Recent Developments in the Medical Tribunal

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The aim of this paper is to bring to attention recent decisions of the Courts and the Medical Tribunal of New South Wales and interstate, in an effort to alert lawyers and medical practitioners to the general problem areas and pitfalls in the practice of medicine and how they are regarded and dealt with in disciplinary proceedings.

By reason of the Health Practitioner Regulation National Law Act 2009 (the National Law), there is a greater ability to draw applicable lessons from the decisions of the various Tribunals, Australia wide. By way of brief introduction, it is useful to examine the history and introduction of the National Law. For the sake of convenience, I will refer to the New South Wales version of the National Law as the National Law (New South Wales).

Scheme under the National Law

In June 2004, an agreement was made by the Council of Australian Governments (COAG) to commission a paper relating to the health workforce. Consequently, the Australian Productivity Commission completed a research report entitled Australia's Health Workforce. Amongst a number of recommendations, the Productivity Commission recommended the establishment of a single national registration board for health professionals and a single national accreditation board for health professionals' education and training.

In March 2008, the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions was signed by COAG, in which agreement was reached to establish a single national scheme and a single

national agency encompassing the registration and accreditation of health professionals.

The National Law states that the objectives of the scheme include to provide for the protection of the public by ensuring that only suitably trained and qualified health practitioners are registered; to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions; and to facilitate the provision of high quality education and training of health practitioners.

Initially, only ten health professions were covered including medical practitioners, but on 1 July 2012, four other health professions were added. The scheme requires that all health practitioners undergo compulsory professional development and produce evidence of recent practice; undertake compulsory professional indemnity insurance; there is a mandatory requirement to report improper or incompetent conduct of health professionals and to submit to compulsory police checks.

The scheme was implemented in three stages – the first being the enactment of the Commonwealth law – the Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 – which as its name suggests, established the administrative arrangements for the National Scheme; the second stage was that subsequent to the agreement by the Ministers, Queensland undertook the drafting of the model Bill – Health Practitioner Regulation National Law Act – which set out the legal framework for the new scheme and which began on 1 July 2010. The third stage involved the introduction of the legislation by Parliaments across Australia to adopt the new National Law. The New South Wales version is Health Practitioner Regulation National Law Act (NSW) No 86a. As a consequence, the Medical Practice Act 1992 was repealed.

Although it is expressed to be a “national law”, there are significant differences between the legislation enacted in the various states and territories. As is noted above, the enabling legislation was passed by the Queensland Parliament and then adopted with modifications by some but not all of the States and Territories.

National Law and Disciplinary Scheme

The National Law is a comprehensive piece of legislation containing in excess of 300 provisions. The general objectives and guiding principles are set out in section 3, and reference has been made to those above. New South Wales has enacted a further and overarching objective and guiding principle namely: that the protection of the health and safety of the public “must be” the paramount consideration in the exercise of functions under the New South Wales Law – section 3A.

Parts 2 to 7 of the National Law refer to the role of the Ministerial Council (Part 2) the establishment of the Australian Health Workforce Advisory Council (Part 3) and the National Boards (Part 4). New South Wales however declined to participate in the health, performance and conduct process provided by Divisions 3 to 12 of Part 8 of the National Law - section 6, Health Practitioner Regulation (Adoption of National Law) 2009. The net result of this is that whilst there are concepts in common amongst the jurisdictions, they are not identical. In particular, New South Wales did not adopt a number of central definitions including: “unprofessional conduct” and “professional misconduct” contained in the National Law. Consistently with the repealed Act, New South Wales adopted its own formulation of “unsatisfactory professional conduct” and “professional misconduct” – sections 139B and 139E of the National Law (New South Wales).

The central feature of the definition of “unprofessional conduct” in the National Law (applicable in other than NSW) is “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 peers” and includes amongst other things: breaches of the present law, the contravention of conditions on the practitioner’s registration or undertakings provided by him or her, the conviction for offences under other Acts “the nature of which may affect the practitioner’s suitability” to continue in practice, over-servicing and accepting or offering benefits for referring patients to another health service provider or receiving such a referral – section 5 of the National Law.

“Professional misconduct” is defined in the same provision as involving either unprofessional conduct amounting to conduct that is “substantially below the standard reasonably expected of a registered health practitioner of equivalent level of training or experience” or more than one instance of such conduct and conduct whether or not occurring in connection with the practice of the profession that is “inconsistent with the practitioner being a fit and proper person to hold registration”.

The National Law by section 196 (1) empowers a responsible tribunal inter alia, to make findings of unsatisfactory professional performance, unprofessional conduct, professional misconduct or impairment. Such a tribunal is empowered to caution or reprimand the practitioner, to impose counselling conditions, to find the practitioner and/or to suspend or cancel the practitioner’s registration – section 196 (2).

Part 5A of the National Law (New South Wales) provides for the establishment of a number of councils including the Medical Council of New South Wales, an important function of which is to consult with the Health Care Complaints Commission in relation to complaints made against health practitioners – section 145A. It may also deal with less serious complaints in the manner set out in section 145B.

The Health Care Complaints Commission (HCCC) is constituted under the Health Care Complaints Act 1993 as an independent body responsible for dealing with complaints under the Act with particular emphasis on the investigation and prosecution of serious complaints in consultation with relevant professional councils – section 3A of the HCCC Act 1993. A complaint may be made to the HCCC or to the Council - section 144C. Where either body forms the view that if the complaint is substantiated, it may provide grounds for the suspension or cancellation of a health practitioner's registration, each body is under a duty to refer the matter to the Medical Tribunal – section 145D.

The National Law (New South Wales) penalises incompetence (section 139) and unsatisfactory professional conduct (section 139B). Relevantly, the term "competent" refers to a sufficient physical and mental capacity as well to knowledge and skill to practise in the relevant profession and sufficient communication skills to do so.

"Unsatisfactory professional conduct" is extensively defined to include the following:

a. Conduct demonstrating that the knowledge skill or judgment possessed, or the care exercised by the medical practitioner in his or her profession is

significantly below the standard “reasonably expected of a practitioner of equivalent level of training or experience”;

b. a contravention by the medical practitioner of a provision of this Law or the regulations thereunder, whether or not the practitioner has been prosecuted for or convicted of an offence for such contravention;
c. breaching any condition attaching to the practitioner’s registration or contravening an undertaking to a National Board;
d. accepting from or offering any benefits to a health provider as an inducement or reward for referring another person to/from the health provider;
e. over-servicing; and
f. “any other improper or unethical conduct relating to the practice or purported practice of” medicine.

This is not a complete list of the defined unsatisfactory professional conduct.

The National Law (New South Wales) also defines “professional misconduct” as either a sufficiently serious instance of unsatisfactory professional conduct sufficient to justify the suspension or cancellation of the practitioner’s registration or more than one instance of unsatisfactory professional conduct that when considered together amount to a course of conduct sufficiently serious to justify suspension or cancellation of the practitioner’s registration – section 139E.

Division 10 of the National Law (New South Wales) provides for the establishment of the Medical Tribunal and the manner in which proceedings should take place before it. The Medical Tribunal is constituted to deal with complaints and appeals – sections 165A and 167. The Tribunal may conduct its proceedings as it thinks fit and the proceedings should generally be conducted in public – section 167B. The Tribunal is not bound to observe the rules of evidence, but may inform itself in any manner that it thinks fit – clause 2, Schedule 5D of the National Law (NSW). Medical practitioners are entitled to have legal representation in proceedings before the Tribunal – section 167C.

