	No	No	Yes (see p 63)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission to USP only)	Deregistration - no minimum period specified
45	14/09/12	-	Smith	M	90	Urologist	Breach of conditions	No	No	Yes (see p 17)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Deregistration - no minimum period specified

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
46	17/09/12	-	Woolcock	M	-	GP	Criminal convictions; breach of AVO	No	No	No	Professional Misconduct, s 139E *Health Practitioner*	Reprimand; conditions
47	18/10/12	2 Years 5 Months	Di Mascio	M	44	GP	Breach of conditions	No	Yes - adjustment disorder; anxiety; depression	No (see p 12)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*(admission)	Reprimand; conditions
48	30/11/12 25/1/13	3 years	Snell	M	-	Anaesthetist	Self prescribing and administering;breach of undertaking	Yes	Yes - depression, alcohol abuse	Yes (see p 5 of 25/1/13)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Requested to be deregistered; deregistered; not to be registered for 18 months; reprimand

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
49	14/12/12	-	Howari	F	31	GP	Breach of conditions; practising withouta licence; working whilst suspended	Yes	Yes - narcissistic personality disorder	Yes (see p 27)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission to someparticulars)	Deregistration - no minimum period specified
50	14/12/12	-	Ristevski	M	60	GP	Sexual misconduct; record keeping	No	No	Yes (see [38])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*(admission)	Deregistration 1 year -reprimand
51	6/2/13 (Decision on 5/5/11 remitted to Tribunal by CA)	-	King	M	62	GP	Sexual misconduct - digital penetrationof patients; record-keeping; low level of competence	No	Yes - limited insightinto offending conduct	Yes (see [33])	Professional Misconduct, s 139E *Health Practitioner Regulation National Law*	Deregistration 1 year

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
52	22/02/13	-	Sudath	M	45	Emergency Physician	Convictions for rape and common assault	No	Yes - Pre-Release report - lack of empathy, blaming victim	Yes (see [66], [71])	Professional Misconduct, s 139E *Health Practitioner Regulation National Law*	Deregistration 2 years
53	22/02/13	2 Years	Leslie	M	62	GP	Inappropriate prescribing; record keeping	NO	Yes - vulnerable in his dealings with difficult and complex patients	Yes (see [44] and restriction on prescribing)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Reprimand; conditions
54	1/03/13	2 Years 1 Month	Herron	M	55	GP	Sexual misconduct - sexual relationship with patient; records; business relationship with patient	No	Yes - relationship developed from need for status and admiration	No (see p 9- 10)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law* (admission)	Reprimand; conditions

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
55	8/3/13; 22/5/13	-	Maendel	M	45	GP	Inappropriate Treatment; records	No	No	No (see Risk Assessment Report, [73] of 8/3/13] and [14] 22/5/13)	Unsatisfactory Professional Conduct, s 139B *Health Practitioner Regulation National Law* (dissenting views)	Reprimand; conditions
56	11/03/13	1 Year	Chang	M	-	GP/Anaesthetist	Inappropriate treatment; hygiene failures (failure to wash hands and/orwear gloves)	No	No	Nodiscussion	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Reprimand; conditions
57	15/3/13; 6/6/13	4 years 2 Months	Pogmore	F	68	GP	Inappropriate conduct; failure/refusal toattend performance review; Online abuse/harassment	No	No	Yes (see [18] of 6/6/13)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Deregistration - minimum 12months

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
58	12/04/13	4 years 6 Months	Ramrakha	M	53	GP	Alcohol abuse; Use of illicit drugs at surgery; Inappropriate sexual commentsto patients and staff; violence and aggression; Inappropriate prescribing; Records; Failure to observe professional boundaries; consulting with patients whilst under the influence of alcohol	Yes - Impaired Registrant's Programme 2008	Yes - anxiety, depression, alcoholism, drugs; but was now abstinent from drugs/alcohol	No (see [104]-[107])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Reprimand; conditions
59	17/4/13; 18/4/13	2 Years 10 Months	Moss	M	50	GP	Sexual misconduct	No	No	Nodiscussion	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E Health Practitioner Regulation National Law(admission)	Suspended 6 months;conditions
60	22/04/13	-	Rahman	M	46	GP	Convictions for 1 count aggravatedsexual assault and 22 counts of indecentassault all against patients	No	No	Yes (see [34] [37])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Deregistration (permanent if possible); no re-registration for a minimum of 8 years

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
61	29/4/13; 2/8/13	2 Years 4 Months	Doa Quynh Do	F	45	GP	Inappropriate Prescribing; Record Keeping; De-facto relationship withpatient	No	No	Division amongst Commissione rs (see [13] of 2/8/13)	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Conditions; no registration prior to completing specified educational courses
62	15/05/13	-	Hutchins	M	-	GP	Breach of conditions	No	No	No (see p 17)	Unsatisfactory Professional Conduct, s 139B *Health Practitioner Regulation National Law*	Reprimand; continuation of conditions
63	17/05/13	-	Rolleston	M	75	GP	Criminal convictions - indecent assaulton male patients; Breach of Conditions	No	No	Yes (see [70])	Professional Misconduct, s 139E *Health Practitioner Regulation National Law*	Deregistration - minimum 4years

NSW Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
64	21/06/13	-	Saedlounia	M	35	GP	Breach of conditions	No	No	Yes (see [133])	Professional Misconduct & Unsatisfactory Professional Conduct, ss 139B & 139E *Health Practitioner Regulation National Law*	Reprimand; fine $5,500;conditions

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
1	5/08/2010	-	Williams & Anor	M	-	Specialist/Anaesthetist	Failure to adequately assess/manage patient post-natal	No	No	No discussion	Unprofessional Conduct of a Serious Nature, ss 3(1), 45A(1)(a) Medical Practice Act 1994	Adjourned for orders
2	5/08/2010	-	Lichter & Anor	M	-	Specialist/Anaesthetist	Failure to adequately assess/manage patient post-natal	No	No	No discussion	Unsatisfactory Professional Conduct, ss 3(1), 45A(1)(a) Medical Practice Act 1994	Adjourned for orders
3	25/08/2010	9 Months	Bajpe	M	-	GP	Medicare Fraud - failure to disclose conviction; registration obtained by fraud or misrepresentation	No	Yes - 'Chronic stress', chronic adjustment disorder with mixed anxiety and depression	Yes (see [44] and [47])	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1), 45A(1)(a) Medical Practice Act 1994; s 3(1)(b) Health Professions Registration Act 2005	Reprimand; registration cancelled for 2 years
4	9/09/2010	-	Hafizullah	M	-	GP - accident and emergency section	Sexual misconduct - sexual harassment of female nurses	No	No	No discussion	Professional Misconduct, s 3(1) Medical Practice Act 1994	Adjourned - further hearing for orders

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
5	21/09/2010	-	Young	M	42	GP	Sexual misconduct - sexual relationship with sex worker patient; breach of conditions; inappropriate prescribing	No	Yes - traits of a risk- taking personality and being a narcissist, these are now under control. Body dysmorphic disorder.	Yes, (see previous history with Board, [92] and [98]) risk of reoffending not low - psychiatrist's evidence 95-99% certain the doctor would not relapse rejected.	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1), 45A(1)(a) *Medical Practice Act 1994*	Deregistered; not to reapply for 9 months; reprimanded
6	5/11/2010	-	Jabbar	M	-	GP	Inappropriate performance of circumcision; failure to monitor patient post-operatively; improper treatment of patient aged 26 months with type 1 diabetes	No	No	Yes: Previous history with Board (see [34]-[35])	Unsatisfactory Professional Conduct, s 3(1)(a) and (b) *Health Professions Registration Act 2005*	Reprimand; registration suspended for 3 months; conditions on circumcision practice; imposition of remedial education and counselling requirements
7	16/11/2010	2 Years, 11 Months	Poon	F	48	GP	Sexual misconduct; providing medical services which weer not urgent and or necessary; Medicare fraud	Y: VDHP	Previously undiagnosed and untreated ADHD; associated anxiety and bipolar mentation; Iatrogenic benzodiazepine	Some (see [114]-[116])	Unsatisfactory Prosfessional Conduct, ss 3(1), 45A(1)(a) *Medical Practice Act 1994*	Reprimand; conditions on registration

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
8	7/04/2011	10 Months	White	M	-	GP	Inappropriate Prescribing	No	Yes - Bipolar affective disorder	Yes (see [46]-[51] and Previous History with Board)	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1)(a) & (b) *Health Professions Registration Act 2005*	Deregistered for 2 years
9	15/4/11; 12/10/11	3 Years 3 Months	Skehan	M	57	GP	Inappropriate personal and emotional relationship with patient; sexual misconduct; incompetent clinical management; dishonest record keeping and clinical practice	No	No	No (see [36] of 12/10/11)	Unsatisfactory Professional Conduct & Professional Misconduct, s 3(1) *Medical Practice Act 1994* & s 3(1) *Health Professions Registration Act 2005*	Registration cancelled for 18 months; re-registration conditional on undertaking appropriate education and/or training to address issues arising from finding 3 (incompetent clinical management)
10	20/04/2011	4 Months	Hrstic	F	-	GP	Inappropriate prescribing; breaching agreement with Board; providing false Statutory Declarations to Board; Practising when not registered; Pleading guilty to 168 summary offences	VDHP	Yes: anxiety and low moods but no psychiatric illness or disorder	No (see [48] re. insight into offending behaviour, however note restrictions on prescribing and [53])	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1)(a) and/or (b), 45A(1)(a) *Medical Practice Act 1994* ; s 3(1) *Health Professions*	Suspended for 9 months; no contact with patients for this time; conditions on registration

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
11	6/05/2011	1 Year 11 Months	Petrovic	F	-	GP	Sexual Misconduct	No	No	Limited (see [33] but also [36] and mandatory counselling sessions to minimise risk)	Unsatisfactory Professional Conduct, ss 3(1), 45A(1)(a) *Medical Practice Act 1994*	Caution; Reprimand; Counselling with certain conditions
12	12/05/2011	9 Months	Venkataraman	F	-	GP	Inappropriate cosmetic procedures in relation to 3 patients including: liposuction and cosmetic skin excision; records	No	No	Yes (see [8](d), Order 7 - mentoring)	Unsatisfactory Professional Conduct, ss 3(1), 45A(1)(a) and (b) *Medical Practice Act 1994*	Caution; Reprimand; Further education; Mentoring Conditions; Conditions on registration - restricted from performing certain procedures; Fine $2,000
13	23/05/2011	-	Piesse	M	-	GP	Failure to undertake further education and provide statutory declaration to Board re. intravenous administration of herbal infusions and other products	No	No	No discussion	Unsatisfactory Professional Conduct, s 3(1) *Health Professions Registration Act 2005*	Caution; Reprimand; Further education

