Protection, Prevention or Punishment? A Cross-Jurisdictional Analysis of Regulatory Immediate Action against Medical Practitioners

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Medical regulators protect the public from unsafe, unwell, or unscrupulous medical practitioners. To facilitate a swift response to serious allegations, many regulators are equipped with far-reaching emergency powers to immediately suspend, or impose conditions on, medical practitioners' registration before facts are proven. Failing to take urgent action may expose the public to ongoing avoidable harm and may erode public trust in the profession. Equally, imposing immediate action in response to allegations that are not subsequently proven can precipitously and irreparably injure a practitioner's career and emotional wellbeing. This is the second of two articles published in the Journal of Law and Medicine that explores the emerging jurisprudence in relation to these emergency regulatory powers. This article compares the approaches to immediate action in seven countries, providing insights for policy-makers and decision-makers into how modern regulatory frameworks attempt to balance the inherent tensions between the profession, the public and the State.

Keywords: *immediate action; medical regulation; public protection; public interest; cross-jurisdictional analysis*

I. Introduction

Over the last two decades, medical regulators have progressively acquired far-reaching interim powers to protect the public and maintain public confidence in the medical profession. "Immediate action"[1] refers to the power to immediately suspend, or impose conditions on, the registration of a medical practitioner while serious allegations are being investigated and before all the facts are known. The exercise of these powers raises a dilemma for decision-makers. Failing to take immediate action in response to serious allegations may erode public trust in the profession and its regulation and expose patients to avoidable harm. Allegations of serious misconduct or illness can result in intense media scrutiny and pressure on medical regulators to react promptly. Conversely, taking immediate action in response to allegations that are ultimately not found proven can irreparably damage a practitioner's reputation, personal life, and livelihood. Immediate action has been described as "regulatory capital punishment before trial".[2]

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[1] "Immediate action" is referred to as "interim action" or "summary action" overseas but, for consistency, will be referred to as "immediate action" throughout this article. See C Stewart and C Rudge, "The Public Interest Test in Immediate Action Hearings under the Health Practitioner Regulation National Law" (2021) 28 JLM 976.

[2] G Mileikowsky and B Lee, "How to Protect Physician Whistleblower – Patient Advocates – From Retaliation to Benefit Patients: A Legal Analysis Regarding Summary Suspension, Retaliation, Peer Review and Remedies" (2019) 16(1) *US-China Law Review* 21, 33.

Immediate action powers are available to the regulators of many professions including lawyers,[3] judges,[4] police officers,[5] pilots,[6] teachers,[7] and unregistered health practitioners.[8] Despite their ubiquity, they are rarely studied. Most scholarly articles in the field of professional regulation focus on ultimate outcomes following final determinations of fact, even though much regulatory action occurs in advance of concluded investigations.[9] This gap in the academic literature provides an opportunity to ask important questions about how regulators can best protect the public from harm, while ensuring adequate procedural safeguards for practitioners. Comparing the approaches to this dilemma in different countries can assist in answering this important question.

Immediate action is available to medical regulators in at least 50 jurisdictions.[10] In this article we identify, analyse, and compare legislation, case law and statistics relating to immediate action in seven countries: Australia, the United Kingdom, Singapore, Ireland, New Zealand, Canada, and the United States (focusing on California). We selected these countries as they are jurisdictions with broadly comparable legal traditions,[11] similar health care systems, similar medical regulatory frameworks, and legal texts that are available in English. Comparing similarities and differences allows us to draw inferences about how and why decision-makers impose immediate action and offers a deeper understanding of contextual factors. In turn, these insights may inform improvements in regulatory practice, in Australia and internationally.[12]

We identified immediate action legislation and cases by searching publicly available databases. Exact search terms were adapted to different jurisdictions, as outlined in Appendix 1, to include the name of the medical regulator and the phrases used in each jurisdiction to describe immediate action. Only cases that reviewed immediate action imposed on doctors were included in the analysis. We excluded stay applications, costs applications and cases that referenced, but did not judicially review, earlier immediate action decisions. We counted cases once where there were multiple appeals in relation to the same first-instance decision. We compared the frequency of immediate action use in each jurisdiction by accessing data published in medical regulators' annual reports.[13] Appendix 2 summarises the statutory powers available in the jurisdictions studied, while Appendix 3 summarises our analysis of the published case law.

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[3] *Legal Profession Uniform Law Application Act 2014* (Vic) s 278.

[4] *Judicial Commission of Victoria Act 2016* (Vic) s 97.

[5] *Victoria Police Act 2013* (Vic) s 127.

[6] *Civil Aviation Act 1988* (Cth) s 30DC (and CASA Enforcement Manual).

[7] *Education and Training Reform Act 2006* (Vic) ss 2.6.27–2.6.28.

[8] *Health Complaints Act 2016* (Vic) s 90.

[9] Only two prior studies have specifically examined immediate actions: P Case, "Putting Public Confidence First: Doctors, Precautionary Suspension, and the General Medical Council" (2011) 19(3) *Medical Law Review* 345; and OM Bradfield et al, "Characteristics and Predictors of Regulatory Immediate Action Imposed on Registered Health Practitioners in Australia: A Retrospective Cohort Study" (2020) 44(5) *Australian Health Review* 784.

[10] OM Bradfield, MJ Spittal and MM Bismark, "In Whose Interest? Recent Developments in Regulatory Immediate Action against Medical Practitioners in Australia" (2020) 28(1) JLM 244.

[11] JH Merryman and R Pérez-Perdomo, "Two Legal Traditions" in *The Civil Law Tradition* (Stanford University Press, 2020) 1–5 <https://doi.org/10.1515/9781503607552-003>.

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

[13] Medical Board of Australia <https://www.ahpra.gov.au/Publications/Annual-reports.aspx>; Medical Council of NSW <https://www.mcnsw.org.au/our-publications>; Office of the Health Ombudsman Queensland, *Annual Reports* <https://www.oho.qld.gov.au/news-and-updates/annual-reports>; Medical Council of New Zealand, *Annual Reports* <https://www.mcnz.org.nz/about-us/publications/annual-reports/>; Medical Practitioners Tribunal Service UK, *Reports and Management* <https://www.mpts-uk.org/about/how-we-work/reports-and-management>; General Medical Council, *Our Annual Report* <https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/annual-reports>; Singapore Medical Council, *Annual Reports* <https://www.healthprofessionals.gov.sg/smc/publications-newsroom/smc-annual-reports>; Irish Medical Council <https://www.medicalcouncil.ie/news-and-publications/publications/annual-reports-statistics-/>; California Medical Board, *Annual Reports* <https://www.mbc.ca.gov/Resources/Publications/Annual-reports.aspx>.

II. Analysis of Immediate Action Laws around the World

A. Australia

In Australia, doctors in all States and Territories are regulated under a national scheme with some minor jurisdictional differences. The *Health Practitioner Regulation National Law Act 2009* (Qld) (the *National Law*) allows the Medical Board of Australia (MBA) (the Medical Council in New South Wales or the Health Ombudsman in Queensland), to immediately suspend or impose conditions on the registration of a medical practitioner if "necessary" to protect public health or safety (the *public risk test*).[14] In New South Wales, immediate action is permitted if "appropriate" rather than "necessary".[15] Doctors facing immediate action have a right to notice,[16] an opportunity to make submissions,[17] and reasons for decision.[18] Once immediate action has been imposed, there are no time limits or requirements for review. Instead, it continues unless or until set aside on appeal,[19] or revoked by the MBA.[20]

According to a long line of Australian judicial decisions, immediate action to protect public health and safety requires urgent action, even when based on "incomplete information".[21] It is not a substitute or shortcut for regulatory action that may follow an investigation of allegations of professional misconduct or unprofessional conduct.[22] A doctor's suitability to practise will be revisited following further investigation and a full hearing on the merits.[23] There must be a risk that cannot wait the usual process of investigation and hearing, and the risk must currently exist at the time the immediate action decision is made.[24] Hearings are held in private and there is no maximum duration on the tenure of immediate actions. However, a principle of the scheme is that decisions should be timely.

Immediate action does not require proof of conduct but, rather, the existence of objective circumstances sufficient to "induce the belief in a reasonable person" that the medical practitioner poses a serious risk.[25] This may be based on the fact or seriousness of written complaints or charges, even if untested.[26] There must be some "tangible support" beyond mere assertion by an applicant.[27] A complaint that is trivial or misconceived on its face should not be given weight.[28] Taking immediate action requires the "need to carefully consider the protection of the public on the one hand and the impact upon the practitioner on the other".[29] When full information is later obtained, a reasonable belief that immediate action was necessary on limited information may be later shown to be in error. One way of minimising the harm associated with such potential errors is to ensure the timely prosecution of allegations. While public

[14] *Health Practitioner Regulation National Law Act 2009* (NSW) s 156; *Health Ombudsman Act 2013* (Qld) s 58.

[15] *Health Practitioner Regulation National Law Act 2009* (NSW) s 150.

[16] *Health Practitioner Regulation National Law Act 2009* (Qld) s 157(1).

[17] *Health Practitioner Regulation National Law Act 2009* (Qld) s 157(2).

[18] *Health Practitioner Regulation National Law Act 2009* (Qld) s 158(2)(b).

[19] *Health Practitioner Regulation National Law Act 2009* (Qld) s 159(2)(a).

[20] *Health Practitioner Regulation National Law Act 2009* (Qld) s 159(2)(b).

[21] *Syme v Medical Board of Australia* [2016] VCAT 2150, [22].

[22] *Gerstman v Medical Board of Australia* [2020] VCAT 1367, [71].

[23] *Kozanoglu v The Pharmacy Board of Australia* (2012) 36 VR 656, [73]; [2012] VSCA 295.

[24] *Syme v Medical Board of Australia* [2016] VCAT 2150, [122].

[25] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [64].

[26] *Syme v Medical Board of Australia* [2016] VCAT 2150.

[27] *Coppa v Medical Board of Australia* (2014) 34 NTLR 74, [55]; [2014] NTSC 48.

[28] *WD v Medical Board of Australia* [2013] QCAT 614 (Horneman-Wren J), citing *I v Medical Board of Australia* [2011] SAHPT 18, *Lindsay v NSW Medical Board* [2008] NSWSC 40, and *Liddell v Medical Board of Australia* [2012] WASAT 120.

[29] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [28]; [2015] NTSC 39.

protection is paramount,[30] it "should be secured with as little damage to the practitioner as is consistent with its maintenance":[31]

> because a practitioner's reputation or their capacity to earn a livelihood in their registered vocation is at stake, the Tribunal must feel an actual persuasion of the occurrence or existence of the relevant facts.[32]

Immediate action may also be taken in relation to conduct where no treating relationship exists or where there is no connection to the practice of medicine.[33] The decision-maker must form a reasonable belief that, because of the conduct, there would be a serious risk to public health or safety unless immediate action is taken.[34] For example, an allegation of sexual misconduct unrelated to medical practice could still raise concerns about the health or safety of the practitioner's own patients.[35]

A recent Australian decision concerning the application of the *public risk test* is *Morris v Medical Board of Australia*.[36] In this case, immediate action conditions were imposed on a neurosurgeon limiting where he could work and the procedures he could perform and requiring him to practise under supervision. These conditions followed concerns about his clinical judgment and skill after two hospitals identified a high rate of post-operative complications in his patients. Instead of reviewing these adverse events and implementing changes to reduce the risk of recurrence, he resigned. The MBA was concerned that this demonstrated a lack of insight that gave rise to a "real and tangible risk" of harm to the public.[37]

On appeal, nine expert neurosurgeons and orthopaedic surgeons expressed disparate views about his professional performance. The nature and extent of their criticism or support for his conduct varied widely. Ultimately, the Victorian Civil and Administrative Tribunal (VCAT) held that, despite these divergent views, there remained a "substantial foundation for criticism" and a real (rather than remote, fanciful, or trivial) possibility that Mr Morris would avoid adopting measures to ensure the safe practice of neurosurgery within the limits of his capabilities, unless conditions were imposed.[38] VCAT was concerned that neurosurgery is a high-risk, complex, and intricate specialty that requires proper identification, management, and escalation of potential serious events at the earliest opportunity before, during and after surgery.[39] It was also concerned that Mr Morris' unwillingness and reluctance to accept measures aimed at reducing this risk demonstrated insufficient insight into the limits of his training and experience.[40] The immediate action conditions were upheld.