If the Medical Tribunal finds that the subject matter of the complaint has been proved, it may do a number of things: caution or reprimand the practitioner or impose conditions – section 149A; impose a fine – section 149B; suspend or cancel the practitioner's registration if it is satisfied that the practitioner lacks competence, or if he or she is guilty of professional misconduct, or if he or she has been convicted or found guilty of a criminal offence and "the circumstances of the offence render the practitioner unfit in the public interest to practise" in the medical profession or if the practitioner is an unsuitable person for registration – section 149C.

Other States and Territories have enacted counterpart legislation which deal with the issues that are contained in Part 5A and following – for example, the Health Practitioners (Disciplinary Proceedings) Act 1999 (Queensland) and the Health Professionals Act 2004 and the ACT Civil and Administrative Tribunal Act 2008 (ACT). It is noteworthy however that whilst some common concepts remain for example "unsatisfactory professional conduct" in the Queensland legislation, other jurisdictions such as ACT, have opted for newer concepts such as "a ground for occupational discipline", which term includes contravening a standard of practice relevant to the profession, putting public safety at risk and failing to satisfy suitability to practise requirements.

Central concepts

Nature of jurisdiction

The jurisdiction is exercised for the protection of both the public and the medical profession. It is protective rather than punitive. Deregistration is not an automatic outcome of a finding of professional misconduct even where that conduct is sufficiently serious to justify deregistration – **Health Care Complaints Commission v Karalasingham** [2007] NSWCA 267.

Deregistration may be required in serious cases of professional misconduct in order to adequately achieve the objectives of minimising the risk of recurrence and of deterring other practitioners from engaging in such conduct and thereby maintaining public confidence in the profession: **Health Care Complaints Commission v Litchfield** (1997) 41 NSWLR 630.

Whether the degree of seriousness is sufficient to warrant suspension or cancellation is a matter of degree and judgment: **Sabag v Health Care Complaints Commission** [2001] NSWCA 411 at [42]

Character

Character involves, inter alia, two things: the acceptance of high standards of conduct; and acting in accordance with those standards under pressure: **Council of Law Society of New South Wales v Foreman** (1994) 34 NSWLR 408 at 499.

Character concerns matters reflecting the moral standards, attitudes and qualities of the medical practitioner and not merely his general reputation. Those matters include personal misconduct not connected with the practice of medicine, to the extent that such conduct reveals defects of character which are incompatible with the standards of behaviour required of a member of the medical profession: **Sudath v Health Care Complaints Commission** [2012] NSWCA 171

Competence

Competence is characterised by the person having a sufficient physical capacity, mental capacity and skill to practise medicine and sufficient communication skills to do so - **Lindsay v Health Care Complaints Commission** [2010] NSWCA 194. This formulation, it should be noted, comes from the repealed Medical Practice Act 1992, but nevertheless appears to have application in the present Scheme.

Professional Misconduct

The seminal statement in the New South Wales context is contained in the judgment of Kirby P in **Pillai v Messiter (No 2)** (1989) 16 NSWLR 197 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 incompetence 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.
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> …
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> The public needs to be protected from delinquents and wrongdoers within professions. It also needs to be protected from seriously incompetent professional people who are ignorant of basic rules or indifferent as to rudimentary professional requirements. Such people should be removed from the register or from the relevant roll of practitioners, at least until they can demonstrate that their disqualifying imperfections have been removed.

The conduct must not be judged in hindsight. The definition of professional misconduct is focused on the nature of the conduct, which must have the capacity to justify such an order, whether or not such an order should be made in the particular case: **Health Care Complaints Commission v Karalasingham** [2007] NSWCA 267 at [67].

The "seriousness" of the unsatisfactory professional conduct depends on the extent to which it departs from proper standards: **Health Care Complaints Commission v Litchfield** (1997) 41 NSWLR 630 at 638.

"Misconduct in a professional respect" means conduct that incurs the strong reprobation of colleagues of good repute and competence. Frequently such conduct

involves “moral turpitude” but it need not do so: **Qidwai v Brown** (1984) 1 NSWLR 100 at [104].

Court of Appeal Cases

Challenging the Facts underpinning a Conviction

Sudath v Health Care Complaints Commission [2012] NSWCA 171: in 1998, an offence of common assault was found to have been proved against the practitioner and he was fined. In 2005, the practitioner was convicted after trial by jury, of having anal intercourse with his wife without consent and assaulting her. He was sentenced to a non-parole period of 6 months in relation to the assault and a further non-parole period of 3 years for the anal intercourse, with a two-year balance of term.

In 2008, the HCCC lodged complaints with the Medical Tribunal alleging that he had been convicted of offences and there was a criminal finding against him; and further that he was not a good character. At an interlocutory hearing, the Tribunal ruled that it would not allow the practitioner to adduce evidence inconsistent with the evidence of his wife concerning the circumstances of the sexual assault and any evidence to dispute his conviction for assault “for the purpose of challenging that evidence or those findings”. The nature of that evidence was that based upon his cultural upbringing in Sri Lanka, the practitioner believed that a husband and wife each gave unconditional consent to the other to engage in sexual intercourse during the course of the marriage. The Tribunal considered that this involved “a clear collateral attack upon the finding of guilt in both cases”. The practitioner was permitted to rely upon his statement as being material relevant to the issues of remorse or rehabilitation, those matters being relevant to the question whether he was of good character. The practitioner challenged that ruling in the Court of Appeal.

Meagher JA (with whom Whealy JA agreed) reasoned as follows: the Tribunal is given jurisdiction to enquire into complaints against registered medical practitioners

and if they are made out, to exercise disciplinary powers. Although its jurisdiction is essentially a protective one, the exercise of powers has potentially grave consequences for a medical practitioner in the event of an adverse decision - [74]. Once complaints are referred to it, the Tribunal has a duty to conduct an inquiry and although it is not bound by the rules of evidence, it remains subject to an overriding obligation to accord procedural fairness - [75]

His Honour stated at [81]:

> An allegation as to a medical practitioner not being "of good character" is concerned with matters reflecting the moral standards, attitudes and qualities of the medical practitioner and not merely his general reputation. Those matters include personal misconduct not connected with the practice of medicine, to the extent that such conduct reveals defects of character which are incompatible with the standards of behaviour required of a member of the medical profession. Allegations of personal misconduct may be met with a denial of the conduct or explanations for it together with evidence as to earlier and subsequent conduct to enable an assessment of whether the alleged misconduct is a true indicator of underlying qualities of character …

Because the complainant in the present case, relied upon not only the convictions but the underlying conduct which gave rise to them, His Honour reasoned at [82]:

> The underlying conduct is not limited to the essential facts upon which the convictions were based. In relation to the proof of that conduct, the … (HCCC) tendered and relies upon the whole of the transcript of proceedings before … (the sentencing court)".