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
14	31/05/2011	3 Years 5 Months	Jansz	M	Relative Youth (see [435])	GP	Inappropriate Prescribing; inappropriate and inadequate medical management; Records; prescribing and administering drugs of dependence without a permit; post-dating prescriptions	No	No	Yes (see [400]; [434])	Unsatisfactory Professional Conduct & Professional Misconduct, s 3(1)(a), (b), (c) and (e), s 45A(1)(a) *Medical Practice Act 1994* ; s 3(1)(a) and (b) *Health Professions Registration Act 2005*	Suspension for 12 months; conditions during suspension; reprimand; conditions during first 12 months of re-registration
15	24/06/2011	2 Years 8 Months	Freeman	M	-	Specialist/Anaesthetist	Failure to monitor patient after surgery	No	No	Yes (see [29] counselling to minimise risk)	Unsatisfactory Professional Conduct, s 3(1)(a) and/or (b) *Health Professions Registration Act 2005*	Reprimand; conditions - Counselling, report to Board
16	13/07/2011	7 Months	Saykao	M	-	GP (sole practitioner)	Inappropriate prescribing of anabolic steroids	No	No	No discussion	Unsatisfactory Professional Conduct, ss 3(1)(b) and 3(1)(h)(iii) *Health Professions Registration Act 2005*	Caution; Reprimand; Conditions on registration

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
17	21/07/2011	7 Months	Ballard	M	-	GP	Alternative treatment for cancer patients; inappropriate prescribing; failure to obtain adequate or appropriate informed consent; inappropriate management	No	Yes - psychiatric evidence: serious anxiety, depression and chronic fatigue since 2002	Yes (see [25] and [38], restrictions on practice to protect public)	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1)(a), (b) and (c), 45A(1)(a) and (b) *Medical Practice Act 1994*	Reprimand; conditions on registration and practice - restricted solely to medical acupuncture
18	28/07/2011	3 Years 3 Months	Laska	M	-	GP	Failed to obtain informed consent to examination	No	No	Yes (see [55] and imposition of counselling sessions to minimise risk)	Unsatisfactory Professional Conduct, s 3(1)(a) *Health Professions Registration Act 2005*	Caution; reprimand; conditions - counselling and report to medical board
19	9/09/2011	3 Months	Erhardt	M	70	GP	Sexual misconduct - relationship with patient	No	No	No (see [15] and [24] protection of public not relevant)	Professional Misconduct, *s 17 Medical Practitioners Act 1970* (admission)	Suspended 3 months; conditions on registration - two counselling sessions
20	14/09/2011	-	Lai	M	72	GP	Advertisement and practice of chelation therapy; records; self-prescribing; failure to properly disclose health risks and warning statements; inappropriate prescribing	No	No	Yes (see [22] counselling to protect public)	Unsatisfactory Professional Conduct, ss 3(1)(a), (b) & (f) *Health Professions Registration Act 2005* and s 3(1)(a) & (b), s 45A(1)(a) *Medical Practice Act 1994 (admission)*	Caution; reprimand; conditions; counselling

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
21	30/11/2011	-	Kemp	M	-	GP	Breach of agreement with MPBV	No	No	No discussion	Unsatisfactory Prosfessional Conduct, s 3(1)(a), (b) and (k) Health Professions Registration Act 2005	Adjourned for orders
22	5/01/2012	-	Mak	M	66	GP	Inappropriate prescribing; inappropriate treatment and provision of medical care	No	No	Yes (see [23]-[24] restrictions on prescribing if reregistered)	Unsatisfactory Professional Conduct & Professional Misconduct, s 3 *Medical Practice Act 1994* & s 3(1)(a) and (b) *Health Professions Registration Act 2005*	Deregistered for 2 years; conditions upon reregistration - not prescribing
23	13/02/2012	3 Years	Steinberg	M	-	Specialist - obstetrician	Failed to take proper instructions from patient in antenatal period	No	No	No (see [20])	Unsatisfactory Professional Conduct, ss 3(1)(a), 45A(1)(a) *Medical Practice Act 1994*	Caution

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
24	31/8/12; 10/12/12 (NOTE: earlier tribunal decision of 10/6/11 set aside)	-	Dewan	M	-	Specialist - Paediatric Surgeon	Appeal against finding of Medical Board; Failed to take pre-operative procedures; failed to trial medical management prior to surgery; not obtaining informed consent from parents; not informing parents of charge of diagnosis; failed to make adequate investigations of previous medical history/treatment; performance of unwarranted surgery	No	No	Limited (see [38] of 10/12/12, terms of counselling and retraining should protect public, also [30]-[33] as mitigating factors)	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1)©, 45(1)(a) *Medical Practice Act 1994*	Reprimand; before re-commencing practice to undergo counselling and re-training by a senior paediatric surgeon; conditions on registration; regular audits; Note: registration suspended on 10/6/11 this was set aside on 21/11/11
25	27/09/2012	3 Years 11 Months	Myers	M	65	Specialist - Geriatrician	Failure to obtain informed consent from involuntary patients; inappropriate billing; Failure to provide investigator with required records	No	No	Limited (see [455]-[456] Dr Myers shows limited insight and is required to attend counselling)	Unsatisfactory Professional Conduct, s 3(1)(a), (b) and (c), s 45A(1) Medical Practice Act 1994	Reprimand; Caution; Counselling (Note: further complaint against respondent - 31/7/13)
26	2/11/2012	2 Years 9 Months	Scarff	M	-	Anaesthetist	Inadequate post-operative care; failure to review patient; failure to advise Nurse	No	No	No	No complaints made out; some withdrawn	N/A

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
27	5/11/2012	2 Years 8 Months	Christian	M	64	GP	Inappropriate Prescribing; Record Keeping; Prescribing without a permit	No	No	Yes (see [91] poor insight)	Unsatisfactory Professional Conduct & Professional Misconduct, ss 3(1)(a), 45A(1)(a) *Medical Practice Act 1994* & s 3(1)(a) and (b) *Health Professions Registration Act 2005*	Deregistered for 2 years; reprimand; conditions if reregistered - education, health assessments
28	7/12/12; 24/5/13	-	Schulberg	M	58	GP	Inappropriate prescribing; record keeping	No	No	Yes (see [27], [39]-[42])	Unsatisfactory Professional Conduct, ss 3(1)(a), (b) & (c) *Medical Practice Act 1994* ; ss 3(1)(a) & (b), 77(1) *Health Professions Registration Act 2005*	Deregistered 1 year; reprimand
29	13/12/2012	5 Months	DRP	M	-	Specialist - Endoscopy (see condition vii)	Obtain pethidine by false representation; self-administered drugs; create false records	Y: VDHP	Yes	No discussion - but conditions on drug testing, counselling and supervision	Professional Misconduct, s 3(1)(b) *Health Professions Registration Act 2005* Admission	Suppression order re. doctor's name and evidence; caution; reprimand; conditions - VDHP & prescription

Victorian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
30	1/02/2013	2 Years 5 Months	Topchian	M	-	Cosmetic surgeon	Sexual misconduct; attempt to bribe patient not to pursue action - referred himself to the Board	No	Yes - high level of insight into offending behaviour	Limited (see [48](a), (e) & [59])	Unsatisfactory Professional Conduct & Professional Misconduct, s 5 *Health Practitioner Regulation National Law Act 2009*, s 3(1)(b) *Health Professions Registration Act 2005*	Suspended 12 months; reprimand; mentor
31	21/3/13 (hearing); 5/6/13 (orders);12/6/13 (stay application); 29/8/13 (Appeal to VSCA)	2 Years 6 Months	Naim	M	42	GP	Sexual misconduct - inappropriate internal examination of female patient; failure to obtain informed consent	No	Yes - Dr suffered from no underlying psych disorder (see [15] of 12/6/13)	No discussion	Professional Misconduct, s 5(a) *Health Practitioner Regulation National Law Act 2009*	Reprimand; disqualified for minimum 12 months. NOTE: the orders below made on 5/6/13 (not published) were stayed on 12/6/13 pending hearing of respondent's appeal. Leave to appeal refused on 29/8/13 cancellation to take effect from 5/9/13

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
1	2/11/2010	-	Bonney	M	-	GP	Criminal conviction - accessing child pornography	No	Yes - depression, offending not motivated by sexual gratification, compulsive access of all forms of pornography	Yes (see [2], [8])	Unsatisfactory Professional Conduct, s 124(1)(i) *Health Practitioners (Professional Standards) Act 1999* -Improper conduct and conduct discreditable to the profession [5]	Conditions on practice -chaperone present during assessment ofunder 18
2	25/02/2011	-	Nandam	M	-	GP	Sexual misconduct - relationship with patient	No	Yes - conduct not predatory, no grooming of patient	Limited (see [9]-[10])	Unsatisfactory Professional Conduct,*Health Practitioners (Professional Standards) Act 1999* - Conduct falling lower than that expected by public and peers [6].	Reprimand; suspension for3 months to be lifted after 1 month subject to compliancewith conditions(non-compliancewithin 2 years will reinstitute suspension); Conditions

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
3	24/3/11; 23/5/11	-	Henderson	M	-	GP	Sexual misconduct towards 3 patients; breached chaperone requirement; misleading information sheet re. Chaperone requirements	No	Yes - Emotional vulnerabilities which resulted in inappropriate behaviour	Yes (see [31] of 24/3/11and previous history with Board)	Unsatisfactory Professional Conduct, s 240(1) *Health Practitioners (Professional Standards) Act 1999* ;23/5/11 decision implemented under *Health Practitioners Regulation National Law Act 2009*	Deregistered - minimum 18months; conditions upon application forre-registration
4	14/04/2011	-	O'Sullivan	F	-	GP	Unconventio nalmedicine totreat a naturopath with cancer; improperly enabled the unconvention altreatment of others; did notobtain informed consent to treatment	No	No	Limited (see [20] the need toprovide ongoing deterrence)	Unsatisfactory Professional Conduct, s 124(1)(i) *Health Practitioners (Professional Standards) Act 1999* at [18]	Suspended 6months partially remitted after 3 months (so long as not subject to further proceedingswithin 18 months);conditions on registration - counselling,ethical decisionmaking training

