PROTECTING THE PUBLIC?
AN ANALYSIS OF COMPLAINTS AND DISCIPLINARY PROCEEDINGS AGAINST DOCTORS IN AUSTRALIA AND NEW ZEALAND

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ABSTRACT

The professional regulation of doctors is commonly justified as necessary for the protection of the public. However, the degree to which regulatory decision-making is actually consistent with public protection considerations is unclear. The impact of other influences, such as the wider public interest in ensuring an adequate supply of doctors in the workforce, is also unknown. This thesis uses empirical analyses of the complaints and disciplinary mechanisms of the Australian and New Zealand medical regulatory frameworks to explore these questions.

The first empirical study is an analysis of the 485 determinations made by medical tribunals between 2000 and 2009 in the four most populous states of Australia and in New Zealand. The characteristics of the doctors involved are described, together with the characteristics of the cases. The nature of the misconduct at issue is analysed according to a new typology that is more refined than previous typologies and, for the first time, considers misconduct according to both its type and the underlying reason for that misconduct. Disciplinary sanctions imposed by the tribunals are explored in some detail, with removal from practice given special attention due to the unique role of that sanction in protecting the public. The results lead the author to question whether the potential for rehabilitation is being weighted too heavily by the tribunals, and whether this may indicate that other considerations (such as doctor supply and the doctor’s own interests) are being allowed to obscure the primary goal of public protection.

The second empirical study investigates 5,323 complaints made to medical boards in Victoria and Western Australia between 2001 and 2008. Again, the characteristics of the doctors concerned are analysed, with particular attention paid to how those characteristics appear at different stages of the complaints and disciplinary process. A focus of the second study is doctor country of training, which is considered in a more nuanced way than ever before. Due to the regulatory response to doctor shortage in Australia, this doctor characteristic is of contemporary significance, including in relation to what it reveals of the tension between public protection and the wider public interest. The increased risk of complaints and disciplinary proceedings among international medical graduates suggests that more may need to be done in ensuring that
the approach to the registration, support and supervision of such doctors does not expose the public to risk. The apparent association between elevated complaints risk and doctors from specific countries of training is highlighted as deserving of further study and analysis.

As well as being instructive as to the priorities and operation of the complaints and disciplinary system, the knowledge gained through the empirical studies may be useful to medical boards in furthering their public protection agendas. In summary, the results indicate that the risk of being subject to complaints and/or disciplinary action is particularly elevated for doctors who: are male; specialise in obstetrics/gynaecology; psychiatry or general practice; obtained their primary medical qualification outside of Australia or New Zealand; hold general registration; and have previously come to the negative attention of the regulator. In terms of case characteristics, the first study shows that sexual misconduct, illegal or unethical prescribing, and inappropriate or inadequate treatment are the most common issues leading to disciplinary action. This increased knowledge may move regulators one step closer to being able to proactively identify of ‘at risk’ doctors and behaviours, thus allowing them to target training, support and interventions towards such doctors and concerns.
DECLARATION

This is to certify that:

a) the thesis comprises only my original work towards the PhD except where indicated in the Preface;

b) due acknowledgement has been made in the text to all other material used; and

c) the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

______________________________________  __________________
Katherine Jane Elkin                        Date
PREFACE

Chapters 6, 7, 8 and 9 of this thesis contain sections of three published co-authored papers. I contributed 70% of the content of the work contained in those papers and am the primary author of each paper. I wrote the original draft of the papers and performed subsequent editing in response to the contributions of my co-authors and editors. Copies of each of these papers are included as appendices to this thesis.

A small section of chapter 4 and a section of chapter 9 of this thesis (as indicated in footnotes to the text) contain some material that I wrote and submitted as part of an assignment for a course that contributed towards my Graduate Diploma in Health and Medical Law.

The opinions and conclusions expressed in this thesis are my own and do not necessarily reflect those of my past or current employers.
ACKNOWLEDGEMENTS

Thank you to the Medical Practitioners Board of Victoria and the Medical Board of Western Australia (as they then were) for the generous provision of their complaints and registration data that formed the basis of one of the empirical studies.

I am very grateful to my supervisors. First, to Professor David Studdert, my principal supervisor, for his guidance and support, particularly as I planned and conducted the empirical studies, through to eventual publication. Thanks also to David for the scholarship that I enjoyed in connection with his ARC Federation Fellowship. I would also like to thank Professor Lesleyanne Hawthorne, my other main supervisor, for her wisdom, enthusiasm and encouragement as I have progressed through the process of completing the thesis. Associate Professor John Howe has also been involved in my supervision, and I thank him for the valuable insights that he has offered on parts of the thesis. I am very grateful for all of my supervisors' flexibility and understanding as my circumstances have changed and competing demands have taken priority over the years, and for continuing to offer me opportunities that have enriched my PhD experience. Thanks also to Professor Jane Pirkis for the role she played as my Advisory Committee Chair.

To the other co-authors of the research papers encompassed within this thesis, thank you too: Dr Matthew Spittal, for your patience and optimism as we worked together through many statistical complexities; and David Elkin, for all your work in reading and coding the cases, and discussing them endlessly with me. Thanks also to Zsofia and Diana for their assistance with various tasks.

There are a number of people who were instrumental in me beginning this journey, who inspired me and encouraged me to follow my dreams. Thanks particularly to the following colleagues and friends: Karen, Paul, Megan, Viv, Deb, Dr Marty and Rochelle, Tony, Steph, and Cath and Dave. And to those who have helped me get through to the end, including Miriam and Nathan, Maggie, Andrea, Sarah, Lynley and Michael, Jono and Lucy, Jo, Logan, Mary, Anthony, Aaron and Kerry.
Completing this thesis, and all of the empirical research it contains, has involved significant sacrifice, not just for me but for many of my friends and family. I have been frequently preoccupied, late, tired, and, at times, absent. But the support, love and encouragement have not wavered. Thank you all. To my parents, who are always there, good days and rough days alike, and who brought me up to believe I could do anything I set my mind to, thank you. To my parents-in-law, in particular for the hours of PhD-related childcare and other assistance you have provided, thank you too. To my dearest friend, Diana, thanks for being you. To my two amazing boys, Joshua and Samuel, thank you for keeping me sane, for being forgiving and accommodating, and for loving me without reserve. I look forward to spending a lot more time with you instead of with the PhD!

Finally, my greatest thanks and most heartfelt admiration goes to my incredible husband of 15 years, David. Dave, we both know that this could never ever have happened without you. This is your PhD as much as it is mine. Thank you for keeping me strong and focussed, and for doing so much more than your share of everything else.

Phil 4:13.
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<tr>
<td>Advisory Council</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>AHPRA</td>
<td>Australian Health Practitioners Regulation Agency</td>
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<td>AMC</td>
<td>Australian Medical Council</td>
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<tr>
<td>APC</td>
<td>Annual practicing certificate</td>
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<td>CAC</td>
<td>Complaints Assessment Committee</td>
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<td>CoAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CPD</td>
<td>Continued professional development</td>
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<td>FSMB</td>
<td>Federation of State Medical Boards</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>HCCC</td>
<td>Health Care Complaints Commission (NSW)</td>
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<td>HDC</td>
<td>Health and Disability Commissioner (NZ)</td>
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<td>HPCA Act</td>
<td><em>Health Practitioner Competence Assurance Act 2003</em> (NZ)</td>
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<td>HPDT</td>
<td>Health Practitioners Disciplinary Tribunal (NZ)</td>
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<td>HQCC</td>
<td>Health Quality and Complaints Commission (Qld)</td>
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<td>HSC</td>
<td>Health Services Commissioner (Vic)</td>
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<td>IMGs</td>
<td>International medical graduates</td>
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<td>MBoA</td>
<td>Medical Board of Australia</td>
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<tr>
<td>MCNZ</td>
<td>Medical Council of New Zealand</td>
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<tr>
<td>MPDT</td>
<td>Medical Practitioners Disciplinary Tribunal (NZ)</td>
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<td>National Law Act</td>
<td><em>Health Practitioner Regulation National Law Act 2009</em> (Qld)</td>
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<td>NCAS</td>
<td>National Clinical Assessment Service (UK)</td>
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<td>NSWMT</td>
<td>New South Wales Medical Tribunal</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<tr>
<td>PCP</td>
<td>Professional Conduct Committee</td>
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<td>PCRP</td>
<td>Professional Conduct Review Panel</td>
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<td>PESCI</td>
<td>Pre-employment Structured Clinical Interview</td>
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<td>PSC</td>
<td>Professional Standards Committee</td>
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<tr>
<td>PSP</td>
<td>Professional Standards Panel</td>
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<tr>
<td>QCAT</td>
<td>Queensland Civil and Administrative Tribunal</td>
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<td>RACS</td>
<td>Royal Australasian College of Surgeons</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>RANCOG</td>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
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<td>The Scheme</td>
<td>National Registration and Accreditation Scheme</td>
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<td>VCAT</td>
<td>Victorian Civil and Administrative Tribunal</td>
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<td>Western Australia State Administrative Tribunal</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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CHAPTER 1 – INTRODUCTION

Professional regulation is commonly justified, including by regulators themselves, as being necessary for the protection of the public. This is particularly so in the area of medical professional regulation. It is an easily acceptable proposition that rogue doctors will expose patients to harm and that regulating medical practice offers a measure of protection from such risk. However, the extent to which the decision-making of medical regulatory bodies is consistent with public protection considerations has not, as yet, been empirically analysed. Are there, for example, other objectives and agendas that influence that decision-making equally, or more so, than public protection?

The aim of this thesis is to study key parts of the complaints and disciplinary mechanisms of the Australian and New Zealand systems of medical professional regulation in order to gain a clearer, empirically robust understanding of the:

a) nature of the complaints and cases that come before the medical boards and tribunals;
b) characteristics of the doctors concerned;
c) relationship between the doctor characteristics and type of misconduct;
d) basis for the disciplinary decision-making; and

in so doing:
a) analyse the extent to which the operation of the complaints and disciplinary system appears to be consistent with, and effective in promoting, public protection; and
b) test the effectiveness of other selected parts of the regulatory system, in particular registration and supervision requirements for international medical graduates, in protecting the public.

Chapter 2 of this thesis provides an overview of the regulatory framework for doctors in Australia and New Zealand; two countries with similar systems for regulating doctors but with some key differences that allow for comparative analysis. The next chapter describes the complaints and disciplinary systems in more detail, including the context.
in which the systems operate and the way in which they have evolved over the last decade.

Chapter 4 moves from discussing the mechanics of the relevant framework to an analysis of the purpose of that system, taking into account theoretical and legislative considerations. The dominance and robustness of the public protection rationale evident in the design of the system is also assessed. The chapter is concerned with the questions about rationale: Why regulate? Why discipline? And what, exactly, is meant by public protection and how does that differ from public interest?

Next, chapter 5 introduces the empirical studies that are at the heart of this thesis by critically reviewing similar studies in the area and highlighting the limitations of that extant research. The empirical studies are key to the thesis as they are essentially the means for analysing whether the systems at issue are delivering on their expressed objectives.

The methods, main results, and some preliminary discussion of the first of the two empirical studies ('First Study') are described in chapter 6. The First Study involves the analysis of determinations made by disciplinary tribunals over the last decade, with a focus on the characteristics of the disciplined doctors and of the cases themselves. The second empirical study ('Second Study') is described in chapter 7; it uses complaint data from two medical boards to examine complaints at the earlier stages of the complaints and disciplinary process. While the Second Study is narrower (in terms of the number of jurisdictions considered) than the First Study, it sets disciplinary proceedings in context by looking the whole spectrum of complaints that boards receive, thus allowing consideration of the impact of what is received on eventual disciplinary decision-making.

Through the two major empirical studies, a doctor characteristic (country of training) and a case characteristic (the disciplinary outcome of removal from practice) of particular significance for public protection are identified. Additional results relating to those characteristics are presented in chapters 8 and 9, along with a more in-depth analysis of the public protection implications of each.
Doctor country of training is a doctor characteristic that has been the subject of much speculation over previous years. Chapter 8 looks in more depth at the regulatory system as it pertains to international medical graduates (IMGs), including differential barriers to entry, along with the supply and availability aspects of public interest.

Chapter 9 explores the critically important case characteristic of removal from practice and the other case characteristics, such as the nature of misconduct, that are associated with that disciplinary outcome. The tribunal decisions involving sexual misconduct are used as a case study for advancing understanding of the factors that appear to drive disciplinary decision-making and the relationship between those factors and public protection considerations.

In a short final chapter, conclusions are drawn and recommendations made for further research, and possible legislative and policy change.
CHAPTER 2 – THE REGULATORY FRAMEWORK

I INTRODUCTION

The professional regulation of doctors in Australia and New Zealand is predominantly the domain of medical boards and councils; statutory entities with a structure and function designated by the relevant legislation.¹ These medical boards are responsible for each of the three main areas of regulation:

a) registration of doctors ï determining entry to the profession;
b) regulation of practising doctors ï by, for example, issuing annual practising certificates, imposing continued professional development requirements, and assessing ongoing competence; and
c) management of doctors identified as potentially problematic ï addressing competence, fitness to practice and conduct concerns, including managing the complaints and disciplinary process.

This chapter begins by describing the structure and general mandate of the medical boards throughout Australia and New Zealand.² It then goes on to provide an overview of how the regulatory system operates in respect of the first two of the above three areas, putting the medical boards' role in context and explaining its basis and parameters. The management of potentially problematic doctors, particularly through the complaints and disciplinary system, is the subject of the next chapter and, indeed, the focus of the remainder of this thesis.

¹ In Australia, the term medical board is used; in New Zealand, it is the medical council. Throughout this thesis, where referred to generically, the term medical board is used.
² Both at the time of the empirical studies and now.
II  MEDICAL BOARDS

A  Australia

I  State-based medical boards

Until recently, every state and territory of Australia had its own medical board, each established according to its own Act. On 1 July 2010, these medical boards were amalgamated into the Medical Board of Australia as part of the implementation of the national accreditation and registration scheme (Nationalisation), as discussed later in this chapter. However, as the empirical studies reported in this thesis (the Studies) draw on data from the decade prior to Nationalisation, it is important to also understand the way in which the state medical boards operated during that time.

This thesis, largely for reasons of data availability, focuses on the four most populous states of Australia: New South Wales, Victoria, Queensland, and Western Australia which, together, account for over 85% of all registered doctors in Australia. The medical boards that operated historically in each of these states (and were in operation for all or part of the decade of interest) are described briefly in the following section. Broadly, each of the medical boards carried responsibilities for registering doctors (including assessing their suitability for registration and formulating conditions on registration where appropriate), for ensuring ongoing competence and safety of those practising, and for managing potentially problematic registrants, for example by receiving complaints, undertaking performance assessments and invoking more serious disciplinary processes as necessary.

Over the ten year period of interest, many of the States had changes in their legislation, commonly leading to newly constituted boards with more explicit public protection objectives.

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a) New South Wales

Prior to Nationalisation, doctors in New South Wales were subject to the *Medical Practice Act 1992* (NSW). Under s 129 of that Act, the New South Wales Medical Board (NSW Board) consisted of 20 members, including both doctors and lay members. As well as the functions conferred and duties imposed on it under the Act, the NSW Board was charged with promoting and maintaining high standards of medical practice in New South Wales.  

b) Victoria

The Medical Practitioners Board of Victoria (Vic Board) was established by s 65 of the *Medical Practice Act 1994* (Vic) and given specific powers and functions to regulate doctors in that state. In 2005, that Act was repealed and replaced by the *Health Professions Registration Act 2005* (Vic) which, unlike the 1994 Act, did not just regulate doctors but a range of other health professionals – namely, nurses, dentists, chiropractors, optometrists, osteopaths, physiotherapists, podiatrists, psychologists, Chinese medicine practitioners and medical radiation technologists. Under the 2005 Act, the Vic Board continued in operation in much the same form as it had done under the previous legislation. Under s 119(1)(b) of the 2005 Act, however, it was made explicit, in a way not done in the 1994 Act, that in carrying out any of its functions and exercising any of its powers, the Vic Board was required to have regard to the following objectives:

a) promoting the safe use of regulated health services and medicines;
b) minimising the community’s exposure to health risks associated with the provision of regulated health services; and
c) promoting the community’s access to regulated health services.

c) Queensland

The *Medical Act 1939* (Qld) established the Medical Board of Queensland (Qld Board) that remained in operation until 2001. That Act was repealed by the *Medical Practice Act 1992* (NSW), s 132(2)(a).
Practitioners Registration Act 2001 (Qld), s 9 of which established a new Qld Board as the legal successor to the former board, but with the same membership.\(^5\) As was the case in Victoria, the newer legislation set out more express expectations as to the functions of the new Qld Board, including that it promote high standards of practice of the profession by registrants\(^6\) Section 12 also contained the requirement that the Qld Board act in the public interest when performing its functions under the Act.

d) Western Australia

In Western Australia, the Medical Act 1894 (WA) established that state’s medical board and continued to govern its operation until more than 100 years later when the Act was repealed and replaced by the Medical Practitioners Act 2008 (WA).\(^7\) The new board established under s 6 of the 2008 Act (WA Board) was a continuation of, and the same legal entity as, the former Board ...\(^8\) Again, the new legislation was more explicit as to the functions of the new WA Board, including bestowing on it the responsibility to promote and encourage ... increased levels of skill, knowledge and competence in the practice of medicine\(^9\)

2 Nationalisation

a) From conception to implementation

In 2005, the Productivity Commission, in a report commissioned by the Federal Government, recommended that a single national registration board be established for all health workers. It was envisaged that the national registration board would replace the more than 90 separate boards operating at that time across the states and territories and the multiple health professions in Australia.\(^10\) The main aim of the proposed

\(^5\) Medical Practitioners Registration Act 2001 (Qld), ss 283 and 289.

\(^6\) Medical Practitioners Registration Act 2001 (Qld), s 11(e).

\(^7\) The 1894 Act was, however, amended many times during that period, including seven separate amendments to s 4, the section that was eventually entitled Constitution and proceedings of Medical Board.

\(^8\) Medical Practitioners Act 2008 (WA), s 4(1).

\(^9\) Medical Practitioners Act 2008 (WA), s 11(f).

\(^10\) Productivity Commission, ‘Australia’s Health Workforce: Productivity Commission Research Report’ (22 December 2005), pxxv. Those boards separately governed various types of health workers including doctors, nurses, dentists, psychologists, and pharmacists: see chapter 4 for further detail on which professions were regulated. Among these boards were seven state or territory medical boards, including the four described above.
change was to address a number of problems arising from the existing fragmented system, namely variations in standards across the country, administrative duplication, and impediments to the movement of health practitioners from one state to another.\textsuperscript{11} In July 2006, the Council of Australian Governments (CoAG) adopted the Productivity Commission\textsuperscript{a} recommendation and agreed to establish a National Registration and Accreditation Scheme (the Scheme).\textsuperscript{12}

However, CoAG does not itself have the power to pass legislation; it must rely on its members to do so. In Australia, certain matters (as provided for in the Australian Constitution) are set aside for legislation by the Federal Government, while all other matters are state responsibility.\textsuperscript{13} While successive reforms have increased federal responsibility for, and funding of, healthcare and hospitals in recent years,\textsuperscript{14} professional regulation remains the statutory responsibility of states.\textsuperscript{15} Consequently, in order to establish the Scheme, legislation at state-level was required across the various states and territories. Thus began a National Law Model of legislative reform across Australia.\textsuperscript{16}

First, in November 2008, the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Qld), was passed in the Queensland Parliament, giving effect to the administrative arrangements necessary for the implementation of the Scheme. Next, in November 2009, the Queensland Parliament passed the *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law Act) which continued those administrative arrangements and provided for the full operation of the Scheme. Then other states and territories passed their own similar Acts, also adopting the National Law Act or very similar variants of it. Each of the National Law Acts

\begin{itemize}
  \item \textsuperscript{11} Ibid, pxxv.
  \item \textsuperscript{12} Council of Australian Governments, 'Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions' (CoAG, 2008).
  \item \textsuperscript{13} Commonwealth of Australia Constitution Act 1900 (Cth).
  \item \textsuperscript{14} Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2010).
  \item \textsuperscript{15} Ibid.
  \item \textsuperscript{16} For further detail on the process of legislative enactment across the states and the rationales behind the method, see Louise Morauta, 'Implementing a COAG Reform Using the National Law Model: Australia’s National Registration and Accreditation Scheme for Health Practitioners' (2011) 70(1) *Au Jnl of Public Admin* 75.
\end{itemize}
came into effect on 1 July 2010, thus giving effect to the Scheme. This complex process of separately-enacted prototype legislation needed to implement the National Scheme has been described by some critics as ‘federation politics gone mad’.

b) New national structure

Under the Scheme, there is a now a national structure for the regulation of health practitioners in Australia, as illustrated in Figure 1. At the head of the structure is a Ministerial Council consisting of the Health Ministers from each state/territory. The Ministerial Council is advised by the independent Australian Health Workforce Advisory Council. Under the Ministerial Council sit the Agency Management Committee and fourteen national profession-specific boards (the National Boards), including the Medical Board of Australia (MBoA). The Agency Management Committee governs the Australian Health Practitioners Regulation Agency (AHPRA). AHPRA supports the National Boards through administrative assistance and the development of standards and requirements.

AHPRA has a national office (based in Melbourne) as well as at least one local presence in each state and territory. The national office of AHPRA maintains the new national register of health practitioners, while local offices are responsible for processing registration applications, receiving and managing complaints, monitoring conditions and managing impaired health practitioners.

While most states were ready to begin operating under the Scheme on that date, Western Australia took a little longer to pass the required legislation, finally entering the Scheme on 18 October 2010. In this thesis section references and quotes from the National Law Acts are, in fact, from the Queensland Act. However, where there is a relevant and material difference between states, that difference is noted. Most notably, New South Wales did not adopt the Scheme in its entirety, retaining its own separate system for disciplinary matters: see p69 for further detail.


Note that the following four professions only became part of the Scheme as of 1 July 2012: Chinese Medicine practitioners, Medical Radiation practitioners, Occupational Therapists, and Aboriginal and Torres Strait Islander health practitioners.

It also provided information and advice to the Ministerial Council regarding the implementation of the Scheme: *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (Qld), s 20.

AHPRA and the National Boards have jointly developed a National Registration and Accreditation Scheme Strategy 2011–2014 which sets out AHPRA’s vision, mission and strategic priorities for the Scheme. The stated vision is for a ‘competent and flexible health workforce that meets the current and future needs of the Australian community’, while the mission is ‘to regulate health practitioners in Australia in the public interest’. Two of the values identified relate particularly to public interest and safety: to ‘act in the interests of public health and safety’ and to ‘promote safety and quality in health practice’. According to its website, AHPRA’s ongoing priorities include supporting the National Boards in their ‘primary role of protecting the public’.

The National Boards are largely comprised of members of the profession they regulate, but each must also include at least two community members. The functions of the National Boards include (through local and national committees, where necessary)
managing registration functions, complaints and disciplinary processes, accreditation of courses of study, and assessment of internationally trained practitioners. However, the actual management of disciplinary investigations is now being undertaken by AHPRA on behalf of the National Boards.

The transition to the new national structure was not without difficulty, with many reports citing long delays in registration processing and other functions, leading to implications for registration status and Medicare rebate eligibility. As a result, on 23 March 2011, the Australian Senate referred the administration of AHPRA to the Finance and Public Administration References Committee for inquiry and report (the Senate Inquiry). The Senate Inquiry focussed on the capacity, ability, and performance of AHPRA in carrying out its registration functions, the impact of AHPRA’s processes, and AHPRA’s financial viability. The Senate Inquiry received almost 300 submissions and released its report in June 2011. The report is damning of AHPRA’s achievements during its first year, using language such as ‘deplorable’, ‘unacceptable’, ‘inefficient’, and ‘detrimental’ to describe the Senate’s view of the agency’s performance. The report makes ten recommendations for improvement to AHPRA’s processes, including that AHPRA apologise to practitioners who were deregistered as a result of AHPRA’s administrative shortcomings.

In a media release issued in response to the Senate Inquiry report, AHPRA advised that the inquiry had not identified any ‘new issues’ that were not already being addressed by AHPRA. The Chair of the Agency Management Committee, Peter Allen, noted:

25 Council of Australian Governments, 'Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions' (CoAG, 2008).
27 See, for example, Julia Medew, 'Thousands Fail to Register after Regulation Shake-Up', The Age (Melbourne), 2 February 2011 and Kate Hagan, 'Recruitment of Overseas G.Ps ‘Threatened’', The Age (Melbourne), 27 April 2011.
28 Australian Senate Finance and Public Administration References Committee, 'The Administration of Health Practitioner Regulation by the Australian Health Practitioners Regulation Agency' (Commonwealth of Australia, 2011).
29 Ibid.
The National Scheme is a world-first regulatory reform of unprecedented scope and ambition. While the transition period was not as smooth as we had hoped, that chapter is now behind us.\(^{30}\)

AHPRA’s 2011/12 Annual Report expresses similar optimism about the future.\(^{31}\)

\(\textit{B} \quad \text{New Zealand}\)

The Medical Council of New Zealand (MCNZ) has long had national jurisdiction over the regulation of doctors in that country. Until 2004, this was via the \textit{Medical Practitioners Act 1995} (NZ) which continued the same council as had been constituted under the \textit{Medical Practitioners Act 1968} (NZ).\(^{32}\)

In September 2004, doctors were brought together with other health practitioner groups under the umbrella of the \textit{Health Practitioner Competence Assurance Act 2003} (NZ) (HPCA Act), an Act that was modelled on the \textit{Medical Practitioners Act 1968} (NZ) and so meant less change for the medical profession than for some others. Similar to the National Law Act in Australia, the HPCA Act now regulates 22 separate professions on a national basis.\(^{33}\) Until 2004, different health professions had been regulated quite separately from one another, sometimes under separate pieces of legislation, although some related professions already shared legislation and boards/councils. Upon commencement, the HPCA Act recognised the 11 pre-existing boards and councils (collectively termed Responsible Authorities), giving them statutory powers and responsibilities in terms of practitioner regulation.\(^{34}\) There are now 16 Responsible Authorities charged with implementing the provisions of the HPCA Act.\(^{35}\)

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\(^{32}\) \textit{Medical Practitioners Act 1995} (NZ), s 122(1).

\(^{33}\) These are the professions of Chiropractic, Dentistry, Dental Hygiene, Clinical Dental Technology, Dental Technology, Dental Therapy, Dietetics, Medical Laboratory Science, Medical Radiation Technology, Medicine, Midwifery, Nursing, Occupational Therapy, Optometry, Optical Dispensing, Osteopathy, Pharmacy, Physiotherapy, Podiatry, Psychology, and Psychotherapy.

\(^{34}\) HPCA Act, Part 6, ss 114-152.

The status, capacity and functions of the Responsible Authorities are set out in sections 117 and 118 of the HPCA Act. While many specific functions that relate to public protection are given to the authorities (such as the duty of notification of serious harm: s 118(g); and the duty to set standards of practice: s 118(i)), unlike many of the Australian statutes (discussed above), the HPCA Act contains no overriding, aspirational commitment as to the role of the authorities in promoting public protection. Nevertheless, the goal of public protection is explicitly recognised in the MCNZ’s own tag-line: "Protecting the public, promoting good medical practice."36 One of the main avenues through which the MCNZ (and the MBoA) can deliver on that goal is through the registration process, as discussed in the following section.

III REGISTRATION OF DOCTORS

A The practical effect of registration

Registration-based regulation of those performing particular activities is commonly achieved via licensing, certification, or a mixture of the two. With licensing, prescribed activities may only lawfully be undertaken by a person who is appropriately registered or licensed, as with for example, drivers’ licensing. Conversely, certification is where registration is not required as a precondition to lawful practice but, if held, is likely to enhance the holder’s perceived legitimacy, for example, as a ‘certified’ or ‘accredited’ provider, or where registration gives that person the legal right to use a particular title.

The difference between the impact of certification compared to licensure is clear when considering the effect of the loss of either one’s certification or one’s licence.37 While some business may be lost, a practitioner who loses certification is still entitled to practice. Not so for a practitioner who loses their licence. As noted by Lowenberg:

The ability to use the power of the state to deny a practitioner the right to practice if he engages in undesirable behaviour is what makes licensure more effective than certification in assuring quality.\textsuperscript{38}

However, the application of such ‘state power’ prima facie erodes individual rights and freedoms; not just of the practitioner who was once licensed and is no longer able to practice, but of those who have never been licensed and wish to practice, along with those who would prefer to seek the (often cheaper) services of an unlicensed provider. As the New Zealand Ministry of Health recognised when considering the operation of the HPCA Act in 2012:

The more that professions are regulated, the greater the potential for regulation to affect the volume and cost of services available to meet the needs of the public.\textsuperscript{39}

The principle of regulatory minimalism, as articulated in the National Law Act,\textsuperscript{40} dictates that restriction should only be imposed to the degree necessary (also called the principle of necessity). This means that if a particular profession commonly provides a range of services, some of which carry risk and some of which do not, it is not justifiable to restrict all of those activities (including those that carry no or negligible risk) simply because they fall within the scope of that profession’s usual practice. Such restriction may indicate a scatter-gun approach to regulation that raises suspicions that the covert intention is to protect the profession not the public interest.\textsuperscript{41}

The solution to this balancing act, in both Australia and New Zealand, has been to adopt models of health practitioner regulation that contain elements of both licensure (through the designation of ‘restricted activities’) and certification (through the use of ‘restricted

\textsuperscript{38} Ibid, p573. For a fuller evaluation of the advantages and disadvantages of certification versus licensure, see Ministry of Health (NZ), '2012 Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document' (MoH, 2012).


\textsuperscript{40} See p89.

\textsuperscript{41} Weir, 'Regulation of Complementary and Alternative Medicine Practitioners' (2006) 23(2) Law in Context, p183.
titles, albeit focussed on certification. The approach to restricted activities and restricted titles in the two countries is outlined below.

I Restricted activities

Evidently, there are some activities undertaken by doctors that are particularly risky and carry the potential for serious harm if undertaken by individuals without medical training. As a result, in both countries, a task-based or risk-based approach to licensure has been taken. Activities which have serious health implications are identified and dubbed restricted activities and those who are not appropriately registered are prohibited from undertaking such activities. In Australia, the restricted activities are various dental acts, prescriptions of optical appliances and spinal manipulation. In New Zealand, s 9 of the HPCA Act allows the Governor-General, on recommendation from the Minister of Health, to declare, by Order in Council, an activity to be a restricted activity under that Act. Such a recommendation may only be made if the Minister is satisfied that members of the public risk serious or permanent harm if the activity is performed by a person other than a member of a particular health profession practising in accordance with their scope of practice. The Minister also requires, before declaring an activity to be restricted, that:

a) no existing prohibitions or restrictions apply to the activity, for example, under the Medicines Act 1981 (NZ), the Radiation Protection Act 1965 (NZ) or the Crimes Act 1961 (NZ);

b) there are strong grounds to suggest that someone other than a registered health practitioner might undertake the activity (taking into account the specialised equipment required);

42 The 2012 review of the HPCA Act (discussed in chapter 3) is intended to expressly address whether the current balance is appropriate: Ministry of Health (NZ), '2012 Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document' (MoH, 2012).

43 National Law Act, ss 121-123. Note that these restricted activities may be carried out by registered doctors or other health professionals, as dictated by the legislation.

44 HPCA Act, s 9(3).

c) the activity is, in principle, one capable of being done to a person as opposed to an activity that does not itself involve contact with a person; and

d) the words used to describe the activity do not inadvertently prevent an established but unregistered professional group from continuing to safely perform that activity.

Currently, the restricted activities are various surgical, operative and orthodontic procedures, the prescription of enteral or parenteral nutrition, the prescription of ophthalmic or optical devices, and various spinal manipulation techniques.\(^46\)

To the extent that an activity is not specifically restricted, it may be undertaken by health professionals and non-health professionals alike. However, as noted in a 1996 report from Queensland Health, the boundaries of such distinctions may sometimes be unclear, leading to pedantic, technical and nice questions of law on what does or does not constitute a particular practice\(^47\)

2 Restricted titles

Notwithstanding the exceptions noted above, for the most part, the Australian and New Zealand systems do not impose controls on the performing of activities themselves but on ensuring that the public are not misled as to the qualifications of the person performing those activities. Thus, the focus is on (as described in the National Law Act\(^48\)) title protections rather than practice protections\(^49\). In both countries, it is an offence for a person to use a protected title in a way that could be reasonably expected to induce a belief that they or another person is registered in a particular health profession when they are not so registered.\(^50\) In New Zealand, there is the additional


\(^{48}\) National Law Act, Part 7, Division 10.

\(^{49}\) During the process of developing the National Law Act, protection of professional title was described by CoAG as the primary basis for registration: Council of Australian Governments, 'Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions' (CoAG, 2008), cl 1.28(b).

\(^{50}\) National Law Act, s 113. See also, HPCA Act, s 7. Under the National Law Act the maximum penalty for breach of that requirement is $30,000 for an individual and $60,000 for a body corporate. Under the HPCA Act, the maximum penalty is $10,000.
requirement that a person must also hold a current practising certificate in order to lawfully use such a title for the purposes of practising their profession. 51

3 Conclusion

Medical boards are able to exert some control over the practice of doctors by determining who can undertake various activities, and who may use the title ‘doctor’ and under what conditions. The risk-based, mixed certification and licensure regime in place enables regulatory attention to be focused on areas of most risk so that the overall burden of regulation can fall whilst regulatory outcomes are maintained or even improved. 52

Initial registration processes (including the criteria used) are key to a medical boards’ decision making about the registration status of the vast majority of doctors, as the ongoing registration of most doctors is never again considered by the boards in a detailed fashion (for example, as part of a competence or disciplinary process). The next two sections of this chapter therefore examine the pathways to local registration for Australian and New Zealand medical graduates, followed by trans-Tasman registration, and then the registration processes that apply to international medical graduates (IMGs).

B Pathways to registration for Australian and New Zealand medical graduates

A local graduate must complete a number of steps in order to become registered as a doctor in Australia or New Zealand. For the most part, New Zealand graduates wanting to register to practice in Australia are treated in the same way as Australian graduates, and vice versa. This section outlines the pathway to registration for local graduates in each country, highlights the few points of trans-Tasman difference, and explores the implications of those disparities.

51 HPCA Act, s 7(2)(b).
Australian medical graduates in Australia

a) Basic medical training

In Australia, medical schools and courses in medical education are assessed and accredited by the Australian Medical Council (AMC) under contract to the MBoA. Since 2000, 10 new medical schools have been established, and the number of students in existing schools has increased. The number of medical school graduates per annum rose by 86% (from 1586 to around 3000) between 2007 and 2012, and is projected to rise to almost 4,000 by 2016. The driver for this expansion was the recognition that the supply of doctors in Australia had not been keeping pace with the ever-increasing demand for their services. In 2006, for example, Australia had 10% fewer than the average number of doctors per capita seen among OECD countries.

b) Registration

Upon graduating from an accredited medical school, a graduate will have completed the educational requirements for provisional registration as it is termed under the National Law Act. In addition to the educational requirements, a graduate must also establish that they are a suitable person to hold provisional and general registration. There are a number of bases on which the MBoA may decide an individual is not suitable for registration, including where, for any reason, the board considers that the individual is unable to practise the profession competently and safely (the suitable person test).

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53 This is provided for by the National Law Act, Part 6.
55 Department of Human Services, 'Planning for Growth in Victoria's Medical Workforce' (State Government of Victoria, 2008).
59 National Law Act, s 62. Under the previous state-specific legislation, various terms were used for the equivalent type of registration such as conditional registration in New South Wales and Western Australia: Medical Practice Act 1992 (NSW), s 5; and Medical Practitioners Act 2008 (WA), s 31.
60 National Law Act, ss 62, 63 and 55.
competence and safety, registration may be denied where, due to the individual’s criminal history, it is not in the public interest to allow the individual to practice medicine. Precisely what the public interest test is intended to add, in the context of adverse criminal history, which is not already covered by the assessment of competence and safety, is unclear. Moral, personal or reputational judgments made apart from considerations of qualification, competence, and safety in assessing applications for registration, may lead down a difficult path when it comes to legitimising regulatory restrictions on the basis that they are necessary for public protection.

The purpose of provisional registration is to enable a medical graduate to complete the 12-month internship (period of supervised practice) required to become eligible for general registration. While the number of internship positions has increased in some states/territories of Australia, it has become evident that the number of positions is unlikely to keep pace with growth in the number of medical graduates. This has the potential to, for the first time in Australian history, leave some graduates without the capacity to complete their professional training in this country.

The suitable person test, as described above in relation to provisional registration, also applies to eligibility for general registration. An individual with current general registration, is entitled to practice without restriction, unless and until any conditions or restrictions are imposed on their practice.

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63 This interplay between considerations of public safety, public protection and public interest is discussed further in chapter 4.
64 National Law Act, s 52.
65 Brendan Crotty and Terry Brown, ‘An Urgent Challenge: New Training Opportunities for Junior Medical Officers’ (2007) 186(7 Suppl) MJA S25; Department of Human Services, ‘Planning for Growth in Victoria’s Medical Workforce’ (State Government of Victoria, 2008); and The University of Sydney, Internship and Professional Registration (2009) <www.medfac.usyd.edu.au/futurestudent/internship/index.php>. Just who will miss out on internship places is a question that raises questions of law, fairness and public policy, discussed by the author and her supervisor in Katie Elkin and David M Studdert, ‘Restricted Career Paths for Overseas Students Graduating from Australian Medical Schools’ (2010) 192 MJA 517. Note that the University of Sydney website no longer (as of 15 September 2012) includes the document listed above, but now contains a statement that says internships are therefore determined by the relevant State Health Departments, not universities. These Departments have made it clear that no student is guaranteed an internship upon graduation from a medical program. See University of Sydney, Internship and Professional Regulation (2012) <www.sydney.edu.au/medicine/current-students/essential-information/medical-program/internships.php>, accessed 15 September 2012.
66 National Law Act, ss 52 and 55.
While some doctors do not seek further professional specialisation upon achieving general registration, this is becoming increasingly rare. In order to gain employment as a specialist doctor or to receive public funding as such (for example, by billing on Medicare\textsuperscript{67}), further training and specialisation, culminating in eligibility for fellowship of the appropriate specialist college is now required. This increasing focus on specialisation has been criticised, with a return to generalism being cited as one possible route to alleviating medical workforce shortages.\textsuperscript{68}

In Australia, an Australian-trained doctor who becomes a specialist continues to hold general registration albeit with additional specialist qualifications. Specialist registration\textsuperscript{69} as described in ss 57 to 61 of the National Law Act does not apply to such practitioners but is a restricted registration type that applies only to IMGs with specialist qualifications or experience but who are not eligible for general registration.\textsuperscript{69}

2 \hspace{1em} New Zealand medical graduates in New Zealand

The pathway from medical school through to general registration is similar for local graduates in New Zealand to that described above for local graduates in Australia.

a) Basic medical training

As well as accrediting medical schools in Australia, the AMC, in conjunction with the MCNZ, accredits New Zealand medical schools. There are currently two medical schools in the country, with clinical programmes in four cities. Like Australia, New Zealand also has fewer doctors per capita than the OECD average\textsuperscript{70} and has increased medical school intakes as one way of addressing that shortage.\textsuperscript{71}

\textsuperscript{67} For example, under s 19AA of the \textit{Health Insurance Act 1973} (Cth), doctors who graduated after 1996 are unable to bill on Medicare until they have successfully completed the Royal Australasian College of General Practitioners (RACGP) training programme.

\textsuperscript{68} Des Gorman and Peter Brooks, 'On Solutions to the Shortage of Doctors in Australia and New Zealand' (2009) 190(3) \textit{MJA} 152; Des Gorman, 'The Future Disposition of the New Zealand Medical Workforce' (2010) 123(1315) \textit{NZMJ}.

\textsuperscript{69} See p27.


\textsuperscript{71} New Zealand Medical Students' Association, 'Medical Student Numbers - Position Statement' (NZMSA, 2011). Reasons for the doctor shortage in New Zealand are similar to those noted above for Australia, however, the impact of migration is greater in New Zealand, including significant
The number of students accepted into medical schools in New Zealand was 285 in 2003, rising to 445 in 2011, with the number expected to reach 565 by 2014. The New Zealand Medical Students’ Association’s 2011 position statement on the increase recognises that the number of doctors needs to increase to meet demand, and agrees that this is best done through training more doctors locally and achieving self-sufficiency in supply. However, the Association argues that the increase must be accompanied by steps to ensure that the quality and accessibility of medical education in New Zealand is maintained and there is a corresponding increase in workforce places for these students to fill post-graduation.

b) Registration

After graduating with a medical degree, a New Zealand graduate becomes eligible to apply for registration with the MCNZ. New Zealand does not have as many different registration categories as Australia. Instead, the HPCA Act requires Responsible Authorities to define ‘scopes of practice’ in respect of each regulated profession. For medicine, the available scopes are general (including provisional general for an initial period), vocational and special purpose. The special purpose scope of practice is available for up to 12 months and for limited reasons, such as teaching as a visiting expert, working as a locum, or working in an emergency situation or as a visiting researcher or trainee.

Before registering a doctor (in any scope, provisional or not), the MCNZ must be satisfied not only that the applicant has a New Zealand medical degree, but that he or she is also competent to practise in the particular scope, and is fit for registration. Fitness for registration is defined in s 16 of the HPCA Act by reference to considerations that may disqualify a person from registration. Included among the

outward migration to Australia. Trans-Tasman migration and its impact is discussed in paragraph 3(c) below.

72 Ibid.
73 Ibid, p1. The concern underlying this point seems to echo the reality of the Australian situation, discussed above, where increasing numbers of medical graduates is putting significant pressure on internship availability.
75 HPCA Act, s 15(1).
disqualifications is the broad requirement that the MCNZ must refuse registration if it has reason to believe that the applicant may endanger the health or safety of members of the public. There is no public interest test for fitness for registration in New Zealand as is imposed on some of those who apply for registration in Australia.

Initial registration in New Zealand is provisional registration in the general scope. As in Australia, provisional registration is usually for a period of 12 months, during which time the holder completes a trainee internship. Post-internship, non-provisional (full) registration in the general scope continues to be the registration status for those who have chosen not to do vocational training (known as specialist training in Australia), have not yet started vocational training, or are currently undertaking vocational training. Once vocational training is completed, a doctor’s registration widens to include that vocational scope as well as the existing general scope. Doctors who are registered in the general scope in New Zealand do not transition through the provisional vocational scope of practice en route to the vocational scope; rather, the provisional vocational scope is reserved for those who have never before been registered in New Zealand at the time of applying for registration in the vocational scope (ie, IMGs, as discussed below).

3 Trans-Tasman registration

a) Migration as an intern

Due to medical schools in Australia and New Zealand all being accredited by the AMC, qualifications from those institutions are recognised interchangeably across the Tasman. At the end of medical school, a graduate of an Australian medical school may apply to do their intern year in New Zealand, just as a graduate of a New Zealand medical school may apply to do theirs in Australia. However, while this is technically permitted, transferring graduates are likely to find themselves prioritised well below local

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76 HPCA Act, s 16(1)(h).
77 Medical Council of New Zealand, 'Policy on Registration in New Zealand' (MCNZ, 2011)
graduates on internship allocation lists. In Australia, due to the predicted shortage of intern positions, this may, in time, mean that graduates of New Zealand medical schools will effectively be unable to obtain internships in Australia.

b) Migration as a fully qualified doctor

Once a locally-trained doctor has successfully completed their internship in Australia, they are entitled to registration in the general scope in New Zealand, without any provisional period, despite never having been registered in New Zealand. Registration will only be granted, however, if the doctor intends to practice in New Zealand. Similarly, a New Zealand trained doctor who has completed their internship in New Zealand is, on migration, eligible for general registration in Australia.

Trans-Tasman migration of doctors who have become fellows of specialist colleges is facilitated by the fact that many of the medical speciality colleges are joint Australia and New Zealand colleges anyway, for example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANCOG). The result is that specialist standing in one country is generally recognised in the other.

c) Implications of trans-Tasman arrangements

The mutual recognition of medical professional status across the Tasman is one of the factors responsible for the considerable flow of doctors between Australia and New Zealand.

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78 In Australia, graduates are not offered intern training positions solely based on merit. Rather, each state has developed its own criteria for allocating intern training positions, depending on place of graduation and citizenship. Generally, Australian permanent residents or citizens who are graduates of a university within the relevant state or who completed their final year of secondary schooling in that state get first priority. Second priority typically goes to Australian permanent residents or citizens who are graduates of medical schools in other states or in New Zealand: Katie Elkin and David M Studdert, 'Restricted Career Paths for Overseas Students Graduating from Australian Medical Schools' (2010) 192 MJA 517.

79 See Ibid.

80 Medical Council of New Zealand, 'Policy on Registration in New Zealand' (MCNZ, 2011).

81 Ibid.

82 Ibid; Medical Board of Australia, General Registration (2011) <http://www.medicalboard.gov.au/Medical-Registration/General-Registration.aspx>. Note that, unlike all other registered health professionals, mutual recognition is through the National Law Act and the HPCA Act only, not through the Trans Tasman Mutual Recognition Act 1997 (NZ), which does not apply to doctors.

83 A notable exception is General Practitioners who have separate colleges: the Royal Australian College of General Practitioners (RACGP) and the Royal New Zealand College of General Practitioners (RNZCGP).
Zealand. However, while the recognition of status is mutual, the resulting benefit of migration is not, as the number of New Zealand trained doctors migrating to Australia far outweighs the number migrating in the other direction. As noted above, both New Zealand and Australia currently face shortages in their supply of doctors, with both countries plugging the gaps in their workforce with imported doctors. While Australia’s situation is assisted by New Zealand trained imports, New Zealand’s situation is being made worse.

In 2009, over 2100 New Zealand trained doctors were working in Australia; a number equivalent to five times New Zealand’s annual graduate pool. In contrast, latest figures show that only 339 Australian trained doctors hold annual practising certificates in New Zealand; about a tenth of the Australian annual graduate pool. Reasons for this uneven migration are varied, with higher salaries in Australia generally being cited as the principal driver. Not only does New Zealand lose its own graduates to Australia, but IMGs arriving in New Zealand often do so with the intention of eventually moving to Australia; a feat that is more easily achieved once New Zealand citizenship has been secured.

Whatever the reason, the detrimental impact of trans-Tasman migration on the New Zealand healthcare system (that is, contribution to worsening doctor shortage) is undeniable and seems set to increase, with one of the remaining encumberances to practice for NZ trained doctors in Australia having recently been removed. Until 1 April 2010, despite being eligible for registration, New Zealand trained doctors were

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86 ‘Salary Gap Sends Nz Doctors Packing’, TVNZ News 9 August 2010 <http://tvnz.co.nz/health-news/salary-gap-sends-nz-doctors-packing-3688712>; and Hayden Donnell, ‘Three-Fold Increase in Doctors Heading to Oz - Recruiters’, New Zealand Herald (Auckland), 15 February 2011. Note that medical migration from New Zealand to Australia is just one part of a general migratory trend. By 2010, 12% of New Zealand’s population was resident in Australia: Lesleyanne Hawthorne, ‘Competing for skills: migration policies and trends in New Zealand and Australia’ (IMSED and NZ Department of Labour, 2012).
87 Lesleyanne Hawthorne, Bob Birrell and D Young, General Practitioners in Regional Victoria (Rural Workforce Agency of Victoria, 2003), p23. See also, Lesleyanne Hawthorne, ‘Competing for Skills: Migration Policies and Trends in New Zealand and Australia’ (IMSED Research, NZ Department of Labour, 2011).
unable to recover Medicare (government funded) subsidies for services provided in the community until ten years after first being registered and becoming a permanent resident of Australia. However, New Zealand graduates (and New Zealanders graduating from Australian universities) have now been removed from the scope of that moratorium, which remains in force for other IMGs.

C Pathways to registration for IMGs

Both New Zealand and Australia are facing significant medical workforce shortages. In recent years, there has been a sharpened focus on finding domestic solutions to resolve the shortages, such as by increasing the number and size of Australian medical schools. In addition, retention of former international student has become a key source of additional medical workforce in Australia. However, these are relatively recent changes, coming after years of reliance on imported medical labour. Today, both the Australian and New Zealand health systems are heavily reliant on IMGs, to the extent that approximately 25% of the doctors currently registered to work in Australia were trained outside of Australia. In New Zealand, the percentage is over 40%, with over 80% of all new doctor registrations per year being IMGs. It is widely accepted that, without IMGs, the Australian and New Zealand health systems would be critically

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88 Health Insurance Act 1973 (Cth), s 19AB, amended by the Health Insurance Amendment (Overseas Trained Doctors) Act 2009 (Cth). The main way to become exempt from this requirement was to work in a designated District of Workforce Shortage during that period.
89 For further discussion on these changes and their likely implications, see Katie Elkin, 'Changes to the Eligibility to Bill on Medicare in Australia: A Threat to New Zealand's Medical Workforce' (2010) 123(1325) NZMJ 66.
90 Most notably, Principle 1 of the National Health Workforce Strategic Framework, as endorsed by the Australian Health Ministers in 2004, requires Australia to focus on achieving, at a minimum, national self-sufficiency in health work-force supply, whilst acknowledging it is part of a global market: Australian Health Ministers' Conference, 'National Health Workforce Strategic Framework' (AHMC, 2004), p15.
91 Lesleyanne Hawthorne, 'Competing for skills: migration policies and trends in New Zealand and Australia' (IMSED and NZ Department of Labour, 2012).
92 Australian Institute of Health and Welfare, 'Medical Workforce 2009' (AIHW, 2011). Note that an IMG is defined, for the purposes of this thesis as a doctor living in Australia or New Zealand, registered to practice or not, who obtained their primary medical qualification from a country other than Australia or New Zealand. Numbers of IMGs may in fact be higher than as reported: Lesleyanne Hawthorne, "Health Workforce Migration to Australia: Policy Trends and Outcomes" (Health Workforce Australia, 2012).
93 Medical Council of New Zealand, 'Medical Workforce in New Zealand 2011' (2012).
94 Pascal Zurn and Jean-Christophe Dumont, 'Health Workforce and International Migration: Can New Zealand Compete?' (OECD 2008); ibid.
under-staffed and unable to respond adequately to patient demand and that this reliance will continue for the foreseeable future.\textsuperscript{95} The use of IMGs to address workforce shortages, and the possible implications for public protection, are discussed in detail in chapter 8.

IMGs arrive in Australia and New Zealand from a vast array of countries, having followed different migratory trajectories, and with a range of past medical training and experience. The subsequent route to registration in Australia or New Zealand is influenced by each one of these factors. The following section briefly outlines the different pathways to medical registration for IMGs, under the National Law Act and the HPCA Act. As Australia and New Zealand have traditionally taken quite different approaches to the registration of IMGs, the two countries are considered separately.

1 \textit{Australia}

Under the National Law Act, there are six registration categories available: general, specialist, provisional, limited, non-practising,\textsuperscript{96} and student.\textsuperscript{97} Similar registration categories existed under the predecessor legislation in most states/territories. As noted above, graduates of Australia and New Zealand progress through the following four registration categories in a predictable fashion, from student, to provisional, to general, to general plus specialist.

\textsuperscript{95} See, for example: Lesleyanne Hawthorne, \textit{International Medical Migration: What is in the future for Australia?}\textsuperscript{\textcopyright}(2012) 1 Supp 3 \textit{MJA} 18; House of Representatives Standing Committee on Health and Ageing, \textit{Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors}\textsuperscript{\textcopyright}(The Parliament of the Commonwealth of Australia, 2012). However, note also the recent minority view expressed by Bob Birrell that Australia now has an oversupply of general practitioners as, he says, shown by high bulk-billing rates and an increase in the number of GP services billed per person per year in Australia: Bob Birrell, \textit{Too many GPs}\textsuperscript{\textcopyright}(Centre for Population and Urban Research, Monash University, 2013).

\textsuperscript{96} Non-practising registration is defined very narrowly and applies only where the doctor is not involved in any medical activity, including research, education, policy development or management. It is used mainly by doctors who have retired, are temporarily not practising due to, for example, parental leave, or who practice overseas but not in Australia.

\textsuperscript{97} Note that student registration was not previously required in all states/territories. From March 2011, under the National Law Act, all students are required to be registered from the first year of their course. The relevant board takes no role in academic progress or professional conduct, just health issues that might present a risk to the public and certain criminal offences committed by the student. Registration as a student is automatic and free of charge.
The pathways for IMGs are, however, much more varied, and result in many IMGs never obtaining general registration in Australia and only ever practising on a restricted basis of some kind.98

a) Pathways to registration

While registration decisions are ultimately the domain of the medical board, the AMC has long been involved in certifying IMGs as eligible for registration in Australia. On 1 July 2008, the AMC introduced a nationally consistent set of four assessment pathways for IMGs seeking general or specialist registration in Australia, as follows:

a) Competent Authority pathway.

b) Standard pathway ï AMCP examination.

c) Standard pathway ï workplace-based assessment.

d) Specialist pathway.

Two years later, in November 2010, the MBoA announced that they and the AMC would be reviewing those pathways and the effectiveness of their implementation99

How AMC certification is achieved depends on the country in which the IMG became medically qualified (or completed subsequent training and assessment). If that country is recognised by the AMC as a Competent Authority (the United Kingdom, Ireland, the United States, Canada and New Zealand100), the IMG is granted an Advanced Standing Certificate by the AMC, exempting them from the requirement to sit the AMC multi-choice examination (MCQ) which tests medical knowledge via written test. The IMG is then able to apply to the MBoA for limited registration, which allows them to provide medical services under supervision for 12 months, with the aim of achieving a successful workplace performance assessment and thus AMC certification.

98 For more information on the pathways to registration, see: Rick McLean and Jan Bennett, ‘Nationally consistent assessment of International Medical Graduates’ (2008) 188 MJA 464.
99 Medical Board of Australia, ‘Media Release: Board and AMC To Review Implementation of IMG Pathways’ (MBoA, 8 November 2010).
100 Note that both Singapore and South Africa declined to be recognised in this category in an attempt to make migration to Australia less attractive for its doctors, thereby stemming their own tides of outward migration.
If the IMG has trained in a country that is not a Competent Authority, and has not subsequently been fully registered in a Competent Authority country, they must pass the MCQ before progressing to any form of clinical assessment (unless seeking specialist registration only, as explained below). That clinical assessment is generally in the form of the AMC clinical examination. However, an alternative pathway allowing for workplace assessment in place of the AMC clinical examination has also been developed and pilot programmes are now available in some states.

Once AMC certification is achieved, an IMG may apply for provisional registration in the same way as a graduate from an Australian medical school. It is only upon successful completion of the following 12-month internship that the IMG will become eligible for general registration. The extent to which internship placements will be available to IMGs in the future is unclear given the rapidly growing pool of domestic graduates.\(^{101}\) Competition for these places has also intensified due to Australia’s recent success in retaining international medical students upon graduation from medical school.\(^{102}\)

An IMG may also enter the registration pathways seeking specialist registration rather than general registration. Such registration will allow the IMG to practice in one particular specialty, but not more widely, and is designed for those whose qualifications are partly recognised by an Australian specialty college, those who are working in specialist roles in Areas of Need (explained below), and those who are in training in Australia for a limited period. Registration is on the basis of an AMC and/or specialist college report arising out of an assessment of the IMG’s skills and experience in the particular specialty. There is no requirement for specialist registrants to pass the AMC MCQ before commencing work.\(^{103}\) Specialist registration (without general registration)

\(^{101}\) IMGs who hold AMC certificates are currently the lowest ranked group in terms of internship allocation priorities: see Katie Elkin and David M Studdert, ‘Restricted Career Paths for Overseas Students Graduating from Australian Medical Schools’ (2010) 192 MJA 517.

\(^{102}\) In many respects, the retention of such graduates is more attractive than recruiting IMGs as the standard of their medical education is known and they already have experience working within the Australian health system: Lesleyanne Hawthorne, ‘International Medical Migration: What is in the future for Australia?’(2012) 1 Supp 3 MJA 18.

is not time limited, and many IMGs remain only able to work in one particular clinical specialty indefinitely.

b) Types of limited registration

While progressing through the pathways described above, most IMGs will hold limited registration at some point. Under the National Law Act, there are now four types of limited registration, all of which allow the registrant to provide medical services under supervision. Limited registration may be granted for the purposes of postgraduate training or supervised practice, filling a position in an Area of Need, teaching or research, or for purposes related to the public interest. According to s 65 of the National Law Act, limited registration is available to doctors who are not qualified for general or specialist registration but are suitable persons to hold limited registration.

Limited registration for postgraduate training or supervised practice is designed for doctors who intend to return to their home country after training, are in the process of having their specialist qualifications assessed in Australia, or who have passed the AMC MCQ and are preparing to sit the AMC clinical examination. A doctor who holds this type of registration is required to comply with their supervision and training plan, to submit regular supervision reports to the MBoA, to perform satisfactorily, and (if intending to stay in Australia) to show evidence of satisfactory progress towards achieving general or specialist registration.

Area of Need registration allows an IMG who has not yet passed the AMC MCQ to work in an Area of Need as designated by a state or territory Minister of Health. Typically, Areas of Need are in rural and remote parts of Australia. In order to commence practice, the IMG must have been assessed by the Board as having the necessary skills, training or expertise to undertake this practice safely. The other requirements imposed on Area of Need registrants are the same as for those registered

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104 Note that the term 'limited registration' is used in the National Law Act but that, previously, different states/territories used different terms, most commonly 'specific registration'. Throughout this thesis 'limited registration' is used for consistency.
105 National Law Act, ss 65 to 69.
for postgraduate training or supervised practice, with the exception that a professional development plan is required in place of a training plan. The use of Area of Need registration, and its relationship to public protection and public interest, is discussed in chapters 4 and 8.\textsuperscript{107}

The remaining two types of limited registration are not pathways to general or specialist registration, but are ends in themselves. Public interest registration is short-term and provides a limited scope of practice that is designed to facilitate responses to natural disasters and pandemics, and for experts to demonstrate new procedures. Registration for teaching and research allows the holder to undertake limited clinical practice relevant to their teaching or research role.

Under s 72 of National Law Act, limited registration may only be renewed three times, however, a new application may be made once renewal options have been exhausted.

2 \textit{New Zealand}

The AMC certificate is not recognised for registration in New Zealand. Rather, the NZREX clinical examination, administered by the MCNZ, must be passed before an IMG will be allowed to practice in that country. As a prerequisite to sitting the NZREX clinical examination, an IMG must have an accepted primary medical qualification, have met English language requirements, and have passed a theory examination (for which the AMC MCQ will qualify, if passed). Unlike in Australia, an IMG cannot be registered on the basis that they are working towards passing the clinical examination: registration is not granted until NZREX is passed. There is no exception for IMGs recruited to work in rural, or hard-to-staff, areas.

Once an IMG has passed the NZREX clinical examination, they become eligible to apply for provisional registration in the general scope. Regardless of seniority, as a new registrant, a minimum of 12 months supervised practice must then be completed before full registration in the general scope will be granted.\textsuperscript{108} An IMG who has completed

\textsuperscript{107} See pp118 and 228.
\textsuperscript{108} Interestingly, requiring such a period of supervised practice is one of the recommendations made in House of Representatives Standing Committee on Health and Ageing, ‘Lost in the Labyrinth: Report
vocational training but never been registered previously in New Zealand may apply for provisional vocational registration at that point.

Registration in the special purpose scope is also available for purposes of teaching or research, locum work for up to six months, or emergency response. Registration in that scope is not a pathway to registration in the general scope and is subject to supervision requirements.

3 Trans-Tasman differences

As can be seen from the descriptions above, Australia has a number of limited registration types that do not exist in New Zealand.

As parts of Australia became more and more desperate for doctors over the last decade, the restrictions on medical registration were progressively relaxed for some groups of IMGs. There are now IMGs registered to practice medicine in Australia who have had no independent standardised assessment of their medical knowledge or their clinical skills. While adequate supervision is usually a condition of such registration, this is often unavailable or lacking in its consistency, particularly in the very remote areas where such IMGs are often required to work.

Perhaps in response to such concerns, one of the stated objectives of the National Law Act is to facilitate the rigorous and responsive assessment of overseas-trained health practitioners.\(^\text{112}\) This objective is further articulated in the following function bestowed on all national boards, including the MBoA:

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\(^{109}\) Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007).


\(^{111}\) Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007); Lesleyanne Hawthorne, Bob Birrell and Doris Young, 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria' (University of Melbourne, 2003).

\(^{112}\) National Law Act, s 3(2)(d).
... to oversee the assessment of the knowledge and clinical skills of overseas trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and to determine the suitability of the applicants for registration in Australia.\(^{113}\)

Indeed, in a November 2010 media release, Dr Joanna Flynn, the Chair of the MBoA, emphasised the need to ensure assessment processes for IMGs are such that

the community and the Board can be confident the IMG has the skills, qualifications and experience to provide safe care in the particular role they are registered to perform, with the level of supervision provided.\(^{114}\)

These issues are explored in more detail, and in the context of the Studies, in chapter 8.\(^{115}\)

The New Zealand approach has remained much less flexible, with NZREX an absolute prerequisite to anything other than very temporary practice.\(^{116}\) This difference in approach has led to an interesting migratory phenomenon whereby IMGs, unable to gain residence in Australia, gain residence and then citizenship in New Zealand. While in New Zealand, the IMGs do not practice medicine, NZREX presumably being too daunting a challenge to embrace, but hone their English language skills in preparation for migration to Australia as New Zealand citizens. Once in Australia, the IMGs are able to secure medical employment in one of the limited registration categories without having to first pass any type of clinical examination.\(^{117}\)

Even those IMGs who do achieve registration as doctors in New Zealand typically have poor retention rates in that country, often using it as a doorway to the more lucrative

\(^{113}\) National Law Act, s 35(1)(e).

\(^{114}\) Medical Board of Australia, 'Media Release: Board and AMC to Review Implementation of IMG Pathways' (MBoA, 8 November 2010).

\(^{115}\) See particularly p228 onwards.

\(^{116}\) Of course, the New Zealand situation is also geographically different to Australia with no locations that present quite the challenge presented by the incredible isolation of remote parts of Australia.

Australian market. According to MCNZ statistics, only 50% of all IMGs remain practising in New Zealand one year after initial registration.  

IV REGULATION OF PRACTISING DOCTORS

A Introduction

Medical professional regulation has the most impact at the beginning of practice and when things go wrong, however, the medical boards are also responsible for overseeing registered doctors throughout their careers. This is achieved via an annual process of practice renewal plus continued professional development reporting requirements, as described briefly below.

B Annual practice renewal

Under the National Law Act, registration has a maximum duration of 12 months. Accordingly, in order to remain registered, a doctor must renew their registration with the MBoA annually. As part of the renewal application process, the doctor must provide the Board with a statement that includes:

a) a declaration that the applicant:
   i) does not have an impairment;
   ii) has met any recency of practice requirements;
   iii) has completed any continuing professional development requirements; and
   iv) has not practised during the preceding period of registration without having appropriate professional indemnity arrangements in place and will continue to ensure such arrangements are in place;

b) details of any:
   i) changes to the applicant’s criminal history since the date of last renewal;
   ii) withdrawal or restriction of the right to practise at any hospital or other facility as a result of conduct, performance or health issues;

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118 Medical Council of New Zealand, 'Medical Workforce in New Zealand 2011' (2012).
119 As for general registration, see s 56 of the National Law Act.
iii) withdrawal or restriction of Medicare billing privileges as a result of conduct, performance or health issues; and
iv) complaints made about the applicant to any regulatory entity.120

The MBoA may then decide to renew the doctor’s registration, renew the registration subject to conditions, or refuse to renew the registration. Upon renewal of registration, doctors are given an annual registration certificate to evidence their registration. The annual registration renewal process gives the Board a degree of regular oversight and control over all doctors.