His Honour concluded at [83]:

> It is not uncommon for the jurisdiction of administrative tribunals to exercise disciplinary or other powers to be founded upon its being satisfied after inquiry as to the fact of the conviction or as to a person not being a good character or being unfit to practise. In the latter cases, if there is a contest as to the occurrence or significance of the conduct relied upon as relevant to the assessment of the character or fitness to practise, material which tends to

> show whether that conduct occurred or places it in context is relevant to the subject matter of inquiry. This remains so even if the conduct has been the subject of an earlier conviction or adverse finding and the evidence sought to be led contradicts the finding or facts essential for the conviction. The mere fact of inconsistency does not of itself excuse the Tribunal from inquiring into the relevant facts or give rise to an abuse of its process. None of this means that a tribunal cannot or should not give significant weight to earlier convictions or findings of a court when addressing whether conduct has occurred. Nor is it the position that a tribunal is required to receive evidence about such conduct if the purpose for which it is proffered is not to challenge the fact of the conduct but to impugn an earlier conviction or the fairness of an earlier trial.

In a separate judgment, Basten JA agreed in the result and concluded at [46]:

> Accordingly, once the Commission tendered evidence upon which it sought to rely to establish the underlying conduct, it could not seek to exclude the practitioner from calling evidence going to the same issues. From the point of view of the Commission, and for the purposes of these proceedings, the conviction and the findings upon which it must have been based, together with further findings of the sentencing judge, were by no means sacrosanct.

His Honour considered that to do otherwise would be procedurally unfair on the practitioner.

Impairment/misconduct – addiction to narcotics

Reimers v Health Care Complaints Commission [2012] NSWCA 317: the applicant who was at the time of the misconduct, working as an anaesthetist, appealed approximately eight years out of time, against a finding by the Medical Tribunal that he was guilty of professional misconduct and that his name be removed from the Register of Medical Practitioners. The misconduct arose out of the applicant's addiction to narcotics and the consequential problems of this addiction in his practice as an anaesthetist. The Court of Appeal refused to entertain the appeal due to the "extraordinary lapse of time, which was not explained, let alone justified" and also the

need for the matter to be remitted to the Medical Tribunal for a rehearing, if the applicant was successful on appeal.

The gravamen of the applicant's contentions was that at the time of the misconduct, he was suffering from an impairment described as a substance abuse disorder, which involved addiction to narcotic drugs. The applicant contended that if impairment was established, he could not be guilty of professional misconduct. The allegation was in part that he abused drugs which were misappropriated from hospital stocks, where he practised.

Basten JA giving the leading judgment in the Court of Appeal, stated as follows at [12]:

> … Gross, repeated, incompetent medical practice does not cease to be such because it is caused by 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 practise 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.

Dealing with the alternative proposition that it was manifestly unreasonable to treat misconduct which was a result of an impairment as professional misconduct warranting deregistration, His Honour stated at [13]:

> … 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, … (citations omitted). Rather, it is to recognise that the primary object of the Medical Practice Act (the repealed 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" …

His Honour accepted that impairment was not conduct, but an impairment may manifest itself in conduct or may explain particular conduct in part or in whole – [14].

Practising without being covered by approved professional indemnity insurance

Lee v Health Care Complaints Commission [2012] NSWCA 80: the Tribunal found the appellant guilty of professional misconduct and suspended his registration for 10 weeks, the misconduct being that he practised as a medical practitioner for a period exceeding 5 years without being covered by approved professional indemnity insurance. In addition, complaints were made against the appellant that he made false declarations in his annual return to the Medical Board that he held approved professional indemnity insurance. In the event, the Tribunal concluded "with some reservation" that the practitioner remained uninsured because of a combination of poor administration, his casual attitude in assuming that he was covered without the need for regular confirmation and a degree of arrogance in expecting that the responsibility for ensuring his cover lay with the authorities and/or the insurance company. On appeal, the appellant did not challenge the finding of professional misconduct, but contended that the period of suspension was excessive.

The Court of Appeal dismissed the appeal. A prominent argument in the appellant's case was the contended inequality between the disciplinary orders made in his case as compared with other suggested analogous cases.

Barrett JA in giving the judgment of the Court, endorsed the notion that the range of orders (as in the range of criminal sentences) is significant as a reflection of "the accumulated experience and wisdom" of those making the decisions – [25] but emphasised the need for care because the decisions relied upon their own facts, taken in the context of the individual cases – [29].

His Honour however did point out at [32] that:

> This Court has said in the past that it must exercise great caution when invited to adopt a characterisation of a medical practitioner's conduct that differs from that which commended itself to the Medical Tribunal … (citations omitted). This is because … the Medical Tribunal is a specialist tribunal being constituted for the purpose of conducting enquiries by a District Court Judge, two registered medical practitioners and one layperson and this Court is not in

> a position to apply such medical expertise, although there may perhaps in some cases be a clear and unanimous view expressed by medical experts who give evidence in the proceedings before the Tribunal on which this Court could act.

The Court of Appeal reviewed the Tribunal's finding that it could not conclude that the appellant was deliberately dishonest in making the incorrect declarations. The Court found no error in that conclusion and agreed that the finding of recklessness was fully justified. Barrett JA stated at [67] and [68]:

> [67] … Cases of dishonesty are very serious. Cases of recklessness are also serious. This is particularly so where the protection of the public is at stake and the default is one that leaves patients exposed to risk against which the practitioner is required by law to provide protection.
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> [68] It is the failure to provide the required protection that constitutes the wrongdoing, not the fact that the failure is (or, as the case may be, is not) attended by dishonesty or a guilty mind. The more pertinent consideration in the formulation of an order is the practitioner's attitude to the wrongdoing and what it indicates about the risk that the misconduct might be repeated.

The Court considered that given the appellant's poor administration, his casual attitude and his arrogance, the Tribunal was entitled to take a negative view of the matter.

Unsatisfactory professional conduct – failure to properly treat mentally ill person

Lucire v Health Care Complaints Commission [2011] NSWCA 99: the practitioner was a psychiatrist who consulted with patient W on 9 occasions between November 2006 and January 2007. In addition, W consulted the practitioner in April, 3 July and on the morning of 5 July 2007. On 5 July 2007, W killed her father and one of her sisters and severely wounded her mother in the course of a psychotic episode. Complaints were made against the practitioner to the Medical Tribunal relating to the practitioner's management of the patient during the period prior to the psychotic

attacks. The Tribunal upheld part of the complaint and made findings of unsatisfactory professional conduct on the practitioner's part in certain respects.

The proceedings before the Tribunal were complicated by the fact that the commission of the Deputy Chairperson, a judge of the District Court, was due to expire some three days after the Tribunal delivered its findings on the question of whether there had been unsatisfactory professional conduct. Consequently due to that time pressure and at the same time, the Tribunal pronounced the protective orders it proposed to make, without according the practitioner a reasonable opportunity to address the Tribunal about those orders.

The complaint against the practitioner alleged that she had demonstrated that her knowledge, skill and judgment and the care exercised by her in the practice of medicine was significantly below the standard reasonably expected of a practitioner of equivalent training or experience. In particular, the Tribunal found that she failed to develop a proper and adequate management plan for patient W and failed to institute or recommend any proper or adequate treatment and management plan for her. Furthermore, it was alleged that the practitioner inappropriately advised the patient to cease taking her antipsychotic medication.

Patient W's history had been that in late 2006, she had been admitted to hospital accompanied by her mother, with reports of deteriorating irrational behaviour over the previous two years. The tentative diagnosis on admission was schizophrenia. During the period immediately before July 2007, patient W consulted her general practitioner on two occasions, again accompanied by her mother, at which time she had reported not taking the recommended medication but taking a herbal preparation provided by her father. The general practitioner noted that patient W was unwell with major depression and was at risk of developing psychotic symptoms if not treated. The general practitioner contacted the practitioner and she agreed with the advice the general practitioner had given.