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
5	19/05/2011	2 Years 4 Months	Yasin	M	-	Psychiatrist	Sexual misconduct - relationship with patient	No	No	Yes (see [12] predatory conduct)	Professional Misconduct & Unsatisfactory Professional Conduct, s 124(1)(i) *Health Practitioners (Professional Standards) Act 1999* -[8] (admission)	Suspended for 2 years partially remitted after12 months if he complies withconditions on registration; counselling
6	20/01/2012	2 Years 10 Months	Lockie	M	-	Surgeon	Performed surgery with inappropriate equipment; inappropriate discharge fromsurgery; sumof failures resulted in death	No	No	No (see [19], [29])	Unsatisfactory Professional Conduct, s 124(1)(i) *Health Practitioners (Professional Standards) Act 1999* -[1] (admission)	Reprimand; not to be recordedon register
7	11/05/2012	-	Karam	M	-	GP	Poor communication skills; record keeping; careof patients;breach ofpatient confidentiality	No	No	Yes (see [10], Tribunal apprehends risks if attitudes underlying conduct not addressed	Unsatisfactory Professional Conduct, *Health Practitioners (Professional Standards) Act 1999*, Sch def of USPC para (a) [12] (admission)	Conditions on registration; conditionsreported onregister

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
8	16/05/2012	-	Dolar	F	72	GP	Inappropriate prescribing of anabolic steroids	No	No	Yes (see [27], [37] andconditions on prescribing)	Unsatisfactory Professional Conduct, *Health Practitioners (Professional Standards) Act 1999*Sch def of USPC para (a), (b), & (d) (admission) [26]	Reprimand; conditions
9	2/07/2012	2 Years 9 Months	Grant	M	65	GP	Inappropriate prescribing of anabolic steroid and other restricted drugs	No	No	Yes (see [65] [67] and conditions on prescribing)	Unsatisfactory Professional Conduct, *Health Practitioners Regulation National Law Act 2009* Schedule, s 5 definition 'unprofes sional conduct' [44]	Reprimand; Conditions on registration; suspension for12 months butwill not takeeffect if DrGrant complieswith registrationconditions for 2 years

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
10	10/07/2012	-	Sykes	M	-	GP	Inappropriate prescribing	No	No	No (see [28])	Unsatisfactory Professional Conduct, *Health Practitioners Regulation National Law Act 2009* Schedule, s 5 definition 'unprofessional conduct'	Reprimand
11	6/7/12; 21/12/12	-	FA	F	-	Specialist -obstetrics & gynaecology	Composed and published a website providing instructions for conduction medication termination or pregnancy without medical supervision	Yes: currently undergoing an impairment assessment	Yes - Bipolar 1 disorder & chronic pain disorder	Yes (see [18] [21] of 21/12/12)	Unsatisfactory Professional Conduct, *Health Practitioners Regulation National Law Act 2009* Schedule, s 5 definition 'unprofessional conduct'	Suspensionpending determinationof impairment proceedings; reported onregister

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
12	20/07/2012	-	North	M	-	GP	Sexual misconduct - relationship with patient; made false statements to the Board's investigators	No	No	No (see [18])	Conduct of a lesser standard thancolleagues and public expect.	Reprimand; suspension for 3 months to belifted after 1 month if Orders 3 & 4 are complied with; Conditions; allow Board toaccess his patient andMedicare records;recorded on register for 2years; Counselling
13	25/07/2012	2 Years	Jones	M	-	GP	Sexual misconduct - relationship with patient	No	No	Yes (see [22])	Professional Misconduct, s 139 Health Practitioners Regulation National Law Act 2009 [12]	Reprimand; suspension for 6 months; Orders suspended after2 months ifcomply with conditions on registration for12 months;Conditions - counselling

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
14	12/11/2012	3 Years 6 Months	Van Opdenbosch	M	88	GP	General competency; concerns aboutage and cognitive function; relationship with a woman 50 yearsyounger thanhimself towhom he was prescribing drugs; inappropriate prescribing; record keeping	No	Yes - no evidence ofpsychiatric or cognitive impairment	No discussion	Unsatisfactory Professional Conduct, *Health Practitioners (Professional Standards) Act 1999,*Sch def of UPC para(a)	Conditions on practice
15	4/02/2013	3 years	Smith	M	-	GP	Criminal conviction - burglary (2009)	No	Yes - PTSD, *characterological problems*	Yes (see [21] [22])	Unsatisfactory Professional Conduct, s 124(1)(i) Health Practitioners (Professional Standards) Act 1999 -conduct discreditable to the profession	Conditions on registration for2 years -including counselling, supervision

Queensland Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
16	30/04/2013	1 Year 1 Month	Evans	M	-	GP (sole practitioner)	Inappropriate prescribing; inadequate treatment - treatment not recognised in Australia; failure to disclose certain matters on registration	No	No	No (see [59])	Unsatisfactory Professional Conduct, s 5 *Health Practitioner Regulation National Law Act 2009* ; s 240*Health Practitioners (Professional Standards) Act 1999*(admission)	Not currently registered; Registration surrendered toBoard duringthese proceedings; undertaking notto reapply forregistration inany Australian jurisdiction.
17	19/06/2013	-	Gallery	M	73	Surgeon	Competency - treatment of patients; death of 1 patient; inappropriate management	No	No	No (see [24], [26])	Unsatisfactory Professional Conduct, s 124(1)(i) s 124(1)(i) Health Practitioners (Professional Standards) Act 1999 - (admission)	Not currently registered;undertaking never toreapply for registration

Western Australian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
1	21/4/11; 24/6/11	-	Wolman	M	-	GP	Sexual misconduct; failed to obtain consent for hypnosis; inappropriate physical contact whilst patient hypnotised	No	No	No discussion	Acted improperly, s 76(1)(b)(iii) *Medical Practitioners Act 2008* (WA)	Reprimand; Fine $4000
2	30/06/2011	-	L	M	-	GP	Sexual misconduct	Yes - s 78(b) *Medical Practitioners act 2008* (WA)	Y - depression, Alexithymia and Frotterism (contentious diagnosis); lack	Yes (see [49])	Improper conduct, s 13(1)(c) *Medical Act 1894* (WA)	Impairment; conditions on practice; non- publication order
3	9/12/2011	-	Kierath	M	-	GP	Gross carelessness - treating a patient then transferring him after surgical complication	No	No	No discussion	Gross carelessness s 13(1)(c) *Medical Act*	Reprimand; conditions on practice; Fine $10,000
4	27/02/2012	-	Wild	F	-	GP	Failed to maintain proper boundaries with patient; improper treatment; records	No	No	No Discussion	Acted improperly, s 76(1)(b)(iii) and carelessly s	Suspended 3 months; condition on registration - including supervision
5	13/4/12; 22/8/12	-	McClure	M	48	Neonatologist	Gross carelessness - medical care of newborn	No	No	No (see [28] of 22/8/12)	Gross carelessness s 13(1)(c)	Reprimand; Fine $10,000
6	25/05/2012	-	Bernadt	M	-	ENT Surgeon	Incompetent and careless surgery; failure to take adequate history	No	No	No discussion	Acted carelessly, s 76 (1)(b)(i) *Medical*	Suspension; Application for review dismissed (*Bernadt v Medical Board of Australia* [2012] WASAT 185)

Western Australian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
7	19/12/2012	-	Woollard	M	-	Specialist - Cardiologist	Incompetent and careless surgery	No	No	Yes (see [30] of second judgmen	Acted carelessly, s 76 (1)(b)(i) *Medical*	Reprimand; Conditions on registration; Fine $20,000
8	8/01/2013	-	Costley	M	57	GP	Sexual Misconduct; relationship with patient; inappropriate prescribing	Yes	Yes - anxiety, depression, adjustment disorder, cluster	Yes (see [48])	Improper conduct, s 13(1)(c) *Medical Act*	Not currently registered; Deregistration; Fined $2,000

Tasmanian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
1	11/07/2011	-	Martin	M	-	Sexual misconduct - expressing feelings to patient; improper and excessive prescribing	Criminal conviction - attempting to interfere with a witness	No	No	No discussion	Professional Misconduct, s 45 *Medical Practitioners Registration Act 1996*	Not currently registered, name had been removed from roll in 2005; Nominal cancellation of registration
2	15/09/2011	6 Months	Whittaker	M	-	Physician	Failure to comply with direction of Board	No	No	No discussion	Professional Misconduct, s 45(2)(k) *Medical Practitioners Registration Act 1996*	Reprimand; Fined $2,500
3	25/06/2012	-	Daware	M	-	Paediatric Consultant	Misdiagnosed heart condition as pneumonia resulting in death of patient; failed to communicate adequately with patients parent's record keeping	No	No	No (see [18])	Incompetence in the practice of medicine, s 52 *Medical Practitioners Registration Act 1996*	Reprimand; counselling

Tasmanian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**Protective Orders**
4	3/07/2012	1 Year 7 months	McGinity	M	-	GP	Deficiencies in professional performance and conduct; failure to accurately diagnose; failure to work reasonable hours; poor relationship with colleagues; records	No	No	No discussion	Treatment less than what could reasonably be expected, s 52 *Health Practitioner Regulation Act 1996*	Conditions

South Australian Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Findings**	**ProtectiveOrders**
1	7/06/2012	5 Months	Dr C	F	-	GP	Self-administration; falsified prescriptions and register	Yes	Yes - depression	Limited (see [31] and [33])	Professional Misconduct, s 196 Health Practitioner Regulation National Law 2009 (admission)	Not currently registered; Reprimand; fined $5,000; conditions if recommence practice; suspension if the practitioner was registered
2	11/12/2012	3 Years 8 Months	Ochnik	M	65	GP	Delay in attendance to an emergency; mislead the Medical Board of SA; making incorrect statements	No	No	No discussion	Unsatisfactory Professional Conduct, admission	Reprimand; fine $12,500

Australian Capital Territory Cases												
	Date	**Delay**	**Case**	**Sex**	**Age**	**GP/Specialist**	**Complaint**	**Impairment under Legislation**	**Psychiatric Evidence**	**Risk**	**Finding**	**ProtectiveOrders**
1	8/06/2012	-	Veness	M		Psychiatrist	Sexual misconduct - expressing feelings to patient; improper and excessive prescribing	No	No	Yes - insight into offending	Professional Misconduct, *Health Practitioners Regulation National Law (ACT) Act 2010*	Registration cancelled for an undetermined period
2	28/06/2012	5 Years 10 Months	Newcombe	M		Neurosurgeon	Incompetent performance of surgery; records	No	No	No (see [114] as has been deregistered since 2004)	Professional Misconduct, *Health Practitioners Regulation National Law (ACT) Act 2010*	Not on register; declaration by Tribunal not fit to practise

Appendix C: Governing legislation for tribunal decisions other than the Health Practitioner Regulation National Law

New South Wales

1. **Medical Practice Act 1992 (NSW)**

Section 36 Meaning of 'unsatisfactory professional conduct'

(1) For the purposes of this Act, 'unsatisfactory professional conduct' of a registered medical practitioner includes each of the following:

(a) Any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

(b) Any contravention by the practitioner (whether by act or omission) of a provision of this Act or the regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.