In New Zealand, registration itself is not renewed annually. Once a doctor is registered, they remain registered for life unless they request to be removed from the register or are deregistered for cause. Instead, annual oversight of the profession is achieved through the issuing of annual practising certificates (APCs). The process for having an APC renewed is very similar to that used for renewal of registration in Australia. Each year, each doctor must apply to the MCNZ for a new APC. Generally, obtaining a new APC is a matter of routine but, in certain circumstances, the MCNZ may refuse to issue one, for example, where the applicant has failed to maintain the required standard of competence or has not complied with a condition on their scope of practice.121

In order to legally practise medicine in New Zealand, a doctor must be both registered and have a current APC.122 This dual requirement has been a source of confusion for some health practitioners in New Zealand, particularly with regard to the status of a practitioner who is registered but does not hold a current APC. As discussed above, most medical activities may be lawfully conducted by a non-medically trained individual, providing that individual does not say or imply that they are medically trained. However, a registered doctor may not perform those same activities unless that practitioner also has a current APC. If the doctor wishes to perform those activities without an APC, they must also remove themselves from the register of doctors and cease referring to themselves with reference to their medical training. From a public

120 National Law Act, s 109.
121 HPCA Act, s 27.
122 HPCA Act, s 8(1).
protection point of view, this seems somewhat irrational but is the unfortunate corollary of having separate registration and APC requirements within the context of a regulatory system based on certification rather than licensure. The potential for confusion (among both doctors and the public) is real\textsuperscript{123} and it is difficult to think of any advantages the separate registration and APC system offers over the integrated system in place in Australia.

\textit{C  Continued professional development}

Another way in which the medical boards regulate practising doctors is via the imposition of continued professional development (CPD) requirements. Such requirements are intended to ensure the ongoing professional competence of the vast majority of doctors who never come to the attention of the medical boards other than for routine renewal of practice.

Section 128 of the National Law Act requires doctors to undertake the CPD requirements as set out by the MBoA\textsuperscript{'s} Continuing Professional Development Registration Standard.\textsuperscript{124} Under that standard, doctors are required to declare annually (as part of the registration renewal process) that they have met the requirements of the standard. The detail of those requirements depends on the type of registration held by the particular doctor. Essentially, for those on the specialist register, requirements are as set by the relevant AMC accredited specialist college; for those with limited registration, requirements are as per individual plans agreed with the board; and for all others, the minimum requirement is 50 hours per year. Failure to meet CPD requirements is regarded as a disciplinary matter. Prior to the advent of the National Law Act, CPD was voluntary, but not anymore; instead there has been movement towards a \textit{command and control} regulatory approach in this area, rather than continuing to leave CPD to doctors\textsuperscript{'}s discretion.\textsuperscript{125}

\textsuperscript{123} See for example, \textit{GS v A Professional Conduct Committee} [2010] NZAR 417 (HC) where the practitioner inadvertently practised without a practising certificate for three years.
\textsuperscript{124} Medical Board of Australia, 'Continued Professional Development Registration Standard' (MBoA, 2010).
\textsuperscript{125} Judith Healy, \textit{Improving Health Care Safety and Quality} (Ashgate, 2010), p119.
For doctors registered in New Zealand, requirements vary according to scope of practice but are similar to the Australian requirements described above.\textsuperscript{126}

Completion of CPD requirements tends, in the absence of other concerns, to be used, by itself, as a proxy for competence\textsuperscript{127} New Zealand law professor, Ron Paterson has remarked on the limitations of traditional CPD, noting that it is a measure of activities, not continued competence\textsuperscript{128} Instead, Paterson suggests a recertification prescription that goes beyond the traditional bounds, suggesting that either periodic assessment of all doctors or targeted screening of at risk doctors may be required.\textsuperscript{129} Either way, he argues, there is a need to go beyond reliance on CPD compliance and undertake regular practice reviews. To be effective, the process of competence assurance must move from being reactive to being proactive.\textsuperscript{130}

\section*{V CONCLUSION}

Doctors in New Zealand and Australia are registered and overseen by medical boards. The medical boards are responsible for ensuring that only those who are appropriately qualified and have the appropriate level of skill, knowledge and competence are registered to practice medicine. While front-end regulation, through the use of registration criteria and restrictions, provides a measure of protection, the ability to investigate and take steps in relation to a registered doctor whose practice appears in some way deficient is at least as important. Annual renewal of registration goes some way to giving a medical board regular assurance of a doctor’s suitability for practice, but there must also be a robust mechanism for intervening and managing doctors whose behaviour is of concern. This is achieved through what is referred to in this thesis as the complaints and disciplinary system, the context for, and operation of which, is described in the following chapter.

\begin{flushleft}
\textsuperscript{126} Medical Council of New Zealand, Recertification and Continuing Professional Development (MCNZ, 2011).
\textsuperscript{128} Ibid, p139.
\textsuperscript{129} Ibid, p155.
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CHAPTER 3 – THE COMPLAINTS AND DISCIPLINARY
SYSTEM

I  INTRODUCTION

For the vast majority of doctors, their interactions with the medical boards and other parts of the regulatory system are simply routine: a matter of applying for and being granted initial registration, followed by a pro-forma annual declaration and unproblematic renewal of that registration. For a minority, who come to the medical boards’ attention as a result of concerns or a complaint about some aspect of their practice, the medical board may become intimately involved in the intricacies of their professional lives. The regulation of such practitioners is at the ‘sharp end’ of the regulatory system’s ability to protect the public from being put at risk by members of the profession. While registration standards and ongoing monitoring of all registered doctors is important, it is the response to and management of problem doctors that is the pivotal concern of the general public. It is when things go wrong that questions are asked and answers demanded, often in relation to the regulatory system as a whole.

This chapter examines the complaints and disciplinary frameworks that operate in Australia and New Zealand, focussing specifically on what they are designed to deliver in terms of public protection. It starts by looking at the scope of doctor liability in each country, then moves to consider the complaints and disciplinary system itself in some detail, both as it is now and from where it has evolved. That detail is important for understanding the context for the Studies that form part of this thesis.

II  THE DISCIPLINARY SYSTEM WITHIN THE WIDER CONTEXT
OF POTENTIAL DOCTOR LIABILITY

  A  Introduction

Complaints, as described in this thesis, are matters concerning a particular doctor that are brought to the attention of a medical board or a complaints commission (Complaints Commission) by any one of a number of interested parties including patients, patient representatives, colleagues, or employers. Complaints which go on to
be investigated may then become the subject of disciplinary proceedings against the doctor. If the doctor is found to have committed the alleged misconduct, there may be implications for the doctor’s continued medical registration.

Doctors who are alleged to have failed in their professional duty in some way may also be subject to criminal prosecutions, civil proceedings, and employment investigations. While this thesis is not focused on those forms of professional accountability, they do form part of the general regulatory environment in which doctors in Australia and New Zealand practice, and within which the complaints and disciplinary system operates. Indeed, the presence, absence and/or effectiveness of other forms of accountability may impact the way in which the disciplinary system is utilised by the public and the profession, the expectations those parties have of the system, and the way in which decisions are made by actors within that system. This section briefly explains the operation of those other avenues of accountability in Australia and New Zealand.

B Criminal liability

In New Zealand, the language often used when referring to professional discipline is the same as that used to refer to criminal proceedings, for example, a ‘charge’ is laid against the doctor, the doctor is found ‘guilty’ or ‘not guilty’ and may be ‘fined’ as a consequence. Despite this language, professional disciplinary proceedings are civil rather than criminal in nature. In Australia, the language used in the National Law Act (in relation to professional disciplinary proceedings) is more obviously that of civil liability; nevertheless, as in New Zealand, there is still provision for a doctor to be fined for breach.

Issues arising for health practitioners under the criminal law are similar across Australia and New Zealand. Consequently, the discussion in the following section ranges across both countries.

131 HPCA Act, s 91.
132 HPCA Act, s 100.
133 HPCA Act, s 101(1)(e).
134 Z v Dental Complaints Assessment Committee [2008] NZSC 55.
135 National Law Act, s 196.
Criminal liability for professional misconduct

As well as providing for professional disciplinary proceedings, the National Law Act and the HPCA Act (the Acts) also establish criminal offences. For example, it is a criminal offence, punishable on summary conviction, to use a restricted title without being properly registered to do so. Such criminal offences are dealt with differently to complaints and disciplinary proceedings under the Acts. A breach of s 7 of the HPCA Act, for example, is within the jurisdiction of the Ministry of Health, not the Responsible Authority.

In some circumstances, a doctor’s conduct will constitute a breach of the general criminal law as well as being professional misconduct. A common example is where a doctor is found guilty in a criminal court of sexually assaulting a patient. Drug-related offences, such as the unlawful supply of steroids, are another oft-cited example of criminal professional misconduct. In such cases, the way the disciplinary system responds may be influenced by any penalty already imposed in the criminal context. Where a doctor is already in prison, it has been argued that there is no public protection purpose to be served by also removing that doctor from the medical register. However, just because a doctor has been found not guilty by a criminal court does not preclude a disciplinary tribunal from finding that doctor guilty of the same conduct. First, the burden of proof in criminal proceedings is higher, being beyond reasonable doubt rather than on the balance of probabilities; secondly, while one or more of the essential elements of the criminal charge may have been missing, the test for professional misconduct may still be met. For example, sexual intercourse with a patient may be

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136 National Law Act, s 113; HPCA Act, s 7.
137 Unlawful use of a restricted title.
138 Section 243 of the National Law Act specifically provides that conduct may constitute both a criminal offence and professional misconduct.
139 For example, Re Morgan Fahey, NZMPDT, 144/00/64C, 29 November 2000.
140 For example, Re Graeme John Harris, NSWMT, 40005/08, 18 December 2008.
141 Z v Dental Complaints Assessment Committee [2008] NZSC 55.
consensual in terms of the criminal law and, therefore, not constitute rape, but may nevertheless constitute a breach of the doctor’s professional obligations.¹⁴²

As well as the more obvious sex and drugs cases, a doctor found guilty of professional misconduct for their clinical treatment of a patient may also go on to be charged criminally for battery (where consent was lacking), for grievous bodily harm (as a result of a botched operation)¹⁴³, or for manslaughter (where the doctor’s grossly negligent treatment has led to the patient’s death)¹⁴⁴. Such cases are rare as they require a high degree of negligence:

The facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.¹⁴⁵

Perhaps the most poignant example of where criminal negligence has been asserted in recent Australian history is the case of Dr Jayant Patel. Dr Patel became the Director of Surgery at Bundaberg Base Hospital in Queensland in 2003. In March 2005, when concerns were raised about his surgical practice, he left Australia and returned to the United States. In June 2005, the Bundaberg Hospital Commission of Inquiry linked him to the deaths of 17 patients.¹⁴⁶ He was extradited to Australia in July 2008, facing charges of manslaughter in respect of three patients and grievous bodily harm in respect of a fourth. In June 2010, Dr Patel was found guilty of all four charges and sentenced to seven years in prison. In March 2011, Dr Patel unsuccessfully appealed his convictions in the Queensland Court of Appeal. However, in August 2012, the High Court of Australia held that there had been a miscarriage of justice arising from a change in the

¹⁴² As, for example, was the case in N v PCC (unreported, HC, Wellington, CIV 2009-485-2347, 17 March 2010).
¹⁴⁴ As in R v Patel [2010] QSC 198. See also the case of midwife Jennifer Crawshaw (discussed below).
¹⁴⁵ Per Lord Hewart CJ in RV Bateman (1925) 19 Cr App R 8. See also R v Taktak (1988) 14 NSWLR 226.
¹⁴⁶ The inquiry also found that the recruiting agency, the Qld Board, Queensland Health, and Bundaberg Hospital systems all also failed in relation to Patel’s appointment. This has led to suggestions that consideration should be given to corporate manslaughter proceedings being available in such cases: Nikita Tuckett, 'Balancing Public Health and Practitioner Accountability in Medical Manslaughter after R v Patel' (2011) 19 JLM 377.
prosecution’s focus during the 2010 trial that meant prejudicial evidence that was admitted was no longer relevant. As a result, the High Court quashed Dr Patel’s convictions and ordered a new trial.\textsuperscript{147} Dr Patel was retried on the first of the four charges in March 2013 and was found not guilty of manslaughter. The prosecutors have announced an intention to continue to pursue the outstanding charges, with additional retrials, but those retrials have yet to be heard.\textsuperscript{148}

Patel is the fifth doctor since 1843 to have been prosecuted in Australia for ‘medical manslaughter’. The others include: Dr Margaret Pearce in 2000, convicted for the manslaughter of a 15-month old girl to whom she gave an adult dose of morphine for a burn; Dr Gerrit Reimers (acquitted in 2001), for failing to notice a patient was not breathing after an operation; and Dr Bruce Ward in 2007, in relation to a patient who bled to death during a hysterectomy (charges dropped mid-trial).\textsuperscript{149}

In New Zealand, the legal test for medical manslaughter is set out in s 155 of the \textit{Crimes Act 1961} (NZ), as follows:

> Everyone who undertakes (except in case of necessity) to administer surgical or medical treatment ... is under a legal duty to have and to use reasonable knowledge, skill, and care in doing any such act ...

However, a person will only be criminally responsible for breach of that duty if

> in the circumstances, the omission or unlawful act is a major departure from the standard of care expected of a reasonable person to whom that legal duty applies or who performs that unlawful act.\textsuperscript{150}

The requirement for a ‘major departure’ was added to the above provision in 1997, after lobbying that followed the convictions for manslaughter of two anaesthetists, one

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\textsuperscript{147} Patel v The Queen [2012] HCA 29.
\textsuperscript{149} Nikita Tuckett, ‘Balancing Public Health and Practitioner Accountability in Medical Manslaughter after R v Patel’ (2011) 19 JLM 377.
\textsuperscript{150} \textit{Crimes Act 1961} (NZ), s 150A.
\end{flushleft}
surgeon and one radiologist for negligence resulting in a patient’s death. Since then, no doctors have been prosecuted for manslaughter arising out of clinical care in New Zealand. However, less than a decade ago, a midwife, Jennifer Crawshaw, was charged with manslaughter for the death of a baby who was being delivered under her care. On 21 March 2006, she was found not guilty, much to the relief of the Midwifery Council of New Zealand, whose Chairperson stated:

We are concerned ... that this case was tried through a criminal court when there are already and robust professional processes in place to investigate alleged breaches of ethics and poor practice, including the Health and Disability Commissioner and the Midwifery Council of New Zealand.

Former Health and Disability Commissioner, Ron Paterson, expressed similar sentiments in his report into the midwife’s conduct:

There is a place for the criminal law in the clinical setting where a health practitioner kills a patient by reckless acts or omissions. But in cases of unexpected patient death, even where gross negligence may be proved, a manslaughter prosecution is likely to do more harm than good. It delays and frustrates the regular mechanisms for health practitioner accountability. Most importantly, no health practitioner is likely to share their mistakes in a peer review setting if Police search and seizure is a possibility. The real causes of patient deaths will remain hidden, and the potential to learn from mistakes will be lost.

Certainly, criminal prosecution seems justifiable where the conduct concerned, if committed outside of a therapeutic interaction, would also be criminal. Otherwise, the therapeutic context of the interaction could end up providing protection for the health practitioner that is not afforded to general members of the public. A woman sexually

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152 Ibid.
154 Note that the Health and Disability Commissioner (HDC) is New Zealand’s complaints commission and is discussed in more detail later in this chapter. The Midwifery Council of New Zealand is the equivalent of the MCNZ, but regulates midwives not doctors.
assaulted by her doctor must be able to claim the full protection of the criminal law, notwithstanding his status as a doctor. However, as in the case of midwife Jennifer Crawshaw, where the conduct concerned was only possible due to the clinical setting—that is, it directly related to the provision of clinical services—the place for the criminal law is less clear. As identified by the Health and Disability Commissioner (HDC), other mechanisms already exist for protecting the public from such practitioners and for holding such practitioners accountable. While this seems a logical conclusion to reach, it does, however, raise the question of why medical manslaughter is provided for in the Crimes Act 1961 (NZ), as discussed above. The legislature has made a clear decision that, where there is an omission or neglect that constitutes a "major departure" from the expected standard of care, criminal liability may attach. Perhaps the answer lies in the fact that s 155 has not been amended since its introduction in 1961, a time when there were fewer other regulatory mechanisms in place for health practitioner accountability and public safety, which may thus have rendered the intervention of the criminal law more necessary.156

2  Professional consequences for criminal conduct

The criminal law and professional disciplinary systems also interact by virtue of the requirement that a doctor be a "suitable person" to practice medicine (Australia) or "fit for registration" (New Zealand). The National Law Act specifically provides that the MBoA may decline an application for registration on the basis that, due to the applicant's criminal history, it is not in the public interest to register that person. Similarly, the HPCA Act requires the MCNZ to take special care as to the fitness for registration of applicants with prior criminal convictions. In New Zealand, if an already registered doctor is convicted of a criminal offence under one of a specified list of statutes, or any offence punishable by imprisonment of three months or more, the

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156 For example, the Health and Disability Commissioner was not established until 1994. Interestingly though, when, on 1 March 2012, related provisions about protection from injury (ss 151 and 152) were amended, thus necessitating consequential amendments to s 150A, s 155 was not also reviewed: Crimes Amendment Act (No 3) 2011 (NZ).
157 National Law Act, s 55(b)(i); HPCA Act, s 52(1)(c).
158 HPCA Act, s 16(c).
160 HPCA Act, s 16(c).
registrar of the court must notify the MCNZ of the conviction and the MCNZ must, in turn, refer the matter for investigation. In Australia, doctors are required to notify the MBoA within seven days if they are charged with a criminal offence punishable by 12 months imprisonment or more, or are convicted of an offence punishable by imprisonment.

In New Zealand, the fact of criminal conviction is itself grounds for disciplinary action to be taken if that conviction reflects adversely on the doctor’s fitness to practice. This was also the case in some states of Australia pre-Nationalisation, but there is no corresponding provision in the National Law Act.

3 Conclusion

While professional disciplinary proceedings are not criminal in nature, there is considerable overlap and interaction between the criminal law and professional regulation. The National Law Act and the HPCA Act both provide for some criminal liability, there may be criminal consequences as well as disciplinary consequences for some conduct, and professional disciplinary proceedings may be initiated as a result of a criminal charge or conviction. Penalty decisions made in the disciplinary context may also be influenced by any penalties already imposed by the criminal courts in relation to the same matter. Similarly, a criminal conviction may impact on a doctor’s entitlement to become, or remain, registered to practice medicine.

C Civil liability

While civil in nature, professional disciplinary proceedings are also distinct from other forms of civil liability in several key respects: civil proceedings are usually brought by one citizen (or entity) against another, while professional disciplinary proceedings are brought by an agent of the state against an individual, pursuant to that agent’s legislative
mandate. In addition, the potential outcomes for each party are quite distinct, depending on the nature of the litigation.

A finding of professional misconduct is likely to have implications for a doctor’s ongoing ability to practice. That privilege may even be removed altogether by suspension or deregistration. There may also be financial consequences through the imposition of a fine and award of costs. Conversely, if a doctor loses a civil case against a patient, the only sanctions imposed will be financial. While those financial consequences may be significant, running to hundreds of thousands of dollars, such amounts are usually covered by professional indemnity insurance and an adverse outcome will not directly fetter the doctor’s continued right to practice.

The potential outcomes are also very different for the complainant in professional disciplinary proceedings. Apart from possibly giving evidence, the complainant typically has no role in the conduct of the proceedings. There is also no mechanism by which that individual may recover damages or any other form of economic compensation from those proceedings. On the other hand, a civil case is usually conducted by the complainant or their representative, with all costs and decisions about its conduct falling to that person. The corollary is that the principal outcome of a successful claim is the award of compensatory damages to the complainant.

The availability of civil action for medical negligence or misconduct differs greatly between Australia and New Zealand, and between states/territories of Australia. Thus the impact of civil action on attitudes to disciplinary proceedings may also differ. This section briefly describes the main features of the relevant systems so as to demonstrate their potential effect on disciplinary proceedings.

165 There may, of course, be other consequences as a result of the proceedings, such as reputational damage, but not as directly imposed by the Court or Tribunal.
166 A notable exception in this area are proceedings brought by the Director of Proceedings, an independent statutory officer who is an employee of the HDC and whose statutory functions and responsibilities are set out in the HDC Act. The HDC may refer practitioners who have been found to have breached the Code of Rights to the Director of Proceedings who may then decide to bring proceedings against the provider in the Health Practitioners Disciplinary Tribunal or in the Human Rights Review Tribunal – discussed in further detail later in this chapter, see p73.
In Australia, civil claims against doctors are usually characterised as actions based on the tort of negligence. A successful action in negligence requires:

a) a duty of care owed by the doctor to the complainant;

b) a breach of that duty of care, for example, a failure to meet the standard expected; and

c) damage resulting from the breach of the duty of care.\footnote{Bolam v Friern Hospital Management Committee [1957] 2 All ER 118.}

The starting position is that a doctor will not be found guilty of negligence if they have acted \textquote{in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art}\footnote{Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 per McNair J at 118.} However, in rare cases, if it can be demonstrated that the body of opinion regarding that practice is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible\footnote{Bolitho v City and Hackney Health Authority [1997] 4 All ER 771 per Lord Browne-Wilkinson.}.

Since 2002, some of the parameters of the law of negligence have been being reformed by statute throughout Australia.\footnote{The catalyst for these reforms was the Ipp Committee's report released in September 2002, published pursuant to the Ipp Committee inquiry commissioned by the federal government to suggest reforms to the law of negligence to address rising insurance premiums and the reported unavailability of indemnity insurance: Ipp Committee, 'Law of Negligence Final Report' (Commonwealth of Australia, 2002).} The two main elements of the tort reform have been to narrow the scope of liability and reduce the damages that may be awarded.\footnote{Minter Ellison, 'Tort Law Reform Throughout Australia: A Brief Review of Recent Amendments' (2005).} The key recommendation relevant to the formulation of the standard of medical care that has been implemented across various states/territories\footnote{Including the states of interest in this thesis. See, for example, the Civil Liability Act 2002 (NSW).} is that:

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\footnote{\footnotetext{167}{Bolam v Friern Hospital Management Committee [1957] 2 All ER 118.}}\footnote{\footnotetext{168}{Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 per McNair J at 118.}}\footnote{\footnotetext{169}{Bolitho v City and Hackney Health Authority [1997] 4 All ER 771 per Lord Browne-Wilkinson.}}\footnote{\footnotetext{170}{The catalyst for these reforms was the Ipp Committee's report released in September 2002, published pursuant to the Ipp Committee inquiry commissioned by the federal government to suggest reforms to the law of negligence to address rising insurance premiums and the reported unavailability of indemnity insurance: Ipp Committee, 'Law of Negligence Final Report' (Commonwealth of Australia, 2002).}}\footnote{\footnotetext{171}{Minter Ellison, 'Tort Law Reform Throughout Australia: A Brief Review of Recent Amendments' (2005).}}\footnote{\footnotetext{172}{Including the states of interest in this thesis. See, for example, the Civil Liability Act 2002 (NSW).}}
A medical practitioner will not be negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, ... unless the opinion is irrational.\textsuperscript{173}

In addition, each of the states studied in this thesis has implemented minimum injury severity thresholds for recovery of non-economic loss. For example, in NSW, the threshold is set at 15 percent of a most extreme case of impairment.\textsuperscript{174} Damages for non-economic loss are also capped, with the level of the cap varying from state to state. In addition, some states (for example, NSW) have abolished exemplary and punitive damages for negligence claims.\textsuperscript{175}

While there is no direct link between a doctor being found to have been negligent in the civil courts and the doctor’s ongoing ability to practice, such a finding may indirectly impact through the decreased accessibility of professional indemnity insurance. Given the legislative requirement that all registered doctors also carry professional indemnity insurance,\textsuperscript{176} the inability to obtain affordable insurance may impact on the feasibility of ongoing registration. The emotional toll of defending oneself in a civil proceeding may also effectively remove a doctor from practice, either for a period of time or, in some cases, permanently. Damage to reputation may also narrow available practice options. In addition, civil proceedings have a ‘flagging’ function – they can bring to light matters that boards subsequently decide to investigation, particularly when the litigation attracts publicity.

2 New Zealand

The New Zealand civil liability landscape is quite different to that in Australia due to the absence of tort-based litigation for medical negligence. The Accident Compensation system (\textit{ACC Scheme}) is a no-fault compensation system that provides compensation from the state for those who sustain personal injury caused by accident. This includes

\textsuperscript{173} The above principle does not, however, apply to liability arising in connection with the giving of, or failure to give, a warning, advice or information about the risk of treatment: Ipp Committee, ‘Law of Negligence Final Report’ (Commonwealth of Australia, 2002).
\textsuperscript{174} Civil Liability Act 2002 (NSW), s 16(1).
\textsuperscript{175} This was also recommended by the Ipp Report: Ipp Committee, ‘Law of Negligence Final Report’ (Commonwealth of Australia, 2002).
\textsuperscript{176} National Law Act, s 129.
where that personal injury is a ‘treatment injury’ under s 32 of the Accident Compensation Act 2001 (NZ), that is, a personal injury that:

a) is a qualifying personal injury, that is, is death or physical injury or a mental injury caused by the physical injury; 177
b) was suffered by a person seeking or receiving medical treatment from a registered health practitioner;
c) was caused by the treatment; and
d) was not a necessary part, or ordinary consequence, of the treatment.

Treatment is defined widely and includes diagnosis, treatment decisions, failure to provide treatment, and failure in support systems intended to facilitate treatment. 178

Where a patient is eligible for coverage under the ACC Scheme, he or she is barred from bringing proceedings independent of the Accident Compensation Act 2001 (NZ) for compensatory damages arising ‘directly or indirectly’ out of the qualifying personal injury. 179 However:

[to the extent that the statutory cover is extended, the right to sue at common law is removed; to the extent that the cover is withdrawn or contracted, the right to sue at common law is revived.] 180

Thus, as there are elements of a doctor’s professional conduct that do not fall within the coverage of the ACC scheme, the ability to claim compensation in civil proceedings against a doctor is not entirely expunged. For example, if a psychiatrist makes a negligent diagnosis that leads a person to suffer emotional harm but no physical harm, compensation would potentially be available in a civil proceeding for that loss. As noted above, such proceedings may also be brought by the Director of Health and Disability Proceedings in the Human Rights Review Tribunal, with compensatory

177 Accident Compensation Act 2001 (NZ), s 26.
178 Accident Compensation Act 2001 (NZ), s 33.
179 Accident Compensation Act 2001 (NZ), s 317(1). Civil claims for exemplary damages can still be brought but this is rarely done and rarely successful.
180 Queenstown Lakes District Council v Palmer [1999] 1 NZLR 549 (CA) at 556 per Thomas J.
damage awards sometimes made. If the HDC finds that a doctor breached the Code of Health and Disability Consumers’ Rights 1996 (NZ) (the Code of Patient Rights) but does not refer the doctor to the Director of Proceedings, or the Director of Proceedings decides not to bring proceedings, the complainant may, themselves, pursue a case in the Human Rights Review Tribunal.

In addition, there is also the ability to bring civil proceedings for exemplary rather than compensatory damages as only compensatory damages are barred under the Scheme. Exemplary damages, however, will only be available in the rare case where the conduct has been exceptional and deserving of punishment.

In sum, the ability to bring civil proceedings for compensatory damages against a doctor is heavily constrained in New Zealand. It is likely that this difference in the availability of civil compensation impacts on the utilisation of the disciplinary system by some aggrieved parties. Unable to ‘have their day in court’ may make frustrated patients more likely to seek a chance to tell their story through complaints and disciplinary processes, irrespective of the fact that no monetary compensation may be available to them there. Making a complaint may also be seen as the only way to make the medical practitioner ‘pay’ for what has occurred. A contrary view is expressed by Alam et al, who suggest that the ‘traditionally more litigious culture of the United States encourages patients to pursue multiple forums for retribution for medical misconduct’.

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181 See, for example, Director of Proceedings v Nikau [2010] NZHRRT 26 (14 December 2010), in which the Human Rights Review Tribunal awarded $100,000 in damages against a former community health coordinator for financially exploiting a client. The amount included $30,000 compensation for humiliation, loss of dignity and injury to feelings, and $20,000 for flagrant disregard of the client’s rights. More recently, in Director of Proceedings v Taikura Trust [2012] NZHRRT 3 (22 March 2012), compensatory damages were sought from two health and disability service providers by the Director of Proceedings in respect of the unlawful detainment of a 43-year-old woman in a secure dementia unit for a year. The outcome of the case was that the Tribunal made declarations against the providers for failures of care and breaches of the woman’s rights. No compensation was actually awarded as the providers had already agreed to pay a confidential sum to the woman’s estate.

182 Bottrill v A [2003] 2 NZLR (PC). This was a case involving gross negligence by a pathologist. The Privy Council held that any award of exemplary damages, while requiring outrageous conduct, would not necessarily require proof of intentional wrongdoing or conscious recklessness.

III THE COMPLAINTS AND DISCIPLINARY SYSTEM

A Introduction

1 Complaints Commissioners and medical boards

Having described the context within which disciplinary proceedings occur, this section describes the complaints and disciplinary system itself. In both Australia and New Zealand, that system has two key components: state-based Complaints Commissioners and Medical Boards.

In both countries, a complaint about a doctor may travel down either of these intersecting avenues. Typically, the Board and the Complaints Commissioner then refer matters between themselves, including in some cases consulting with one another to decide which agency is most appropriate to consider the issue. In general, the Boards have jurisdiction over matters of professional conduct while the Complaints Commissioners’ role is to investigate complaints that (in Australia) may be amenable to conciliation, or (in New Zealand) allege a breach of the Code of Patient Rights. However, this workload is apportioned slightly differently in some jurisdictions, as outlined below.

a) Complaints Commissioners

While the operation and jurisdiction of the Complaints Commissioners provides important context, this thesis is largely concerned with professional discipline by the Boards and disciplinary tribunals and only considers Complaints Commissioners to the extent they play a role in that process (as is the case in New South Wales and, to a lesser extent, New Zealand). This focus on the Boards rather than the Complaints Commissioners is due to two main barriers to empirical analysis of the outcomes of the Complaints Commissioners’ processes:

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184 The complaints commissioners all have slightly different names: Victoria – Health Services Commissioner; New South Wales – Health Care Complaints Commission; Queensland – Health Quality and Complaints Commissioner; Western Australia – Director of the Office of Health Review; and New Zealand – Health and Disability Commissioner.

185 For example, Health Professions Registration Act 2005 (Vic), s 43(2).
a) many complaints received by Complaints Commissioners in Australia, particularly in the public health system, do not refer to identified individual doctors but to, for example, hospital units or clinics as a whole; and
b) due to many of the Complaints Commissioners in Australia having a focus on conciliation, determinations are rarely ever made about the merits of a particular complaint.

b) Medical boards

Broadly, medical boards are concerned with three categories of problems that arise in relation to a doctor’s practice:186

a) Health or fitness — where a doctor has a physical or mental impairment, including an addiction, that detrimentally affects their ability to practice;187
b) Competence — where a doctor is practising below the required standard of competence;188 and

c) Conduct — where a doctor’s professional conduct or practice is below the standard required of the profession.

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186 These three categories are used in both the National Law Act and the HPCA Act (NZ) and were also used in most of the predecessor pieces of legislation.
187 In New Zealand, health and fitness issues are dealt with under Part 3, sections 45 to 51 of the HPCA Act, through requiring doctors to attend medical examinations. Interim suspension is available under s 48 while the medical examination process is being completed. If, as a result of the examination, the MCNZ is satisfied that the doctor is unable to perform the required functions, the doctor may be suspended from practice: s 50 HPCA Act. Under the National Law Act in Australia, a health assessment may be required (s 169), which may result in the MBoA cautioning the doctor, accepting an undertaking from the doctor, imposing conditions on the doctor’s practice, or referring the matter elsewhere (s 178). A health panel may also be established under s 181, leading to possible suspension of the doctor from practice under s 191. Referral to a tribunal is also possible, with similar potential consequences to those discussed below for conduct issues.
188 In New Zealand, competence issues are dealt with through competence programmes, provided for under Part 3, ss 34 to 44 of the HPCA Act. Pending the outcome of such a review, the MCNZ may impose conditions on, or suspend, the doctor for an interim period if the MCNZ considers that there is risk of serious harm to the public due to the competence concerns (s 39). If the results of the competence programme are unsatisfactory, conditions may be imposed on the doctor’s scope of practice, or the doctor may be suspended until the identified issues are rectified (s 43). In Australia, the process for dealing with competence issues is much the same as for health issues, as set out in the previous footnote. Section 170 of the National Law Act provides for performance assessments, and a performance and professional standards panel may be convened pursuant to s 182. The panel may impose conditions on practice, issue a caution or reprimand, or refer the matter to a Tribunal for further consideration (s 191).
This thesis focuses on the third category of problems, and the Studies investigate professional conduct issues of that kind. The main reason for this approach is that the majority of the decisions made by disciplinary tribunals are in relation to conduct, rather than health or competence issues. Conduct decisions are also more often made public, and therefore are more amenable to analysis, than tends to be the case for competence and, especially, health hearings.

The line between the three categories is frequently blurred, however, especially as between conduct and competence. When the behaviour is particularly serious, medical boards tend to categorise borderline cases as conduct rather than performance. When the matter is less serious, it is appears to be more likely to be characterised as performance.

Exactly how medical boards deal with complaints, and interact with the Complaints Commissioners, in the different states of Australia and New Zealand is important as there are subtle but material differences in procedure between jurisdictions. Some of these differences have the potential to impact on some of the results reported in chapters 6 and 7.

2 Empowering legislation

As Complaints Commissioners and medical boards are both creatures of statute, their establishing and empowering legislation is key in determining their operation and the extent of their powers.

The cases included in the Studies described in chapters 6 and 7 were all drawn from the period 2000 to 2009. That is, therefore, the period of most relevance for the present analysis of the complaints and disciplinary systems. Those years also represent an interesting period, being the decade prior to Nationalisation and a period during which all except one\textsuperscript{189} of the jurisdictions of interest experienced a change in the legislation governing their complaints and disciplinary systems. Any change to the legislation governing a regulatory process is usually preceded by consideration of the system that

\textsuperscript{189} New South Wales.
has operated to date, and can be expected to represent an attempt to rectify components that have not been performing optimally (as far as it is possible to address such issues through legislative change). The result is that the legislation in place in 2009 was not so much a product of past regulatory philosophies but a deliberate attempt to design processes that met the objectives of the disciplinary system, as understood during that time period. Therefore, while the legislation that operated throughout the Study Period is important for understanding the progression and outcomes of the complaints and disciplinary cases, it is the latter Acts that offer the best view of contemporary (but pre-Nationalisation) approaches to professional discipline.

Between jurisdictions (both between Australian states and between Australia and New Zealand) during the Study Period there were significant similarities in legislative approach, and hence in the complaints and disciplinary processes. There were, however, also material differences that had the potential to markedly change decision making and outcomes.

B Australia: 2000 to 2010

The remainder of this chapter discusses the operation of the complaints and disciplinary system in each of the four Australian jurisdictions with cases included in the Studies. Cases from Victoria and Western Australia are included in both of the Studies, and so these two states are addressed first.

Queensland and New South Wales cases are included just in the First Study. Even though the First Study concerns only disciplinary proceedings before Tribunals\(^\text{190}\), the route from complaint received through to tribunal hearing is important context, having the potential to influence the number and nature of cases that reach that point. For that reason, the complaints and disciplinary processes in Queensland and New South Wales are also described in some detail.

\(^{190}\) Defined for the purposes of the First Study as any disciplinary body with the power to remove a doctor from practice, other than on an interim basis (see chapter 6, p142). In Queensland, from February 2000, that was the Health Practitioners Tribunal.
Victoria is described first and is then used as a comparator for the other states to avoid unnecessary repetition where states’ processes were similar.

1 Victoria

a) Receiving complaints

Anyone wishing to complain about a doctor, or the quality of care provided more generally, in Victoria may do so by submitting a complaint to the Health Services Commissioner (HSC). An alternative, until Nationalisation, was to notify the Vic Board. After referring the complaint between themselves, the Vic Board and the HSC then consulted and together decided which agency was most appropriate to consider the matter. In summary, the Vic Board had jurisdiction to progress allegations of professional misconduct (including, for example, poor standards of clinical care, unethical behaviour, and sexual misconduct) while the HSC’s mandate was (and remains) to investigate complaints which may be amenable to conciliation.

If the complaint stays within the jurisdiction of the HSC, it then proceeds through a process of mediation and conciliation and, in very rare cases, investigation. The complaint may also be referred back to the Vic Board at a later point if the HSC considers that to be appropriate.

b) The Vic Board’s investigation and interim action

If a complaint was agreed to be within the Vic Board’s jurisdiction, the Vic Board then commenced an investigation into the matter. Investigation was not required if the Vic Board determined that the complaint was frivolous, vexatious, misconceived or lacking in substance, if the complaint did not warrant investigation, or if the doctor was...

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191 Under the Health Services (Conciliation and Review) Act 1987 (Vic).
192 Under the Medical Practice Act 1994 (Vic) until 1 July 2007, then under the Health Professions Registration Act 2005 (Vic).
193 Medical Practice Act 1994 (Vic), s 23(2); Health Professions Registration Act 2005 (Vic), s 43(2).
195 Actually referred to as ‘notifications’ under the Health Professions Registration Act 2005 (Vic). The term ‘complaint’ is used throughout this thesis for the sake of consistency between states and over time.
no longer registered with the Vic Board.\textsuperscript{196} An investigating officer then investigated the complaint and reported back to the Vic Board with recommendations.\textsuperscript{197} Under the 2005 Act, the Vic Board could then choose to:\textsuperscript{198}

a) refer the matter, or part of it, to the HSC;
b) arrange to have the matter, or part of it, settled by agreement between the complainant and the Vic Board;
c) arrange to have the matter settled by agreement between the doctor and Vic Board;\textsuperscript{199}
d) cancel the doctor’s registration, by agreement with the doctor;
e) refer the matter to a health panel;
f) refer the matter to a professional standards panel (PSP, in the case of less serious matters); 
g) refer the matter to the Victorian Civil and Administrative Tribunal (VCAT) for hearing, in the case of more serious matters; 
h) refer the matter to another agency; or 
i) take no further action.

Under the 1994 Act, less serious matters were referred to an ‘informal hearing’ which operated much the same way as a PSP under the 2005 Act. More serious matters were referred to a ‘formal hearing’ which, unlike VCAT was a committee of the Vic Board itself. Under both Acts, the Vic Board was also permitted to refer a matter to an

\textsuperscript{196} Health Professions Registration Act 2005 (Vic), s 45. Only the first of these three reasons for not commencing an investigation applied under the Medical Practice Act 1994 (Vic), thus the new legislation increased the Vic Board’s discretion to decline to investigate.

\textsuperscript{197} Health Professions Registration Act 2005 (Vic), ss 45 to 50; Medical Practice Act 1994 (Vic), ss 24 and 25. There were various procedural safeguards that were required to be followed during the process, such as notification to the medical practitioner that an investigation was to commence. These steps are not outlined in this summary but can be found in the legislation.

\textsuperscript{198} Health Professions Registration Act 2005 (Vic), s 59(2).

\textsuperscript{199} For example, by the medical practitioner agreeing to: alter the way in which they practice; the imposition of conditions on their registration; suspension of registration for a specified period; undergo a health assessment or counselling; or undertake specified education or training: Health Professions Registration Act 2005 (Vic) s 59(4).
informal hearing/PSP or formal hearing/VCAT without first conducting an investigation and/or at its own volition rather than in response to a complaint.\textsuperscript{200}

An important interim public protection measure also available to the Vic Board was the ability to suspend a doctor where the Vic Board was of the opinion that it was \textit{necessary} to do so due to \textit{serious risk} posed by the doctor to the health and safety of the public.\textsuperscript{201}

c) Informal hearings/PSP hearings

Informal hearing panels were appointed by the Vic Board for each informal hearing and were comprised of up to three members of the Vic Board, including at least one registered doctor.\textsuperscript{202} At the hearing, which was held in private, the doctor concerned was entitled to make submissions and be accompanied by a support person but was not entitled to be legally represented.\textsuperscript{203} At the conclusion of the hearing, the panel concluded whether or not the doctor had \textit{whether by act or omission, engaged in unprofessional conduct which [was] not of a serious nature}.\textsuperscript{204} In the case of a finding of unprofessional conduct, the panel was then able to impose various disciplinary measures, as shown in Table 1. At any point during the hearing, either the doctor or the panel were able to stop the informal hearing and instead refer the matter to a formal hearing (if, for example, it became apparent that the conduct at issue may be more serious than first thought).\textsuperscript{205}

The outcome of an informal hearing could also be \textit{appealed} by the doctor to a formal hearing.\textsuperscript{206}

The PSP process, which replaced the informal hearing process in 2005, ran in a very similar fashion; the main differences being that the PSP was required to include one lay

\textsuperscript{200} Medical Practice Act 1994 (Vic), s 26; Health Professions Registration Act 2005 (Vic), s 46.
\textsuperscript{201} Health Professions Registration Act 2005 (Vic), s 40.
\textsuperscript{202} Medical Practice Act 1994 (Vic), ss 39 and 40.
\textsuperscript{203} Medical Practice Act 1994 (Vic), ss 42.
\textsuperscript{204} Medical Practice Act 1994 (Vic), s 43(1).
\textsuperscript{205} Medical Practice Act 1994 (Vic), s 44.
\textsuperscript{206} Medical Practice Act 1994 (Vic), s 45.
person, and on-referral was to VCAT rather than a formal hearing. A PSP was required to refer a matter to VCAT if it formed the opinion that there was a reasonable likelihood that VCAT would find that the [medical] practitioner had engaged in professional misconduct or where it was likely that VCAT would find the doctor's ability to practise to be affected to such an extent that the cancellation of registration may be warranted. A PSP also had the discretion to refer a matter to a health panel under certain circumstances. The precise terms of the findings available to the PSP were also slightly different, being that:

a) the doctor had, whether by act or omission, engaged in unprofessional conduct;

b) the doctor had engaged in professional misconduct (being a more serious finding than unprofessional conduct);

c) the doctor’s professional performance had been unsatisfactory.

Table 1 sets out the possible outcomes of such findings. Any application for review of a decision made by a PSP was heard by VCAT.

d) Formal hearings/VCAT hearings

As with informal hearings, formal hearings were heard by a committee of the Vic Board but were required to include at least three members of the Vic Board, including one lawyer and at least one registered doctor. In addition, the hearings were usually open to the public and the doctor was entitled to be legally represented. The panel had the authority to find that the doctor had or had not whether by act or omission, engaged in

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207 Health Professions Registration Act 2005 (Vic), Sch 2, cl 4.
208 Health Professions Registration Act 2005 (Vic), s 64(2).
209 Health Professions Registration Act 2005 (Vic), s 64(4).
210 For the avoidance of confusion between the different terms used by different jurisdictions and over time, the latter parts of this thesis refer simply to more serious professional misconduct and less serious professional misconduct.
211 Health Professions Registration Act 2005 (Vic), s 63(1).
212 Health Professions Registration Act 2005 (Vic), s 78.
213 Medical Practice Act 1994 (Vic), s 47(1).
214 Medical Practice Act 1994 (Vic), s 49.
unprofessional conduct—either of a serious nature or not of a serious nature. The possible consequences of such findings are set out in Table 1.

Table 1. Outcomes available following an adverse finding, according to decision-making body: Victoria, 1994-2010

<table>
<thead>
<tr>
<th></th>
<th>Less serious matters</th>
<th>More serious matters</th>
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</thead>
<tbody>
<tr>
<td>Referral</td>
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<tr>
<td>Health panel hearing</td>
<td>á</td>
<td>á</td>
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<tr>
<td>VCAT/Formal hearing</td>
<td>á</td>
<td>á</td>
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<tr>
<td>Sanctions</td>
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<tr>
<td>Caution or reprimand</td>
<td>á</td>
<td>á</td>
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<tr>
<td>Counselling</td>
<td>á</td>
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<tr>
<td>Required alteration of practice</td>
<td>á</td>
<td>á</td>
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<tr>
<td>Supervision</td>
<td>á</td>
<td></td>
</tr>
<tr>
<td>Education or training</td>
<td>á</td>
<td>á</td>
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<tr>
<td>Other conditions</td>
<td>á</td>
<td>á</td>
</tr>
<tr>
<td>Fine</td>
<td>á (&lt;$2,000) 216</td>
<td>á (&lt;$50,000)</td>
</tr>
<tr>
<td>Suspension of registration</td>
<td>á</td>
<td>á</td>
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<tr>
<td>Cancellation of registration</td>
<td>á</td>
<td>á</td>
</tr>
<tr>
<td>Disqualification from re-registration for set period</td>
<td>á</td>
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</tbody>
</table>

Appeals from the findings of a formal hearing were heard by the Administrative Appeals Tribunal, more latterly VCAT.217 A VCAT hearing218 is quite different to a

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215 Medical Practice Act 1994 (Vic), s 50(1).
216 However, no fine was permitted where the medical practitioner had already been fined by another tribunal or court in respect of that conduct: Medical Practice Act 1994 (Vic), s 50(4).
formal hearing as it is conducted by a tribunal that is part of the general court system rather than a subcommittee of the Vic Board. Following a hearing, VCAT had the power to make a finding as to whether or not:219

a) the doctor had engaged in ‘unprofessional conduct’ or ‘professional misconduct’220
b) the doctor’s ability to practise was affected;
c) the doctor’s performance had been unsatisfactory; or
d) the doctor was not of good character.

The disciplinary determinations that were available to VCAT under the 2005 Act are set out in Table 1 (under ‘sanctions’). Either the doctor or the Vic Board could appeal a decision of VCAT, but only on a question of law and only with leave, to the Court of Appeal.221

2 Western Australia

Western Australia had a very similar complaints and disciplinary system to Victoria during the decade prior to Nationalisation.

a) Receiving complaints

The Office of Health Review (renamed the Health and Disability Services Complaints Office in 2010) plays a similar role to the HSC in Victoria. The focus is on the settlement and conciliation of complaints and, where that fails, complaint investigation and possible referral.222

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217 Medical Practice Act 1994 (Vic), s 60, as per the Administrative Appeals Tribunal Act 1984 (Vic).
218 Under the Victorian Civil and Administrative Tribunal Act 1998 (Vic).
219 Health Professions Registration Act 2005 (Vic), s 77(1).
220 Note that a finding of the less serious charge of unprofessional conduct was available even though the medical practitioner had been alleged to have committed professional misconduct: Health Professions Registration Act 2005 (Vic), s 77(2).
221 Victorian Civil and Administrative Tribunal Act 1998 (Vic), s 148. Note that VCAT hearings remain a part of the disciplinary system in Victoria, even post-Nationalisation (as discussed below), however, the findings that are available have changed as they are now prescribed by the National Law Act rather than the 2005 Act.
222 See the Health Services (Conciliation and Review) Act 1995 (WA).
b) The WA Board’s investigation and interim action

The initial investigation process undertaken by the WA Board is not clearly prescribed in the *Medical Act 1894* (WA). Rather, the legislation simply says that where it appears to the WA Board that (in relation to conduct matters) a doctor may be guilty of infamous or improper conduct in a professional respect or of not complying with or contravening a condition or restriction imposed by the WA Board, the WA Board may refer the matter either to the Western Australia State Administrative Tribunal (WASAT) (for more serious matters) or to a Professional Standards Committee of the WA Board (PSC) (for less serious matters). Prior to its amendment in 2006, the 1894 Act did not provide for referral to the WASAT but, as in Victoria, more serious matters were referred to hearings before a committee of the WA Board.

Where the WA Board considered that a doctor’s activity involve[d] or [would] involve a risk of imminent injury or harm to the physical or mental health of any person it was able to place an interim constraint on that doctor’s practice (including entire prohibition on practice) for up to 30 days.

c) PSC hearings

The process for a PSC hearing in Western Australia was much the same as a PSP hearing in Victoria, with the PSC and the doctor both able to remove the matter, at any stage, to the WASAT. The available disciplinary measures arising out of a PSC hearing were a reprimand, the imposition of conditions or restrictions on practice, a fine of up to $5,000, or any combination of those measures. A doctor was able to apply for the WASAT to review a PSC decision.

d) WASAT hearings

Like VCAT, WASAT is not a specialist health tribunal but is a tribunal within the general court system. As the result of a WASAT hearing under the 1894 Act, a doctor could be reprimanded, suspended for up to 12 months, deregistered, and/or fined up to

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224 *Medical Act 1894* (WA), s12BA.
225 *Medical Act 1894* (WA), ss 13(5) and (6).
226 *Medical Act 1894* (WA), s 13(8).
$10,000.\textsuperscript{227} Alternatively, WASAT could require the doctor to give an undertaking of good behaviour to the WA Board by which the doctor agreed to comply with any restrictions and/or conditions imposed by WASAT.\textsuperscript{228}

3  \textit{Queensland}

a)  Receiving complaints

Complaints about doctors registered in Queensland may be made to the Health Quality and Complaints Commission (HQCC)\textsuperscript{229} or (prior to Nationalisation) directly to the Qld Board.\textsuperscript{230} A similar process of cross-referral as described above for Victoria then occurred, with similar options available for the disposition or continuation of the matter.\textsuperscript{231}

b)  The Qld Board’s investigation and immediate action

As in Victoria, the Qld Board’s process began with an investigation into the complaint in order to determine if it should be referred for further action. The investigation process is described in considerable detail in ss 61 to 106 of the \textit{Health Practitioners (Professional Standards) Act 1999 (Qld)} but, for the purposes of the current analysis was essentially the same as described above for Victoria.

Once the investigation was complete, the Qld Board was able to choose from among a number of actions, similar to those described above for Victoria. In terms of progressing the matter as a disciplinary issue, the Qld Board could:\textsuperscript{232}

\begin{itemize}
\item[a)] refer the matter to hearing by the Queensland Civil and Administrative Tribunal (QCAT);
\end{itemize}

\textsuperscript{227} \textit{Medical Act 1894 (WA)}, s 13(3).
\textsuperscript{228} \textit{Medical Act 1894 (WA)}, s 13(4).
\textsuperscript{229} Under the \textit{Health Quality and Complaints Commission Act 2006 (Qld)}.
\textsuperscript{230} \textit{Health Practitioners (Professional Standards) Act 1999 (Qld)}. Note that although the Medical Board of Queensland was constituted under the \textit{Medical Act 1939 (Qld)}, the complaints and disciplinary system for all registered health practitioners for all complaints received after 7 February 2000 was prescribed by the \textit{Health Practitioners (Professional Standards) Act 1999 (Qld)}.
\textsuperscript{231} \textit{Health Practitioners (Professional Standards) Act 1999 (Qld)}, ss 51 to 56.
\textsuperscript{232} \textit{Health Practitioners (Professional Standards) Act 1999 (Qld)}, s 118.
b) refer the matter to a professional conduct review panel (PCRP) for hearing; or

c) take disciplinary proceedings itself or by establishing a disciplinary committee to do so.

It is noteworthy that the 1999 Act made an express point of noting that, in deciding which action to take in response to an investigation, the Qld Board was to have regard to the objects of the Act, particularly s 6(a): the object of protecting the public by ensuring health care [was] delivered by registrants in a professional, safe and competent way.\(^{233}\)

c) Disciplinary proceedings taken by the Qld Board/PCRP hearings

As noted above, a differentiating feature of the complaints and disciplinary process operating in Queensland was that disciplinary proceedings could be taken by the Qld Board itself (or a committee of that Board), or by an externally appointed PCRP.\(^{234}\) If, in the course of such proceedings, the Qld Board, disciplinary committee or PCRP reasonably believed that the matter may have provided grounds for suspension or deregistration, immediate referral to QCAT was required.\(^{235}\) The doctor could also insist on referral to QCAT.\(^{236}\) Like informal hearings in Victoria, both types of hearings were held in private and the doctor was not entitled to legal representation.\(^{237}\) The Qld Board, disciplinary committee or PCRP was then required to make a decision about whether or not the doctor had behaved in a way that constituted ‘unsatisfactory professional conduct’.\(^{238}\) If such conduct was found to have occurred, the Qld Board was able to caution or reprimand the doctor and/or, with the doctor’s agreement, enter into an undertaking with them about their conduct or practice.\(^{239}\) A PCRP could also

\(^{233}\) *Health Practitioners (Professional Standards) Act 1999* (Qld), s 118(2).

\(^{234}\) PCRPCs were appointed by the Secretary of Professional Conduct Review Panels, a cross-profession administrative role: *Health Practitioners (Professional Standards) Act 1999* (Qld), ss 15 to 17, and 31.

\(^{235}\) *Health Practitioners (Professional Standards) Act 1999* (Qld), ss 134(1), 135(1) and 178.

\(^{236}\) *Health Practitioners (Professional Standards) Act 1999* (Qld), ss 133 and 177.

\(^{237}\) *Health Practitioners (Professional Standards) Act 1999* (Qld), ss 138, 139, 181 and 182. Note, also, that a disciplinary proceeding conducted by the Qld Board or a committee thereof could also be heard on the papers rather than an actual hearing being convened: s 128(3)(b).

\(^{238}\) *Health Practitioners (Professional Standards) Act 1999* (Qld), ss 164 and 200.

\(^{239}\) *Health Practitioners (Professional Standards) Act 1999* (Qld), s 165(2).
take such actions and, in addition, could impose a range of conditions and restrictions on the doctor’s registration.240 The legislation made it express that in making disciplinary decisions, the Qld Board and the PCRP were required to have reference to the purposes of disciplinary action stated in s 123 of the 1999 Act, namely: protection of the public; upholding the standards of practice within the profession; and maintaining public confidence in the profession.241

d) QCAT hearings

Unlike VCAT and WASAT, under the 1999 Act, QCAT cases were heard by a judge alone rather than a judge plus members of the medical profession.242 Upon finding that a doctor had committed ‘unsatisfactory professional conduct’ QCAT was able to impose any of the disciplinary measures available to a PCRP plus: require the doctor to give an undertaking to QCAT, including a financial assurance for that undertaking; suspend or cancel the doctor’s registration, including setting a minimum period of deregistration and dictating conditions for any future re-registration; and/or impose a fine of up to 1333 penalty units.243 QCAT was also able to impose permanent deregistration so that the doctor could never again be registered by the Qld Board.244 Like the Qld Board and the PCRP, QCAT was required to take into account the purposes set out in s 123 of the 1999 Act in making any disciplinary decisions.

Complaints about serious matters received up until 7 February 2000 were heard under the previous legislation that applied in Queensland, the Medical Act 1939 (Qld), by the Medical Assessment Tribunal.245

4 New South Wales

The complaints and disciplinary system in New South Wales is quite different to other states of Australia, particularly in relation to the involvement of the Health Care

240 Health Practitioners (Professional Standards) Act 1999 (Qld), s 201(2).
241 Health Practitioners (Professional Standards) Act 1999 (Qld), ss 167(1)(a) and 204(1)(a).
242 Health Practitioners (Professional Standards) Act 1999 (Qld), s 213(2).
243 Health Practitioners (Professional Standards) Act 1999 (Qld), ss 240 and 241. Note that in Queensland, in 2010, a penalty unit was $Au100: Penalties and Sentences Act 1992 (Qld), s 5.
244 Health Practitioners (Professional Standards) Act 1999 (Qld), s 241(5).
245 The procedures of the Queensland Medical Assessment Tribunal are not discussed in detail here as only three cases included in the First Study were determined by that entity.
Complaints Commission (HCCC) in the disciplinary process. This is the main reason that New South Wales was not considered for inclusion in the Second Study, despite its large population of doctors. New South Wales' inclusion in First Study, however, does not raise the same concerns because, as illustrated by the remainder of this section, the disciplinary end of the process was similar to that of other states at the time, albeit reached via a different route. As New South Wales decided not to adopt the complaints and disciplinary framework under the National Laws Act, the pre-Nationalisation system continues to apply in relation to the conduct of doctors in that state.

a) Receiving complaints

As in the other jurisdictions, a complainant may address their complaint to either the NSW Board or the HCCC.246

In progressing a complaint, the NSW Board may:247

a) refer the matter to the HCCC for investigation, while also referring it to a Professional Standards Committee (PSC) or to the New South Wales Medical Tribunal (NSWMT);

b) refer the matter to the equivalent of a health or performance assessment panel;

c) direct the doctor concerned to attend counselling;

d) refer the complaint to the HCCC for conciliation or other resolution under the Health Care Complaints Act 1993 (NSW); or

e) determine that no further action should be taken,

while the HCCC may:248

a) refer the matter to the NSW Board or, after consultation with the NSW Board, to a PSC or the NSWMT;

b) refer the complaint for conciliation;

c) determine that no further action should be taken; or

246 Medical Practice Act 1992 (NSW), ss 42 and 49.
247 Medical Practice Act 1992 (NSW), s 50.
248 Medical Practice Act 1992 (NSW), s 51.
d) take any other action as permitted by the Health Care Complaints Act 1993 (NSW).

Thus, either the NSW Board or the HCCC may require that a complaint is investigated by the HCCC.

b) PSC hearings

A PSC is comprised of two doctors, a lawyer, and a lay person, none of whom may be members of the NSW Board. A doctor appearing before the PSC is entitled to be legally represented. If, after hearing a complaint, the PSC upholds the complaint, it may:

a) caution or reprimand the doctor;
b) order that the doctor attend medical or psychiatric treatment or counselling;
c) impose conditions on the doctor’s registration;
d) direct the doctor to complete specified educational courses;
e) set reporting requirements for the doctor to meet; and/or
f) order that the doctor seek and take advice on managing their practice from specified persons.

An order or condition that is imposed may be designated as a ‘critical compliance order or condition’ meaning that if that condition or order is not met the doctor will be deregistered by the NSWMT. If the PSC finds the doctor guilty of ‘unsatisfactory professional conduct’ or ‘professional misconduct’ a fine of up to 50 penalty units may also be imposed, providing that a fine or penalty has not already been imposed by a court in respect of the same conduct. If, at any point, the PSC forms the view that the complaint, if substantiated, may provide grounds for suspension or deregistration, the PSC must immediately terminate the hearing and refer the matter to the NSWMT.

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249 Medical Practice Act 1994 (NSW), s 169.
250 Medical Practice Act 1994 (NSW), s 61.
251 Medical Practice Act 1994 (NSW), s 61(3).
252 Medical Practice Act 1994 (NSW), s 62. Note that, in New South Wales, in 2010, one penalty unit was $A110: Crimes (Sentencing Procedure) Act 1999 (NSW), s 17.
253 Medical Practice Act 1994 (NSW), s 179.
c) NSWMT hearings

Unlike the corresponding tribunals in Victoria, Western Australia and Queensland, the NSWMT is a specialist medical tribunal rather than a tribunal of general jurisdiction. The NSWMT sits with a Chairperson (who is a member of the judiciary) or Deputy Chairperson, plus two registered doctors and one lay person, none of whom may also be members of the NSW Board.254

The NSWMT may impose any of the disciplinary measures available to a PSC. In addition, the NSWMT may suspend or deregister a doctor who it is satisfied is not competent to practise medicine, is guilty of 'professional misconduct' (being a more serious charge than unsatisfactory professional conduct), has been convicted of a criminal offence that renders them unfit in the public interest to practise medicine, or is not of good character.255 If the NSWMT is satisfied that a doctor has breached a critical compliance order or condition, it must order that they be deregistered.256 The NSWMT may also impose a fine of up to 250 penalty units. A decision of the NSWMT may be appealed to the New South Wales Supreme Court.257

C Australia: Post-Nationalisation

1 The new national system

As outlined in Chapter 2, Australia now has a national system for the regulation of doctors that replaces the previous state-based systems. All complaints received and disciplinary issues arising from 1 July 2010 are dealt with under that new system (except for those concerning doctors in New South Wales), as prescribed by the National Law Act.258 Both AHPRA and the MBoA, as described in chapter 2, play key roles in the new system.

254 Medical Practice Act 1994 (NSW), s 147.
255 Medical Practice Act 1994 (NSW), s 64(1).
256 Medical Practice Act 1994 (NSW), s 64(1A).
257 Medical Practice Act 1994 (NSW), s 90.
258 Any complaint received by a Board but that that Board had not started dealing with by 1 July 2010, the complaint is to be treated as a complaint made after 1 July 2010 to AHPRA. If the Board had started dealing with the complaint before that date, it is to be dealt with by the new structures (ie,
a) Receiving complaints

When AHPRA receives a complaint about a doctor it must refer that complaint to the MBoA for assessment. That assessment must be done within 60 days and must include a decision as to whether or not the complaint is one that could have also been made to the relevant state-based Complaints Commission. If so, the complaint must be referred to that entity and, as in the past, the MBoA and the Complaints Commission must then negotiate as to who will progress the complaint and how.

b) The MBoA’s investigation and immediate action

Where a complaint stays with the MBoA, the MBoA may decide to take no further action in relation to the matter, take immediate action (such as order interim suspension), and/or commence an investigation. The MBoA may also conduct an investigation not arising out of a complaint received but at its own initiative. As the result of an investigation, the MBoA may either take no further action, refer the matter back to a Complaints Commission, or take another action, including referring the medical practitioner for a health or performance assessment.

Once the investigation has been completed, including any health or performance assessment, the MBoA may then decide to take action itself, refer the matter to a (health, or performance and professional standards) panel for hearing and decision, or

AHPRA and the MBoA) but using the procedures and appeal processes that applied under the previous legislation: National Law Act, s 289.

- National Law Act, s 148.
- National Law Act, s 149. Note that the Complaints Commissions are the same as those operating prior to Nationalisation, as described above, and retain the same functions as they did previously.
- National Law Act, s 150.
- National Law Act, s 151.
- National Law Act, ss 155 – 159. Although only described briefly in relation to the previous systems outlined above, immediate action has long been an important weapon in the boards’ arsenal in promoting public protection. Available in various forms in all of the jurisdictions prior to Nationalisation, it now allows for the interim suspension of a medical practitioner whom the MBoA reasonably believes poses a serious risk to persons such that immediate action is necessary to protect the health and safety of the public. Such suspension continues in force while the usual disciplinary process is followed.
- National Law Act, s 160.
- National Law Act, s 160.
- Including imposing conditions on the practitioner’s practice or giving the practitioner a caution: s178(2).
refer the matter straight to the relevant disciplinary tribunal. Referral straight to the disciplinary tribunal is required where the MBoA ‘reasonably believes’ that the doctor has committed ‘professional misconduct’ (being more serious than ‘unprofessional conduct’).  

268

c) PSP hearing

PSPs under the National Law Act are similar to PSPs under the previous Victorian legislation. They are made up of at least three members: two registered doctors plus one lay member, preferably from the state in which the matter originated. PSP hearings are not open to the public and, with leave of the PSP, a doctor may be represented by a lawyer.  

When a PSP determines that a doctor has committed ‘unprofessional conduct’ it may impose conditions on the doctor or caution or reprimand the doctor. If, at any time during a hearing, the PSP ‘reasonably believes’ that the doctor has committed ‘professional misconduct’ (being more serious than ‘unprofessional conduct’), the PSP must refer the matter to the relevant disciplinary tribunal.  