The practitioner's notes of the consultation with patient W on 3 July recorded the patient's description of her condition as demonstrating a serious deterioration

resulting in terror and a sense of impending doom. The practitioner advised the patient's father to discontinue giving drugs or herbal remedies to his daughter, and advised patient W to discontinue the antipsychotic medication. The patient's mother who provided a written statement to the Tribunal stated the practitioner advised that patient W did not have schizophrenia, just depression and panic disorder. She reviewed the possibility that the patient might have schizophrenia, bipolar or manic depression but the practitioner stated that W had none of these conditions.

It appears that patient W's condition was deteriorating from 4 July to the time of the killings. She was described as having panic attacks which turned "towards aggression". She oscillated between asking to be taken to hospital and then stating she was not sick. Amongst other irrational behaviours, she was observed to be violently strikingly the keyboard of a computer. As a result of a disagreement about a computer password, she was screaming and uttering obscenities. On the morning of 5 July, the patient's parents coaxed her into the family car and drove her to see the practitioner. They arrived almost an hour early. The patient went into the building and followed her mother into a toilet where she started to beat her with her fists. The practitioner who was seeing another patient was called out of the room apparently as patient W was fleeing the building. The practitioner followed the patient out into the street and eventually persuaded her to sit with her at the back of a nearby coffee shop. The evidence was unclear as to what the practitioner knew about the patient's behaviour on the previous night or the assault on the mother in the toilet. The practitioner prepared no record of the events of that day until after she had learned of the violent attacks.

The patient's mother consulted the general practitioner on the afternoon of the attacks. The note by that general practitioner confirmed that she had spoken to the practitioner on 5 July, asking for her diagnosis and management plan. The practitioner said that patient W had a panic disorder with obsessive ruminations and said the patient had stopped the antipsychotic medication.

The case raised a number of important procedural and substantive issues:

i. the proper formulation of complaints;

ii. issues of procedural fairness;
iii. whether the ultimate orders made by the Tribunal were beyond power;
iv. and the significance of the practitioner not giving evidence before the Tribunal.

Basten JA in giving the leading judgment, noted that the particulars of one of the complaints involved 16 numbered paragraphs, four of which were general in their terms and the remainder of which related to conduct or omissions on particular occasions involving the treatment of the patient. His Honour observed at [43] that this form of pleading "inevitably gives rise to a degree of uncertainty as to the precise matters relied upon by the complainant and is impossible to know the parameters of the case to be presented." His Honour also observed that it is not possible for the Tribunal to deal with the complaint by finding it proven or otherwise but only with the case particular by particular.

In the event Basten JA stated at [45]:

> Failure to formulate the complaint in appropriate terms is not a matter of pedantry or formalism. Imprecision can readily lead to false issues, evidence extending the matters which are not really relied upon and, as already noted, confusion as to the effect of the ultimate orders.

His Honour observed that those dangers were reduced in the present case by reason of the "unusual course taken by the practitioner" of not giving evidence or calling expert evidence.

As was noted above, the Tribunal delivered its reasons for finding unsatisfactory professional conduct on the same occasion as it pronounced the final orders. The practitioner complained that this procedure precluded any reasonable opportunity for her to tender material and to make submissions in respect of appropriate orders. Basten JA thought that the critical question was "whether (the practitioner) had a reasonable opportunity (to present a case on the appropriate protective orders to be made)" – [61]. His Honour observed that by reason of the fact that the Tribunal had upheld some of the particulars and rejected others, it sought submissions as to

whether those particulars either individually or cumulatively constituted professional misconduct. In this context, His Honour noted at [63] that:

> The findings in respect of that exercise of characterisation were of critical importance to the practitioner. Where a complaint was upheld, the Tribunal had a range of powers available to it, …

His Honour observed that even if the Tribunal had found the practitioner guilty of professional misconduct and considered the imposition of a suspension or cancellation of registration at [65]:

> To say that such a penalty was justified was not to say that it should be imposed, or must be imposed, in the particular circumstances of the case. However, the need to maintain this distinction, gives practical support to the practitioner's submission that she should not have been required to address submissions to the Tribunal on the appropriate orders until the Tribunal had determined whether and in what respect her conduct constituted professional misconduct.

The Tribunal had made orders which did not permit the practitioner to treat patients in any circumstances or at any time, the only work which she might undertake being the provision of "medico-legal reports". Basten JA considered that this condition was beyond the power of the Tribunal, absent a finding of professional misconduct. His Honour noted at [73] that the preparation of such reports forms "a significant part of the practice of medicine, particularly for specialists":

> … Nevertheless, they remain entitled to treat patients and the value of the medico-legal reports will depend to a significant extent both on the experience in treating patients and the authority to do so. It is difficult to see how a medical practitioner, particularly a psychiatrist, who is not permitted to treat, manage or advise patients, could be thought by those who commission medico-legal reports to be qualified to provide such reports or to be capable of preparing reports that would carry significant weight with a court. To remove the practitioner's ability to treat patients is tantamount to suspension or deregistration. The fact that the practitioner remains able to undertake some

tasks, the authority for which derives from the status of being a registered medical practitioner, does not undermine that conclusion.

In a cross-appeal, the HCCC argued that the Tribunal erred in its view that it was not entitled to draw adverse inferences from the failure of the practitioner to give evidence. The Court of Appeal reviewed a number of authorities relating to the failure of professionals to give evidence in disciplinary hearings but ultimately decided that there was no need to determine the question of whether a professional is under an obligation to give evidence.

Basten JA at [132] and following, distilled the following principle from his review of the authorities:

> … There is no support for the proposition that a specialist Tribunal (whether a jury or disciplinary Tribunal) is obliged to draw adverse inferences in the absence of an explanation from the respondent. Such an obligation (at least as expressed in such absolute terms) would be inconsistent with the entitlement of the Tribunal to take into account the circumstances in which the failure to offer an explanation arose, including the importance of the matter in the proceedings and the potential adverse consequences for the practitioner of failing to proffer an available explanation.

His Honour concluded that at no stage did the Tribunal deny it was entitled to draw adverse inferences from the practitioner's silence on matters particularly within her knowledge.

Tribunal Cases

Inappropriate prescribing

In **Health Care Complaints Commission v Nemeth** [2012] NSWMT 4, the Medical Tribunal found the practitioner guilty of unsatisfactory professional conduct and professional misconduct in relation to inappropriate prescribing of significant quantities of addictive drugs to many patients (28) over a period of time. Generally,

the patients were either on opiate treatment programs or were drug dependent persons at the relevant time. The Tribunal concluded that the practitioner was aware of the addictive behaviour of the patients and aware of the harmful effects of the inappropriate use of addictive medication. A secondary complaint which was found to be established, was inappropriate medical record-keeping by the practitioner.

The Tribunal endorsed a previous statement in **Spicer v NSW Medical Council** (unreported, Court of Appeal, 19 February 1981) to the following effect:

> … it is clear beyond argument that the proper handling and prescribing of drugs by medical practitioners are of the greatest importance of the community. If a medical practitioner handles or carries out that very great responsibility in a way that is reckless and which shows a disregard to the law it cannot be said that he is fitted at such a time to be a medical practitioner.

The Tribunal accepted that the practitioner pursued her own misguided course of treatment of drug-addicted patients, shutting her eyes to reality. In the event, the Tribunal made protective orders prohibiting the practitioner from prescribing and dealing with addictive drugs.