(c) Any contravention by the practitioner (whether by act or omission) of a condition to which his or her registration is subject.

(d) Any conduct that results in the practitioner being convicted of or being made the subject of a criminal finding for any of the following offences:

(i) an offence under section 204 of the Mental Health Act 1990,

(ii) an offence under section 175 of the Children and Young Persons (Care and Protection) Act 1998,

(iii) an offence under section 35 of the Guardianship Act 1987,

(iv) an offence under section 128A, 128B, 129, 129AA or 129AAA of the Health Insurance Act 1973 of the Commonwealth,

(v) an offence under section 58 of the Private Health Facilities Act 2007 .

(d1) A contravention by the practitioner of section 34A (4) (Power of Commission to obtain information, records and evidence) of the Health Care Complaints Act 1993 .

(e) Accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for:

(i) referring another person to the health service provider, or

(ii) recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter.

(f) Accepting from a person who supplies a health product (or from another person on behalf of the supplier) a benefit as inducement, consideration or reward for recommending that another person use the health product.

(g) Offering or giving any person a benefit as inducement, consideration or reward for the person:

(i) referring another person to the registered medical practitioner, or

(ii) recommending to another person that the person use any health service provided by the practitioner or consult the practitioner in relation to a health matter.

(h) Referring a person to, or recommending that a person use or consult:

(i) another health service provider, or

(ii) a health service, or

(iii) a health product,

when the practitioner has a pecuniary interest in giving that referral or recommendation (as provided by subsection (2)), unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

(i) Engaging in overservicing, as provided by subsection (3).

(j) Permitting an assistant employed by the practitioner (in connection with the practitioner's professional practice) who is not a registered medical practitioner to attend, treat or perform operations on patients in respect of matters requiring professional discretion or skill.

(k) By the practitioner's presence, countenance, advice, assistance or co-operation, knowingly enable a person who is not a registered medical practitioner (whether or not that person is described as an assistant) to:

(i) perform any act of operative surgery (as distinct from manipulative surgery) on a patient in respect of any matter requiring professional discretion or skill, or

(ii) issue or procure the issue of any certificate, notification, report or other like document, or to engage in professional practice, as if the person were a registered medical practitioner.

(l) Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another registered medical practitioner attends instead within a reasonable time.

(m) Any other improper or unethical conduct relating to the practice or purported practice of medicine.

Note: Sections 37A and 38 provide for some exceptions to the above provisions.

(2) A registered medical practitioner has a 'pecuniary interest' in giving a referral or recommendation:

(a) if the health service provider, or the supplier of the health product, to which the referral orrecommendation relates is a public company and the practitioner holds 5% or more of the issued share capital of the company, or

(b) if the health service provider, or the supplier of the health product, to which the referral orrecommendation relates is a private company and the practitioner has any interest in the company, or

(c) if the health service provider, or the supplier of the health product, to whom the referral orrecommendation relates is a natural person who is a partner of the practitioner, or

(d) in any circumstances prescribed by the regulations.

(3) A registered medical practitioner engages in 'overservicing' if the practitioner, in the course of professional practice:

(a) provides a service in circumstances in which provision of the service is unnecessary, not reasonably required or excessive, or

(b) engages in conduct prescribed by the regulations as constituting overservicing.

(4) For avoidance of doubt, a reference in this section to a referral or recommendation that is given to a person includes a referral or recommendation that is given to more than one person or to persons of a particular class.

(5) In this section:

'benefit' means money, property or anything else of value.

'recommend' a health product includes supply or prescribe the health product.

'supply' includes sell.

Section 37 Meaning of 'professional misconduct'

For the purposes of this Act, 'professional misconduct' of a registered medical practitioner means:

(a) unsatisfactory professional conduct, or

(b) more than one instance of unsatisfactory professional conduct that, when the instances are considered together, amount to conduct,

of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register.

Victoria

1**. Medical Practice Act Vic 1994 (Vic)**

Section 3 Definitions

1) In this Act-

'unprofessional conduct' means all or any of the following-

(a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered medical practitioner; or

(b) professional conduct which is of a lesser standard than that which might reasonably be expected of a medical practitioner by her or his peers; or

(c) professional misconduct; or

(d) infamous conduct in a professional respect; or

(e) providing a person with health services of a kind that is excessive, unnecessary or not reasonably required for that person's well-being; or

(f) influencing or attempting to influence the conduct of a medical practice in such a way that patient care may be compromised; or

(g) the failure to act as a medical practitioner when required under an Act or regulations to do so; or

(h) a finding of guilt of-

(i) an indictable offence in Victoria, or an equivalent offence in another jurisdiction; or

(ii) an offence where the practitioner's ability to continue to practise is likely to be affected because of the finding of guilt or where it is not in the public interest to allow the practitioner to continue to practise because of the finding of guilt; or

(iii) an offence under this Act or the regulations; or

(iv) an offence as a medical practitioner under any other Act or regulations; or

(i) the contravention of, or failure to comply with a condition, limitation or restriction on the registration of the medical practitioner imposed by or under this Act; or

(j) the breach of an agreement made under section 27(5), 32 or 38D between a medical practitioner and the Board; or

(k) unsatisfactory professional performance; ‘unsatisfactory professional performance’ of a registered medical practitioner means professional performance which is of a lesser standard than that which the medical practitioner's peers might reasonably expect of a medical practitioner.

2. Health Professions Registration Act 2005 (Vic)

Section 3 Definitions

(1) In this Act:

‘professional misconduct’ includes—

(a) unprofessional conduct of a health practitioner, where the conduct involves a substantial or consistent failure to reach or maintain a reasonable standard of competence and diligence; and

(b) conduct that violates or falls short of, to a substantial degree, the standard of professional conduct observed bymembers of the profession of good repute or competency; and

(c) conduct of a health practitioner, whether occurring in connection with the practice of the health practitioner's health profession or occurring otherwise than in connection with the practice of a health profession, that would, if established, justify a finding that the practitioner is not of good character or is otherwise not a fit and proper person to engage in the practice of that health profession;

‘unprofessional conduct’ includes—

(a) conduct of a health practitioner occurring in connection with the practice of the practitioner's health profession that is of a lesser standard than a member of the public or the health practitioner's peers are entitled to expect of a reasonably competent health practitioner of that kind;

(b) professional performance which is of a lesser standard than that which the registered health practitioner's peers might reasonably expect of a registered health practitioner;

(c) infamous conduct in a professional respect;

(d) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for that person's well-being;

(e) influencing or attempting to influence the provision of health services in such a way that client care may be compromised;

(f) a contravention of section 94 or the guidelines issued under section 95;

(g) the failure to act as a health practitioner when required under an Act or regulations to do so;

(h) a finding of guilt of—

(i) an offence where the health practitioner's suitability to continue to practise is likely to be affected because of the finding of guilt or where it is not in the public interest to allow the health practitioner to continue to practise because of the finding of guilt; or

(ii) an offence under this Act or the regulations; or

(iii) an offence as a health practitioner under any other Act or regulations;

(i) the contravention of, or failure to comply with a condition imposed on the registration of the health practitioner by or under this Act;

(j) in the case of a registered pharmacist, if the pharmacist owns or has a proprietary interest in a pharmacy business approved under Part 6, failure to comply with a condition of approval of that pharmacy business;

(k) the breach of an agreement made under this Act between a health practitioner and the responsible board that registered that practitioner.

Queensland

1. Health Practitioners (Professional Standards) Act 1999 (QLD)

Section 124 Grounds for disciplinary action

(1) Each of the following is a ground for disciplinary action against a registrant—

(a) the registrant has behaved in a way that constitutes unsatisfactory professional conduct;

(b) the registrant has failed to comply with a condition of practice imposed under this Act or the health practitioner registration Act under which the registrant is registered;

(c) the registrant has failed to comply with an undertaking entered into under this Act;

(d) the registrant has failed to comply with a lawful demand of a board, investigator, investigation committee, disciplinary committee, panel, health assessment committee,

inspector or the Tribunal or another entity authorised to make the demand under this Act or a health practitioner registration Act;

(e) the registrant does not meet, or no longer meets, the criteria for registration under the health practitioner registration Act under which the registrant is registered;

(f) the registrant has failed to comply with a provision of this Act or the health practitioner registration Act under which the registrant is registered;

(g) the registrant has been convicted of an offence against an Act of the State, the Commonwealth or another State related to the practise of the registrant's profession, including, for example—

(i) a health practitioner registration Act or this Act; or

(ii) the Health Act 1937; or

(iii) the Fair Trading Act 1989; or

Note—

An offence against the Fair Trading Act 1989 includes an offence against the Australian Consumer Law (Queensland) which forms part of that Act.

(iv) the Health Insurance Act 1973 (Cwlth);

(h) a finding has been made under the Health Insurance Act 1973 (Cwlth) that the registrant engaged in inappropriate practice within the meaning of that Act;

(i) the registrant has been convicted of an indictable offence.

(2) Also, if a registrant is impaired the registrant's impairment is taken to be a ground for disciplinary action against the registrant.

Schedule – Dictionary

unsatisfactory professional conduct, for a registrant, includes the following—

(a) professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant's professional peers;

(b) professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practise of the registrant's profession;

(c) infamous conduct in a professional respect;

(d) misconduct in a professional respect;

(e) conduct discreditable to the registrant's profession;

(f) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person's wellbeing;

(g) influencing, or attempting to influence, the conduct of another registrant in a way that may compromise patient care;

(h) fraudulent or dishonest behaviour in the practise of the registrant's profession;

(i) other improper or unethical conduct.

Western Australia

1. Medical Act 1894 (WA)

Section 13 Inquiries into, and striking off and suspension of, medical practitioner

(1) Where it appears to the Board that a medical practitioner, not being a body corporate, may be —

(a) guilty of infamous or improper conduct in a professional respect;

(b) affected by a dependence on alcohol or addiction to any deleterious drug;

(c) guilty of gross carelessness or incompetency;

(d) guilty of not complying with or contravening a condition or restriction imposed by the Board with respect to the practice of medicine by that medical practitioner; or

(e) suffering from physical or mental illness to such an extent that his or her ability to practise as a medical practitioner is or is likely to be affected,

the Board may allege to the State Administrative Tribunal that disciplinary action should be taken against the medical practitioner for that reason.