272

d) Disciplinary tribunal hearing

The National Law Act continues to utilise state-based tribunals (for example, VCAT, QCAT and WASAT) as the disciplinary tribunals responsible for hearing and making decisions about the most serious disciplinary matters. As those disciplinary tribunals are all established by other Acts, the National Law Act includes a ‘supremacy’ provision giving itself priority in any areas in which both Acts apply and are inconsistent with one another. The parties in any tribunal proceedings under the National Law Act are the doctor whose conduct is at issue and the MBoA.  

275

268 National Law Act, s 183.
269 National Law Act, s 182.
270 National Law Act, ss 186 and 189.
271 National Law Act, s 191.
272 National Law Act, s 190.
274 National Law Act, s 198.
275 National Law Act, s 194.
A disciplinary tribunal may find that the doctor behaved in a way that constituted ‘unsatisfactory professional performance’ ‘unprofessional conduct’ or ‘professional misconduct’. The disciplinary measures that may be imposed by the tribunals are the same as those able to be imposed by VCAT under the *Health Professions Registration Act 2005* (Vic), with the exception that the maximum fine has decreased to $30,000.277

The procedures of the disciplinary tribunals, the precedents they follow and the appeal rights from those tribunals all differ according to the state and territory laws applying to those tribunals. This means that despite Nationalisation, state and territory differences look set to continue in relation to the resolution of the most serious cases of professional misconduct. However, it is too early to tell whether or not this is actually occurring.

2 *New South Wales*

Another limitation on the uniformity offered by Nationalisation is the stance taken by the New South Wales government. As noted above, New South Wales elected not to adopt the new national complaints and disciplinary system. The explanation given for this ‘opt out’ relates to the different role played by the HCCC in New South Wales compared to Complaints Commissioners in other states immediately prior to Nationalisation.278 As noted by the New South Wales Minister for Health:

[The National Law complaints model] is markedly different from the current New South Wales model as it relies primarily on the health professional boards to undertake disciplinary functions and does not provide for an independent investigator and prosecutor, such as the Health Care Complaints Commission. This Government remains committed to the Health Care Complaints Commission as an integral element in complaints management in New South Wales.

...

276 National Law Act, s 196(1).
277 National Law Act, s 196(2).
Stakeholders in New South Wales have uniformly welcomed the commitment of
the Government to retain the existing complaints system and recognise the
benefits that a robust, independent and transparent system delivers to the public,
health practitioners and the health system as a whole.\textsuperscript{279}

In New South Wales, the roles of the NSW Board and the HCCC are essentially the
reverse of what is seen in other states: serious complaints are prosecuted by the HCCC
not the NSW Board, while the NSW Board deals with matters that are amenable to
conciliation.\textsuperscript{280} In addition, the NSW Board articulates a more restrictive approach as to
the types of conduct appropriately addressed by the NSWMT:

The Council recognises that investigation by the HCCC and a subsequent
hearing before a Professional Standards Committee or Medical Tribunal is only
appropriate in matters where there is evidence of unethical, reckless, wilful or
criminal behaviour in either clinical or non-clinical domains. In all other
circumstances, public protection can be achieved and professional standards
maintained through the application of non-disciplinary and educative
responses.\textsuperscript{281}

New South Wales is thus participating in Nationalisation as a \textit{'co-regulatory'} jurisdiction only. The state remains responsible for running and funding its own
complaints and disciplinary framework. If AHPRA receives a complaint about
something that occurred in New South Wales, AHPRA is required to refer that
complaint to the NSW Board.\textsuperscript{282}

\textsuperscript{279} Ibid.
\textsuperscript{281} Ibid.
\textsuperscript{282} National Law Act, s 148.
D    New Zealand

1    The complaints and disciplinary system

a)    Receiving complaints

In New Zealand, as in the other jurisdictions described above, a complaint about a registered doctor may be made either to the HDC or to the MCNZ. Any complaint received by the MCNZ that alleges that a doctor’s conduct has affected a patient must be referred to the HDC.\(^{283}\) If the HDC’s preliminary assessment reveals that the doctor’s competence, fitness to practice, or appropriateness of conduct may be in doubt, the HDC may refer the complaint to the MCNZ.\(^{284}\) To a greater extent than in Australia, the legislation provides for this referral process to be dominated by the HDC’s decision-making rather than by a process of mutual negotiation. If the HDC decides to formally investigate a complaint about a doctor, the HDC must notify the MCNZ of that decision and, while that investigation is ongoing, the MCNZ may not take any disciplinary action (including a disciplinary investigation), other than interim action, as outlined below.\(^{285}\)

b)    The MCNZ’s investigation and immediate action

If there is a criminal proceeding pending or an HDC investigation is underway, and the MCNZ is of the opinion that there is doubt as to the appropriateness of the doctor’s conduct in his or her professional capacity, the MCNZ may suspend the doctor or impose conditions on his or her scope of practice for an interim period.

Under the HPCA Act, one of the steps available to the MCNZ is to refer a complaint to a Professional Conduct Committee (PCC) for hearing. Unlike in the Australian jurisdictions described above, a matter cannot bypass the PCC and go straight to the

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\(^{283}\) HPCA Act, s 64.

\(^{284}\) Health and Disability Commissioner Act 1994 (NZ), s 34(1)(a).

\(^{285}\) HPCA Act, s 66; HDC Act, s 42(1).
Health Practitioners Disciplinary Tribunal (HPDT) for hearing, no matter how serious. It must always go first through a PCC, which plays a gate-keeping role.\textsuperscript{286}

Complaints received prior to 18 September 2003 were dealt with under the \textit{Medical Practitioners Act 1995} (NZ). Under that Act, complaints were able to be referred to a Complaints Assessment Committee (CAC) and, from there, to the Medical Practitioners Disciplinary Tribunal (MPDT).

c) PCC/CAC hearing

PCCs are appointed by the MCNZ and are comprised of two doctors plus a lay person. Having heard submissions from the doctor, the PCC writes a report, making recommendations and/or determinations under s 80 of the HPCA Act. The range of possible recommendations are that the MCNZ:\textsuperscript{287}

\begin{itemize}
  \item [a)] review the doctor's competence;
  \item [b)] review the doctor's fitness to practice;
  \item [c)] review the doctor's scope of practice;
  \item [d)] refer the subject matter of the investigation to the Police; and/or
  \item [e)] counsel the doctor.
\end{itemize}

Alongside one or more of these recommendations, the PCC may determine that:\textsuperscript{288}

\begin{itemize}
  \item [a)] no further steps be taken under the HPCA Act in relation to the subject matter of the investigation; or
  \item [b)] a charge be brought against the doctor in the HPDT; or
  \item [c)] the complaint be submitted to conciliation.
\end{itemize}

The processes in relation to CACs under the 1995 Act were essentially the same as now apply for PCCs under the HPCA Act.

\textsuperscript{286} This factor may be at least partially responsible for some of the inter-state differences identified in chapter 6.
\textsuperscript{287} HPCA Act, s 80(2).
\textsuperscript{288} HPCA Act, s 80(3).
d) HPDT/MPDT hearing

As discussed above, every complaint that becomes the subject of a HPDT hearing after being investigated by the MCNZ must have already been assessed by a PCC as appropriate for such referral. In fact, it is the PCC that lays the charge in the HPDT and is responsible for the conducting of that litigation.\(^{289}\) The alternative route to the HPDT is via the HDC. If the HDC investigates a complaint and makes a finding that the doctor has breached the Health and Disability Services Consumers' Code of Rights (‘Code of Rights’), the HDC may then decide to refer the doctor to the Director of Proceedings, an independent statutory officer within the HDC. The Director of Proceedings will then assess the matter and decide whether to bring the proceeding in the Health Practitioners Disciplinary Tribunal (HPDT). A charge that is brought by a PCC is treated identically by the HPDT as one brought by the Director of Proceedings.

The HPDT sits with a legally qualified chair, three members of the medical profession plus a lay person. The HPDT may find a doctor guilty of:

- a) professional misconduct;
- b) conviction of an offence affecting fitness to practice;
- c) practising without holding a practising certificate or practising outside of their scope of practice;
- d) failing to observe conditions on their scope of practice; or
- e) breaching an HPDT order.

As a result, the HPDT may deregister, suspend or censure the doctor, impose conditions on the doctor’s practice, and/or order that the doctor pay a fine of up to $NZ30,000 and/or costs.\(^{290}\)

The procedures and options available to the MPDT under the 1994 Act were similar but the available findings were described differently, with professional misconduct divided into three possible charges of varying seriousness: ‘disgraceful conduct’, ‘professional

\(^{289}\) HPCA Act, ss 81(2) and 91(4).
\(^{290}\) HPCA Act, s 101(1).
misconduct and conduct unbecoming. The disciplinary measures that could be imposed by the MPDT were also essentially the same.

e) The 2008 Review

Section 171 of the HPCA Act requires that the Director-General of Health review the Act’s operation three years after its commencement. The first review took place in 2008 (the 2008 Review), with a report of that review released in June 2009 (the Report of the 2008 Review). In relation to the complaints and disciplinary system operating under the HPCA Act, the Report of the 2008 Review made a number of recommendations for mostly minor and technical amendments. Perhaps of most note in terms of public protection potential, were the recommendations that:

a) the test for interim suspension be standardised across the HPCA Act so that it is universally restricted to situations in which there are reasonable grounds to believe that a practitioner’s conduct poses a risk of serious harm to the public;

b) the HPDT be given the power to set a minimum period during which a de-registered practitioner may not apply for re-registration; and

c) the HPDT be given the power to advise a practitioner’s employer of orders imposed on the practitioner where to do so would be in the public interest.

The second and third recommendations, if implemented would make the New Zealand situation consistent with that prescribed by the National Law Act in Australia. The first recommendation, however, continues a different standard for interim suspension to the serious risk to persons’ test adopted by the National Law Act.

292 Medical Practitioners Act 1995 (NZ), s 110.
293 Ministry of Health (NZ), ‘Review of the Health Practitioners Competence Assurance Act 2003: Report to the Minister of Health by the Director-General of Health’ (MoH, 2009).
296 Ibid, rec 25.
297 National Law Act, s 156.
According to the New Zealand Ministry of Health, a Bill to progress the recommendations set out in the Report of the 2008 Review has been approved and was expected to be referred to the Parliamentary Health Select Committee in 2012, however, this has not yet occurred. The Report of the 2008 Review also recommended that another review of the HPCA Act be conducted in 2012 in order to consider the policy considerations that were not resolved as part of the 2008 Review (given it being limited to operational matters).

f) The 2012 Review

At the end of August 2012, the New Zealand Ministry of Health began public consultation on a further review of the HPCA Act (the 2012 Review). The 2012 Review is to be guided by the following four principles:

a) Future – a regulatory framework that supports workforce flexibility;
b) Consumer – operation of the HPCA Act in an accessible and transparent way;
c) Safety – a systems perspective that balances individual accountability with team and organisational accountabilities and

d) Cost effectiveness – the level of regulation is matched to the level of risk of harm to the public and ensures value for money is maintained.

Judging from the consultation and report-back timeframes set out by the Ministry of Health, it is unlikely that any resulting changes to the HPCA Act will come into effect (or perhaps even be announced) before 2014.

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301 Ibid.
As discussed above and as illustrated in Figure 2 below, the complaints and disciplinary frameworks that govern conduct issues in various states of Australia, post-Nationalisation and in New Zealand are similar in many respects, but also have some significant differences. The key differences can be summarised as follows:

a) In New South Wales and New Zealand, there is an additional process of investigation that always acts as a gate-keeper to the relevant Tribunal. In New South Wales, this is the Professional Standards Committee of the Complaints Commission while, in New Zealand, it is a Professional Conduct Committee of the Board. The HDC in New Zealand may also play an indirect gatekeeper role in matters getting to a PCC in that any HDC investigation must be completed first.

b) In New South Wales, the Complaints Commission is the body responsible for the investigation of serious conduct issues and the prosecution of related charges in the Tribunal. This continues post-Nationalisation.

c) In New Zealand, a prosecution may be brought in the Tribunal by either the Complaints Commission\(^{302}\) (as in New South Wales) or by the Board (as in the other States).

d) Over time, each jurisdiction has moved to having the most serious disciplinary matters heard by an independent Tribunal, rather than utilising a committee of the relevant Board as was previously the case in some jurisdictions.

\(^{302}\) Through the Director of Health and Disability Proceedings.
Figure 2. Simplified complaints and disciplinary framework for conduct issues in various states of Australia and New Zealand and post-Nationalisation in Australia, setting out the various approaches for comparative purposes.
IV CONCLUSION

As illustrated in this chapter, the complaints and disciplinary systems for doctors in Australia and New Zealand are complex, though less so now that there is consistency across most states of Australia. As well as the internal complexities within the disciplinary systems themselves and the way in which complaints are fed into the disciplinary structures, their operation is also influenced by the general legislative, policy and practical context within which they sit. For example, the constraint on civil litigation following treatment injury in New Zealand may mean that the complaints and disciplinary system is seen in a different light and serves a subtly different purpose (at least in the minds of complainants).

Having considered the professional regulation regime that is in place, it is instructive to now pause briefly to consider the purpose of that regime. The next chapter asks what it is that these complex systems and interactions are intended to achieve, and what contribution is it envisaged that the complaints and disciplinary system will make to professional regulation as a whole.
CHAPTER 4 – REGULATION FOR PUBLIC PROTECTION

I INTRODUCTION

The last two chapters have focussed on the detail of the regulatory framework that applies to doctors in Australia and New Zealand, paying particular attention to the parts of the framework that are activated when things go wrong. As noted in chapter 1, such professional regulatory regimes are commonly justified as necessary for the protection of the public.

This chapter probes that justification as it applies currently and has applied over the last decade to the regulation of doctors in the two countries. First, the chapter considers the basis for the public protection justification for professional regulation generally, taking into account theoretical and legislative considerations. Other, competing rationales for professional regulation are also examined. A similar inquiry is then directed at the complaints and disciplinary system, and its role within that wider regulatory framework. Having assessed the robustness and dominance of the public protection rationale, the chapter then moves on to explore what exactly is meant by ‘public protection’ and how it relates to the wider concept of public interest.

II THE PURPOSE OF PROFESSIONAL REGULATION

A Introduction

Regulation is a concept that has eluded conclusive definition despite many years of legal scholarship. Indeed, regulation can be variously described depending on the context and purpose of the discussion. Definitions range from the broad notion of regulation as anything that influences the flow of events\textsuperscript{303} to the much narrower idea of regulation as rules, regulations and regulatory agencies.\textsuperscript{304} Regulation, even

\textsuperscript{303} Christine Parker and John Braithwaite, 'Regulation' in Peter Cane and Mark Tushnet (eds), \textit{The Oxford Handbook of Legal Studies} (Oxford University Press, 2003), p119.

\textsuperscript{304} Carla Lipsig-Mumme, 'Negotiating Regulation: The State, the Professions and the Dilemma of Autonomy' in Christopher Arup et al (eds), \textit{Labour Law and Labour Market Regulation} (The Federation Press, 2006).
according to the narrower construction, is not the exclusive domain of the state, but includes rules and regulations imposed by other, non-state bodies, such as professional bodies and colleges. Professional regulation usually falls somewhere on the spectrum between pure self-regulation (where regulation is imposed on a profession by members of that profession in a manner dictated by that profession) and state-regulation (where the setting of rules and regulations, plus the assessment of compliance and discipline for non-compliance are all undertaken by a state agency or prescribed in legislation). Hybrid approaches include state-mandated self-regulation, where the state dictates the manner in which regulation is to occur but then leaves implementation to the profession.

As foreshadowed in the previous two chapters, this thesis is concerned chiefly with the mechanisms that surround medical board and Tribunal processes, in particular, the complaints and disciplinary system. This focus on formal structures and functions responds to the aims of this thesis. However, it is important to remember that these systems do not operate in isolation. Even within a formal regulatory system, doctors are also influenced, and thus some would argue 'regulated' by 'professional indemnity insurers and 'softer' forms of regulation ... and by individual colleagues and consumers of [their] services.'

Regulation is also not just about the structures that exist, but is frequently defined according its purpose:

Regulation is the sustained and focused attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve mechanisms of standard-setting, information-gathering and behaviour modification.

It follows, therefore, that understanding the purpose of any particular regulatory system, or components thereof, is vital in assessing the operation of that system.

305 Such an approach was expressly anticipated and approved by Gahan and Brosnan in Peter Gahan and Peter Brosnan, 'The Repertoires of Labour Market Regulation' in Christopher Arup et al (eds), Labour Law and Labour Market Regulation (The Federation Press, 2006).
306 Linda Haller, 'Regulating the Professions' in Peter Cane and Herbert Kritzer (eds), The Oxford Handbook of Empirical Legal Research (Oxford University Press, 2010), p217.
Purpose itself is not necessarily a static or singular notion. Rather, purpose can undergo change due to the decisions as to the forms adopted, the influence of interested groups and subsequent experiences of those charged with implementing it and may be unclear as in any one regulatory regime there may be several policy objectives or concerns competing for priority in both the design and implementation of regulation.

This section looks first at theoretical concepts of the regulation of doctors and the purpose of that regulation. This is followed by an analysis of the design (the relevant legislation) of the health practitioner regulatory system in operation in Australia and New Zealand. Questions of implementation will be considered in later chapters, informed by the results of the Studies.

B Purpose according to regulatory theory

1 Protection of the public

There must be a clear recognition that the medical workforce will always contain a proportion of doctors whose performance or conduct has the potential to harm patients or disrupt the effective delivery of patient care.

Traditional conceptions of the doctor-patient relationship hold that the information asymmetry between doctors and patients means that many patients are unable to adequately protect themselves from such doctors. It thus becomes the province of the professional regulatory system to provide that protection. Typically, the system does this in a number of ways: by restricting entry to the profession to those who have met minimum standards; by setting expectations about behaviour and performance for those who are members of the profession (sometimes described as ‘professionalism’); and by

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intervening in relation to those who do not meet those expectations. The mechanics of each of those processes has been described in the previous two chapters.

However, the regulatory system also has the potential to impinge on individual rights and freedoms. For those wishing to practice medicine, there are minimum standards to be met and maintained, and a requirement that they operate in accordance with the processes and procedures set down by the regulator (for example, by applying for an APC or completing prescribed CPD each year). For the public, registration may lead to a decreased (and likely more expensive) choice of practitioners able to legally perform the services sought, or able to attract government subsidies for providing those services. These erosions of individual rights and freedoms are generally justified by reference to the greater good they achieve by way of public protection, without which justification becomes difficult. In the words of John Stuart Mill:

The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant.\(^{312}\)

To be justifiable from a societal standpoint, therefore, the regulatory system must provide protections to the public that outweigh the costs associated with that regulation.\(^{313}\) Recently, in the UK, the Council for Healthcare Regulatory Excellence has been promoting the concept of ‘right touch regulation’ described as ‘the minimum regulatory force required to achieve the desired result’\(^{314}\). It is regulation informed by the desire to be proportionate, consistent, targeted, transparent, accountable and agile, and recognises that regulation has an important public role but that it exists to protect people, not to control unduly how they choose to live their lives. We think that as individual

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\(^{313}\) The New Zealand Government’s policy framework for occupational regulation operates three key assumptions: a) Intervention by government should generally only occur where there is a problem or potential problem that is either unlikely to be solved in any other way or is such that it is inefficient or ineffective to solve in any other way; b) The amount of intervention should be the minimum required to solve the problem; and c) The benefits of intervention must exceed the costs. Ministry of Health (NZ), ‘2012 Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document’ (MoH, 2012), p16.

citizens we should expect to look after ourselves and those we care about and those we have responsibility for. We should be helped to do so by laws, regulations and standards that restrain those who intend ill, those who are careless of the wellbeing of others and those whose greed or incompetence causes harm.  

To be effective, health professional regulation must appropriately (and only to the extent necessary) limit entry, monitor performance and conduct, and restrict practice, in a manner that protects the public from those doctors who may otherwise put the public at risk.

2 Protection of the profession

While purporting to exist for the benefit of the public, each of the elements of the regulatory system can also be interpreted as fundamentally protective of the profession itself. As described half a century ago:

> For decades it [the American Medical Association] kept down the number of physicians, kept up the costs of medical care, and prevented competition with duly apprenticed and sworn physicians by people from outside the profession all, of course, in the name of helping the patient...

Being a regulated profession conveys benefits on its members. Perhaps the most obvious of these, as alluded to by Freidman above, is the ability to exclude others from the profession, thereby achieving an effective monopoly for the provision of regulated services. Dubbed by some as a professional project of marked control and collective upward social mobility constraints on competition allow a profession to increase costs for services, thus securing its members a good income, and potentially imposing

unnecessary or excessive costs on society.\textsuperscript{318} Regulation also confers legitimacy upon a profession, through the recognition of that profession as ‘special’ and requiring particular training and skills for practice. With the legitimisation of a profession may also come improved social status for its members. For some professions, including medicine, control over ‘subordinated’ occupations is also achieved.\textsuperscript{319}

The perceived professional advantages gained through regulation are self-evident from the numbers of non-regulated health professions that seek to become regulated. For example, when considering the \textit{Health Practitioner Competence Assurance Bill} (NZ), the New Zealand Health Parliamentary Select Committee received 33 submissions from groups (including acupuncturists, homeopaths and naturopaths) who were, at that time, unregulated but who wished to be included as health practitioners under the HPCA Act.\textsuperscript{320}

In the quote above, Freidman also seems to be expressing some cynicism at the idea that benefit to the profession and the public may co-exist. This is often coupled with a perception that benefit to the profession is an inherently negative outcome. In the author’s view, any benefit experienced by the profession is actually irrelevant, provided the attainment of such benefit is not the objective of the regulatory scheme and does not, in any way, diminish the intended benefit to the public (including by increasing the cost of services). As expressed recently by the New Zealand Ministry of Health, it is important to ensure that registration and training requirements are

\begin{center}
set at the level required to ensure public safety, and not at a higher level that
provides more economic benefits to the health professions than is warranted.\textsuperscript{321}
\end{center}

Regulation should be about ensuring that doctors are ‘good enough’ for safety to be assured. It should set the standard for good medical practice

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{319} Judith Healy, \textit{Improving Health Care Safety and Quality} (Ashgate, 2010), p100.
\item \textsuperscript{320} Barbara von Tigerstron and Katherine Ellena, 'Regulation of Contemporary and Alternative Medicine - a Trans-Tasman Perspective' (2006) 23(2) \textit{Law in Context} 198, p205.
\end{itemize}
\end{footnotesize}
at a level that reflects the bottom-line expectations of patients but not so ambitious as to be beyond the reach of ordinary doctors.\textsuperscript{322}

3 \textit{The interaction between public protection and professional interests}

Recognising then that regulation serves both public and professional interests, it is appropriate to consider the way in which the two sets of interests interact. It has been suggested that this interaction is inherently subject to tension and contradiction\textsuperscript{323} However, while the co-existence of two apparently competing agendas suggests one will necessarily become subservient to the other, it is also possible to construe the public and professional interests as aligned with one another.\textsuperscript{324} Regulation confers legitimacy and benefit on the profession, allowing it a privileged position within society. Society then places expectations on that profession which must be upheld by individual members of the profession and insisted upon by the regulator. Members of the profession are deterred from breaching those expectations by the threat of being excluded from the profession, and the benefits membership confers. The idea is that the very fact that the regulatory regime benefits members of the profession encourages high standards within the profession, thereby also protecting the public.\textsuperscript{325} Though attractive, this argument presupposes effective detection of aberrant behaviour and that, when behaviour that may put the public at risk is detected, steps will be taken by the regulator to protect the public, irrespective of the resulting loss of privilege to the individual doctor. The steps that are taken by the regulator must align with and adequately address risk, rather than being influenced by the potential impact the detected behaviour and consequent sanction may have on the individual doctor or on the reputation of the profession. The Studies outlined in the following chapters, and discussed in the remainder of this thesis shed some light on whether or not this presupposition is valid.

\textsuperscript{323} Christopher Arup et al (eds), \textit{Labour Law and Labour Market Regulation} (The Federation Press, 2006), p482 per Carla Lipsig-Mumme.
\textsuperscript{324} Christine Parker, \textit{Just Lawyers} (Oxford University Press, 1999).
\textsuperscript{325} Anton Lowenberg and Thomas Tinnin, 'Professional versus Consumer Interests in Regulation: The Case of the US Child Care Industry' (1992) 24 \textit{Applied Economics} 571, p573.
Fundamentally, what is important from a societal perspective is what happens when the interests of the profession and the interests of the public come into conflict. For example, it may be protective of the public to require registered professionals to complete prescribed CPD each year; yet the profession may see this as unnecessary in advancing its own agendas. In whose favour such conflicts are resolved will be greatly influenced by the identity, the persuasion, and the power of the regulator. This is the friction point between self-regulation and state regulation. Suffice to say 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.

4 The interests of the state

So far, this chapter has dealt with the protection of the public and the interests of the profession, as if they are the only two considerations in play. Haller warns against this stance, emphasising that the state itself also has an interest in professional regulation. In the author’s view, the interests of the state extend beyond protecting the public and furthering the interests of the profession. Rather, the state’s interest may also include considerations such as ensuring adequate supply and appropriate distribution of doctors for the benefit of its citizens. The relationship between public protection and such matters is explored in more detail later in this chapter.

5 Conclusion

As outlined above, professional regulation places limits on the freedoms of various actors, justified by the notion that it does so in order to protect the public. Other agendas, such as those of the profession itself or the state, may compete with public

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326 Although, scepticism has been expressed as to whether or not CPD offers much in the way of competence assurance and, therefore, public protection: see p35.
327 This debate is beyond the scope of this thesis. See Donald Irvine, 'The Performance of Doctors I: Professionalism and Regulation in a Changing World' (1997) 315 BMJ 1540 for more on this debate within the medical context.
328 Linda Haller, 'Regulating the Professions' in Peter Cane and Herbert Kritzer (eds), The Oxford Handbook of Empirical Legal Research (Oxford University Press, 2010), p218.
329 This interest is express in the New Zealand Ministry of Health’s discussion document on the 2012 Review which emphasises the need for a future focus in health practitioner regulation. That future focus is explained as is the need to attract and retain a workforce that delivers services in a context of workforce shortage Ministry of Health (NZ), '2012 Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document' (MoH, 2012).
330 See p112 onwards.
protection and may, at times, be allowed to subvert that objective. The priority given to public protection, and whether or not compromise of that goal is possible, likely, or even legitimate, depends, at least in part, on the specifics of the particular regulatory system. The next section of this chapter considers what the design of the system that regulates doctors in Australia and New Zealand (as set out in the relevant legislation) reveals about the purpose of such regulation.

\[C\] Purpose according to the legislature

1 Introduction

There are two principal ways of determining the purpose of a particular piece of legislation. First, most modern Acts contain specific purpose provisions that set out the purpose of the Act as a whole and, in some cases, parts of that Act. Secondly, the scheme of the legislation should be considered: what does it do, what does it not do, and how well do these things fit with any express purpose? This section explores statutory purpose according to each of those criteria for the legislation that regulates doctors in Australia and New Zealand, beginning with the statements of purpose recorded in each Act, then moving on to consider who and what is regulated, and who is responsible for performing the regulatory function.

2 Purpose according to legislative statement

As outlined in chapters 2 and 3, there are 12 different Acts that have regulated doctors in the jurisdictions of interest since 2000. In every one of those Acts, protection of the public appears as a dominant consideration, albeit sometimes differently focused or expressed. Apart from the two that are over 80 years old (the Medical Act 1939 (Qld) and the Medical Act 1894 (WA)), all of the Acts include statements that set out their objects or purposes. In the Medical Practice Act 1992 (NSW), the Medical Practitioners Act 1995 (NZ) and the HPCA Act,\(^{331}\) it is the health and safety of the public that is to be protected; while, in the Medical Practice Act 1994 (Vic), the Health Professions Registration Act 2003 (Vic) and the more recent Health Practitioners

\(^{331}\)Medical Practice Act 1992 (NSW), s 2A(1); Medical Practitioners Act 1995 (NZ), s 3(1); and HPCA Act, s3(1).
The object is simply to ‘protect the public’. The Medical Practitioners Act 2008 (WA) appears more restrictive in its protective goals, having various objectives, each for the purpose of ‘protecting consumers of medical services provided by medical practitioners in Western Australia’.

The National Law Act contains a number of objectives, including 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’.

The National Law Act also contains a number of ‘guiding principles’ including 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.

It appears that, as public protection is the objective of the legislation, and thus the aim of the regulatory system generally, the regulatory system is only justified to the extent that it is necessary to achieve that protection. In short, the system should not impose restrictions beyond what is ‘necessary to ensure health services are provided safely and are of an appropriate standard’.

3 Purpose according to who and what is regulated

As noted above, there is no shortage of health professions seeking to become regulated under the HPCA Act and/or the National Law Act. If public protection is, as asserted in the provisions above, the primary motivation for the regulation of health professionals, decisions as to which professions and activities are regulated, and which are not, should be consistent with that objective. Due to the enactment of the HPCA.

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332 Medical Practice Act 1994 (Vic), s 1(a); Health Professions Registration Act 2005 (Vic), s 1(a); and Health Practitioners (Professional Standards) Act 1999 (Qld), s 6.

333 Medical Practitioners Act 2008 (WA), s 3.

334 National Law Act, s 3(2). Note that the Regulatory Impact Statement records that ‘the general benefits to public protection associated with the regulation of a profession in the Scheme have long been accepted and were the basic underpinning of the IGA’: Australian Health Ministers’ Advisory Council, ‘Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law’ (2009), p36.

335 National Law Act, s 3(3). While this statement relates to whole professions and the regulation of such professions by the national framework, it is a principle that is equally applicable to conditions that are imposed on the practice of individual practitioners.
Act and the National Law Act, both Australia and New Zealand have recently undertaken a deliberate exercise of determining which professions to include in new umbrella legislation.

a) Which health professions?

In Australia, the decision about who to regulate under the National Law Act was particularly contentious as, prior to Nationalisation, not all state and territories regulated the same professions. The common group, regulated by all Australian jurisdictions was chiropractors, dentists, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, and psychologists. Podiatrists were also considered to be part of this group, despite not being regulated in the Northern Territory.

Alongside these health professions, were seven ‘partially regulated’ professions, that is, professions that were regulated in some jurisdictions but not others, namely Aboriginal and Torres Strait Islander clinical health workers, Chinese medicine practitioners, dental technicians, medical radiation technologists, occupational therapists, optical dispensers, and speech pathologists.

As part of the Nationalisation process, the Australian Health Ministers’ Advisory Council (the Advisory Council) assessed each of the above professions for inclusion against the two guiding principles:

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a) The sole purpose of occupational regulation is to protect the public interest

b) The purpose of regulation is not to protect the interests of health occupations

336 See p9 for a description of where the Advisory Council fits within the national structure.
338 At least one profession (speech pathologists) argued for regulation on the basis that it would assist workforce sustainability, as being in the public interest: ibid, p 48. The relationship between public interest (including workforce issues) and public protection is discussed later in this chapter: see p112 onwards.
339 While also acknowledging that regulation may, as an aside, confer benefits on those professions also.
The guiding principles were further developed into six key criteria, namely whether:  

a) it was appropriate for state Health Ministers to exercise responsibility for regulating that profession;  
b) the activities of the profession posed a significant risk of harm to the health and safety of the public;  
c) existing regulations or other mechanisms failed to address health and safety issues;  
d) it was possible to implement regulation for that profession;  
e) it was practical to implement regulation for that profession; and  
f) the benefits to the public of regulation clearly outweighed the potential negative impact of such regulation.  

On the basis of that assessment, the Advisory Council advised that only four of the partially regulated professions (Aboriginal and Torres Strait Islander clinical health workers, Chinese medicine practitioners, medical radiation therapists, and occupational therapists) should be regulated under the National Law Act. For each of the professions for which regulation was not recommended, this view was based largely on the basis that the Advisory Council had assessed their risk to the public to be insignificant.  

Interestingly, risk assessment was made not just on the basis of the 

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341 The Advisory Council developed a list of risky activities that were taken into account in assessing the professions: putting an instrument, hand or finger into a body cavity; manipulation of the spine; application of a hazardous form of energy or radiation; procedures below dermis, mucous membrane, in or below the surface of cornea or teeth; prescribing or supplying a scheduled drug or supervising a pharmacy that dispenses scheduled drugs; administering a scheduled drug or substance by injection; supplying substances for ingestion; managing labour or delivering a baby; undertaking psychological interventions to treat serious disorders with potential for harm; setting or casting a fracture of a bone or reducing dislocation of a joint; primary care practitioners who see patients with or without a referral from a registered practitioner; treatment that commonly occurs without others present; and treatment that requires patients to disrobe: ibid, p116.  
342 However, given the considerable work required in the jurisdictions not currently regulating those professions, a decision was made to defer application of the National Law Act to those health practitioners until 1 July 2012.  
343 For dental technicians, this was on the basis that they are not independent practitioners but make dental appliances to the specifications of other registered health practitioners who are responsible for patient care. The activities of optical dispensers were found to be adequately controlled by consumer protection legislation as, like dental technicians, their primary role is the supply of appliances rather than actual patient care per se. The decision not to include speech pathologists in the Scheme appears
activities typically undertaken by those professions, but also with regard to current complaint rates for those professions. For example, optical dispensers were found to have a low complaint rate compared to other partially regulated professions, while complaint rates for Aboriginal and Torres Strait Islander clinical health workers were relatively high.\textsuperscript{344} Perversely, from the professions' point of view, a better track record with patients counted against them when it came to gaining the professional advantages of regulation.\textsuperscript{345}

As a result of the decisions made as part of the Nationalisation process, the list of health professions registered in Australia differs slightly from the list of those registered in New Zealand. All of the health professions covered by the National Law Act on commencement are also regulated under the HPCA Act, as are medical radiation technologists and occupational therapists. New Zealand does not, however, regulate Aboriginal and Torres Strait Islander clinical health workers or Chinese medicine practitioners, neither of which are as prevalent in the New Zealand healthcare context.\textsuperscript{346}

There are, however, ten professional groups that are regulated in New Zealand but that are not covered by the National Law Act: dental hygiene, clinical dental technology, dental technology, dental therapy, dietetics, medical laboratory science, anaesthetic technology, optical dispensing, podiatry, and psychotherapy. Most curious among these are dietetics, medical laboratory science, anaesthetic technology, podiatry and psychotherapy, none of which were even partially regulated in Australia and so were not assessed for potential registration under the National Law Act. From a public protection perspective, these professions may be seen as less risky; certainly medical

\textsuperscript{344} Ibid, pp 40 and 47.
\textsuperscript{345} Although, of course, this was just one of the criteria used to assess risk.
\textsuperscript{346} However, in June 2011, the New Zealand Ministry of Health began a public consultation process on whether or not Traditional Chinese Medicine (TCM) should be regulated under the HPCA Act: Ministry of Health (NZ), 'Proposal That Traditional Chinese Medicine Become a Regulated Profession under the Health Practitioners Competence Assurance Act 2003' (MoH, 2011). No summary of submissions or subsequent comment from the Ministry appears to be available yet.
laboratory scientists and anaesthetic technologists do not have the same degree of patient contact or responsibility for patient care as most of the regulated professions, and dietetics and podiatry could be described as less invasive than some of the other regulated professions although, arguably, not all of them. Psychotherapy, however, would seem to sit alongside psychology in terms of risk, although counsellors are not regulated in either country. In relation to some professions, the grounds for inclusion within the statutory regulatory regime seem to be little more than historical when compared to similar professions that are excluded (such as paramedics and ambulance officers). For others, it seems that definitional difficulties may be the barrier, for example, defining what constitutes counselling as opposed to psychology may be a tricky enterprise.

In New Zealand, s 116 of the HPCA Act allows the Minister of Health to add a profession to the Act if the Minister is satisfied that the proposed new profession either poses a risk of harm to the public or it is otherwise in the public interest to regulate that profession. However, one of the recommendations that came out of the 2008 Review of the HPCA Act was that the Ministry of Health review the criteria used to advise the Minister of Health on whether regulation is advisable. The review proposed that the Minister apply the statutory test but also apply the same six criteria adopted in Australia (as outlined above). In January 2010, the NZ Ministry of Health released a discussion document entitled ‘How Do We Determine if Statutory Regulation is the Most Appropriate Way to Regulate Health Professions?’ to explore that issue further. It appears that the consultation on that point has been overtaken by the 2012 Review of the HPCA Act which will consider similar issues.

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347 This is similar to the argument made in the Regulatory Impact Statement for dental technicians - see above.
348 This seems particularly the case for regulation under the National Law Act, where the precondition for consideration for registration was existing partial registration.
349 It must also be practically possible to regulate the profession in terms of general agreement as to qualifications, standards and competencies required: HPCA Act, s116(b).
350 See p74 for further information about the 2008 Review.
351 Ministry of Health (NZ), 'Review of the Health Practitioners Competence Assurance Act 2003: Report to the Minister of Health by the Director-General of Health' (MoH, 2009), recs 16 and 17.
352 Ministry of Health (NZ), 'How Do We Determine If Statutory Regulation Is the Most Appropriate Way to Regulate Health Professions? A Discussion Document' (MoH, 2010).
In New Zealand, there are currently several health professions with registration applications before the Ministry, including Traditional Chinese Medicine practitioners, and many others who have expressed an interest or pursued registration to varying degrees at various times, including clinical physiologists, paramedics, speech language therapists, counsellors, and music therapists. Given the recommendation to apply the same criteria as adopted in Australia, it remains to be seen whether the Minister reaches a different conclusion to that reached in denying speech pathologists registration under the National Law Act and, if so, how this denial is justified in terms of public protection considerations.

b) Student health professionals

The National Law Act provides for the regulation of students who are practising within one of the regulated health professions as part of their training. Again, this was not a stance that was consistent across all jurisdictions within Australia before Nationalisation. In some jurisdictions, student registration was required for all regulated health professions; in some it was required for none; and in others it was required for students in some professions only. The scope of student regulation also varied across the jurisdictions, with some boards having the power only to deal with impairment and drug and alcohol dependency while others had much wider powers.\(^{353}\)

In the Regulatory Impact Statement to the National Law Act, the Advisory Committee noted the lack of consistent student registration as posing a potential risk to the public, given the interaction such students have with the public, notwithstanding the supervised context in which that occurs:

> The current arrangements are deficient in that boards without regulatory powers in relation to students have no powers to look into those cases where a student is seriously impaired and placing the public at risk. The education provider may also have their hands tied because in terms of educational objectives there are no grounds for discontinuing a student on the basis of public protection.\(^{354}\)


\(^{354}\) Ibid, p25.
Accordingly, the National Law Act provides for student registration but gives the separate practitioner boards the discretion to determine at which point in the study programme student registration will commence, in order to ensure that students are not required to be registered prematurely or unnecessarily.\(^{355}\)

The HPCA Act makes no provision for student registration. Rather, a health practitioner is only eligible for registration once they have graduated with the relevant qualification. This means that the boards have no jurisdiction to investigate complaints or undertake disciplinary proceedings in respect of students.\(^{356}\) Perhaps the reason for this is that students are (or should be) closely supervised, giving them minimal opportunity to harm the public. Conversely, one could argue that there is considerable benefit to the boards being made aware of any issues that arise for a student health practitioner while they are a student, given the association that has been found to exist between conduct as a student and later conduct as a registered practitioner.\(^{357}\) Such knowledge could assist the boards in identifying potential high risk practitioners and thus enable the boards to take proactive steps towards ensuring patient safety.

Student practitioners do, however, come within the jurisdiction of the HDC, so are still required to comply with the Code of Rights, and may be subject to complaints under that system.\(^{358}\)

\(^{355}\) See comments in ibid, p58.

\(^{356}\) Nevertheless, there are health practitioners who have been disciplined once they have become registered practitioners, for conduct that occurred when they were still students: see the results of First Study (chapter 6) in which the minimum time since registration for conduct leading to discipline was - 4 years, indicating conduct occurring four years prior to first registration.


\(^{358}\) As well as having jurisdiction in relation to registered health practitioners, the HDC is able to receive complaints about, and investigate, any provider of any health or disability service, regardless of that person’s registration or professional status. However, upon finding that such a person has breached the Code of Rights, the Commissioner (via the Director of Proceedings) may not refer an unregistered person to the Health Practitioners Disciplinary Tribunal in the manner that would be available if the person was registered under the HPCA Act. Instead, referral may be made to the HRRT. See p73 for further discussion of the role of the HDC in relation to registered health practitioners.
c) Which activities?

As discussed in chapter 2, the regulation of health practitioners in Australia and New Zealand is primarily via certification rather than licensure, and relies heavily on the designation of 'restricted titles'. This means that most activities undertaken by registered health practitioners may also be undertaken by unregistered individuals. There are, however, some activities that, based on risk, may only legally be performed by particular groups of health practitioners.

Restricting the use of particular titles to those who are registered, and thus certified as meeting certain minimum standards of qualification and/or competence, offers some measure of protection to the public through the provision of information. It is up to the public to then decide how to interpret, understand and use that information. However, regulation through restricted titles may be an ineffective means of protecting a public that is often ill-equipped to make appropriate use of that information, as illustrated by the following cases.

David Collison was a doctor registered with the New South Wales Board until 1991 when he was deregistered for giving a patient drugs in exchange for sexual intercourse. In 2005, the Sydney Morning Herald reported that Collison had been providing counselling services through the Salvation Army for a number of years, as well as advertising himself as being available to provide 'alternative health services'. As he also held a PhD in environmental medicine, he was entitled to continue to call himself 'Dr Collison' despite his deregistration. However, it is likely that the use of the title 'Dr' in circumstances where the 'PhD' was not also mentioned and health care was being provided, would now fall foul of the provisions against misleading use of titles under the National Law Act (discussed above).

In New Zealand, a similar situation arose in relation to Richard Gorringe, a doctor who was deregistered for his use of an alternative therapy that was found to have no

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359 See p15 onwards.
scientific basis. He was subsequently also found guilty of malpractice in relation to his reliance on that same alternative therapy to the exclusion of conventional diagnoses that led to an earlier patient's death. Despite being deregistered, and the Medical Practitioners Disciplinary Tribunal finding that his conduct had been "grossly irresponsible and unconscionable", Gorringe continued to offer alternative therapy from his clinic without any accountability to the Medical Council or to the Tribunal.

While this thesis is primarily concerned with the medical boards' and tribunals' role in professional regulation, it should be noted that there are other components of the health system that also restrict the provision of health services. Registration also restricts other activities not mentioned in the National Laws Act or the HPCA Act. This is because current registration (and, in New Zealand, a current practising certificate) is the gateway to a number of other privileges not available to unregistered individuals. For example, the entitlement to prescribe drugs, to obtain public funding for providing medical services (such as through Medicare payments), or to be employed as a doctor in a hospital, all have registration as a precondition.

So, while registration is not technically necessary in order to provide medical services, it is critical if a person wishes to market themselves as a doctor, or to obtain employment or funding for the provision of medical services. Such considerations may result in there being little practical difference between certification and licensure. The existence of these other regulatory controls emphasises that professional regulation need not necessarily provide an entire solution by itself. This point has been picked up by the New Zealand Ministry of Health in its discussion document on the 2012 Review: the role of employing organisations in protecting the public from harm (through recruitment checks, and workplace oversight, policies and investigations) is emphasised and

362 Re Richard Gorringe, NZMPDT, 284/03/113C, 10 May 2004.
questions are posed about the additional value that is added by statutory professional regulation.364

4 Purpose according to the identity of the regulator

The effectiveness of a regulatory regime depends not just on legislative statements of purpose and who or what is regulated, but also on the identity of the regulator and, more specifically, that regulator’s approach to resolving conflict between the interests of the regulated and interests of the public. While the way in which the regulator interprets the regulatory regime, as set out in the legislation, may be beyond the control of legislative design, the degree to which the regime provides for self-regulation is indeed a matter for the legislature.

Traditionally, doctors have regulated themselves. Dating back to the medical guilds in the Middle Ages in Europe, doctors have taken the view that only they have the required knowledge to regulate each other.365 The accepted wisdom was that because medicine was an ethical and trustworthy profession self regulation was entirely appropriate.366 However, in the last few decades, this has changed radically. The trend in Australia, New Zealand and internationally has been movement away from the unfettered self-regulation367 of doctors (and other health practitioners) to regulation that offers increased transparency and external accountability.368 In Australia and New Zealand, self-regulation has been retained, but in the form of mandated self-regulation369 where the regulatory bodies (the boards) are still controlled by members of the profession but the operation of those bodies is specified, at least in broad terms, by legislation.369 Lay involvement has also increased. Perhaps most significantly, the

368 Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2010), pp97-98.
369 The term mandatory self-regulation was coined by Ian Bartle and Peter Vass, 'Self-Regulation within the Regulatory State' (2007) 85(4) Public Administration 885, p891. Healy describes the state
disciplinary tribunals have become independent of the boards, rather than operating as sub-committees of the boards as was previously the case.\footnote{370}

The reason for the shift away from pure self-regulation has been explained by the former President of the British General Medical Council as being due to a failure of trust, a growing confidence gap between those who had been regulating themselves and the public.\footnote{371} This sentiment was echoed a decade later by another past-President of that council, who stated:

> The bottom line is that lighter-touch regulation of doctors would mean that some ongoing risks to patients would have to be tolerated by society.\footnote{372}

It appears that the move toward more external regulation has been motivated, at least in part, by concerns about patient safety. Whether or not such concerns were justified, it is likely that, even where the identity of the regulator has not changed, any shift in power from doctors to the state (and/or the public) will sharpen the focus on public protection.

5 Conclusion

The relevant legislation clearly has public protection (and, in some cases, the wider public interest) as its core objective. In addition, for the most part, decisions about who and what to regulate, as expressed by the National Law Act and the HPCA Act, appear to have been made according to an assessment of risk to the public. There are, however, some professions for which this seems less clear, including dieticians, medical laboratory technologists, and psychotherapists, who are regulated in New Zealand but

\footnote{370}{See chapter 3 for a discussion of the tribunals and their function.}
\footnote{371}{Richard Smith, 'The Future of the Gmc: An Interview with Donald Irvine, the New President' (1995) 310 British Medical Journal 1515, citing Donald Irvine, President of the GMC. This lack of public confidence is sometimes described as 'capture theory' the idea that those doing the regulating are insufficiently motivated to regulate in the public interest: Julia Black, 'Critical Reflections on Regulation' (2002) 27 Australian Journal of Legal Philosophy 1.}
\footnote{372}{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), p xiii.}
not in Australia. The lack of student registration in New Zealand also casts some doubt on the robustness of public protection.

While the certification regime that operates in both countries initially appears less protective than a licensing regime would be, it can also be understood in the context of achieving the appropriate balance between public protection and the principle of necessity. The shift from pure self-regulation to more mixed models involving greater state control and public accountability also supports the legislative statements that public protection should be paramount.

The next section of this chapter continues to consider the purpose of professional regulation, specifically the purpose of the complaints and disciplinary system.

III THE PURPOSE OF THE COMPLAINTS AND DISCIPLINARY SYSTEM

A Introduction

As discussed in the last chapter, the disciplinary mandate of any professional regulation regime is vitally important. Arguably, the main reason for registering practitioners is in order to have the option of bringing them within a system by which their practice may be controlled. Generally, this control is only possible in the context of a functioning disciplinary system. Certainly, there are many professionals who will conform to the standards and expectations of their profession simply by virtue of the fact that they are professionals. Indeed, the ability to self-regulate was once considered to be a necessary hallmark of a ‘profession’. But there will always be some members of every profession who will not and who need an external motivator (perhaps in the form of the spectre of disciplinary action) to induce appropriate behaviour. And it is, one would suppose, those very same individuals who have a disproportionate likelihood of finding themselves being brought to account by the disciplinary system.

The disciplinary system is where the rubber of public protection hits the road of public expectation. As outlined in the previous chapter, it is when things go wrong that questions are asked and answers demanded. At that juncture, the disciplinary system must be able to respond in a way that shows the regulatory system as a whole to be effective in evincing its public protection mission. This section explores the purpose of the disciplinary system, again by reference to regulatory theory and legislation, but also according to statements and behaviour of those charged with making the most serious disciplinary decisions: the tribunals and the courts.

B Purpose according to regulatory theory

Regulatory theorists tend to agree that effective enforcement mechanisms are fundamental to the success of any regulatory system. But what form should these enforcement mechanisms take in order to be effective? Perhaps the best way to answer this question is via recourse to Ayres and Braithwaite’s well tested model of responsive regulation.

In the early 1990s, Ayres and Braithwaite coined the term ‘responsive regulation’ and described a suggested model of regulation by way of an ‘enforcement pyramid’. At each level of the enforcement pyramid is an enforcement mechanism, increasing in seriousness and severity as one travels up the pyramid. To summarise, at the bottom of the pyramid is voluntary compliance; with command and control mechanisms at the apex. Figure 3 shows the levels of the enforcement pyramid, as originally described, with examples of health sector regulatory mechanisms that could be applied, as suggested by Healy.

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374 See, for example, Ian Ayres and John Braithwaite, Responsive Regulation: Transcending the Regulation Debate (Oxford University Press, 1992); John Howe, ‘Deregulation’ of Labour Relations in Australia: Towards a More ‘Centred’ Command and Control Model’ in Christopher Arup et al (eds), Labour Law and Labour Market Regulation (The Federation Press, 2006); and Christine Parker and John Braithwaite, ‘Regulation’ in Peter Cane and Mark Tushnet (eds), The Oxford Handbook of Legal Studies (Oxford University Press, 2003).

375 Ian Ayres and John Braithwaite, Responsive Regulation: Transcending the Regulation Debate (Oxford University Press, 1992).

376 Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2010), p5.
The aim of this normative model is to achieve enforcement at the lowest level of the pyramid possible. However, the success of such an approach depends on the regulator also having access to more serious sanctions and instilling in the regulated the belief in the ‘inexorability’ of those sanctions.\textsuperscript{377} As Ayres and Braithwaite state:

\begin{quote}
\ \textsuperscript{377} John Braithwaite, Judith Healy and Kathryn Dwan, ‘The Governance of Health Safety and Quality’ (Commonwealth of Australia, 2005).
\end{quote}
[T]he greater the heights of tough enforcement to which the agency can escalate (at the apex of the enforcement pyramid), the more effective the agency will be at securing compliance and the less likely that it will have to resort to tough enforcement. Regulatory agencies will be able to speak more softly when they are perceived as carrying big sticks.\(^{378}\)

Not only must the regulator have access to a big stick, but it must also show preparedness to use it when necessary. This is essential as a signal to others that non-compliance will not be tolerated\(^{379}\).

Although it is widely accepted that the availability and use of serious sanctions is important in ensuring the effectiveness of a regulatory regime, it has been suggested that professional discipline itself does not have an appreciable direct impact on public protection. Such criticism tends to take one of two forms. The first critique suggests that while the removal of doctors through the disciplinary system is helpful on some levels, it does not appreciably improve the overall quality of medical care. Although this may be true, this thesis argues that quality of care and public protection are related but distinct concepts, hence the oft-used expression “safety and quality” in health care system analysis. While perhaps not raising the quality of care across the board, the removal of dangerous doctors will certainly have an impact on public protection, at least at the extreme end of quality of care. As shown in many high profile cases, the detrimental effect of just one miscreant doctor can be enormous, and the disciplinary system is the mechanism by which such doctors can be stopped.\(^{380}\)

The second criticism attacks the disciplinary system’s focus on individual doctors rather than systemic failures. As noted by Donaldson, former President of the GMC, the level of harm caused by unsafe systems is an order of magnitude higher than the harm caused by unsafe doctors.\(^{381}\) Concentrating on removing “bad apples” at the expense of whole


\(^{380}\) Recall, for example, Dr Jayent Patel in Queensland: see p40 onwards.

systems improvements, the argument runs, will never bring about the changes that are needed.\(^{382}\) Nevertheless, Donaldson also acknowledges that this does not diminish the importance of targeting unsafe individual doctors.\(^{383}\) In fact, it has historically been the identification of the failures of particular individuals (through the complaints and disciplinary system) that has been the catalyst for public inquiries into failures of whole systems.\(^{384}\)

Disciplinary proceedings are an essential component of the regulatory system. Theory and practical experience suggest that such proceedings are important for ensuring the robustness of the rest of the regulatory system\(^{385}\) but can also have a direct impact on public protection by removing dangerous doctors from practice. So how is this contribution reflected in the design of the system? And, does it accord with the purpose set out in the legislation?

\section*{C Purpose according to the legislature}

While most of the Acts that have regulated doctors over the last decade contain overall statements of purpose, there are very few purposive provisions that deal specifically with the complaints and disciplinary part of the regulatory regime. One exception is the \textit{Health Practitioners (Professional Standards) Act 1999} (Qld), perhaps because it is an Act that deals separately with complaints and discipline (with other aspects of health practitioner regulation, such as registration, being covered in another piece of legislation). As well as overarching objects for the Act as a whole, 'purposes' are also articulated for each Part of the Act. Section 123 states:

\begin{quote}
   The purposes of disciplinary proceedings and disciplinary action against registrants are as follows
\end{quote}


\(^{383}\) 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), pp28 and 29.

\(^{384}\) For example, in the cases of Jayant Patel in Australia (see p40), and Harold Shipman in the United Kingdom: The Shipman Inquiry, \textit{The Shipman Inquiry} (2001) <http://www.shipman-inquiry.org.uk/>.

\(^{385}\) As discussed later, this may be due to a range of factors, for example, the deterrent effect or the positive impact on public confidence of identifying and appropriately dealing with 'bad apples'.
(a) to protect the public;
(b) to uphold standards of practice within the health professions;
(c) to maintain public confidence in the health professions.

Although it appears that all three of the above purposes are equally important, it is perhaps no accident that protection of the public is the first purpose listed and that the other two purposes are best understood as important not for their own sake but as essential elements in achieving public protection. This argument is developed further in the following part of this chapter, drawing on the commentary provided in a number of disciplinary decisions.

There are no corresponding provisions in any of the other Acts described in chapters 2 and 3.386

D Purpose according to the decision-makers387

In the absence of much in the way of clear legislative statements of purpose, this chapter turns now to examine the way in which the tribunals and courts have interpreted the purpose of the complaints and disciplinary system. There is considerable judicial commentary on the purpose of disciplinary sanctions and, by extension, the purpose of disciplinary proceedings per se. Almost without exception, the determinations of the tribunals recognise, either expressly or implicitly, the primary purpose as being that of public protection. More contentious are suggestions of other purposes and the way in which those purposes should be allowed to influence decision making.

In the 2010 case of Dr Johannes Ignatius Viljoen Wilson,388 the Health Practitioners Disciplinary Tribunal (HPDT) listed four functions of disciplinary proceedings: protecting the public; maintaining professional standards; punishing the practitioner;
and, where appropriate, rehabilitating the practitioner. What is interesting is the complete acceptance by the Tribunal of those four functions as justifiable in their own right. Each of those four functions is discussed below.

1 Maintenance of professional standards

The maintenance of professional standards is a commonly expressed purpose of the disciplinary process. The importance of maintaining such standards is two-fold. First, diligently-enforced high professional standards protect the public. Second, such standards protect the profession and its reputation. Indeed, under the HPCA Act, bringing discredit on the profession can itself be grounds for a finding of professional misconduct. Why is it important to protect the reputation of the profession? In Clyne, this question was discussed in relation to the discipline of solicitors stating that, from a professional standpoint, disciplinary orders are made ‘... in order that abuse of privilege may not lead to loss of privilege’. Put like that, the Court could be seen to be reinforcing the theory that professional regulation, while publicly described as being for the protection of the public, is equally about maintaining a professional monopoly and the privileges that go with it. However, there is an argument that the health professions are different, as public protection is inextricably linked to the reputation of the relevant profession. It is a profession’s reputation that gives the public confidence in that profession; confidence that is vitally important as, in order to function properly, the doctor-patient relationship must be one of special trust and patients must be prepared to seek care. As expressed by Freckelton, mistrust of

389 At para 119.
390 HPCA Act, s 100(1)(b).
health professionals, especially medical practitioners, is becoming endemic and has the potential to erode therapeutic relationships.

Some suggest that one of the reasons for that diminishing trust is, in fact, regulation itself. The thesis of Mark Henaghan’s recently published book is that the effect of the trend towards heightened regulation has been to undermine the traditional dynamic of trust in health professionals and to diminish reliance upon their professional judgment, whilst simultaneously failing to trust patients to make decisions about their own care.

While it may be true that excessive accountability can destroy rather than build trust in a profession, the author’s view is that appropriate accountability through appropriate regulation may allow appropriate trust in a profession to grow and flourish. As has been demonstrated in some of the cases discussed in chapter 9, misplaced trust in a doctor, as in any other person, may be very harmful for a patient. Regulation, chiefly through discipline or the perception of discipline, can operate productively as a counterpoint to distrust by controlling its most apparent causes. Accordingly, the maintenance of professional standards can be understood as part of the overarching purpose of public protection.

2 Punishment

It has long been contentious whether one of the purposes of imposing a disciplinary sanction is to punish the doctor concerned. As noted above, in the recent New Zealand decision of Dr. Johannes Wilson, the Tribunal readily accepted punishment as one of the

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395 However, note that trust of health professionals is still high in comparison to most other professional groups, just lower than it has been in the past.
398 Ibid, pi.
399 As argued by Onora O’Neill in Onora O’Neill, A Question of Trust (Cambridge University Press, 2002).
functions of disciplinary proceedings. This has also been the approach taken in a number of other decisions of the HPDT. However, the higher courts in New Zealand and in other jurisdictions have tended to draw a subtle but important distinction between the purpose of disciplinary proceedings and their consequence. As articulated by the Privy Council in Taylor v General Medical Council, protection of the public is the exclusive purpose of deregistration and suspension but the consequence of such an order inevitably imports some punitive element for the doctor concerned. While cancellation has a punitive effect ... that is not the purpose of the order. Although this distinction might be credible in respect of the clearly protective sanctions of suspension and deregistration, it is less intuitive, indeed, less plausible, in relation to sanctions such as hefty fines, reprimands, and significant cost awards. However, even those sanctions have been justified by the courts in protective terms. One of the clearest examples of this analysis comes from the determination in Honey v Medical Practitioners Board of Victoria, an appeal from a decision of the Vic Board:

In our view, the order to reprimand will have the salutary effect of underscoring the seriousness of the doctor’s actions. It will remind him lest he is tempted again. It will flag to others practising the profession of psychiatry that the behaviour he has engaged in is to be condemned. And it will give some comfort to members of the public that behaviour of this sort, when uncovered, will be outed for what it is - a flagrant violation of the fundamental principles of the doctor patient relationship.

402 [1990] 2 All ER 263.
403 PCC v Martin, para 23, per Gendall J. See also Pillai v Messiter (No. 2) (1989) 16 NSWLR 197 (NSW CA), p201: ‘It must be kept in mind that the consequence of an affirmative finding is drastic for the practitioner. And the purpose of providing such a drastic consequence is not punishment of the practitioner as such but protection of the public’.
404 Of up to SNZ$30,000 under the HPCA Act and $Au30,000 under the National Law Act.
405 See, for example, Honey v Medical Practitioners Board of Victoria [2007] VCAT 526 and Giele v General Medical Council (QBD) [2006] 1 WLR 942.
407 At para 64.
Even in *Patel v Complaints Assessment Committee*,\(^{408}\) where a fine and reprimand were described as ‘purely punitive in nature’\(^{409}\) Lang J went on to justify such sanctions as appropriate on the basis of their deterrent value which, in the author’s view and as argued above, can be viewed as an element of public protection.\(^{410}\) Perhaps, in reality, fines and reprimands are best characterised as both punitive and protective.

So why are the Tribunals and the courts generally so hesitant to punish? Where does the general reluctance to be seen to be acting from punitive motives come from? It may come from the purposive provisions of the relevant Acts, which are driven by public protection and do not even mention punishment. This is distinct from legislation in the criminal law area which freely acknowledges its punitive intent. Take, for example, the *Crimes Act 1961* (NZ), Part 2 of which is entitled ‘Punishments’. Another possibility relates to the makeup of the Boards and Tribunals which have developed the relevant jurisprudence. Perhaps it is more comfortable for the health practitioners sitting as part of those decision-making bodies to talk about protection of patients than of punishment of their professional colleagues. Whatever the reason for the observed reluctance, the point of relevance to the current analysis is that even the most apparently punitive sanctions can be understood as protective of the public (whether or not they simultaneously punish the doctor).

3  **Rehabilitation**

While there are cases in which rehabilitation is deemed impossible or inappropriate, in the majority of cases, the sanctions imposed have a rehabilitative element. Generally, rehabilitation sanctions are in the doctor’s own interest, allowing him or her to continue

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\(^{408}\) Unreported, HC, Auckland, CIV-2007-404-1818, 13 August 2007, Lang J.

\(^{409}\) A comment subsequently relied on by the New Zealand Health Practitioners Disciplinary Tribunal in concluding that punishment is one of the purposes of disciplinary sanctions: see above.

\(^{410}\) Although public protection, deterrence and punishment were seen as separate considerations by the judge in that case. The link between deterrence and public protection is summarised neatly by Ian Freckelton as follows: ‘On the one hand it is accepted that disciplinary tribunals must not punish. However, they can dispense sanctions (including substantial fines) that are perceived by practitioners as punishment so long as tribunals do so avowedly to protect the public by deterring the practitioner from like conduct or to discourage other practitioners from comparable conduct.’ Ian Freckelton, ‘Regulation of Health Practitioners: Grappling with Temptations and Transgressions ’ (2004) 11 *Journal of Law and Medicine* 401, 407.
in the profession. This is consistent with the approach advocated by Braithwaite’s enforcement pyramid, discussed above:

As we move up the pyramid in response to a failure to elicit reform and repair, we often reach the point where finally reform and repair are forthcoming. At that point responsive regulation means that we must put escalation up the pyramid into reverse and de-escalate down the pyramid. The pyramid is firm yet forgiving in its demands for compliance. Reform must be rewarded just as recalcitrant refusal to reform following wrongdoing will ultimately result in punishment.411

However, rehabilitation may also be consistent with public protection considerations, including the public interest in ‘not ending the career of a competent doctor’412. In Giele v General Medical Council,413 Collins J of the Queen’s Bench division recognised that there is a particular public interest in rehabilitating doctors (in order to keep them in practice) that does not exist to the same extent for other professionals, for example, lawyers (and other professions not experiencing workforce shortage). The court went on to accept the inevitable extension to this position, that is, that the skills and abilities of the individual doctor will have some bearing on the weight given to the public interest in rehabilitation. Even though, for a less skilled doctor, the balance may point towards deregistration; for a doctor with unique or highly in-demand skills, the potential loss of those skills to the public may tip the balance in favour of a rehabilitative sanction.414

Another protective feature of taking rehabilitation seriously is what such an approach indicates to doctors generally and the potential it has to increase reporting of issues. In an environment where a doctor knows that by reporting a problem they will not necessarily be ending their own, or a colleague’s career, reporting is likely to be more common.

413 Giele v General Medical Council (QBD) [2006] 1 WLR 942 at para 20, citing Council for the Regulation of Healthcare Professionals v General Medical Council (2005) 84 BMLR 7.
414 At para 30.
However, this does not mean that the disciplinary process is, or should be, ‘blame free’. As recognised by Dame Janet Smith in the Shipman Inquiry Fifth Report, justice and patient safety require holding people appropriately to account. Proper investigation and identification of cause is a necessary precondition to learning from adverse events. In the author’s view, focus on rehabilitation should not be used as a ‘soft’ option allowing less blame to be attributed, but as a possible remedial option following analysis of failure.