In **Medical Board of Australia v Schulberg** [2013] VCAT 823, the Victorian Civil and Administrative Tribunal cancelled the practitioner's registration for inappropriate prescribing of drugs of addiction over a 9 year period. The practitioner was stated to be a unique practitioner in the field of pregnancy termination, being the only provider currently offering services to 24 weeks gestation. Nationally he was the only practitioner offering surgical termination beyond 20 weeks.

After reviewing the authorities and considering the submissions of the parties, the Tribunal concluded that "the findings were of a kind that constitute the most serious and grave lapse of professional standards." The Tribunal continued at [41]:

> His conduct was consistent poor practice, it endangered the patients, it continued over a number of years and we view the pattern of prescribing as reckless. It was not an isolated lapse of judgment but a systemic pattern occurring over a number of years. Although the doctor expressed the view

> that he thought it better that his patients continue to be treated by him than perhaps turning to crime to sustain their habit, we did not consider that to be mitigation but rather signified a lack of insight about his patients' well-being.

In **Medical Board of Australia v Evans** [2013] QCAT 217, the practitioner prescribed restricted drugs of dependency to 18 identified patients, when he knew or ought to have known they were drug dependent. He conceded that this constituted unsatisfactory professional conduct. Furthermore, the practitioner accepted that he had engaged in unsatisfactory professional conduct by providing those persons with health services of a kind that were excessive, unnecessary or not reasonably required for the person's well-being. There were additional complaints that the practitioner treated a child patient by providing the child a solution containing sodium chlorite. As a result of that, the child was ill and vomited.

In relation to the latter complaint, the Queensland Civil and Administrative Tribunal stated at [30]:

> Medical practitioners cannot embark upon such unconventional and potentially dangerous methods simply because a loved one of the patient implores them to do something. To submit to such exhortations is to abdicate responsibility and to abandon professional propriety. It was conduct which certainly constituted unsatisfactory professional conduct within the meaning of (the Act).

The Tribunal noted that the practitioner made certain undertakings not to apply for re-registration as a health practitioner in any jurisdiction in Australia and that any sanction beyond that "would be to act in a punitive rather than a protective manner".

Self administration of drugs

In **Medical Board of Australia v Dr C** [2012] SAHPT 4, the Health Practitioners Tribunal of South Australia dealt with a complaint that the practitioner had for a period slightly less than two years, self-administered drugs of addiction. In addition, on 35 occasions, she had falsified prescriptions for the supply of the drugs, on each

of those occasions providing a patient's name other than her own in circumstances where the drugs were not supplied to the patient. Additionally it was alleged that she falsified a register maintained in the practice where she was working to record the supply and administration of drugs of dependence pursuant to the provisions of the applicable South Australian statute.

It was alleged that the practitioner's conduct was substantially below the standard expected of a registered medical practitioner of equivalent level of training or experience and constituted professional misconduct. Alternatively, it was argued that the practitioner had an impairment sufficient to impose one or more of the disciplinary sanctions set out in the National Law – section 196 (2).

The practitioner admitted the conduct alleged and admitted that her conduct constituted professional misconduct.

The Tribunal summarised the complaints by stating that "there are three aspects to her conduct, the self administration of drugs of dependence, the falsification of prescriptions, and thirdly an effort to hide behaviour by making false entries in the relevant practice registers." The Tribunal reviewed the personal and subjective circumstances of the practitioner and concluded that she had demonstrated "an appropriate attitude for return to work. She has accepted personal responsibility for her behaviour which appears to indicate insight into the position." The Tribunal found that there were good grounds to conclude that she was able to effectively return to practise and was unlikely to re-offend.

Inappropriate boundaries – sexual and otherwise

In **Health Care Complaints Commission v Schultz** [2012] NSWMT 7, the medical practitioner a psychiatrist, was found guilty of professional misconduct by the Medical Tribunal on the basis that he failed to maintain appropriate professional boundaries and had a brief sexual relationship with the patient lasting 4 days. That patient had "borderline personality disorder" and the practitioner knew and treated members of the patient's family. Furthermore, the practitioner paid the patient

$20,000, ostensibly for work performed by her, but the Tribunal rejected that explanation. The practitioner also provided the patient with prescriptions without consultation over a 10 month period, for antipsychotic medication and for narcotic analgesics.

It appears that the practitioner allowed the patient to work part-time in the practice, a matter which drew strong criticism from an expert witness who found such conduct to be "grossly unprofessional given the necessity for the confidentiality of the other patients in the practice". The Tribunal agreed with those views observing at [34]:

> Confidentiality of patients could easily have been breached.

In the event, the Tribunal concluded at [31]:

> The respondent has clearly demonstrated by his conduct and admissions, a failure to keep proper boundaries with Patient A. It is trite to observe a medical practitioner must be particularly alert to the difficulties that may have to be confronted in treating the daughter of longtime friends and colleagues. There was a clear failure to adhere to professional boundaries by providing Patient A with charity by offering her food, money, employment and subsequently engaging in a sexual relationship with her. Clearly, Patient A was vulnerable at the commencement of the therapeutic relationship and the respondent should have been alert to the situation and, in the light of the family relationship, should have given serious consideration to referring her to another practitioner.

The Tribunal disqualified the practitioner's registration for 18 months.

In **Medical Board of Australia v Topchian** [2013] VCAT 86, the practitioner – a cosmetic surgeon – consented to findings and was found guilty of professional misconduct in two respects: that he engaged in a sexual relationship with a 21-year-old female patient he was treating in his practice as a cosmetic surgeon and secondly, that he participated in negotiations whereby he proposed to pay a sum of money to the patient on condition that she signed formal documents that she would refrain from taking action in relation to or disclosing their sexual relationship. The

sexual relationship took place over three months. She had been his patient for a little less than three years. The practitioner had transformed her from a 21-year-old woman working in a pet shop, to a model whose photographs appeared on the front cover of popular men's magazines. In the three year period, the practitioner performed a number of cosmetic procedures on the patient.

After the sexual relationship had ended, the patient emailed the practitioner seeking financial help from him and making a veiled threat, if there was no payment. The patient wanted $50,000 but the practitioner only offered $20,000. In the event, the practitioner informed the Board that he engaged in a sexual relationship with the patient and also disclosed the matter to his wife.

The Tribunal referred to the definition of "professional misconduct" in the National Law and in accordance with it, concluded that his conduct fell short to a substantial degree, of the standard of professional conduct observed by members of the profession of good repute or competency.

The Tribunal at [34] adopted a previous formulation by the Tribunal as to the impropriety of the conduct in the following terms:

> Sexual relationships between patients and doctors are always inappropriate. Medical practitioners are placed in a position of trust in the community and have available to them knowledge of their patients' physical and psychological well-being. This places the practitioner in a position to exploit the trust that has been given to them.
>
> The community expects that when they attend a medical practitioner, they will not be regarded as potential sexual parties nor that the relationship with the doctor will be sexualised. Likewise, the profession expects members to refrain from using consulting rooms as a means of establishing sexual relationships with patients. To do otherwise brings the profession into disrepute by reducing the trust that the community has in the profession.

The Tribunal relied upon an analogy with the position of a consultant psychiatrist considered in an earlier authority to the effect that a psychiatrist has access to the most intimate secrets of the patient – secrets they may never tell another human being. The Tribunal in the instant case saw an analogy between a cosmetic surgeon who also has intimate access to a patient's concerns.