2**. Medical Practitioners Act 2008 (WA)**

Section 76 . Disciplinary matters

(1) The following are disciplinary matters —

(a) that a person has contravened a condition applying to that person's registration or the practice of medicine by that person;

(b) that a person in the course of his or her practise as a medical practitioner —

(i) acted carelessly;

(ii) acted incompetently;

(iii) acted improperly;

(iv) breached this Act;

(v) failed to comply with an undertaking given to the Board under this Act;

(vi) provided services that were excessive, unnecessary or not reasonably necessary for the recipient's wellbeing;

(c) that a person has been convicted of an offence the nature of which renders the person unfit to practise as a medical practitioner;

(d) that a person has engaged in conduct in a professional respect that falls short of the standard —

(i) that a member of the public is entitled to expect of a medical practitioner; or

(ii) that a member of the medical profession would reasonably expect of a medical practitioner;

(e) that a person has engaged in sexual misconduct.

(2) The matters referred to in subsection (1)(a), (b)(i) to (iii), (v) and (vi), and (c) to

(e) are disciplinary matters whether or not they occur in this State or in a State or Territory that has a corresponding law.

Section 77 . Competency matters

The following are competency matters —

(a) that a person does not have sufficient knowledge and skill to practise medicine safely and competently either generally or in a particular area of medicine in which the person is practising or is likely to practise;

(b) if the person is a specialist, the person does not have sufficient knowledge and skill to practise his or her specialty.

South Australia

No cases under old laws

ACT

1. Health Professional Act 2004 (ACT)

Section 41 Grounds for occupational discipline

(1) Each of the following is a ground for occupational discipline in relation to a health professional:

(a) the health professional has contravened, or is contravening, a standard of practice that applies to the health professional;

(b) the health professional has put, or is putting, public safety at risk;

(c) the health professional does not satisfy the suitability to practise requirements.

(2) A ground for occupational discipline applies to a health professional who is no longer registered if the ground applied to the health professional while registered.

Section 18 What is the required standard of practice?

(1) The 'required standard of practice', for a health professional, is the exercise of professional judgment, knowledge, skill and conduct at a level that maintains public protection and safety.

Section 23 Suitability to practise requirements

The suitability to practise requirements for each regulated health profession must state the requirements to be satisfied for a person to be unconditionally registered to practise in the health profession, including, for example—

(a) qualification requirements; and

(b) requirements about mental and physical health; and

(c) requirements for admission to a specialist area (if any) within the profession; and

(d) requirements in relation to the maintenance and demonstration of continuing competency, recency of practice and professional development.

Tasmania

1**. Medical Practitioners Registration Act 1996**

45 Specific matters of complaint

(1) Without limiting the generality of section 44(1), a person may complain to the Council that a registered medical practitioner –(a)

has been registered by reason of a false or misleading statement or declaration; or

(b) no longer holds, or is no longer entitled to hold, a qualification by reason of which he or she was registered; or

(c) lacks sufficient physical capacity, mental capacity or skill to practise; or

(d) is not entitled on other grounds to be registered; or

(da) is not of good fame and character; or

(e) is guilty of professional misconduct.

(2) Without limiting the matters that may constitute professional misconduct, a medical practitioner is guilty of such misconduct if the medical practitioner

(a) contravenes a provision of this Act; or

(b) contravenes a foreign medical law; or

(c) contravenes a condition of his or her registration; or

(d) fails to pay, within the time specified for payment, a fine imposed on the medical practitioner under section 52(1)(c) or costs or expenses ordered to be paid under section 53(1); or

(e) fails to comply with a requirement made of that medical practitioner under section 52(1)(e); or

(f) fails to honour an undertaking given to the Council or Tribunal; or

(g) is incompetent in the practice of medicine; or

(h) behaves in a deceptive or misleading manner in the practice of medicine; or

(i) engages in conduct that is capable of bringing the medical profession into disrepute; or

(j) advertises his or her practice or services in an inappropriate or fraudulent way; or

(k) fails, without reasonable excuse and within a reasonable time, to comply with a request by the Council to provide it with information; or

(l) practises while his or her registration is wholly suspended; or

(m) practises, while his or her registration is partially suspended, in the area of practice to which the partial suspension relates; or

(n) tries, by means of any threat or inducement, to stop a person from making or proceeding with a complaint against that medical practitioner.

Appendix D: Cases dealt with under the Health Practitioner Regulation National Law

NEW SOUTH WALES

1. *Health Care Complaints Commission v Gorman* [2011] NSWMT 7 (17 August 2011)[1061]
2. *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011)[1062]
3. *Health Care Complaints Commission v Il-Song Lee* [2011] NSWMT 12 (6 October 2011)
4. *Health Care Complaints Commission v Perroux* (No. 2) [2011] NSWMT 15 (9 December 2011)[1063]
5. *Health Care Complaints Commission v Tsouroutis* [2012] NSWMT 2 (12 March 2012)
6. *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012)
7. *Health Care Complaints Commission v Tiong* [2012] NSWMT 6 (5 April 2012)
8. *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012)
9. *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012)
10. *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012)
11. *Health Care Complaints Commission v Amigo* [2012] NSWMT 13 (22 June 2012)
12. *Health Care Complaints Commission v Cooke* [2012] NSWMT 12 (28 June 2012)
13. *Health Care Complaints Commission v Ozme* [2012] NSWMT 15 (28 June 2012)
14. *Health Care Complaints Commission v Philipiah* [2012] NSWMT 14 (28 June 2012)
15. *Health Care Complaints Commission v Bosnich* [2012] (3 July 2012)

[1061] First Notice Complaint brought under *Medical Practice Act*. Second Notice of Complaint brought pursuant to s 139B of the *Health Practitioner Regulation National Law* (NSW) and complaint proved that he does not have sufficient physical capacity, mental capacity, knowledge and/or skill to practise medicine.

[1062] Findings made under *Medical Practice Act* ss 36 & 37. Pursuant to s 163B(4) of the *Health Practitioner Regulation National Law* (NSW) the Tribunal imposed conditions upon the registration.

[1063] Findings (USP) made under *Medical Practice Act*. Orders were made under the National Law.

16. *Health Care Complaints Commission v Small* [2012] NSWMT 18 (19 July 2012)
17. *Health Care Complaints Commission v Jones* [2012] NSWMT 19 (1 August 2012)
18. *Health Care Complaints Commission v Underwood* [2012] (22 August 2012)
19. *Health Care Complaints Commission v Fiay* [2012] (unreported 31 August 2012)
20. *Health Care Complaints Commission v Smith* [2012] (unreported 14 September 2012)
21. *Health Care Complaints Commission v Woolcock* [2012] (17 September 2012)
22. *Health Care Complaints Commission v Mascio* [2012] (18 October 2012)
23. *Health Care Complaints Commission v Snell* [2013] (30 November 2012)
24. *Health Care Complaints Commission v Howari* [2012] (14 December 2012)
25. *Health Care Complaints Commission v Ristevski* [2012] NSWMT 23 (14 December 2012)
26. *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013)
27. *Health Care Complaints Commission v Leslie* [2013] NSWMT 1 (22 February 2013)
28. *Health Care Complaints Commission v Sudath* [2013] NSWMT 2 (22 February 2013)
29. *Health Care Complaints Commission v Herron* [2013] (1 March 2013)
30. *Health Care Complaints Commission v Maendel* [2013] NSWMT 3 (8 March 2013)
31. *Health Care Complaints Commission v Chang* [2013] (11 March 2013)
32. *Health Care Complaints Commission v Pogmore* [2013] (15 March 2013)
33. *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013)
34. *Health Care Complaints Commission v Moss* [2013] (18 April 2013)
35. *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013)
36. *Health Care Complaints Commission v Dao Quynh Do* [2013] NSWMT 7 (29 April 2013)
37. *Health Care Complaints Commission v Hutchins* [2013] (15 May 2013)
38. *Health Care Complaints Commission v Rolleston* [2013] NSWMT 12 (17 May 2013)

39. *Health Care Complaints Commission v Saedlounia* [2013] NSWMT 13 (21 June 2013)

VICTORIA

40. *Medical Board of Australia v Christian* (Occupational and Business Regulation) [2012] VCAT 1647 (5 November 2012)[1064]
41. *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012)
42. *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013)
43. *Medical Board of Australia v Naim* (Review and Regulation) [2013] VCAT 329 (21 March 2013)
44. Medical Board of Australia v Schulberg (Review and Regulation) [2013] VCAT 823 (24 May 2013)

QUEENSLAND

45. *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011)[1065]
46. *Medical Board of Australia v Grant* [2012] QCAT 285 (2 July 2012)
47. *Medical Board of Australia v Dr FA* (No 2) [2012] QCAT 288 (6 July 2012)
48. *Medical Board of Australia v Sykes* [2012] QCAT 293 (10 July 2012)
49. *Medical Board of Australia v Jones* [2012] QCAT 362 (25 July 2012)
50. *Medical Board of Australia v Evans* [2013] QCAT 217 (30 April 2013)[1066]

WESTERN AUSTRALIA

[1064] Finding made under *Medical Practice Act*. Orders: deregistration made under s 77 National Law.

[1065] Case decided under *Health Practitioners (Professional Standards) Act 1999* decision implemented under the National Law.

[1066] Findings under both *National Law and Health Practitioners (Professional Standards) Act 1999*.

51. *Medical Board of Australia and Bernadt* [2012] WASAT 108 (25 May 2012); Bernadt and Medical Board of Australia [2012] WASAT 185 (4 September 2012)[1067]

AUSTRALIAN CAPITAL TERRITORY CASES

52. *Medical Board of Australia & Veness* (Occupational Discipline) [2012] ACAT 36 (8 June 2012)

SOUTH AUSTRALIAN CASES

53. *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012)
54. *Medical Board of Australia v Ochnik* [2012] SAHPT 7 (11 December 2012)

[1067] Findings under *Medical Practitioners Act 2008*. Order of Board to deregister made under National Law.

Appendix E: Formal impairment cases

1. *Health Care Complaints Commission v Dr McKenzie* [2011] NSWMT 6 (27 July 2011)
2. *Health Care Complaints Commission v Hasil* [2012] NSWMT 1 (15 February 2012)

   For protective orders see: *Health Care Complaints Commission v Hasil* (No 2) [2012] NSWMT 21 (7 November 2012)
3. *Health Care Complaints Commission v Dr Leonard Philipiah* [2012] NSWMT 14 (28 June 2012)
4. *Health Care Complaints Commission v Dr Andrew Snell* (NSW Medical Tribunal, Deputy Chairperson Balla J, 30 November 2012)

   For protective orders see: *Health Care Complaints Commission v Dr Andrew Snell* (NSW Medical Tribunal, Deputy Chairperson Balla J, 25 January 2013)
5. *Health Care Complaints Commission v Dr Rasha Howari* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012)

Western Australia

6. *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011)

All Impairment Cases

1 July 2010 -1 July 2013

New South Wales

1. *Health Care Complaints Commission v Mukherjee* [2010] NSWMT 11 (7 October 2010)[1068]

   Not primary complaint

2. *Re Dr Swapan Chowdhury* [2010] NSWMT 13[1069] Not primary complaint.