4 Public protection

As discussed above, sanctions that maintain professional standards or punish or rehabilitate are all commonly justified through their relationship with the overarching purpose of public protection. Perhaps then, a better way of considering the function of disciplinary proceedings is according to the framework set out in Re Dr Parajuli: 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.

Having argued that the pre-eminent purpose of the regulatory system, including the complaints and disciplinary systems, is protection of the public, the next part of this chapter looks in more detail at exactly what ‘public protection’ means in the context of the professional regulation of doctors.

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IV WHAT IS PUBLIC PROTECTION?

A Introduction

As argued above, public protection is the fundamental purpose of both professional regulation as a whole and of the disciplinary system specifically. But what does public protection really mean and how far does it extend? And how does it relate to the similar, but subtly different notion of public interest? These questions are addressed in the following section in order to build a more nuanced understanding of the purpose of disciplinary proceedings and allow some suggestions to be made about which factors can legitimately be taken into account in furthering that purpose.

B Public protection and public interest

Public protection is a subset of public interest. While all public protection considerations are ultimately also public interest considerations, public interest is a broader concept that includes additional, not necessarily ‘protective’ elements.417

Upon consideration of the matters listed by the New South Wales Medical Tribunal in Re Dr Parajuli,418 as outlined above, four key aspects of public interest have been identified for discussion: specific protection; general protection; maintenance of public confidence; and ensuring access to and availability of services. The first three are clearly elements of public protection, whereas the fourth, it is argued, extends beyond public protection and into the broader concept of ‘public interest’.

1 Public protection419

Public protection is the domain of traditional professional regulation approaches which are concerned with ensuring the competence and fitness to practice of those who are registered to provide particular services. In medical professional regulation, the focus is

417 Haller makes a similar distinction but uses the labels ‘absolute protection’ (for public protection type considerations) and ‘relative protection’ (for the broader public interest type considerations): Linda Haller, ‘Regulating the Professions’ in Peter Cane and Herbert Kritzer (eds), The Oxford Handbook of Empirical Legal Research (Oxford University Press, 2010), p222.
419 Parts of this section are taken from a research paper that the author wrote and submitted as an assignment for a paper that formed part of her Graduate Diploma in Health and Medical Law.
on protecting the public from being harmed by the actions of doctors. Certainly, this appears to be the focus of the purposive provisions of the Acts outlined, which unanimously refer to either ‘protection’ ‘safety’ or both. However, ‘protection is a subtle and complex concept encompassing more than just dissuasion of health practitioners from unsafe or reckless conduct’\(^{420}\). Within the complaints and disciplinary system, public protection may be advanced via specific protection, general protection, or the protection of public confidence, each of which is discussed below.

a) Specific protection

The most indisputable element of public protection is that of specific protection from a particular medical practitioner who is not considered to be safe to continue practice. The doctor’s past conduct is seen as an indication that he or she is likely to subject the public (either current patients, future patients, or their families) to future harm if allowed to continue practising unfettered. In such cases, overtly protective sanctions are usually imposed: deregistration, suspension, or restrictions of some kind (including conditions, education, or supervision). Specific protection does not require that the doctor has actually caused harm in the past, just that there is a likelihood that he or she will cause harm in the future. That harm may be physical, it may be psychological, or it may simply expose patients to unnecessary and unacceptable risk. It is any form of conduct or behaviour that, without good reason, violates the ethical principle of non-maleficence.\(^{421}\)

b) General protection

General protection is advanced through disciplinary sanctions that have the effect of deterring other doctors from behaving in a similar way or from not meeting the required high standards of practice. Any disciplinary sanction, even a fine, is theoretically capable of serving as a deterrent to other doctors. However, 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. At


\(^{421}\) For a discussion of non-maleficence see Raanan Gillon, ‘“Primum Non Nocere” and the Principle of Non-Maleficence’ (1985) 291 British Medical Journal 130.
present, publication occurs mainly through the ‘name and shame’ pages of various publications which are widely distributed and read within the medical community.}\textsuperscript{422}

c) Protection of public confidence

Considerations of public protection require incorporation of the consideration of the harm done by health practitioners’ conduct to the intangible reputation and standing of the professions.\textsuperscript{423} Such harm is relevant given, as discussed above, the importance of trust in enabling effective operation of the doctor-patient relationship.

The protection of public confidence can be assisted through the imposition and protection of high professional standards and the denouncement of the conduct of doctors who fail to meet those standards. In order to have this effect, a record of the denouncement needs to be publicly available or reported accurately by the media. The sanctions themselves must also be such that public confidence in the disciplinary process, and thus the profession, is maintained.\textsuperscript{424} Haller suggests that professional discipline plays a ‘symbolic role’ as it sends ‘more powerful messages about character and integrity’ in a way that other, more mundane activities, such as requiring CPD, cannot.\textsuperscript{425} Public confidence, in turn, protects the public as it makes it more likely that

\textsuperscript{422} Brennan, however, disputes that this necessarily follows, arguing that there is no evidence that disciplining a few bad doctors acts as a deterrent to other doctors: Troyen Brennan, ‘The Role of Regulation in Quality Improvement’ (1998) 76 Milbank Quarterly 709. Certainly, the evidence for general deterrence through civil litigation in the tort of negligence is weak (W Jonathan Cardi, Randall Penfield and Albert Yoon, ‘Does Tort Law Deter Individuals? A Behavioural Science Study’(2012) 9(3) Journal of Empirical Legal Studies, 567). However, it is argued that this does not necessarily translate into the disciplinary arena. Civil litigation is distinct in its degree of ‘randomness’ and its separation from the regulator, who should ensure that, unlike in civil litigation, baseless proceedings are not brought. Disciplinary proceedings, it is argued, are more akin to criminal proceedings in their deterrent effect, that is, they are effective in deterring individuals from similar behaviour: Ibid.

\textsuperscript{423} Ian Freckelton, ‘The Margins of Professional Regulation: Disjunctions, Dilemmas and Deterrence’ (2006) 23(2) Law in Context 148, p167.

\textsuperscript{424} While it could be argued that disciplinary proceedings should be kept entirely confidential so that the public are not alerted to the misconduct that sometimes occurs, it is never possible to achieve this. Also, such action would be contrary to the principles of open justice on which the judicial system is built. Far better to allow the disciplinary process to be open to public scrutiny, with care taken in imposing sanctions that will stand up to such scrutiny thereby allowing public confidence in the profession to remain intact or even to improve.

\textsuperscript{425} Linda Haller, ‘Regulating the Professions’ in Peter Cane and Herbert Kritzer (eds), \textit{The Oxford Handbook of Empirical Legal Research} (Oxford University Press, 2010), p218.
[1]hose who need medical attention will not be inhibited from seeking it because they know that doctors who are guilty of serious misconduct will be dealt with in an appropriate fashion.  

Increased public confidence in the medical profession (that is justified) also has the potential to improve the quality of therapeutic relationships by enhancing trust and the ease with which that trust can be established, recognising that it is essential that the community can repose absolute trust in the members of the [medical] profession.  

Perhaps this is what distinguishes the regulation of doctors and some other health professionals from the regulation of most other professional groups. Of course, trust is beneficial in any client-professional relationship as its absence may lead to assistance not being sought in a timely fashion or to the non-disclosure of important information that compromises the professional’s ability to properly assist the client. A client who does not sufficiently trust their lawyer to disclose the smoking gun before trial may irreparably and unnecessarily damage their case, with significant consequences for the client’s finances or their liberty. However, a client is generally able, within reason, to choose who to have as a lawyer, an accountant, a real estate agent, or an architect. And even if that is not the case, the client needs, by and large, to only build professional rapport and trust with that one professional, often having a period of time or interactions over which to do that. In the health system, neither of those precepts necessarily hold true. First, while there may be the notion that patients have choice of provider, within the public health system that is often far from true, particularly in rural and remote settings. Secondly, the interdisciplinary and 24/7 nature of healthcare means that a patient will often be seen by a number of different health professionals, including a number of different doctors, in the course of receiving treatment. Thirdly, there is often little time to establish rapport in health care settings before intimate details are

426 *Giele v the General Medical Council* [2005] EWHC 2143 per Justice Collins at para 16.

427 It is possible, therefore, that the maintenance of public confidence in the profession can be seen as either a matter of public protection by decreasing the potential for a doctor patient relationship that is not based on adequate trust and the harm that may result from this through, for example, non-disclosure of vital medical background etc; or as a matter of public interest by enhancing access to medical services by increasing patient willingness to seek such services. See also, *N v PCC* (unreported, HC, Wellington, CIV 2009-485-2347, 17 March 2010) where the court noted at para 24: "A doctor/patient relationship is one of special trust. Thus maintaining the integrity of the medical profession and in turn, the maintenance of that trust is of vital importance."

428 *Re Hare and the Medical Practitioners Act* (unreported, NSWMT, 14 December 1990), p7.
exchanged. All of these factors mean that the public must have confidence in doctors as a profession generally, rather than simply as individuals within a profession. Therefore, the notion of public confidence in the profession becomes all the more important, as noted by Freckelton:

Along with the privileges of registration should come the responsibility for medical practitioners to comport themselves in a way which does not diminish the standing of the profession of medicine as both honourable and worthy of trust. Without community confidence in the profession and its practitioners, the capacity of medicine to satisfy its therapeutic objectives would be unacceptably impaired.

2 Public interest

Each of the above elements of public protection are also public interest considerations as public protection is obviously a matter of public interest. However, the public interest is wider than public protection, perhaps implying a positive obligation to do good, rather than simply an obligation to prevent harm (as could be argued for public protection). But what interests do the public have in relation to health care that are wider than traditional notions of protection? And are such interests legitimate considerations for the boards and tribunals to take into account when making decisions?

Another difficult question is assessing whose interests, among the public, are paramount. The challenge in identifying the public is exemplified in the following quote:

... there is no singular public; publics have many different interests that change and compete from one situation to another. It seems that the profession

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429 It is recognised that some of these arguments also apply to other professional groups, for example to duty solicitors for criminal lists in the District Court, but less widely, less frequently, and less often all in concert. These arguments also do not apply to all doctors, for example, general practitioners often have an established relationship with their patients.


431 Although it is acknowledged that the obligation to prevent harm may mean that once a therapeutic interaction has begun, there is an obligation to take positive steps such as preventing harm by identifying and treating a particular condition.
enabling legislation is the place to start when attempting to determine the public interest.\textsuperscript{432}

Unfortunately, although each of the relevant Acts mentions public protection, and some give examples of that, elaboration as to what is meant by ‘the public’ and which of their interests should be considered is much less common.

While the other Acts speak of protecting ‘the public’ the \textit{Medical Practitioners Act 2008} (WA) specifies that the purpose of its various objects is to protect ‘consumers of medical services provided by medical practitioners in Western Australia’\textsuperscript{433} Initially, it may appear that the specificity in this provision is simply an articulation of what must, in any event, be read into the provisions in the other Acts. After all, it is only \textit{consumers} of medical services who could be put at risk by errant doctors, and the Act concerned only applies to services provided within the particular state. However, such a construction excludes any consideration of the interests of those members of the public who wish to become consumers of medical services but are unable to access those services. Arguably, such considerations do come within the ambit of the other Acts, particularly when making decisions about whether or not a doctor who has been disciplined will be allowed to continue to practice. In the National Law Act, the relevance of such considerations is not left to implication. Rather, one of the express purposes of the Act is the facilitation of ‘access to services provided by health practitioners in accordance with public interest’\textsuperscript{434}

It is the issue of access to, and availability of, medical services that is perhaps the best example of a relevant public interest consideration taken into account in the regulatory and disciplinary systems, as evidenced by the reference to it in \textit{Re Dr Parajuli}\textsuperscript{435} (cited above), and the clear statement of purpose in the National Law Act. The ambit and consequences of this consideration are discussed in the following section.

\textsuperscript{433} \textit{Medical Practitioners Act 2008} (WA), s 3.
\textsuperscript{434} National Law Act, s 3(2).
\textsuperscript{435} [2010] NSWMT 3 at para 32.
a) Ensuring access to, and availability of, services

As noted above, rehabilitative sanctions (such as conditions, education, or supervision) should not be motivated solely by generosity to the individual doctor, but out of an appreciation of the public investment represented by each practising doctor, and the related public interest in ensuring that doctor, if safe, is able to continue to provide services. However, this rehabilitative approach does not always meet the anxieties fanned by the media or the need to uphold the reputation and standards of the profession. This tension arises particularly where medical services are in demand, either due to their specialist nature or due to general shortage, as is the case in many rural and most remote areas of Australia.

In taking account of this public interest consideration, there is the also real potential for conflict with the three aspects of public protection set out above. Should doctors who have committed professional misconduct be permitted to remain in practice due to access and availability considerations when they would otherwise have been removed? Or put more simply: Is a doctor who represents an elevated risk to the public preferable to having no doctor at all? The answer is probably one of degree and is grappled with at all stages of the regulatory process. It is particularly challenging in setting registration standards and making disciplinary decisions. As noted in Giele:

It must be obvious that misconduct which is so serious that nothing less than erasure would be considered appropriate cannot attract a lesser sanction simply because the practitioner is particularly skilful. But if erasure is not necessarily required, the skills of the practitioner are a relevant factor.

The same argument may have traction in situations where the skills are in demand due to general workforce shortage. There is some evidence that it does. For example, registration requirements are lower in respect of Areas of Need around Australia with chronic shortages of doctors; in New Zealand, consultation has begun on the idea of

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437 This issue is discussed in relation to the regulation of IMGs in chapter 8.

imposing supply considerations as part of registration decision making by the MCNZ.\textsuperscript{439} However, even though there are concessions made at the point of registration, it is quite another matter to accept lesser standards once a doctor appointed to such a position has demonstrated himself or herself to have fallen short. For this reason, while there are good arguments that access and availability considerations may have relevance to registration decisions, caution should be exercised in attempting to take them into account in making disciplinary decisions. While the National Law Act gives legislative mandate to the inclusion of such factors as part of the decision-making process, this does not necessarily mean that the weight given to such factors when making disciplinary decisions will be the same as the weight given when making registration decisions. Nevertheless, a better understanding of the demographics of doctors involved in complaints and disciplinary proceedings, such as is provided by the Studies reported later in this thesis, may assist in better informing registration decisions based on likely future risk.

### 3 Applying the UNESCO criteria

Another way of understanding how public protection fits within the broader framework of public interest is by reference to the scheme set out in the UNESCO General Comment No. 14 to Article 12 of the International Covenant on Economic, Social and Cultural Rights (\textsc{\textit{UNESCO general comment}}).\textsuperscript{440} The UNESCO general comment defines the right to health according to four \textsc{\textit{interrelated and essential elements}} namely availability, accessibility, acceptability and quality.\textsuperscript{441}

Quality, according to UNESCO, is about ensuring that medical services are \textsc{\textit{scientifically and medically appropriate and of good quality}}.\textsuperscript{442} As noted earlier in this chapter, there is a difference between protection and quality, although at the extremes of poor quality, protection becomes an issue. Quality can, therefore, be considered in terms of both public protection and wider public interest. Protection

\textsuperscript{441} Ibid.
\textsuperscript{442} Ibid.
requires that doctors providing medical care are sufficiently skilled and competent so as not to pose a danger to their patients, while there is a wider public interest in improving the quality of health care services more generally at all levels, e.g. from good to excellent.

Acceptability is also about the standard of the medical care that is provided. For a health care service to be acceptable it must be respectful of medical ethics and culturally appropriate.\textsuperscript{443} Investigation of doctor attitudes and conduct towards patients falls under this head. Requiring medical care to be acceptable confers protection on the emotional and psychological well-being of patients. The requirement for cultural appropriateness may also raise issues in relation to the large number of IMGs currently practising medicine in Australia and New Zealand, as discussed in chapter 8, as well as both countries’ increasingly multi-cultural patient populations. Again, ensuring doctors provide services that reach a baseline level of acceptability is a public protection consideration, while optimising acceptability relates to the wider public interest.

Availability, insofar as it relates to human resources, is about having a sufficient quantity of doctors available to meet healthcare objectives. It relates to the wider public interest, rather than public protection, and takes a broad view of the public applying to potential patients rather than those already receiving the health services concerned. As outlined in chapter 2, availability is becoming an increasing struggle for the Australian and New Zealand healthcare systems. Later in this thesis, the impact of this struggle is discussed, in terms of disciplinary decisions to remove doctors from practice, and in relation to relying on doctors trained in other countries to cover the workforce shortages.

The last of the UNESCO criteria is accessibility, that is, the non-discriminatory access to healthcare services. Again, this is a public interest criterion that takes into account the interests of non-patient members of the public. The shortage of doctors in Australia and New Zealand has significant geographical dimensions that are being addressed via the use of various policy levers, including (in Australia) special registration categories

\textsuperscript{443} Ibid.
for doctors practising in areas of need and (in New Zealand) the voluntary bonding scheme for graduates who agree to work in hard-to-staff communities.444

4 The conflict between public protection and public interest

As discussed above, availability and accessibility considerations have serious potential to conflict with quality and acceptability. In an environment of shortage, therefore, the question becomes: to what extent is it justifiable to compromise the latter to ensure the former? To what extent can the wider public interest be allowed to trump public protection? While these are broad philosophical questions for health policy, the focus of this thesis is the regulation of doctors through the mechanisms of medical boards and tribunals, particularly in terms of disciplinary proceedings. How, therefore, must the boards and tribunals weigh up the duty of public protection against any competing public interest considerations?

To find the answer to such questions, one option is to revert back to the legislation that governs the boards and the tribunals, as both are creatures of statute, legally required to act within the limits of their empowering legislation. As outlined above, until the advent of the National Law Act, there was no legislative mandate for any of the boards or tribunals to take into account wider public interest considerations in making disciplinary decisions. Rather, the exclusive purpose of the disciplinary regime was to protect the public. Access and availability issues, if they fell within the jurisdiction of the boards at all, were only relevant to registration and not to disciplinary decisions. By the time there was a disciplinary decision being made, public protection considerations, due to the existence of past risk or damage to the public confidence, rendered access and availability considerations inconsequential; at least the letter of the legislation would suggest they should have done so.

The tribunals repeatedly say that they will only take the degree of disciplinary action that is ‘necessary’ and so will not remove a doctor from practice unless that action is ‘necessary’ to protect the public. However, the question of necessity can be

problematic. It is always necessary to remove a doctor if one seeks to remove all risk. The threshold question should be: what is the acceptable level of risk? Only after that determination is made should consideration be given to what action is necessary to reduce risk below that level. It is illegitimate to subsequently redefine the acceptable level of risk on the basis that achieving the lower level of risk is unacceptable for other, public interest, reasons. While that might be a philosophically and practically acceptable approach, it is not in accordance with the pre-2010 legislation. Put simply, a doctor’s remediation must not be allowed to put their patients at risk.

Since 1 July 2010, the National Law Act has changed this argument fundamentally for all Australian jurisdictions except New South Wales. Now, the facilitation of access to services, in accordance with the public interest, is expressly stated as an additional objective of the legislation, and so may legitimately be considered by the boards and tribunals when making disciplinary decisions. The New Zealand legislative position is, however, unchanged at this stage.

V CONCLUSION

To state that the purpose of medical professional regulation is to protect the public is somewhat simplistic. As can be seen from the discussion above, different parts of the system have different dominant purposes. Considerations that may be legitimate at one stage of the process may not be legitimate at another. What is meant by public protection is also not straightforward, especially when one places this concept in the broader realm of ‘public interest’ where competing considerations and goals arise.

From their decisions, it appears that the approach of the tribunals to date has been to take account of considerations of the quality and acceptability of care first and foremost, but to allow those to be tempered by accessibility and availability considerations (such as rehabilitation and ensuring supply) where doing so will not result in unacceptable risk. The danger with this approach is that what qualifies as ‘unacceptable risk’ is a

445 Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2010).
446 However, as noted above, supply considerations are clearly part of the picture being considered as part of the 2012 Review: Ministry of Health (NZ), ‘2012 Review of the Health Practitioners Competence Assurance Act 2003: A Discussion Document’ (MoH, 2012).
moving target that can easily be influenced by wider public interest considerations, such as doctor shortage. The author has argued that such an approach lay outside of the legislative parameters given to the boards and tribunals up until 2010 and risked compromising what should have been the primary focus of the decision-makers, that is, public protection.

Having now described both the structure and function of medical professional regulation, the following chapters outline the Studies. The Studies explore empirically what is going on within the complaints and disciplinary system. The goal is to shed light on whether the system and its operations, as described in the foregoing chapters, is effectively achieving its ultimate purpose of public protection.
CHAPTER 5 – PREVIOUS STUDIES

I INTRODUCTION

As argued in the previous chapters, a well-functioning complaints and disciplinary system is a critical component of any professional regulation framework. However, very few studies to date have robustly investigated the workings of this part of the regulatory system. Consequently, information about disciplinary cases tends to be anecdotal, with public perceptions shaped by the intense media coverage that surrounds selected 'scandals' such as the case of Dr Jayant Patel. This chapter describes the relevant studies – both from Australia and New Zealand, and internationally – that have been conducted throughout the last quarter century and their results, and highlights the gaps left by that research up until the time that the first results from the First Study, as described in chapter 6, were published (April 2011).

II PREVIOUS STUDIES OF COMPLAINTS AND DISCIPLINARY PROCEEDINGS

A The studies

1 Disciplinary proceedings

a) Studies using data from the Federation of State Medical Boards

Most of the significant studies conducted to date looking at disciplinary proceedings against doctors come from the United States. Those concerning disciplinary action have generally been done using data from the national database of 'disciplinary orders' as referred to in this thesis means complaints that remain within the jurisdiction of the medical board rather than ones that are progressed by the Complaints Commissioners (except for in those jurisdictions where Complaints Commissioners are responsible for prosecuting charges arising from such complaints in disciplinary tribunals).

Katie Elkin, Matthew Spittal and David Elkin, 'Doctors Disciplined for Professional Misconduct in Australia and New Zealand, 2000-2009' (2011) 194(9) MJA 452: See Appendix One. Note that two relevant studies have been published since that date: Asim Alam et al, 'The Characteristics of Physicians Disciplined by Professional Colleges in Canada' (2011) 5(4) Open Medicine and Sander Gaal et al, 'Complaints against Family Physicians Submitted to Disciplinary Tribunals in the Netherlands: Lessons for Patient Safety' (2011) 9(6) Ann Fam Med 522. Those studies are flagged in this chapter but their findings are not discussed until chapter 6, given their publication post-dates the publication of the results of the First Study, as discussed in that chapter.
maintained by the Federation of State Medical Boards (FSMB data). FSMB data is published annually in the Summary of Board Actions.450

The first such study was published in 1985, when Feinstein compared rates of disciplinary action reported in various states of the United States.451 In 1989, Kofoed et al published a description of the inappropriate prescribing investigations undertaken by the Oregon Board of Medical Examiners, analysing both the cases and the characteristics of the medical practitioners concerned. The next major study was published in JAMA in 1998 by Dehlendorf and Wolfe who analysed 21,000 disciplinary orders in order to describe the characteristics of medical practitioners disciplined for sex-related offences.452 Next came three studies all employing the same case control method, again using FSMB data. The first was a general analysis of the characteristics of medical practitioners disciplined by the Medical Board of California from 1995 to 1997 published by Morrison (James) and Wickersham, also in JAMA.453 Clay and Conaster’s study applied the same method to data from the Medical Board of Ohio.454 And another study by James Morrison, this time co-authored by Theodore Morrison, focused on psychiatrists within the California sample from their earlier JAMA study.455 Another Californian study followed in 2004: Kohatsu et al’s non-matched case control study was design to describe medical practitioners disciplined between 1998 and 2001. Then, in 2005, Khaliq et al published a study of medical practitioners disciplined by the Medical Board of Ohio. Two years later, Grant and Alfred published an analysis of disciplinary actions across all states from 1994 to 2002, focusing on patterns of

450 See, for example, Federation of State Medical Boards. Summary of 2007 Board Actions, available at www.fsmb.org/pdf/2007_SummaryBoardActions.pdf. This 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.
453 James Morrison and Peter Wickersham, 'Physicians Disciplined by a State Medical Board' (1998) 279(23) JAMA 1889.
454 Steven Clay and Robert Conaster, 'Characteristics of Physicians Disciplined by the State Medical Board of Ohio' (2003) 103(2) JAOJ 81.
recidivism. In 2008, Wolfe and Resnevic used FSMB data to rank each state medical board according to its rate of disciplinary action. These rankings were published by the Public Citizen Research Group which, as noted below, also compiles its own data on complaints and disciplinary actions. FSMB data is still used for analyses of disciplinary action, with the most recent study having been published in 2010. In that paper, Law and Hansen compare the operation of Boards in different states and over time in order to determine the effect of Board features on disciplinary activity.

b) Studies using data from narratives of disciplinary action

A second dataset used in analysing disciplinary proceedings is that constructed from data gathered for the Public Citizen Health Research Group's 'Questionable Doctors' series. In that dataset, misconduct types are coded from narratives of disciplinary action taken. In 2000, Wolfe et al published a study using this data, reporting types of misconduct observed, along with types of sanctions imposed. In 2006, Jung, Lurie and Wolfe then conducted a descriptive study of all doctors disciplined for criminal activity in the United States between 1990 and 1999.

Since the author's publication of the results of the First Study (see chapter 6), two other studies using data collected from narrative records of disciplinary decisions or Tribunal judgments have been published. The first, published by Alam et al, involved the construction of a database of the 606 identifiable doctors disciplined by Canadian

457 Sidney Wolfe and Kate Resnevic, 'Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007' (Public Citizen Health Research Group, 2008).
460 Ibid.
provisional licensing authorities between 2000 and 2009.\textsuperscript{463} Both case and doctor characteristics were analysed. Later in 2011, a Dutch study reported the analysis of 250 randomly selected disciplinary law verdicts published by disciplinary tribunals between 2008 and 2010 involving family physicians.\textsuperscript{464} In that study, a range of case characteristics were reported, but there was no analysis of the demographics of the doctors concerned.

In addition, there have been a few prospective studies in which complaints were followed through the disciplinary process to eventual disciplinary outcome. Those studies are discussed in the complaints section of this chapter, below.

2 Complaints

Another set of studies have analysed complaints against doctors, rather than disciplinary proceedings. Again, most of these studies have been done in the United States, but there have also been a number conducted in New Zealand and in Australia. "Complaints" is, however, a broad term, with studies considering complaints within hospitals, to Complaints Commissioners,\textsuperscript{465} and to medical boards. Although this thesis is concerned primarily with complaints to medical boards, the other complaint studies provide some useful context.

a) Studies of non-medical board complaints

In 1994, Donaldson published an analysis of complaints raised within one particular administrative area of the UK’s National Health Service.\textsuperscript{466} The study was small, with only 49 problem doctors identified, but doctor characteristics were investigated along with the nature of the concerns expressed. Another, much larger study of patient complaints to 67 different hospitals in Victoria, Australia, was published in 2004 by Taylor et al.\textsuperscript{467} However, the focus of that study was on the characteristics of the

\textsuperscript{465} See p50 onwards for an explanation of these bodies and how they relate to medical boards.
complainants and the complaints, rather than of the doctors themselves. In July 2011 (after the publication of the first set of results from the First Study), a study of complaints to the Victorian Health Services Commissioner was published, analysing the prevalence and characteristics of doctors who had been the subject of multiple complaints between 2000 and 2009.\footnote{Marie Bismark, Matthew Spittal and David Studdert, 'Prevalence and Characteristics of Complaint-Prone Doctors in Private Practice in Victoria' (2011) 195 \textit{MJA}.}

Two studies have been conducted using surveys to investigate complaints made to Complaints Commissioners. In the first of these, based in New South Wales, survey forms were sent to complainants;\footnote{Ann E Daniel, Raymond J Burn and Stefan Horarik, 'Patients' Complaints About Medical Practice' (1999) 170 \textit{MJA} 598.} while the second, a New Zealand study, surveyed surgeons who had been the subject of a complaint.\footnote{Richard Tapper, Laurence Malcolm and Frank Frizelle, 'Surgeons' Experiences of Complaints to the Health and Disability Commissioner' (2004) 117(1198) \textit{NZMJ} 975.} Both studies reported on the demographics of the complainants and the doctors, as well as reporting on the features of the complaints received.

The National Clinical Assessment Service (NCAS) of the UK’s National Health Service published a 2009 report about referral rates of doctors to their service and the characteristics of such doctors. In early 2011, the NCAS released an updated report that included details of the country of qualification of referred doctors (the NCAS 2011 Report).\footnote{National Clinical Assessment Service, 'Concerns About Professional Practice and Associations with Age, Gender, Place of Qualification and Ethnicity - 2009/10 Data' (NHS, 2011) <www.ncas.nhs.uk/publications/statistics>.}

\textbf{b) Studies of complaints to medical boards}

In 1993, Jost and Strasser used complaint files from the Ohio State Medical Board to study the characteristics of complainants and the processes used by the Boards to address complaints.\footnote{Timothy Jost and Linda Strasser, 'Consumers, Complaints and Professional Discipline: A Look at Medical Licensure Boards' (1993) 3(2) \textit{Health Matrix: JLM} 309.} Ten years later, Cunningham et al published a cross-sectional survey of doctors in New Zealand who had ever received a complaint, however, the
investigators left the definition of ‘complaint’ up to the respondents.\textsuperscript{473} Unsurprisingly this resulted in a wide range of events being analysed, including complaints made to the Health and Disability Commissioner, the Accident Compensation Corporation, and the Medical Council of New Zealand, as well as complaints dealt with directly by the provider (for example, the hospital’s own complaints process). The study analysed both doctor and complainant demographics, however, the only analysis done was univariabl, with no account taken of potential confounders.

A much more statistically robust study was later conducted by Tamblyn et al, and published in \textit{JAMA} in 2007.\textsuperscript{474} While designed specifically to look at the predictive effect of scores on a national clinical skill examination on subsequent complaint rates to various Canadian state medical boards, the study also included some multivariable analyses of particular characteristics associated with complaint rates.

In 2011, Humphrey et al published an analysis of inquiries received by the General Medical Council (GMC) in the United Kingdom. Specifically, the study analysed the proportion of inquiries that were referred for further investigation after initial triage, the proportion of those inquiries that proceeded to adjudication, and then, finally, the proportion leading to removal or suspension from practice.\textsuperscript{475} At each stage, the doctors’ country of qualification (in broad groupings) and ethnicity were the variables of interest.

\textit{B} \hspace{1cm} \textit{Characteristics of doctors}

\textit{1} \hspace{1cm} \textit{Doctors disciplined by the tribunals}

Universally, the studies have found that more male doctors were disciplined than female doctors. Where the results were adjusted according to the relative number of male and female doctors in the population, male doctors were still found to be overrepresented in


\textsuperscript{474} Robyn Tamblyn et al, ‘Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities’ (2007) 298(9) \textit{JAMA} 993.

\textsuperscript{475} Charlotte Humphrey, S Hickman and MC Gulliford, ‘Place of Medical Qualification and Outcomes of U.K. ‘Fitness to Practise’ Process: Cohort Study’ (2011) 342 \textit{BMJ}.
the disciplined group. 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 each. Most of the studies have reported that specialty board certification is associated with a lower rate of discipline.\textsuperscript{476} The effect of time since qualification on odds of disciplinary action is contested, with three studies finding increased length of prior practice to be associated with a higher rate of discipline,\textsuperscript{477} one finding such time to be associated with a lower rate of discipline,\textsuperscript{478} and the third finding no difference based on time in practice.\textsuperscript{479} Similarly, results have been split on the effect of international medical graduate (IMG) status, with three studies finding IMGs to have a lower or same discipline rate as other medical practitioners, but two studies finding their rate to be higher.\textsuperscript{480} However, in every study (pre-2011), IMG status was considered simply as a binary variable, with no breakdown by actual country (or group of countries) of qualification. Consequently, any effect for IMGs from one part of the world may have been nullified by low rates of discipline for IMGs from others part of the world.

Recidivism among disciplined doctors has been found to be high. In one study, a relative risk of 12 of offending within a second four year period was reported for doctors who had been disciplined in an earlier period, compared to those who had


\textsuperscript{478} Steven Clay and Robert Conaster, 'Characteristics of Physicians Disciplined by the State Medical Board of Ohio' (2003) 103(2) \textit{JAOA} 81.

\textsuperscript{479} James Morrison and Theodore Morrison, 'Psychiatrists Disciplined by a State Medical Board' (2001) 158(474) \textit{Am J Psychiatry} 474.

\textsuperscript{480} Neal Kohatsu et al, 'Characteristics Associated with Physician Discipline: A Case-Control Study' (2004) 164 \textit{Archives of Internal Medicine} 653; Amir Khaliq et al, 'Disciplinary Action against Physicians: Who Is Likely to Get Disciplined?' (2005) 118 \textit{American Journal of Medicine} 773, although this difference was only present on univariable analysis and disappeared on multivariable analysis in the Khaliq study.
not.\textsuperscript{481} That relative risk increased to over 30 if the sanctions imposed for the original misconduct were medium or severe (as opposed to mild). Recidivism is reported as likely to be even higher if a period longer than four years is reviewed; the authors suggest that a four year study window was capable of showing only the lower bounds of the true rate of recidivism.\textsuperscript{482}

2 \textit{Doctors subject to complaints}

Male gender has consistently been found to be associated with higher rates of complaints with male doctors accounting for between 60\% and 88\% of all complaints received.\textsuperscript{483} The NCAS 2011 Report put the risk of referral for male doctors at almost three times that for females.\textsuperscript{484} Tamblyn et al found this effect persisted in multivariable analyses that controlled for place of qualification, specialty, and province of practice.\textsuperscript{485} Humphrey et al reported that 80\% of the inquiries to the GMC involved male doctors, despite only 58\% of NHS-employed doctors being male.\textsuperscript{486}

Studies of complaints show different results concerning association between time in practice and complaint rate. In his hospital study, Donaldson found no difference between the age of problem doctors and the population of doctors from which they were drawn.\textsuperscript{487} More commonly, midcareer doctors have been found to be subject to complaints at the highest rate, albeit with some disagreement about the precise age-group most at risk. For example, Tapper et al concluded that surgeons aged 40-49 were


\textsuperscript{482} Ibid, p880.


\textsuperscript{484} National Clinical Assessment Service, 'Concerns About Professional Practice and Associations with Age, Gender, Place of Qualification and Ethnicity - 2009/10 Data' (NHS, 2011) <www.ncas.nhs.uk/publications/statistics>.

\textsuperscript{485} Male doctors were found to have a relative rate of complaints of 1.64 (95\% CI: 1.39, 1.94) compared to female doctors.

\textsuperscript{486} Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 \textit{BMJ}.

at highest risk,\textsuperscript{488} while Cunningham et al simply noted that 53\% of complaints recorded in their study concerned doctors who had been in practice for more than 20 years.\textsuperscript{489} The NCAS 2011 Report found the likelihood of referral to their services increased with age. Doctors aged over 60 years were seven times more likely to be referred than doctors under 40.\textsuperscript{490} Similarly, Humphrey et al reported that 62\% of the inquiries to the GMC during their study period involved doctors who had been qualified for more than 20 years, despite such doctors only making up approximately 39\% of the relevant population of doctors.\textsuperscript{491}

Only one of the studies described above considered rurality as a risk factor for complaints and no significant difference was found.\textsuperscript{492}

Doctor specialty was associated with the number of complaints received in all except one\textsuperscript{493} of the studies in which that variable was considered. General practitioners were consistently found to receive more complaints, with Tamblyn reporting general practitioners as having a relative rate of complaint of 1.79 compared to other doctors (except for surgical specialties which had an even higher relative rate).\textsuperscript{494}

\begin{itemize}
\item \textsuperscript{488} Richard Tapper, Laurence Malcolm and Frank Frizelle, 'Surgeons' Experiences of Complaints to the Health and Disability Commissioner' (2004) 117(1198) NZMJ 975.
\item \textsuperscript{489} Wayne Cunningham, Raewyn Crump and Andrew Tomlin, 'The Characteristics of Doctors Receiving Medical Complaints: A Cross-Sectional Survey of Doctors in New Zealand' (2003) 116(1183) ibid.625.
\item \textsuperscript{490} National Clinical Assessment Service, 'Concerns About Professional Practice and Associations with Age, Gender, Place of Qualification and Ethnicity - 2009/10 Data' (NHS, 2011) <www.ncas.nhs.uk/publications/statistics>.
\item \textsuperscript{491} Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ.
\item \textsuperscript{493} Liam J Donaldson, 'Doctors with Problems in an N.H.S. Workforce' (1994) 308 BMJ 1277.
\end{itemize}
Country of qualification was considered as a binary variable (IMG/non-IMG) in the studies by Cunningham et al, and Tamblyn et al.\textsuperscript{495} Both studies found no significant difference between IMGs and non-IMGs regarding numbers of complaints received.

The NCAS 2011 Report compared doctors according to ethnicity (white vs non-white) and place of qualification (UK vs Other EEA vs Non-EEA\textsuperscript{496}), concluding that, for hospital doctors, there was no difference in complaint-rate according to ethnicity for UK doctors who qualified outside the UK. Regardless of ethnicity, however, hospital doctors and GPs who qualified outside of the UK had higher odds of referral than those trained in the UK. The study also examined rates of suspension and exclusion from work (as opposed to suspension or deregistration by a tribunal), concluding that similar patterns existed as for referrals.

Humphrey et al is the most sophisticated county of training study to date.\textsuperscript{497} Using first the binary variable of UK trained/non-UK trained, they reported that 37% of inquiries concerned non-UK trained doctors despite non-UK trained doctors only making up 33% of the relevant doctor population. They then divided the doctor population into three cohorts – those trained in the UK, those trained in the EU outside of the UK (EU trained) and those trained outside of the EU (non-EU trained). Following the inquiries received through the GMC process (from inquiry, to investigation, to adjudication, to sanction imposed), the researchers found that non-UK trained doctors were more likely to receive ‘high impact’ decisions at each stage, leading to referral to the next stage, or at adjudication, to suspension or removal from practice. For doctors who were ‘black or minority ethnic’ that difference was even more pronounced. Humphrey et al offer two possible explanations for the differences in the way the cases moved through the GMC processes: first, that real differences exist


\textsuperscript{496} The European Economic Area (EEA) comprises the countries of the European Union (EU) plus Iceland, Liechtenstein and Norway.

\textsuperscript{497} Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ.
in fitness to practice between groups referred to the GMC; or secondly, that GMC processes discriminate against certain groups of doctors.

C Characteristics of cases

1 Disciplinary proceedings

Overall annual rates of discipline detected in the studies vary from 240 per 100,000 doctors in Morrison and Wickersham’s sample to 500 per 100,000 reported by Kohatsu et al. However, significant variation was found between states. For example, 2005-2007 FSMB data shows discipline rates ranging from 800 per 100,000 doctor-years for Alaska, which had the highest rate, to 110 per 100,000 doctor-years for South Carolina, which had the lowest rate.498

Khaliq et al found that 66% of complaints that led to disciplinary action came from the general public and only 5% from other doctors.

All of the studies recorded and analysed the type of misconduct for which the doctors were disciplined, however, the specificity with which that misconduct was categorised varied greatly and was typically fairly crude. For example, broad and vague labels such as ‘unprofessional conduct’, ‘negligence or incompetence’, ‘substandard care’ and ‘professional misconduct’ were used. In addition, in every study prior to the publication of the First Study, the list of misconduct types included both negligence and/or incompetence, and inappropriate prescribing. This categorisation approach confuses misconduct types (the actual misconduct), such as inappropriate prescribing, with the underlying reason for that misconduct, such as incompetence. It is possible, for example, for inappropriate prescribing to occur as a result of a doctor’s incompetence. In many of the studies, the typology that was used was adopted out of necessity, due to the way in which the FSMB data was recorded. However, even the Public Citizen’s Health Research Group typology is not much more sophisticated, again using vague and

499 With the exception of James Morrison and Theodore Morrison, ‘Psychiatrists Disciplined by a State Medical Board’ (2001) 158(474) Am J Psychiatry 474, which only investigated sexual conduct issues.
apparently overlapping labels, thus preventing the development of a nuanced picture of
the misconduct concerned. As noted by Grant and Alfred, neither database allows the
pinpointing of the number of actions that were directly, or even indirectly, attributed to

Disciplinary measures imposed on doctors found guilty of misconduct are reported in
most of the studies, with between 21\%\footnote{This was the lower bound reported by Sidney Wolfe et al, ‘Questionable Doctors Disciplined by State and Federal Governments’ (Public Citizen Health Research Group, 2000), who found a range of 21-39\%.} and 64\%\footnote{Steven Clay and Robert Conaster, ‘Characteristics of Physicians Disciplined by the State Medical Board of Ohio’ (2003) 103(2) JAOA 81.} of such doctors being removed
from practice, with other sanctions imposed with varied regularity. In most of the
studies, the severity of disciplinary measures imposed were not found to vary by gender
or specialty of the doctor involved.\footnote{James Morrison and Peter Wickersham, ‘Physicians Disciplined by a State Medical Board’ (1998) 279(23) JAMA 1889; James Morrison and Theodore Morrison, ‘Psychiatrists Disciplined by a State Medical Board’ (2001) 158(474) Am J Psychiatry 474.}

However, disciplinary measure imposed did vary systematically according to the type of misconduct found to have occurred. In
particular, sexual misconduct (and, in some studies, drug offences) was found to be
strongly associated with removal from practice, with removal being imposed in between
41\%\footnote{James Morrison and Peter Wickersham, ‘Physicians Disciplined by a State Medical Board’ (1998) 279(23) JAMA 1889.} and 80\%\footnote{Steven Clay and Robert Conaster, ‘Characteristics of Physicians Disciplined by the State Medical Board of Ohio’ (2003) 103(2) JAOA 81.} of cases. However, the misconduct category ‘sexual misconduct’ is
rather non-specific given the two quite distinct types of sexual misconduct cases that are
typically seen by the medical boards. The first is where the doctor is found guilty of
having had a sexual relationship with a current or former patient and the second is
where a doctor has committed some other sexual misconduct on a patient, such as a
sexual assault or an inappropriate physical examination. These categories of sexual
misconduct raise very different issues and so would be better considered separately in
any analysis of disciplinary measure imposed. The only insight into this difference is
given by Jung et al, who reported that 80% of doctors found guilty of criminal sex offences were removed from practice.\textsuperscript{506}

Other case characteristics, such as the setting of the misconduct, the number of patients affected, and the patient outcome are not reported in any of the studies, either as variables of interest in their own right or as possible confounders of relationships examined.

2 Complaints and their progress through the disciplinary system

Tamblyn et al reported an overall complaint rate to the Ohio State Medical Board of 4,900 complaints per 100,000 doctor-years.

Jost and Strasser found that the majority of complainants (71%) in their study were female.\textsuperscript{507} The rate ratio for female complainants was found to be 1.3 (95% CI: 1.2-1.3) compared to male complainants in Taylor et al\textsuperscript{508} study of complaints received by hospitals in Victoria. It has been suggested that this may be because females tend to have more interactions with doctors than males and are also likely to be the ones to complain on behalf of other family members.\textsuperscript{509}

An interesting feature of complaints and disciplinary proceedings is that what is being observed is a process. There is not one sole outcome point (guilty or not), but many outcome points along the way, as illustrated by the processes described in the previous chapter. Only two studies have been identified that have followed the progress of complaints received through the disciplinary process. The first was conducted by Jost and Strasser almost two decades ago. Of the 400 complaints considered by the authors of that study, the ¿vast majority¿ were investigated, around a quarter were referred to some kind of hearing, and approximately 9% of the original number resulted in a guilty

finding. That study did not, however, investigate the characteristics of the doctors concerned at any of the various stages of the disciplinary process to test whether the profile of the doctor cohort remained constant throughout the process. More recently, Humphrey et al. traced inquiries through the GMC process from receipt, to investigation, to adjudication, and on to eventual disciplinary outcome. As noted above, the authors of that study focused their analyses on a country of training. Of 7526 inquiries received, just over a third (2663) were investigated by the GMC, about 7% were adjudicated (512), and about 2% (164) resulted in the doctor concerned being suspended or removed from practice.\(^{510}\)

\[D\] Associations between doctor and case characteristics

One previous study has found some associations between type of misconduct (though poorly defined) and doctor characteristics.\(^{511}\) The study reported that: criminal activity was associated with older age, lack of board certification, and the specialties of general practice, psychiatry and family practice; fraud was most common among general practitioners and psychiatrists; and drug related misconduct was associated with general practice and family practice.

No studies exploring any other associations between doctor and case characteristics have been identified from the literature.

\[E\] Limitations of previous studies

As summarised above, the studies that have investigated complaints and disciplinary proceedings to date suffer from various limitations, some of which are addressed in the Studies described in the following two chapters of this thesis.

\[I\] Quality of data

The majority of the previous studies of disciplinary proceedings have been based on FSMB data. One of the major issues with this data is that reporting to the Federation of

\(^{510}\) Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ.

State Medical Boards has not traditionally been standardised, and that lack of standardisation may account for much of the observed variation between states.\textsuperscript{512} It is possible that the reporting mechanisms have since been standardised, but this does not appear to have occurred before the studies described above were conducted. Researchers using the FSB data have also been constrained by the typologies used for collecting that data which, as discussed below, are suboptimal.

Missing data is a problem in the FSB data set. In particular, as acknowledged in one study, in 66\% of cases the 'basis for sanction' was coded as 'not applicable' while a further 33\% were coded simply as 'unprofessional conduct'.\textsuperscript{513}

\textbf{2 Typologies used}

Issues surrounding the typologies used are described in some detail above. Suffice to say that the shortcomings include the fact that, in many studies:

\begin{itemize}
  \item a) a limited range of case and doctor characteristics are recorded, and even fewer are used as possible confounders in the analyses;
  \item b) misconduct types are vague and non-specific;
  \item c) misconduct types are conflated with underlying explanations for misconduct; and
  \item d) IMGs are not considered according to country of qualification but according to a simple binary IMG/Non-IMG variable.
\end{itemize}

\textbf{3 Outcome variables}

A further weakness in the majority of the research to date is that only two studies have attempted to map the progress of complaints through to eventual disciplinary outcome,\textsuperscript{514} and only the study by Humphrey et al has done this in such a way as to allow comparison of doctor and case characteristics at various stages of the disciplinary

\begin{footnotesize}
\textsuperscript{512} Richard Feinstein, 'Special Report: The Ethics of Professional Regulation' (1985) 312(12) \textit{New England Jnl of Medicine} 801.
\textsuperscript{513} Ibid.
\end{footnotesize}
process. Instead, complaints and disciplinary action are commonly viewed as discrete outcomes rather than as interconnected stages in a complex process.

4 Quality of analysis

Some of the studies described above present proportions and percentages only, sometimes with an accompanying univariate analysis giving a p-value for any association identified. Given the complexity of the complaints and disciplinary process, and the numerous links and interactions between doctor characteristics such as gender, specialty, country of qualification, and length of time in practice, ideally analyses should adjust for other variables when examining these relationships.

5 Dominance of US research

A further gap in the literature is that all of the studies of disciplinary outcome published prior to April 2011, apart from the one by Humphrey et al, were conducted in the United States. For Australia and New Zealand, even a basic understanding of the descriptive demographics of what is going on in the jurisdictions is lacking. While there have been several Australian and New Zealand studies of complaints received, they have generally involved data collected by survey, vague definitions of complaint, and/or small sample sizes.

III CONCLUSION

Past research has investigated complaints and disciplinary proceedings against doctors. However, differences in findings and various methodological limitations mean that robust empirical understanding of those processes is still fairly limited.

The Studies described in the following chapters were designed to advance the knowledge base in several key ways. Some shortcomings in the data available for the Studies has not allowed the author to overcome all of the limitations described above; however, in many respects, significant advances in knowledge and in the methodological robustness of existing knowledge have been made. The next two chapters introduce the First Study and the Second Study and describe their methods and main results. Central themes emerging from those results are then developed and discussed in the remaining chapters of the thesis, chiefly by way of in-depth analysis of
one key doctor characteristic (country of training) and one key case characteristic (removal from practice) of particular relevance for public protection.
CHAPTER 6 – THE FIRST STUDY: ANALYSIS OF TRIBUNAL DETERMINATIONS

I INTRODUCTION

The First Study is an analysis of Tribunal determinations. As outlined in chapter 3, it is only the most serious of disciplinary matters that end up before the Tribunals. By analysing the determinations of the tribunals, considerable insight into the characteristics of doctors and cases that come before the Tribunals can be gained, together with a better understanding of the way in which the Tribunals tend to address what comes before them.

This chapter sets out the methods used for the First Study and the descriptive findings arising from that study.515

II AIMS

The aim of the First Study was to develop an empirically robust understanding of the:

a) nature of the cases that come before the Tribunals;

b) characteristics of the doctors concerned;

c) relationship between the case characteristics and the doctor characteristics;

and

d) basis for the Tribunals' disciplinary decision-making, particularly the choice of disciplinary action imposed.

In order to achieve the above aims, it was necessary to develop and apply a new and robust typology for describing the nature of the misconduct at issue in the cases.

In addition to the above aims, and in keeping with the broader aims of the thesis, the First Study also sought to analyse the extent to which the operation of the complaints and disciplinary system appears to demonstrate consistency with, and effectiveness in promoting, public protection.

III METHODS

A Sample

The sample frame was all disciplinary cases adjudicated by Tribunals in Australia’s four most populous states (New South Wales, Victoria, Queensland and Western Australia) and New Zealand (the Jurisdictions) between 1 January 2000 and 30 September 2009 (the Study Period). The Jurisdictions cover approximately 85% of Australian registered doctors and all New Zealand registered doctors. For the purposes of the First Study, a Tribunal was defined as any disciplinary body with the power to remove a doctor from practice, other than on an interim basis. These bodies are known by various names, and in some Jurisdictions were historically constituted as committees of medical boards but, by the end of the study period, all of the Jurisdictions had transferred this function to independent tribunals (which are, in several jurisdictions, part of the general court system). This evolution is further detailed in chapter 3. Table 2 summarises the Tribunals according to date of operation.

After excluding cases in which the Tribunal dismissed all charges (n=65) and those exclusively concerned with non-disciplinary matters such as impairment or ill-health (n=138), the study sample consisted of 485 cases. In all included cases, therefore, the doctor concerned was found guilty of at least one disciplinary charge.

The data came from two main sources. First, the written determinations associated with all sampled cases were gathered. Determinations ranged in length from a couple of paragraphs to 110 pages. For 80% of cases, the full text of the determination was available; for the rest, essentially cases from Victoria in 2000 and early 2001, and cases from Western Australia, only summaries of the determinations were available. Second,

516 Australian Institute of Health and Welfare, ‘Medical Labour Force 2006’ (AIHW, 2008), Table 1.2.
information on doctors was extracted from the medical registers. In every Jurisdiction, for the study period, this information was publicly accessible online.

The Human Research Ethics Committee at the University of Melbourne approved the First Study.

Table 2. The Tribunals in operation in the Jurisdictions during the study period

<table>
<thead>
<tr>
<th>State</th>
<th>Regime 1: Serious cases</th>
<th>Date of change</th>
<th>Regime 2: Serious cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Medical Practice Act 1992: Medical Tribunal</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Victoria</td>
<td>Medical Practice Act 1994: Complainet received from 1 July 2007</td>
<td>Health Professions Registration Act 2005: Victorian Civil and Administrative Tribunal hearing</td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>Medical Act 1939: Medical Assessment Tribunal</td>
<td>Complaints received from 7 February 2000</td>
<td>Health Practitioners (Professional Standards) Act 1999: Health Practitioners Tribunal</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Medical Act 1894: Hearing by the Medical Board</td>
<td>Complaints received from 1 January 2007</td>
<td>Medical Act 1894 (amended) and then Medical Practitioners Act 2008: State Administrative Tribunal</td>
</tr>
</tbody>
</table>

**B Key variables**

The key variables of interest can be divided into **doctor**variables and **case**variables. Doctor variables of particular interest were gender, specialty, the number of years that had passed since the doctor obtained his or her primary medical qualification, and the
country in which that qualification was obtained. A variable indicating whether or not the doctor had any previous disciplinary history was also recorded. This was coded as positive whenever there was evidence of past Tribunal or board proceedings (either as referred to in the Tribunal determination or as established from cross-matching of those determinations).

For case variables, the focus was on misconduct type, explanation for misconduct, patient outcome, and disciplinary measures imposed. As discussed in the previous chapter, the literature review identified substantial limitations in existing typologies for defining the nature of misconduct. Limitations included too few categories, non-specific categories, and conflating types of misconduct (eg, misprescribing) with the underlying reasons for the misconduct (eg, incompetence or criminality). Therefore a new typology was created using standard coding methodologies.

Disciplinary measure and patient outcome involved explicit judgments. A subsample of 40 determinations was reviewed and the disciplinary measure and patient outcome was listed for each. The author and a research assistant then discussed the list and reached consensus on an appropriate typology. For disciplinary measure, three categories and nine subcategories indicated varying levels of intervention from a public protection standpoint. The categories (subcategories) were: removal from practice (deregistration, suspension), restrictions on practice (education programme, counselling, supervision, other conditions), and non-restrictive sanction (reprimand, fine, costs). The eight patient outcome categories were: death, physical injury, (diagnosed) psychiatric injury, drug dependency, upset to patient, risk to patient, no consequence, and not applicable.

Development of a typology for misconduct type followed a similar method, except it began with a draft typology derived from merging the categories used by two boards (Victoria and Queensland) with relatively comprehensive typologies. The author and the research assistant independently reviewed 100 determinations, applying the draft typology to the misconduct in each case, and adding and modifying categories as appropriate. The results of this review were then compared and discussed to determine

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a final set of 12 misconduct types: illegal or unethical prescribing; sexual relationship with patient; inappropriate or inadequate treatment; inappropriate sexual contact with patient (not relationship); non-sexual misconduct towards patient; breach of registration conditions; inadequate or inappropriate medical certificates or records; missed, delayed or incorrect diagnosis; failure to obtain informed consent; criminal offence; breach of privacy; and failings in the supervision of others. These misconduct types were then grouped into five parent categories to facilitate the comparison of some misconduct types against existing literature.

Table 3 gives examples of the way in which forms of professional misconduct were classified using this typology.

For the variable indicating explanation for misconduct, the author and the research assistant independently reviewed 40 determinations and compiled a list of candidate categories, based on the evidence adduced and the Tribunal’s assessment of that evidence. Comparison and discussion of the two lists led to agreement on a six category typology: poor judgement (defined as inappropriate decision making), wilful wrongdoing (deliberate breach of required standards), personal situation (including family issues, psychological disorder, addiction, financial issues, and cultural misunderstanding); work environment (including workload, stress, isolation, and administrative issues within the doctor’s practice); incompetence (systemic inability to practice to the required standard); and insufficient knowledge (a specific gap or gaps in the required knowledge).

C Study instrument

An instrument was then developed to facilitate case-by-case recording of values for the variables described above. The instrument allowed coding of up to four misconduct types but, in cases with multiples, directed reviewers to select a primary one. The primary misconduct type was defined as the behaviour of most concern to the Tribunal. This was determined by close reviews of the determinations, focusing on express comments by the Tribunal and the weight of attention given to each misconduct type at issue. The instrument allowed for coding of as many explanations for the misconduct per case as the Tribunal identified and discussed in the determination. Both of these
variables were dummy coded. The study instrument also captured other information about the case, including the number of patients affected by the misconduct, who initially notified the matter to the regulatory body, the patient outcome, plus a range of doctor variables such as sex, years since qualification, and specialty.

\[D\quad Data\ collection\]

Between September and December 2009, the determinations associated with all sampled cases were reviewed. Data from these reviews was supplemented with basic socio-demographic data (year of qualification, specialty and gender) on doctors involved, collected from medical registries. When a doctor’s registration record could not be found, it was obtained from the registration database of another jurisdiction (for doctors registered in multiple jurisdictions), from the facts mentioned in the determinations themselves, or, as a last resort, through a request to the board in the relevant Jurisdiction.

To test the reliability of the review in relation to variables that included implicit judgment (primary misconduct type, misconduct type, explanation for misconduct), 5% of cases (n=24) were reviewed again by a second reviewer who was blinded to the results of the first review.

\[E\quad Statistical\ analysis\]

Counts and proportions were calculated for the descriptive variables. To calculate rates, population-level denominators were required. The total number of doctors per study year, including breakdown by gender, was estimated by taking an average of the registration data, as reported by the board in each Jurisdiction, for the years 2001-02, 2004-05, and 2007-08.\(^{518}\) For the comparison of rates by gender, the denominator for female doctors was adjusted to allow for their lower mean working hours per week relative to males (38 hours versus 47 hours per week).\(^{519}\)

\(^{518}\) See Annual Reports for each Board for each time period.

Table 3. Examples of the application of the developed typology for misconduct type and explanation for misconduct

<table>
<thead>
<tr>
<th>Misconduct type</th>
<th>Explanation for misconduct</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner prescribed without authority. Medications were prescribed at inappropriate dosages and medical records kept were inadequate. Administrative problems within the general practitioner’s practice were an issue.</td>
<td>Illegal or unethical prescribing; Medical certificates or records; Treatment Insufficient knowledge; Poor judgement; Work environment</td>
</tr>
<tr>
<td>Patient presented with unexplained bleeding numerous times over six months. Obstetrician/gynaecologist did not do an internal examination and missed diagnosing a benign growth.</td>
<td>Missed, delayed or incorrect diagnosis Insufficient knowledge</td>
</tr>
<tr>
<td>Ophthalmologist performed laser surgery on patient’s eye without informing her of risks of procedure. Despite complications, ophthalmologist proceeded to operate on other eye.</td>
<td>Informed consent; Treatment Poor judgement</td>
</tr>
<tr>
<td>General practitioner had sexual relationship with patient while doctor for patient’s entire family, including husband. GP told patient’s husband she was not having an affair. GP was stressed from changes in work situation and suffering from a psychological disorder.</td>
<td>Wilful wrongdoing; Work situation; Personal situation Sexual relationship with patient</td>
</tr>
<tr>
<td>Doctor concealed his Hepatitis B infection on his application for registration then lied to investigators about it. Also concealed from own treating doctor that he was practising as a doctor.</td>
<td>Wilful wrongdoing; Poor judgement Inappropriate conduct not in relation to patients</td>
</tr>
<tr>
<td>General practitioner performed an unsuccessful examination and then an intimate internal examination of female patient. The second examination was medically unnecessary. Communicated poorly with patient. GP was foreign-trained and tribunal identified some cultural misunderstandings at play.</td>
<td>Inappropriate sexual conduct towards patient; Treatment; Inappropriate non-sexual conduct towards patient Incompetence; Personal situation</td>
</tr>
</tbody>
</table>
To calculate rates of variables of interest by specialty, denominators were obtained from medical workforce reports for 2003 and 2006. These methods gave a measure of rates per 100,000 registered doctor-years by specialty. Mean years since qualification for doctors in the wider population during the study period (using mean age minus 24 years) was also estimated from medical workforce report data.

Multivariable logistic regression analysis was used to identify doctor variables associated with misconduct types. Specifically, the outcome was a binary variable indicating the presence or absence of each misconduct type. The predictor variables of interest were the doctor variables of gender, specialty, and years since qualification. The outcome variable was regressed on the first two of these predictors in separate models, adjusting for potential confounders from among the other doctor variables. For the doctor variable years since qualification, percentages for each misconduct type for each ten year period were calculated.

A two-step process was used to identify potential confounders. First, bivariate analyses were undertaken (using either t-tests or x² tests) to establish whether each independent variable was associated (p<0.1) with both the outcome variable and the predictor of interest. Second, the relevant logistic regression model was run with and without each of the variables that met this threshold, and the results of the two models were compared. Where inclusion of an independent variable led to a change in odds ratio of 20% or more, the independent variable was included in the final model.

In addition, Poisson regression analysis was used to identify whether state (as an exposure variable) was associated with overall rate of Tribunal cases (as the outcome variable).

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Kappa scores were used to measure the reliability of the classifications of misconduct type and explanation for misconduct. All analyses were conducted using the Stata, version 10 (STATA Corp, College Station, Tex, USA).

IV RESULTS

A Data quality

1 Data availability

Data availability was generally good, allowing most cases to be coded for most variables of interest (as shown in Table 4). The variables with the most missing data were notifier (21% of cases unable to be coded), years since qualification (24%), and explanation for misconduct (26%).

Table 4. Missing data for variables of interest in Tribunal cases (n=485)

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disciplinary measure</td>
<td>4 (1)</td>
<td>44 (9)</td>
</tr>
<tr>
<td>Doctor gender</td>
<td>5 (1)</td>
<td>47 (10)</td>
</tr>
<tr>
<td>Misconduct type</td>
<td>5 (1)</td>
<td>49 (10)</td>
</tr>
<tr>
<td>Number of patients</td>
<td>15 (3)</td>
<td>118 (24)</td>
</tr>
<tr>
<td>Patient outcome</td>
<td>17 (3)</td>
<td>127 (26)</td>
</tr>
<tr>
<td>Previous disciplinary matter</td>
<td>18 (4)</td>
<td></td>
</tr>
</tbody>
</table>

2 Inter-rater reliability

Reliability testing was performed on 24 pairs of reviews (5% of cases). Agreement between the author and the research assistant was excellent. The percentage agreement for explanation for misconduct, misconduct type, and primary misconduct type was 78%, 86% and 96%, respectively; the kappa scores were 0.74 (std error = 0.06), 0.85 (std error = 0.05) and 0.96 (std error = 0.08), respectively.

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B  Characteristics of Tribunal cases

1  General

Tribunals in the Jurisdictions heard 550 disciplinary cases against doctors between January 2000 and September 2009. In 88% of all of those cases (range among Jurisdictions, 76% to 93%), the doctor concerned was found guilty of misconduct and disciplined accordingly.

The overall incidence of discipline was 60 cases per 100,000 registered doctor-years. The rate of Tribunal cases (where the doctor was found guilty of professional misconduct) therefore varied by State, with the highest rate in Western Australia (119 per 100,000 doctor-years) and the lowest rate in Queensland (29 per 100,000 doctor-years). About one third of the cases analysed were adjudicated by a Tribunal in Victoria and a quarter by a Tribunal in New South Wales (Table 5), even though there are more doctors registered to practise in New South Wales than there are in Victoria.\(^{523}\)

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>n(%)*</th>
<th>Rate†</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW (ref)</td>
<td>130 (27)</td>
<td>48</td>
</tr>
<tr>
<td>Vic</td>
<td>157 (32)</td>
<td>90</td>
</tr>
<tr>
<td>WA</td>
<td>87 (18)</td>
<td>119</td>
</tr>
<tr>
<td>NZ</td>
<td>71 (15)</td>
<td>63</td>
</tr>
<tr>
<td>Qld</td>
<td>40 (8)</td>
<td>29</td>
</tr>
</tbody>
</table>

\(^{*}\) Percentages were calculated with the number of available observations used as the denominator.
\(^{†}\) Rate per 100,000 registered doctor-years during the decade 2000-2009 inclusive, calculated from Annual Report data.

The misconduct at issue occurred in a clinical setting in two thirds of cases, with the majority of clinical cases (74%, 217/293) occurring in non-inpatient settings.