In the event, the Tribunal considered it appropriate to suspend and reprimand the practitioner, on the basis that at [47], it concluded that the practitioner had "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."

In **Medical Board of Australia v Costley** [2013] WASAT 2, the practitioner admitted to two findings of sexual misconduct relating to two separate patients. He also admitted to improper conduct by instigating a personal relationship with a third patient. In addition, the practitioner admitted writing a prescription without having examined the patient and also issuing a false certificate as to the patient's unfitness for work.

The practitioner began a sexual and intimate personal relationship with a patient born in 1985. The patient had a history of having been sexually abused as a child and being treated for depression, self harming and suicidal behaviours amongst other psychological issues. As to the second complaint, that patient was born in 1983 and was being treated by the practitioner for depression, substance abuse, self harming and suicidal behaviours. The practitioner had sexual intercourse with that patient on three occasions.

The practitioner knew patient P in a personal capacity and wrote a prescription in the name of one of his employees but which he intended to supply to P after the medication was dispensed. He did not examine P at any stage before he wrote the prescription. In addition, the practitioner provided P with a medical certificate stating

she was unfit for work for 24 hours in circumstances where he knew that she was not unfit.

The State Administrative Tribunal of Western Australia considered that the findings of sexual misconduct were the most serious. It stated at [21]:

> … Both patients were extremely vulnerable, a fact which must have been abundantly clear to (the practitioner). The agreed facts concerning the nature of the treatment which (the practitioner) had administered to (the patients) respectively, demonstrate that vulnerability. There was a very significant age difference between (the practitioner) and the 2 patients concerned. (The practitioner) maintained a therapeutic relationship with both (patients) during the period he was in a sexual relationship with them.

The Tribunal concluded at [24]:

> Save that the sexual relationship was apparently consensual (in the criminal law sense and ignoring the significant power imbalance between the parties and the vulnerability of the patient), it is not easy to imagine a more egregious breach of trust or of appropriate professional boundaries that occurred in relation to (one of the patients). The behaviour by (the practitioner) has the hallmarks of an opportunistic event designed to take advantage of the extreme vulnerability of the patient.

The Tribunal concluded that in the circumstances the cancellation of the practitioner's registration was the appropriate penalty.

In relation to the complaint involving the prescription, the Tribunal noted at [50]:

> The privilege extended to medical practitioners to prescribe medication requires appropriate adherence to careful and proper practice. In that context, the creation of a document which is known to be false in a material way, is not be treated lightly.

In relation to the complaint involving the false certificate, the Tribunal said at [52]:

> Like prescribing drugs, the certification of a patient as unfit for work requires care and propriety on the part of medical practitioners. The obvious purpose

of such certificates is to enable employers to rely on the doctor's opinion for the purpose of accepting that the patient is entitled to sick leave. This did give rise to financial consequences. The provision of a false certificate is therefore to be viewed seriously.

In **C v Medical Council of New Zealand** [2013] NZHC 825, the High Court of New Zealand (Dobson J) considered an application by a psychiatrist contesting the findings that she had acted in breach of trust of the doctor-patient relationship and she must submit to counselling and mentoring. The complainant was receiving treatment for cancer in the oncology department of a hospital at which C was a specialist. C was not one of the doctors assigned to look after the patient, and the medical treatment required for her condition was outside the scope of C's specialisation.

Despite this, C interacted with the complainant on three occasions: she provided a prescription to nurses who were tending to the complainant to enable morphine to be administered; she attempted to calm the complainant following a procedure and she took a blood sample from the complainant when she returned to the hospital after her discharge and her treatment team was not available.

The complainant had for some time been living in a civil union with Ms A. C was acquainted with both the complainant and Ms A before the professional attendances referred to above. Shortly after the complainant's period in hospital, her civil union partnership with Ms A ended and approximately two months later, Ms A entered into a de facto relationship with C which was ongoing. At about that time, the complainant wrote to the District Health Board expressing concerns at the prospect of C having access to her medical records. She was provided with an unconditional assurance on behalf of C that C would not access the complainant's clinical records.

The Professional Conduct Committee concluded that C had breached the Council's guidelines on providing care to herself and to those close to her and also breached the underlying principle of trust in the doctor-patient relationship as expressed in the Sexual Boundary Policy. Amongst other relevant policies, it was the Council's

position that it was wrong for a doctor to enter into a relationship with a former patient or a close relative of a patient if this breaches the trust that the patient placed in the doctor.

The practitioner challenged the Committee's decision on the basis that it was unreasonable in the sense that no reasonable body in that position could make the determination that it did. Further she contended that the findings on the existence of a doctor-patient relationship were wrong and that the protective orders made were unreasonable. The applicable test for acceptable professional conduct is whether the conduct conforms with "the standards applied by competent, ethical and responsible practitioners" – [41].

Dobson J at [63] made the following observations about the doctor–patient relationship:

> Whether such a relationship existed was a question of fact and degree. I was not referred to any definition of the criteria for a doctor–patient relationship. The touchstone is presumably the existence of sufficient professional interactions between a doctor and the patient of a type and in a context in which it becomes objectively reasonable for the patient to repose trust and confidence in the doctor in relation to a medical condition for which the patient has sought treatment from that doctor.

His Honour concluded that the finding that there had been a breach of trust, contingent upon the proposition that C and Ms A were in a relationship during the period of Cs attendances on the patient, was not reasonably open to the Committee.

Competence

In **Krause v Medical Board of Australia** [2013] VCAT 1009, the applicant was an international medical graduate qualified in Germany. She applied for general registration as a medical practitioner in accordance with section 77 of the National Law and the Board determined to refuse to grant such registration.

The applicant had studied medicine in Hanover in Germany and was granted a licence to practise there in 1996. Between 2000 and 2012, the applicant worked in Australia with special purpose and limited registration for postgraduate training in various orthopaedic and surgical positions. Between 2002 and 2005, the applicant sat and failed the first part of the Royal Australasian College of Surgeons examination on three occasions. She abandoned the specialist pathway and attempted to register via the standard pathway under the auspices of the Australian Medical Council. She failed to pass that clinical assessment phase after 4 attempts. Thereafter, the applicant sought to obtain ongoing general medical registration with a view to working exclusively as a surgical assistant, alternatively that she be restricted to work only as such.

The Tribunal reviewed her failed tests and assessments and observed that the worst designation “very unsatisfactory” was recorded across all of the assessment domains including management plans for asthma and occupational risk; and managing cardiac arrests. It was conceded before the Tribunal that the applicant had adequately performed the role of surgical assistant for some years whilst subject to limited registration.

The Tribunal concluded at [70]:

> The Tribunal endorses the submission of the Board’s counsel to the effect that registration by way of conditions, notwithstanding that the applicant does not satisfy the basic requirements of general registration, would subvert the registration system. Indeed such a “sub-category” of registration would enable serious deficiencies in satisfaction of criteria for general registration to be remedied by the imposition of conditions, which purport to obviate those deficiencies by restricting the registrant’s right to practise medicine. In the Tribunal’s view, such an outcome would … be anomalous, confusing and problematic and would undermine the system of registration as it is structured.