VCAT noted that its role was not to determine *facts* from the expert testimony but to determine whether the expert opinions ignited a reasonable belief in relation to *risk* to public health and safety. Therefore, while there were factual disagreements, they were not about the "qualifications, credit or character" of witnesses.[41] VCAT placed weight on the decision of the MBA which it said has specialist expertise and experience in dealing with issues under the *National Law*, particularly in relation to a highly specialised and evolving branch of surgery.[42]

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[30] *MLNO v Medical Board of Australia* [2012] VCAT 1613.

[31] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [60].

[32] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [27].

[33] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [92].

[34] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [93].

[35] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [89].

[36] *Morris v Medical Board of Australia* [2021] VCAT 548.

[37] *Morris v Medical Board of Australia* [2021] VCAT 548, [32].

[38] *Morris v Medical Board of Australia* [2021] VCAT 548, [310].

[39] *Morris v Medical Board of Australia* [2021] VCAT 548, [324].

[40] *Morris v Medical Board of Australia* [2021] VCAT 548, [325].

[41] *Morris v Medical Board of Australia* [2021] VCAT 548, [176].

[42] *Morris v Medical Board of Australia* [2021] VCAT 548, [180], citing *Shvetsova v Medical Board of Australia* [2018] VCAT 867. See Stewart and Rudge, n 1.

In addition to the *public risk test*, s 156(1)(e) of the *National Law* also allows the MBA to take immediate action if "otherwise in the public interest" (the *public interest test*).[43] Immediate action may be in the public interest when a registered health practitioner is charged with a serious criminal offence, unrelated to the practitioner's practice, for which immediate action is required to be taken to maintain public confidence in the provision of services by health practitioners. While a public interest limb for immediate action has existed in New South Wales since 1992,[44] the *public interest test* was only introduced into the *National Law* in March 2018.[45] This amendment mirrored the *public interest test* adopted in the United Kingdom and Singapore and was designed to capture historical issues uncovered after the passage of time, and patterns of repeated conduct, none of which individually may meet the threshold for public risk, but which are suggestive of an underlying issue.

The *public interest test* considers matters which impact upon the honour and integrity of the medical profession, rather than potential harm to the public. In *Crickitt v Medical Council of NSW (No 2)*,[46] it was held that the public must have confidence that medical practitioners exhibit integrity, trustworthiness and high moral and ethical values and are compliant with regulatory requirements and codes of practice established by those responsible for the administration of the medical profession. This was applied in *Farshchi v Medical Board of Australia* (*Farshchi*).[47] There, immediate action was imposed in the public interest on a doctor charged with slavery and people trafficking when he allegedly forced and threatened a refugee to work unpaid in his wife's sweet shop. VCAT held that a case involving prolonged abuse and exploitation cast doubt on the doctor's suitability and capacity to practice medicine safely or ethically.

Similarly, in *Kok v Medical Board of Australia*,[48] immediate action was taken in the public interest on a doctor who allegedly published outrageous and discriminatory comments on social media in which he condoned rape, endorsed violence and/or genocide towards racial and religious groups, and demeaned Lesbian, Gay, Bisexual, Queer, Transgender, and Intersex persons. VCAT said the *public interest test* required it to "reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession as a whole" and that nothing short of suspension would preserve public confidence in the medical profession, which would be undermined if a practising medical practitioner broadcast views of the kind posted by Dr Kok:

> We have grave concerns about whether the community would accept that any medical practitioner could switch, as though he were a light, from airing disrespectful views online to providing respectful and appropriate treatment for those who fall within a class he denigrates online … He does not simply drop his profession each time he enters the playground of social media engagement.[49]

However, in *CJE v Medical Board of Australia*,[50] immediate action was not taken in the public interest against a doctor charged with raping another medical practitioner. In that case, the minority followed the position in *Farshchi* that if the public knew about these allegations, it would seriously question the profession's reputation and CJE's suitability to practise medicine safely and ethically. However, the majority relied on competing public interest considerations. It held that the public would not judge the profession solely on untested allegations against a single medical practitioner, even if egregious, because such situations arise rarely. Moreover, the public would understand the importance of presuming CJE to be innocent.

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[43] In Queensland, the equivalent provision can be found in *Health Ombudsman Act 2013* (Qld) s 58(1)(d). In New South Wales, the equivalent provision can be found in the *Health Practitioner Regulation National Law Act 2009* (NSW) s 150(1)(a).

[44] In New South Wales, the ability to impose conditions on, or suspend, the registration of a medical practitioner in the public interest has existed since the enactment of the *Medical Practice Act 1992* (NSW) s 66.

[45] Queensland, *Parliamentary Debates*, Legislative Assembly, 13 June 2017, 1544 (Cameron Dick, Minister for Health and Minister for Ambulance Services).

[46] *Crickitt v Medical Council of NSW (No 2)* [2015] NSWCATOD 115, [56].

[47] *Farshchi v Medical Board of Australia* [2018] VCAT 1619.

[48] *Kok v Medical Board of Australia* [2020] VCAT 405.

[49] *Kok v Medical Board of Australia* [2020] VCAT 405, [66], [88].

[50] *CJE v Medical Board of Australia* [2019] VCAT 178.

In *Harirchian v Health Ombudsman*,[51] McGill SC stated that the *public interest test* ought not be "topped up" by covering considerations of public risk. Instead, it would be most relevantly applied in cases where there is little or no justification for immediate action by reference to the *public risk test*. Nevertheless, with the enactment of the *public interest test* in Australia, doctors are clearly subject to greater professional accountability for their private actions unrelated to the practice of their profession and the reach of the Australian regulator is widening. Between 1 July 2015 and 30 June 2020, immediate action was imposed 1344 times across Australian jurisdictions.[52] In 2016–2017, immediate action was imposed 184 times. However, by 2019–2020, this figure had doubled to 370 times, representing 5% of all complaints. It is possible that the enactment of a wider *public interest test* beyond New South Wales contributes to this observation. During the same period, immediate action decisions were appealed 28 times. The majority of cases related to males, General Practitioners, and allegations of misconduct. In more than half of cases, the first instance decision was either set aside or substituted for different immediate action. A summary of the relevant cases can be found in Appendix 3.

B. United Kingdom

The United Kingdom was the first jurisdiction to introduce immediate action powers for its medical regulator, the General Medical Council (GMC).[53] Section 41A of the *Medical Act 1983* (UK) (the *Medical Act*) gives an Interim Orders Tribunal the power to order interim suspension or interim conditions if: necessary for the protection of members of the public (*public risk test*); or otherwise in the public interest (*public interest test*).[54] As in Australia, the *public interest test* is broader and was enacted later, following highly publicised concerns about Dr Harold Shipman. Despite being charged with hundreds of murders and despite a lengthy police investigation, Shipman remained on the medical register, even after his conviction for murder.[55] The media was critical of the GMC for not immediately suspending Shipman.[56] In response to the Inquiry, the United Kingdom government enacted regulatory reforms to restore public confidence in the medical regulator. These reforms included interim public interest powers to protect, promote, and maintain "the health and safety of the public",[57] by facilitating a rapid response to urgent cases where the need to avert damage to public confidence in the profession was required.[58]

As in Australia, United Kingdom doctors facing immediate action have a right to notice,[59] a hearing[60] held in private,[61] and reasons for decision.[62] However, unlike in Australia, immediate action may not exceed 18 months[63] and must be reviewed six-monthly,[64] unless the medical practitioner requests an

[51] *Harirchian v Health Ombudsman* [2020] QCAT 414, [26].

[52] See Annual reports of the Medical Board of Australia, Medical Council of NSW and Health Ombudsman Queensland. This includes immediate action cases where conditions or suspensions were imposed, or where voluntary undertakings or registration surrender was accepted. This excludes immediate action cases where no action was taken or where decisions were pending at the time of publication.

[53] *Medical Act 1983* (UK) s 42(3)(c) as originally enacted.

[54] *Medical Act 1983* (UK) s 41A(1).

[55] J Smith, "The Shipman Inquiry – Fifth Report: Safeguarding Patients: Lessons from the Past – Proposals for the Future" (2004) 6394(9) *Command Paper Cm* 142.

[56] United Kingdom, *Parliamentary Debates*, House of Commons, 1 February 2000, vol 343 cc907-19.

[57] *Medical Act 1983* (UK) s 1(1A).

[58] NHS Executive, *Modernising Medical Regulation: Interim Strengthening of the GMC's Fitness to Practise Procedures* (Consultation Paper, May 2000) 1.6.

[59] *Medical Act 1983* (UK) s 41A(5).

[60] *Medical Act 1983* (UK) s 41A(4).

[61] The General Medical Council (Fitness to Practise) Rules Order of Council 2004 as amended by The General Medical Council (Fitness to Practise) (Amendment in Relation to Standard of Proof) Rules Order of Council 2008 and The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009, Rules 41(3), (4) and (6).

[62] General Medical Council (Fitness to Practise) Rules, n 61, Rule 27(4)(g).

[63] *Medical Act 1983* (UK) s 41A(1)(a).

[64] *Medical Act 1983* (UK) s 41A(2).

earlier review or new information becomes available.[65] An Interim Orders Tribunal may vary or revoke immediate action at any time[66] and may seek subsequent 12-month extensions[67] from a court.[68] Immediate action extended by a court must also be reviewed.[69] Immediate actions must not influence the outcome of any subsequent full hearing of the case.[70]

Before taking immediate action, an Interim Orders Tribunal must consider the seriousness of allegations, the weight of information, the likelihood of ongoing incidents occurring, and whether public confidence in the medical profession is "likely to be seriously damaged" if the medical practitioner continues to hold unrestricted registration.[71] The impact on public confidence and the expectations of the "reasonable onlooker"[72] must be considered, as must the consequences for "vulnerable service users"[73] if immediate action is not taken and allegations are subsequently proven, particularly in the case of serious allegations, such as rape, sexual assault, child abuse, or predatory behaviour towards patients.[74] However, the impact of immediate action on medical practitioners subsequently acquitted must also be contemplated.[75] This requires consideration of the wider impact on a doctor's patients, not just their inability to practise.[76] The nature and duration of immediate action must be proportionate to the risk posed.[77] Interim suspension must only be imposed if interim conditions are deemed insufficient to protect the public.[78]

As in Australia, immediate action does not require findings of fact. A prima facie case with sufficient corroborating information on initial examination will be sufficient to justify an order.[79] A decision-maker must not prejudge the truth or otherwise of criminal charges and must not make findings of fact. Instead, they must consider the substance of the allegations, without looking beyond them.[80] Courts will expect allegations to be confirmed in writing.[81] For example, courts often rely on the prosecution of criminal charges as evidence that a complaint is serious and that the State considers there is a sufficient prospect of success. The parties can make submissions on the necessity and terms of immediate action, but not on the credibility or merits of a disputed allegation because "the result would be a trial before the trial", which is "not what fairness requires at the interim stage".[82] Finally, while immediate action must be "necessary" under the *public risk test*, it need only be "desirable".[83]

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[65] *Medical Act 1983* (UK) s 41A(2).