Table 6. Characteristics of Tribunal cases (n=485)

<table>
<thead>
<tr>
<th>Jurisdiction,* n(%)</th>
<th>Notifier, n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vic 157 (32)</td>
<td>Patient or patient rep 191 (50)</td>
</tr>
<tr>
<td>NSW 130 (27)</td>
<td>Court 64 (17)</td>
</tr>
<tr>
<td>WA 87 (18)</td>
<td>Medical board or council 56 (15)</td>
</tr>
<tr>
<td>NZ 71 (15)</td>
<td>Other health professional 20 (5)</td>
</tr>
<tr>
<td>Qld 40 (8)</td>
<td>Other 50 (13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision date, n(%)</th>
<th>Patient outcome;‡ n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-02 175 (36)</td>
<td>Death 36 (8)</td>
</tr>
<tr>
<td>2003-05 160 (33)</td>
<td>Physical injury 41 (9)</td>
</tr>
<tr>
<td>2006-08 116 (24)</td>
<td>Psychiatric injury 28 (6)</td>
</tr>
<tr>
<td>To 9/09 34 (7)</td>
<td>Drug dependency 66 (14)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting of misconduct, n(%)</th>
<th>Number of patients affected †</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical 293 (66)</td>
<td>Mixed clinical/non-clinical 99 (22) 0 75 (16)</td>
</tr>
<tr>
<td>Outpatient 217 (49)</td>
<td>Non-clinical 14 (3) 1 240 (51)</td>
</tr>
<tr>
<td>Inpatient 76 (17)</td>
<td>Not applicable 35 (8) 2+ 155 (33)</td>
</tr>
</tbody>
</table>

* Percentages were calculated with the number of available observations used as the denominator.
† Number of patients mentioned in the Tribunal’s decision as having been affected by the doctor’s conduct.
‡ For cases in which multiple patient outcomes apply, the most severe is reported; shown in descending order of ostensible severity.

Patients, or friends or family members acting on patients’ behalf, notified one half of cases to the tribunals. Referral by a court (17%) or at the medical boards’ own initiative (15%) were the next most common channels. Only 5% of cases were notified by another health professional.

Half of the cases concerned misconduct towards one patient and one third of cases involved misconduct towards multiple patients (ranging from two to over 100 patients). Sixteen percent of cases involved issues unrelated to patient contact. Physical harm occurred in 9% of cases and patient death in 8%. However, the most prevalent outcome for affected patients was being upset at what had occurred and, in 78% of cases (380/470), there was no mention in the Tribunal determination of either physical or psychiatric harm to the patient as a result of the misconduct.
2. Nature of misconduct

a) Misconduct type

As noted above, two separate components of the nature of misconduct were classified in the analysis: misconduct type and explanation for misconduct.

The leading type of misconduct was sexual misconduct towards a patient, which was the primary issue in 24% of cases (Table 7). This type of misconduct occurred almost exclusively among male doctors (110/114, 96%). Two-thirds of the sexual misconduct cases involved sexual relationships with patients, as opposed to other inappropriate sexual contact (eg, unnecessary examination and touching of sexual organs). Illegal or unethical prescribing (the primary issue in 21% of cases) was the next most common type of misconduct, followed by inappropriate medical care (20%), which was split between treatment problems (73%, 69/95) and diagnostic errors (27%, 26/95). Other types of misconduct for which doctors were disciplined were breaches of registration conditions that had already been imposed (primary issue in 7% of cases), inadequate or inappropriate issuing of medical certificates or keeping of medical records (5%), failure to obtain informed consent (5%), and criminal offences unrelated to patients (4%).

Fifty eight percent of cases involved more than one type of misconduct (mean per case, 1.85; std dev, 0.86). Expanding the analysis beyond the primary issues to include all issues in the cases dramatically increased the prominence of two types of misconduct: problems with medical certificates or records (5% to 26% of cases) and treatment issues (14% to 36%).

b) Explanation for misconduct

The two most prevalent explanations for misconduct were poor judgement (46% of cases) and wilful wrongdoing (45%). The other four explanations for misconduct (personal situation, work environment, incompetence, and insufficient knowledge) were each present in about one quarter of cases. In 63% of cases, Tribunals identified and discussed multiple explanations for the misconduct (mean per case, 1.90; std dev, 0.82).
Table 7. Type of misconduct and explanation for misconduct in Tribunal cases

<table>
<thead>
<tr>
<th>Type of misconduct</th>
<th>Primary Issue n (% of all cases)</th>
<th>Any Issue n (% of all cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual misconduct towards patient</td>
<td>114 (24)</td>
<td>123 (25)</td>
</tr>
<tr>
<td>Relationship with patient</td>
<td>76 (16)</td>
<td>79 (16)</td>
</tr>
<tr>
<td>Other sexual misconduct</td>
<td>38 (8)</td>
<td>47 (10)</td>
</tr>
<tr>
<td>Illegal or unethical prescribing</td>
<td>102 (21)</td>
<td>119 (25)</td>
</tr>
<tr>
<td>Inappropriate medical care</td>
<td>95 (19)</td>
<td>184 (38)</td>
</tr>
<tr>
<td>Treatment (inappropriate or inadequate)</td>
<td>69 (14)</td>
<td>175 (36)</td>
</tr>
<tr>
<td>Diagnosis (missed, delayed or incorrect)</td>
<td>26 (5)</td>
<td>37 (8)</td>
</tr>
<tr>
<td>Misconduct not in relation to patient</td>
<td>52 (11)</td>
<td>97 (20)</td>
</tr>
<tr>
<td>Inappropriate conduct not in relation to patient</td>
<td>34 (7)</td>
<td>79 (16)</td>
</tr>
<tr>
<td>Criminal offence</td>
<td>18 (4)</td>
<td>18 (4)</td>
</tr>
<tr>
<td>Other misconduct</td>
<td>115 (27)</td>
<td>277 (57)</td>
</tr>
<tr>
<td>Non-sexual misconduct towards patient</td>
<td>32 (7)</td>
<td>71 (15)</td>
</tr>
<tr>
<td>Breach of registration conditions</td>
<td>32 (7)</td>
<td>60 (13)</td>
</tr>
<tr>
<td>Failure to obtain informed consent</td>
<td>22 (5)</td>
<td>54 (11)</td>
</tr>
<tr>
<td>Medical certs or records (inadequate or inappropriate)</td>
<td>26 (5)</td>
<td>127 (26)</td>
</tr>
<tr>
<td>Breach of privacy</td>
<td>3 (1)</td>
<td>11 (2)</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>2 (0.5)</td>
<td>10 (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Explanation for misconduct</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor judgement</td>
<td>164 (46)</td>
</tr>
<tr>
<td>Wilful wrongdoing</td>
<td>162 (45)</td>
</tr>
<tr>
<td>Personal situation</td>
<td>90 (25)</td>
</tr>
<tr>
<td>Work environment</td>
<td>86 (24)</td>
</tr>
<tr>
<td>Incompetence</td>
<td>84 (23)</td>
</tr>
<tr>
<td>Insufficient knowledge</td>
<td>82 (23)</td>
</tr>
</tbody>
</table>

*Primary misconduct type was judged from among =<4 misconduct types recorded per case (mean per case, 1.98; SD, 0.86). Note that, due to missing data (see Table 3), frequency statistics used 477 cases for the analysis of misconduct types and 357 cases for the analysis of explanations for misconduct.

†Percentages were calculated with the number of available observations used as the denominator.

‡No primary issue classified for the explanation of misconduct variable.
Disciplinary measures imposed

As shown in Table 8 below, the doctor was removed from practice in 43% of cases. Among cases that resulted in removal from practice, two thirds (138/209) effected this by de-registration and one third (71/209) by a temporary suspension of registration. In 37% of cases, the most serious disciplinary sanction imposed was some sort of restriction on practice. In 19% of cases, only a non-restrictive sanction was imposed.

Table 8. Disciplinary sanctions imposed by the Tribunals in the cases (n=481)

<table>
<thead>
<tr>
<th>Sanction</th>
<th>Most serious disciplinary sanction, n(%)&lt;sup&gt;*&lt;/sup&gt;</th>
<th>All disciplinary sanctions, n(%)&lt;sup&gt;*&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal from practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deregistration</td>
<td>138</td>
<td>138 (29)</td>
</tr>
<tr>
<td>Suspension</td>
<td>71</td>
<td>71 (15)</td>
</tr>
<tr>
<td>Restrictions on practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education programme</td>
<td>57</td>
<td>68 (14)</td>
</tr>
<tr>
<td>Counselling</td>
<td>39</td>
<td>51 (11)</td>
</tr>
<tr>
<td>Supervision</td>
<td>33</td>
<td>40 (8)</td>
</tr>
<tr>
<td>Other conditions</td>
<td>130</td>
<td>169 (35)</td>
</tr>
<tr>
<td>Non-restrictive sanction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reprimand</td>
<td>85</td>
<td>281 (58)</td>
</tr>
<tr>
<td>Fine</td>
<td>32</td>
<td>100 (21)</td>
</tr>
<tr>
<td>Costs</td>
<td>51</td>
<td>267 (56)</td>
</tr>
</tbody>
</table>

<sup>*</sup> Percentages were calculated with the number of available observations used as the denominator. Data on disciplinary measure imposed was missing in 4 cases (<1%).

A Parent categories of disciplinary measures are mutually exclusive with overlaps sorted into the category above. Within categories, multiple subcategories per case were allowed.

When considered as non mutually-exclusive categories, non-restrictive sanction was the most commonly imposed disciplinary sanction, occurring (either alone or alongside other measures) in 88% (422/481) of cases. Restrictions on practice were imposed in 47% (226/481) of cases (including nine cases in which the Tribunal also deregistered
the doctor), with no one type of restriction being particularly prevalent. Supervision was imposed in only 8% (40/481) of cases.

C Characteristics of doctors

Ninety-one percent of cases concerned the conduct of male doctors (Table 9). Although a greater proportion of the doctor workforce across the Jurisdictions is male (about 67%), this alone does not account for the difference. Male doctors were disciplined at four times the rate of female doctors (91 per 100,000 registered doctor-years compared to 22 per 100,000 registered doctor-years), taking into account the lower average working hours of female doctors.

Table 9. Characteristics of doctors in Tribunal cases (n=485)

<table>
<thead>
<tr>
<th></th>
<th>n (%)*</th>
<th>Rate †</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>440 (91)</td>
<td>91</td>
</tr>
<tr>
<td>Female</td>
<td>42 (9)</td>
<td>18</td>
</tr>
<tr>
<td><strong>Specialty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>285 (65)</td>
<td>131</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>43 (10)</td>
<td>178</td>
</tr>
<tr>
<td>Surgery</td>
<td>32 (7)</td>
<td>95</td>
</tr>
<tr>
<td>Obstetrics/Gynaecology</td>
<td>24 (6)</td>
<td>224</td>
</tr>
<tr>
<td>Hospital generalist</td>
<td>19 (4)</td>
<td>65</td>
</tr>
<tr>
<td>Other specialty</td>
<td>14 (3)</td>
<td>53</td>
</tr>
<tr>
<td>Anaesthesiology</td>
<td>13 (3)</td>
<td>15</td>
</tr>
<tr>
<td>Registrar</td>
<td>6 (1)</td>
<td>15</td>
</tr>
<tr>
<td><strong>Country of primary medical qualification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>281 (64)</td>
<td>71</td>
</tr>
<tr>
<td>New Zealand</td>
<td>33 (8)</td>
<td>35</td>
</tr>
<tr>
<td>Other</td>
<td>124 (29)</td>
<td>81</td>
</tr>
<tr>
<td><strong>Previous disciplinary matter</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>136 (28)</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Percentages were calculated with the number of available observations used as the denominator.
† Per 100,000 registered doctor years.
General practitioners accounted for 65% of the sample. Doctors specialising in psychiatry (10%), surgery (7%), and obstetrics/gynaecology (6%) were the next largest groups in the sample. However, these crude proportions are strongly influenced by the prevalence of these specialities in the workforce from which these cases come. When calibrated against baseline prevalence values (expressed in the form of 100,000 registered doctor-years) rates of cases against specialists in obstetricians/gynaecologists were highest at 224, followed by psychiatrists at 178, general practitioners at 131, and surgeons at 95.

On average, disciplined doctors gained their primary medical qualification 21.4 years before committing the misconduct concerned (range, -4 to 55 years; std dev, 9.8 years). Assuming a mean primary qualification age of 24 years, this equates to a mean age of 45.4 years which is identical to the estimated mean age for the wider doctor population in the Jurisdictions during the study period.

In over a quarter of the cases, the Tribunal’s determination referred to the doctor’s involvement in one or more previous misconduct matters.

Seventy percent of the disciplined doctors obtained their primary medical qualification in the country in which they were subsequently disciplined (Australia or New Zealand); in other words, they were non-IMGs. The rate of cases imposing disciplinary action for non-IMGs (65 per 100,000 registered doctor-years) was lower than the rate of discipline for doctors who obtained their primary medical qualification in another country (IMGs) (76 per 100,000 registered doctor-years).\textsuperscript{524} IMG status and its relationship to complaints and discipline, and hence public protection, is discussed in detail in chapter 8, as a key doctor characteristic emerging from both the First Study and the Second Study.

\textit{D \hspace{1cm} Associations between misconduct types and characteristics of doctors}

Doctor gender was not significantly associated with any misconduct type.

\textsuperscript{524} However, when this apparent difference in rate was analysed by logistic regression, the difference was not found to be significant: see p216.
Three specialties were significantly associated with three different misconduct types, as follows. The odds of an anaesthetist being found guilty of sexual relationship with a patient were 3.6 times (95% CI: 1.1, 11.6; p=0.03) the odds of a general practitioner being found guilty of the same misconduct. The odds of a surgeon having committed a criminal offence were 3.9 times (95% CI: 1.2, 13.4; p=0.03) the odds of that being the case for a general practitioner. Finally, the odds of an obstetrician/gynaecologist failing to properly supervise others were 5.7 times (95% CI: 1.4, 23.6; p=0.02) the odds observed for general practitioners.

There was moderate to strong evidence of an association between years since qualification and four misconduct types: sexual relationship with patient (p=0.02); inappropriate or inadequate treatment (p=0.04); inappropriate conduct not in relation to patient (p=0.005); and inadequate or inappropriate medical certificates or records (p=0.02). For two of these misconduct types (inappropriate or inadequate treatment, and inadequate or inappropriate medical certificates or records) incidence increased with time since qualification (Figure 4). The pattern for sexual relationship with patient was the inverse, with the incidence dropping as time since qualification increased.

![Figure 4. Misconduct type stratified by years since qualification](image-url)
V DISCUSSION

A Characteristics of Tribunal cases

1 General

The overall discipline rate of 80 per 100,000 doctor-years found in the First Study is lower than that observed in previous US studies, where that rate was between 240 and 500 per 100,000 doctor-years. At least part of the explanation is likely to be due to differences in the disciplinary systems and in the rate at which reports and investigations are channelled into full-blown cases. However, subsequent to the publication of the First Study, a Canadian study has reported a discipline rate of between 60 and 110 per 100,000 doctor-years which is much closer to the results reported here. While these rates may seem low, Sawicki urges a focus on the numbers rather than the rates, noting that, if each doctor who is seriously disciplined sees an average of 3,000 patients annually, then the disciplinary process may have a direct impact on a very large number of patient interactions, potentially reducing practitioner related risks in many of these encounters.

The only other previous study that classified notifiers reported results very similar to this study, with 66% of cases coming from the general public and 5% from other doctors.

Incidence of disciplinary action varied markedly across the Jurisdictions, with the rate in Western Australia four times the rate of cases in Queensland. However, this result should not be interpreted as indicating a higher incidence of misconduct among doctors in Western Australia than in Queensland; a small number of cases does not necessarily mean a small number of problems. As is widely recognised in the patient safety

525 James Morrison and Peter Wickersham, 'Physicians Disciplined by a State Medical Board' (1998) JAMA 1889
literature, frequent reporting is often a sign of a well-functioning system. Incidence of cases is properly seen as a function of three interrelated variables: the underlying rate of misconduct; the rate at which misconduct is reported; and the manner in which the various regulatory bodies act on such reports. The First Study does not seek to distinguish between each of these variables in order to determine the cause of differential case incidence. What it does show, however, is a number of significant differences in the caseloads of the Tribunals in the various states, perhaps due to the different approaches taken by the referring state medical boards.

2 Nature of misconduct

a) Misconduct type

The First Study maps the frequency of specific types of misconduct among doctors in Australia and New Zealand for the first time. Sexual misconduct and illegal or unethical prescribing lead the way. A fifth of the cases involved illegal or unethical prescribing as the primary issue, which is close to figures from recent US studies that have identified this as an issue in 11% to 19% of disciplinary cases there (although care must be taken in making such comparisons because some of US studies include impairment findings, which were excluded from the present study). By contrast, sexual misconduct, at issue in a quarter of cases, was a far more prevalent and highly-ranked misconduct type than in comparable US studies, where it was at issue in only 4-10% of cases.

530 Ibid.
533 It is not possible to compare the recent Dutch study on types of misconduct, as the classification types cited in that study do not map well to the typology developed and used in the present study.
Inappropriate medical care also features prominently among the cases in the First Study, particularly when all misconduct types (not just primary) are considered. It is not possible to compare this against any previous research as none of the other studies cut the categories of misconduct types as finely as was done in the First Study, opting for broader categories such as ‘quality of care’ instead.\textsuperscript{534} However, these findings do challenge popular conceptions of medical boards as self-regulators with a near-exclusive focus on sexual misconduct and substance misuse.\textsuperscript{535} There is clear evidence that they are asserting their authority to also address quality of care concerns. As discussed in chapter 9 though, this does not necessarily translate into serious disciplinary sanctions being imposed for this class of cases.

Finally, a type of misconduct that warrants special mention is inadequate or inappropriate issuing of medical certificates and maintaining of medical records. This was the primary issue in only one in 20 cases, but more than a quarter of cases produced negative findings in this area. In other words, misconduct regarding medical certificates and records frequently coexisted with other forms of misconduct. Such shortcomings were often uncovered during the investigation process that targeted another breach, and may well exist much more widely for other doctors too but not be recognised due to lack of investigation. International research has identified the same phenomenon: in a previous Canadian study, for example, among doctors observed to be providing inadequate care, 90\% were also found to be keeping deficient medical records.\textsuperscript{536} From a policy perspective, this result highlights the fact that professional misconduct is often multi-layered rather than confined to a single, isolated breach.


\textsuperscript{535} For example, Nadia Sawicki, 'Character, Competence, and the Principles of Medical Discipline' (2010) 13 Jnl of Health Care Law & Policy 285.

b) Explanation for misconduct

i) Typology developed

As noted above, there are no previous studies known to the author that attempt to describe explanations for misconduct, as distinct from misconduct type. However, there have been some attempts by the Boards themselves to develop typologies for understanding the nature of misconduct. In 2000, the NSW Board analysed complaints and disciplinary actions for the purpose of grouping doctor behaviour according to its underlying features. A four-category matrix of behaviour deserving of disciplinary intervention was developed:

a) Unethical conduct — behaviour outside the accepted boundaries of professional conduct.

b) Reckless conduct — behaviour in which practitioners are apparently heedless of potentially adverse consequences of their behaviour.

c) Criminal conduct — criminal behaviour ... in the context of medical practice or external to it.

d) Wilful conduct — the least represented category and involved practitioners deliberately causing harm.\(^5\)

The NSW Board then adopted a process whereby every complaint received is assessed according to the above markers, with matters generally only progressing to disciplinary investigation if one or more of the markers is present. Matters devoid of such markers are deemed suitable for a non-disciplinary approach to their management, provided that the approach is able to fulfil the Board's public protection role.\(^6\)

While the approach taken by the NSW Board does attempt to look more deeply at the underlying cause of misconduct, the categorisations chosen are still somewhat confused. For example, the distinction between wilful and reckless is difficult, particularly in terms of the way it has been linked to harm: it is possible for conduct to be wilful, with recklessness as to whether harm is caused, or for conduct to be wilful as to harm but for

\(^5\) Alison Reid, 'To Discipline or Not to Discipline? Managing Poorly Performing Doctors' (2006) 23(2) Law in Context 91.

\(^6\) Ibid.
no actual harm to result. In the author’s view, the actual causation of harm should not form part of the categorisation. Furthermore, the notion that only conduct that carries one of these markers is appropriate for disciplinary action is flawed. There are doctors who, despite no malice, ill-intention or recklessness, put patients at risk through sheer incompetence. There comes a point where performance assessment mechanisms will not be enough, either from the point of view of the public or the point of view of maintaining the integrity of the professional regulatory system. This is tacitly acknowledged by the NSW Board in the proviso that public protection may require a disciplinary approach to be taken irrespective of the absence of the designated markers.

Reid notes that by taking the approach described above, the NSW Board aims to differentiate practitioners who are doing their best, where their best is not good enough, from those who are indifferent to the well being of their patients. While the author acknowledges that motivation and underlying reason for misconduct is important, a doctor’s motivation should not be the primary ground for deciding whether or not a matter should be investigated via the disciplinary process. Rather, it is public protection that is paramount, and public protection may require that a doctor whose best is not good enough be disciplined and removed from practice to ensure public protection while efforts are made to improve his or her performance. It is, instead, at the point of determining the appropriate disciplinary action that the underlying reason for misconduct is likely to become especially significant; a doctor with the wilful marker, as described above, is an unlikely candidate for successful rehabilitation. This issue is explored further in chapter 9.

Another categorisation used within the literature that is indicative of an attempt to identify underlying reasons for doctor behaviour is the ‘four key domains’ approach adopted by the National Clinical Assessment Service in the UK for the purposes of

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539 Ibid.
performance assessment. Although designed to assess performance rather than misconduct, the domains provide some guidance on possible categorisations, being:

a) clinical capacity (including knowledge and skills);
b) health and wellbeing;
c) behaviour; and

d) immediate work environment (including the functioning of the clinical team and wider organisation).

In relation to the typology developed in the First Study, clinical capacity appears reasonably well-aligned with knowledge and incompetence, health and wellbeing with personal situation, behaviour with wilful wrongdoing and judgment, and immediate work environment with work environment.

The closeness of the fit between the NCAS performance assessment typology and the typology for explanation for misconduct, and the comments earlier in this thesis in relation to the respective roles of discipline and performance assessment processes, highlight that the distinction between performance and conduct is not clear. Seriously poor performance may do serious harm to patients, while some conduct issues may be relatively benign and readily amenable to rehabilitation.

The typology developed in the First Study, along with the results of applying that typology represent a significant contribution to the current understanding of doctor misconduct as assessed by disciplinary tribunals. Of particular significance is the development and application of a matrix that distinguishes actual conduct (type of misconduct) from its cause or motivation, which is defined as explanation for misconduct.

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540 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).
Almost half of all doctors found guilty by the tribunals were judged to have deliberately breached the required standards of practice. That is, the doctors chose not to do what was required of them professionally, as opposed to having been unable, by reason of incompetence or lack of knowledge, to do so. However, the regular presence of more than one explanation for misconduct suggests that, in many cases, both elements are present. Further results relating to explanation for misconduct, and its relationship to disciplinary sanctions imposed, are presented and discussed in chapter 9.541

3 Patient outcome

Several measures in the First Study highlight that serious harm to patients is not a prerequisite for serious disciplinary action against doctors. Forty one percent of cases involved only upset or risks to patients, 5% had no impact on the patient involved, and 15% involved misconduct unrelated to patients. Yet 43% of these non-injurious cases resulted in removal from practice (equal to the proportion of cases that led to removal where patient injury did result). However, it does not necessarily follow that the reasons for decisions made in those cases were divorced from broader and more general considerations of public safety. Rather, taken together, these findings indicate that the Tribunals interpret their public protection mandate as extending to intervening on risky actors and behaviours, not merely reacting to circumstances where damage has been done. A subsequent study looking at disciplinary findings in the Netherlands has reported that in 28% of cases examined, there were no health consequences for the patient, while in 10% of cases the patient had died. These are similar results to the present study. However, the Dutch study did not go on to analyse the patient outcomes in terms of disciplinary outcomes. The First Study’s findings regarding patient outcome are also consistent with commentary from Freckleton that seriousness of misconduct

541 See Table 21 and Table 22. Multivariable odds of removal from practice, by types of misconduct, explanations for misconduct and patient outcome
should be gauged not by its effects on the patient (which can sometimes be unforeseeably adverse) but by reference to its objective seriousness.\textsuperscript{542}

4 Disciplinary measures imposed

a) General

Tribunals hear only the most serious cases. Nonetheless, the First Study found that only 43% of doctors disciplined by Tribunals in Australia and New Zealand in the decade to 2010 were removed from practice as a consequence, and nearly a fifth received a non-restrictive sanction. These statistics are similar to those reported by Morrison and Wickersham in relation to the Medical Board of California, where removal occurred in 34% of cases, restrictions on practice in 45%, and non-restrictive sanctions in 21% of cases. In their study of the State Medical Board of Ohio, Clay and Conaster reported removal in a much higher proportion of cases (64%).\textsuperscript{543}

As discussed below, removal will only be justifiable in cases where it is necessary for the protection of the public, that is, cases where any lesser sanction is considered to expose the public to unacceptable levels of risk. The range of other restrictions a Tribunal may impose on a doctor to ensure public safety probably explains why the proportion of cases resulting in removal from practice is not higher.

b) Non-restrictive sanctions

As discussed in chapter 4, it is common for non-restrictive sanctions to be perceived in terms of punishment and retribution rather than in terms of public protection. Nevertheless, as argued in that chapter, public protection is still the dominant purpose and must be the driving force behind the decision to impose such sanctions, irrespective of whether or not the effect also happens to be punitive for the doctor. Certainly, non-restrictive sanctions, by definition, do not offer any specific protection and so should not be the only measures imposed in cases where specific protection is warranted. Such sanctions do, however, protect the public generally by deterring other doctors from

\textsuperscript{542} Ian Freckelton, 'The Margins of Professional Regulation: Disjunctions, Dilemmas and Deterrence' (2006) 23(2) Law in Context 148, p153.

\textsuperscript{543} Steven Clay and Robert Conaster, 'Characteristics of Physicians Disciplined by the State Medical Board of Ohio' (2003) 103(2) JAOA 81.
behaving in a similar fashion, or may deter the same doctor from behaving in that manner again. A message is sent to the profession at large that certain conduct is not acceptable and will have consequences. While fines are capped at the relatively low level of $30,000 in both countries, costs awards frequently exceed the amount fined.

In analysing the difference between formal legal sanctions and informal sanctions, Christine Parker argues that it is usually the informal moralising features of sanctions that have more deterrent effect than the formal punitive features of those same sanctions. The informal sanctions include negative publicity, public criticism, gossip, embarrassment, and shame and may occur independently or be triggered by formal sanctions. It is perhaps the capacity for non-restrictive sanctions, such as fines and censure or reprimand, to generate informal sanctions that is their greatest strength. However, the impact of such informal sanctions may be significantly diminished if the doctor concerned is given name suppression. Name suppression may also deprive the public of the ability to make an informed choice not to seek services from that doctor in future. Note that among the 485 cases analysed in the First Study, 52 (10.7%) resulted in permanent name suppression for the doctor concerned. Of those doctors, only ten (19%) had been removed from practice but 20 had only non-restrictive sanctions imposed only (39%). When compared with general rates of removal from practice, this suggests that those found guilty of more serious disciplinary offences, and thus removed from practice, are less likely to be granted name suppression.

However, while deterrence may be achieved by a message that is sent to the profession, the protection of public confidence is about the message that is sent to the public. Whether justified or not, there will always be members of the public who will view non-restrictive sanctions as inadequate (particularly when combined with name suppression). This problem is exacerbated by media reporting that embraces the salacious and, as a result, may unjustifiably erode public confidence. Hence, from a

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544 The latter could, arguably, be categorised as specific protection rather than general protection. However, it is of quite a different nature to other forms of specific protection as it operates via deterrence; the mechanism generally associated with general protection.

545 See, for example, Director of Proceedings v Nikau [2010] NZHRRT 26.

546 Christine Parker and John Braithwaite, 'Regulation' in Peter Cane and Mark Tushnet (eds), The Oxford Handbook of Legal Studies (Oxford University Press, 2003), p133.
public protection perspective, it is important that non-restrictive sanctions, without concurrent restrictive sanctions or removal, are used only in circumstances where the rationale for doing so can be clearly articulated to both the profession and the public.

c) Restrictions on practice

Many different types of restrictions on practice may be imposed, from the requirement to undertake additional training to the requirement to have a chaperone present at every consultation with a female patient. As outlined in chapter 3, before nationalisation, each of the Jurisdictions provided for a range of restrictions on practice. Most also included a catch-all provision that allowed a tribunal to impose such additional conditions as it saw fit. As for suspension, under the HPCA Act conditions only apply for up to three years whereas most Australian states, and now the National Law Act, allow conditions to continue for any period a Tribunal specifies. In Queensland and Western Australia, the Tribunals could further require the doctor to give an undertaking to comply with the conditions imposed including, in Queensland, giving a financial assurance for that undertaking. In New South Wales, a condition may be elevated to the status of a "critical compliance condition". If the Tribunal is subsequently satisfied that such a condition has been breached by the doctor, the Tribunal must order that the doctor be deregistered.

It seems, from the above, that conditions on practice may be viewed by the Tribunals as a mechanism for giving a doctor a final chance. The message appears to be that but for the conditions, the doctor would have been deregistered. Essentially, the restrictions on practice are seen to provide sufficient specific protection to allow continued registration. From a public protection perspective, therefore, it is important that the conditions that are imposed are indeed sufficient to address the risks to the public that have been identified by the Tribunal. This is likely to be achieved most convincingly by conditions that require the doctor to work under supervision, to be chaperoned when seeing certain classes of patient (if that fits the misconduct at issue),

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547 Medical Practice Act 1994 (NSW), s 64(1A). Note that this still applies in NSW given NSW's decision not to adopt the complaints and disciplinary part of the National Law Act: see p69.
or to alter their practice in specified ways, including through restrictions on practice scope.

Other restrictive sanctions offer little in the way of specific protection or offer specific protection but with benefits that are delayed at best. For example, if a doctor is required to undergo counselling, complete further education or training, or attend periodic supervision meetings, there is unlikely to be an immediate impact on the doctor’s practice. Perhaps it is for this reason that such restrictions are often imposed in concert with other restrictive sanctions that apply until the completion of a particular milestone associated with the less protective restriction.

d) Removal from practice

Removal from practice can be imposed through suspension or deregistration. Deregistration is generally regarded as the most protective sanction available, providing specific protection by preventing the doctor concerned from affecting, and potentially harming, the public. However, does removal from practice necessarily achieve that purpose?

The National Law Act allows tribunals to disqualify a doctor from applying for re-registration for a specified period.\footnote{National Law Act, s 196(4)(a).} This does not go as far as some Tribunals were able to go before nationalisation. For example, the \textit{Health Practitioners (Professional Standards) Act 1999} (Qld) allowed the Queensland Tribunal to cancel a doctor’s registration permanently so that the doctor could never again be registered by the Queensland Medical Board.\footnote{Section 241(5).} The \textit{Medical Practitioners Act 1995} (NZ) also gave the Medical Practitioners Disciplinary Tribunal the power to set a minimum time that must elapse before re-registration could be considered, where previously no minimum period could be dictated.\footnote{Medical Practitioners Act 1995 (NZ), s 111(1)(a).} By contrast, the HPCA Act is silent on time limitations for re-registration, but does allow a tribunal to set conditions that must be satisfied before an individual may apply for re-registration. Some have argued that a tribunal could impose
a condition that is, in effect, a time limit, thus achieving the same result.\textsuperscript{551} The alternative argument is, of course, that decisions around the timing for re-registration have now been taken out of the tribunal’s hands and have become the exclusive domain of the Boards.\textsuperscript{552}

In any event, being deregistered will not necessarily stop a doctor from providing services to the public due to the nature of the regulatory regimes in both countries. As discussed in chapter 2, registration is not necessary for the lawful performance of most doctor tasks\textsuperscript{5} but allows providers to represent themselves as doctors and to access funding streams that are restricted to those with current registration. As the cases of David Collison and Richard Gorringe illustrate, while deregistration is the Tribunals’ ultimate weapon, it will not always offer ultimate public protection.\textsuperscript{553}

The less severe variant of removal from practice is temporary removal by way of suspension. Under the HPCA Act, in New Zealand, suspension can be imposed for a maximum period of three years, whereas under the Australian National Law Act there is no maximum period specified but the tribunal must impose a specific period of suspension at the time the order is made.\textsuperscript{554} Suspension offers specific protection to the public (in the same way as deregistration, albeit for a shorter time), but can also be rehabilitative, in that it gives the doctor a period of time during which to remedy issues that may have contributed to the situation. It is common for tribunals to impose conditions that must be met before suspension will be lifted.

The distinction between suspension and deregistration was discussed in \textit{Taylor v General Medical Council},\textsuperscript{555} where the House of Lords made the following key points:

\begin{itemize}
  \item [a)] Despite the purpose still being public protection, the punitive effect for the doctor is greater for deregistration than for suspension.
\end{itemize}

\textsuperscript{551} Joanna Manning, ‘Professional Discipline of Health Practitioners’ in Peter Skegg and Ron Paterson (eds), \textit{Medical Law in New Zealand} (Brookers, 2006).
\textsuperscript{552} As also acknowledged by Joanna Manning in ibid.
\textsuperscript{553} See also, Barbara von Tigerstron and Katherine Ellena, ‘Regulation of Contemporary and Alternative Medicine - a Trans-Tasman Perspective’ (2006) 23(2) \textit{Law in Context} 198., p206.
\textsuperscript{554} HPCA Act, s 101(1)(b); National Law Act, s 196(2)(d).
\textsuperscript{555} [1990] 2 All ER 263, cited extensively in decisions of the New Zealand Health Practitioners Disciplinary Tribunal.
b) The choice between suspension and deregistration turns on what is proportionate, with suspension implying that deregistration would have been disproportionate.

c) Suspension is appropriate where there is ‘some condition affecting the practitioner’s practice which may or may not be amenable to cure’

As well as offering specific protection and, in the case of suspension, rehabilitation for the doctor concerned, removal from practice is also capable of protecting the public via general protection, chiefly deterrence, and by protecting public confidence in the profession. If the public see doctors being removed from practice for particular behaviours or substandard performance, the public should be reassured that such doctors are being identified and dealt with appropriately.

Nevertheless, removal is a very severe sanction for the doctor concerned and must only be imposed where necessary. As emphasised in many court and Tribunal decisions, alternatives short of removal must always be considered, and must be implemented if they would be sufficient to protect the public.556

B Characteristics of doctors

The finding that male doctors were more often disciplined by the Tribunals than female doctors resonates internationally; all previous studies have found the same,557 as has a Canadian study published after the publication of the First Study.558 The standard

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556 See, for example, Patel v CAC, High Court, Auckland, CIV 2007-404-1818. For the philosophical dimensions of this principle, see chapter 4.


558 Asim Alam et al, 'The Characteristics of Physicians Disciplined by Professional Colleges in Canada' (2011) 5(4) Open Medicine. Note that this study found that 92% of disciplined doctors were males compared to only 68% of the general doctor population being male. However, practice hours were not taken into account.
explanation is that female doctors tend to display more of the attributes "that underpin a good doctor-patient relationship", thereby provoking fewer patient complaints and reduced exposure to disciplinary processes. This is a plausible explanation, but should be tested in future research. If the explanation is accurate, the continuing shift in the medical workforce towards female doctors may bode well for both complaint rates and patient satisfaction with care more broadly.

Disproportionately high rates of disciplinary action were observed among obstetrician/gynaecologists, psychiatrists, general practitioners, and surgeons. All previous studies have also found psychiatrists to be overrepresented in disciplinary proceedings, with Morrison and Morrison reporting in their Californian study that psychiatrists were disciplined at twice the rate of non-psychiatrists. Other studies have also found obstetricians/gynaecologists experience higher rates of disciplinary action than other specialists, with results for general practitioners and surgeons less consistent but still found to be high in the majority of studies.

The explanation for such results is contested. Provider-side 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. A rival explanation underlines the distinctive aspects of the clinical activities these specialists perform, and the patient populations they serve, as independent risk factors. For example, some patients of psychiatrists do not want to be patients and so may view their doctor with hostility, or may have particular pathologies that predispose them to filing complaints. For obstetricians, tolerance for unhappy experiences or suboptimal outcomes in childbirth is typically very low, fuelled by the modern view of pregnancy and childbirth as risk-free endeavours. Nonetheless, while such patient-side factors may contribute to the patterns observed, they are unlikely to tell the whole story. For starters, about half of all cases were not referred to tribunals as a result of patient notification, but as a

result of notification by some other person or body (although, admittedly, some of these cases may have originated from a patient complaint). In sub-analyses of the data on the 50% of cases not referred by patients, psychiatrists and obstetrician/gynaecologists still featured as the specialists with the highest rates of discipline.

With respect to doctor age as a risk factor for discipline, previous research has yielded mixed results,\(^ {562}\) with the majority of studies reporting increased age as being associated with increased rates of discipline.\(^ {563}\) In the First Study, no age difference was found between disciplined doctors and the general population of doctors practising in the Jurisdictions during the study period.

The finding that only 28% of the cases involved doctors with a previous history of misconduct noted by the Tribunal was surprising. Given the Tribunal process only deals with the most serious of misconduct, it was anticipated that more of the doctors appearing before it would have previously come to the negative attention of the regulator.

Previous research has also been split on the effect of IMG status on discipline rate. On a simple rate analysis, the results of the First Study appear to accord with the two previous studies which found discipline rate to be higher for IMGs.\(^ {564}\) However, in one of those studies,\(^ {565}\) the rate difference initially observed disappeared on multivariable analysis. Subsequent to the First Study, another study has, on simple rate analysis, found IMGs to be overrepresented in disciplinary cases, at 33% compared with 23% in the general doctor population.\(^ {566}\) Further investigation of this issue, including

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\(^{562}\) Ibid; Steven Clay and Robert Conaster, 'Characteristics of Physicians Disciplined by the State Medical Board of Ohio' (2003) 103(2) *JAOA* 81.


multivariable analysis and delineation into specific countries of training, has been undertaken by the author and is reported and discussed in chapter 8.

C Characteristics of doctors associated with type of misconduct

When considering the associations between the misconduct types and characteristics of doctors, it is important to note that lack of significant association may be due to sample size limitations rather than there actually being no association. For example, all 47 cases of sexual misconduct (not relationship) and 75 out of 79 cases of sexual relationship with patient involved male doctors, yet the small number of female doctors in the total study sample (42) meant that no significant association was found. In a larger study, it is expected that both of these types of misconduct would show significant differences by doctor gender.

Similarly, while only three specialties were significantly associated with particular misconduct types, it is likely that other significant associations would be found if the sample size was increased. For example, it is likely that psychiatry may actually be associated with a higher incidence of criminal offence (18% of all such cases were psychiatrists) and with sexual relationship with patient (17%). The latter would be consistent with the findings of Morrison and Morrison who reported that psychiatrists were more likely than non-psychiatrists to be disciplined for sexual relations with patients.567

The higher incidence of inappropriate or inadequate treatment, and inadequate or inappropriate medical certificates or records, as time since qualification increased, suggests atrophy of skills and competencies, perhaps due to failures to keep those skills current or to adapt to changing protocols and expectations. Previous research has also found age to be a predictor of incompetence and researchers have postulated that this may be due to declining ability to acquire new knowledge.568 Conversely, being found guilty of having a sexual relationship with a patient becomes less likely with age or time

since qualification. There may be a two-fold explanation for this result: first, increased age may be associated with more stable personal relationships and a lower libido for the doctor, both of which may decrease the likelihood of forming sexual relationships with patients; second, 82% of doctors found to have had a sexual relationship with a patient were removed from practice by the Tribunals, leading to the number of doctors with such a proclivity decreasing as age or time since qualification increases.

\[D\] Limitations of the study

The First Study had several limitations. First, in constructing descriptive variables, reliance was placed on information contained in the Tribunal determinations. As with any content analysis of decisions in an adversarial legal system, the data accessible through determinations were necessarily constrained, both by the information parties chose to bring to Tribunals and by how Tribunals chose to express their written findings. Moreover, interpretations and coding of this information, particularly the explanations for misconduct variable, introduced another level of subjectivity, although the excellent inter-reliability of the reviews provides reassurance on this front.

Secondly the rate statistics used data from the results of workforce surveys which were not sent to some classes of registrants in Queensland. However, the statistical properties of the fractions (small numerators and very large denominators) make them very robust to slight-to-moderate variations in the population-level counts. Thirdly, the rate comparisons were not adjusted for specialty-gender effects. However, the three specialties with the highest complaint rates (psychiatry, obstetrics/gynaecology and general practice), are no more male-dominated than medicine generally, suggesting that the specialist effect seen in the results is not the artefact of an underlying gender effect.

Finally, as noted earlier in this chapter, the figures reported for particular variables, such as the prevalence of various misconduct types, should not be construed as direct indicators of the incidence of such behaviours in practice. Rather, the figures reported are a function of three interrelated elements: the underlying rate of misconduct, the rate at which misconduct is reported to Tribunals, and how boards and the Tribunals act on such reports. The First Study observes the product of these interactions but cannot
separate the independent role of any one in determining counts and rates of disciplinary action.

VI CONCLUSION

Ultimately, the core goal of any rigorous empirical analysis of professional misconduct should be to assist regulators in ensuring patients receive safe care at the hands of competent practitioners. However, improved public understanding of these cases is also important. Without that, anecdotes and media reports of particular ‘scandals’ may produce a distorted perspective.

The results of the First Study provide substantive new insights into the nature of the cases that come before the Tribunals, the characteristics of the doctors concerned, the relationship between the case characteristics and the doctor characteristics, and the basis for the Tribunals’ disciplinary decision-making (as discussed further in chapter 9).

A new and robust typology for describing misconduct was also developed and applied. That typology separates the type of misconduct from the underlying reason for the misconduct and considers those elements independently of one-another. The recent nationalisation of Australia’s disciplinary framework for health professionals under AHPRA opens up new possibilities for tracking and learning from disciplinary matters, and the tools developed in this study should prove useful in that work.

The next chapter takes a step back and looks at the complaints received by medical boards, with the intention of setting the Tribunal cases in context within the wider complaints and disciplinary system, and gaining a deeper understanding of the workings of that system as a whole.
CHAPTER 7 – THE SECOND STUDY: ANALYSIS OF COMPLAINTS TO MEDICAL BOARDS

I INTRODUCTION

The Second Study is an analysis of complaints made to medical boards and the progress of those complaints through the complaints and disciplinary system. The outcomes that are considered in this study are fundamentally different to those considered in the First Study. First, the doctors about whom complaints are made will not necessarily have engaged in any form of misconduct, serious or otherwise. This is distinct from those doctors who featured in the First Study, all of whom were found guilty of some kind of misconduct by a Tribunal. Secondly, in every case, the nature of the misconduct at issue in the First Study was serious in nature, unlike the present study which encompasses all levels of potential or perceived misconduct and performance failings. The relationship between the two studies is demonstrated in Figure 5 below.

It is instructive to analyse the characteristics of doctors who have had one or more complaints brought against them and to compare them with those same characteristics in doctors who have not been the subject of any complaints. Are there particular characteristics that are more or less prevalent among doctors who have been complained about? If so, does that differentiation between the complaint and no-complaint group continue as cases progress through the disciplinary system? For example, are there characteristics that are particularly prevalent among doctors who are complained about, but not among doctors in respect of whom such complaints proceed to investigation or hearing?

Answering these questions may allow inferences to be drawn about both the behaviour of complainants in respect of particular groups of doctors, the likely prevalence of particular issues among particular groups of doctors, and the apparent seriousness of any shortcomings identified.

Note also that many doctors whose behaviour would have justified a complaint will not have received a complaint.
This chapter sets out the methods used for this study and the study’s main findings. Some of the methods and results presented in this chapter have already been published by the author (and her co-authors).\textsuperscript{570} Chapter 8 contains additional results regarding international medical graduates, along with a more detailed exploration of the association between country of training and interaction with the complaints and disciplinary process.\textsuperscript{571}

\textsuperscript{570} Katie Elkin, Matthew Spittal and David Studdert, ‘Risks of Complaints and Adverse Disciplinary Findings against International Medical Graduates in Victoria and Western Australia’ (2012) 197(8) \textit{MJA} 448; see Appendix Three.

\textsuperscript{571} See particularly Table 19.
II AIMS

The aims of the Second Study were to:

a) describe the characteristics of doctors who were the subject of complaints made to the Medical Board of Western Australia (the WA Board) from 2003 to 2009, and the Medical Practitioners Board of Victoria (the Vic Board) from 2001 to 2009;

b) follow the complaints through the disciplinary process, determining the characteristics of the doctors appearing at each stage and whether there are any particular doctor characteristics that were especially prevalent among cases at the complaint stage or the investigation/hearing stage, or among those doctors with adverse findings made against them; and

c) analyse the results in terms of public protection.

III METHODS

A Sample

The boards maintained separate datasets for complaints and registrations. From the complaints datasets, information on complaints resolved between 2001 and 2010 was extracted. Specifically, the sampling criteria were based on lodgement date (all complaints lodged between 1 July 2001 and 31 December 2008 in Victoria, and between 1 October 2003 and 31 December 2008 in Western Australia — the study period). The dates of the extractions were February 2010 in Western Australia and June 2010 in Victoria. Extracting the data in 2010 and fixing the end of the lodgement period at the end of 2008 allowed at least a year for the latest complaints to reach resolution (nearly all complaints are resolved within 12-18 months). From the registration datasets, we extracted information on all doctors registered to practice in the corresponding time periods.

These two states were chosen due to data availability, the similarity of their disciplinary processes, their numbers of registered doctors, and their differing geographies and
degrees of urbanisation. In 2006 Victoria had the lowest proportion of IMGs (18%) of all Australian states, and Western Australia had the highest (35%).\textsuperscript{572} Between them, they accounted for 37% of all registered doctors in Australia over the time period.

The study was approved by the Human Research Ethics Committee at the University of Melbourne.

\textit{B \hspace{1cm} Data collection and variables}

The Vic Board and the WA Board (the Boards) provided access to de-identified versions of their internal complaints and registration databases (the Board data).

Complaint type was initially coded from free text fields in the Board data. However, it was ultimately excluded from the analysis due to the high proportion of complaints (about 75%) with no such data available.

The variable \textit{registration type} refers to the form of registration the doctor held. Registration types were either explicit in the Board data or were identified via references to the relevant legislation. This variable was coded into four categories: general, specialist (registration to work for a limited time in a specified specialty), area of need (registration to work in specified geographical areas with acute workforce shortages), and other (including provisional registration and registration granted for specific purposes, such as training and supervision or research).

Practice location was recorded in the Board data via postcodes. Postcodes were converted to an urban/rural variable by mapping them onto the \textit{official status} areas designated by the Australian Bureau of Statistics.\textsuperscript{573} Country of qualification was explicit in the Vic Board data and was deduced from internet searches of medical school names for those registered in Western Australia. Years since qualification was calculated as the difference between year of qualification and year of complaint received. This variable was then categorised into ten-year groups. Doctor specialty was


\textsuperscript{573} Wherever the postcode fell within an area that was designated as a \textit{city} the postcode was labelled as urban. All other postcodes were labelled as rural.
unable to be included given the poor availability of that data within the databases provided.574

Once the variables of interest had been cleaned and coded, the Vic Board and WA Board data were combined and three separate databases were created:

- A complaint level database containing the variables describing the complaints;
- A doctor level database containing the variables describing all doctors registered during the study period, regardless of whether or not they had experienced a complaint; and
- A doctor-year level database containing both complaint and doctor variables.

The doctor-year database was created by merging the doctor level and complaint level databases via a unique doctor identification number. So, for example, a doctor registered continuously for 5 years of the study period generated five observations in that database. In addition, a new set of count variables in the database indicated the number of cases doctors had at each of these levels in the disciplinary process, namely: complaint received, investigation or hearing conducted,575 and adverse findings.

Any complaint which did not contain an identifier that allowed matching of the complaint data to doctor information had to be dropped from the doctor-year level dataset.576 In addition, any doctor-year during which the doctor concerned was registered for fewer than six months was deleted.577

574 Around 25% availability for each state. This data was also self-reported and not verified by the Boards.
575 Originally, the intention had been to examine these two stages of the complaints process separately; however, this was not possible due to the way in which the data had been collected by the boards. As a result, the investigation/hearing category contains some complaints that were simply investigated informally by a board, as well as those that ended up before a Tribunal. Essentially, it is a measure of complaints considered to have sufficient substance by the boards to warrant more than a preliminary assessment.
576 This was the case for 89 complaints contained in the complaints database; all from Western Australia (<0.02%).
577 This led to 6,804 doctor-years (2.6%) being deleted. This was to avoid overrepresentation of those doctors within the database.
C  Statistical analysis

Using the doctor level database, counts and proportions for the following variables were calculated to describe the background doctor population according to the following variables: gender, years since qualification, registration type, practice location, and country of qualification. Similar statistics were generated for the complaint variables of state, complaint year, and complainant type, using the complaint level database.

To calculate predictors of complaints, we fit three logistic regression analyses using the doctor-year level dataset. In the first model, the outcome variable was a binary variable indicating whether one or more complaints occurred in the doctor-year; the predictors of interest were doctor sex and years since qualification, country of training (as a binary Australia/other variable), practice location, and registration type. Year of complaint and state were included as covariates in the model. The model corrected standard errors for clustering at the doctor level (ie, to account for repeated measures of the same doctors across registration years).

The second model was identical to the first model, except for the outcome variable, which was a binary variable indicating whether one of more complaints were investigated or went to hearing during the doctor-year. The third model was the same again except that the outcome variable was whether there was an adverse finding made against the doctor in relation to the complaint.

P < 0.05 was considered statistically significant.

Finally, a poisson regression analysis was also undertaken to test the sensitivity of the results from the logistic regression models. The poisson regression model specified the outcome variable as counts in each doctor-year for complaints, investigation/hearing and adverse finding respectively.

All analyses were conducted using the STATA 10 (STATA Corp, College Station, TX).

Note that country of qualification was analysed to varying degrees of specificity, as shown and discussed in chapter 8. This chapter simply treats country of qualification as a binary variable: Australia and Overseas.
IV RESULTS

A Characteristics of doctors

The study sample consisted of 196,646 doctor-years and 39,155 unique doctors, 69% of whom were registered in Victoria and 31% of whom were registered in Western Australia (Table 10). On average, approximately 28,000 doctors were registered per year across the two states, with approximately 69% registered in Victoria and the remainder registered in Western Australia. The number of doctors registered per year gradually increased across the study period, from around 27,000 in 2003 to 31,000 in 2008.

Sixty five percent of the doctors were male, a proportion that decreased steadily from 68% in 2003 to 65% in 2008. Doctors in the study graduated from medical school between 1933 and 2008, with a mean graduation year of 1999 (std dev = 8 years). Thirty seven percent of the doctors had been in practice for fewer than 10 years.

General registration was the most common registration type, accounting for 70% of all doctors in the sample. Around a fifth of the doctors in the study were registered as practising in a rural location, with the vast majority practising in an urban setting. Over a third (37%) of the doctors registered in the two states during the study period gained their primary medical qualification outside of Australia. These doctors came from more than 120 different countries and from every continent. The places of origin of those doctors are described in more detail in chapter 8.\footnote{See particularly Table 17.}
Table 10. Characteristics of all doctors in the Study Sample (n=39,155)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State of registration</strong></td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>27,144 (69)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>12,041 (32)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25,587 (65)</td>
</tr>
<tr>
<td>Female</td>
<td>13,555 (35)</td>
</tr>
<tr>
<td><strong>Years since qualification</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 10</td>
<td>14,394 (37)</td>
</tr>
<tr>
<td>10-20</td>
<td>11,263 (29)</td>
</tr>
<tr>
<td>21-30</td>
<td>6,715 (17)</td>
</tr>
<tr>
<td>31-40</td>
<td>3,919 (10)</td>
</tr>
<tr>
<td>More than 40</td>
<td>2,826 (8)</td>
</tr>
<tr>
<td><strong>Registration type</strong></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>27,406 (70)</td>
</tr>
<tr>
<td>Non-general</td>
<td>11,621 (30)</td>
</tr>
<tr>
<td>Area of need</td>
<td>2,985 (8)</td>
</tr>
<tr>
<td>Specialist</td>
<td>2,743 (7)</td>
</tr>
<tr>
<td>Other</td>
<td>5,893 (15)</td>
</tr>
<tr>
<td><strong>Practice location</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>26,778 (81)</td>
</tr>
<tr>
<td>Rural</td>
<td>6,212 (19)</td>
</tr>
<tr>
<td><strong>Country of qualification</strong></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>24,542 (63)</td>
</tr>
<tr>
<td>Other</td>
<td>14,613 (37)</td>
</tr>
</tbody>
</table>

* Percentages were calculated with the number of doctors for which the variable of interest was available as the denominator. Data were missing for <1% of all variables, except for practice location for which data was missing for 6,165 doctors (16%).
There were 5,323 complaints made to the Boards during the study period. This equates to an overall incidence of 2220 complaints per 100,000 registered doctors per year (Table 11).

Almost a third of the complaints that were received by the Boards were investigated or went to hearing (either informal or formal, such as a Tribunal hearing). In 7% of the complaints received, a formal adverse finding was eventually made against the doctor concerned.

Table 11. Complaints made to the Boards during the Study Period (n=5,323)

<table>
<thead>
<tr>
<th>State</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vic</td>
<td>4,428 (83)</td>
</tr>
<tr>
<td>WA</td>
<td>895 (17)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complaint year</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-2002</td>
<td>890 (17)</td>
</tr>
<tr>
<td>2003-2004</td>
<td>1,439 (27)</td>
</tr>
<tr>
<td>2005-2006</td>
<td>1,553 (29)</td>
</tr>
<tr>
<td>2007-2008</td>
<td>1,541 (29)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage of process</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint received</td>
<td>5,323 (100)</td>
</tr>
<tr>
<td>Investigation/hearing</td>
<td>1,606 (30)</td>
</tr>
<tr>
<td>Adverse finding</td>
<td>373 (7)</td>
</tr>
</tbody>
</table>

* Percentages were calculated with the number of complaints for which the variable of interest was available as the denominator.
A Note that the study period began in July 2001 for Victoria and in October 2003 in Western Australia.

C Characteristics of doctors stratified by stage of the disciplinary process

Male doctors were about three times more likely than female doctors to be subject to any of the stages of the disciplinary process. In terms of experience, doctors with fewer
than 10 years were least likely to have received a complaint, had a complaint investigated or been subject to a hearing, or had an adverse finding made against them. Rates among such doctors were around a tenth of the rates observed for doctors with 31 to 40 years of experience, who had the highest rates.

Doctors with general registration were the most likely to have been subject to complaint, while practice location was not associated with to the likelihood of complaint or subsequent action by the Boards. A higher percentage of IMGs received complaints, were the subject of investigations or hearings, and had adverse findings made against them than was the case for Australian-trained doctors. The effect of country of qualification is explored in detail in chapter 8.

D Association between doctor characteristics and stage of the complaints and disciplinary process

Multivariate analysis (logistic regression) confirmed a statistically significant association between many of the doctor characteristics and the stages of the disciplinary process, as described in Table 12.

Compared to their male colleagues, female doctors had half the odds of complaint and less than half the odds of adverse findings. The odds of a doctor with fewer than 10 years' experience being subject to a complaint were less than a fifth those of a doctor 21-30 years' post-qualification. The odds of receiving a complaint peaked among doctors 31-40 years' post-qualification, whose odds were 13% higher than the reference group.

In a multivariable analysis, doctors with general registration had significantly higher odds of being subject to each stage of the disciplinary process. As expected from the percentages reported above, there was no significant difference based on practice location.

IMGs had higher odds of complaint than non-IMGs, and also higher odds of being subject to an investigation or hearing arising out of a complaint, and of being the subject of an adverse finding.
Table 12. Associations between doctor characteristics and involvement in various stages of the disciplinary process

<table>
<thead>
<tr>
<th></th>
<th>Stage 1: Complaint</th>
<th>Stage 2: Investigation/Hearing</th>
<th>Stage 3: Adverse finding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio (95% CI)</td>
<td>Odds Ratio (95% CI)</td>
<td>Odds Ratio (95% CI)</td>
</tr>
<tr>
<td>Female (ref: Male)</td>
<td>0.49 (0.44, 0.54)</td>
<td>0.49 (0.41, 0.59)</td>
<td>0.42 (0.30, 0.58)</td>
</tr>
<tr>
<td>Years since qualification (ref: 21-30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>0.15 (0.13, 0.18)</td>
<td>0.15 (0.11, 0.20)</td>
<td>0.19 (0.11, 0.31)</td>
</tr>
<tr>
<td>10-20</td>
<td>0.55 (0.50, 0.61)</td>
<td>0.57 (0.49, 0.67)</td>
<td>0.60 (0.44, 0.81)</td>
</tr>
<tr>
<td>31-40</td>
<td>1.13 (1.03, 1.24)</td>
<td>1.19 (1.02, 1.40)</td>
<td>0.97 (0.72, 1.31)</td>
</tr>
<tr>
<td>&gt;40</td>
<td>0.82 (0.71, 0.94)</td>
<td>0.91 (0.73, 1.14)</td>
<td>0.85 (0.57, 1.28)</td>
</tr>
<tr>
<td>Registration type (ref: General)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>0.67 (0.57, 0.79)</td>
<td>0.83 (0.63, 1.07)</td>
<td>0.57 (0.34, 0.96)</td>
</tr>
<tr>
<td>Area of need</td>
<td>0.55 (0.39, 0.77)</td>
<td>0.99 (0.61, 1.60)</td>
<td>0.39 (0.12, 1.25)</td>
</tr>
<tr>
<td>Other</td>
<td>0.26 (0.18, 0.38)</td>
<td>0.33 (0.20, 0.56)</td>
<td>0.52 (0.23, 1.21)</td>
</tr>
<tr>
<td>Urban practice location (ref: Rural)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International medical graduate</td>
<td>1.24 (1.13, 1.36)</td>
<td>1.19 (1.04, 1.38)</td>
<td>1.41 (1.07, 1.85)</td>
</tr>
</tbody>
</table>

* Data were missing for <1% of all exposure variables, except for practice location for which data was missing for 6,710 doctors (18%). Data were missing for outcome variables as follows: investigation, 10% of complaints; hearing, 1% of complaints; and adverse finding, 6% of complaints.

† Results in bold are significant at the p<0.05 level.
V DISCUSSION

A Complaints received

The overall complaint incidence of 2.2% is lower than the 4.9% reported in the only equivalent overseas study to date.\textsuperscript{580} However, given differences in regulatory regimes and the existence of robust Complaints Commissioners in Victoria and Western Australia, who also receive complaints, this is hardly surprising.

The incidence of complaints is four times higher than the overall incidence of guilty findings by Tribunals as revealed by the First Study, discussed in chapter 6. This is entirely consistent with the way in which the disciplinary system is designed to function, with only the most serious of complaints reaching a Tribunal for decision.\textsuperscript{581}

B Progress of complaints through the stages of the disciplinary process

As shown in Table 12, just under half of the complaints received by the Boards were subsequently investigated and/or went to hearing. A complaint may fail to proceed to investigation for a range of reasons, including because the Board determines that no further action is appropriate or because the Board refers the complaint to another body, (e.g. the police) for investigation. The hearings were either informal hearings by a subcommittee of the Board, or a formal hearing before a Tribunal. The data shows that around 23% of complaints that were investigated or went to hearing resulted in a finding of misconduct against the doctor concerned. This equates to an adverse outcome incidence of around 7% for all complaints received by the Boards.

While caution must be taken in comparing such statistics across jurisdictions that have different legislative and policy requirements, the eventual outcomes noted in this study were not dissimilar to those reported by Jost and Strasser in whose study around a quarter of complaints led to a hearing and around 9% resulted in an adverse finding.\textsuperscript{582}

\textsuperscript{580} Robyn Tamblyn et al, "Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities" (2007) 298(9) JAMA 993.
\textsuperscript{581} See chapter 3 for detail on the structure and function of the complaints and disciplinary system.
\textsuperscript{582} Timothy Jost and Linda Strasser, "Consumers, Complaints and Professional Discipline: A Look at Medical Licensure Boards" (1993) 3(2) Health Matrix: JLM 309.
C Association between doctor characteristics and stage of the complaints and disciplinary process

Before looking at the associations between specific doctor characteristics and the various stages of the disciplinary process, it is important to consider more generally how differences in odds ratios across those stages should be interpreted. Such differences could be due to one of three potential impacts: complainant bias; investigator bias; or nature of the conduct subject to complaint.

First, if a certain characteristic is over-represented at the complaint stage relative to subsequent stages, this could indicate either a higher number of complaints being made against doctors with this characteristic or a lower number of complaints being made against doctors without that characteristic. While the present study cannot definitively answer why this may be, it could be as the result of a characteristic of the doctors in that group that lends themselves to complaints, or of the population served by those doctors, that is, the potential complainants. Second, an odds ratio that is lower at subsequent stages of the complaint process may indicate some form of bias on the part of the Boards, causing the Boards to be more reluctant to investigate such doctors or to make adverse findings against them. Third, the difference could indicate a higher proportion of complaints that, while justified, were not serious enough or of an appropriate type, to warrant further investigation or referral to hearing by the Boards.

Conversely, an odds ratio that is larger at the later stages of the disciplinary process suggests a higher proportion of investigations/hearings and adverse findings per complaint received compared to the reference group. This may be as a result of any of the same three factors working in the opposite direction. Complaints may, for some reason, be made less readily about this particular group of doctors, such that those that are made are more serious and thus more likely to be referred for investigation/hearing. Alternatively, there may be some form of bias operating at the Board level that makes investigation/hearing and adverse finding more likely.

Leaving aside comparisons between the odds ratios at different stages of the process, the absolute odds ratio at any one stage of the process may be due to any of the above factors or may, instead, be due to more complaint-worthy behaviour being exhibited by
particular groups of doctors or, in the case of adverse findings, more misconduct being committed by such groups.

1 Gender

The finding that male doctors were complained about more than female doctors is consistent with previous studies.\(^{583}\) It is also in line with the findings in the First Study that male doctors were disciplined by the Tribunals at four times the rate of female doctors.\(^{584}\)

The disparity between male and female doctors widened, rather than narrowed, as complaints moved through the stages of the disciplinary process. This indicates either that more of the complaints that were made against female doctors should not have been made (complainant bias), the complaints against female doctors were less serious, or that the boards were less rigorous in respect of female doctors (Board bias). While the third explanation may be open in respect of the smaller odds ratio at the investigation/hearing stage compared to the complaint stage, the fact that the odds ratio for the adverse findings stage was even smaller suggests that Board bias is not the reason for the disparity (unless, of course, a similar bias exists among the Tribunals also).

The most likely explanation for the gender difference seen is that the complaints about female doctors tend to be less serious than those about male doctors and consequently, are less likely to move to upper levels of the process. As seen in the First Study, female doctors were much less likely to engage in particular forms of misconduct, such as sexual misconduct, that were viewed particularly seriously by the Tribunals.\(^{585}\) Further research in this area, particularly stratification of type of complaint by gender, would be required in order to test this proposition.

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\(^{584}\) Adjusted for proportion of workforce and average working hours.

\(^{585}\) See also, chapter 9, where the Tribunals approach, in terms of disciplinary sanction, to various types of misconduct is discussed.
Midcareer doctors, and those with over 20 years of experience, have previously been identified as the groups at highest risk of being subject to a complaint. The results of the present study are consistent with those results showing, in multivariable analysis, the highest odds of complaint at 31 to 40 years after qualification (approximately age 54 to 63).