In **Medical Board of Australia v McCarthy** [2012] WASAT 210, the practitioner a consultant psychiatrist was charged with gross carelessness in that he allegedly made false statements in a medical report. The report was prepared at the request of

the patient's former employer for use in legal proceedings between it and the patient. In the event, the Tribunal was not satisfied to the requisite standard that the complaints were established.

The lack of appropriate skill and diligence

In **Medical Board of Australia v Ochnik** [2012] SAHPT 7, the South Australian Health Practitioners Tribunal dealt with an allegation alleging unprofessional conduct in that the practitioner failed to attend an emergency involving the health of the patient and provided a misleading and incorrect account in response to the complaint to the Medical Board. The practitioner was a general medical practitioner working in a country town in South Australia. The patient was 93 years of age and telephoned the practitioner at the hospital, where he was working, complaining of feeling unwell nauseated and dizzy. Rather than send an ambulance, the practitioner indicated that he would attend. The practitioner did not directly attend at the patient's house because he had gone to the TAB agency at a local hotel.

When a complaint was made and the Medical Board sought the practitioner's response, he provided an incorrect and misleading explanation for what had occurred. It was argued that he misled the Board into concluding the matter in his favour.

The Tribunal agreed with position of the parties that "the best way to characterise the explanation is that it was a negligent action on his part lying somewhere, perhaps midway, between negligence and gross negligence." – [12]. The Tribunal concluded:

> In this matter the Tribunal regards the original incorrect answers more seriously than the parties … In other words it was a mistake he made in his own favour. It is also a matter of concern to us that the respondent in his response … diverts the blame … It is our view, … that his second letter does in fact aggravate the position because the respondent was trying to justify his position and pass the blame for what he now recognises was an inaccurate first response."

The Tribunal considered that the practitioner's conduct was serious and that "he ought not have put the patient's interests and well-being behind his own personal interests."

In **Medical Board of Australia v Woollard** [2012] WASAT 209, the Board alleged that the practitioner had acted carelessly or incompetently in the conduct of an angioplasty, during which a balloon catheter that the practitioner was using, burst inside the patient's right coronary artery. The Tribunal found that the practitioner caused the inflation of the balloon to a pressure of 18 atmospheres, which was 4 atmospheres above its rated burst pressure.

The Tribunal determined that the practitioner had acted carelessly in causing the inflation of the balloon to that pressure and failing to change to a non-compliant balloon which had thick walls and a higher rated burst pressure. The practitioner had been a medical practitioner for over 40 years and a specialist cardiologist for over 30 years. During the procedure, the practitioner performed the angioplasty under the supervision of an interventional cardiologist. The purpose of the procedure was to dilate or clear a blockage in the patient's right coronary artery and to open up the blood flow. The practitioner denied that the balloon had been inflated to 18 atmospheres, but the Tribunal concluded to the contrary, based upon the contemporaneous notes of the assisting nursing staff. In so doing, the Tribunal did not accept the veracity of the practitioner's testimony.

One of the expert witnesses gave evidence to the effect that it was not uncommon for some interventional cardiologists to exceed the rated burst pressure of the balloons. The Tribunal concluded that having regard to the expert testimony that this should not occur and "to the serious potential consequences of the balloon rupture", it was not a safe practice to do so.

The Tribunal considered the issue of whether the practitioner had acted carelessly or incompetently within the meaning of those terms as set out in the Western Australian legislation. The Tribunal at [104] adopted a previous formulation from the same body as to the meaning of "acted carelessly" as follows:

> In our view, acting carelessly … still requires that the carelessness requires that the conduct complained of assumes a scale of gravity which is sufficiently serious to warrant, in the eyes of professional colleagues of good repute and competence, punishment and disciplinary action for the protection of the public.
>
> Acting carelessly involves … not giving sufficient attention or thought to avoiding harm or mistakes or showing no care or interest or effort in the treatment of a patient, it does not include trivial error not warranting disciplinary action.
>
> In our view, the term "acted carelessly" does not encompass an error of judgment where a medical practitioner acts with care and diligence, but simply makes a wrong decision unless … the decision involves a departure "from elementary and generally accepted standards, of which a medical practitioner could scarcely be heard to say that he or she was ignorant".

The Tribunal concluded that the practitioner had indeed acted carelessly and that his conduct was of a scale of gravity which was sufficiently serious to warrant, in the eyes of professional colleagues of good repute and competence, punishment and disciplinary action for the protection of the public – [105].

The Tribunal also considered whether or not the practitioner acted incompetently and reviewed the principles relating to this concept at [112] in the following terms:

> … the concept of incompetency involves an unfitness to practise in a particular field of medicine or an inability to perform the techniques or judgments needed for the proper practice of medicine in that field. … Incompetency is usually suggestive of a generalised deficiency in the way in which the practitioner handles his or her affairs rather than individual or sporadic shortcomings.

In addition, the Tribunal agreed with the formulation that: "Incompetence … involves the view that such falling short of the proper standards of care and skill thought to be required on the occasion in question, reveals a lack of knowledge or skill justifying an

adverse judgment about the practitioner's professional capacity or fitness to practise in the particular field of expertise involved".

Applying these principles, the Tribunal was prepared to conclude that the practitioner may be found to have acted incompetently in relation to a single instance, but on balance they were not satisfied that the conduct on that occasion relevantly amounted to "acting incompetently". Consequently, the Tribunal considered that the appropriate orders were a reprimand and a requirement that the practitioner act in accordance with the conditions of his registration.

In **Medical Board of Australia v Bernadt** [2012] WASAT 108, the Board alleged as against the practitioner, and ear nose and throat surgeon, that he was guilty of carelessness, incompetence, or conduct falling short of the standards that the public may expect, in the treatment of a 2½-year-old patient. It was alleged that the practitioner failed to take an adequate history of the infant patient before performing an adenoidectomy and that he knew or ought to have known that the child had a cleft palate and that adenoidectomy was contraindicated in a child with that condition.

It was accepted by the practitioner and all three experts called in the proceedings, that two anatomical markers, present in the infant patient, were indicators of the presence of a cleft palate. The practitioner denied that he actually knew of the existence of the cleft palate at the time of the operation. The experts agreed that three anatomical markers were identifiers of a cleft palate.

The Tribunal stated at [51]:

> In our view, in a context where … (the practitioner) had experienced some difficulty in obtaining an adequate history prior to the operation, his discovery, at the operation of … (one of the anatomical markers) coupled with his knowledge of … (a second anatomical marker), required that he not proceed with the operation. If, as appears to be the case, on palpating … (the first anatomical marker), … (the practitioner) dismissed its significance on the basis that … (such a marker) may be present in the absence of a cleft palate, we considered that he acted carelessly in doing so.

…

The carelessness was, we consider, a departure "from elementary and generally accepted standards of which (the practitioner) could scarcely be heard to say that he was ignorant …"

The Tribunal concluded that the practitioner should have taken "a more complete history" and engaged in "more thorough questioning" of the patient's parents; whilst this was not the practitioner acting incompetently, the Tribunal considered that he acted carelessly in the relevant sense.

Criminal Conduct

In **I v Medical Board of Australia** [2011] SAHPT 18, the practitioner was charged with two sexual offences and action was taken to immediately suspend his registration, on the basis that the Board reasonably believed that because of his alleged conduct, he posed a serious risk to persons and it was therefore necessary to suspend his registration to protect the public. The practitioner appealed against that decision. The practitioner had been charged with two counts of indecent assault upon two separate female patients occurring in March and July 2010. He denied the allegations. He was charged with the first count and gave certain undertakings to the Medical Board that he would not treat or consult female patients over the age of 10 years and those under 10 years were to be accompanied by a parent or guardian.