[66] *Medical Act 1983* (UK) s 41A(3).

[67] *Medical Act 1983* (UK) s 41A(7).

[68] Court of Session in Scotland (*Medical Act 1983* (UK) s 40(5)(a)); the High Court of Northern Ireland (*Medical Act* s 40(5)(b)); or the High Court of England and Wales (*Medical Act* s 40(5)(c)).

[69] *Medical Act 1983* (UK) s 41A(9).

[70] W Roche, "Medical Regulation for the Public Interest in the United Kingdom" in JM Chamberlain and M Dent (eds), *Professional Health Regulation in the Public Interest: International Perspectives* (Policy Press, 2018) 90.

[71] MPTS, *Imposing Interim orders: Guidance for the Interim Orders Tribunal, Tribunal Chair and the Medical Practitioners Tribunal* (2012) Version 1.10 (Revised 8th Edition 2018) <https://www.mpts-uk.org/-/media/mpts-documents/DC4792_Imposing_Interim_Orders___Guidance_for_the_IOT_and_MPT_28443349.pdf>; Roche, n 70, [24a] and [24b].

[72] *Bhatnagar v GMC* [2013] EWHC 3417 (Admin).

[73] *Chigoya v Health and Care Professions Council* [2015] EWHC 1109.

[74] MPTS, n 71, [40].

[75] *R (on the application of Sosanya) v GMC* [2009] EWHC 2814 (Admin), [26].

[76] *Harry v General Medical Council* [2012] EWHC 2762 (QB).

[77] *Madan v General Medical Council* [2001] EWHC 577.

[78] *Perry v Nursing and Midwifery Council* [2007] 1 WLR 2007.

[79] *R (George) v General Medical Council* (GMC) [2003] EWHC 1124 (Admin).

[80] *GMC v Hiew* [2007] 1 WLR 2007.

[81] *GMC v Sheill* [2006] EWHC 3025.

[82] *GMC v Sheill* [2006] EWHC 3025, [33].

[83] *NH v General Medical Council* [2016] EWHC 2348 (Admin).

Our analysis of the GMC and MPTS annual reports reveals that interim sanctions were imposed 1,418 times between 1 January 2016 and 31 December 2020. This represents around 3% of all regulatory complaints received by the GMC during this period. Therefore, immediate action appears to be used less frequently in the United Kingdom when compared to Australia. Despite this, first instance decisions in the United Kingdom are less frequently appealed and such appeals are less likely to succeed. During the same period, there were only 12 published cases in which interim decisions were judicially considered, half of which were applications for extension of existing immediate action decisions brought by the regulator. In all but two cases, the Court upheld the original decision of the Interim Orders Tribunal. This may reflect the general deference shown by United Kingdom Courts to the Interim Orders Tribunal, which is considered to be an expert body, well-acquainted with the requirements of the medical profession.[84]

The most controversial United Kingdom immediate action case in the last five years was that of *Bawa-Garba v General Medical Council*.[85] It drew unprecedented ire from the media[86] and consternation from the medical profession in the United Kingdom[87] and internationally.[88] A six-year-old boy with Down Syndrome was admitted to hospital with sepsis and pneumonia. Dr Bawa-Garba was the most senior paediatric registrar on duty, and it was her first day at work after maternity leave. She had not received a formal workplace induction. Another staff member was absent due to illness, and she was performing three doctors' work over a long shift. The hospital computers were down, and test results were delayed. She failed to recognise the boy's clinical deterioration. He required resuscitation, which was suspended when Dr Bawa-Garba mistaken believed that the boy was "not for resuscitation". He subsequently died. Dr Bawa-Garba's supervising consultant was off site and did not review the boy, despite being aware of worrying blood test results.

In 2015, Dr Bawa-Garba was charged with gross negligence manslaughter. In response, an Interim Orders Tribunal imposed an interim suspension. On appeal, Knowles J held that immediate action was justified, because the Crown Prosecution Service was sufficiently satisfied that there was a realistic prospect of conviction.[89] However, he believed that interim conditions were sufficient for public protection:

> The mere fact of a criminal charge, even a very serious one such as manslaughter, does not, in my assessment, automatically mean that suspension is necessary or appropriate; there is a judgment to be made. … in my judgment, the public, if properly informed … can be expected to accept that a responsible and proportionate course is taken if Dr Bawa-Garba works with the Trust but without patient contact, pending her trial in the Crown Court or any determination at a final stage by the GMC. If, after hearing evidence on both sides, the jury gives a verdict, guilty or not guilty, that will be quite different. So too if the GMC reaches a final determination.[90]

Dr Bawa-Garba was subsequently convicted of gross negligence manslaughter,[91] and erased from the register of practitioners by the GMC,[92] before her erasure was replaced with a suspension on appeal.[93]

As in Australia, the reach of the United Kingdom regulator has widened. While most cases still reserve immediate action for urgent circumstances involving public risk,[94] courts are increasingly willing to

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[84] *Medical Council v Hiew* [2007] 1 WLR 2007.

[85] *Bawa-Garba v General Medical Council* [2015] EWHC 1277.

[86] N Ross, "Letter to the GMC Chair Regarding Hadiza Bawa-Garba" (2018) 360 *British Medical Journal* k195.

[87] S Brown, "We Are All Hadiza Bawa-Garba. Any Doctor Could Make the Same Mistake", *The Guardian*, 7 February 2018 <https://www.theguardian.com/healthcare-network/views-from-the-nhs-frontline/ 2018/feb/07/hadiza-bawa-garba-doctor-make-same-mistake>.

[88] J Coleman, "Opinion: A Career Destroyed in One 'Exceptionally Bad' Day", *Australian Doctor News*, 5 February 2018 <https://www.ausdoc.com.au/news/opinion-career-destroyed-one-exceptionally-bad-day>. See I Freckelton, "Regulation of Substandard Medial Practice: Lessons from the Bawa-Garba Case" (2018) 25 JLM 603.

[89] *Bawa-Garba v GMC* [2015] EWHC 1277, [12].

[90] *Bawa-Garba v GMC* [2015] EWHC 1277, [15], [16].

[91] *Bawa-Garba v The Queen* [2016] EWCA Crim 1841.

[92] *General Medical Council v Bawa-Garba* [2018] EWHC 76.

[93] *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879.

[94] *R (on the application of Sosanya) v GMC* [2009] EWHC 2814 (Admin).

employ immediate action for alleged conduct unrelated to the practice of medicine, such as cases involving alleged fraud[95] or dishonesty,[96] or to manage public expectations and confidence. This has led the United Kingdom medical profession to lament what they see as the apparently limitless scope of public interest regulation.[97] Some legal academics have questioned the "instinctual and unreliable" grounds upon which judges can realistically know what the public expects and commands.[98]

C. Singapore

Legislation governing immediate action in Singapore is modelled largely on that from the United Kingdom.[99] An Interim Orders Committee can impose interim conditions, or an interim suspension, based on *public risk* or *public interest*.[100] Similar time limits and rights to procedural fairness exist.[101] However, unlike the United Kingdom and Australia, interim sanctions are rarely imposed. Between 2015 and 2020, interim sanctions were imposed just six times on five doctors. Conditions were imposed four times and suspensions twice. Four involved alleged sexual misconduct, one involved deceptive conduct and one related to substandard professional performance. We found no cases in which first-instance immediate action decisions were appealed to a court.

In *Singapore Medical Council v Dr Wee Teong Boo*,[102] Dr Wee was charged with sexually assaulting and raping a female patient during a medical examination while working alone at night. The Singapore Medical Council (SMC) argued that the public would be appalled at, and insufficiently protected by, anything less than interim suspension. It submitted that sufficient evidence of risk existed because the Attorney-General's Chambers had exercised its prosecutorial discretion. Conversely, Dr Wee argued that any immediate action based on charges untested by a court would be tantamount to prejudging his guilt and would adversely impact his patients.

Rather than suspending Dr Wee, the Interim Orders Committee imposed interim conditions preventing Dr Wee from seeing patients unless a fully registered medical practitioner was present. The Interim Orders Committee emphasised that it could not make findings of fact, determine criminal responsibility, or subvert the presumption of innocence. Instead, it needed to consider the likelihood and gravity of any future offending and act proportionately to that risk by balancing the impact of its decision on Dr Wee's livelihood with the impact on the profession's standing if it failed to act. In this case, the Interim Orders Committee was satisfied that interim conditions were sufficient to guard against public outcry if Dr Wee was subsequently convicted.[103] In reaching this conclusion, the Interim Orders Committee relied on *Y v General Medical Council*:

> I have a great deal of sympathy for [the doctor]. If the allegations are found to be untrue, he will have lost the opportunity to practice as a doctor during the period of investigation and the consideration of the case

[95] *Sandler v GMC* [2010] EWHC 1029 (Admin) involved allegations of fraudulently completed cremation certificates.

[96] In *Bradshaw v GMC* [2010] EWHC 1296 (Admin), Dr Bradshaw allegedly lied to defend himself during an investigation by his employer following a complaint made by a colleague. Davis J held that an interim suspension order was "in the public interest" because if a complaint was made against Dr Bradshaw by a patient, "a right-thinking member of the public" may be concerned that Dr Bradshaw might similarly conduct himself with a lack of probity.

[97] H Williams, C Lees and M Boyd, "The General Medical Council: Fit to practise?" (Institute for the Study of Civil Society (CIVITAS), 2014) <http://www.civitas.org.uk/content/files/GMCFittoPractise.pdf>.

[98] P Case and G Sharma, "Promoting Public Confidence in the Medical Profession: Learning from the Case of Dr. Bawa-Garba" (2020) 20(1) *Medical Law International* 58.

[99] *Medical Registration Act 1997* (Singapore).

[100] *Medical Registration Act 1997* (Singapore) s 59B.

[101] *Medical Registration Act 1997* (Singapore) ss 59B, 59C, 59D, 59E, 59F, 59G.

[102] *Singapore Medical Council v Dr Wee Teong Boo* (Unreported, Singapore Medical Council Interim Orders Committee, 9 May 2017); *Singapore Medical Council v Dr Wee Teong Boo* (Unreported, Singapore Medical Council Interim Orders Committee, 29 May 2019).

[103] The Interim Orders Committee cited *NH v General Medical Council* [2016] EWHC 2348, [112].

> by the GMC. But the court's sympathy for him must be tempered by the need to guard against possible risks to patients, to the public interest and to the public's confidence in the medical profession.[104]

When Dr Wee was subsequently convicted of sexual assault,[105] these interim conditions were replaced with an interim suspension. The Interim Orders Committee held that this was required to abate "potential public backlash and outcry and to maintain public confidence in the medical profession" because of the gravity of proven sexual misconduct. Media interest in this case called into question the approach of the SMC in not immediately suspending doctors charged with serious sexual offences.[106] Similarly, in *Singapore Medical Council v Dr Lee Siew Boon Winston*,[107] the SMC Disciplinary Tribunal was critical of the SMC for not imposing interim restrictions on the registration of a doctor long after he was convicted of indecent assault. The SMC is now more proactive in imposing immediate suspensions and has since relied upon media commentary as evidence of public outrage in response to alleged egregious conduct.[108]

D. Ireland

The law in Ireland does not grant the medical regulator the power to take immediate action on its own accord. Rather, s 60 of the *Medical Practitioners Act 2007* (Ireland) allows the Irish Medical Council (IMC) to apply ex parte to the High Court to suspend a medical practitioner's registration at any time and for such period as is "necessary to protect the public".[109] Unlike in Australia, the United Kingdom and Singapore, this *public risk test* is not supplemented by a wider *public interest test*.