Compared to doctors at 21 to 30 years post qualification, doctors with less than ten years experience since qualification had a particularly low (and stable) odds of being subject to any stage of the disciplinary process. A possible explanation for this is that these doctors are less likely to have sole or senior responsibility for patient care or interactions and thus may avoid being implicated in complaints arising from systemic or multi-doctor interactions. As expressed by Cunningham et al, it is possible that it is the more experienced doctors who are carrying the burden of responsibility for patient care, and are more vulnerable to receiving a complaint as a consequence. The exposure time for these doctors was also shorter than for those who had been in practice longer. Although entry into the complaint group for this study was based on complaint date, the event leading to the complaint may well have occurred prior to the study period. This means that a doctor who qualified in 2001, while able to be complained about in 2002, would only have had one year of exposure to potential complaints by 2002. On the other hand, a doctor who qualified in 1981 will have had 21 years of exposure to potential complaints by 2002. While most complaints are made within months of the trigger event, some complaints do go back many years. Another possibility for the difference is that more recently qualified doctors are more likely to have been trained in recent paradigms of the doctor-patient relationship, such as the demise of medical paternalism and the importance of patient autonomy and informed consent. It would have been useful to be able to test this explanation against types of

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complaints received for each group of doctors but, as noted in the methods section above, the data on complaint type needed to do this was not available.

Finally, it is of note that the odds of a doctor more than 40 years post-qualification being complained about or having a complaint investigated were less than the odds for doctors 21-30 and 31-40 years post-qualification groups. It is possible that the decrease in complaint-rate in this oldest age group was due to a concurrent decline in practice time per registered doctor year.\textsuperscript{588}

3 \textit{Registration type and doctor location}

Although overall statistical correlation was low (corr = 0.03), in some instances registration type and doctor location are related variables. For example, by definition, doctors with Area of Need registration work in rural and/or remote locations around Australia. Both variables have been the subject of anecdotal speculation in the past, the typical view being that the level of medical care provided in rural locations (often by doctors with limited registration) is often lower quality but the patients in such areas are less likely to complain. The results of the Second Study do not show any significant difference in the odds of complaint (or odds of investigation/hearing or adverse finding) for doctors according to whether practice location was urban or rural.

Doctors with all types of non-general registration had a lower odds of complaint than doctors with general registration. Possible explanations for this are discussed above in relation to gender. One further explanation is that, by its nature, limited registration is time limited. This may mean that a Board that is aware a specialist registrant is not going to renew their registration may, especially in marginal cases, be less motivated to expend resources on investigating that doctor’s conduct, as the perceived ongoing risk to the public is low.

\textsuperscript{588} Note, however, that the model does adjust for registration type which includes non-practising as one of its categories.
4 Country of training

The finding that IMGs were subject to a higher rate of complaint is inconsistent with the results of most previous studies,\(^589\) however, most such studies have been in relation to complaints to agencies other than medical boards. One set of results that are consistent with the present findings are those from NCAS in the UK, which found that non-UK trained doctors had higher rates of referral to their service than UK-trained doctors.\(^590\) It may well be that one of the reasons that most of the previous studies have found no difference between complaint rates for IMGs compared to non-IMGs is a result of those studies treating IMGs as a single group. Perhaps a more nuanced treatment of country of qualification would have led, in some of the previous studies, to doctors from certain countries or groups of countries emerging as having distinct complaints and disciplinary profiles. Such an analysis has also been done as part of the present study and is reported and discussed in detail in chapter 8.

D Limitations of the study

The main limitation of this study is that data was not available on all variables for which it might have been useful. In terms of doctor characteristics, it would have been helpful to have had information about doctor clinical specialty. As a doctor characteristic that has previously been found to be associated with complaint rates, and was found, in the First Study, to be associated with findings of misconduct at tribunal level, it is possible that clinical specialty in some way confounds some of the associations revealed in this study, possibly leading to biases in the coefficients reported. Doctor specialty would have been an interesting predictor variable in its own right, not just as a covariate in the model.

The other important variable that was insufficiently available for analysis was complaint type. It is likely that much of the reason for whether or not a complaint progresses

\(^{589}\) With the exception of Robyn Tamblyn et al, 'Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities' (2007) 298(9) JAMA 993 and Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ.

through the stages of the disciplinary process is due to the type and seriousness of that complaint. Information about complaint type would also allow targeted interventions if particular issues, such as communication, were found to be more prevalent among particular groups of doctors.

VI CONCLUSION

This study provides insight into the characteristics of doctors who become the subject of complaints to medical boards. Gender, time since qualification, registration type and IMG status all emerge as important risk factors.

The last two chapters have analysed medical board complaints and Tribunal cases. What emerge from that analysis are several key characteristics that stand out as justifying further investigation and consideration, particularly regarding their relationship to, and potential impact on, the protection of the public.

In terms of doctor characteristics, country of training looms large, as IMG status has been demonstrated to be associated with both complaints and adverse findings, in the Second Study, and with being found guilty of misconduct by the Tribunals, in the First Study. While the latter result did not hold on multivariable analysis, it appears that a more nuanced assessment of country of training is warranted. Such investigation has been undertaken and is set out in the following chapter. That chapter also analyses the context for IMGs work in Australia, and the public protection ramifications of the results in relation to this important doctor characteristic.
CHAPTER 8 – KEY DOCTOR CHARACTERISTIC:
COUNTRY OF TRAINING

I INTRODUCTION

Perhaps the most unfortunate aspect of the recognition of [IMGs] in Australia has been the tension between considerations of workforce supply and standards.591

As outlined in the previous chapter, IMGs in the Second Study had higher odds of complaints and adverse findings than Australian-trained doctors. This is an important finding given the number of IMGs working within the Australian and New Zealand health systems and the reliance that is placed on them by those systems. This chapter begins by giving some background to that reliance and the context in which IMGs tend to practice in Australia and New Zealand. The chapter then moves on to look at the results of the First Study, stratified by country of qualification. Next, the chapter reports additional results from the Second Study, looking at more refined subcategories of IMGs rather than just treating IMG status in a binary fashion.592

Finally, the chapter discusses what the findings may mean in terms of the conduct and performance of IMGs in Australia and New Zealand, primarily in relation to protection and public interest considerations.

592 Given the First Study and the Second Study between them have sample frames of (broadly) 2000 to 2009, much of the background discussion in this chapter is focussed on that time period. Parts of the country-by-country analysis presented and discussed in this chapter have already been published in a paper by the author and her co-authors: Katie Elkin, Matthew Spittal and David Studdert, 'Risks of Complaints and Adverse Disciplinary Findings against International Medical Graduates in Victoria and Western Australia' (2012) 197(8) MJA 448.
II IMGs IN AUSTRALIA AND NEW ZEALAND

A Australia’s and New Zealand’s reliance on IMGs

The supply of doctors in Australia and New Zealand is not keeping pace with the ever-increasing demand for their services. As a result, there is currently a shortage in the number of doctors available to work. In 2007, Australia and New Zealand both had below the average number of doctors per capita among OECD countries.\(^\text{593}\) By 2009, this had been addressed in Australia, due to a 21% increase in the medical workforce between 2005 and 2009, bringing Australian doctor numbers in line with the OECD average.\(^\text{594}\) However, 2009 data for New Zealand is less encouraging, with New Zealand continuing to have fewer doctors per capita than most OECD countries.\(^\text{595}\)

While partly due to health workforce policy decisions (discussed below), shortages in doctors have been exacerbated by increased demand for medical services (due to the ageing population and rising consumer expectations).\(^\text{596}\) The pattern of supply of medical services has also had an impact due to increased emigration and feminisation of the medical workforce.\(^\text{597}\)

1 Australia

Of particular concern in Australia is the geographical mal-distribution of the medical workforce. As described by the Hon Nicola Rixon, the then Australian Minister for Health and Ageing, ‘distribution of the workforce is poor, declining significantly with greater remoteness.’\(^\text{598}\) For example, in 2006, major Australian cities had an average of 347 full-time equivalent doctors per 100,000 people; compared to 178 per 100,000

\(^{595}\) Organisation for Economic Cooperation and Development, ‘O.E.C.D. Healthdata 2012 - How Does New Zealand Compare?’ (2012). In 2009, New Zealand had 2.6 doctors per 1,000 people compared to an OECD average of 3.1 per 1,000 people.
\(^{596}\) Des Gorman, ‘The Disposition and Mobility of Medical Practitioners in New Zealand’ (2011) 124(1330) NZMJ.
\(^{597}\) Ibid.
\(^{598}\) Department of Health and Ageing, ‘Report on the Audit of Health Workforce in Rural and Regional Australia’ (Commonwealth of Australia, 2008).
people in remote and very remote areas of Australia. While this distribution may be explained, to some degree, by the presence of hospitals in major cities, the numbers are similar for the density of general practitioners. For example, in 2006-07, Medicare data shows that there were 97 full-time equivalent general practitioners per 100,000 people in major Australian cities, that number dropping to 68 and 47 in remote and very remote areas respectively. 2009 figures show that the overall increase in the number of doctors working in Australia has not addressed this maldistribution. Consequently, regional and remote Australians continue to be disadvantaged in their access to health professionals compared to their urban counterparts.

To a large extent, the current shortage of doctors in Australia has its heritage in the health workforce policies of the 1990s. During that decade, concern began to mount about the increasing cost of Medicare, the finger pointed at Australia’s persistent oversupply of doctors. Policy measures introduced in response included:

a) reduced numbers of medical school places;

b) tougher immigration standards for doctors;

c) restrictions on the practice of IMGs who arrived in Australia with temporary medical appointments; and

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599 Australian Institute of Health and Welfare, 'Medical Labour Force 2006' (AIHW, 2008) Supplementary data, Table 2.8, cited as preliminary data only.

600 Department of Health and Ageing, 'Report on the Audit of Health Workforce in Rural and Regional Australia' (Commonwealth of Australia, 2008). This is not to say, however, that the shortage is solely impacting on the general practitioner workforce. There has been a similar effect on medical specialties, as is evidenced by the fact that the Australian Critical Skills List includes all medical specialties: Department of Immigration and Citizenship, Critical Skills List (2009) Australian Government <www.immi.gov.au/skilled/general-skilled-migration/pdf/critical-skills-list.pdf>.

601 In 2009, major Australia cities had an average of 392 full-time equivalent doctors per 100,000 people, compared to 206 per 100,000 people in outer regional areas (which had dropped below remote and very remote areas for number of doctors per head of population): Australian Institute of Health and Welfare, 'Medical Labour Force 2009' (AIHW, 2011).

602 Department of Health and Ageing, Report on the Audit of Health Workforce in Rural and Regional Australia' (Commonwealth of Australia, 2008), p44.


604 Places were capped by the Australian Commonwealth Government from 1996 onwards: Lesleyanne Hawthorne, 'Doctor Shortages and Their Impact on the Quality of Medical Care in Australia' (2002) 10(3) People and Place 55.

605 By applying penalty points to doctors applying under the skilled migration category, then by removing that option altogether: Ibid.
d) restrictions on the number of doctors eligible to bill on Medicare.  

Although these measures had the desired effect of decreasing the supply of doctors, they also exacerbated the urban/rural distribution problem. As the number of general practitioners decreased, competition for positions in the cities also decreased, lessening the pressure on doctors to seek employment in rural areas. By the end of the 1990s, it began to become apparent that the Australian ‘oversupply’ assessment had been wrong. Accordingly, over the last decade, the focus has been on remediying the shortages and mal-distribution entrenched by the policies of the previous ten years.

2 New Zealand

The reasons for doctor shortages in New Zealand are different but related. Like Australia, New Zealand trains fewer local doctors than it needs to sustain its medical workforce and has traditionally had proportionately fewer graduates than the OECD average. However, unlike Australia, New Zealand also suffers from very high levels of doctor emigration. In 2005-06, New Zealand had the highest percentage of foreign-born (52%) and foreign-trained (36%) doctors in the OECD, plus the third highest expatriation rate for doctors in the OECD, at around 29% for the year. New Zealand is, for example, a major source of doctors to Australia, but the converse is not true. New Zealand also has some geographical mal-distribution, but not to the extent seen in Australia.

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606 Ibid.
607 This was done via the Health Insurance Amendment Act (No 2) 1996 (Cth) under which doctors who graduated after 1996 were unable to bill on Medicare until they had passed the Royal Australasian College of General Practitioners (RACGP) training programme, entry to which was tightly controlled (s15, inserting s19AA into the principal Act). For IMGs, the Act withheld access to Medicare provider numbers until 10 years after registration from 1997 (s16, inserting s19AB into the principal Act).
609 Ibid. This incorrect oversupply assessment was also made in a number of other countries, for example, the US: L Chen and T Evans, ‘Human Resources for Health: Overcoming the Crisis’ (2004) 364 Lancet 1984.
611 Ibid.
3  **IMGs as the solution**

In an effort to combat these workforce supply problems, over the last 10-15 years, Australia and New Zealand have increasingly looked to the rest of the world to supplement their medical workforces. The use of IMGs is an attractive option as it:

a) may offer an immediate solution (compared to the lag associated with training additional doctors domestically),

b) is cheap (compared to the cost of domestic training); and

c) allows a targeted response to workforce mal-distribution (by tailoring immigration and registration policy to require IMGs to work in areas of particular shortage).

Fortunately for Australia and New Zealand, there is also no shortage of doctors wanting to immigrate here, particularly from developing countries, even in the face of prescriptive requirements about practice conditions on arrival. As noted in chapter 2, and discussed in more detail later in this chapter, the Australian government and regulatory authorities have realised the attractiveness of Australia to overseas doctors and immigration policy in relation to IMGs has changed remarkably, as has the ease with which IMGs may become registered to practice here.

Now, according to the World Health Organisation (WHO), Australia and New Zealand are now the most reliant on foreign-born doctors of all OECD countries.

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613 Note, however, that this is only the case for specifically registered temporary resident IMGs who go immediately into practice and those who enter through the competent authority pathway. For other IMGs, it can take years to obtain medical employment due to the AMC requirements: Lesleyanne Hawthorne, ‘Unesco Global Comparison Study: Migration and Education Quality Assurance and Mutual Recognition of Qualifications: Country Report: Australia’ (UNESCO, September 2008). See chapter 2 for an outline of the different registration categories.

614 Note that the 457 temporary visa allows location of employment to be specified for up to four years as a condition of the visa: Lesleyanne Hawthorne, ‘Competing for skills: migration policies and trends in New Zealand and Australia’ (IMSED and NZ Department of Labour, 2012). The norm is now for these temporary migrants to eventually become permanent migrants in a two step migratory process.

615 Although, as competition for IMGs increases among OECD countries, New Zealand may find it more difficult to attract the number of IMGs it needs; Pascal Zurn and Jean-Christophe Dumont, ‘Health Workforce and International Migration: Can New Zealand Compete?’ (OECD 2008).

Approximately 25% of doctors currently registered to work in Australia are IMGs, as are over 40% of doctors currently on the New Zealand medical register. That reliance looks set to continue, at least for the foreseeable future.

### B The IMG population in Australia and New Zealand

Historically, Australia and New Zealand have sourced most of their IMGs from other developed countries such as the UK and Ireland. Increasingly, however, IMGs entering Australia and New Zealand are coming from African and Asian countries, including many developing nations. In 1997, 70% of all IMGs migrating to Australia came from the UK but, by 2002-03, this percentage had decreased to 43%. Australia and New Zealand are also popular destinations for medical practitioners migrating from other parts of the Pacific. While the total numbers of Pacific migrants are not especially high, the numbers are significant when seen as a proportion of the workforce remaining in the Pacific source countries.

The IMG population varies among states of Australia, just as between Australia and New Zealand. Victoria has been described as 'characterised by strong ongoing dependence on temporary as well as permanent medical migration' while Western Australia is 'characterised (like Queensland) by longstanding dependence on temporary medical migration ...' Western Australia has traditionally been a destination of choice for 'backpacker doctors' leading to an IMG population that is younger and

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618 Medical Council of New Zealand, 'Medical Workforce in New Zealand 2011' (2012).
619 Lesleyanne Hawthorne, *Competing for skills: migration policies and trends in New Zealand and Australia* (IMSED and NZ Department of Labour, 2012).
620 This is consistent with temporary skilled migration to Australia generally. For example, in 2008-09, 21% of all Business (Long Stay) (subclass 457) visas were granted to British citizens, 13% to Indians, 11% to South Africans, 10% to Filipinos, 6% to Chinese, 5% to North Americans, and only 3% to Irish citizens: Department of Immigration and Citizenship, 'Subclass 457 Business (Long Stay): State/Territory Summary Report 2007-08' (Australian Government, 2008).
622 For example, there are now almost as many Fijian medical practitioners practising in Australia and New Zealand as remaining in Fiji: Joel Negin, 'Australia and New Zealand's Contribution to Pacific Island Health Worker Brain Drain' (2008) 32(6) *Au & NZ Jnl of Public Health* 507.
623 Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007), pp 77-78.
dominated by doctors from English speaking countries and Western Europe. Such doctors only ever intend to stay in Australia short-term, planning to return to their country of origin after a period of travel. New Zealand is also a popular destination for young doctors from Europe who are eligible to live and work in New Zealand for up to two years as part of the Working Holiday Scheme. This massive turnover is illustrated by the fact that, between 2001 and 2011, 75% to 82% of all new doctor registrations in New Zealand were IMGs.

The top eight source countries for each of Western Australia, Victoria and New Zealand are shown below in Table 13. As can be seen from that table, a greater proportion of IMGs registered to practice in Western Australia and New Zealand were from English-speaking backgrounds and Western nations, with the UK/Ireland very strongly represented as a source country.

Table 13. Top eight countries for IMGs registered in Victoria (01-09), Western Australia (03-09), and New Zealand (09-10)

<table>
<thead>
<tr>
<th></th>
<th>Victoria (%)*</th>
<th>Western Australia (%)*</th>
<th>New Zealand (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>UK/Ireland (30)</td>
<td>UK/Ireland (43)</td>
<td>UK/Ireland (47)</td>
</tr>
<tr>
<td>2</td>
<td>India (14)</td>
<td>India (10)</td>
<td>United States (20)</td>
</tr>
<tr>
<td>3</td>
<td>New Zealand (11)</td>
<td>New Zealand (9)</td>
<td>India (5)</td>
</tr>
<tr>
<td>4</td>
<td>Sri Lanka (6)</td>
<td>South Africa (9)</td>
<td>South Africa (3)</td>
</tr>
<tr>
<td>5</td>
<td>South Africa (5)</td>
<td>Sri Lanka (3)</td>
<td>Canada (3)</td>
</tr>
<tr>
<td>6</td>
<td>Egypt (3)</td>
<td>Singapore (3)</td>
<td>Germany (3)</td>
</tr>
<tr>
<td>7</td>
<td>China (3)</td>
<td>Germany (2)</td>
<td>Sweden (2)</td>
</tr>
<tr>
<td>8</td>
<td>Iraq (3)</td>
<td>Pakistan (1)</td>
<td>Pakistan (1)</td>
</tr>
</tbody>
</table>

* Percentage of total number of IMGs who were registered in that state during the relevant period.

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624 Ibid, p84. For example, 11% of the IMGs registered in WA in 2005 were aged between 20 and 29 (compared with 4% in Victoria), and 88% were from English-speaking backgrounds: pp 84 and 112.

625 Pascal Zurn and Jean-Christophe Dumont, 'Health Workforce and International Migration: Can New Zealand Compete?' (OECD 2008).

626 Ibid; Medical Council of New Zealand, 'Medical Workforce in New Zealand 2011' (2012)

Compared to non-IMGs in Victoria and Western Australia, IMGs in those states are significantly more likely to be male. Male IMGs in those states (and across Australia) have also been found to be older, on average, than female IMGs. In Victoria and Western Australia, the mean number of years that a doctor has been in practice is roughly equivalent among IMGs and non-IMGs. However, in the period 2001 to 2009, there were fewer IMGs among doctors with less than 10 years practice experience and a correspondingly higher number of IMGs among those who had been qualified for between 10 and 20 years.

IMGs are not evenly distributed around Australia but, due to immigration and registration restrictions, are disproportionately represented in rural and remote locations. For example, by 2010, 46% of doctors working in rural and remote Queensland were IMGs, as were 36% of general practitioners in rural and remote Victoria and 53% of general practitioners in rural and remote Western Australia. Consequently, states which have more rural and remote locations tend to have a greater proportion of IMGs, than states which have fewer such locations. For example, 40% of doctors registered in Western Australia from 2003 to 2008 were IMGs, compared to only 27% for the same period in Victoria.

Many IMGs do not come to New Zealand or Australia directly from their country of qualification but have migration patterns described as ‘hyper-mobile’ as illustrated by a 2003 Victorian study which found that:

... 66 per cent of all [IMG] survey respondents report[ed] 5 major geographical moves prior to their current position ... A substantial number of such doctors ha[d] worked in a second country for 2-7 years prior to migration to Australia,

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629 Ibid, p122.
630 Data taken from the database constructed for the Second Study: see chapter 7 for details of that study.
631 Lesleyanne Hawthorne, ‘Competing for skills: migration policies and trends in New Zealand and Australia’(IMSED and NZ Department of Labour, 2012).
632 Data taken from database constructed for the second empirical study: see chapter 7 for details of that study.
with Asian-origin ... doctors significantly more likely to have experienced a high degree of global mobility.\textsuperscript{633}

New Zealand is often used as a stepping stone along an IMG's global trajectory towards eventual settlement in Australia.

It has previously been assumed that country of training can be interpreted as a proxy for place of birth but it is now known that, due to the hyper-mobility referred to above, this is not correct. For example, just 58\% of IMGs from some African nations, 64\% from North East Asia, 67\% from Commonwealth South Asia, and 79\% from Oceania were found, in a 2007 study, to have qualified in their birth region.\textsuperscript{634}

C Drivers for migration to Australia and New Zealand

Reasons for migration to Australia and New Zealand are as varied as the IMGs who migrate. Certainly, country of origin plays a significant role in what those drivers will be. As noted above, many of the younger IMGs migrating from English-speaking and Western European countries have been lured by \textquoteleft active promotion\textquoteleft (particularly by Western Australia) of \textquoteleft adventure medicine\textquoteleft.\textsuperscript{635} Coming mainly from the Netherlands, North America, South Africa and Denmark, these doctors are encouraged to \textquoteleft see WA as a lifestyle\textquoteleft.\textsuperscript{636} The appeal of the lifestyle offered by Australia and New Zealand is key to many Western doctors\textquoteleft decisions to migrate across the world, not just young adventure seekers.

Migration from developing countries tends to be a much more desperate endeavour, with doctors looking to escape stressed and collapsing health systems.\textsuperscript{637} Common \textquoteleft push factors\textquoteleft include poverty-level wages, unsupportive management, insufficient

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{633} Lesleyanne Hawthorne, Bob Birrell and Doris Young, 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria' (University of Melbourne, 2003), p73.
\item \textsuperscript{634} Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007), p80.
\item \textsuperscript{635} Ibid, p128.
\item \textsuperscript{636} Ibid.
\end{itemize}
\end{footnotesize}
social recognition, ... weak career development, unsanitary and/or unsafe working conditions, the impact of the HIV/AIDS epidemic, oppressive political climate, threat of violence, [and] persecution of intellectuals. Pull factors include lifestyle opportunities, financial incentives, career development, children's education, and the chance to work in a more technologically advanced health sector.

As noted above, many IMGs who migrate to Australia have been actively recruited by employers, State and Territory governments, and health authorities. Considerable sums of money are sometimes directed towards this recruitment effort. For example, in the Victorian 2009-10 State Budget, $1.5 million was allocated to create a "one stop shop" service for the recruitment of, and incentive packages for, IMGs. This followed an extensive recruitment campaign launched in 2007 under the title Health Careers for a Healthy Future which provided significant monetary incentives to IMGs recruited to fill vacancies that had proved hard to fill. Similarly, the Victorian Overseas Trained Doctor Rural Recruitment Scheme and the Rural Locum Relief Program have successfully recruited many IMGs to work in rural Victoria. Employers and government entities also make use of health professional recruitment companies, such as the Australian company Allied Health which has established an

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639 Department of Health and Ageing, 'Report on the Audit of Health Workforce in Rural and Regional Australia' (Commonwealth of Australia, 2008). Hagopian describes her research in an East African country in 2006 where she was told of hospitals with no electricity, no x-ray machine, no ambulances, no running water, and situations in which access to drugs, supplies and equipment was grossly inadequate: Amy Hagopian, 'Recruiting Primary Care Physicians from Abroad: Is Poaching from Low-Income Countries Morally Defensible?' (2007) 5(6) Annals of Family Medicine 483.
641 Ibid.
643 'A World of Expertise: Supporting International Medical Graduates in Victoria: Showcase Programme' (Department of Human Services, 2009).
office in South Africa in order to facilitate recruitment. By 2005, the Commonwealth government had contracted with 16 such agencies to place IMGs in positions within Australia. According to Zurn and Dumont, recruitment agencies have not played a major role in recruiting IMGs to New Zealand, but the Department of Labour’s Relationship Management Team has taken a number of initiatives.

IMG recruitment efforts around the world have proved to be successful, as seen by the early experience of the UK. Two years after the National Health Service (NHS) began a ‘global advertising campaign’ to recruit IMGs, the number of IMGs newly registered in the UK had doubled, with the number from sub-Saharan Africa having tripled. The wider public interest dimensions of employing such recruitment strategies are discussed later in this chapter.

The Competent Authority pathway has also proved a very successful recruitment strategy in attracting doctors from other developed countries, the response being ‘immediate and positive’. Those IMGs using this pathway tend to be younger than other IMGs, and are predominantly trained in the United Kingdom.

Overseas governments appear to take one of three attitudes towards medical migration:

a) Active attempts to prevent doctors leaving their country of training as seen by South Africa’s and Singapore’s decision not to be recognised as competent authority pathway countries by Australia;

b) A laissez-faire attitude to migration for example, India;

c) An active recruitment strategy, as seen by the Commonwealth of Australia’s recruitment of IMGs in South Africa.

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648 Pascal Zurn and Jean-Christophe Dumont, 'Health Workforce and International Migration: Can New Zealand Compete?' (OECD 2008). Note that the Department of Labour is no longer a stand-alone government department in New Zealand but is part of the new Ministry of Business, Innovation and Employment.
650 See p27.
651 Lesleyanne Hawthorne, 'Health Workforce Migration to Australia: Policy Trends and Outcomes' (Health Workforce Australia, 2012), p98.
652 Ibid.
653 Ibid.
c) Overproduction for export, for example, the Philippines.\textsuperscript{655}

In terms of immigration policy, the emerging pattern for skilled migration over the last decade in both Australia and New Zealand has been a ‘two-step migration’ approach.\textsuperscript{656} For New Zealand, the focus has been on ‘conversion of temporary workers’ to permanent resident status: in 2008/09, 81\% of permanent resident grants were to migrants who were already in New Zealand on temporary permits.\textsuperscript{657} As a result, the flow of temporary migrant doctors into New Zealand far exceeds that of permanent migrants. Between 2005 and 2009, 7,102 temporary work permits were issued to IMGs, on top of 1,612 skilled migrant category residence permits.\textsuperscript{658} Australia, on the other hand, had relied heavily on retaining international students as permanent residents,\textsuperscript{659} but has now intensified its focus on employer sponsorship of temporary visa holders via the SkillSelect programme. SkillSelect is an online tool where potential migrants lodge an expression of interest to be considered for a skilled visa, often to work in regional Australia.\textsuperscript{660} It is likely that many temporary migrants who enter Australia in this way will become permanent residents over time.

\textbf{Conclusion}

The Australian and New Zealand health systems have become increasingly reliant on IMGs over the last decade. The IMGs who arrive are a very diverse group, drawn from all corners of the globe, with different histories and reasons for migration, although often in response to deliberate recruitment strategies. IMG labour is used to plug gaps in the local workforce, particularly in hard-to-staff rural and remote locations.

However, despite the enormous contribution they make, the public perception of IMGs, particularly those who may look, sound and behave the most different to Australians and New Zealanders, is not altogether positive. The next section of this chapter

\textsuperscript{655}Indrajit Hazarika et al, ‘Country Report: India’ (Public Health Foundation of India, 2009).
\textsuperscript{655}See later in this chapter.
\textsuperscript{656}Lesleyanne Hawthorne, ‘Competing for Skills: Migration Policies and Trends in New Zealand and Australia’ (Department of Labour (NZ), 2012).
\textsuperscript{657}Ibid.
\textsuperscript{658}Ibid.
\textsuperscript{659}Ibid.
\textsuperscript{660}See www.immi.gov.au/skills/skillselect.
explores those public perceptions and the foundations on which they rest, using additional data from the First Study and the Second Study to test the validity of public concerns.

III IMGs, AND COMPLAINTS AND DISCIPLINE

A Public perceptions

Once the media get hold of the kind of story that sells newspapers, like that of Dr Jayent Patel ('Dr Death'), it becomes easy for all overseas-trained doctors in our country to be tarred with the same brush. It seems that much of the Australian and New Zealand public are wary of IMGs, believing that the care they provide is, in some way, not up to the standard of the care provided by locally trained doctors. There is general public anxiety that some IMGs are entering the Australian workforce before they are competent (clinically or culturally) to do so. But where do these perceptions come from, and are they justified?

Anecdotes abound about doctors who barely seem to be able to speak English, who seem uncertain and unclear, who simply do not seem to know what they are doing. Often-times, the teller of the anecdote identifies the doctor concerned as being 'foreign'. This judgment is often made, at least initially, on the basis of what the doctor looks or sounds like. Patients generally have no other way of distinguishing a doctor trained in Australia or New Zealand from an IMG. Similarly, patients may assume a doctor who looks and sounds 'foreign' was trained overseas, when in fact they may have attended medical school in Australia or New Zealand. As noted above, there are also many IMGs who have English as a first language, and who look and sound virtually indistinguishable from the majority of locally-trained doctors.

There have also been several high profile IMG scandals over the last decade that have fuelled the perceptions of some that IMGs are incompetent or dangerous. By far the most notorious in Australia was the case of Dr Jayent Patel, the Indian-American

661 Sanjov Wijesinha, 'Australians See Doctor Death in Every Overseas-Trained Doctor', The Age (Melbourne), 14 June 2005.

Director of Surgery at Bundaberg Base Hospital. Dr Patel’s apparent misconduct and incompetence, in light of issues surrounding his Australian registration status, led to several full-scale inquiries, including what has become known as the Davies Report. As well as investigating Dr Patel and Bundaberg Base Hospital, the Commission of Inquiry looked at five other public hospitals in Queensland, including three where the incorrect registration, and/or supervision of, particular IMGs (from Fiji, Russia, and South Africa) had led to patient safety concerns. It is worth noting that the status of Dr Patel’s registration status in the US was revealed first by the media, with journalists having searched the internet and found information about which the Qld Board itself had not been aware.

In New Zealand, it is Dr Roman Hasil who most readily comes to mind when recalling IMG scandals (although his misconduct reached to Australia as well). Dr Hasil was trained in the Czech Republic and worked around the world, being sacked from a number of positions, on several occasions for drinking. He served a jail term in Singapore for domestic violence and was deregistered in several countries. After working in New South Wales (having been refused registration by other Australian states), he moved to New Zealand where he worked at Whanganui Hospital as an obstetrician/gynaecologist. In 2008, an Inquiry by the Health and Disability Commissioner found that Dr Hasil had ‘botched’ 25% of all sterilisation operations he had performed in Whanganui (with six women falling pregnant as a consequence), and had also removed one woman’s healthy ovaries. Like Dr Patel, Dr Hasil’s qualifications and background were found not to have been properly checked before he was granted medical registration.

663 See p40.
666 Health and Disability Commissioner, ‘Dr Roman Hasil and Whanganui District Health Board: A Report by the Health and Disability Commissioner’ (HDC, 2008).
There have, of course, been other scandals involving locally-trained doctors,\textsuperscript{667} but these tend not to be recognised, reported or remembered in terms of ethnicity or country of training. As a consequence:

.. it becomes all too easy for simple folk to see a Dr Death in every doctor who bears an ethnic resemblance to Patel or who speaks with the kind of accent they expect the Patels of the world to have.\textsuperscript{668}

So, are IMGs, as a group or as particular sub-groups, worse doctors than those who have been locally-trained? Are the fears justified? According to the Davies Report, they might be (or have been), at least in some parts of Australia:

The dependence of Australia upon IMGs is unsustainable and unacceptable for the general community ... It raises a series of difficult accreditation and quality of service provision dilemmas.\textsuperscript{669}

\textit{B The evidence}

1 \textit{Introduction}

This section uses complaints and disciplinary proceedings as a metric for investigating the conduct and performance of IMGs in Australia and New Zealand. While an imperfect measure, given complaint and discipline rates cannot be assumed to closely mirror actual misconduct or competence concerns, such proceedings do provide some insight into the experiences of some IMGs and that of some of their patients.

The section begins by outlining previous research regarding the conduct and performance of IMGs and recapping the findings regarding IMG complaints and discipline (as introduced in chapter 5). Additional methods and results from the Studies, as they relate to the IMG variable, are then presented and discussed.

\textsuperscript{667} For example, in New Zealand, Dr Morgan Fahey, convicted in 2000 of rape and sexual assault of patients stretching back over 31 years of practice; and Dr Michael Bottrill, found to have misread hundreds of cervical screening tests in the late 1990s.

\textsuperscript{668} Sanjov Wijesinha, 'Australians See Doctor Death in Every Overseas-Trained Doctor', \textit{The Age} (Melbourne), 14 June 2005.

2 Existing knowledge

As noted above, public perceptions of IMGs tend to be informed by the retelling of anecdotes and/or media reports of ‘scandals’. The conclusions reached by various inquiries have also contributed. In addition, there has been academic suggestion that the pre-Nationalisation mechanisms of IMG registration, particularly the practice of allowing some IMGs to practice without first having their medical skills assessed, has had a detrimental effect on the quality of medical care that is provided in Australia.670

a) Research into quality of care

To date, the only way that the above assertion about quality has been empirically tested (other than by extrapolation from AMC test pass rates671) has been by canvassing the views and experiences of those working with IMGs within the Australian healthcare system.672 For example, a 2007 survey conducted by the Australian Medical Association revealed that the introduction of ‘credible, nationally consistent processes of assessment and support’ for IMGs was viewed by rural doctors as the second most important of a list of 25 policy proposals.673 Self-reported measures were also used by Bayram et al in a 2007 study designed to describe the clinical activity of IMGs working in general practice in Australia.674 While not directly indicative of performance, the study found that the IMGs ‘prescribed more medications, other treatments and referrals, and ordered more pathology and imaging tests’ than a control group of non-IMG general practitioners. The authors reported this result not just in terms of quality but as

672 Postgraduate Medical Council of Victoria, ‘Overseas Trained Doctors in the Victorian Public Hospital System’ (PMCV, 2002); Australian Medical Association, ‘Rural Doctors Have Their Say on Key Solutions to Improve Rural Health Care Delivery’ (AMA, 2007).
673 Australian Medical Association, ‘Rural Doctors Have Their Say on Key Solutions to Improve Rural Health Care Delivery’ (AMA, 2007). However, it should be noted that the survey concerned had a response rate of only 13%.
having economic implications as the patient management measures chosen by the IMGs were typically more expensive.

Outside Australia, scarce research has been conducted in this area, and most of what there is, is now decades old. In 1977, a review paper from the United States concluded that the few studies that had focused on clinical competence of IMGs up until that date had been seriously flawed. Discounting the findings of the earlier studies that had cast doubt on the adequacy of the performance of IMGs, the review paper went on to call for further research into the issue. In 1979 and 1980, Saywell et al obliged, publishing two studies comparing the performance of IMGs to non-IMGs practicing in US hospitals. Both studies found no significant difference between the performance of IMGs and non-IMGs in relation to taking patient histories and conducting physical examinations. In 1986, Rhee et al investigated performance differences in the ambulatory care setting concluding that IMGs provided equal or marginally better care than the non-IMGs. A decade later, Ko et al again tested the popular perception that IMGs may provide inferior care compared with non-IMGs by analysing the use of secondary prevention medications and cardiac procedures and the mortality of acute myocardial infarction patients. Again, the results suggested that IMGs were not inferior to non-IMGs in terms of the care provided.

While the US studies are of interest, they all arise out of a very different health care system to those which operate in Australia and New Zealand, particularly in terms of the entry controls that are imposed on IMGs seeking medical registration. In that country, there are rigorous screening processes that are applied to all applicants for

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678 Sang-O Rhee et al, 'USMGs versus FMGs: Are There Performance Differences in the Ambulatory Care Setting?' (1986) 24(3) Medical Care 248.
680 They are also limited in terms of sample size.
medical residencies (including IMGs), including examinations, interviews and other assessments.  

b) Research into complaints and disciplinary proceedings

Research into the involvement of IMGs in complaints and disciplinary proceedings has also been limited, particularly outside of the United States. The main studies that have been conducted, and their key findings, are described in chapter 5 above. To summarise, the main results have been as follows:

a) Most studies (all conducted in the United States) have found IMGs to have the same, or lower, discipline rates as non-IMGs.  

b) Two studies have found IMGs to have a higher rate of discipline than non-IMGs.  

c) Most studies have found IMGs to have rates of complaint that do not differ significantly from non-IMGs.  

d) One study has found IMGs to have a higher rate of complaints than non-IMGs, and IMG referral rate to NCAS in the UK has also been reported to be higher.  

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681 Data provided by Lesleyanne Hawthorne, Professor International Workforce, University of Melbourne, 14 March 2013, based on direct ECFMG (Educational Commission for Foreign Medical Graduates) advice from a senior informant, see www.ecfmg.org.  
685 Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ.  
686 National Clinical Assessment Service, 'Concerns About Professional Practice and Associations with Age, Gender, Place of Qualification and Ethnicity - 2009/10 Data' (NHS, 2011).
c) Limitations of previous research

The main limitation of the previous studies of IMG conduct and performance, including those which have analysed complaints and disciplinary proceedings, is that, until very recently, IMGs have generally been considered as a homogeneous group for comparison against non-IMGs. As outlined earlier in this chapter, the IMG populations in Australia and New Zealand are far from homogeneous, including doctors from all over the world. It is quite conceivable that some groups of IMGs do better on the various outcome measures investigated than do locally-trained doctors. It is possible that, when IMGs are considered as a single group, sub-groups of IMGs with particularly low complaint rates may mask higher complaint rates among other sub-groups of IMGs. The results outlined in the following section suggest that this may indeed have been the case in previous studies.

3 The First Study: Analysis of Tribunal determinations

The aims, main methods and general results of the First Study are reported in chapter 6. In summary, the First Study was an analysis of the 485 determinations made by Tribunals in New South Wales, Victoria, Queensland, Western Australia and New Zealand between 2000 and 2009, in which a doctor was found guilty of professional misconduct. The First Study also involved an analysis of the doctors in the sample, by IMG status, and according to categories of countries of qualification. Supplementary methods plus additional findings are set out in this section.

a) Supplementary methods

Country of (basic medical) qualification was identified as an additional doctor variable of interest in the study. For most cases, country of qualification was obtained from the online medical register for the state concerned. Where the doctor did not appear on the register, country of qualification was often specified within the determination itself and so was extracted from there. In 47 cases (10%), country of qualification was unavailable and so was coded as missing in the database.

Counts and proportions were calculated for country of qualification. Again, the calculation of rates required population-level denominators. The doctor population by country of qualification was calculated using a combination of data from medical
workforce reports for 2003 and 2006, plus various annual reports of the Boards. Some interpolation was necessary to complete the population level data for the other years. These denominators allowed calculation of rates per 100,000 doctors per year.

The countries of qualification were classified into groups to reflect the registration regime in Australia. Those groups were non-IMGs (Australian-trained doctors disciplined in one of the Australian states, or New Zealand-trained doctors being disciplined in New Zealand), IMGs from one of the Australian-recognised competent authorities (Competent Authority IMGs), and other IMGs.

Poisson regression analysis was used to test whether IMG status generally, and grouped country of qualification category specifically, were associated with the rate of disciplinary action (the outcome variable). The method outlined in chapter 6 was used to identify any covariates for inclusion in the model; however, none met the test for inclusion.

Multivariate logistic regression analysis was also performed to see whether IMG status was associated with any of the particular misconduct types. Again, the method outlined in chapter 6 was used to identify any covariates for inclusion in the model, with notifier and state eventually included.

b) Results

Doctors who were subject to disciplinary action by the tribunals during the study period gained their primary medical qualifications in 33 different countries. Table 14 shows the numbers of cases involving a doctor trained in each country contributing more than two cases to the sample.

---


688 In particular, populations of IMGs from Asia and North America registered in New South Wales were not available and so were extrapolated from the data from other similar states. In some other states, data for both 2003 and 2006 was not available for all countries, in which case, that country was assigned the same percentage as it made up in the available year.

689 See p146 onwards.
Table 14. Countries of primary medical qualification of doctors disciplined in Australia and New Zealand, 2000-09 (n=438)

<table>
<thead>
<tr>
<th>Country of qualification</th>
<th>Number of cases (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>281 (64)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>33 (8)</td>
</tr>
<tr>
<td>UK/Ireland</td>
<td>33 (8)</td>
</tr>
<tr>
<td>India</td>
<td>26 (6)</td>
</tr>
<tr>
<td>South Africa</td>
<td>12 (3)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>9 (2)</td>
</tr>
<tr>
<td>Iraq</td>
<td>4 (1)</td>
</tr>
<tr>
<td>Egypt</td>
<td>3 (0.7)</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>3 (0.7)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>3 (0.7)</td>
</tr>
</tbody>
</table>

* Percentage of total cases where country of qualification known

As shown in Table 15, the rate of disciplinary action was not significantly different between IMGs and non-IMGs in the sample. However, once IMGs were divided into those trained in countries that are recognised in Australia as Competent Authorities and those that trained in countries that are not, a significant difference became apparent, with IMGs not coming from Competent Authority countries being disciplined at almost one and half times the rate of non-IMGs.

Table 15. Rates for doctors disciplined in Australia and New Zealand, 2000-09, by IMG status and country of training (n=438)

<table>
<thead>
<tr>
<th></th>
<th>Cases, n(%)</th>
<th>Rate Â</th>
<th>Rate Ratio (95%CI), p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia (ref)</td>
<td>307 (70)</td>
<td>65</td>
<td>1</td>
</tr>
<tr>
<td>IMGs</td>
<td>131 (30)</td>
<td>76</td>
<td>1.17 (0.95, 1.43), p=0.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cases, n(%)</th>
<th>Rate Â</th>
<th>Rate Ratio (95%CI), p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia (ref)</td>
<td>307 (70)</td>
<td>65</td>
<td>1</td>
</tr>
<tr>
<td>Competent authority IMGs</td>
<td>41 (9)</td>
<td>53</td>
<td>0.81 (0.58, 1.12), p=0.2</td>
</tr>
<tr>
<td>Other IMGs±</td>
<td>90 (21)</td>
<td>95</td>
<td><strong>1.46 (1.16, 1.85), p=0.001</strong></td>
</tr>
</tbody>
</table>

* Percentage of total cases where country of qualification known
Â Rate per 100,000 registered doctor years
± Made up of doctors trained in Hong Kong, India, Iran, Iraq, Lebanon, Myanmar, Pakistan, Philippines, Russia, Singapore, Sri Lanka, and Vietnam.
As shown in Figure 6, there were also differences in the rates of discipline for the various types of misconduct among the three groups (non-IMGs, competent authority IMGs and other IMGs). As can be seen from the very low rates at which some of the types of misconduct were observed, the analysis of these patterns is somewhat constrained by sample size limitations.

Figure 6. Rates (per 10,000 registered doctor years) of types of misconduct according to IMG status (n=438)
However, there are several types of misconduct that do appear to have been at issue at a proportionately higher rate among other IMGs than among non-IMGs, and are therefore responsible for the overall higher rate of discipline among other IMGs. Table 16 shows the two misconduct types that, on multivariate logistic analysis, were significantly associated with IMG status. As noted earlier, it is important to note that lack of significant association may be due to sample size limitations rather than an actual lack of association between IMG status and particular misconduct types and that, in a larger study, other associations of significance may well emerge.

### Table 16. Significant associations between IMG status and misconduct type for doctors disciplined in Australia and New Zealand, 2000-09

<table>
<thead>
<tr>
<th>Informed consent failure</th>
<th>Cases, n(%*)</th>
<th>Odds Ratio (95%CI), p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-IMGs</td>
<td>27 (52)</td>
<td>1</td>
</tr>
<tr>
<td>IMGs</td>
<td>25 (48)</td>
<td>2.04 (1.02, 4.10), p=0.04</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual misconduct (not r/ship)</th>
<th>Cases, n(%*)</th>
<th>Odds Ratio (95%CI), p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-IMGs</td>
<td>22 (49)</td>
<td>1</td>
</tr>
<tr>
<td>IMGs</td>
<td>23 (51)</td>
<td>3.00 (1.52, 5.77), p=0.001</td>
</tr>
</tbody>
</table>

* Percentage of total cases where that misconduct type was present and where country of qualification known

### 4 The Second Study: Analysis of complaints to Boards

The aims, main methods and general results of the Second Study are reported in the previous chapter. The Second Study was, in short, an analysis of all complaints received by the medical boards of Victoria and Western Australia from 2001 or 2003 respectively, until 2008. Each complaint was followed through three stages of the complaints and disciplinary process: complaint received, investigation/hearing, and adverse finding. Supplementary methods plus additional findings are set out in the following section.
a) Supplementary methods

IMG status was analysed as a binary variable, as per the methods described in chapter 7. However, as noted in that chapter, the databases contained sufficient detail for this to be reduced to actual country of qualification for more than 99% of doctors included in the study. All countries of qualification contributing 0.3% or more of the total doctor population were analysed separately, with the remaining countries of qualification grouped together in another category.

Logistic regression analysis was then used to investigate whether country of qualification was associated with each of the three stages of the complaints and disciplinary process. Separate models were run for each of the outcomes of interest, with country of qualification as the independent variable of interest. Country of qualification was treated variously as a binary variable, categorised according to Competent Authority Pathway designation, categorised according to OECD status, and as individual countries. As with the models described in chapter 7, gender, years since qualification, practice location and state were included as covariates in both models. The models corrected standard errors for clustering at the doctor level to account for repeated measures of the same doctors across multiple registration years.

b) Results

IMGs registered in the two states during the study period gained their primary medical qualification in more than 120 different countries. The percentage of doctors from each country contributing more than 0.3% of the total registered doctor population is shown in Table 17 below.

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690 See p181.
691 See chapter 2, p27, for a description of the Competent Authority Pathway. Competent Authority Pathway countries are New Zealand, UK, Ireland, US and Canada.
Table 17. Country of training of doctors in the Study Sample (n=39,155)

<table>
<thead>
<tr>
<th>Country</th>
<th>n(%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>24,542 (63)</td>
</tr>
<tr>
<td>UK/Ireland</td>
<td>5,129 (13)</td>
</tr>
<tr>
<td>India</td>
<td>1,871 (5)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1,422 (4)</td>
</tr>
<tr>
<td>South Africa</td>
<td>893 (2)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>689 (2)</td>
</tr>
<tr>
<td>Germany</td>
<td>311 (0.8)</td>
</tr>
<tr>
<td>Egypt</td>
<td>292 (0.7)</td>
</tr>
<tr>
<td>Iraq</td>
<td>291 (0.7)</td>
</tr>
<tr>
<td>China</td>
<td>256 (0.7)</td>
</tr>
<tr>
<td>Singapore</td>
<td>249 (0.7)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>228 (0.6)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>204 (0.5)</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>184 (0.5)</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>172 (0.4)</td>
</tr>
<tr>
<td>Philippines</td>
<td>148 (0.4)</td>
</tr>
<tr>
<td>Iran</td>
<td>131 (0.3)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>127 (0.3)</td>
</tr>
<tr>
<td>Nigeria</td>
<td>124 (0.3)</td>
</tr>
<tr>
<td>Russia</td>
<td>120 (0.3)</td>
</tr>
<tr>
<td>Poland</td>
<td>95 (0.3)</td>
</tr>
<tr>
<td>Other ±</td>
<td>1,619 (4)</td>
</tr>
</tbody>
</table>

* Percentages were calculated with the number of doctors for which the variable of interest was available as the denominator. Data were missing for <1% of all variables, except for practice location for which data was missing for 6,165 doctors (16%).

± Countries of qualification that contributed less than 0.3% of the total number of doctors during the study period.

When country of qualification was specified as a binary variable distinguishing IMGs from non-IMGs, IMGs had significantly higher odds of being subject to each stage of the complaints and disciplinary process. When country of qualification was specified as a three-category variable distinguishing Competent Authority Pathway IMGs and other
IMGs, respectively, from Australian trained doctors, the odds for the other IMGs group was around one and a half times the odds for Australian trained doctors (see Table 18).

Table 18. Multivariable odds of complaint, hearing/investigation and adverse finding, by IMG status*

<table>
<thead>
<tr>
<th></th>
<th>Complaint received</th>
<th>Hearing/investigation</th>
<th>Adverse finding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio (95% CI)</td>
<td>Odds Ratio (95% CI)</td>
<td>Odds Ratio (95% CI)</td>
</tr>
<tr>
<td>Australia (ref)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>IMGs</td>
<td>1.24 (1.13, 1.36)</td>
<td>1.19 (1.04, 1.38)</td>
<td>1.41 (1.07, 1.85)</td>
</tr>
<tr>
<td>Comp authority IMGs</td>
<td>0.97 (0.84, 1.12)</td>
<td>0.86 (0.68, 1.10)</td>
<td>0.99 (0.61, 1.56)</td>
</tr>
<tr>
<td>Other IMGs</td>
<td>1.44 (1.30, 1.59)</td>
<td>1.42 (1.21, 1.66)</td>
<td>1.71 (1.27, 2.30)</td>
</tr>
</tbody>
</table>

* The model adjusted for doctor sex, doctor practice years, registration type, complaint year, practice location, and state.

† Results in bold are significant to p<0.05.

Stratifying according to actual countries of qualification, revealed substantial variation between different countries in terms of complaints received (Table 19). Doctors trained in Nigeria emerged as having the highest odds of complaint, at over four times that of Australian-trained doctors. Doctors trained in three other countries (Egypt, Poland and Russia) also had odds of complaint that were over double the odds for Australian-trained doctors. Significantly elevated odds of complaint were also found for doctors trained in Iran, Pakistan, the Philippines and India, with odds ratios of between 1.61 and 1.85. Although doctors trained in several countries appeared to have lower odds of complaints (New Zealand, Malaysia, Bangladesh, Hong Kong, Germany) than Australian-trained doctors, the differences were not significant.

The author attempted to extend the by-country analysis past the complaint received stage to the hearing/investigation and adverse finding stage. However, on reviewing the results of that analysis, it was apparent that the study did not have sufficient power to support such an analysis, so only results for the complaint rate outcome are reported.
Table 19. Multivariable odds of complaints, by country of training*

<table>
<thead>
<tr>
<th>Country</th>
<th>Odds Ratio (95% CI)</th>
<th>P value</th>
<th>Adjusted annual probability of complaint †</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia (ref)</td>
<td>1.00</td>
<td></td>
<td>2.4%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>4.02 (2.38, 6.77)</td>
<td>&lt;0.001</td>
<td>8.6%</td>
</tr>
<tr>
<td>Egypt</td>
<td>2.32 (1.77, 3.03)</td>
<td>&lt;0.001</td>
<td>5.2%</td>
</tr>
<tr>
<td>Poland</td>
<td>2.28 (1.43, 3.61)</td>
<td>&lt;0.001</td>
<td>5.1%</td>
</tr>
<tr>
<td>Russia</td>
<td>2.21 (1.14, 4.26)</td>
<td>0.02</td>
<td>5.0%</td>
</tr>
<tr>
<td>Iran</td>
<td>1.85 (0.87, 3.93)</td>
<td>0.11</td>
<td>4.2%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1.80 (1.09, 2.98)</td>
<td>0.02</td>
<td>4.1%</td>
</tr>
<tr>
<td>Philippines</td>
<td>1.80 (1.08, 3.00)</td>
<td>0.02</td>
<td>4.1%</td>
</tr>
<tr>
<td>India</td>
<td>1.61 (1.33, 1.95)</td>
<td>&lt;0.001</td>
<td>3.7%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1.33 (0.99, 1.78)</td>
<td>0.06</td>
<td>3.1%</td>
</tr>
<tr>
<td>Iraq</td>
<td>1.15 (0.70, 1.87)</td>
<td>0.59</td>
<td>2.7%</td>
</tr>
<tr>
<td>Singapore</td>
<td>1.05 (0.69, 1.61)</td>
<td>0.82</td>
<td>2.5%</td>
</tr>
<tr>
<td>South Africa</td>
<td>1.06 (0.80, 1.42)</td>
<td>0.68</td>
<td>2.5%</td>
</tr>
<tr>
<td>UK/Ireland</td>
<td>1.00 (0.86, 1.17)</td>
<td>0.98</td>
<td>2.4%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.97 (0.23, 4.10)</td>
<td>0.96</td>
<td>2.3%</td>
</tr>
<tr>
<td>China</td>
<td>0.90 (0.53, 1.50)</td>
<td>0.67</td>
<td>2.1%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>0.83 (0.59, 1.16)</td>
<td>0.28</td>
<td>2.0%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>0.67 (0.28, 1.59)</td>
<td>0.36</td>
<td>1.6%</td>
</tr>
<tr>
<td>Germany</td>
<td>0.59 (0.26, 1.30)</td>
<td>0.19</td>
<td>1.4%</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>0.56 (0.24, 1.28)</td>
<td>0.17</td>
<td>1.3%</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>0.49 (0.18, 1.30)</td>
<td>0.15</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

* The model adjusted for doctor sex, doctor practice years, registration type, complaint year, practice location, and state. Not shown is an “other country of training” category, which grouped doctors trained in countries other than those specified (3.2% of all doctor-years). A full set of results for the model is available in the Appendix.

† These figures are derived from the multivariable model and indicate doctors' adjusted probabilities of complaints by country of training, within each doctor-year.

While the odds ratios reported in Table 19 give a sense of the relative likelihood of an event occurring, they do not well express what that means at a population level. Therefore, as also shown in Table 19, an annual probability of complaint was also calculated, adjusted for the same covariates as the main model. Australian-trained doctors had an adjusted annual probability of 2.4% of having a complaint made against
them. For doctors trained in Nigeria, this probability was 8.6%. This means that, on average between 8 and 9 Nigerian-trained doctors in every 100 received at least one complaint against them each year. For doctors trained in Egypt, Poland and Russia, the probability was around 5%. For all other countries analysed, the adjusted annualised probability was 4.2% or below.

5 Possible explanations

There are two principal ways of interpreting the above results. The first is that, despite the above results, IMGs, including when grouped by country, are no different from Australian trained doctors in terms of any quality or safety measures. Rather, the above results are due to bias or confounding in the study design or prejudice within the complaints and disciplinary system itself. The second principal explanation is that, for some reason, some groups of IMGs have interactions with patients that are of an inferior quality or expose those patients to increased risk. The potential quality dimension may take a number of forms, not necessarily related to technical competence as a doctor; it may also relate to the 'softer' aspects of the doctor-patient relationship, such as communication and manner, both of which may be heavily influenced by cultural experiences and expectations.

Each of these possible explanations (that there is no difference in conduct and performance between IMGs and non-IMGs, and that there is such a difference) is elaborated below.

a) Conduct and performance of IMGs is not inferior to that of non-IMGs

   i) Bias in study design

One way to explain the results of the empirical studies as they relate to IMGs is by reference to short-comings in the study design. For the First Study, legitimate criticisms may be made about the manner in which the population-level denominators were calculated, particularly for New South Wales. However, given the rarity of the event being measured (disciplinary actions) and the large size of the population from which those events are drawn, any inaccuracy in the denominators is unlikely to have had much of an impact statistically. In the Second Study, the countries of qualification of the case group of doctors and the comparison population were all recorded specifically.
Provided accurate data was provided to the Boards and was correctly transcribed into their databases, one can be confident that the country of qualification data is accurate, at both a population and a case level.

In the Second Study, the primary limitation is the possible presence of confounding variables that were, due to data limitations, unable to be taken into account in describing the associations concerned. In particular, it would have been helpful to have had information about doctor specialty, practice environment and complaint type. The importance of these variables as potential confounders is discussed in the previous chapter. Other reported differences in the way that many IMGs practice may also have an impact on the observed associations. In their 2007 study, Bayram et al noted that IMGs tend to work more sessions per week and in smaller practices, treat more new patients, patients holding concession cards and indigenous people, treat fewer children and elderly people, and deal with more acute conditions, than their non-IMG counterparts.\textsuperscript{692} It is possible that some of these factors (for example, dealing with more acute conditions) may lead to more complaints, however, others of those factors (for example, treating more indigenous patients) may lead to fewer complaints being received. These factors could not be taken into account in the current study given the data that was available. However, other differences acknowledged by Bayram et al, including rurality and amount of experience, were controlled for in the models.

\textit{ii) Prejudice in the complaints and disciplinary system}

Prejudice may arise at several stages of the complaints and disciplinary process; the first being at the point of complaint. It is entirely plausible, particularly in the context of the public perceptions discussed at the start of this chapter, that there may be racial prejudice in complainant behaviour. The argument is that members of the community are more ready to complain about doctors who appear to come from particular countries. For example, patients may associate ethnically Indian doctors, perhaps subconsciously, with Dr Patel, and thus be more likely to perceive them as having done something

\textsuperscript{692} Clare Bayram et al, 'Clinical Activity of Overseas-Trained Doctors Practising in General Practice in Australia' (2007) 31(3) \textit{Australian Health Review} 440.
Of course, any such prejudice would probably be linked to a doctor's appearance and accent, rather than their place of training. However, the strong (but not perfect) correlation between the two must be acknowledged. As poignantly expressed by one IMG participant in a US study:

In the beginning, I had fear that I may be punished if I make a small mistake being foreigner.\(^694\)

Some past studies have shown that patients report higher levels of satisfaction from medical encounters if the doctor is of the same race and/or ethnicity as the patient.\(^695\) However, other researchers have concluded that satisfaction is as much about preference fulfilment as race concordance.\(^696\) That is, if a patient has a preference for a doctor of the same race as the patient and that preference is not fulfilled, the patient is more likely to be dissatisfied. Either way, non-racially concordant doctor-patient encounters will inevitably occur much more often for IMGs practising in Australia than for Australian-trained doctors practising here. This has the potential to lead to an increased rate of complaints against IMGs.

Notwithstanding the above, a couple of features of the studies serve, to some extent, to protect the results from being affected by such an effect. In the First Study, what was being measured were cases where a Tribunal had determined that the doctor concerned had committed professional misconduct of some kind. Any complaints without proper foundation, by definition, should not have been part of the final sample. However, it is well understood that not all complaint-worthy events, not even most such events, ever become the subject of a complaint. If, for some groups of doctors, more of those events

\(^{693}\) As described by the President of the Australian Medical Association, Dr Mukesh Haikerwal, shortly after the Patel scandal broke: "Because of the Patel case, doctors with funny names, accents, coloured skin and different backgrounds are getting a hard time" David Wroe, 'Exodus Fear over 'Medical Racism'', The Age (Melbourne), 21 July 2005.

\(^{694}\) Kevin Fiscella et al, "Being a Foreigner, I May Be Punished If I Make a Small Mistake": Assessing Transcultural Experiences in Caring for Patients' (1997) 14(2) Family Practice 112, p113.

\(^{695}\) For example, Lisa Cooper-Patrick et al, 'Race, Gender, and Partnership in the Patient-Physician Relationship' (1999) 282(6) JAMA 583.

are reported, those doctors will have a higher exposure to the disciplinary system and a
greater chance of eventually being found guilty of misconduct by a tribunal. The
argument is that IMGs are not being over-reported, rather, that rates of under-
complaining against IMGs are not as high as rates of under-complaining against non-
IMGs. Construing the problem in that way may sound less prejudicial, but it would
amount to the same bias in terms of the findings from the First Study.

The Second Study permits some investigation of complaint bias. As already described
in detail in the previous chapter, a higher odds ratio for complaints received, followed
by a lower odds ratio (albeit still $>1$) for investigation/hearing, may be indicative of
disproportionately more inconsequential complaints being made against IMGs than non-
IMGs. The more complaints that progress through the stages of the disciplinary process
and result in adverse findings, the less convincing complaint bias becomes as an
explanation. Of course, the possibility that non-IMGs are being under-reported still
remains, as does the argument that the decision makers, such as the boards and
tribunals, demonstrate prejudice against IMGs of particular types and so are not treating
complaints consistently. Assertions of decision maker bias are easy to make and very
difficult to rebut. Suffice to say, it is the author's view that one should generally
proceed on the basis that no such bias exists among judicial decision-makers unless and
until one has real evidence to the contrary. Humphrey et al's analysis of inquiries
received by the General Medical Council, published in 2011, was designed to test just
such an assertion about the similar body in the United Kingdom.\footnote{Charlotte Humphrey, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ.} The study found
that non-UK trained doctors were more likely to receive 'high impact' decisions at each
stage of the Council process, leading to referral to the next stage, or to eventual
removal from practice. Perhaps unsurprisingly, however, the authors were not able to
conclude whether there were real differences between the groups referred to the Council
or whether the differences that were seen were evidence that the Council processes
discriminated against certain groups of doctors.
b) Conduct and performance of IMGs is inferior to that of non-IMGs

As recognised by Humphrey et al, the alternative interpretation (to one of prejudice in the complaints and disciplinary system) is that the results of the studies indicate that certain groups of IMGs conducted themselves, or performed, in a manner that was in some way inferior to non-IMGs. Leaving aside the above criticisms, it appears that IMGs trained in the following countries, and groups of countries, are at particularly at risk: non-Competent Authority countries; and, specifically, a range of Asian, Eastern European and African countries; and that the risk for some groups (at least at the Tribunal stage) appears to be especially high in relation to some particular types of misconduct.

What might it be about IMGs trained in the above (groups of) countries that may be responsible for this outcome? The next part of this chapter seeks to answer that question, raising a number of possibilities as to why the conduct and/or performance of some of these doctors may be suboptimal and, consequently, exposing the public to risk.

IV IMGs, AND CONDUCT AND PERFORMANCE

A Introduction

It is unlikely that the methodological and sociological limitations described above are responsible for the entire difference in complaints and disciplinary profile observed between non-IMGs and the particular groups of IMGs that have been identified. If one concludes, therefore, that certain groups of IMGs are at heightened risk of performing and behaving below the required standard, what are the possible reasons for that phenomenon? This section explores a range of possible explanations (including inadequate assessment and supervision; differences in training, experience and cultural expectations; and lack of support) that have been mooted for the perceived underperformance of some groups of IMGs in Australia (and, to a limited degree, New Zealand).
B Possible explanations

1 Inadequate assessment, bridging/orientation, and supervision

It is recognised throughout the academic literature that IMGs face language, communication, professional and cultural barriers upon commencement of practice in Australia. In 2011, the House of Representatives Standing Committee on Health and Ageing conducted an inquiry into registration processes and support for overseas trained doctors. The resulting report entitled ‘Lost in the Labyrinth’ makes a number of recommendations for improvement to registration processes for IMGs but notes that any such changes must be achieved without compromising public safety. The challenges faced by both IMGs and those responsible for making registration decisions are well summarised in the following passage from the AMC’s submission made to that inquiry:

There is considerable diversity in the format, content and methodology of medical training across [overseas medical] courses. Equally, there are significant variations in:

- The clinical context of medical practice, including the burden of disease, levels of technology and the delivery of health services.
- Professional ethics, including non-discriminatory treatment and the rights of all patients.
- The educational context, including principles, systems and delivery of medical education.