3. *Health Care Complaints Commission v McKenzie* [2011] NSWMT 6 (27 July 2011)

   Not primary complaint – Second complaint – **formal complaintof impairment**

4. *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011) Not primary complaint – breach of conditions

5. *Health Care Complaints Commission v Hasil* [2012] NSWMT 1 (15 February 2012)[1070]

   Not primary complaint – Third complaint - **formal complaint of impairment**

6. *Health Care Complaints Commission v Nemeth* [2012] NSWMT 4 (5 April 2012)[1071]

   Not primary complaint – inappropriate prescribing - but on Impaired Registrants program

7. *Health Care Complaints Commission v Von Marburg* [2012] NSWMT 5 (8 May 2012)[1072]

[1068] Also inappropriate prescribing.

[1069] <http://www.mcnsw.org.au/page/379/doctors--performance--conduct---health/professional-conduct-/hearings-and-decisions/decisions/medical-tribunal-decisions-index/medical-tribunal-decisions-2010/>.

[1070] For judgment on orders see: *Health Care Complaints Commission v Hasil* (No 2) [2012] NSWMT 21 (7 November 2012).

[1071] Also inappropriate prescribing.

Not primary complaint – inappropriate prescribing – self administration

8. *Health Care Complaints Commission v Philipiah* [2012] NSWMT 14 (28 June 2012)

   Inappropriate medical care Complaint 2 **Formal impairment**

9. *Health Care Complaints Commission v Woolcock* [2012] (17 September 2012) Not primary complaint -drinking

10. *Health Care Complaints Commission v Snell* [2013] (30 November 2012)[1073]

    Complaint 2 **Formal complaint of impairment**

11. *Health Care Complaints Commission v Howari* [2012] (14 December 2012)

    Complaint 2 **Formal complaint of impairment**

12. *Health Care Complaints Commission v Ramrakha* [2013] NSWMT 8 (12 April 2013)[1074]

    Not primary complaint - drinking

Victoria

13. Medical Board of Australia v Poon (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010)

14. (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010)[1075]

    Not primary complaint - undiagnosed ADHD

[1072] Also inappropriate prescribing.

[1073] Also inappropriate prescribing. For judgment on orders see: *Health Care Complaints Commission v Snell* [2013] (unreported, 25 January 2013).

[1074] Also inappropriate prescribing.

[1075] Also sexual misconduct.

15. *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010)

    Not primary complaint Body dysmorphic disorder

16. *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012)

    Not primary complaint

Queensland

17. *Medical Board of Australia v Dr FA* (No 2) [2012] QCAT 288 (6 July 2012); *Medical Board of Australia v Dr No FA* (3) [2012] QCAT 705 (21 December 2012)

Western Australia

18. *Medical Board of Western Australia and L* [2011] WASAT 98 (30 June 2011)[1076]

    Formal complaint of Impairment (diagnosed during tribunal hearing)

South Australia

19. *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012)

[1076] Also sexual misconduct.

Appendix F: Sexual misconduct cases

New South Wales

1. *Health Care Complaints Commission v Howe* [2010] NSWMT 12 (30 September 2010)
2. *Health Care Complaints Commission v Robert Sims* [2010] NSWMT 17 (30 November 2010)
3. *Health Care Complaints Commission v Holmes* [2010] NSWMT 19 (14 December 2010)
4. *Health Care Complaints Commission v Dr Timothy Tristan Tang-Tat Wong* [2010] NSWMT 21 (17 December 2010)
5. *Health Care Complaints Commission v Dr Basavaraj Vastrad* [2011] NSWMT 1 (15 February 2011)
6. *Health Care Complaints Commission v Dr Elizabeth Millard* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 24 February 2011)
7. *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012)
8. *Health Care Complaints Commission v Dr A* [2012] NSWMT 11 (22 June 2012)
9. *Health Care Complaints Commission v Dr Anne Amigo* [2012] NSWMT 13 (22 June 2012)
10. *Health Care Complaints Commission v Dr Small* [2012] NSWMT 18 (19 July 2012)
11. *Health Care Complaints Commission v Dr Anthony Underwood* (NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012)

12. *Health Care Complaints Commission v Dr Ristevski* [2012] NSWMT 23 (14 December 2012)
13. *Health Care Complaints Commission v King* [2013] NSWMT 9 (6 February 2013)
14. *Health Care Complaints Commission v Dr Sudath* [2013] NSWMT 2 (22 February 2013)
15. *Health Care Complaints Commission v Dr Guy Herron* (NSW Medical Tribunal, Deputy Chairperson Balla J, 1 March 2013)
16. *Health Care Complaints Commission v Dr David Moss* (NSW Medical Tribunal, Deputy Chairperson Walmsley J, 18 April 2013)
17. *Health Care Complaints Commission v Rahman* [2013] NSWMT 6 (22 April 2013)
18. *Health Care Complaints Commission v Rolleston* [2013] NSWMT 12 (17 May 2013)

Victoria

19. *Medical Board of Australia v Young* (Occupational and Business Regulation) [2010] VCAT 1542 (21 September 2010)
20. *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010)
21. *Medical Board of Australia v Skehan* (Occupational and Business Regulation) [2011] VCAT 2424 (15 April 2011)

For protective orders see: *Medical Board of Australia v Skehan* (Occupational and Business Regulation List) (No 2) [2011] VCAT 1935 (12 October 2011)

22. *Medical Board of Australia v Petrovic* (Occupational and Business Regulation) [2011] VCAT 795 (6 May 2011)
23. *Medical Board of Australia v Laska* (Occupational and Business Regulation) [2011] VCAT 1888 (28 July 2011)[1077]
24. *Medical Board of Australia v Erhardt* (Occupational and Business Regulation) [2011] VCAT 1702 (9 September 2011)
25. *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013)
26. *Medical Board of Australia v Naim* (Review and Regulation) [2013] VCAT 329 (21 March 2013)[1078]

Queensland

27. *Medical Board of Australia v Bonney* [2010] QCAT 549 (2 November 2010)
28. *Medical Board of Australia v Nandam* [2011] QCAT 65 (25 February 2011)
29. *Medical Board of Australia v Henderson* [2011] QCAT 90 (24 March 2011)

[1077] The tribunal specifically found that the examination was not conducted in a sexual manner, see [34] but found failure to obtain informed consent in conducting an intimate examination of the patient in her breast and genital area.

[1078] Orders were made on 5 June 2013 but the orders were stayed on 12 June 2013: *Medical Board of Australia v Naim* (Review and Regulation) [2013] VCAT 1006 On 29 August 2013 Dr Naim's appeal against the orders was dismissed *Naim v Medical Board of Australia* [2013] VSCA 205 (29 August 2013).

For judgment on orders see: *Medical Board of Australia v Henderson* (No 2) [2011] QCAT 222 (23 May 2011)

30. *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011)

31. *Medical Board of Australia v North* [2012] QCAT 546 (20 July 2012)

32. *Medical Board of Australia v. Jones* [2012] QCAT 362 (25 July 2012)

Western Australia

33. *Medical Board of Australia and Costley* [2013] WASAT 2 (8 January 2013)

Australian Capital Territory

34. *Medical Board of Australia & Veness* (Occupational Discipline) [2012] ACAT 36 (8 June 2012)

Appendix G: Women doctors found guilty of misconduct

1 July 2010 – 1 July 2013

1. In *Re Dr Yolande Lucire and the Medical Practice Act* (unreported, NSW Medical Tribunal, Deputy Chairperson Puckeridge J, 24 August 2010) (Inappropriate treatment)

2. *Health Care Complaints Commission v Dr Elizabeth Millard* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 24 February 2011) (Sexual misconduct)

3. *Health Care Complaints Commission v Gorondy-Novak* [2011] NSWMT 3 (15 April 2011) (Inappropriate prescribing)

4. *Health Care Complaints Commission v Dr Denise Perroux* [2011] NSWDC 99 (16 August 11) (Practising without insurance)

5. *Health Care Complaints Commission v Dr Nemeth* [2012] NSWMT 4 (5 April 2012) (Inappropriate prescribing)

6. *Health Care Complaints Commission v Dr Anne Amigo* [2012] NSWMT 13 (22 June 2012) (Sexual misconduct)

7. *Health Care Complaints Commission v Dr Carolyn Cooke* [2012] NSWMT 12 (28 June 2012) (Competence)

8. *Health Care Complaints Commission v Dr A Esin Dalat Ozme* [2012] NSWMT 15 (28 June 2012) (Inappropriate treatment)

9. *Health Care Complaints Commission v Dr Rasha Howari* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2012) (Breach of conditions)

10. *Health Care Complaints Commission v Dr Annette Dao Quynh Do* [2013] NSWMT 7 (29 April 2013) (Inappropriate prescribing)

11. *Medical Board of Australia v Poon* (Occupational and Business Regulation) [2010] VCAT 1840 (16 November 2010) (Sexual misconduct)

12. *Medical Board of Australia v Petrovic* (Occupational and Business Regulation) [2011] VCAT 795 (6 May 2011) (Sexual misconduct)

13. *Medical Board of Australia v Hrstic* (Occupational and Business Regulation) [2011] VCAT 707 (20 April 2011) (Inappropriate prescribing)

14. *Medical Board of Australia v Petrovic* (Occupational and Business Regulation) [2011] VCAT 795 (6 May 2011) (Sexual misconduct)

15. *Medical Board of Australia v Venkataraman* (Occupational and Business Regulation) [2011] VCAT 751 (12 May 2011) (Inappropriate treatment)

16. *Medical Board of Australia v O'Sullivan* [2011] QCAT 135 (14 April 2011) (Inappropriate treatment)

17. *Medical Board of Australia v Dr FA* (No 2) [2012] QCAT 288 (6 July 2012) (Inappropriate treatment)

18. *Medical Board of Australia and Wild* [2012] WASAT 37 (27 February 2012) (Sexual misconduct)

19. *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012) (Self-administration of drugs of dependence)