In deciding whether to refer a medical practitioner to the High Court for suspension, the IMC must consider the seriousness of the alleged conduct and the apparent strength of the evidence.[110] It must provide reasons for its decision and must notify European authorities, under European law[111] and Irish law,[112] if a medical practitioner has been suspended. The High Court can only suspend a practitioner if satisfied that the need for public protection outweighs the implied constitutional right[113] of medical practitioners to earn a living.[114] Irish courts are mindful that suspension of a doctor's registration "will work a great hardship" on them and their family.[115] Suspension is, therefore, reserved for exceptional cases.[116] As a result, the threshold for taking immediate action in Ireland is high and, like in Singapore, it occurs rarely. However, where there is the need for public protection, this outweighs the rights and interests of medical practitioners:

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[104] *Y v General Medical Council* [2013] EWHC 860, [52].

[105] CNA, *Both Sides Appeal in Case of Doctor Acquitted of Raping Patient but Convicted of Sexual Assault* (26 March 2020) <https://www.channelnewsasia.com/news/singapore/doctor-wee-teong-boo-sexual-assault-12579566>.

[106] L Lam, "Both Sides Appeal in Case of Doctor Acquitted of Raping Patient but Convicted of Sexual Assault", *Channel News Asia*, 26 March 2020 <https://www.channelnewsasia.com/news/singapore/doctor-wee-teong-boo-sexual-assault-12579566>.

[107] *Singapore Medical Council v Dr Lee Siew Boon Winston* [2018] SMCDT 4.

[108] In *Singapore Medical Council v Dr Ong Kian Peng Julian* (Unreported, Singapore Medical Council Interim Orders Committee, 18 June 2020) and *Singapore Medical Council v Dr Chan Herng Nieng* (Unreported, Singapore Medical Council Interim Orders Committee, 18 June 2020), the SMC noted the "swift condemnation" and calls for the doctors to be "dealt with sternly" in its reasons for these decisions.

[109] Irish Medical Council, *Immediate Suspension Orders. Guidance for the Medical Council* (2019) Version 1.2 <https://www.medicalcouncil.ie/public-information/making-a-complaint-/section-60-guidelines-july-2019.pdf>.

[110] *O'Ceallaigh v An Bord Altranais* [2000] 4 IR 54.

[111] *Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications* [2005] OJ L 255/22, Art 56a.

[112] European Union (Recognition of Professional Qualifications) Regulations 2017, Regulation 87(3) of SI No 8/2017.

[113] *Murtagh Properties Ltd v Cleary* [1972] IR 330, 336.

[114] *PC v Medical Council* [2003] IR 600.

[115] *Medical Council v Whelan* (Unreported, High Court of Ireland, Morris J, 20 February 2001), cited in *Medical Council v Dr Gerard Waters* [2021] IEHC 252, [19].

[116] *Casey v Medical Council* [1999] 2 IR 534.

> The reputation of the medical profession must … be upheld. This exceeds in importance, where the misconduct is serious, the regrettable misfortune that must necessarily be visited upon a doctor.[117]

Hearings before the High Court are usually held in private, but where judgments are delivered in open court in the public interest, doctors' names are often anonymised.[118] The IMC began publicly reporting the number of section 60 applications in its annual reports from 2017. Between 1 January 2017 and 31 December 2019, there were 33 such applications. As in the United Kingdom, this equates to approximately 3% of all recorded complaints received in the same year. We found only two cases that judicially considered interim suspensions during the relevant period. In *Medical Council v Dr Gerard Waters*,[119] Dr Waters was referred to the High Court by the IMC for an interim suspension on the basis that he posed an urgent risk to the public in the context of the COVID-19 pandemic. He claimed the pandemic was a government hoax, refused to wear a mask, refused to refer patients for COVID-19 testing, and refused to administer COVID-19 vaccines. In this case, the High Court suspended Dr Waters because the risk he posed to his patients and the public in not following public health measures was imminent and serious, with real and potentially severe consequences. The Court concluded that an interim suspension was proportionate in the circumstances. In so doing, the Court's reasoning was broadly consistent with the approach to risk reduction adopted in Australia, the United Kingdom and Singapore.

E. New Zealand

In New Zealand, the *Health Practitioners Competence Assurance Act 2003* (NZ) (the *HPCAA*) permits the Medical Council of New Zealand (MCNZ) to take immediate action if: a doctor's competence is being reviewed;[120] they are unable to perform required functions due to a mental or physical condition;[121] they have engaged in conduct that is related to pending criminal proceedings or that may not be appropriate in a professional capacity;[122] or it is necessary to protect public health or safety.[123] Like in Australia, immediate action in New Zealand is unrestricted in duration, and there is no requirement for regular review. However, there is no *public interest test*. According to the MCNZ Annual Reports, immediate action was imposed 18 times between 1 July 2015 and 30 June 2020 for conduct-related issues and 92 times due to the doctor's health. In all health-related cases, interim sanctions were secured through voluntary agreements.[124] We found two publicly available appellate judgments, both involving male practitioners alleged to have engaged in sexual misconduct.

In *Ahmad v Medical Council of New Zealand*,[125] Dr Ahmad was immediately suspended only after he was convicted of indecently assaulting six patients during medical examinations. The New Zealand Medical Council was criticised[126] for not suspending Dr Ahmad's registration immediately after charges were laid.[127] Seemingly in response to this criticism, in *Lim v Medical Council of New Zealand*,[128] Dr Lim was immediately suspended after being charged with 13 counts of indecently assaulting sedated patients. The High Court of New Zealand upheld the suspension, citing that public confidence is indispensable

[117] Cited in *Medical Council v Deidre Lohan-Mannion* [2018] IEHC 401.

[118] *Medical Council v FCM* [2018] IEHC 616.

[119] *Medical Council v Dr Gerard Waters* [2021] IEHC 252.

[120] *Health Practitioners Competence Assurance Act 2003* (NZ) s 39.

[121] *Health Practitioners Competence Assurance Act 2003* (NZ) s 48.

[122] *Health Practitioners Competence Assurance Act 2003* (NZ) s 69.

[123] *Health Practitioners Competence Assurance Act 2003* (NZ) s 93.

[124] Medical Council of New Zealand, *Annual Report* (2020) <https://www.mcnz.org.nz/assets/Publications/ Annual-Reports/7080513fe1/MCNZ-Annual-Report-2020.pdf>.

[125] *Ahmad v Medical Council of New Zealand* [2016] NZDC 21788.

[126] O Carville, "Predatory Health Professionals still Practising", *Herald on Sunday*, 14 August 2016.

[127] O Carville, "Dodgy Doctors Continue to Practise", *The New Zealand Herald*, 15 August 2016.

[128] *Lim v Medical Council of New Zealand* [2018] NZHC 485.

to public protection.[129] As a proportion of total complaints received, the use of immediate action in New Zealand appears high, but that may be because many health-related actions are imposed by mutual agreement.

F. Canada

In Canada, medical regulation is primarily a Provincial responsibility.[130] In all Provinces except for Yukon,[131] these regulatory agencies have the power to impose immediate action, although the precise requirements vary, as outlined in Appendix 2. In most Provinces, a public health threat or emergency must exist before immediate action may be taken. Apart from in New Brunswick, there is no *public interest test*.[132] Therefore, the statutory threshold for taking immediate action is higher in Canada than in Australia, the United Kingdom and Singapore. Additionally, courts are reluctant to impose interim suspensions and are more sympathetic to the impact that interim suspension can have on the livelihoods of Canadian doctors. In *Huerto v College of Physicians and Surgeons of Saskatchewan*,[133] the Court said:

> Dr. Huerto pays, on a daily basis, the same price of total suspension from practice that could arise if he were eventually found to be guilty. Guilt has in no way been established, no charges have been laid, nor is any investigation underway. The Committee had before it only unsworn allegations from sources the credibility of which remains to be tested.[134]

While Canadian courts consider the practice of a profession to be privilege rather than a right,[135] a "high standard of justice"[136] is required before a doctor's right to practise medicine can be restricted or removed. Immediate action has been described as "an extraordinary remedy" that ought to be used "sparingly",[137] only when necessary, or in "special circumstances",[138] rather than when merely desirable. This differs to the legal position in the United Kingdom. As such, "total suspension" is only used as a "last resort"[139] when interim conditions have been reasonably rejected,[140] and some courts have been reluctant to uphold indefinite interim suspension orders on the basis that they are contrary to the interests of justice.[141] In Québec, the regulator must consider whether public trust would be compromised if immediate action is not taken, but must also proceed with caution where guilt is not yet proven.[142] As in Australia and the United Kingdom, Canadian regulators should not weigh up evidence at an interim stage because it cannot conduct a "mini-trial" of the allegations before facts are concluded.[143] Instead, it must provisionally assess the reliability, plausibility, and consistency of the allegations and discount evidence that is manifestly unreliable, unfounded, or exaggerated.[144] Also as occurs in Australia and the

[129] *Lim v Medical Council of New Zealand* [2018] NZHC 485.

[130] Halsbury's Laws of Canada (online), *Medicine and Health*, at HMH-19 "Jurisdiction of licensing authority".

[131] *Medical Profession Act*, RSY 2002, c 149.

[132] *Medical Act*, SNB 1981, c 87, s 56.1.

[133] *Huerto v College of Physicians and Surgeons of Saskatchewan* 2004 SKQB 423.

[134] *Huerto v College of Physicians and Surgeons of Saskatchewan* 2004 SKQB 423, [27].

[135] *Comptables professionnels agréés (Ordre des) c Szaroz* 2016 QCTP 91 (CanLII).

[136] *Youssef v College of Physicians and Surgeons of New Brunswick* 2012 NBQB 253 (CanLII), citing *Kane v Board of Governors of University of British Columbia* 1980 CanLII 162 (SCC).

[137] *Saskatchewan College of Psychologists v Lebell* 2019 SKQB 54.

[138] *Youssef v College of Physicians and Surgeons of New Brunswick* 2012 NBQB 253, [45].

[139] *Youssef v College of Physicians and Surgeons of New Brunswick* 2012 NBQB 253, [22].

[140] *Youssef v College of Physicians and Surgeons of New Brunswick* 2012 NBQB 253, [27].

[141] *Derry v College of Physicians and Surgeons of British Columbia* 2002 BCSC 946.

[142] S Godbout, "La suspension ou la limitation provisoire du droit d'un professionnel d'exercer ses activités professionnelles lorsqu'il fait l'objet d'une poursuite criminelle" (Repères EYB2018REP2622, 2018).

[143] *Scott v College of Massage Therapists of British Columbia* 2016 BCCA 180, [81].

[144] *Scott v College of Massage Therapists of British Columbia* 2016 BCCA 180, [63].