These factors have been shown to impact on the ability of an IMG to integrate into the medical workforce.

This variation means that assessment, supervision and support are critically important in ensuring that IMGs allowed to practice in Australia and New Zealand will do so safely.

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700 Australian Medical Council, ‘Submission to House of Representatives Standing Committee on Health and Ageing on the Inquiry into Registration Processes and Support for Overseas Trained Doctors’ (4 February 2011).
and appropriately. However, it is not clear that, historically, these measures have been adequately organised and implemented.

a) Inadequate assessment

There is a large cohort of IMGs who are coming through the system and are being registered ... without anybody having assessed their skills at all.\(^{701}\)

The worrying point is that there are many IMGs undertaking surgery who have never been required to be assessed.\(^{702}\)

Indeed, inadequate assessment prior to registration is the most oft-cited reason for concerns about IMGs skills and capabilities.\(^{703}\) The Australian registration processes for IMGs, together with the proliferation of limited registration categories, is described in chapter 2 above.\(^{704}\) To recap, various types of limited registration are available for IMGs who are not qualified for general or specialist registration. To become registered in any of the limited registration categories (or for specialist registration), there is no requirement to first pass any component of the AMC assessment process. Rather, assessment of skills was, until Nationalisation, the domain of state medical boards and individual employers, with no nation-wide consistency as to how that assessment was

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\(^{702}\) Professor John Collins, Dean of Education, Royal Australasian College of Surgeons, cited in ibid.

\(^{703}\) For studies that investigate the recognition of IMG qualifications generally, see Lesleyanne Hawthorne, 'Migration and Education: Quality Assurance and Mutual Recognition of Qualifications' (UNESCO, 2008); Joint Standing Committee on Migration, 'Negotiating the Maze: Review of the Arrangements for Overseas Skills Recognition, Upgrading and Licensing' (Commonwealth of Australia, 2006); Lesleyanne Hawthorne, 'UNESCO Global Comparison Study: Migration and Education Quality Assurance and Mutual Recognition of Qualifications: Country Report: Australia' (UNESCO, 2008).

\(^{704}\) See p27. For additional studies discussing the AMC process and use of limited registration, see Postgraduate Medical Council of Victoria, 'Overseas Trained Doctors in the Victorian Public Hospital System' (PMCV, 2002); Lesleyanne Hawthorne and Julie Toth, 'The Impact of Language Testing on the Registration of Immigrant Doctors' (2005) 2(3) People and Place 47.; Lesleyanne Hawthorne, Bob Birrell and Doris Young, 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria' (University of Melbourne, 2003); Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007);Lesleyanne Hawthorne, 'Doctor Shortages and Their Impact on the Quality of Medical Care in Australia' (2002) 10(3) People and Place 55.; Robert Birrell, 'Australian Policy on Overseas-Trained Doctors' (2004) 181(11) MJA 635.
It was a process driven by mal-distribution and undersupply. For example, as of 2003, the Royal Australasian College of Surgeons (RACS) had no mechanism for controlling the appointment of overseas-trained surgeons, as they were recruited directly by state hospitals as non-accredited surgical registrars regardless of RACS views of those doctors' registration status. States competing with one another to attract IMGs also had an interest in making their own registration processes as easy as they could for IMGs. This led to a gradual whittling down of the requirements imposed by states for medical registration.

An additional barrier to IMGs becoming ready for full registration is the current waiting time for sitting the clinical examination component of AMC accreditation. Thousands of IMGs are stuck in this process, unable to obtain full registration.

Lack of adequate assessment was identified in the Davies Report as a major contributor to Dr Patel, and other IMGs, being negligently registered and employed in Queensland. The Report found that several Queensland hospitals and the Queensland Medical Board failed to verify independently the credentials of IMGs and to assess the suitability of those IMGs for the positions to which they were to be appointed. The Report suggests that this was a situation that was likely to be also happening elsewhere.

One of the things that has typically made qualification and background due diligence difficult for the Boards is the extraordinary mobility, both nationally and internationally, that is a feature of many IMGs' pathways to Australian registration. For example,

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705 In 2007, the AMC estimated that it only saw as few as a third of all IMGs in Australia: Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007), p77.
706 Ibid, p22.
707 Bob Birrell, Lesleyanne Hawthorne and Virginia Rapson, 'The Outlook for Surgical Services in Australasia' (Monash University, 2003).
710 For additional discussion on the movement of IMGs within Australia, see: Rural Workforce Agency of Victoria, 'Victorian Rural General Practice Workforce: Planning for 2002-12: Summary Report' (RWA, 2003); Lesleyanne Hawthorne, Bob Birrell and Doris Young, 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria' (University of Melbourne, 2003). For material regarding the international migration patterns of IMGs who end up in Australia, see: Jean-
both Dr Patel and Dr Hasil had practised in several different countries, having been
deregistered and had other sanctions imposed in some, and having been refused
registration in others. Until recently, the absence of a single medical register in
Australia made it difficult to track a doctor’s registration and discipline history within
that country (let alone internationally) and led to inconsistent registration decisions
being made across the states. Dr Hasil, for example, was refused registration by other
states in Australia before becoming registered in New South Wales.

Such inconsistencies should now be consigned to history as, on 1 July 2010, with the
enactment of the National Law Act, two key parts of the assessment picture changed:
first, a national health practitioner register was created; and secondly, the new nationally
consistent model of assessing IMGs was enshrined in legislation. All doctors registered
to practice in Australia must now have their details recorded on the national health
practitioners register, which is maintained and administered by the Australian Health
Practitioners Regulatory Agency (AHPRA). Having just one place to check the
status of an IMG’s registration should make it harder for doctors to slip through the
cracks as a result of domestic relocation.

The need for a nationally consistent model for assessment of IMGs was first formally
mooted by the Productivity Commission in 2005 in its report entitled ‘Australia’s health
workforce’. The Commission noted the widespread support for national consistency
in this area, and the proposal to adopt a national assessment process for [IMGs] to
ensure appropriate standards in qualifications and training as well as increase the
efficiency of the assessment process was accepted by the Council of Australian

Christophe Dumont and Pascal Zurn, ‘Immigrant Health Workers in OECD Countries in the Broader
Context of Highly Skilled Migration’ in International Migration Outlook (OECD, 2007); Bob Birrell
and Lesleyanne Hawthorne, ‘Medicare Plus and Overseas-Trained Medical Doctors’ (2004) 12(2)
People and Place 84; Bob Pond and Barbara McPake, ‘The Health Migration Crisis: The Role of Four
David Barton et al, ‘Victoria’s Dependence on Overseas Trained Doctors in Psychiatry’ (2003) 11(1)
People and Place 54; Department of Health and Ageing, ‘Report on the Audit of Health Workforce in
Rural and Regional Australia’ (Commonwealth of Australia, 2008); Edward Miller et al, ‘Emigration
of New Zealand and Australian Physicians to the United States and the International Flow of Medical

711 See p9 for details of the new national framework, including AHPRA.
(22 December 2005).
Governments (CoAG) in 2006. This led to the development of the pathways described in chapter 2. These processes then became part of the National Law Act, which included the objective of facilitating the rigorous and responsive assessment of IMGs With decisions as to registration outcomes now being made by the National Board, or at least according to uniform policy, any impact of previous interstate competition in lowering registration standards should be removed.

Another initiative that has been introduced recently, is the Pre-employment Structured Clinical Interview (PESCI). This is a form of assessment that may be ordered by the MBoA in order to determine whether a particular practitioner has the required skills for the position they are intending to assume, and to establish any supervision or conditions that may be required. As noted by the AMC, this is a reflection of the fact that in the interests of public safety, as the level of risk increases [such as with specialist appointment] so should the rigour of the assessment.

In Lost in the Labyrinth the House of Representatives Standing Committee on Health and Ageing, made several recommendations touching directly on IMG assessment. In particular, the Committee Report recommends that:

a) objective guidelines be developed and published clarifying how overseas qualifications, skills and experience are assessed for those seeking specialist registration;

b) workplace-based assessment, rather than specialist college examinations, be used to assess the clinical competence of those seeking specialist registration;

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713 Council of Australian Governments, 'Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions' (CoAG, 2008).
714 See p27 onwards.
715 National Law Act, s 3(2)(d).
716 Australian Medical Council, 'Submission to House of Representatives Standing Committee on Health and Ageing on the Inquiry into Registration Processes and Support for Overseas Trained Doctors' (4 February 2011).
718 Ibid, rec 8.
c) prior to undertaking practise in an Area of Need or other position where supervision is likely to be limited, IMGs be placed for a period in a teaching hospital, base hospital or similar setting in order to allow their clinical competence to be assessed and assist with their orientation to the Australian healthcare system.719

b) Inadequate bridging/orientation

Bridging programmes are a means of skill development and orientation to facilitate registration and employment. They may take many forms and may be designed for the period prior to assessment and registration or may be implemented concurrent with the commencement of an IMG’s practice in Australia.

The comprehensiveness of such programmes also differs markedly from provider to provider, and area to area. Despite heavy investment in bridging support in some areas (by organisations such as the Rural Workforce Agency of Victoria), the major limitation of these programmes throughout Australia continues to be funding. In addition, according to the AMC, bridging and other support programmes have sometimes targeted the wrong groups.720 As a consequence, bridging support for many IMGs has been inadequate, particularly outside of Victoria.721 Adopting the recommendation in the Committee’s Report, that IMGs spend a period being orientated to the Australian health care system prior to commencing isolated practice, would be a positive step towards addressing this issue. Another promising recommendation in the Committee’s Report is that a program of orientation be made available to all IMGs and their families to assist them with adjusting to living and working in Australia.722

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719 Ibid, rec 15. This also relates to the points made below in relation to supervision.
Specifically, those orientation materials are recommended to include 'an introduction to the Australian healthcare system'\textsuperscript{723}

c) Inadequate supervision

As well as lack of proper assessment and orientation, the Patel case exposed failures to provide supervision to Dr Patel in accordance with his registration conditions. Instead, Dr Patel was made the Director of Surgery and allowed to practise independently of any medical colleagues who would have been in a position to assess the quality of his work.\textsuperscript{724} As expressed in the Davis Report:

\begin{quote}
[I]n the case of each of Dr Patel at Bundaberg Base Hospital, and Dr Krishna and Dr Sharma at Hervey Bay Hospital, the applications for registration indicated that each would be supervised, although that could never have occurred at either place, and Dr Nydam at Bundaberg and Dr Hanelt at Hervey Bay knew that. It would have been appropriate in the interests of patient safety, for the Board not only to impose a condition on the registration of each, that he be so supervised, but to ensure that such a condition was enforced.\textsuperscript{725}
\end{quote}

In its recent submission, the AMC emphasised the need for recognition that where there is a trade-off in assessment, such as through fast-tracking particular groups of IMGs, there needs to be a corresponding increase in the level of monitoring of clinical performance and patient outcomes.\textsuperscript{726} The submission noted specifically that ongoing assessment of Dr Patel's clinical outcomes would have raised a red flag long before the whistle was blown on his practice. The AMC goes on to describe 'the availability of appropriate supervision' as 'a critical element in the development of more efficient processes for the assessment and registration of IMGs'\textsuperscript{727}

\textsuperscript{723} Ibid, rec 40.
\textsuperscript{725} Ibid, para 6.100.
\textsuperscript{726} Australian Medical Council, 'Submission to House of Representatives Standing Committee on Health and Ageing on the Inquiry into Registration Processes and Support for Overseas Trained Doctors' (4 February 2011).
\textsuperscript{727} Ibid, p29.
Historically, however, it is those IMGs most in need of supervision who have been the least likely, due to geographical factors, to receive it. As noted above, one of the solutions to this problem proposed in the Committee’s Report is that IMGs spend a period of time in a setting where supervision is readily available before being placed in Areas of Need or other settings where supervision is less likely to be available. The Committee’s Report also recommends exploring the innovative use of new technologies to increase clinical supervision capacity in such locations.\footnote{House of Representatives Standing Committee on Health and Ageing, ‘Lost in the Labyrinth: Report on the Inquiry into Registration Processes and Support for Overseas Trained Doctors’ (The Parliament of the Commonwealth of Australia, 2012), rec 14. See also recommendation 40 of the Committee’s Report.}

Possibly in response to the Committee’s Report, in AHPRA’s 2011/12 Annual Report the MBoA has announced a review of supervision arrangements for IMGs as one of its priorities for the 2012/13 year.\footnote{Australian Health Practitioners Regulation Agency, ‘Annual Report 2011/12’ (AHPRA, 2012).}

d) Worst for limited registration types?

The above considerations have led to the view among many academics and commentators that the lack of adequate assessment and supervision that often accompanies temporary registration is what puts the public at risk. Certainly, in the case of Dr Patel, this appears to have been the case. However, that conclusion is not supported by the results of the Second Study. Alongside other variables, registration type was evaluated as an independent predictor of complaints and adverse findings.\footnote{See p181.}

For specialist registrants, the odds of being subject to each stage of the complaints and disciplinary process were actually significantly lower than for general registrants. For IMGs registered under the Area of Need provisions, the odds of receiving a complaint were also lower than for general registrants, but there was no significant difference for the other stages of the disciplinary process. The study, therefore, cuts against the thesis that doctors with limited registration (particularly those with Area of Need registration) are more likely to be the subject of complaints or to be found guilty of misconduct than doctors with general registration.
It is plausible that, in Areas of Need, the community and other health workers are so desperate for medical assistance, that they are willing to overlook quality and safety shortcomings to a greater degree than would be the case for a less vulnerable community. As noted by Ian Frank, Chief Executive of the AMC, ‘constantly we hear from the health authorities: “it doesn’t matter what the standard of this guy is. We need to have a doctor in that town.”’ Indeed, the Davies Report found that internal hospital complaints made about Dr Patel, and there were lots of them, were minimised or ignored by hospital management who had no proper complaints system in place and were focussed on ensuring Dr Patel could continue to contribute towards achievement of budget through high elective surgery throughput. A recent study by Harding et al has found that patients’ perceptions of rural general practitioners did not differ significantly according to whether or not the doctor was an IMG. However, in their discussion of the results, the authors acknowledge that, in rural areas, doctor choice is often limited.

2 Lack of social and professional support

Another possible explanation for the IMG effect identified in the Studies could be that IMGs are relatively unsupported in Australia and New Zealand. Lack of support may be in terms of the IMG’s personal situation, with friends, family and sometimes a spouse and children living in another country. Other IMGs, forced to practice in rural locations, live apart from their spouse and children, who live in the nearest city in order to ensure high quality education for the children or access to career opportunities for the spouse. Any such situation that compromises an IMG’s personal wellbeing has very real potential to impact on the performance of that IMG’s professional duties.

Lack of support from Australian trained colleagues and other health professionals has also been cited as a problem. In their article in the Medical Journal of Australia which,

734 Lesleyanne Hawthorne, Bob Birrell and Doris Young, 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria' (University of Melbourne, 2003).
735 Ibid.
interestingly, predates the Patel scandal, Srivastava and Green tell the confronting story of the barriers faced by IMGs within the Australian health system.\textsuperscript{736} They write of the derogatory connotations of being labelled an ‘AMC doctor’ the ‘barbed remarks’ from colleagues, the ‘glaring lack of encouragement’ and the indignity of ‘working in an unsupported and hostile environment as a second-class doctor’ even once having achieved the very high standard required for AMC certification. However, it may be that the focus on that examination may itself be problematic; as observed by the AMC in its submission to the Standing Committee, the focus of various initiatives has

\[ \text{é} \] \text{often been on passing examinations and securing registration, rather than providing ongoing support to IMGs and facilitating their integration into the medical workforce in Australia.}\textsuperscript{737}

As well as being ethically preferable in terms of the interests of the IMG, fair treatment of IMGs also has other general social benefits. First, Australia\textsuperscript{\textregistered} and New Zealand\textsuperscript{\textregistered} dependence on IMGs is such that both countries need to continue to attract and retain such doctors. Secondly, like any doctor, an IMG who is both personally and professionally supported is probably less likely to put patients at risk.

Many of the recommendations in the Committee\textsuperscript{\textregistered} Report focus on increasing and making such supports more accessible for IMGs. Along with the provision of personal and professional support, there is recognition of the difficulties and frustrations often faced by IMGs in trying to pass the various regulatory hurdles along the pathway to registration in Australia.\textsuperscript{738} This situation, and the Committee\textsuperscript{\textregistered} priorities for change, are aptly reflected in the following words taken from the Forward to the Committee\textsuperscript{\textregistered} Report:

\[ \text{é} \] \text{it is my sincere hope that the report’s recommendations will help to resolve the administrative difficulties faced by many IMGs, and ensure that those

\textsuperscript{736} Ranjana Srivastava and Declan J Green, ‘What’s in a Name?’ (2004) 181(11/12) \textit{MJA} 643.
\textsuperscript{737} Australian Medical Council, ‘Submission to House of Representatives Standing Committee on Health and Ageing on the Inquiry into Registration Processes and Support for Overseas Trained Doctors’ (4 February 2011), p31.
wishing to practice medicine and call Australia home in future may do so with certainty and clarity of what is expected of them.\footnote{Ibid, pxii.}

3 \textit{Differences in training, experience and cultural expectations}

Having found that the IMG effect seen in the Studies is independent of registration type and practice location, it is necessary to consider other possible explanations. Perhaps the lack of clarity of expectation, noted above, has a part to play.

The groups of IMGs who appear most at risk of complaints or disciplinary action are those from countries where medical training and practice is very different to Australia and New Zealand. Quite simply, doctors whose training and experience occurred in some of those countries may find the adjustment to diagnosing diseases as they present in the developed world, using more advanced technology, and negotiating the Australian and New Zealand health systems, very difficult.

As noted by Fiscella et al, in the US context, IMGs are

\begin{quote}
... often confronted by a series of transcultural challenges that include not only language, but also culture, lifestyle, sex-role differences, discrimination, and changes in status.\footnote{Kevin Fiscella et al, "Being a Foreigner, I May Be Punished If I Make a Small Mistake": Assessing Transcultural Experiences in Caring for Patients' (1997) 14(2) \textit{Family Practice} 112, p112.}
\end{quote}

One such challenge identified in their research was that many male IMGs from India and Pakistan have never been taught how to take sexual histories or perform genital examinations of female patients, as a male doctor would not generally perform this task in those countries.\footnote{Ibid.} This discomfort and inexperience may mean that the IMG does not understand what he is doing or when such an examination is indicated and so ends up doing unwarranted intimate examinations or performs them in a rough or unskilled way.

The risk for IMGs around sexual misconduct issues is also apparent from the results of the First Study where IMGs were found to have three times the odds of being found guilty of sexual misconduct (not involving a sexual relationship) than non-IMGs. In

\footnotesize
\begin{itemize}
\item \footnote{Ibid, pxii.}
\item \footnote{Kevin Fiscella et al, "Being a Foreigner, I May Be Punished If I Make a Small Mistake": Assessing Transcultural Experiences in Caring for Patients' (1997) 14(2) \textit{Family Practice} 112, p112.}
\item \footnote{Ibid.}
\end{itemize}
four of the cases where IMGs (trained in countries including India, Iran and Hong Kong) were found guilty of sexual misconduct, the Tribunal made specific observations about the lack of knowledge and cultural misunderstandings of the doctor concerned.

In *Re Dr A*,\(^{742}\) the patient attended the doctor feeling unwell and with lumps in her armpits and groin area. The doctor undertook several unnecessary and unjustified examinations, including a breast examination, and a digital vaginal examination. The Tribunal found that the doctor’s conduct was due to his lack of confidence and competence and was not motivated by sexual or moral impropriety. The Tribunal noted the difficulties the doctor had experienced in adapting to life in New Zealand, and the gap between his academic abilities and his practical skills. In *Re Dr Tong Eng Gan*,\(^ {743}\) similar issues arose for the doctor who performed unnecessary breast and ungloved vaginal examinations on several women with insufficient explanations and no informed consent. He also failed to provide the women with sufficient privacy while undressing and made inappropriate comments about their breasts. The Tribunal accepted that his behaviour was not sexually motivated but came from a lack of understanding about appropriate behaviour. Unorthodox breast examinations are also described in *Re Behzad Alizadeh*\(^ {744}\) and in *Re Dr Mohammed Mateen Ui Jabbar*\(^ {745}\).

It could be that specific, targeted training of IMGs from particular countries would yield results in this area thus protecting patients from unnecessary risk or harm, and ensuring IMGs are well equipped to behave in the way expected of them.

4 Communication difficulties

Another type of misconduct that the First Study found IMGs to be at greater odds of being found guilty of is the failure to appropriately obtain informed consent. Obtaining informed consent has two key aspects: first, the recognition that the patient’s views and wishes are paramount and the patient (in most cases) is entitled to make their own health care decisions; and secondly, the ability to communicate information to, and

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\(^{742}\) *Re Dr A*, MPDT(NZ), 181/01/78C, 10 December 2001.

\(^{743}\) *Re Dr Tong Eng Gan* [2004] MPBV 23.

\(^{744}\) *Medical Board of Western Australia v Dr Behzad Alizadeh* [2007] WASAT 52.

\(^{745}\) *Re Dr Mohammed MateenUi Jabbar* [2007] MPBV 4.
receive information from, a patient in the course of obtaining the consent. The first of these elements may represent a significant cultural shift in the understanding of the doctor-patient relationship for some IMGs, particularly IMGs from countries where medical interactions are still characterised by paternalistic attitudes towards patients. However, it is also possible that failures in informed consent are symptomatic of more general communication difficulties.746

While English-language standards are imposed on IMGs in Australia, effective communication is about much more than technical use of language, and can be very culturally specific. Cross-cultural communication carries with it an increased risk of misunderstanding. Communication difficulties may be partly responsible for the increased complaint risk experienced by IMGs, particularly when the countries that feature strongly in the results of the Second Study are considered. This impact may be seen in increased numbers of complaints relating to communication (including communication-dependent issues such as informed consent), but also in increased numbers of complaints about other matters. It is axiomatic that good communication skills are protective when it comes to complaint risk. If a doctor is able to appropriately explain an issue or address a patient’s concern or unease, a complaint is much less likely to follow. As noted by the UK doctor, philosopher and writer Raymond Tallis:

Avuncular, kindly doctors… are more likely to get away with technically poor medicine than a brusque, technically competent doctor will get away with failing to show he cares. The process often weighs more in patients’ judgment of their care than the outcome.747

It is argued that the same protection is experienced by doctors who are skilled communicators, able to successfully portray themselves as competent and caring, and that poor communication skills (including in terms of the cultural aspects of communication) are likely to put a doctor at increased risk of complaint, both complaints relating to communication itself as well as other, unrelated, complaints.

746 Note that the issue of IMG communication skills was formally reviewed by AHPRA in 2013.
V OTHER PUBLIC INTEREST (INCLUDING PUBLIC PROTECTION) IMPLICATIONS

A Balancing public protection against public interest: Quality and acceptability vs availability

As discussed above, there are particular groups of IMGs practising medicine in Australia and New Zealand who have greater risks of being subject to complaints and/or of being found guilty of professional misconduct than their non-IMG colleagues. However, can it be argued that the potentially increased risk of registering such practitioners is justified, given serious workforce shortages? The crux of the issue is emphasised in the following comments from the Chair of the Victorian Rural Workforce Agency and Australian Medical Association committee member, Dr Sam Lees, and from the Chief Executive of the Australian Medical Council, Ian Frank:

The bottom line is that in certain areas, if we weren’t able to access [IMGs], the communities wouldn’t have any medical services at all.748

[I]t’s evident that whenever you have a major workforce shortage, issues of quality and safety tend to become less important. The thinking behind putting numbers ahead of safety and quality is a really serious issue.749

Much more recently, the AMC, in its submission to the Inquiry Committee made a similar observation:

It appears that in times of perceived workforce shortage, considerations of workforce supply may take precedence over issues of standards with potentially adverse outcomes for patient safety.750

Whether or not a doctor who poses a higher risk to the public should be preferred to no doctor at all, is a decision for the policy makers and, through the political process, the public, to make. However, in order to make such assessments in an informed manner, it

is necessary to understand the degree of risk involved. Clearly, a community would be better off with no doctor at all than a doctor who represents the degree of risk shown by Dr Patel but he, of course, was not typical. Decisions about risk cannot legitimately be made on the basis of the outliers. So what do the results of the Studies reveal about ‘average’ levels of risk and how can those lessons be applied in terms of balancing public protection against public interests in developing IMG workforce policy?

There are seven source countries of particular interest, given their increased odds of complaints: Nigeria, Egypt, Poland, Russia, Pakistan, the Philippines, and India. However, the study findings should be interpreted in light of the fact that multivariable models estimate the strength and significance of the association between IMG status and complaint risk, not the contribution of IMGs to the overall burden of complaints and adverse findings. Table 20 below gives the absolute numbers for complaints for doctors trained in each of those countries in order to give the results some perspective.

Table 20. Number of complaints received regarding doctors trained in selected countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall no. of doctors</th>
<th>No. of doctors with complaints (%*)</th>
<th>No. of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>24,542</td>
<td>2,260 (9)</td>
<td>3,728</td>
</tr>
<tr>
<td>Nigeria</td>
<td>124</td>
<td>15 (12)</td>
<td>21</td>
</tr>
<tr>
<td>Egypt</td>
<td>292</td>
<td>61 (21)</td>
<td>116</td>
</tr>
<tr>
<td>Poland</td>
<td>95</td>
<td>18 (19)</td>
<td>28</td>
</tr>
<tr>
<td>Russia</td>
<td>120</td>
<td>13 (11)</td>
<td>38</td>
</tr>
<tr>
<td>Pakistan</td>
<td>228</td>
<td>15 (7)</td>
<td>25</td>
</tr>
<tr>
<td>The Philippines</td>
<td>148</td>
<td>13 (9)</td>
<td>18</td>
</tr>
<tr>
<td>India</td>
<td>1,871</td>
<td>153 (8)</td>
<td>291</td>
</tr>
</tbody>
</table>

* Percentage with overall number of doctors trained in that country in the sample used as the denominator.

Despite disproportionately high complaint rates among doctors trained in certain countries (for example, Nigeria and Egypt), their contribution to total complaints was small. Consideration of total complaints spotlights India as especially important. Indian-trained doctors had 60% higher odds of attracting complaints than Australian-
trained doctors and they accounted for 5% of the total complaints lodged during the study period.751

Focussing any remedial attention on doctors trained in the above countries, particularly those trained in India, would arguably have the greatest public protection impact; however, such focus could also have the greatest public interest detriment, if it resulted in a decreased supply of doctors trained in those countries. Perhaps the best approach would be for further research to investigate the specific types of complaints typically being received in relation to IMGs trained in these countries, and to explore whether particular targeted interventions (such as training in gynaecological examinations and informed consent, as discussed above) could be implemented to address public protection considerations while not compromising public interest in ongoing supply beyond what is absolutely necessary for public protection.

It is difficult to find the correct balance between public protection and the public interest in supply. However, that balancing exercise is only relevant to the Boards to the extent that their empowering legislation allows these dual considerations to be taken into account in decision-making. As argued in chapter 4, pre-Nationalisation, none of the Jurisdictions specifically allowed for this. So, rather than undertaking a balancing exercise, the correct approach was to first designate the acceptable level of risk and then to make registration decisions designed to keep risk below that threshold irrespective of the possible implications for workforce supply. If that approach led to supply becoming too far compromised, this should have been addressed via other, non-Board, mechanisms, such as changes to immigration policy or amendments to the legislation. The National Law Act merged these competing considerations at the level of a single decision-maker, with ensuring the supply of health practitioners now a specific objective that may legitimately colour the Boards’ decision-making processes. In New Zealand, however, no such change has yet been made: the HPCA Act still requires that the MCNZ to make decisions on the basis of public protection as the overarching objective.

As noted above, the distribution of IMGs around Australia and New Zealand is not uniform. Particularly in Australia, IMGs are concentrated in rural and remote areas that find it difficult to attract locally-trained doctors. This has led some commentators to suggest that the overreliance on IMGs in such areas is creating a two-tier system of medicine:

"It has been going on for 50 years that rural areas rely on IMGs and it’s a little bit like experimenting on rural citizens, which is not right. Doctors should, if they are allowed to work, be accepted as Australian doctors. If (they are) not (acceptable), they should not be allowed to work as doctors at all."

This concern, however, does not appear to be borne out by the results of the Second Study. Although particular types of IMGs were found to represent higher risk to patients, there was no positive correlation between rural location or temporary registration types, respectively, and rates of complaints or discipline. As postulated earlier, this may possibly be attributed to an increased tolerance in rural and remote locations for less than perfect medical care. Patients living in such communities are more likely to be aware of the reality that their options for alternative doctors are limited. Communities may well have a shared acceptance that an imperfect doctor, IMG or not, is better than no doctor at all, thus raising their complaint thresholds. This is, of course, pure speculation; the results of the study simply show that doctors practicing in rural settings were not at higher risks of complaints or adverse findings.

There will always be selection mechanisms that mean the more desirable areas to work attract the best doctors. However, the key is to ensure that all doctors who are registered to work, in Areas of Need or otherwise, meet the minimum safety thresholds that are acceptable to the public. Beyond that, one enters the domain of quality improvement rather than being concerned about pure public protection.

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Thus far, this thesis has defined the public narrowly: first as recipients of medical care, when discussing public protection, then, when discussing public interest, as those within the relevant jurisdictions who wish to become recipients of medical care. This section widens that focus to consider the interests of the wider public, recognising that, by its nature, Australia's and New Zealand's utilisation of large numbers of IMGs has global implications.

1 International shortages

According to WHO, there is not a country in the world that is not facing major health workforce challenges Overall, there is an estimated global deficit of approximately 4.3 million health workers and it is projected that this number will grow over the coming years. Although health workforce shortages occur in both rich and poor countries, the size of the problem differs by orders of magnitude. While Australia has approximately 2.47 doctors per 1000 persons and New Zealand has 2.6, many African nations have doctor densities of less than 0.05 per 1000 persons, including Malawi and Tanzania at only 0.02. Similarly, the WHO Region of the Americas has only 10% of the global burden of disease yet 37% of the global supply of health workers and consumes more than 50% of the global health spend; while the African Region has 24% of the burden but only 3% of the health workers and 1% of the health expenditure. The greatest relative shortage is in sub-Saharan Africa, where an increase of 140% would be required to reach the critical density threshold set by WHO, but the greatest absolute shortage is in South-East Asia (principally Bangladesh, India and Indonesia).

754 Ibid.
755 Ibid Annex, Table 4. The Australian data is correct as at 2001, while the Malawian and Tanzanian data are correct as at 2004 and 2002 respectively.
756 In addition, far fewer of the health workers in the African Region are medical practitioners as opposed to, for example, nurses or community workers: ibid.
757 Ibid.
As well as the difference in magnitude, reasons for the supply problems in developing countries are not the same as the reasons for shortages in Australia and New Zealand (as outlined above). Instead, infectious disease epidemics and their legacies of chronic disease affect both sides of the supply and demand equation. Notably, HIV/AIDS has vastly increased the disease burden while also causing many health workers to exit the workforce (due to sickness, death or migration).\textsuperscript{758} In addition, where local market conditions are sub-optimal (for example, wages are low or conditions are poor), shortages based on need can co-exist with unemployment of health workers\textsuperscript{759}. This is, of course, not helped by the migration of health workers, including doctors, from such countries to the developed world.

2 \textit{The impact of migration}

In 2003, WHO identified migration as a critical problem for the provision of health services in developing countries.\textsuperscript{760} For the source country, migration means the loss of services together with a loss of educational investment. The destination country, on the other hand, gains a trained doctor without having to invest in that training.\textsuperscript{761} This 'perverse subsidy' means that some developing countries end up investing in education on the behalf of developed countries.\textsuperscript{762} The impact of this is even greater than the numbers portray as research shows that it is the highest academic achievers who tend to migrate.\textsuperscript{763}

In 2008, the Australian Department of Health and Ageing reported that long-term trends showed the percentage of IMGs had increased significantly in most OECD countries.\textsuperscript{764} The Report goes on to cite Canada, the United Kingdom, New Zealand,

\begin{itemize}
\item \textsuperscript{758} Ibid; Linda Ogilvie et al, 'The Exodus of Health Professionals from Sub-Saharan Africa: Balancing Human Rights and Societal Needs in the Twenty-First Century' (2007) 14(2) \textit{Nursing Inquiry} 114.
\item \textsuperscript{761} How that destination country decides to regard that training, in terms of whether it is recognised or not, is another issue, as discussed in chapter 2 and earlier in this chapter.
\item \textsuperscript{762} Kwadwo Mensah, Maureen Mackintosh and Leroi Henry, 'The 'Skills Drain' of Health Professionals from the Developing World: A Framework for Policy Formulation' (Medact, 2005).
\item \textsuperscript{763} Manas Kaushik et al, 'High-End Physician Migration from India' (2008) 86(1) \textit{Bulletin of the World Health Organization} 40.
\item \textsuperscript{764} Department of Health and Ageing, 'Report on the Audit of Health Workforce in Rural and Regional Australia' (Commonwealth of Australia, 2008), p26.
\end{itemize}
and the United States of America as examples.\textsuperscript{765} India and the Indian subcontinent have the largest absolute number of doctors who migrate internationally. However, in a number of Caribbean and African countries, the percentage of doctors who migrate is higher, leading to an even much more devastating impact on the functioning of the health systems concerned.\textsuperscript{766}

Despite the above, some argue that the migration of doctors from developing countries to developed countries should be encouraged as such globalization leads to collaboration, skill and idea sharing, and gains in source countries from returning or visiting emigrants\textsuperscript{767}. As well, some of the money earned by migrants is often returned as remittances to the source country. In 2008, officially recorded remittances from all workforce sectors amounted to $265 billion, the biggest single flows going to India, China, Mexico and the Philippines, which received between $18 billion and $30 billion each. In Latin America and the Caribbean, 61\% of the region’s 2008 GDP came from remittance income.\textsuperscript{768} In light of these potential benefits, some middle income countries, such as the Philippines, have begun training doctors expressly for export.\textsuperscript{769} While the Philippines benefitted from this programme initially, there is evidence that the Philippines is now experiencing its own shortage of health professionals.\textsuperscript{770} In sum, the weight of evidence suggests that

\begin{itemize}
  \item \textsuperscript{765} Ibid.
  \item \textsuperscript{766} Organisation for Economic Cooperation and Development, ‘The Looming Crisis in the Health Workforce: How Can OECD Countries Respond?’ (OECD, 2008).
  \item \textsuperscript{768} Dilip Ratha, Sanket Mohapatra and Zhimei Xu, ‘Outlook for Remittance Flows: 2008-2010’ (The World Bank, 2008). However, remittances received from health workers are not necessarily reinvested into the health system and so do not necessarily provide adequate compensation for the loss of those workers: Amy Hagopain et al, ‘The Migration of Physicians from Sub-Saharan Africa to the United States of America: Measures of the African Brain Drain’ (2004) 2(17) \textit{Human Resources for Health}.
\end{itemize}
unless migration is temporary, the intellectual and financial capital accrued to sending countries does not balance the detrimental effects of losing a much-needed health workforce.\textsuperscript{771}

The experience of the Philippines in relation to training nurses for export has also been salutary, with quality impacts including a proliferation of low quality nursing schools and production of large numbers of under-skilled graduates. Nurse education has also been compromised by the educators themselves taking the opportunity to migrate.\textsuperscript{772}

Even if a country tends to receive IMGs from less poor source countries, that migration is still likely to indirectly diminish supply in the very poorest nations. As described by Pond et al, the situation is properly viewed as a hierarchy of inter-related labour markets with high income countries recruiting medical practitioners from lower-income countries, which in turn fill the gap with migrants from still lower-income countries.\textsuperscript{773} A similar phenomenon is also seen in the migration patterns of individual IMGs who, as noted above, are often highly mobile and may migrate through a number of different locations, typically from developing countries to increasingly more developed destinations.\textsuperscript{774}

While international migration trends are largely beyond the scope of this thesis, it is important to see Australia\textsuperscript{#} and New Zealand\textsuperscript{#} dependence on IMGs in a global context. This reliance clearly represents risk for the source countries and their health systems and, as demonstrated by the results of Studies, may also represent potential risk for destination countries, despite the alleviation of shortage that it may also provide. It is partly in response to these risks (for both source countries and for Australia) that Australia has begun to pursue a policy of self-sufficiency, as explained below.

\textsuperscript{771} Ibid, p119.  
Self-sufficiency as a possible solution

Principle 1 of the National Health Workforce Strategic Framework, as endorsed by the Australian Health Ministers in 2004, requires Australia to focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market.\(^775\) In late 2005, the Productivity Commission\(^776\) questioned whether Principle 1 was unduly restrictive given the international nature of the health workforce.\(^777\) The Commission expressed the view that, provided ethical protocols are complied with, migration of health workers to and from Australia is not inappropriate but provides a valuable avenue for skills transmission and through this productivity gains.\(^778\) In 2006, the Council of Australian Governments agreed to review the wording of Principle 1 but no change was made.

The above debate illustrates the two opposing schools of thought in relation to self sufficiency. The nationalist model fully endorses self sufficiency, arguing that developing nations must be enabled to retain their doctors in order to support the health of their country.\(^779\) The internationalist or cosmopolitan model, on the other hand, views the global health workforce market as just like any other global market where supply and demand dictate conditions.\(^780\) The view is that

\[
\text{[I]ike any factor of production, such human capital will move to those regions where its productivity and reward are high. In short, it will tend to flow where its use produces the greatest contribution, which will end up maximizing world output. Furthermore, those professionals left behind will enjoy opportunity and gain that they would not otherwise have had, generally adding to the social welfare of the entire society.}\]

\(^777\) Ibid, p40.
\(^778\) Ibid, p39.
\(^780\) Ibid.
\(^781\) Ibid.
While that analysis may be theoretically appealing, it does not reflect the reality of medical practitioner migration. The contribution to world health made by an individual remaining as one of two doctors serving 100,000 people in Malawi would arguably be greater than the contribution that they would make as one of 247 doctors serving the same population in Australia. Similarly, the notion that opportunities will increase for those left behind is somewhat moot when there are already insufficient numbers of qualified people to take up those opportunities, as is the case in many of the poorest nations. It is quite true that notions of self sufficiency are, as Feldstein and Butter point out, inconsistent with the approach taken in other domains, such as commerce, education and science where there is also heavy reliance on imported talent. Yet, given the fundamental importance of retaining doctors in developing countries, and the stark global mal-distribution of skills, maybe means a case for medical exceptionalism can be made.

Perhaps the debate can, at least in part, be resolved by more clearly defining what is meant by self sufficiency. While self sufficiency is not defined in the Framework, it appears that the Productivity Commission read the Framework as advocating an end to migration. This should not be the objective. What matters is whether or not Australia is producing the number of doctors that it needs. Therefore, in this thesis, the definition used by Carver is adopted, that is, the number of doctors entering Australia (temporarily or permanently) equates to the number of doctors leaving Australia (temporarily or permanently) in the same period. Self sufficiency, as a national objective, should not be about low migration per se but about achieving net zero gain. Quite conceivably this was the point behind both Principle 1 and the concerns of the Productivity Commission.

782 Ibid.
783 Sabina Alkire and Lincoln Chen, "Medical Exceptionalism' in International Migration: Should Doctors and Nurses Be Treated Differently?" (Paper presented at the Global Migration Regimes Workshop, Stockholm, 2004).
784 Peter Carver, ‘Self Sufficiency and International Medical Graduates - Australia’ (National Health Workforce Taskforce, 2008).
785 Australia currently falls well short of this ideal and is the OECD country that contributes the fourth least (behind France, Spain and the US) to the global health workforce: Des Gorman and Peter Brooks, 'On Solutions to the Shortage of Doctors in Australia and New Zealand' (2009) 190(3) *MJA* 152.
Increasing self-sufficiency in developed countries would certainly relieve some of the pressure on the health systems of developing countries. Migration that does occur could then take place in the context of true knowledge transfer rather than the one-sided exchange that typically occurs at present. Of course, achieving this might also require that the ‘rights’ of individual doctors to migrate from developing countries be constrained.

While the majority of commentators and regulators seem to agree that self-sufficiency is the primary way in which developed countries should seek to address workforce shortages and their reliance on IMGs, the practicalities of achieving this are rather more challenging. A number of initiatives have been implemented to this end in Australia to date. As categorised by Gorman and Brooks, these include initiatives to:

   a) reduce the demand for health services (via public health and preventative health programs);
   b) increase the percentage of the population employed in health services and increase the output from the current workforce (particularly through the increase in medical school places and the development of nurse practitioner and physician assistant programs);
   c) better align medical education with health system and patient care needs (including through primary-care-based medical curricula, rural medical schools, and a national system of accreditation and registration786);
   d) increase health service supply (through the use of innovative models of training and employment); and
   e) reorganise the ‘fiscal basis of the healthcare system’ including ‘the balancing of private and taxpayer contributions’787.

A 2008 OECD report on the ‘looming crisis’ in the health workforce recognises that countries essentially have four options for closing the gap between supply and demand

786 The new national system of accreditation and registration is discussed in detail in chapter 2. See p9 onwards.
for health workers: train more workers locally; encourage retention and delaying retirement; increase productivity of the existing workers; or recruit internationally.\textsuperscript{788}

In Australia and New Zealand, particular reliance has been placed on increasing the number of local medical graduates. However, there is some suggestion that increasing the number of local medical graduates in this way will simply shift the problem, as pressure is put on the supply of medical educators, residency training positions and supervision programmes.\textsuperscript{789} This effect is already being seen in the pressure put on internship availability.\textsuperscript{790}

Even so, there remains a gap between the projected number of medical practitioners needed and the number of medical graduates that will be produced.\textsuperscript{791} As recognized by the Productivity Commission, \textit{supply responses have limits and will not by themselves be sufficientâ€|to ensure self sufficiency.\textsuperscript{792} If self sufficiency is to be achieved, it will be necessary, as recognized by Gorman and Brooks, to maximise productivity within the health workforce by ensuring that skills and knowledge are fully utilized.\textsuperscript{793}

While the steps that are being taken will no doubt go some way towards achieving the ultimate goal of self sufficiency, the size of the existing shortfall and the ever rising demands of the health system mean that Australia and New Zealand are both likely to remain dependent on IMGs to some extent for the foreseeable future. As discussed, the impacts of this will need to be further explored and managed appropriately.
Before moving on from this discussion on the other public interest considerations that apply in relation to the utilisation of large numbers of IMGs, it is timely to revisit the further element of public protection outlined in chapter 4, that is, the maintenance of public confidence in the medical profession. While there may appear to be increased risks in relation to the practice of some groups of IMGs within Australia and New Zealand and an understanding of the existence and nature of such risks may be necessary to enable those risks to be addressed, it is also important that the public messages around such risks do not impact negatively on public confidence in the medical profession.

As outlined above, the impact of the Patel scandal was devastating for the public’s confidence in certain sectors of the medical workforce. Simply knowing that one Indian-trained doctor had been found to have practised in a way that epitomised unsafe and incompetent practice was sufficient to generate public reactions such as those described by Rob Walters, at that time Chair of the Australian Divisions of General Practice Ltd:

> It has got to the ridiculous stage where patients, in some areas, are cancelling surgery with skilled surgeons because of the ethnic inflection of their surnames.⁷⁹⁴

Public responses like this are not in anybody’s interests and do not serve the purpose of public protection or operate in the public interest. It is important that, if the information revealed by studies such as those described in this thesis are to have a positive effect on medical care, they are taken in context and seen as a first step towards identifying issues that may need to be addressed in a more targeted manner for some groups of IMGs than for others. Identifying and addressing any issues is far preferable, in the longer term, than pretending such issues do not exist. It is argued that this is the population-level parallel to identifying shortcomings for an individual doctor through the disciplinary process and then enhancing public confidence by imposing appropriate disciplinary

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⁷⁹⁴ Rob Walters, ‘We Need Our Foreign Doctors’, *The Australian* 7 June 2005.
consequences. In a similar way, acknowledgement of any problems that may exist and then taking appropriate remedial action has the potential to eventually enhance rather than destroy public confidence.

Encouragingly, the results of the Second Study, insofar as they relate to countries that are part of the Competent Authority Pathway, should immediately boost the public confidence in terms of the preferential treatment being afforded to applicants coming to Australia from those countries. The designation of such countries as Competent Authorities does not appear to represent any risk to public safety or satisfaction with services provided, at least not on the basis of the results about complaints and adverse findings shown by the Studies, and, in that sense, appears justified.

VI CONCLUSION

we have turned repeatedly to the rest of the world to fill shortages that have existed in many health professions for the last half century. This is bad domestic policy and bad foreign policy. 795

While medical school places have been increased and other initiatives undertaken, these changes are predicted to be inadequate. 796 Consequently, resources continue to be poured into attracting IMGs who, as a result, will almost certainly remain a significant part of the Australian and New Zealand health workforce for many years to come.

It appears that some groups of IMGs may represent an increased risk to the public compared to other groups of IMGs and non-IMGs. While the results outlined in this chapter provide some initial indications of the level and types of risk, additional research is needed to enhance understanding of the quality of IMG care and guide an appropriate regulatory response. The challenge is to ensure that IMGs are engaged in a way that minimises risk both to source countries and to patient safety on arrival, and in practice, in Australia or New Zealand.


796 Des Gorman and Peter Brooks, 'On Solutions to the Shortage of Doctors in Australia and New Zealand' (2009) 190(3) *MJA* 152.
CHAPTER 9 – KEY CASE CHARACTERISTIC:
REMOVAL FROM PRACTICE

I  INTRODUCTION

As discussed in chapter 4, having robust complaints and disciplinary processes is critical in ensuring the effectiveness of any system of professional regulation. Ayres and Braithwaite's model of responsive regulation requires that the regulator has access to real sanctions and shows readiness to impose those sanctions as appropriate. It is the very availability of such sanctions that enable most cases to be resolved without recourse to those sanctions. Consistent with that model, the complaints and disciplinary processes for doctors in Australia and New Zealand offer various levels at which issues may be resolved, as discussed in chapter 3. Even when matters progress to the most serious level, hearing by a Tribunal, there are a range of disciplinary sanctions that may be imposed on a doctor who is found to have engaged in misconduct. Removal from practice is reserved for the most serious of cases.

This chapter begins by presenting some additional results from the First Study, detailing the relationship between removal from practice and the nature of the misconduct concerned. The chapter then goes on to analyse the public protection implications of the Tribunals' approach to disciplinary sanctions. Finally, being found guilty of having a sexual relationship with a patient, the type of misconduct most strongly associated with removal from practice, is used as a case study for a more in-depth analysis of the factors that appear to drive Tribunal decision-making in relation to removal.

797 Ian Ayres and John Braithwaite, Responsive Regulation: Transcending the Regulation Debate (Oxford University Press, 1992).
798 Recall that tribunal is defined, for the purpose of this thesis, as any decision-making body that has the power to remove a doctor from practice as a result of finding them to have committed some kind of professional misconduct. Latterly, such Tribunals have become independent of the Boards, but during the earlier years of the Study Period, it was often committees of the Boards who were charged with hearing such cases and making disciplinary decisions: see chapter 3 and 6 for further details.
799 The main results reported in this chapter, along with some of the discussion, have already been published in a paper by the author (and her co-authors): Katie Elkin et al, 'Removal of Doctors from Practice for Professional Misconduct in Australia and New Zealand' (2012) 10(1136) BMJ Quality & Safety.
II  MORE FROM THE FIRST STUDY

As noted in chapter 5, previous studies have been limited in their categorisation of the nature of misconduct and in relation to the investigation of other case characteristics as predictors for explaining rates of removal from practice.\footnote{800} The First Study was designed to address some of these limitations and to provide a picture of Tribunal behaviour in the Australian and New Zealand context.

The aims, main methods and general results of the First Study are reported in chapter 6, with some additional results presented in chapter 8. In summary, the First Study was an analysis of the 485 determinations made by Tribunals in New South Wales, Victoria, Queensland, Western Australia and New Zealand between 2000 and 2009 in which a doctor was found guilty of professional misconduct. It also involved an analysis of disciplinary action taken by the Tribunals in each of the cases. Disciplinary actions were analysed to identify any associations between removal from practice, the ultimate public protection sanction, and the nature of the misconduct concerned. Supplementary methods plus additional findings are set out in this section.

A  Supplementary methods

Logistic regression analysis was used to identify variables associated with removal from practice. The outcome variable in these analyses was a binary variable distinguishing cases that resulted in removal of a doctor from practice from cases with lesser penalties (restrictions on practice or non-restrictive sanction). The predictors of interest were misconduct type and explanation for misconduct. The relationship between the outcome variable and the predictors of interest was examined using separate regression models for misconduct type and explanation type respectively, and adjusting for a range of potential confounders.\footnote{801}
Results: predictors of removal from practice

1 Univariable analysis

The doctor was removed from practice in 81% of cases in which sexual relationship with patient had occurred (Table 21). Other types of misconduct associated with high removal rates were breach of registration conditions (58%), inappropriate sexual conduct towards patient (not relationship) (53%), inappropriate conduct not in relation to patient (52%), and illegal or unethical prescribing (46%).

Among explanations for misconduct, wilful wrongdoing (69%), incompetence (61%), and personal situation (57%) all had higher rates of removal than the overall average.

Causing diagnosed psychiatric injury to a patient was associated with a very high rate of removal from practice at 85%. Death and physical injury were associated with low rates of removal: 38%, and 33% respectively.

2 Multivariable analysis

The covariates adjusted for in the multivariable analysis were determined as per the method outlined in chapter 6. Both models were adjusted for doctors' sex, specialty and state. Other variables (notifier, number of patients affected, patient outcome and previous disciplinary matters) were not found to affect the relationships of interest and so were not included as covariates in the models.

The odds of removal from practice were 22 times higher in cases in which doctors were found to have had a sexual relationship with a patient (OR, 22.59; 95% CI, 10.18-50.14) compared to all other cases (Table 22).

Ibid.
Table 21. Types of misconduct, explanations for misconduct and patient outcome, by removal rate (n=477)

<table>
<thead>
<tr>
<th>Type of misconduct&lt;sup&gt;A&lt;/sup&gt;</th>
<th>Cases, n (%) of all cases*</th>
<th>Cases resulting in removal, n (category %)</th>
<th>Deviation from mean removal rate of 43%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>175 (36)</td>
<td>65 (38)</td>
<td>-5%</td>
</tr>
<tr>
<td>Medical certificates or records</td>
<td>127 (26)</td>
<td>53 (42)</td>
<td>-1%</td>
</tr>
<tr>
<td>Illegal or unethical prescribing</td>
<td>119 (25)</td>
<td>55 (46)</td>
<td>+3%</td>
</tr>
<tr>
<td>Inapprop. conduct not re pt.</td>
<td>79 (16)</td>
<td>41 (52)</td>
<td>+9%</td>
</tr>
<tr>
<td>Sexual relationship with pt.</td>
<td>79 (16)</td>
<td>64 (81)</td>
<td>+38%</td>
</tr>
<tr>
<td>Inapprop. non-sexual conduct re pt.</td>
<td>71 (15)</td>
<td>30 (42)</td>
<td>-1%</td>
</tr>
<tr>
<td>Breach of conditions</td>
<td>60 (13)</td>
<td>35 (58)</td>
<td>+15%</td>
</tr>
<tr>
<td>Informed consent</td>
<td>54 (11)</td>
<td>14 (26)</td>
<td>-17%</td>
</tr>
<tr>
<td>Sexual conduct re pt (not r/ship)</td>
<td>47 (10)</td>
<td>25 (53)</td>
<td>+10%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>37 (8)</td>
<td>9 (24)</td>
<td>-19%</td>
</tr>
<tr>
<td>Criminal offence</td>
<td>18 (4)</td>
<td>7 (39)</td>
<td>-4%</td>
</tr>
<tr>
<td>Breach of privacy</td>
<td>11 (2)</td>
<td>3 (27)</td>
<td>-16%</td>
</tr>
<tr>
<td>Supervision of others</td>
<td>10 (2)</td>
<td>2 (20)</td>
<td>-23%</td>
</tr>
</tbody>
</table>

**Explanation for misconduct**

| Poor judgement                 | 164 (46)                  | 64 (39)                                  | -4%                                  |
| Wilful wrongdoing              | 162 (45)                  | 112 (69)                                 | +26%                                 |
| Personal situation             | 90 (25)                   | 51 (57)                                  | +14%                                 |
| Work environment               | 86 (24)                   | 24 (28)                                  | -15%                                 |
| Incompetence                   | 84 (23)                   | 51 (61)                                  | +18%                                 |
| Insufficient knowledge         | 82 (23)                   | 18 (22)                                  | -21%                                 |

**Patient outcome**

| Death                          | 36 (8)                    | 9 (25)                                   | -18%                                 |
| Physical injury                | 41 (8)                    | 10 (26)                                  | -17%                                 |
| Psychiatric injury             | 28 (6)                    | 24 (86)                                  | +45%                                 |
| Drug dependency                | 66 (14)                   | 29 (44)                                  | +1%                                  |
| Upset to patient               | 126 (27)                  | 58 (46)                                  | +3%                                  |
| Risk to patient                | 72 (15)                   | 28 (39)                                  | -4%                                  |
| No consequence                 | 99 (21)                   | 99 (21)                                  | -22%                                 |

* Percentages were calculated with the number of available observations used as the denominator.

<sup>A</sup> All misconduct types included, not just primary misconduct type. Note that 58% of cases involved >1 type of misconduct (mean per case = 1.85; SD = 0.86). For explanations for misconduct, 63% of cases involved >1 explanation for misconduct (mean per case = 1.90; SD = 0.82).
Table 22. Multivariable odds of removal from practice, by types of misconduct, explanations for misconduct and patient outcome (n=477)

<table>
<thead>
<tr>
<th>Model 1: Type of misconduct</th>
<th>Odds Ratio (95%CI)*</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual relationship with patient</strong></td>
<td>22.59 (10.18, 50.14)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Inappropriate sexual conduct towards patient (not r/ship)</strong></td>
<td>4.39 (1.99, 9.68)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Criminal offence</strong></td>
<td>4.11 (1.26, 13.39)</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Inappropriate conduct not in relation to patient</strong></td>
<td>3.06 (1.65, 5.68)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Breach of conditions</strong></td>
<td>2.40 (1.19, 4.85)</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Illegal or unethical prescribing</strong></td>
<td>2.27 (1.28, 3.99)</td>
<td>0.005</td>
</tr>
<tr>
<td><strong>Inappropriate or inadequate treatment</strong></td>
<td>1.69 (0.98, 2.91)</td>
<td>0.06</td>
</tr>
<tr>
<td><strong>Inappropriate non-sexual conduct towards patient</strong></td>
<td>1.67 (0.88, 3.17)</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>Inadequate or inappropriate medical certificates or records</strong></td>
<td>1.12 (0.67, 1.89)</td>
<td>0.66</td>
</tr>
<tr>
<td><strong>Failure to obtain informed consent</strong></td>
<td>0.89 (0.42, 1.88)</td>
<td>0.76</td>
</tr>
<tr>
<td><strong>Missed, delayed or incorrect diagnosis</strong></td>
<td>0.70 (0.28, 1.75)</td>
<td>0.45</td>
</tr>
<tr>
<td><strong>Supervision of others</strong></td>
<td>0.62 (0.11, 3.34)</td>
<td>0.58</td>
</tr>
<tr>
<td><strong>Breach of privacy</strong></td>
<td>0.37 (0.08, 1.77)</td>
<td>0.21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Model 2: Explanation for misconduct</th>
<th>Odds Ratio (95%CI)*</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wilful wrongdoing</strong></td>
<td>17.14 (8.62, 34.09)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Incompetence</strong></td>
<td>6.02 (2.87, 12.63)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Personal situation</strong></td>
<td>4.17 (2.07, 8.41)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Poor judgement</strong></td>
<td>1.15 (0.64, 2.06)</td>
<td>0.64</td>
</tr>
<tr>
<td><strong>Insufficient knowledge</strong></td>
<td>0.68 (0.32, 1.43)</td>
<td>0.31</td>
</tr>
<tr>
<td><strong>Work environment</strong></td>
<td>0.67 (0.33, 1.37)</td>
<td>0.27</td>
</tr>
</tbody>
</table>

* ORs come from two separate multivariable models (type of misconduct model, explanation for misconduct model) and are adjusted for doctors' sex, specialty and state.

Other types of misconduct associated with relatively high odds of removal were inappropriate sexual conduct towards a patient outside the context of an intimate relationship (OR, 4.39; 95% CI, 1.99-9.68), criminal offence (OR, 4.11; 95% CI, 1.26-13.39), inappropriate conduct not in relation to a patient (OR, 3.06; 95% CI, 1.65-5.68),
breach of registration conditions (OR, 2.40; 95% CI, 1.19-4.85), and illegal or unethical prescribing (OR, 2.27; 95% CI, 1.28-3.99).

In the multivariable model in which explanations for the misconduct were the predictors of interest, the odds of removal were 17 times higher for behaviour judged to be the result of wilful wrongdoing (OR, 17.14; 95% CI, 8.62-34.09). Odds of removal were also relatively high for behaviour linked to incompetence (OR, 6.02; 95% CI, 2.87-12.63) and issues in the doctor's personal life (OR, 4.17; 95% CI, 2.07-8.41).

C Discussion: removal from practice and nature of misconduct

1 General

To the extent it is possible to compare, the distribution of cases across misconduct types in the First Study looks broadly similar to distributions reported in previous research. For example, combining the two sexual misconduct categories used in the First Study, the proportion of cases that resulted in removal (70%) lies in the middle of the range (60-80%) identified in previous US studies. The removal rates among cases involving breach of conditions and illegal and unethical prescribing are also similar to rates detected for broadly analogous types of misconduct in previous studies. However, the ability to compare the results of the First Study with those other studies is constrained by the fact that the typologies used here to describe the nature of misconduct at issue are more nuanced and detailed than those used in previous studies.

Finding near zero-tolerance for sexual relationships was not unexpected. However, the size of the odds of removal compared to that found for some other misconduct types (for example, inappropriate sexual conduct with patient (not r/ship), criminal offence, breach of conditions, and illegal or unethical prescribing) was surprising. Possible explanations for this finding are explored in some detail later in this chapter.


Clinical versus non-clinical types of misconduct and explanations for misconduct

The above findings show that failings in relation to delivery of medical care, such as treatment and diagnosis, result in removal from practice much less frequently than does misconduct involving personal failings, such as inappropriate conduct towards patients, unprofessional personal conduct, and non-adherence to practice conditions already imposed by the Board. Sawicki recently criticised this approach, arguing that it is not the (low) frequency of discipline that undermines the Board's public protection objectives, but the focus on matters indicative of character flaw rather than issues of clinical competence:

It hardly seems obvious why, given the harms suffered by patients on a daily basis as a result of 'never events' and other medical errors and instances of medical negligence, boards should be using their scarce resources to discipline physicians for character-related misconduct occurring outside the clinical sphere.

805 There are really two ways of framing criticism of the fact that character issues rather than clinical competence issues are what most frequently lead the Tribunals to remove doctors from practice. The first option is to say that Tribunals should not invest in sanctioning character-related conduct as heavily as they appear to do; secondly, one could argue that Tribunals should take a more active role in severely disciplining doctors for clinical shortcomings.806 Sawicki's argument is that, as Tribunal resources are limited, Tribunals must decrease investment in targeting character-related conduct in order to have sufficient remaining resource to focus on clinical issues. Wachter, in his editorial commenting on the author's July 2012 publication, is adamant that when it comes to assessing the fitness of physicians to practice, character matters, but so does

806 Note, however, that the character-related conduct reported to result in removal in the First Study, although not strictly clinical, was generally related in some way to the professional obligations of the doctor, such as inappropriate behaviour towards patients. It is much easier to argue that the Tribunals have a legitimate interest in such conduct, from a public protection perspective, as opposed to other conduct that appears entirely divorced from the professional context, such as, for example, dishonesty in one’s personal life.
In terms of public protection, Wachter’s argument carries weight as both character-related misconduct and clinical incompetence have the capacity to harm patients and both should be assessed with a view to removing the doctor concerned from practice if necessary. So why is it that character-related misconduct results in removal from practice so much more frequently than findings of misconduct that relate to clinical skill, competence and/or decision-making?

In the July 2012 publication, the author (and her co-authors) posited one possible explanation, related to Tribunals’ possible views of the feasibility of rehabilitation. Tribunals and Boards have at their disposal a range of interventions to address deficiencies in core medical competencies, including retraining programs and practice conditions, and progress achieved via such interventions is generally measurable. Thus, the feasibility of intervention and the perceived potential for rehabilitation are likely to make penalties short of removal seem appealing. By contrast, dysfunctional behaviours and clear signs of bad character may be perceived as relatively untreatable. As expressed by Freckelton:

é 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 é examples of predatory sexual misconduct or persistent lack of probity rarely give rise to much by way of the perception of potential for rehabilitation. 808

The â€œrelative feasibility of rehabilitationâ€ explanation, if correct, may appear to be at odds with the public protection purpose of the regulatory regime. In the author’s view, however, it is entirely consistent. Aberrant acts of care delivery, independent of underlying flaws in personality, present as treatable risks. They are threats to public safety that can be managed, perhaps better managed, through sanctions other than removal, such as conditions on practice. Indeed, time away from practice may atrophy skills further. In addition, taking public interest considerations into account elevates the

808 Ian Freckelton, ÔThe Margins of Professional Regulation: Disjunctions, Dilemmas and DeterrenceÔ (2006) 23(2) Law in Context 148, p153.
importance of (where possible) rehabilitating these doctors so that they can practice effectively in the future, thus assisting ongoing supply in the medical workforce. On the other hand, Tribunals may perceive certain behaviours or underlying explanations for those behaviours, indirectly related to quality of care, as evidence of deep personality flaws and low chances of effective rehabilitation. There may also be some entirely competence-based issues that are so fundamental as to also be seen as incapable of remediation. In such situations, the decision to more readily impose a non-rehabilitative sanction is entirely in keeping with the Tribunal’s public safety mandate.

While agreeing that the above is a plausible interpretation of the Tribunals’ assessment of rehabilitation and its impact on removal from practice, Wachter suggests that, in the US context at least, there are a number of other possible explanations for the bias towards character-related shortcomings in decisions to remove doctors from practice, as follows:

i. Tribunals may not be sufficiently expert to judge clinical competence, particularly if the issue concerns a highly specialised area of practice.

ii. Tribunals may consider that judgments about clinical care should be made within the context of civil litigation where substantial expert testimony would be available.

iii. Judgments about clinical care are more challenging than judgments about ethical lapses.

iv. Tribunals may feel that doctors should not be held solely responsible when their errors may be, at least in part, attributable to faulty systems rather than personal shortcomings.

809 Yet noting that it is not clear whether or not that assessment is, in fact, correct given there are cases in which doctors have been rehabilitated for character-related issues while rehabilitation for clinical issues has been unsuccessful: Robert M Wachter, ‘Disciplining Doctors for Misconduct: Character Matters, But So Does Competence’ (2012) BMJ Quality & Safety, 10.1136/bmjqs-2012-001449.

810 Note that although Wachter’s editorial is a commentary on the author’s July 2012 paper, his arguments are applied to the US context and thus refer to medical boards rather than Tribunals.