Appendix H: Specialists found guilty of misconduct

1 July 2010 - 1 July 2013

Name of doctor	Specialty
1.Lucire	Psychiatrist
2. Howe	Plastic and reconstructive surgeon
3. Bhatia	Surgeon
4. Halder	Obstetrician and Gynaecologist
5. Pembroke	Anaesthetist
6. Zachariah	ENT surgeon
7. Hasil	Obstetrics and Gynaecology registrar
8. Tiong	Cosmetic surgeon
9.Schulz	Psychiatrist
10.Marburg	ENT surgeon
11. Underwood	Paediatrican
12. Smith	Urologist
13. Snell	Anaesthetist
14. Sudath	Emergency physician
15. Williams & Anor	Anaesthetist
16. Lichter	Obstetrician
17. Freeman	Anaesthetist
18. Steinberg	Obstetrician
19. Dewan	Paediatric surgeon
20. Myers	Geriatrician
21. Scarfe and Anor	Anaesthetist
22. Christian	Anaesthetist
23. DRP	Anaesthetist
24. Topchian	Cosmetic surgeon
25. Yasin	Psychiatrist
26. Lockie	Obstetrician and

	gynaecologist
27. Gallery	Surgeon
28. McClure	Neonatolgist
29.Bernhardt	ENT surgeon
30.Woollard	Cardiologist
31.Whittaker	Physician
32. Daware	Paediatric consultant
33.Veness	Psychiatrist
34. Newcombe	Neurosurgeon

1. In *Re Dr Yolande Lucire and the Medical Practice Act* (unreported, NSW Medical Tribunal, Deputy Chairperson Puckeridge J, 24 August 2010) (Psychiatrist)
2. *Health Care Complaints Commission v Howe* [2010] NSWMT 12 (30 September 2010) (Plastic and reconstructive surgeon)
3. *Health Care Complaints Commission v Dr Satya Pal Bhatia* (unreported, NSW Medical Tribunal, Deputy Chairperson Johnstone J, 2 November 2010) (plastic surgeon)
4. *Health Care Complaints Commission v Halder* [2011] NSWMT 8 (26 August 2011) (Obstetrician and Gynaecologist)
5. *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011) (Anaesthetist)
6. *Health Care Complaints Commission v Dr Michael William Zacharia* (unreported, NSW Medical Tribunal, Deputy Chairperson Sidis J, 20 December 2011) (Cosmetic and plastic surgeon)
7. *Health Care Complaints Commission v Hasil* [2012] NSWMT 1 (15 February 2012) (Obstetrics and Gynae registrar)
8. *Health Care Complaints Commission v Dr Tat Kong Joseph Tiong* [2012] NSWMT 6 (5 April 2012) (Cosmetic surgeon)
9. *Health Care Complaints Commission v Schultz* [2012] NSWMT 7 (26 April 2012) (Psychiatrist)
10. *Health Care Complaints Commission v Dr Roland Von Marburg* [2012] NSWMT 5 (8 May 2012) ENT surgeon)

11. *Health Care Complaints Commission v Dr Anthony Underwood* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 22 August 2012) (Paediatrican)
12. *Health Care Complaints Commission v Dr Robert Darlow Smith* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 14 September 2012) (Urologist)
13. *Health Care Complaints Commission v Dr Andrew Snell* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 30 November 2012) (Anaesthetist)
14. *Health Care Complaints Commission v Dr Sudath* [2013] NSWMT 2 (22 February 2013) (Emergency physician)
15. *Medical Practitioners Board of Victoria v Williams & Anor* (Occupational and Business Regulation) [2010] VCAT 1277 (5 August 2010) (Anaesthetist)
16. Dr Litcher (Obstetrician)
17. *Medical Board of Australia v Freeman* (Occupational and Business Regulation) [2011] VCAT 1166 (24 June 2011) (Anaesthetist)
18. *Medical Board of Australia v Steinberg* (Occupational and Business Regulation) [2012] VCAT 218 (13 February 2012) (Obstetrician)
19. *Dewan v Medical Board of Australia* (Occupational and Business Regulation) [2012] VCAT 1327 (31 August 2012) (Paediatric surgeon)
20. *Medical Board of Victoria v Myers* (Occupational and Business Regulation) [2012] VCAT 1470 (27 September 2012) (Geriatrician)
21. *Medical Board of Australia v Scarff & Anor* (Occupational and Business Regulation) [2012] VCAT 1732 (2 November 2012) (Anaesthetist)
22. *Medical Board of Australia v Christian* (Occupational and Business Regulation) [2012] VCAT 1647 (5 November 2012) (Anaesthetist)
23. *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012) (Anaesthetist)
24. *Medical Board of Australia v Topchian* (Occupational and Business Regulation) [2013] VCAT 86 (1 February 2013) (Cosmetic surgeon)
25. *Medical Board of Australia v Yasin* [2011] QCAT 300 (19 May 2011) (Psychiatrist)

26. *Medical Board of Australia v Lockie* [2012] QCAT 34 (20 January 2012) (Obstetrican and gynaecologist)
27. *Medical Board of Australia v Gallery* [2013] QCAT 334 (19 June 2013) (Surgeon)
28. *Medical Board of Australia and McClure* [2012] WASAT 69 (13 April 2012) (Neonatologist)
29. *Medical Board of Australia and Bernadt* [2012] WASAT 108 (25 May 2012) (ENT surgeon)
30. *Medical Board of Australia and Woollard* [2012] WASAT 209 (19 December 2012) (Cardiologist)
31. *The Tasmanian Board of the Medical Board of Australia v Dr Ross Whittaker* (Ref No. 3/2011) [2011] TASHPT 3 (15 September 2011) (Physician)
32. *The Tasmanian Board of the Medical Board of Australia v Dr Amol Daware* (Ref No. 6/2011) [2012] TASHPT 3 (25 June 2012) (Paediatric consultant)
33. *Medical Board of Australia & Veness* (Occupational Discipline) [2012] ACAT 36 (8 June 2012) (Psychiatrist)
34. *ACT Medical Board of the Medical Board of Australia & Newcombe* (Occupational Discipline) [2012] ACAT 43 (28 June 2012) (Neurosurgeon)

Appendix I: Inappropriate prescribing

New South Wales

1. *Health Care Complaints Commission v Dr Gopal Chandra Mukherjee* [2010] NSWMT 11 (7 October 2010)
2. *Health Care Complaints Commission v Dr Ray Woods* (NSW Medical Tribunal, Deputy Chairperson Balla J, 15 October 2010)
3. *Health Care Complaints Commission v Dr Bao-Quy Nguyen-Phuoc* [2010] (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 December 2010)
4. *Health Care Complaints Commission v Dr Ly* [2010] NSWMT 20 (15 December 2010)
5. *Health Care Complaints Commission v Gorondy-Novak* [2011] NSWMT 3 (15 April 2011)
6. *Health Care Complaints Commission v Dr Stamatios Ktenas* (NSW Medical Tribunal, Deputy Chairperson Balla J, 21 April 2011)
7. *Health Care Complaints Commission v Dr Mazzaferro* [2011] NSWMT 9 (31 August 2011)
8. *Health Care Complaints Commission v Dr John Edwards* [2011] NSWMT 10 (14 September 2011)
9. *Health Care Complaints Commission v Dr Michael William Zacharia* (NSW Medical Tribunal, Deputy Chairperson Sidis J, 20 December 2011)
10. *Health Care Complaints Commission v Dr Nemeth* [2012] NSWMT 4 (5 April 2012)
11. *Health Care Complaints Commission v Dr Roland Von Marburg* [2012] NSWMT 5 (8 May 2012)

12. *Health Care Complaints Commission v Dr Anthony Bosnich* (NSW Medical Tribunal, Deputy Chairperson, Elkaim J, 3 July 2012)
13. *Health Care Complaints Commission v Dr Jones* [2012] NSWMT 19 (1 August 2012)
14. *Health Care Complaints Commission v Dr Thomas Fiay* (NSW Medical Tribunal, Deputy Chairperson Balla J, 31 August 2012)
15. *Health Care Complaints Commission v Dr Leslie* [2013] NSWMT 1 (22 February 2013)
16. *Health Care Complaints Commission v Dr Riju Ramrakha* [2013] NSWMT 8 (12 April 2013)
17. *Health Care Complaints Commission v Dr Annette Dao Quynh Do* [2013] NSWMT 7 (29 April 2013)

    For protective orders see: *Health Care Complaints Commission v Dr Annette Dao Quynh Do* (No. 3) (unreported, NSW Medical Tribunal, Deputy Chairperson Colefax J, 2 August 2013)

Victoria

18. *Medical Practitioners Board v White* (Occupational and Business Regulation) [2011] VCAT 592 (7 April 2011)
19. *Medical Board of Australia v Hrstic* (Occupational and Business Regulation) [2011] VCAT 707 (20 April 2011)
20. *Medical Board of Australia v Jansz* (Occupational and Business Regulation) [2011] VCAT 1026 (31 May 2011)
21. *Medical Board of Australia v Saykao* (Occupational and Business Regulation) [2011] VCAT 1338 (13 July 2011)

22. *Medical Board of Australia v Mak* (Occupational and Business Regulation) [2012] VCAT 315 (5 January 2012)
23. *Medical Board of Australia v Christian* (Occupational and Business Regulation) [2012] VCAT 1647 (5 November 2012)
24. *Medical Board of Australia v Schulberg* (Occupational and Business Regulation) [2012] VCAT 1879 (7 December 2012)

    For protective orders see: *Medical Board of Australia v Schulberg* (Review and Regulation) [2013] VCAT 823 (24 May 2013)
25. *DRP v Medical Board of Victoria* (Occupational and Business Regulation) [2012] VCAT 1904 (13 December 2012)

Queensland

26. *Medical Board of Australia v Dolar* [2012] QCAT 271 (16 May 2012)
27. *Medical Board of Australia v Grant* [2012] QCAT 285 (2 July 2012)
28. *Medical Board of Australia v Sykes* [2012] QCAT 293 (10 July 2012)
29. *Medical Board of Australia v Van Opdenbosch* [2012] QCAT 703 (12 November 2012)
30. *Medical Board of Australia v Evans* [2013] QCAT 217 (30 April 2013)

South Australia

31. *Medical Board of Australia v Dr C* [2012] SAHPT 4 (7 June 2012)

Appendix J: Inappropriate medical care

New South Wales

1. In *Re Dr Yolande Lucire and the Medical Practice Act* (NSW Medical Tribunal, Deputy Chairperson Puckeridge J, 24 August 2010)

   For protective orders see: *Health Care Complaints Commission v Dr Yolande Lucire* (NSW Medical Tribunal, Deputy Chairperson Puckeridge J, 27 August 2010)
2. *Health Care Complaints Commission v Dr Satya Pal Bhatia* (NSW Medical Tribunal, Deputy Chairperson Johnstone J, 2 November 2010)
3. *Health Care Complaints Commission v Gorman* [2011] NSWMT 7 (17 August 2011)
4. *Health Care Complaints Commission v Halder* [2011] NSWMT 8 (26 August 2011)
5. *Health Care Complaints Commission v Dr Hameiri* [2011] NSWMT 13 (11 November 2011)
6. *Health Care Complaints Commission v Dr Tat Kong Joseph Tiong* [2012] NSWMT 6 (5 April 2012)
7. *Health Care Complaints Commission v Dr Carolyn Cooke* [2012] NSWMT 12 (28 June 2012)
8. *Health Care Complaints Commission v Dr A Esin Dalat Ozme* [2012] NSWMT 15 (28 June 2012)
9. *Health Care Complaints Commission v Dr Maendel* [2013] NSWMT 3 (8 March 2013