United Kingdom, Canadian courts give deference to expert committees convened by medical regulators when determining the reasonableness of imposing measures to protect the public.[145]

In *Rohringer v Royal College of Dental Surgeons of Ontario*,[146] Dr Rohringer was charged with sexual offences in Florida that he denied. The College received a copy of Dr Rohringer's purported police confessions and then interviewed Dr Rohringer's colleagues. One said that Dr Rohringer told inappropriate sexual jokes with patients. In 1994, the College previously investigated a complaint from a former employee that Dr Rohringer made inappropriate sexual comments to her. No action was taken on this complaint except to advise Dr Rohringer to "draw stronger distinctions between his personal and professional life". Dr Rohringer provided an expert report from a forensic psychiatrist, who said that Dr Rohringer had "deviant urges" to expose himself but did not pose a risk to patients.

The College imposed an interim suspension based on his admissions of guilt to police and the likelihood that his conduct would expose his patients to harm from "boundary violations of a sexual nature".[147] This decision was overturned on appeal. The Court held that interim suspension requires more than "mere speculation". The legal test for imposing immediate action in Ontario is "probable harm" rather than "risk of harm". In this case, there was insufficient evidence of this degree of risk, particularly when considering that an interim suspension would render Dr Rohringer unable to earn a livelihood for an indefinite period.

Since this decision, medical regulators across Canada have been reluctant to impose immediate action.[148] No data on immediate action were published in the annual reports of Canadian regulators between 2016 and 2020. However, we found five reported judgments in which immediate action was appealed. All involved male doctors facing a range of allegations relating to performance, conduct, or health concerns. All were legally represented. In half of the appealed cases, the original immediate action was overturned.

Canadian courts and regulators only allow interim sanctions when there is a pressing need for public protection based on a prima face case involving serious allegations from a credible source, having regard to the impact of any proposed action on the medical practitioner's livelihood. In practice, taking immediate action is difficult, even impractical in many jurisdictions due to a reluctance on the part of regulators in many Canadian jurisdictions to seek interim sanctions.[149]

G. United States

In the United States, medical practitioners are regulated by State licensing boards, each with their own requirements for licensing and discipline. State laws regulating medical practitioners often regulate other diverse occupational licensees, such as lawyers, architects, real estate agents, accountants, nurses, dentists, firefighters, locksmiths, and teachers.[150] Most State laws provide for immediate action, variously referred to as an "interim order", "summary suspension", or "temporary restraining order".

In California, the State Department of Consumer Affairs administers more than 3.9 million occupational licenses and supports more than 40 professional boards, including the Medical Board of California (MBC). Provisions relating to immediate action in California are found in the California Government Code[151] and the *Medical Practice Act 1992* (NSW).[152] First, the MBC can file a motion with the Office of Administrative Hearings seeking an "interim order", which may be issued by an administrative law judge

[145] *College of Physicians and Surgeons of Ontario v McIntyre* 2017 ONSC 116, [62].

[146] *Rohringer v Royal College of Dental Surgeons of Ontario* 2017 ONSC 6656.

[147] *Rohringer v Royal College of Dental Surgeons of Ontario* 2017 ONSC 6656, [15].

[148] E Larney, "The Latest in Interim Orders from around the World" (Council on Licensure, Enforcement and Regulation (CLEAR) Annual Education Conference, Minneapolis Minnesota, US, 2019).

[149] Law Reform Commission of Saskatchewan, *Handbook on Professional Discipline Procedure*, 2017 CanLIIDocs 207.

[150] BJ Bennett, "The Rights of Licensed Professionals to Notice and Hearing in Agency Enforcement Actions" (2006) 7 Tex Tech Admin LJ 205.

[151] California Government Code § 11529.

[152] Cal Business & Professions Code § 2227.

if a medical practitioner will endanger public health, safety or welfare by continuing to practice medicine in violation of the *Medical Practice Act* or because of a mental or physical condition.[153] A hearing must be held within 20 days of an order being made; otherwise the order is dissolved.[154] Second, the MBC may seek a temporary restraining order through a Superior Court, on similar grounds as an interim order,[155] although this is rarely used. Third, the MBC may seek an injunction preventing a doctor from practising if it would endanger public health, safety or welfare.[156] For example, in *Gray v Superior Court*,[157] as a condition of release on bail pending criminal charges for unlawful prescribing, the trial court imposed an interim suspension on a psychiatrist on the application of the MBC. This was overturned on appeal as it violated the doctor's due process rights.

The MBC has a statutory obligation to publish the number of immediate actions taken in its annual reports.[158] In the last five years, it imposed interim sanctions on 148 occasions. This comprises less than 1% of the 51,461 complaints received by the MBC and is well below the rate of immediate action use in Australia and the United Kingdom. This is not surprising. In the United States, it is difficult for medical licensing boards to suspend a doctor summarily. First, the threshold for summary action is high and an emergency must exist before summary suspension can be used.[159] Once a State issues a licence to a medical practitioner, it can only be suspended, revoked, or restricted if the licensee is afforded procedural rights,[160] including: notice; an administrative hearing; the right to appear personally or be represented; the right to present evidence, contest allegations and argue points of law;[161] and the right to examine and cross-examine witnesses.[162] Second, professional licenses are constitutionally protected.[163] The 14th Amendment to the *United States Constitution*[164] and most State constitutions[165] recognise property interests in a licencee's occupational license and "liberty interests"[166] in the continued enjoyment of that licence,[167] free from unreasonable governmental interference.[168] Third, the standard of proof required to remove a professional licence is high, because it requires "clear and convincing evidence", rather than a "preponderance of the evidence".[169] Therefore, such action is rare and the cases are usually managed by consent agreements.[170]

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[153] California Government Code § 11529(a).

[154] California Government Code § 11529(f).

[155] Cal Business & Professions Code § 125.7.

[156] Cal Business & Professions Code § 2312; Code Civ Proc § 525.

[157] *Gray v Superior Court* (2004) 20 Cal Rptr 3d 753.

[158] Cal Business & Professions Code § 2220.05(c).

[159] *Bd of Physician Quality Assurance v Mullian*, 381 Md 157, 167 (2003).

[160] Bennett, n 150.

[161] *Cleveland Board of Education v Loudermill*, 470 US 532, 546 (1985).

[162] TJ Aspinwall, "Representing Healthcare Professionals in Disciplinary Actions: Containing the Collateral Damage" (2007) 20 *Health Law* 1.

[163] M Moody, "When Courts Do not Protect the Public: How Administrative Agencies Should Suspend Professionals' Licenses on an Emergency Basis" (2008) 10 Fla Coastal L Rev 551.

[164] *United States Constitution Amendment XIV* § 1.

[165] For example, *Texas Constitution* Art 1, § 19 and *California Constitution* Art 1, § 7.

[166] *Meyer v Nebraska*, 262 US 390 (1923).

[167] AF Greenbaum, "Administrative and Interim Suspensions in the Lawyer Regulatory Process: A Preliminary Inquiry" (2014) 47 Akron L Rev 65.

[168] *US v Robel*, 389 US 258, 265 n.1 1 (1967).

[169] Bennett, n 150, 234.

[170] M Cooke, "Regulation of Nurses: Cross-Jurisdictional Comparative Case Study into the Management of Health, Performance and Conduct Notifications by Regulatory Bodies" (Winston Churchill Memorial Trust of Australia, 2013) <https://www.churchilltrust.com.au/media/fellows/Regulatory_requirements_to_improve_safety_standards_for_nurses-midwives_-_Cooke_M_2013.pdf>.

> The right to practice a profession has been called a property right, but it is more. To obtain a license and proficiency requires the expenditure of money and years of preparation, attended by toil and self-denial. Such right is the capital stock of its possessor from which dividends are expected sufficient to protect him from the infirmity of old age, and to provide his family with the comforts of life. There is moreover a prestige and good name and should be a pride attached to the practice of an honorable profession superior to any material possessions. To cancel a professional license is to take the entire capital stock of its possessor and to leave him in most instances the equivalent of a bankrupt. But it does much more than this; it takes from him his professional standing and in a manner whatever good name he has, which leaves him "poor indeed".[171]

It is difficult to discern a consistent standard or clear precedent from US case law. Some US courts have upheld summary suspensions where the risk of endangerment to public welfare was high, including: conspiracy to distribute controlled substances;[172] harming patients through unorthodox and complementary treatments;[173] gross negligence;[174] forced sex on a patient;[175] and treating patients while intoxicated.[176] This notwithstanding, courts have also struck down summary suspensions where the allegations were egregious, including: knowingly distributing adulterated prescription drugs;[177] administering nitrous oxide and sexually fondling a patient;[178] a suspended chiropractor posing as a doctor;[179] and a psychiatrist prescribing excessive and unwarranted narcotics.[180]

Despite this variation, US courts will often guard professional licences at considerable risk to public safety. It has been said that it may be easier to prevent a medical practitioner from practicing if they are criminally convicted than if investigated by a State licensing board.[181] This contrasts starkly with the approach taken in Australia and the United Kingdom, and likely reflects the political and cultural emphasis on individual rights and freedoms in the United States, and a tradition of practitioner-centric protections.[182]

III. Discussion

Immediate action is arguably the most coercive power available to medical regulators. Decisions that can have devastating implications for medical practitioners or far-reaching benefits for the community need to be made quickly, without concluded facts. While immediate action powers are afforded to many medical regulators, there are subtle differences in interpretation, scope and equipoise that reflect disparate legal traditions and history. Therefore, it is curious that, to date, little academic attention has been given to this important area of medical law. This is the first article to examine and compare the application of immediate action powers across multiple jurisdictions. We found similarities and differences. Looking beyond a single jurisprudence provides opportunities for regulators, policy-makers and decision-makers to reflect on ways in which this powerful regulatory tool can be employed most fairly and effectively.

The use of immediate action across the seven countries reviewed is consistent in several crucial ways. First, all jurisdictions studied require a public risk to exist before immediate action can be taken. Although

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[171] *Louisville & Nashville RR Co v Tomlinson*, 68 SW2d 601, 605 (Tex Civ App-Amarillo, 1934).

[172] *Bethencourt-Miranda v State Department of Health*, 910 So 2d 927, 928 (Florida District Court of Appeal, 2005).

[173] *Johnson v Tennessee Board of Medical Examiners* (No M2002-00048-COA-R3-CV, 2003 WL 1442413, 1 (Tenn Ct App 19 March 2003)).

[174] *Tauber v State Board of Osteopathic Medical Examiners*, 362 So 2d 90, 92–93 (Fla Dist Ct App, 1978).

[175] *Field v State Department of Health*, 902 So 2d 893, 894 (Florida District Court of Appeal, 2005).

[176] *Board of Physician Quality Assurance v Mullan*, 848 A2d 642, 644, 652 (Md, 2004).

[177] *Bio-Med Plus, Inc v State Department of Health*, 915 So 2d 669, 671, 674 (Florida District Court of Appeal, 2005).

[178] *Dahnad v Buttrick*, 36 P3d 742, 744, 748 (Arizona Court of Appeal, 2001).

[179] *Stjernholm v Colorado State Board of Chiropractic Examiners*, 865 P2d 853, 855, 856 (Colo App, 1993).

[180] *Cunningham v Agency for Health Care Admin*, 677 So 2d 61, 62 (Florida District Court of Appeal, 1996).

[181] Moody, n 163.