Approximately one month after giving the undertakings, the practitioner was charged with the second offence and shortly thereafter a report was provided to the Board indicating that he had on three occasions, consulted with a female patient over the age of 10 years. In addition, there was evidence before the Tribunal that the practitioner had made 19 calls to the female patient the subject of the second count in the two months following the consultation.

The Tribunal at [26] considered that the proper approach to the matter was on the basis that an immediate action order did not entail a detailed inquiry. It required

action on an urgent basis because of the need to protect the public. The Tribunal stated at [27] and [28]:

> 27. The Tribunal adopts the approach of the New South Wales Supreme Court in **Lindsay v New South Wales Medical Board** as authority for the proposition that material upon which an immediate action order might be based may "include material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations".
>
> 28. That matter refers to other authority which indicates that the body in question is not embarking on a fact-finding exercise. The rules of evidence do not apply but it is up to the Tribunal to look at the allegations in question and consider the source and the potential seriousness of any complaint. A complaint that is trivial or misconceived on its face, will clearly not be given weight and the nature of the allegations will be highly relevant to the issue of whether an order is justified.

The Tribunal stated at [31]: "… section 156 (of the National Law Act) clearly contemplates immediate action in certain situations where it is necessary to protect the public even before the sometimes lengthy criminal process is complete. The appellant's submissions seem … to eviscerate section 156 and substantially defeat its purpose". Furthermore, the Tribunal concluded at [44]:

> There is a significant cause for concern of possible harm or danger to the health or safety of others. … (The Tribunal is) of the view that: "It is inimical to the safety of persons for them to be exposed to the potential of the same type of conduct complained of and there is more than one complaint and they are similar".

In **Medical Board of Australia v Smith** [2013] QCAT 52, the practitioner pleaded guilty to two charges of burglary, the circumstances of which were that his sister prevailed upon him to recover certain property that she thought a former friend had stolen from her. The practitioner and another male armed with baseball bats forced their way into two homes on the one night in their attempt to locate and secure the property. In doing so they terrorised a number of people. The practitioner was sentenced to a 12 month suspended sentence, the sentencing judge accepting that he was suffering

from an un-diagnosed post-traumatic stress disorder. The Tribunal noted that the offences and the psychiatric condition called into question the practitioner's suitability to practise.

Additionally, the Board relied upon evidence of previous offences which the practitioner had disclosed to it when he was first registered, namely drug possession and driving charges.

The Tribunal determined that notwithstanding evidence that the practitioner was contemptuous of the victims of these offences and showed no empathy for the effect of his conduct on them and notwithstanding that his insight into how he came to offend in this way was superficial, that it was appropriate to allow him to practise subject to conditions.

Other

In **Vatsyayann v Professional Conduct Committee of the New Zealand Medical Council** [2012] NZHC 1138, Priestley J of the High Court of New Zealand considered an appeal by a medical practitioner against findings of professional misconduct made by the Committee. The appellant's practice attracted considerable interest and attention because it offered "free" medical consultations and treatment. Four charges were preferred against the appellant and each of them was established. The first charge related to the enrolment of patients in the appellant's clinic without their informed consent. A large number of patients were involved. That charge arose out of the online enrolment requirements of the publicly funded healthcare scheme under which medical practitioners have to enrol their patients to receive per capita funding.

By way of background, in the mid-2000s, public health funding in New Zealand changed from paying doctors for each visit by a patient to a system whereby medical practitioners enrolled patients on their publicly funded health scheme register and received funding for that patient (regardless of the number of visits) on a per head or capitation basis. The amount of capitation payments was driven not only by the

number of enrolled patients but also by other variables such as age, sex and ethnicity. Capitation payments were paid to medical practitioners on a monthly basis.

The evidence disclosed that after a review of the registers, some unusual information was unearthed: for example on one day, 269 patients had been enrolled in the appellant's practice and on the same day, some 274 patients had reported consultations at the clinic. A selection of 45 patients enrolled in this fashion showed the following: four had never been to the appellant's clinic although a family member had visited and was enrolled; four patients had died before the time of enrolment; patients who had never attended the clinic at all and patients who had received flu vaccinations from the appellant at their place of work but not at the clinic. [In challenging the penalty, the appellant drew attention to the adverse publicity including "a tabloid type billboard of the New Zealand Herald "Dr signed up dead for cash""].

The second charge related to consultations which allegedly took place in the appellant's surgery whilst another patient was behind a curtain and these arrangements were allegedly inadequate to protect patients' privacy.

The third charge related to a number of procedures carried out by the appellant's wife who had trained and qualified as a dentist in India, but was not registered in New Zealand as a nurse or enrolled nurse. She was however trained in New Zealand as a technician who could extract blood for medical purposes.

Furthermore, it was alleged that the appellant's wife carried out a number of medical/clinical procedures which could only be carried out by a qualified nurse. Finally it was alleged that the appellant kept inaccurate clinical records which indicated that he had provided treatment or procedures which had in fact been provided by his wife.

The Tribunal found all the charges against the appellant proved. In considering the first complaint, the Tribunal was satisfied that 44 to 45 patients had been enrolled without their knowledge and informed consent. The Tribunal rejected the appellant's

explanations which included IT problems, errors on the part of the insurer, computer operator errors and mistakes and the general complexity of what was called a "bewildering" process.

As to the charge relating to patient privacy, the Tribunal accepted evidence which showed that the appellant consulted his patients in a large consulting room. At the far end of that room, there was a partition in a temporary fashion, initially by a cupboard and later (after a complaint) by a curtain. Various patients deposed that the appellant's wife had performed smear tests on them in the curtained-off area whilst the appellant and another patient were on the far side of the curtain. The Tribunal accepted that there was overwhelming evidence that this was a regular practice which had occurred over a period of years.

The Tribunal was also satisfied that the appellant's wife was an unqualified person and carried out inappropriate medical/clinical procedures on patients. The evidence suggested that a considerable number of the patients of the practice were from immigrant groups whose command of English and the knowledge of medical hierarchies was poor.

In the event, the Tribunal cancelled the appellant's registration, censured him and ordered him to pay $256,000 in costs. Priestley J noted that the costs award was the highest award ever made in New Zealand by a Tribunal against a medical practitioner.

In dealing with the issue of penalty, the Tribunal noted that the conduct in relation to the first charge occurred over a long period of time, it had resulted in adverse consequences for patients, and it had resulted monies being received by the practitioner which he was not justified in receiving from a public source. The Tribunal considered that a clear message must be sent to the profession that offences of dishonesty against the public insurer will not be tolerated and would be treated seriously with significant penalty.

The appellant did not give evidence in the proceedings, ostensibly because he asserted that his daughter who was assisting him in the hearing, threatened to walk out if he did. That submission was rejected. Furthermore, the appellant did not attend the penalty hearing because he was conducting a thirty-three day hunger strike which was described as a traditional high profile form of protest in India. In the final analysis, Priestley J concluded that the Tribunal was justified in acting as it did in relation to penalty, based on the material before it. His Honour concluded that because of "his stupid decision to absent himself from the Tribunal's penalty hearing," he did not have the opportunity to advance any appropriate mitigating factors. His Honour considered that as a matter of fairness, the appellant should be extended the opportunity of doing so.