For protective orders see: *Health Care Complaints Commission v Dr Maendel* (No 2) [2013] NSWMT 10 (22 May 2013)

10. In *Re Dr Peter Chang and the Medical Practice Act* (NSW Medical Tribunal, Deputy Chairperson Colefax J, 11 March 2013) (GP Anaesthetist)

Victoria

11. *Medical Practitioners Board of Victoria v Williams & Anor* (Occupational and Business Regulation) [2010] VCAT 1277 (5 August 2010)[1079]
12. Dr Litcher[1080]
13. *Medical Board of Australia v Jabbar* (Occupational and Business Regulation) [2010] VCAT 1772 (5 November 2010)
14. *Medical Board of Australia v Venkataraman* (Occupational and Business Regulation) [2011] VCAT 751 (12 May 2011)
15. *Medical Board of Australia v Freeman* (Occupational and Business Regulation) [2011] VCAT 1166 (24 June 2011)
16. *Medical Board of Australia v Ballard* (Occupational and Business Regulation) [2011] VCAT 1386 (21 July 2011)
17. *Medical Board of Australia v Lai* (Occupational and Business Regulation) [2011] VCAT 1754 (14 September 2011)
18. *Medical Board of Australia v Steinberg* (Occupational and Business Regulation) [2012] VCAT 218 (13 February 2012)

[1079] Adjourned for protective orders. No judgment available.

[1080] Joint proceedings. See above *Medical Practitioners Board of Victoria v Williams & Anor* (Occupational and Business Regulation) [2010] VCAT 1277 (5 August 2010).

19. *Dewan v Medical Board of Australia* (Occupational and Business Regulation) [2012] VCAT 1327 (31 August 2012)

    For orders see: *Dewan v Medical Board of Australia* (Occupational and Business Regulation) [2012] VCAT 1840 (10 December 2012)

20. *Medical Board of Victoria v Myers* (Occupational and Business Regulation) [2012] VCAT 1470 (27 September 2012)

21. *Medical Board of Australia v Scarff & Anor* (Occupational and Business Regulation) [2012] VCAT 1732 (2 November 2012)

Queensland

22. *Medical Board of Australia v O'Sullivan* [2011] QCAT 135 (14 April 2011)

23. *Medical Board of Australia v Lockie* [2012] QCAT 34 (20 January 2012)

24. *Medical Board of Australia v Karam* [2012] QCAT 198 (11 May 2012)

25. *Medical Board of Australia v Gallery* [2013] QCAT 334 (19 June 2013)

Western Australia

26. *Medical Board of Australia and Kierath* [2011] WASAT 193 (9 December 2011)

27. *Medical Board of Australia and McClure* [2012] WASAT 69 (13 April 2012)

    For judgment on orders see: *Medical Board of Australia and McClure* [2012] WASAT 69 (22 August 2012)

28. *Medical Board of Australia and Bernadt* [2012] WASAT 108 (25 May 2012)

29. *Medical Board of Australia and Woollard* [2012] WASAT 209 (19 December 2012)

Tasmania

30. *The Tasmanian Board of the Medical Board of Australia v Dr Amol Daware* (Ref No. 6/2011) [2012] TASHPT 3 (25 June 2012)
31. *The Tasmanian Board of the Medical Board of Australia v Dr Paul McGinity* (Ref No. 1-7/2010 & 5/2011) [2012] TASHPT 4 (3 July 2012)

South Australia

32. *Medical Board of Australia v Ochnik* [2012] SAHPT 7 (11 December 2012)

Australian Capital Territory

33. *ACT Medical Board of the Medical Board of Australia & Newcombe* (Occupational Discipline) [2012] ACAT 43 (28 June 2012)

Appendix K: Breach of Conditions

New South Wales

1. *Re Dr Swapan Chowdhury* [2010] NSWMT 13 (20 October 2010)
2. *Health Care Complaints Commission v Pembroke* [2011] NSWMT 11 (19 September 2011)
3. *Health Care Complaints Commission v Tsouroutis* [2012] NSWMT 2 (12 March 2012)
4. *Health Care Complaints Commission v Dr Robert Darlow Smith* (NSW Medical Tribunal, Deputy Chairperson Balla J, 14 September 2012)
5. *Health Care Complaints Commission v Dr Renato Di Mascio* (unreported, NSW Medical Tribunal, Deputy Chairperson Balla J, 18 October 2012)
6. In the matter of Dr Ian Robert Hutchins (NSW Medical Tribunal, Deputy Chairperson Mahony J, 15 May 2013)
7. *Health Care Complaints Commission v Dr Saeid Saedlounia* [2013] NSWMT 13 (21 June 2013)

Victoria

8. *Medical Board of Australia v Kemp* (Occupational and Business Regulation) [2011] VCAT 2271 (30 November 2011)[1081]

Tasmania

9. *The Tasmanian Board of the Medical Board of Australia v Dr Ross Whittaker* (Ref No. 3/2011) [2011] TASHPT 3 (15 September 2011)

[1081] Adjourned for protective orders. No judgment available.

Appendix L: Other types of complaints

New South Wales

1. *Health Care Complaints Commission v Allen* [2010] NSWMT 8 (2 July 2010)
2. *Heath Care Complaints Commission v Dr Joseph Nicholas* [2011] NSWMT 2 (30 March 2011)
3. *Health Care Complaints Commission v Dr Denise Perroux* [2011] NSWDC 99 (16 August 11)

   For protective orders see: *Health Care Complaints Commission v Dr Perroux* (No. 2) [2011] NSWMT 15 (9 December 2011)
4. *Health Care Complaints Commission v Dr Peng Seng Chan* (NSW Medical Tribunal, Deputy Chairperson Balla J, 9 September 2011)
5. *Health Care Complaints Commission v Dr Il-Song Lee* [2011] NSWMT 12 (6 October 2011)
6. In *Re Dr James Woolcock and the Medical Practice Act* (NSW Medical Tribunal, Deputy Chairperson Colefax J, 17 September 2012)
7. In the matter of Dr Robyn Lesley Pogmore (NSW Medical Tribunal, Deputy Chairperson Mahony J, 15 March 2013)

   For protective orders see: In the matter of Dr Robyn Lesley Pogmore (NSW Medical Tribunal, Deputy Chairperson Mahony J, 6 June 2013)

Victoria

8. *Medical Board of Australia v Bajpe* (Occupational and Business Regulation) [2010] VCAT 1439 (25 August 2010)

9. *Medical Practitioners Board of Victoria v Hafizullah* (Occupational and Business Regulation) (Correction) [2010] VCAT 2126 (9 September 2010)[1082]
10. *Medical Board of Australia v Piesse* (Occupational and Business Regulation) [2011] VCAT 859 (23 May 2011)

Queensland

11. *Medical Board of Australia v Dr FA* (No 2) [2012] QCAT 288 (6 July 2012)

    For judgment on orders see: *Medical Board of Australia v Dr FA* (No 3) [2012] QCAT 705 (21 December 2012)
12. *Medical Board of Australia v Smith* [2013] QCAT 52 (4 February 2013)

Western Australia

13. *Medical Board of Australia and Wild* [2012] WASAT 37 (27 February 2012)
14. *Medical Board of Western Australia and Wolman* [2011] WASAT 69 (21 April 2011)

    For judgment on orders see: *Medical Board of Western Australia and Wolman* [2011] WASAT 69 (24 June 2011)

Tasmania

15. *The Tasmanian Board of the Medical Board of Australia v Ian Martin* (Ref No. 4/2011) [2011] TASHPT 1 (11 July 2011)

[1082] Adjourned for protective orders. No judgment available.

Appendix M: Protective orders

Order	Sexual Misconduct	Inappropriate Prescribing	Impairment	Inappropriate medical care	Breach of conditions	Other
Deregistration	1. Sims 2. Tang-Tat Wong 3. Schultz 4. Ristevski 5. King 6. Sudath 7. Rahman 8. Rolleston 9. Young 10. Skehan 11. Naim 12. Henderson 13. Costley 14. Veness	15. Mukherjee 16. Fiay 17. White 18. Mak 19. Christian 20. Evans 21. Schulberg	22. McKenzie 23. Hasil 24. Snell 25. Howari	26. Gorman 27. Gallery 28. Newcombe	29. Smith (NSW)	30. Pogmore 31. Bajpe
Suspension	1. Holmes 2. Millard 3. Moss 4. Erhardt 5. Topchian 6. Nandam 7. Yasin 8. North 9. Jones	10. Grant 11. Hrstic 12. Jansz	13. Philipiah	14. Jabbar 15. Scarff & Anor 16. O'Sullivan 17. Bernadt		18. Chan 19. Il-Song-Lee 20. Dr FA 21. Wild 22. Martin
Conditions only	1. Dr A 2. Bonney	3. Mazzaferro 4. Nemeth 5. Von Marburg 6. Doa Quynh Do 7. Van Opdenbosch	8. L	9. Lucire 10. Karam 11. McGinity	12. Pembroke	13. Smith (QLD)

Order	Sexual Misconduct	Inappropriate Prescribing	Impairment	Inappropriate medical care	Breach of conditions	Other
Conditions and Reprimand	1. Howe 2. Vastrad 3. Amigo 4. Small 5. Underwood 6. Herron 7. Poon 8. Petrovic 9. Laska	10. Woods 11. Nguyen-Phuoc 12. Ly 13. Gorondy-Novak 14. Ktenas 15. Edwards 16. Zacharia 17. Bosnich 18. Jones 19. Leslie 20. Ramrakha 21. Saykao 22. DRP 23. Dolar 24. Dr C		25. Bhatia 26. Tiong 27. Cooke 28. Maendel 29. Chang 30. Venkatatraman 31. Freeman 32. Ballard 33. Lai 34. Dewan 14. Myers 15. Kierath 35. Woollard 36. Daware	37. Chowdhury 38. Di Mascio 39. Hutchins 40. Saedlounia	41. Nicholas 42. Perroux 43. Woolcock
Reprimand only		1. Sykes		2. Hameiri 3. Ozme 4. Lockie 5. McClure 6. Ochnik	7. Tsourourtis 8. Whittaker	9. Allen 10. Smith 11. Piesse 12. Wolman
Caution				1. Halder 2. Steinberg		
Orders Uknown				1. Williams 2. Lichter	3. Kemp	4. Hafizullah

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B Cases

A complete list of the cases that formed the basis of the research for this thesis are listed in Appendix A

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