[182] R Queiroz, "Individual Liberty and the Importance of the Concept of the People" (2018) 4(1) *Palgrave Communications* 1.

precise wording may differ, most regulators only employ immediate action when "necessary to protect the public" from harm. Appendix 2 summarises the exact phraseology adopted in each jurisdiction. Second, decision-makers must carefully balance the impact on the public if immediate action is not taken with the impact on doctors if immediate action is taken.[183] Third, when balancing public and practitioner interests, public protection is paramount to maintain trust in the profession and its systems of regulation.[184] Fourth, immediate action is reserved for exceptional[185] or extraordinary[186] circumstances, and only employed when it is the minimum regulatory force necessary.[187] Fifth, courts demonstrate considerable deference to regulators whom they view as in adjudicating complex matters involving medical practitioners.[188] Sixth, immediate action requires a reasonable belief in relation to risk, rather than proof of alleged conduct[189] and regulators cannot engage in a pre-trial examination of disputed allegations.[190]

Despite these similarities, there are some notable points of difference. First, while the *public risk test* is ubiquitous, the degree of harm required to justify immediate action varies considerably, with the threshold applied in Australia and the United Kingdom being lower than in North America, where evidence of "probable or likely" harm is required, rather than merely a "risk" of harm. Second, Australia and the United Kingdom are among a minority of jurisdictions that have embraced a *public interest test* for immediate action, where the reach and scope of the regulator is wider. Third, Australia is unusual in that there is no limit on the duration of immediate action. The United Kingdom and Singapore limit the duration of immediate action and allow extension only upon judicial review. In Canada, courts have held that indefinite immediate action orders are contrary to the interests of justice,[191] while in California, the MBC has a statutory obligation to expedite the prosecution of physicians representing the greatest threat of harm.[192] Fourth, doctors in Australia, Canada, and the United Kingdom do not enjoy constitutional protections that exist in Ireland[193] and the United States,[194] which curtail regulators' ability to restrict doctors' employment or professional licences. Overall, across the seven countries, Australia offers regulators the greatest discretion to act in the public interest: the bar for immediate action is lower, the scope is wider, and the limitations on regulatory power are fewer.

We reviewed regulatory annual reports and outcomes of published judgments to see whether these differences impact on the use of immediate action by regulators or the attitude of courts to immediate action. Between 1 July 2015 and 31 December 2020, we found that the use of immediate action as a proportion of total complaints received was higher in Australia than in the other jurisdictions studied. Moreover, during the same period, the rate of immediate action use doubled in Australia. We suspect that this may be due to the enactment of a wider *public interest test* that is unconstrained by procedural

[183] *Nitschke v Medical Board of Australia* [2015] NTSC 39, [28]; *Y v General Medical Council* [2013] EWHC 860, [52]; *Singapore Medical Council v Dr Wee Teong Boo* (Unreported, Singapore Medical Council Interim Orders Committee, 9 May 2017); *Huerto v College of Physicians and Surgeons of Saskatchewan* (2004) SKQB 423; *Medical Council v Whelan* (Unreported, 20 February 2001), cited in *Medical Council v Dr Gerard Waters* [2021] IEHC 252, [19].

[184] *MLNO v Medical Board of Australia* [2012] VCAT 1613.

[185] *Casey v Medical Council* [1999] 2 IR 534.

[186] *Saskatchewan College of Psychologists v Lebell* 2019 SKQB 54.

[187] AHPRA, *Regulatory Principles for the National Scheme* <https://www.ahpra.gov.au/documents/default.aspx?record=WD15%2f18913&dbid=AP&chksum=Ukl9LcAenbddeQ6iX5w%2fyQ%3d%3d>. Cited in: *Dr Stuart Lynch v Medical Board of Australia* [2020] TASHPT 1.

[188] *Morris v Medical Board of Australia* [2021] VCAT 548; *Medical Council v Hiew* [2007] 1 WLR 2007; *College of Physicians and Surgeons of Ontario v McIntyre* 2017 ONSC 116, [62].

[189] *Morris v Medical Board of Australia* [2021] VCAT 548.

[190] See *GMC v Sheill* [2006] EWHC 3025 in the United Kingdom and *Scott v College of Massage Therapists of British Columbia* 2016 BCCA 180 in Canada.

[191] *Derry v College of Physicians and Surgeons of British Columbia* 2002 BCSC 946.

[192] *Cal Bus & Prof Code* § 2220.05(a).

[193] Cited in *PC v Medical Council* [2003] IR 600.

[194] *United States Constitution Amendment XIV* § 1.

or Constitutional safeguards. Indeed, data from the United Kingdom show that, following the enactment of the *public interest test* in 2000, the use of immediate action also increased: between 1980 and 1996, immediate action was used only four times. However, in 2009 alone, it was used 455 times.[195]

The adoption of a broader *public interest test* has been justified on the basis that regulators need the flexibility and latitude to censure doctors for conduct outside the practice of medicine in order to maintain public confidence, which ultimately improves health outcomes for individuals[196] and the community.[197] Patients who trust their doctor are more willing to divulge personal information, allow invasive examinations and tests, and adhere to treatments. However, a malleable "public interest" test with wide meaning and unsettled boundaries[198] may leave doctors vulnerable to inconsistent decision-making and regulatory over-reach. With growing evidence of the adverse impact that poor doctor wellbeing has on quality of patient care,[199] overly coercive regulation may paradoxically compromise patient care and undermine the safety, quality, and confidence sought to be protected.

An additional problem with immediate action is that medical regulators cannot determine criminal responsibility, make findings of fact, or look beyond the substance of charges or allegations at an interim stage. Instead, they must provisionally assess the allegations, determine the likelihood and gravity of any future risk to the public and cautiously equilibrate the impact of a decision on the medical practitioner with the impact on the standing of the profession if it failed to act. A legal framework that favours public protection in circumstances where allegations cannot be tested leaves doctors exposed to a precautionary and conservative approach that operates systematically against their interests, leading them to feel "guilty until proven innocent".[200]

These disadvantages may be compounded by the absence of statutory time limits for immediate action in Australia. A recent report[201] suggested that immediate action in Australia lasts too long – 20 months, on average. The common practice is for the MBA to adjourn matters if police investigations are active, pending their resolution. Other scholars have observed that this also generates an over-reliance on criminal findings of guilt that may not specifically address issues of public interest or protection from a regulatory perspective. In other words, decisions are often made "by different bodies, with different functions, addressing different questions and at different times".[202]

An inherent challenge with immediate action is that it is necessarily based on incomplete information. This means that there it is often incongruity between the immediate action taken and the final regulatory outcome. This was quantified in a recent Australian study[203] of 14,000 notifications between 2011 and 2016, which revealed that, in nearly half of all notifications where immediate action was taken, no final regulatory action was required. Similarly, over 80% of notifications resulting in final regulatory action were not preceded by any immediate action. This calls into question the specificity, sensitivity, and reliability of immediate action in protecting the public and raises real questions about whether a more flexible approach to fact-finding ought to be adopted at an interim stage to reduce this mismatch. Of course, there are several explanations for this observed discordance. For instance, evidence of risk might be unavailable until completion of an investigation. Similarly, immediate action might prompt some doctors to retire or undertake corrective behaviours (eg treatment, education, training, mentoring) that

[195] P Case, n 9.

[196] D Bonds et al, "The Association of Patient Trust and Self-care among Patients with Diabetes Mellitus" (2004) 5 *BMC Family Practice* 26; D Jones et al, "Patient Trust in Physicians and Adoption of Lifestyle Behaviors to Control High Blood Pressure" (2012) 89(1) *Patient Education and Counseling* 57.

[197] LO Gostin, "Public Health Law: Power, Duty, Restraint" (University of California Press, 2000) 95.

[198] *Right to Life Association (NSW) Inc v Secretary, Department of Human Services and Health* (1995) 56 FCR 50.

[199] Editorial, "Physician Burnout: The Need to Rehumanise Health Systems" (2019) 394(10209) *Lancet* 1591 DOI: 10.1016/S0140-6736(19)32669-8.

[200] Williams, Lees and Boyd, n 97, 6.

[201] R Paterson, "Independent Review of the Use of Chaperones to Protect Patients in Australia" (Medical Board of Australia, 2017).

[202] Case and Sharma, n 98, 64.

[203] Bradfield et al, n 9.

remediate risk and obviate the need for restrictive final action. An *ex-post* determination that a risk was insufficient to warrant final regulatory action does not impugn the immediate action taken *ex ante*, but it does sound a note of caution that regulators need to constantly ensure they are re-examining cases in a timely manner when new evidence comes to light. The problem with the *National Law* in Australia is that there is no statutory requirement for the MBA to expedite investigations into the most serious allegations of misconduct. Similarly, there is no statutory requirement to review immediate action decisions while matters are being investigated and as new information comes to hand.

Ultimately, it is impossible for medical regulators to avoid the dilemmas posed by taking immediate action without full knowledge of the facts. Failure to move proactively can cause avoidable harm, while imposing immediate action that later proves unnecessary will invariably be perceived as imprudent and injurious by the profession. One way of assuring balance is through greater transparency.[204] In most jurisdictions studied, only a handful of recent or noteworthy first instance decisions are publicly available. This deprives patients, practitioners, the public and the press from scrutinising regulatory decisions. It is important that medical regulators constantly make clear the foundations for regulatory choices and be prepared to recognise when new information commands re-evaluation. Another mechanism for ensuring balance is through robust judicial review. In this study, we found that courts in Australia were more willing to set aside first-instance immediate action decisions than in other jurisdictions. In the absence of regular review of immediate action, judicial review provides a crucial check on the extensive power wielded by regulators.

Our analysis of the history, content, and application of immediate action laws in seven countries highlights the significant influence exerted by the media. This is not surprising given the often shocking and salacious nature of allegations facing doctors at an interim stage. For example, in the United Kingdom, the public response to the Shipman inquiry, amplified by the media, spawned an intense wave of regulatory reform that included enacting novel immediate action laws in the public interest. Similarly, in Singapore and New Zealand, failures by medical regulators to take timely immediate action in response to egregious allegations resulted in intense media disquiet and criticism. In both jurisdictions, the regulators took immediate action in later cases at a much earlier opportunity.

The SMC even had regard to opinions expressed through newspaper reports as a means of gauging public sentiment. However, this is problematic, as views espoused by editors employed by privately-run media enterprises may not represent (or may even misrepresent) public opinion. For example, a recent qualitative study[205] of 2,000 people commissioned by the GMC found that most respondents considered one-off mistakes committed by doctors to have little impact on their wider confidence in the medical profession. However, if the mistake resulted in the death of a patient, respondents were more likely to desire de-registration. This suggests that the public struggles to differentiate the severity of the outcome from the seriousness of the clinical error. In cases involving alleged criminal conduct or boundary violations outside the practice of medicine, the public was more likely to seek de-registration if the alleged conduct was intentional, deliberate, or reckless.

The growing influence of the media in influencing regulatory action has created angst within the medical profession. Doctors argue that public interest regulation is subjective, politically-motivated, ill-defined and based on "public mood" rather than evidence.[206] They are apprehensive that the media can distort public perceptions and regulatory outcomes[207] by creating unrealistic expectations that doctors will always be "superhuman paragon[s] of virtue" possessing a "conscience beyond reproach".[208] They also argue that it fans the politicisation of medical regulation and destabilises the relationship between the profession and the public.[209]

[204] Gostin et al, n 197, 69.

[205] L Hamilton, *Independent Review of Gross Negligence Manslaughter and Culpable Homicide* (General Medical Council, 2019).

[206] H Williams and C Lees, "A Turning Point for Medical Regulation" (2015) 350 *British Medical Journal* 284.