811 Sawicki also suggests this as a reason why medical boards pursue discipline against some types of misconduct and not others. The point is made that, as investigations of character-related issues are easier than assessments of clinical competence, more such investigations are pursued, as they promise resource-constrained medical boards good value resolution: Nadia Sawicki, ‘Character, Competence, and the Principles of Medical Discipline’ (2010) 13 Jnl of Health Care Law & Policy 285.
v. Tribunals may consider that adequate scrutiny of clinical competence is already provided by professional colleges (or, in US terminology 'certifying boards').

While some of the above explanations have appeal, some of them (particularly the first three) relate more to decision making about whether or not a doctor has committed professional misconduct at all, rather than being explanations for why particular disciplinary sanctions are imposed for particular types of conduct. When a Tribunal gets to the point of determining disciplinary outcome, the doctor's conduct or performance has already been found wanting. In a case concerning clinical competence, the Tribunal has already made a finding that the care was, in some way, clinically inadequate.812

Wachter's fourth point, however, is more compelling as a plausible influence on decision-making regarding penalty as it relates directly to assessments of appropriate accountability.813 The suggestion that alternative mechanisms for public protection exist, such as the scrutiny of professional colleges, also has merit. If such oversight was not available, the Tribunals' ability to impose meaningful conditions on practice, including the availability of supervision and/or additional training, would be diminished.

Another possibility (perhaps more closely related to decisions as to misconduct itself) is that medical boards' differing approach to different types of misconduct is a product of regulatory capture. That is, by focussing on discipline for character-related issues, the medical community is able to improve the public standing of physicians by emphasising their moral superiority which is much easier for the public to judge or second guess than technical clinical skills.814 In the author's view, this seems an

812 It is noted, however, that decision making about misconduct per se may not, in practice, be entirely distinct from decision making about penalty. This is because inability to prove all aspects of a particular charge of misconduct may itself mean that a lesser sanction is imposed (due to the more serious aspects remaining unproved).

813 In both Australia and New Zealand, systemic issues are able to be addressed through the Complaints Commissioners' processes see p50 onwards for further detail.

unlikely explanation for the disciplinary decision-making of the Tribunals included in the current study, particularly for independent Tribunals no longer dominated by members of the medical profession.

In summary, considerations about rehabilitative potential, combined with a reluctance to heavily sanction an individual doctor for shortcomings that might also be the product of systemic failures, may provide the most compelling explanations for the higher rates of removal for misconduct seen in the First Study.

Results from the analysis of explanations for misconduct reinforce the plausibility of this general explanation for the main study findings. Wilful wrongdoing, incompetence, and issues in a doctor’s personal life were all associated with high removal rates; whereas removal rates were much lower when the misconduct at issue was judged to stem from problems in the work environment or insufficient knowledge. From the results, it seems that explanations for misconduct generally had stronger predictive power in relation to removal from practice. This suggests that Tribunals look behind the labels used in the charges brought before them and look to the reason for that misconduct. Risk to the public appears to be assessed according to such explanations, rather than the type of misconduct or the outcome of the case for the patient. The focus on underlying explanations for misconduct may allow the Tribunals to better determine ongoing public safety concerns, as well as evaluate the rehabilitative potential of the doctor concerned.

\[ \text{Conclusion} \]

The conceptualisation of professional misconduct introduced by the First Study offers a new way of understanding how the Tribunals pursue their protective function, in particular, when and why they choose to deploy the most potent sanction at their disposal. The results suggest that standard descriptors of disciplinary caseloads (ie. misconduct type) are of some use in understanding how Tribunals act. But descriptors that focus on underlying causes of the behaviour and longer-term risks to public safety may offer clearer insights into regulators’ decision making. It is suggested that this may be because of the way in which these factors relate to perceived rehabilitative potential.
But does this rehabilitative focus explain why the odds of removal from practice are so high for doctors found guilty of having a sexual relationship with a patient? More particularly, why are the odds of removal so much greater for doctors who are found to have had a sexual relationship with a patient than for doctors who have committed other forms of (apparently equally serious) misconduct? The remainder of this chapter explores particular instances of doctors disciplined for sexual relationships with patients to try and gain a more nuanced understanding of the Tribunals’ reasoning behind their disciplinary decision-making. It explores the factors that are taken into account and their influence on disciplinary outcome. Many of the factors identified are of more general significance; their analysis facilitates a deeper understanding of how the Tribunals decide on appropriate disciplinary sanctions in all types of cases. The chapter concludes with an assessment of the public protection implications of the Tribunals’ approach to the imposition of disciplinary sanctions.

III SEXUAL RELATIONSHIPS WITH PATIENTS

A Introduction

1 The prohibition on sexual relationships with patients

For the last 2,500 years, the Hippocratic Oath has banned sexual relations between doctors and their patients:

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons.\(^{816}\)

This prohibition has continued, largely undisturbed, to the present day. The MCNZ has a zero tolerance position on doctors who breach sexual boundaries with a current patient,\(^{817}\) while the MBoA has adopted the existing Code of Conduct which requires

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815 Parts of this section are taken from a research paper that the author wrote and submitted as an assignment for a paper that formed part of her Graduate Diploma in Health and Medical Law.
817 Medical Council of New Zealand, 'Sexual Boundaries in the Doctor-Patient Relationship: A Resource for Doctors' (MCNZ, 2009). Note, however, that the High Court has said, in reference to the zero-
that doctors do not exploit patients physically, emotionally, sexually or financially. The Code notes that good medical practice involves, among other things:

Never using [the doctor’s] professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under [the doctor’s] care. 818

The Australian Medical Association Code of Ethics also requires that doctors avoid engaging in sexual activity with [their] patients. 819

But what about apparently consensual sexual relationships between doctors and their adult patients? What is it about the doctor-patient relationship that makes it necessary, or even appropriate, for the disciplinary system to interfere in such private matters?

In justifying its zero-tolerance position, the MCNZ distinguishes the doctor-patient relationship on the basis that ‘there is a physical and intimate aspect to the relationship that does not exist with most other professionals’. 820 Indeed, there are number of characteristics of the doctor-patient relationship that are either important for good medical care or that arise as a consequence of the delivery of such care, as discussed below. 821

tolerance policy: ‘There can be no principle that every case of a sexual relationship between a doctor and patient must result in a disciplinary finding, each case must be judged on its facts’. Director of Proceedings v Medical Practitioners Disciplinary Tribunal & Wiles [2003] NZAR 250 per Ellen France J at para 50. And, as cited in that case, the comment of Oppal J in Patterson v College of Physicians & Surgeons of BC [1988] 5 WWR 398 at para 401: ‘Sexual relations between a doctor and a patient will not in all circumstances constitute infamous conduct. Rather the surrounding circumstances must be examined. Nevertheless, it is clear for the reasons in the following section of this chapter, that while there may be some degree of discretion, a sexual relationship between a doctor and a current patient will almost always be sexual misconduct worthy of sanction.

818 Medical Board of Australia, ‘Good Medical Practice: A Code of Conduct for Doctors in Australia’ (Medical Board of Australia, 2010), clauses 3.2 and 8.2.
819 Australian Medical Association, ‘Code of Ethics’ (AMA, 2004), clause 1.1i.
820 Medical Council of New Zealand, ‘Sexual Boundaries in the Doctor-Patient Relationship: A Resource for Doctors’ (MCNZ, 2009), para 11. This is perhaps a rather broad statement of medical exceptionalism and that there is a physical and intimate aspect to the relationship between many other health practitioners and their patients also. Perhaps it would be more accurate to claim that such an aspect does not exist with most other non-health professionals.
821 The MCNZ’s zero-tolerance stance does not extend to former patients, but the MCNZ notes that it is ‘wrong for a doctor to enter into a relationship with a former patient ... if this breaches the trust the patient placed in the doctor’ ibid, para 1. The MCNZ’s guidelines state that whether or not such a relationship is permissible depends on the likelihood of harm being suffered by the former patient,
a) Trust and objectivity

Fundamentally, the relationship between a doctor and patient must be based on trust. Trust is what enables a patient to discuss private and often intimate information with the doctor and gives the patient the confidence to consent to physical contact that would normally be reserved for close family or a partner.\footnote{Ibid, para 12.} When engaging in a sexual relationship with a patient, the doctor’s self-interest inappropriately becomes part of the professional relationship\footnote{Tanya Dobash, ‘Physician-Patient Sexual Contact: The Battle between the State and the Medical Profession’ (1993) 50 \textit{Washington & Lee Law Review} 1725, p1735.} A doctor (like many other professionals) must also be able to act objectively and make decisions that are unclouded by emotions. The impaired clinical judgement that may result from a concurrent sexual relationship with a patient has the potential to compromise the care that is provided to that patient.\footnote{Medical Council of New Zealand, ‘Sexual Boundaries in the Doctor-Patient Relationship: A Resource for Doctors’ (MCNZ, 2009), clauses 21 and 22; and American Medical Association, ‘Code of Ethics’ (AMA, 1990), opinion 8.14 \textendash; Sexual Misconduct in the Practice of Medicine.} Indeed, a medical practitioner who has an intense emotional relationship with a patient is unlikely to be the best person to treat the patient.\footnote{\textit{N v PCC} (unreported, HC, Wellington, CIV 2009-485-2347, 17 March 2010) at para 25. In that particular case, the doctor continued to provide care to the woman’s husband and son, notwithstanding the doctor’s own sexual relationship with the woman. The Court noted that this most likely meant that the doctor’s objectivity in providing medical care was also compromised in respect of those patients due to the “confusion and high emotion that was engendered”; para 53. See also, \textit{Re Dr Jerome Lindsay Gelb} [2008] MPBV 6 where, due to the sexual relationship he had with the patient, the doctor failed to refer the patient appropriately and did not keep adequate medical records.}  

b) Balance of power

Another dynamic of the doctor-patient relationship that lends itself to misunderstanding and abuse is the inherent imbalance of power, described by the MCNZ as often subconscious and independent of the intelligence, education or confidence of the patient\footnote{Medical Council of New Zealand, ‘Sexual Boundaries in the Doctor-Patient Relationship: A Resource for Doctors’ (MCNZ, 2009), para 18.} whether they be a child or the chief executive of a company\footnote{Ibid, para 12.} While issues of transference and counter-transference may arise, put simply, the power imbalance taking account of the circumstances of the past clinical interactions along with the particular characteristics of the patient concerned. According to Duffy J, the existence of any power imbalance will turn on facts relevant to the individuals concerned rather than emanate from the relationship of doctor and former patient\footnote{\textit{G v Director of Proceedings} (unreported, HC, Auckland, CIV-2009-404-000951, 5 March and 12 November 2009), para 44.}
results from the relationship being one-sided, both in terms of the sharing of information and with respect to intimate physical contact.\textsuperscript{827} The inherent power imbalance can be further exacerbated by the characteristics of some patients. Patients who have dependent or borderline personalities, patients who have psychotic conditions, and patients with intellectual disabilities all have less power and so are more vulnerable to inappropriate sexual relationships.\textsuperscript{828} Other patients have life circumstances or previous life experiences (such as past sexual abuse) that can predispose them to engage in counter-productive emotional attachments.\textsuperscript{829} A doctor who is aware of such vulnerabilities, often more so than anyone else in the patient’s life, is positioned either to protect the patient or to take advantage.

The power imbalance between doctors and their patients, as is clear from the above, exists regardless of the surroundings in which the doctor and patient find themselves. However, some of the Tribunals' commentary suggests recognition (logically, in the author's view) that the power imbalance is particularly pronounced during a medical consultation and in the environs of the clinic. A sexual relationship in the clinical setting speaks of a doctor who gains access to the patient by purporting to provide a professional service in a safe environment, and then acts in a way that meets the doctor's objectives not the patient's needs.\textsuperscript{30} Indeed, in the case from that quote comes \textit{(Re Dr Wiles)}, the fact that no sexual or romantic contact was initiated in the clinical setting was important in determining that no professional misconduct had been committed.

c) Consent

Consent is generally a prerequisite to all activity within the doctor-patient relationship. Without consent, physical touch can become assault or battery, information sharing can become a breach of privacy, and the patient may lose his or her autonomy. In New Zealand, the nature and extent of consent is determined by the patient's capacity.\textsuperscript{829} The consent must be given voluntarily and with an understanding of the implications of the proposed action. Consent is generally a prerequisite to all activity within the doctor-patient relationship.

\textsuperscript{830} \textit{Re Dr Wiles}, MPDT(NZ) 155/00/65D, 5 March 2001, majority judgment, para 4.35.
Zealand, the right to consent is specifically enshrined in the *Code of Health and Disability Services Consumers’ Rights 1996* (NZ) (the Code), as upheld by the Health and Disability Commissioner.\textsuperscript{831}

Capacity to consent arises in relation to sexual relationships. The argument is that, due to several of the unique aspects of the doctor-patient relationship, a patient is rendered unable to give valid consent to engaging in a sexual relationship with his or her doctor. According to the American Medical Association:

> When a physician acts in a way that is not to the patient’s benefit, the relative position of the patient within the professional relationship is such that it is difficult for the patient to give meaningful consent to such behaviour, including sexual contact or sexual relations.\textsuperscript{832}

However, this assumption of incapacity to consent does not sit well with contemporary notions of patient autonomy and self-determination.\textsuperscript{833} Smith argues that doctors no longer enjoy the same esteem and deference that they once did, such that the balance of power no longer always rests with the doctor.\textsuperscript{834} It has been suggested that this dynamic may be better described as *undue influence* than incompetence to consent.\textsuperscript{835}

In the author’s view, the issue is not so much about whether a patient is able to give valid consent to entering into a sexual relationship with his or her doctor, but whether the doctor is ethically able to accept and act on that consent. A doctor is not necessarily legally or ethically justified in taking a particular action simply because a patient says *yes.* The responsibility is the doctor’s, not the patient’s. The onus is on the doctor to act with integrity irrespective of the patient’s own behaviour.

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\textsuperscript{831} *Right 7.* The consent that is required must also be informed. This ties into *Right 6* which entitles every patient to *the information that a reasonable consumer, in that consumer's circumstances, would expect to receive.*

\textsuperscript{832} AM\textsuperscript{A} Report, as cited by Tanya Dobash, 'Physician-Patient Sexual Contact: The Battle between the State and the Medical Profession' (1993) 50 *Washington & Lee Law Review* 1725 at p1732.

\textsuperscript{833} See, for example, *Rights 7*(2) and (3) of the Code.


Despite the condemnation articulated by the medical boards, and the frequency of removal for such conduct, sexual relationships between doctors and their patients are not as rare as one might assume. In a 2009 New Zealand meta-analysis of reports of anonymous self-report survey data regarding sexual relationship with patients, between 3.3% and 14.5% of all doctors were reported to have such a relationship at some point during their career, with an overall prevalence of around 6.8%. The cases that come before the Tribunals appear to be just the tip of the iceberg. Interestingly, it was doctors from the very specialties identified by the MCNZ as engendering greater patient vulnerability that reported the highest rates of sexual relationship with patients: general practice, psychiatry, and obstetrics/gynaecology.

More than 85% of the relationships disclosed in the survey data involved a male doctor and female patient.

Some have argued that the prohibition on doctor-patient relationships is no longer appropriate, given changing societal values, including the relaxation of attitudes towards sexual relationships generally. The MCNZ has (quite rightly, in the author’s view) expressly rejected this assertion. While attitudes may have changed, the risk to patients remains the same, as does the fiduciary responsibility of every doctor to put the needs of his or her patients ahead of their own.

B Factors influencing removal from practice

1 Introduction

As noted above, in 81% of the cases where a Tribunal found a doctor guilty of professional misconduct for having had a sexual relationship with a patient, the doctor concerned was removed from practice. Using sexual relationship decisions as case

837 Ibid.
838 Ibid.
studies and examples of judicial reasoning, the following section considers a number of factors that appear to influence Tribunal decision-making in this area.

As outlined in the chapter 4, there are many different sanctions that offer different degrees of public protection according to different mechanisms. The Tribunal’s role is to balance relevant aggravating and mitigating factors in fixing a reasonable and proportionate penalty. Many aggravating factors are, by their absence, mitigating factors. For example, lack of remorse will aggravate the penalty that is imposed while the presence of genuine remorse may mitigate penalty. For that reason, the following section does not discuss aggravating and mitigating factors separately, but looks at the range of factors that appear to be commonly taken into account by the Tribunals (and courts on appeal) in determining appropriate disciplinary action.

2 Relevant factors

a) Contrition and/or appreciation of wrongdoing

Whether the doctor understands that his or her conduct was inappropriate, and whether the doctor expresses contrition or remorse in respect of that conduct appears to be critically important. The Victorian Civil and Administrative Tribunal has characterised insight as having four elements:

a) understanding of the nature of the conduct;

b) acceptance that the conduct was seriously wrong;

c) appreciation of why the doctor engaged in that conduct; and

d) empathy with the consequences.

In *Re Dr Maria Bastas*, the Tribunal did not remove the doctor from practice despite her relationship with a patient (including his acting as a sperm donor for her), citing her admissions and newfound insight into the seriousness of her conduct. The Tribunal was also impressed by the steps the doctor was taking to remedy defects in her

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841 Medical Practitioners Board of Victoria v Kaur (Occupational and Business Regulation) [2010] VCAT 364 (17 March 2010).

842 Re Dr Maria Bastas, NSWMT, 40020/05, 17 February 2006.
understanding of boundary violations.\textsuperscript{843} The relevance of contrition was discussed specifically in the case of \textit{Re Dr Rahual Sant Ram}\textsuperscript{844} where the Tribunal adopted the position taken previously by the Court of Appeal that \textquote{contrition, if accepted as honest, may indicate that no occasion for protection exists}\textsuperscript{845}

While the presence of contrition may or may not, depending on the circumstances, lead to a doctor who would otherwise have been removed being permitted to continue in practice, the absence of contrition almost invariably leads to a more severe disciplinary sanction than would otherwise have been the case. Among the sexual relationship cases, there are many examples where, throughout the Tribunal process, the doctor maintained his or her entitlement to engage in the relationship concerned. For example, in \textit{Re Dr Ebenezer Jeyanathan Danforth},\textsuperscript{846} the doctor was charged in relation to many instances of sexual misconduct regarding several patients. In deregistering the doctor and setting a seven-year minimum period before re-registration could be sought, the Tribunal noted that the doctor was at \textquote{very high risk} of reoffending

\begin{quote}
... having regard to his total lack of insight into his wrong doing and the likely harm to his patients: his total lack of contrition or remorse, and his attempts to blame the women for his conduct; and the length of time over which he committed this offending behaviour.\textsuperscript{847}
\end{quote}

Requiring contrition, or, at least, acknowledgement of wrongdoing, is entirely consistent with the public protection mandate of the Tribunals. If a doctor does not appreciate the error of his or her conduct, especially when there is no dispute as to whether that conduct actually occurred, the chances of successful rehabilitation are likely to be markedly reduced.

\begin{flushleft}
\textsuperscript{843} At page 28.
\textsuperscript{844} \textit{Re Dr Rahual Sant Ram}, NSWMT, 19 March 2004, p12, citing Justice Samuels in \textit{Childs v Walton}, CA, unreported, 13 November 1990.
\textsuperscript{845} \textit{Re Dr Rahual Sant Ram}, NSWMT, 19 March 2004, p14. Emphasis added.
\textsuperscript{846} NSWMT, 40007/00, 21 May 2001.
\textsuperscript{847} Page 30.
\end{flushleft}
b) Rehabilitation efforts and progress

As alluded to above, the central importance of contrition and insight stems from the fact that both are preconditions for effective rehabilitation. Indeed, efforts and progress towards rehabilitation are commonly seen as relevant to the assessment of the level of ongoing risk to the public and thus as important factors in determining whether to remove a doctor from practice.

In *Re Dr George David Angus*, the doctor treated the patient for a gynaecological condition, including performing a hysterectomy on her. The patient was also a nurse and subsequently worked alongside the doctor at the hospital. The doctor provided the patient with further treatment and a sexual relationship developed, beginning with sexual intercourse during a medical consultation. The Tribunal concluded that, to avoid being removed from practice, the doctor would need to prove he had been rehabilitated, noting that ‘reformations of character and of behaviour can doubtless occur but their occurrence is not the usual but the exceptional thing.’

The mere passage of time without further incident does not mean rehabilitation can be assumed to have occurred. Rehabilitation seems, therefore, to require some positive evidence rather than mere absence of problems. In that case, the Tribunal took account of the re-establishment of a good marital relationship between the doctor and his wife, reorganisation of the doctor’s work practices, the doctor’s contrition and renewed insight into his conduct, and the doctor’s strong involvement in community activities.

As is noted above in relation to contrition, steps towards rehabilitation appear to be almost preconditions for a doctor who has been found guilty of having a sexual relationship with a patient being allowed to continue practising, although such steps do not guarantee non-removal. Where there are clear contraindications of rehabilitation, removal from practice is especially likely. One such contraindication, aside from expressing no contrition or appreciation of wrongdoing, is where the doctor is found to

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848 *Re Dr George David Angus*, NSWMT, 24 October 2000.
850 For example, see *Re Dr David John Wignall* [2005] MPBV 10 where the doctor admitted the sexual relationship with a patient, accepted it was wrong, and undertook remedial steps, but was still suspended from practice for six months by the Tribunal.
have lied to the Tribunal, or to his or her own treating clinician, about the conduct. This was the case in *Re Dr Stanley James Vincent*\(^\text{851}\) where the doctor had had a series of sexual relationships and inappropriate sexual contact with 13 patients and former patients. The doctor persisted in this behaviour despite directions from his practice manager to stop making advances to patients. The doctor was found to have systematically lied to the practice manager and his treating clinician about the relationships. As a result, the doctor was deregistered for a minimum of two years. Similarly, in *Re Dr Ian McColl Fitzgerald*,\(^\text{852}\) the doctor was removed from practice for having sexual relationships with several patients, one after the other, and lying about those relationships to the Tribunal at previous hearings.

As discussed in chapter 4,\(^\text{853}\) the decision to take a rehabilitative approach should not be motivated solely by generosity to the doctor concerned but must arise out of a proper assessment of the risk posed by the particular doctor and consideration of whether sanctions short of removal will be adequate to protect the public. Public protection, rather than remediation for its own sake, must be the overriding consideration.

c) Prior disciplinary action for sexual misconduct

Where a doctor has been the subject of previous disciplinary action for sexual misconduct, there is an increased likelihood that the Tribunal will remove the doctor from practice if the doctor comes before it again. In *Re Dr John Drury*,\(^\text{854}\) the doctor had sexual relationships with five psychiatric patients over a three year period, simultaneously engaging in behaviour such as not keeping accurate notes and writing false prescriptions for those patients. The behaviour was found to have continued long after the first complaint was made. The Tribunal deregistered the doctor, giving the following reasons:

> He has repeatedly demonstrated that he is untrustworthy. The Panel is therefore unable to conclude that anything other than cancellation of Dr Drury's registration will afford the public sufficient protection. In reaching this

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\(^{851}\) *Re Dr Stanley James Vincent*, NSWMT, 40021/01, 20 September 2002.

\(^{852}\) *Re Dr Ian McColl Fitzgerald* [2007] MPBV 5.

\(^{853}\) See p118 onwards.

\(^{854}\) *Re Dr John Drury* [2001] MPBV 1.
conclusion the panel finds it hard to imagine how Dr Drury would be able to convince any medical registration authority of his trustworthiness in the future.\footnote{Page 68.}

d) Current practising status

As discussed in chapter 4, removing a doctor from practice will only be justifiable in circumstances where such action is necessary to protect the public. Thus, where a doctor has already ceased practice by the time of the disciplinary hearing, removal may not be necessary or justifiable. Public condemnation of the doctor’s behaviour may still be necessary in order to achieve general deterrence, but this is sometimes achieved via a reprimand or fine. For example, in \textit{Re Dr George Robert Wardrop},\footnote{\textit{Re Dr George Robert Wardrop} [2002] MPBV 1.} a doctor, who would most likely have otherwise have been removed from practice for having a sexual relationship with a vulnerable psychiatric patient, was not removed as he had already retired from practice with no intention to return to medicine.\footnote{See also \textit{Re Dr A}, MPDT(NZ), 304/04/122C, 28 October 2004.}

Nevertheless, while there are cases where a doctor is not removed due to current non-practising status, this is not always the case, as shown by a number of cases included in the sample of the First Study. For example, in \textit{Re Dr Julian Joseph Brennan},\footnote{\textit{Re Dr Julian Joseph Brennan} [2005] MPBV 11.} the doctor had a sexual relationship with a patient for whom he also supplied drugs of dependence on demand, claimed Medicare for four occasions for which he kept no medical records, and had no clear treatment plan. The doctor voluntarily gave up his medical registration in the months leading up to the hearing but was still deregistered by the Tribunal. Similarly, in \textit{Re XX}\footnote{MPDT(NZ), 198/01/87D, 30 April 2002.} and \textit{Re Clarence Alexander Gluski},\footnote{\textit{Re Dr Clarence Alexander Gluski}, NSWMT, 2001.} both doctors were deregistered for their sexual relationships with patients, irrespective of the fact that they both relinquished their registration once investigations into their conduct began.

Comparisons of cases in which current non-practising status protected the doctor from removal by the Tribunal, with cases in which it did not, show a pattern. It appears that where the Tribunal itself has already deregistered the doctor, there would be little to be
served by a further order of deregistration. However, the impact of previous voluntary cessation of practice seems to depend on the circumstances under which that voluntary cessation occurred. For doctors who relinquish their registration in the lead-up to the disciplinary hearing, in circumstances where, essentially, the ‘writing is already on the wall’ such action seems to have little effect on a subsequent order for removal. This is, as expressly noted in Re Ian McColl Fitzgerald,\textsuperscript{861} due to the fact that such an order is still needed to ensure that the doctor cannot later opt to return to practice. Where the circumstances suggest that it is very unlikely that the doctor will ever resume practice, such as in the case where he or she has retired for extraneous reasons, such as age, sanctions short of removal may be invoked. In any event, it appears that the Tribunals are indeed influenced by considerations of what is ‘necessary’ in order to protect the public. It is, therefore, not determinative whether or not a doctor has already stopped practice, but whether the Tribunal considers it necessary to impose a formal order of removal to protect the public in the longer-term.

e) Impairment

In Re Dr Rahual Sant Ram,\textsuperscript{862} the doctor was an addict who was being supervised pursuant to the impaired doctors programme. He breached a range of conditions to do with the programme, including having a sexual relationship with a current patient. The Tribunal found that the relationship could be attributed to the medication the doctor was taking, causing him to act in a hypomanic manner. The Tribunal did not find that the doctor’s actions were conscious or deliberate and accepted the doctor’s contrition as genuine. This, coupled with an assessment that the risk of re-offending was extremely low, led to the Tribunal reprimanding the doctor and imposing conditions on his practice, rather than removing him from practice. Similarly, in Re Dr Maria Bastas,\textsuperscript{863} discussed above, the fact that the doctor was suffering from depression (referred to as an impairment) at the time of the events in question was relevant in allowing her to continue practising.

\textsuperscript{861} [2007] MPBV 5.
\textsuperscript{862} Re Dr Rahual Sant Ram, NSWMT, 19 March 2004.
\textsuperscript{863} Re Dr Maria Bastas, NSWMT, 40020/05, 17 February 2006.
The above cases are examples of where the impairment present at the time of the misconduct had resolved by the time of the hearing. It is only in such cases that an impairment can properly be considered to mitigate the need for removal. Where an impairment still exists, that impairment may render the doctor more, not less, likely to behave in a similar manner subsequently. Again, the issue is fundamentally one of public protection: is it necessary for the particular doctor to be removed from practice in order to protect the public? In relation to cases of impairment, the aim must be specific protection, as the individual particularities of such cases do not lend themselves to more general application or deterrence.

f) Access and availability considerations

In Re Dr Il-Song Lee, the doctor began a sexual relationship with a friend and patient after the patient’s husband died. The doctor continued to treat the patient during the relationship, including prescribing medication and counselling her through suicidal thoughts. Even after the acrimonious breakup of the relationship, treatment continued. The Tribunal noted that the doctor was providing a valuable medical service to the Korean community, thus tipping the balance in favour of his being allowed to continue practice. Instead, the doctor was reprimanded, and required to undergo psychiatric assessment and comply with any recommended treatment. The public interest in the continued availability of access to medical services in typically understaffed areas was also highlighted in Re Dr George David Angus, discussed above. The Tribunal recognised that it was important that the doctor be allowed to continue practising in the rural community where he lived, having brought to that community a level of expertise that was previously not available to the women of [that] region.

As discussed in chapter 4, taking access and availability considerations into account has long been a part of registration decision-making. However, it seems quite a different matter to apply such considerations when making disciplinary decisions about a doctor who has already been found to have fallen short of their professional

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864 Re Dr Il-Song Lee, NSWMT, 40009/01, 21 March 2002.
865 At page 13.
866 See p122.
obligations. It is well known that past conduct is a good predictor of future conduct and, as shown in the results of the First Study, recidivism rates among doctors found guilty of professional misconduct are high. Therefore, should doctors who have committed professional misconduct be permitted to remain in practice due to workforce shortages when they would otherwise have been removed? Is a doctor who may present an increased risk to the public better than no doctor at all? In the author’s view, the level of acceptable risk should be set independent of any access and availability considerations, and disciplinary decisions be made accordingly. Access and availability issues should be solved through mechanisms other than allowing doctors who would otherwise have been removed to remain in practice.

3 Conclusion

Unlike misconduct type and explanation for misconduct, which are closely related to the misconduct itself and the time at which that misconduct occurred, the factors discussed above relate instead to how the doctor presents to the Tribunal at the time of hearing. The significance of each factor appears to lie in what it indicates about the doctor’s capacity for effective rehabilitation and, conversely, their likelihood of reoffending. As the ultimate sanction offering specific protection, the primary focus of the Tribunals’ decision making about removal from practice appears to be an assessment of whether reoffending is likely. Deterrence is an important objective, but if a Tribunal is not confident that the doctor is unlikely to reoffend, removal will usually be appropriate.

While recent rehabilitative efforts and progress are a direct barometer of rehabilitative potential, the other factors provide more indirect evidence. If a doctor has no insight into his or her conduct, does not appreciate that he or she behaved wrongly, expresses no contrition regarding the conduct, has a past history of similar behaviour, or is still impaired by the condition that led to the original misconduct, then chances of effective rehabilitation will be low and, consequently, there will remain an appreciable risk of reoffending. Once rehabilitative potential is established, it then becomes a question of risk. If the doctor is allowed to continue practising, what risk will this pose to the public? At that point, issues such as current practising status and access and availability considerations appear to become relevant. It is argued, however, that once the level of
acceptable risk has been set, it is illegitimate to redefine the level of acceptable risk on the basis of wider public interest considerations, such as ensuring access and availability of medical services.

Although most of the factors set out above are not determinative, each factor is incorporated into the Tribunal's assessment of the likelihood of reoffending and, thus, the consequent risk to the public. The typical presentation of these factors in cases involving sexual relationships with patients may provide some insight into why such cases so frequently lead to removal from practice for the doctor concerned. Sexual relationships, by their nature, are not one-off events but may continue for months or even years. Such conduct is repetitive and ongoing, suggesting rehabilitation will be more difficult. Sexual relationships with patients also do not arise from ignorance or mistake, but are deliberate and undertaken wilfully. Frequently, the doctors concerned defend their right to have engaged in such a relationship, rather than express contrition or appreciation of any wrongdoing.

The disciplinary responses seen in the sexual relationship cases suggest that public protection is indeed at the centre of the Tribunals' decision making in that area. Factors that point to future risk, rather than merely acknowledge the seriousness of the misconduct concerned, appear to be pivotal in decisions about whether or not removal from practice is necessary. A picture emerges of Tribunals generally acting to protect the public from doctors who have been inclined wilfully to put their own interests on multiple occasions ahead of those of their patients. However, the extent to which wider public interest considerations are being taken into account is a live issue. Given the recent changes in legislative recognition of access and availability considerations, it would be interesting to keep a watching brief on this aspect of disciplinary decision making.

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IV CONCLUSION

Tribunals in Australia and New Zealand have a wide range of disciplinary sanctions available to them, with the most protective being that of removing a doctor from practice. This is an action that is not taken lightly, and only in the most serious of cases. Even when a doctor’s conduct has been quite outrageous, removal from practice will not necessarily follow. What emerges from the above analysis is a sense that the Tribunals’ disciplinary decision-making is driven more by considerations of future risk than by an assessment of the seriousness of the conduct that has brought the doctor before the Tribunal. Appropriately, it does not appear that removal is being used to punish but to protect. Thus, it is not the type of misconduct that is the best determinant of removal from practice but, rather, the underlying reasons for that misconduct, and the way in which the doctor presents to the Tribunal at the time of hearing. Where particular types of misconduct, such as sexual relationships with patients, show high rates of removal from practice, this may be due to similar underlying reasons for the misconduct and similar attitudes among the doctors concerned. However, if a doctor can demonstrate that they are capable of rehabilitation, or that they have already begun that process, removal from practice is unlikely. Several of the cases considered suggest that evidence of rehabilitative potential may be an even more potent predictor of non-removal in circumstances where access and availability issues also arise. 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 temptation to use disciplinary decision-making to address broader issues of workforce supply.
For the doctor patient relationship to function optimally, the doctor must be able to look at the patient in the eye and say ‘You can trust me. I will not confuse your needs with my own’. For the professional regulatory system to function optimally, those responsible must be able to make the same declaration. Not only must that system avoid becoming captured by its own agendas, and those of the doctors it regulates, but it must also stay true to the legislative mandate it has been given.

There has been considerable change in the design of health professional regulation throughout Australia and New Zealand since the beginning of the last decade. Professions and states have been brought together under umbrella legislation designed to streamline administration and allow for greater continuity and consistency of approach. As well as ushering in significant structural reform, the new legislation in both countries is now more explicit regarding its public protection objectives. In New Zealand, the HPCA Act is singular in its focus on public protection, while in Australia the National Law Act envisages the striking of a balance between public protection and the wider public interest, including considerations of medical workforce mobility and supply.

Fundamental to the success of any regulatory regime is the effectiveness of the associated complaints and disciplinary system. However, in Australia and New Zealand, little was known about the characteristics of the doctors or the cases that end up in that system. While several overseas studies point to various trends, many of those studies have suffered from problems with data quality, weaknesses in the typologies used, and lack of multivariable analysis. The Studies described in this thesis overcome a number of these limitations and thus advance the knowledge base in significant respects.

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I GENERAL CHARACTERISTICS OF DOCTORS AND CASES

The First Study describes, for the first time, the characteristics of doctors found guilty of professional misconduct by the Tribunals in Australia and New Zealand. As in the overseas studies, those doctors found to be at elevated risk of guilty findings were male, and working in the specialties of obstetrics/gynaecology, psychiatry, general practice, and surgery. IMGs in the First Study were found guilty of professional misconduct at a higher rate than non-IMGs. Unlike some previous studies, older age or longer time in practice were not found to be associated with higher rates of disciplinary findings. However for two particular types of misconduct (treatment issues, and problems with medical certificates or reports), length of time in practice was a significant risk factor. Understanding the points in their careers at which doctors are more likely to become vulnerable has implications for surveillance, training and oversight, and may allow resources to be selectively applied at the points of greater risk.

The Second Study illuminates the characteristics of a slightly different group of doctors — all doctors who have become the subject of complaints to medical boards. As in the First Study, males were disproportionately represented. IMG-status was associated with significantly increased odds of being subject to a complaint, and of subsequent action by the board, including an eventual adverse finding. Mid-career doctors also had an increased odds of receiving a complaint, as did doctors with general registration. These findings were not as anticipated, with doctors nearing retirement and those with limited registration anecdotally fingered as more likely to have problems. Again, understanding the true pattern of complaint risk may allow more appropriately targeted interventions.

One of the major successes of the First Study is the development of a new, more robust typology for describing the nature of misconduct at issue in disciplinary cases. Significantly, a matrix has been developed that distinguishes actual conduct (type of misconduct) from its cause or motivation, which is defined as explanation for misconduct. There are no previous studies known to the author that have separately analysed and considered these distinct elements of the nature of misconduct.

In the First Study, use of this novel typology showed some types of misconduct to be dominant primary issues in disciplinary cases (eg, sexual misconduct, illegal or
unethical prescribing), while other types of misconduct emerged more regularly as secondary issues (eg, problems with medical certificates or records, general treatment issues). From a policy perspective, this result highlights the need to view professional misconduct as a multi-layered issue.

II IMGS

One of the most important contributions made by this thesis is the work relating to IMGs. As noted above, IMG-status is identified in each of the Studies as being associated with increased risk of complaints and adverse disciplinary findings. Real regulatory value is gained from the demonstration, in the Second Study, that the risk varies considerably according to particular countries of training. Results from the First Study provide some insight into the possible reasons for that difference, thus highlighting areas in which the specific application of further resource may yield improvements.

IMGs play a pivotal role in the Australian and New Zealand healthcare systems, and are likely to continue to do so. The approach to assessing whether such doctors are ready for practice has been quite different in the two countries, with Australia’s urgent need for doctors in rural and remote areas driving down registration requirements. The results of the Second Study suggest, but do not show definitively, that these supply considerations may have compromised other public interest considerations, such as public protection. Recent development of more robust, nationally consistent, processes for the assessment of IMGs, along with initiatives designed to better integrate, supervise and support such doctors, is encouraging. However, further research in this area should be done, with a view to further identifying how to appropriately tailor such initiatives and interventions in order to ensure scarce regulatory resources are not wasted and patients are not put at risk.

III DISCIPLINARY DECISION-MAKING

The First Study also analysed disciplinary outcomes, along with the relationship between those outcomes and the characteristics of the cases concerned. In total, 43% of cases resulted in the doctor being removed from practice, with removal strongly
associated with several types of misconduct and explanations for misconduct. Of particular note, the odds of removal from practice were 22 times higher in cases where the doctor was found to have had a sexual relationship with a patient, relative to all other types of cases. Similarly, the odds of removal were 17 times higher for behaviour judged to be the result of wilful wrongdoing. The overall results of this analysis offer important new intelligence into the Tribunals’ decision-making, suggesting that the Tribunals are prepared to look behind the labels used in the charges brought before them and consider the underlying explanation for the misconduct at issue.

However, sensitivity to doctor shortages in Australia and New Zealand also appears to manifest in disciplinary decision-making. As seen from the analysis of sexual relationship cases, rehabilitation of problem doctors appears to be a primary driver for the Tribunals. Where rehabilitation is perceived to be possible, it is pursued. In the author’s view, the focus on rehabilitation may have gone too far. 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. As argued in the thesis, it is illegitimate to increase the level of acceptable risk posed by a doctor on the basis that what would be required to lower that risk is unpalatable for other, public interest, reasons. While the move (in the National Law Act, and signalled in the 2012 Review of the HPCA Act) is towards legislative recognition of wider public interest considerations, including workforce shortages, the author argues that such considerations should never be determinative of whether or not a doctor is removed from practice by a Tribunal. Rather, such considerations must be weighed differently according to the particular regulatory function being undertaken. It is recommended that the critical function of the complaints and disciplinary system, in according absolute priority to strict notions of public protection, be recognised within the relevant legislation, even if supply considerations become an explicit part of the boards’ decision-making in other areas.
IV FUTURE RESEARCH

Scope and opportunities for additional research are identified throughout the thesis. Suffice to say that the more that is known about the characteristics of the doctors who become involved in the complaints and disciplinary system, the nature of the conduct that leads them there, and the interrelationships between relevant considerations, the better placed the regulatory system will be to identify how to proactively protect the public. Such knowledge may allow some vulnerabilities to be addressed before they develop into problems, preferably without requiring recourse to the ‘big stick’ of disciplinary action. Future research, as well as any resulting regulatory action, should be greatly facilitated in Australia through the nationalisation of the regulatory framework and the gathering together of relevant information within AHPRA. Future research will also be assisted by the typologies developed in this thesis, especially the characterisation of the nature of misconduct into types and underlying explanations for the misconduct.

V CONCLUSION

This thesis has provided a range of new insights into medical professional regulation in Australian and New Zealand, particularly in relation to the complaints and disciplinary systems.

Armed with the knowledge from the Studies, regulators should find themselves one step closer to being able to proactively identify ‘at risk’ doctors and target resources, for example increased support and training, into preventing the types of events that precipitate complaints. The ability to effectively pin-point risk further according to particular types of misconduct and underlying behaviours would be a particularly potent regulatory tool. For example, the results of the First Study indicate that the prevalence of disciplinary action for certain types of misconduct varies with length of time in practice. The ability to look beyond simple constructions of types of misconduct may also prove beneficial from a regulatory perspective. The unique characterisation of the nature of misconduct developed in this thesis provides a framework for doing just that.
The most important contribution of this thesis is its production of a more nuanced, robust and complete knowledge of the complaints and disciplinary system, of how that system operates, and with whom it interacts. This increased knowledge should enable a more focused, and thus effective, regulatory response to be implemented. Critically, that response should appropriately position public protection considerations within the broader context of the wider public interest, in order to ensure that medical services are, at once, available, accessible, acceptable, and of appropriate quality.
BIBLIOGRAPHY

I ARTICLES, BOOKS, REPORTS AND WEBSITES

'Midwife Found Not Guilty of Manslaughter', NZ Herald (Auckland), 21 March 2006


'A World of Expertise: Supporting International Medical Graduates in Victoria: Showcase Programme' (Department of Human Services, 2009)


Alkire, Sabina and Lincoln Chen, "Medical Exceptionalism' in International Migration: Should Doctors and Nurses Be Treated Differently?" (Paper presented at the Global Migration Regimes Workshop, Stockholm, 2004)

American Medical Association, 'Code of Ethics' (AMA, 1990)

Arup, Christopher et al (eds), Labour Law and Labour Market Regulation (The Federation Press, 2006)


Australian Health Practitioners Regulation Agency, 'Fundamentals Sound - AHPRA Future Focused' (AHPRA, 3 June 2011)


Australian Medical Association, 'Rural Doctors Have Their Say on Key Solutions to Improve Rural Health Care Delivery' (AMA, 2007)

Australian Medical Council, 'Submission to House of Representatives Standing Committee on Health and Ageing on the Inquiry into Registration Processes and Support for Overseas Trained Doctors' (4 February 2011)

Australian Senate Finance and Public Administration References Committee, 'The Administration of Health Practitioner Regulation by the Australian Health Practitioners Regulation Agency' (Commonwealth of Australia, 2011)

Ayres, Ian and John Braithwaite, Responsive Regulation: Transcending the Regulation Debate (Oxford University Press, 1992)

Bartle, Ian and Peter Vass, 'Self-Regulation within the Regulatory State' (2007) 85(4) Public Administration 885

Barton, David et al, 'Victoria's Dependence on Overseas Trained Doctors in Psychiatry' (2003) 11(1) People and Place 54

Bayram, Clare et al, 'Clinical Activity of Overseas-Trained Doctors Practising in General Practice in Australia' (2007) 31(3) Australian Health Review 440

Birrell, Bob, 'Too many GPs' (Centre for Population and Urban Research, Monash University, 2013)

Birrell, Bob and Lesleyanne Hawthorne, 'Medicare Plus and Overseas-Trained Medical Doctors' (2004) 12(2) People and Place 84

Birrell, Bob, Lesleyanne Hawthorne and Virginia Rapson, 'The Outlook for Surgical Services in Australasia' (Monash University, 2003)


Braithwaite, John, Restorative Justice and Responsive Regulation (Oxford University Press, 2002)
Braithwaite, John, Judith Healy and Kathryn Dwan, 'The Governance of Health Safety and Quality' (Commonwealth of Australia, 2005)

Brennan, Troyen, 'The Role of Regulation in Quality Improvement' (1998) 76 Milbank Quarterly 709

Carver, Peter, 'Self Sufficiency and International Medical Graduates - Australia' (National Health Workforce Taskforce, 2008)


Clay, Steven and Robert Conaster, 'Characteristics of Physicians Disciplined by the State Medical Board of Ohio' (2003) 103(2) JAOA 81


Cooper-Patrick, Lisa et al, 'Race, Gender, and Partnership in the Patient-Physician Relationship' (1999) 282(6) JAMA 583


Council of Australian Governments, 'Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions' (CoAG, 2008)


Dehlendorf, Christine and Sidney Wolfe, 'Physicians Disciplined for Sex-Related Offenses' (1998) 279(23) *JAMA* 1883

Department of Health and Ageing, 'Report on the Audit of Health Workforce in Rural and Regional Australia' (Commonwealth of Australia, 2008)


Department of Human Services, 'Planning for Growth in Victoria`s Medical Workforce' (State Government of Victoria, 2008)


Donaldson, Liam J, '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)

Donnell, Hayden, 'Three-Fold Increase in Doctors Heading to Oz - Recruiters', *New Zealand Herald* (Auckland), 15 February 2011

Dumont, Jean-Christophe and Pascal Zurn, 'Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration' in *International Migration Outlook* (OECD, 2007)

Elkin, Katie, 'Changes to the Eligibility to Bill on Medicare in Australia: A Threat to New Zealand's Medical Workforce' (2010) 123(1325) *NZMJ* 66

Elkin, Katie, Matthew Spittal and David Elkin, 'Doctors Disciplined for Professional Misconduct in Australia and New Zealand, 2000-2009' (2011) 194(9) *MJA* 452

Elkin, Katie et al, 'Removal of Doctors from Practice for Professional Misconduct in Australia and New Zealand' (2012) 10(1136) *BMJ Quality & Safety*
Elkin, Katie, Matthew Spittal and David Studdert, 'Risks of Complaints and Adverse Disciplinary Findings against International Medical Graduates in Victoria and Western Australia' (2012) 197(8) MJA 448

Elkin, Katie and David M Studdert, 'Restricted Career Paths for Overseas Students Graduating from Australian Medical Schools' (2010) 192 MJA 517


Fiscella, Kevin et al, "'Being a Foreigner, I May Be Punished If I Make a Small Mistake': Assessing Transcultural Experiences in Caring for Patients' (1997) 14(2) Family Practice 112


Freckelton, Ian, 'The Margins of Professional Regulation: Disjunctions, Dilemmas and Deterrence' (2006) 23(2) Law in Context 148

Freckelton, Ian, 'Regulating Health Practitioner Professionalism' (2006) 23(2) Law in Context 1

Freckelton, Ian, 'Regulation of Health Practitioners' in Ian Freckelton and Kerry Peterson (eds), Disputes & Dilemmas in Health Law (The Federation Press, 2006)


Gorman, Des, 'The Disposition and Mobility of Medical Practitioners in New Zealand' (2011) 124(1330) *NZMJ*

Gorman, Des, 'The Future Disposition of the New Zealand Medical Workforce' (2010) 123(1315) *NZMJ*

Gorman, Des and Peter Brooks, 'On Solutions to the Shortage of Doctors in Australia and New Zealand' (2009) 190(3) *MJA* 152


Hagan, Kate, 'Recruitment of Overseas G.Ps 'Threatened'', *The Age* (Melbourne), 27 April 2011


Haller, Linda, 'Regulating the Professions' in Peter Cane and Herbert Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2010)
Harding, Catherine et al, 'Comparing Patients' Perceptions of IMGs and Local Australian Graduates in Rural General Practice' (2010) 39(4) *Australian Family Physician* 231


Harvey, Karina and Thomas Faunce, 'A Critical Analysis of Overseas-Trained Doctor (OTD) Factors in the Bundaberg Base Hospital Surgical Inquiry' (2006) 23(3) *Law in Context* 73

Hawthorne, Lesleyanne, 'Competing for Skills: Migration Policies and Trends in New Zealand and Australia' (IMSED Research, NZ Department of Labour, 2011)

Hawthorne, Lesleyanne, 'Competing for Skills: Migration Policies and Trends in New Zealand and Australia' (Department of Labour (NZ), 2012)

Hawthorne, Lesleyanne, 'Doctor Shortages and Their Impact on the Quality of Medical Care in Australia' (2002) 10(3) *People and Place* 55

Hawthorne, Lesleyanne, 'Health Workforce Migration to Australia: Policy Trends and Outcomes' (Health Workforce Australia, 2012)

Hawthorne, Lesleyanne, 'International Medical Migration: What is in the Future for Australia?' (2012) 1 Supp 3 *MJA* 18


Hawthorne, Lesleyanne 'Migration and Education: Quality Assurance and Mutual Recognition of Qualifications' (UNESCO, 2008)

Hawthorne, Lesleyanne, Bob Birrell and Doris Young, 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria' (University of Melbourne, 2003)

Hawthorne, Lesleyanne, Graeme Hawthorne and Brendan Crotty, 'Final Report: The Registration and Training Status of Overseas Trained Doctors in Australia' (University of Melbourne, 2007)

Hawthorne, Lesleyanne and Julie Toth, 'The Impact of Language Testing on the Registration of Immigrant Doctors' (2005) 2(3) *People and Place* 47

Hazarika, Indrajit et al, 'Country Report: India' (Public Health Foundation of India, 2009)
Health and Disability Commissioner, 'Dr Roman Hasil and Whanganui District Health Board: A Report by the Health and Disability Commissioner' (HDC, 2008)

Health Workforce Australia, 'Doctors in Focus' (Department of Health and Ageing, 2012)

Health Workforce Australia, 'The Effects of Medical Graduate Expansion in Australia - Final Report' (AHWO, 2012)


Healy, Judith, Improving Health Care Safety and Quality (Ashgate, 2010)


Humphrey, Charlotte, S Hickman and MC Gulliford, 'Place of Medical Qualification and Outcomes of U.K. 'Fitness to Practise' Process: Cohort Study' (2011) 342 BMJ


Joint Standing Committee on Migration, 'Negotiating the Maze: Review of the Arrangements for Overseas Skills Recognition, Upgrading and Licensing' (Commonwealth of Australia, 2006)


Ko, Dennis et al, 'Quality of Care of International and Canadian Medical Graduates in Acute Myocardial Infarction' (2005) 165(4) Archives of Internal Medicine 458


Lennon, Brett, 'International Physician Migration - the Push for Self Sufficiency' (Paper presented at the 9th International Medical Workforce Collaborative Conference, Melbourne, 2005)


Lloyd-Bostock, Sally and Bridget Hutter, 'Reforming Regulation of the Medical Profession: The Risk of Risk-Based Approaches' (2008) 10 Health, Risk & Society 69

Lowenberg, Anton and Thomas Tinnin, 'Professional versus Consumer Interests in Regulation: The Case of the US Child Care Industry' (1992) 24 Applied Economics 571

McLean, Rick and Jan Bennett, 'Nationally consistent assessment of International Medical Graduates' (2008) 188 MJA 464

Manning, Joanna, 'Professional Discipline of Health Practitioners' in Peter Skegg and Ron Paterson (eds), Medical Law in New Zealand (Brookers, 2006)

Mechanic, David, 'The Functions and Limitations of Trust in the Provision of Medical Care' (1998) 23(4) *Journal of Health Politics, Policy and Law* 661

Medew, Julia, 'Thousands Fail to Register after Regulation Shake-Up', *The Age* (Melbourne), 2 February 2011


Medical Board of Australia, 'Continued Professional Development Registration Standard' (Medical Board of Australia, 2010)


Medical Board of Australia, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (Medical Board of Australia, 2010)


Medical Board of Australia, 'Media Release: Board and AMC To Review Implementation of IMG Pathways' (Medical Board of Australia, 8 November 2010)


Medical Board of Queensland and the Office of the Medical Board of Queensland, 'Annual Report 2007/08' (2008)

Medical Council of New Zealand, 'Annual Report 2009/10' (MCNZ, 2010)

Medical Council of New Zealand, 'Annual Report 2010/11' (MCNZ, 2011)


Medical Council of New Zealand, 'The New Zealand Medical Workforce in 2006' (MCNZ, 2006)

Medical Council of New Zealand, 'The New Zealand Medical Workforce in 2009' (MCNZ, 2010)

294
Medical Council of New Zealand, 'The New Zealand Medical Workforce in 2011' (MCNZ, 2012)

Medical Council of New Zealand, Policy on Registration in New Zealand (<www.mcnz.org.nz/Registration/Forms/policiesandfees/Registrationpolicies/PolicyonregistrationinNewZealand/tabid/107/Default.aspx>)

Medical Council of New Zealand, 'Policy on Registration in New Zealand' (MCNZ, 2011)

Medical Council of New Zealand, 'Providing Care to Yourself and Those Close to You' (MCNZ, 2007)


Medical Council of New Zealand, 'Sexual Boundaries in the Doctor-Patient Relationship: A Resource for Doctors' (MCNZ, 2009)

Medical Practitioners Board of Victoria, 'Annual Report 2007/08' (Medical Board of Victoria, 2008)


Mill, John Stuart, On Liberty (PF Collier & Son, 1909)


Ministry of Health (NZ), 'How Do We Determine If Statutory Regulation Is the Most Appropriate Way to Regulate Health Professions? A Discussion Document' (MoH, 2010)
Ministry of Health (NZ), 'Proposal That Traditional Chinese Medicine Become a Regulated Profession under the Health Practitioners Competence Assurance Act 2003' (MoH, 2011)


Ministry of Health (NZ), 'Review of the Health Practitioners Competence Assurance Act 2003: Report to the Minister of Health by the Director-General of Health' (MoH, 2009)


Morauta, Louise, 'Implementing a COAG Reform Using the National Law Model: Australia’s National Registration and Accreditation Scheme for Health Practitioners' (2011) 70(1) *Au Jnl of Public Admin* 75

Morrison, James and Theodore Morrison, 'Psychiatrists Disciplined by a State Medical Board' (2001) 158(474) *Am J Psychiatry* 474

Morrison, James and Peter Wickersham, 'Physicians Disciplined by a State Medical Board' (1998) 279(23) *JAMA* 1889


Nair, Balakrishnan R and Mulavana S Parvathy, 'Editorial: Setting up International Medical Graduates to Succeed' (2012) 197(8) *MJA* 428


Negin, Joel, 'Australia and New Zealand's Contribution to Pacific Island Health Worker Brain Drain' (2008) 32(6) *Au & NZ Jnl of Public Health* 507

New Zealand Medical Students' Association, 'Medical Student Numbers - Position Statement' (NZMSA, 2011)


Oakeshott, George, 'Prescription for Trouble' (2006) (September) *About the House* 20


Papadakis, Maxine A et al, 'Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board' (2004) 79(3) *Academic Medicine* 244


Parker, Christine, *Just Lawyers* (Oxford University Press, 1999)

Parker, Christine and John Braithwaite, 'Regulation' in Peter Cane and Mark Tushnet (eds), *The Oxford Handbook of Legal Studies* (Oxford University Press, 2003)


Postgraduate Medical Council of Victoria, 'Overseas Trained Doctors in the Victorian Public Hospital System' (PMCV, 2002)


Pryor, Lisa, 'Struck Off Doctor Counsels for Salvos', Sydney Morning Herald (Sydney), 21 September 2005


Reid, Alison, 'To Discipline or Not to Discipline? Managing Poorly Performing Doctors' (2006) 23(2) Law in Context 91

Rhee, Sang-O et al, 'USMGs Versus FMGs: Are There Performance Differences in the Ambulatory Care Setting?' (1986) 24(3) Medical Care 248


Savage, Jared, 'Dark Secrets of Dr Hasil', The Herald (Auckland), 2 November 2008


Saywell, Robert et al, 'A Performance Comparison: USMG-FMG Attending Physicians' (1979) 69 American Jnl of Public Health 57


Srivastava, Ranjana and Declan J Green, 'What's in a Name?' (2004) 181(11/12) MJA 643

Stone, Julie, 'Regulating Complementary Medicine' (1996) 312 BMJ 1492

Tamblyn, Robyn et al, 'Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities' (2007) 298(9) JAMA 993

Tan, Kong Meng, 'Foreign Medical Graduate Performance - Review' (1977) 15(10) Medical Care 822

Tapper, Richard, Laurence Malcolm and Frank Frizelle, 'Surgeons' Experiences of Complaints to the Health and Disability Commissioner' (2004) 117(1198) NZMJ 975


Thomas, David, 'The Co-Regulation of Medical Discipline: Challenging Medical Peer Review' (2004) 11 JLM 382

Tuckett, Nikita, 'Balancing Public Health and Practitioner Accountability in Medical Manslaughter after R v Patel' (2011) 19 JLM 377

von Tigerstron, Barbara and Katherine Ellena, 'Regulation of Contemporary and Alternative Medicine - a Trans-Tasman Perspective' (2006) 23(2) *Law in Context* 198

Walters, Rob, 'We Need Our Foreign Doctors', *The Australian* 7 June 2005


Weir, 'Regulation of Complementary and Alternative Medicine Practitioners' (2006) 23(2) *Law in Context*

Wijesinha, Sanjov, 'Australians See Doctor Death in Every Overseas-Trained Doctor', *The Age* (Melbourne), 14 June 2005

Wilson, Andrew and Frank Hume, 'Sexual Misconduct: Is Censure Enough?' (1993) 27(2) *Jnl of Psychiatry* 329

Wolfe, Sidney et al, 'Questionable Doctors Disciplined by State and Federal Governments' (Public Citizen Health Research Group, 2000)

Wolfe, Sidney and Kate Resnevic, 'Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007' (Public Citizen Health Research Group, 2008)


Wroe, David, 'Exodus Fear over 'Medical Racism'', *The Age* (Melbourne), 21 July 2005

Zelas, Karen, 'Sex and the Doctor-Patient Relationship' (1997) 110(1038) *NZMJ* 60

Zurn, Pascal and Jean-Christophe Dumont, 'Health Workforce and International Migration: Can New Zealand Compete?' (OECD 2008)
II CASE LAW

A v Professional Conduct Committee (unreported, HC, Akld, CIV-2008-404-2927, Keane J, 5 September 2008)

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118

Bolitho v City and Hackney Health Authority [1997] 4 All ER 771

Bottrill v A [2003] 2 NZLR (PC)

Clyne v New South Wales Bar Association (1960) 104 CLR 186

Council for the Regulation of Healthcare Professionals v General Medical Council (2005) 84 BMLR 7

Director of Proceedings v Nikau [2010] NZHRRT 26

Director of Proceedings v Patel Med06/36D

Director of Proceedings v Taikura Trust [2012] NZHRRT 3

G v Director of Proceedings (unreported, HC, Auckland, CIV-2009-404-000951, 5 March and 12 November 2009)

Giele v General Medical Council (QBD) [2006] 1 WLR 942

Honey v Medical Practitioners Board of Victoria [2007] VCAT 526

LWB v the Preliminary Proceedings Committee of the Medical Council of New Zealand and the Medical Council of New Zealand (unreported, HC, Auckland, HC169/95, 8 August 1996)

Medical Board of Western Australia v Dr Behzad Alizadeh [2007] WASAT 52

Medical Practitioners Board of Victoria v Kaur [2010] VCAT 364

Patel v Complaints Assessment Committee, High Court, Auckland, CIV 2007-404-1818

Patel v The Queen [2012] HCA 29

PCC v Martin (unreported, HC, Wgtn, CIV2006-485-1461, 27 February 2007)

Pillai v Messiter (No. 2) (1989) 16 NSWLR 197 (NSW CA)

Queenstown Lakes District Council v Palmer [1999] 1 NZLR 549 (CA)
R v Bateman (1925) 19 Cr App R 8

R v Mobilio [1991] 1 VR 339

R v Patel [2010] QSC 198

R v Taktak (1988) 14 NSWLR 226

Re Dr A, MPDT(NZ), 181/01/78C, 10 December 2001

Re Dr A, MPDT(NZ), 304/04/122C, 28 October 2004

Re Dr Aftab Aslam, [2004] NSWMT 1

Re Dr Alfred Harold Leitmanis [2003] MPBV 33

Re Dr Bernard Tse, NSWMT, 40001/04, 24 September 2004, Patten J

Re Dr Christopher John Alroe, QHPT, D657/2003, 17 December 2003

Re Dr Clarence Alexander Gluski, NSWMT, 2001

Re Dr David John Wignall [2005] MPBV 10

Re Dr E, HPDT(NZ), 136/Med07/76D, 3 December 2007

Re Dr Ebenezer Jeyanathan Danforth, NSWMT, 21 May 2001

Re Dr George David Angus, NSWMT, 24 October 2000

Re Dr George Robert Wardrop [2002] MPBV 1

Re Dr Ian McColl Fitzgerald [2007] MPBV 5

Re Dr Il-Song Lee, NSWMT, 40009/01, 21 March 2002

Re Dr Jerome Lindsay Gelb [2008] MPBV 6

Re Dr Johannes Ignatius Wilson, HPDT(NZ), 314/Med10/145P, 12 July 2010

Re Dr John Drury [2001] MPBV 1

Re Dr Julian Joseph Brennan [2005] MPBV 11

Re Dr Maria Bastas, NSWMT, 40020/05, 17 February 2006

Re Dr Mohammed Mateen Ui Jabbar [2007] MPBV 4

Re Dr Parajuli [2010] NSWMT 3
Re Dr Rahual Sant Ram, NSWMT, 19 March 2004

Re Dr Stanley James Vincent, NSWMT, 40021/01, 20 September 2002

Re Dr Tong Eng Gan [2004] MPBV 23

Re Dr Wiles, MPDT(NZ), 155/00/65D, 5 March 2001

Re Graeme John Harris, NSWMT, 40005/08, 18 December 2008

Re Medical Practitioners Act (1966) 67 SR (NSW) 448

Re Morgan Fahey, MPDT(NZ), 144/00/64C, 29 November 2000

Re Mr Albert Habib Joseph [2004] MPBV 15

Re Richard Alexander Vesi Gulliver, HPDT(NZ), Nur06/35P, 19 September 2006

Re Richard Gorringe, MPDT(NZ), 237/02/89D, 5 August 2003

Re Richard Gorringe, MPDT(NZ), 284/03/113C, 10 May 2004

Re Ronald Cyril Hare and the Medical Practitioners Act, NSWMT, 14 December 1990

Re S, HPDT(NZ), 135/Nur07/62P, 18 September 2007

Re XX, MPDT(NZ), 198/01/87D, 30 April 2002

Taylor v General Medical Council [1990] 2 All ER 263

Z v Dental Complaints Assessment Committee [2008] NZSC 55

III LEGISLATION

Accident Compensation Act 2001 (NZ)

Administrative Appeals Tribunal Act 1984 (Vic)

Civil Liability Act 2002 (NSW).

Crimes (Sentencing Procedure) Act 1999 (NSW)

Crimes Act 1961 (NZ)

Crimes Amendment Act (No 3) 2011 (NZ)

Health Care Quality Improvement Act 1986 (US)

Health Insurance Act 1973 (Cth)
Health Insurance Amendment (Overseas Trained Doctors) Act 2009 (Cth)

Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 (Qld)

Health Practitioner Regulation National Law Act 2008 (Qld)

Health Practitioners (Professional Standards) Act 1999 (Qld)

Health Practitioners Competence Assurance (Restricted Activities) Order 2005 (SR 2005/182) (NZ)

Health Practitioners Competence Assurance Act 2003 (NZ)

Health Professions Registration Act 2005 (Vic)

Health Quality and Complaints Commission Act 2006 (Qld)

Health Services (Conciliation and Review) Act 1987 (Vic)

Health Services (Conciliation and Review) Act 1995 (WA)

Medical Act 1894 (WA)

Medical Act 1939 (Qld)

Medical Practice Act 1992 (NSW)

Medical Practice Act 1994 (Vic)

Medical Practitioners Act 1995 (NZ)

Medical Practitioners Act 2008 (WA)

Medical Practitioners Registration Act 2001 (Qld)

Trans Tasman Mutual Recognition Act 1997 (NZ)

Victorian Civil and Administrative Tribunal Act 1998 (Vic)
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