[207] Williams, Lees and Boyd, n 97.

[208] P De Prez, "Self-Regulation and Paragons of Virtue: The Case of 'Fitness to Practise'" (2002) 10(1) *Medical Law Review* 28.

[209] B Salter, "Who Rules? The New Politics of Medical Regulation" (2001) 52(6) *Social Science & Medicine* 871.

There is no doubt that the media can inform and amplify public debate on issues of health regulation. Widespread news coverage about systemic failures within the health system can lead to independent inquiries, regulatory reform and safer care, while coverage of legal proceedings can increase judicial consistency and transparency.[210] Nevertheless, pre-trial publicity can deleteriously influence perceptions of the defendant by judges and jurors.[211] Interim regulatory decisions uninformed by concluded facts that rely on a mutable *public interest test* may be particularly susceptible to subconscious interference from media reports. It has even been suggested that intense media interest may elicit more severe interim sanctions,[212] but this remains to be empirically tested.

Indeed, not all media coverage of interim regulatory decisions is adverse to the interests of the medical profession. We found evidence of the media favourably reporting doctors facing criminal prosecution. For example, in the case of Dr Bawa-Garba, many sections of the mainstream media were sympathetic to her predicament and were critical of the harsh approach adopted by the GMC.[213] Likewise, we found examples of judges resisting the temptation to be seduced by "knee-jerk" "tabloid journalism", recognising that such coverage is not always well-informed:

> It was said that there was a background of concern that matters involving sexual misconduct in particular were not being adequately dealt with by the regulators, which carried the risk of loss of confidence by patients in both the profession and the regulators. That does not mean that a legitimate function of immediate registration action is to protect regulators from criticism, even if ill-informed.[214]

This quote raises one final observation from our analysis of immediate action case law. A close reading of the written reasons of many cases suggests that regulators and courts often conflate the issue of public confidence in the medical profession with public confidence in the regulator. In fact, there is little empirical evidence that the public considers the reputation of the regulator at all when having regard to its confidence in the profession. For example, a recent study[215] found that high levels of confidence in the medical profession was primarily based on personal experiences receiving healthcare from individual doctors, rather than awareness of regulatory functions or decisions. Clearly, it is crucial that regulators maintain their focus on public interests and protection, and that immediate action not become a vehicle for protecting the regulator's own public image or excusing unreasonable delays in finalising investigations.

IV. Conclusions

Immediate action is the most powerful sanction at the disposal of medical regulators yet, despite its various manifestations across the world, it remains understudied. This article has analysed the context, substance, and interpretation of immediate action powers in seven countries. Courts in all countries recognise the vulnerability of practitioners who are subject to these powers: there is no presumption of innocence, and no ability to establish the veracity of allegations. At the same time, courts acknowledge the potentially serious harm to patients that can occur if regulatory action is delayed pending the final resolution of allegations. The fulcrum for balancing these competing tensions varies from country to country – shaped by cultural norms and seminal events such as the Shipman Inquiry in the United Kingdom.

While the primary purpose of immediate action is to protect the public from unsafe or impaired practitioners, a growing global trend embraces a broader construction of immediate action that encompasses the need to maintain the public interest and confidence in the profession and its regulation.

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[210] C Lim, "Media Influence on Courts: Evidence from Civil Case Adjudication" (2015) 17(1) *American Law and Economics Review* 87.

[211] J Robbennolt, "News Media Reporting on Civil Litigation and Its Influence on Civil Justice Decision Making" (2003) 27(1) *Law and Human Behavior* 5.

[212] Case, n 9.

[213] D Bhagawati, "Blaming Dr Hadiza Bawa-Garba Won't Protect Other Patients", *The Guardian*, 15 August 2018 <https://www.theguardian.com/society/2018/aug/14/blaming-hadiza-bawa-garba-wont-protect-other-patients>.

[214] *Harirchian v Health Ombudsman* (2020) QCAT 414, [15].

[215] Hamilton, n 205.

Without careful procedural safeguards, such as clear timeframes for final decisions, mechanisms for review, and transparency of decision-making, this approach may leave doctors vulnerable to regulatory over-reach. Similarly, reliance on unrepresentative media reports, the unavailability of the presumption of innocence at an interim stage in regulatory proceedings, and the inability to cross-examine witnesses or test allegations also puts doctors at an evidentiary disadvantage. Together, this translates into Australia having one of the highest rates of immediate action use.

There is still a pressing need to continue to research the use of interim powers. Future research could usefully explore: the experiences of doctors subject to immediate action; the influence of media coverage on regulatory decision-making in the public interest; and the impact of the regulatory response to urgent cases on measures of public trust and on the health-seeking behaviours of complainants. In addition, greater public engagement is required to elucidate what the public expects of the profession and the regulator. Currently, this is based on conjecture and speculation, rather than empirical evidence. Our analyses were limited by a dearth of publicly available information on first-instance immediate action decisions in most jurisdictions. We believe that greater transparency and publication of decisions, especially when anonymised or de-identified, would assist regulators, practitioners, and the public to better understand how important regulatory decisions are reached that seek to balance the inherent tensions between the public, the practitioner, and the profession.

APPENDIX 1. Search Strategy Employed to Retrieve Relevant Cases

Jurisdiction	Database(s) Used	Primary Search by Case Title	Secondary Search by Exact Phrase	Number of Cases Identified between 2016 and 2020
Australia	AHPRA AustLII Lexis Advance	"Medical Board" or "Medical Council" or "Health Ombudsman"	"Immediate action"	28
United Kingdom	GMC BAILII Westlaw UK	"General Medical Council" or "GMC"	"Interim action" or "Interim suspension" or "Interim conditions" "Section 41A"	14
Singapore	SMC Website CommonLII Lexis Advance	"Medical Council" or "SMC" or "Interim Orders Committee"	"Interim action"	5
Ireland	BAILII IRLII	"Medical Council"	"Interim suspension"	2
New Zealand	NZLII Lexis Advance	"Medical Council" or "MCNZ"	"Interim suspension" or "Interim conditions"	2
Canada	CanLII WestlawNext Canada Lexis Advance	"College of Physicians and Surgeons" or "College of Physicians & Surgeons" or "Yukon Medical Council" or "Health and Social Services" or "Health and Social Services"	"Interim suspension" or "Interim order" or "Extraordinary action"	5
California	Westlaw LexisNexis	"California Medical Board"	"Summary suspension" or "interim suspension" or "temporary restraining order"	0

APPENDIX 2. Immediate Action Legislation

Jurisdiction	Statute	Statutory Test(s) of Immediate Action	Decision-Maker	Sanctions Available	Length
Australia	*Health Practitioner Regulation National Law Act 2009* (Qld)	– Necessary to protect public health or safety because the practitioner's conduct, performance or health poses a serious risk to persons; or … – Is otherwise in the public interest.	Immediate Action Committee of the Medical Board of Australia	– Suspension; or – Conditions; or – Accepting voluntary undertakings; or – Surrender of registration.	Not specified
United Kingdom	*Medical Act 1983* (UK) s 41A	– Necessary for the protection of members of the public; or – Is otherwise in the *public interest*; or – Is in the interests of the practitioner.	Interim Orders Tribunal, or General Medical Council	Suspension or conditions	Up to 18 months. Must be reviewed at six months and then every three months. High Court may extend for up to 12 months. No limit on the number of extensions.
Singapore	*Medical Registration Act* (Singapore, cap 174, 1997) s 59B	– Necessary for the protection of members of the public; or – Is otherwise in the *public interest*; or - Is in the interests of the practitioner.	Interim Orders Committee of the Singapore Medical Council	Suspension or conditions	Up to 18 months. Must be reviewed at six months and then every three months. High Court may extend for up to 12 months. No limit on the number of extensions.
Ireland	*Medical Practitioners Act 2007* (Ireland) s 60	– Necessary to protect the public	High Court (following ex parte application)	Suspension only	Not stipulated. Usually until complaint or investigation is completed
New Zealand	*Health Practitioners Competence Assurance Act 2003* (NZ) ss 39, 48, 69, 93.	– Competence is being reviewed; or – May be unable to perform required functions due to a mental or physical condition; or – Has engaged in conduct that is related to pending criminal proceedings or that may not be appropriate in a professional capacity; or – Necessary to protect the health or safety of members of the public.	Medical Council of New Zealand	– Suspension; or – Conditions; or – Alter scope of practice	In the case of impairment, no more than 20 days. May be extended for up to another 20 days. Until professional capacity no longer in doubt, or until criminal or disciplinary matter resolved. In the case of competence reviews, upon completion of the review or upon passing any required tests or examinations

APPENDIX 2. Continued

Canada					
British Columbia	Extraordinary action to protect public *Health Professions Act,* RSBC 1996, c1 83, s 35(1)	Extraordinary action to protect the public	Inquiry Committee of the College of Physicians and Surgeons of British Columbia.	• Suspension • Conditions • Limitations	Until no longer necessary
Saskatchewan	Suspension of member *Medical Profession Act 1981,* SS 1980-81, c M-10.1, s 48	On the basis of the charge, the allegations or the nature of the case	Council or Discipline Hearing Committee OR Registrar (emergency) College of Physicians and Surgeons of Saskatchewan	• Suspension	Not specified
Ontario	Interim suspension *Regulated Health Professions Act,* SO 1991, c 18, ss 25.4, 51(4.2) & 62(1)	Conduct of the member exposes or is likely to expose patients to harm or injury	Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario	Suspension Specifically prevents gender-based conditions or limitations	Until order is varied or matter resolves
Alberta	Conditions, suspension during proceedings *Health Professions Act,* RSA 2000, cH-7, s 65(1)	– Not specified	Person or Committee designated by Council of the College of Physicians and Surgeons of Alberta	• Suspension • Condition requiring supervision	Until completion of proceedings

Manitoba	Suspension or conditions pending decision *Regulated Health Professions Act 2009*, CCSM c R138, s 110	– Necessary to protect the public from exposure to serious risk	Complaints Investigation Committee or Chair of the College of Physicians and Surgeons of Manitoba	• Suspension • Conditions	Not specified
New Brunswick	*Medical Act*, SNB 1981, c 87, s 56.1	- Necessary in the *public interest*	Council of Executive Committee of the College of Physicians and Surgeons of New Brunswick	• Suspension • Conditions	Not specified
Québec	*Professional Code*, CQLR c C-26, s 52.1 *Professional Code*, CQLR c C-26, s 122.0.1 *Medical Act*, CQLR c M-9.	The physical or mental condition of a professional requires immediate action to protect the public OR If a professional is charged with an offence punishable by a term of imprisonment of at least five years that is related to the practice of the profession, may take immediate action if protection of the public requires it. Must consider how the alleged offence is related to the practice of medicine or how public trust could be compromised if fails to take immediate action.	Board of Directors of the Collège des Médecins du Québec Disciplinary Council of the Collège des Médecins du Québec	• Suspension • Conditions • Restrictions	Not specified Until the earliest date on which, the order is stayed or withdrawn, the practitioner is acquitted, or expiry of 120 days.
Newfoundland & Labrador	*Medical Act*, SNL 2011, c M-4.02, s 44(6)(c)	Reasonable grounds to believe that a respondent has engaged in conduct deserving of sanction	Complaints Authorization Committee of the College of Physicians and Surgeons of Newfoundland & Labrador	• Suspension • Conditions	Not stipulated

APPENDIX 2. Continued

Nova Scotia	Interim suspension, conditions or restrictions *Medical Act*, SNS 2011, c 38, s 45	Is exposing or is likely to expose the public, patients, the medical profession or member to harm or injury	Registrar upon the direction of the Investigation Committee of the College of Physicians and Surgeons of Nova Scotia	• Suspension • Conditions • Restrictions	Until lifted, superseded, or annulled
Prince Edward Island	Action pending outcome of disciplinary process *Medical Act*, RSPEI 1988, c M-5, s 32.5	(1) substantial evidence of professional misconduct, incapacity or unfitness; and (2) demonstrable risk of harm or injury to patients or the general public (3) need for urgent intervention to prevent immediate risk of harm.	Fitness to Practise Committee or Board of Inquiry of the College of Physicians and Surgeons of Prince Edward Island	• Suspension • Conditions	10 days if action taken urgently
Northwest Territories	Measures to Protect the Public *Medical Profession Act*, SNWT 2010, c 6, s 50	Necessary to protect the health or safety of the public	Complaints officer of Health and Social Services	• Suspension • Conditions	Until no longer necessary
Nunavut	Interim suspension *Medical Profession Act*, RSNWT 1988, c M-9, s 42.	Pending an investigation	Minister of the Department of Health and Social Services	• Suspension	Not exceeding six weeks
California	*Cal Gov Code* § 11529 (West, 2008) Cal Bus & Prof Code §125.7 (West, 2008)	Will endanger the public health, safety or welfare because: – has violated the Medical Practice Act; or – unable to practice safely due to a mental or physical condition; or – failed to comply with an order. The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licencee in issuing the order. Will endanger the public health, safety or welfare.	Medical Quality Hearing Panel (Office of Administrative Hearings)	• Suspension • Conditions • Limitations • Restrictions	Not specified

APPENDIX 3. Immediate Action Case Law – 1 January 2016 to 31 December 2020

Case Citation	Jurisdiction	Summary of Allegation(s)	Health/ Conduct/ Performance	Sex	Specialty	Legally Represented?	First instance Interim Decision	Appeal Outcome: Conditions or Suspension?
Gerstman v Medical Board of Australia [2020] VCAT 1367	Australia (Victoria)	Examined breasts without proper consent	Conduct	Male	Endocrinologist	Yes	Conditions	Substituted for different conditions
Vo v Medical Board of Australia [2020] VCAT 1072	Australia (Victoria)	Sexual relationship with patient 20 years ago	Conduct	Male	General Practitioner	Yes	Suspension	Overturned (no immediate action)
Sevdalis v Medical Board of Australia [2020] VCAT 913	Australia (Victoria)	Continued to practise while suspended.	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Ellis v Medical Board of Australia [2020] VCAT 862	Australia (Victoria)	Misleading social media posts about vaccines and COVID-19, contrary to accepted medical practice	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Zhao v Medical Board of Australia [2020] VCAT 662	Australia (Victoria)	Sexual assault of patient	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Kok v Medical Board of Australia [2020] VCAT 405	Australia (Victoria)	Outrageous online posts	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
CJE v Medical Board of Australia [2019] VCAT 178	Australia (Victoria)	Rape	Conduct	Male	Dermatologist	Yes	Suspension	Overturned (split decision)
Syme v Medical Board of Australia [2016] VCAT 2150	Australia (Victoria)	Assisting patient to die	Conduct	Male	Urologist	Yes	Conditions	Overturned

APPENDIX 3. continued

Farshchi v Medical Board of Australia [2018] VCAT 1619	Australia (Victoria)	Slavery and people trafficking	Conduct	Male	General Practitioner	Yes	Conditions	Upheld
Das v Medical Board of Australia [2017] VCAT 2009	Australia (Victoria)	Breach of gender-based registration conditions	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Ahmad v Medical Board of Australia [2017] VCAT 1646	Australia (Victoria)	Opioid prescribing leading to suspension in Alaska	Performance	Male	Anaesthetist	No	Suspension	Upheld
Al Raheb v Medical Board of Australia [2017] VCAT 637	Australia (Victoria)	Substandard home practice, including poor hygiene and infection control practices.	Performance	Female	General Practitioner	Yes	Suspension	Upheld
EYJ v Medical Board of Australia [2019] VCAT 742	Australia (Victoria)	Inadequately managed health impairment	Health	Male	Surgeon	Yes	Suspension	Replaced with conditions
LCK v Health Ombudsman [2020] QCAT 316)	Australia (Queensland)	Charged with taking photos under female's dress in a shopping centre	Conduct	Male	Paediatrician	Yes	Conditions	Overturned
Harirchian v Health Ombudsman (No 2) [2020] QCAT	Australia (Queensland)	Charged with sexual offences and fraudulently obtaining prescriptions	Conduct	Male	General Practitioner	Yes	Suspension	Substituted for conditions
Peters v Medical Board of Australia [2020] QCAT 169	Australia (Queensland)	Sexualised comments. Sexual touching. Taking photos of naked patient.	Conduct	Male	Dermatology trainee	Yes	Conditions (gender-based)	Overturned

APPENDIX 3. continued

De Villiers v Medical Board of Australia [2020] QCAT 269	Australia (Queensland)	Performed surgical procedures beyond his competence, training, and skills	Performance	Male	General Practitioner	Yes	Conditions	Substituted for different conditions
Colagrande v Health Ombudsman [2017] QCAT 107	Australia (Queensland)	Convicted of sexual assault of patient. Sentenced to 9 months imprisonment, suspended for 18 months	Conduct	Male	Cosmetic surgeon	Yes	Condition not see female patients	Substituted for different conditions (chaperone)
Dr Stuart Lynch v Medical Board of Australia [2020] TASHPT 1	Australia (Tasmania)	Sexual misconduct. Then breached conditions on his registration.	Conduct	Male	General Practitioner	Yes	Suspension	Overturned
Liyanage v Medical Board of Australia [2016] NTCAT 587	Australia (Northern Territory)	Altering medical records and knowingly misleading AHPRA	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Gupta v Medical Board of Australia [2019] SAHPT 6	Australia (South Australia)	Charged with aggravated indecent assault	Conduct	Male	General Practitioner	Yes	Conditions	Revoked some of the conditions as requested by the doctor
Steel v Medical Council of New South Wales [2020] NSWCATOD 77	Australia (NSW)	Charged with assault, domestic violence and property damage	Conduct	Male	Neurosurgeon	Yes	Suspension	Upheld

APPENDIX 3. continued

Karimi v Medical Council of New South Wales [2017] NSWCATOD 180	Australia (NSW)	Dishonesty. Inappropriate prescribing, dispensing and storage of medications, poor clinical records.	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Segal v Medical Council of New South Wales [2020] NSWCATOD 113	Australia (NSW)	Sexual relationship with patient	Conduct	Male	General Practitioner	Yes	Suspension	Substituted for conditions
Ghosh v Medical Council of New South Wales [2018] NSWCATOD 186	Australia (NSW)	Treated her own son with multiple complex needs	Performance	Female	General Practitioner	Yes	Conditions	Upheld
Knowles v Medical Council of New South Wales [2019] NSWCATOD 46	Australia (NSW)	Inappropriate prescribing and poor medical records	Performance	Male	General Practitioner	Yes	Suspension	Substituted for conditions
Hanna v Medical Council of New South Wales [2017] NSWCATOD 27	Australia (NSW)	Indecent assault of female employee.	Conduct	Male	General Practitioner	Yes	Conditions	Upheld
Hill v Medical Council of New South Wales [2019] NSWCATOD 52	Australia (NSW)	Examination of patient without consent while anaesthetised.	Conduct	Male	Anaesthetist	Yes	Suspension	Overturned
Kalaf v Interim Orders Panel of the General Medical Council [2017] EWHC 982 (Admin))	UK (England and Wales)	Deficiencies in prescribing and communication. Functioning below the expected standard	Performance	Male	Paediatrician	No	Suspension	Suspension upheld

APPENDIX 3. continued

NH v General Medical Council [2016] EWHC 2348 (Admin)	UK (England and Wales)	False imprisonment of sister	Conduct	Male	Trainee	Yes	Suspension	Suspension upheld
Aliu v General Medical Council [2018] EWHC 3659 (Admin)	UK (England and Wales)	Serious deficiencies in professional performance. Unable to complete prescription or safely perform basic life support.	Performance	Male		No	Suspension	Suspension upheld
Uwen v The General Medical Council (Rev 1) [2018] EWHC 2484 (Admin)	UK (England & Wales)	Practised without indemnity insurance. Lied to regulator about not having insurance.	Conduct	Female	Psychiatrist	Yes	Suspension	Suspension upheld
Agoe v General Medical Council [2020] EWHC 39 (Admin)	UK (England and Wales)	Operated a practice that was closed down due to significant safety concerns. Did not comply with regulatory requirements.	Conduct	Female	General Practitioner	Yes	Suspension	Suspension upheld
Ali v General Medical Council [2020] EWHC 39 (Admin)	UK (England and Wales)		Conduct	Male	General Practitioner	Yes	Suspension	Suspension upheld
General Medical Council v Obasi [2019] NIQB 27	UK (Northern Ireland)	Requires supervision due to poor performance	Performance	Male	Anaesthetics	No	Conditions	Conditions extended
General Medical Council v Chopra [2017] EWHC 819 (Admin)	UK (England and Wales)	Probity (alleged falsification of records)	Conduct	Male	General Practitioner	Yes	Suspension	Suspension not extended
General Medical Council v Charaf [2015] EWHC 1501 (Admin)	UK (England and Wales)	Does not have appropriate skills	Performance	Male	Medical registrar	Yes	Suspension	Suspension extended (for 6 not 9 months)

APPENDIX 3. continued

D v General Medical Council [2015] EWHC 847 (Admin)	UK (England and Wales)	Blackmailed ex-girlfriend by threatening to send naked photos to her family and in-laws unless paid £70,000	Conduct	Male	(Not stated in judgement)	Yes	Suspension	Suspension upheld
General Medical Council v Nankhonya [2015] EWHC 1425 (Admin)	UK (England and Wales)	Below standard expected	Performance	Male	Stroke consultant	Yes	Supervision conditions	Supervision conditions extended
Bawa-Garba v General Medical Council [2015] EWHC 1277 (QB)	UK (England and Wales)	Single episode of deficient clinical care resulting in death of child	Performance	Female	Paediatric registrar	Yes	Suspension	Overturned
Howells v General Medical Council [2015] EWHC 348 (Admin)	UK (England and Wales)	Deficient professional performance	Performance	Male	Anaesthetics	No	Conditions	Conditions upheld
Interim Orders Committee Inquiry for Dr Kay Aih Boon Erwin	Singapore	Inappropriately treating children with ASD with antibiotics	Performance	Male	General Practitioner	Yes	Conditions	N/A
Interim Orders Committee Inquiry for Dr Ong Kian Peng Julian	Singapore	Received details of another doctor's patients for sex	Conduct	Male	General surgeon	Yes	Conditions	N/A
Interim Orders Committee Inquiry for Dr Chan Herng Nieng	Singapore	Passed on a patient to another doctor to have sex	Conduct	Male	Psychiatrist	Yes	Conditions	N/A

APPENDIX 3. continued

Interim Orders Committee Inquiry for Dr Wee Teong Boo; Interim Orders Committee Inquiry for Dr Wee Teong Boo	Singapore	Indecent assault of female patients while working alone in clinic at night	Conduct	Male	GP	Yes	Conditions, replaced with suspension when convicted.	N/A
Interim Orders Committee Inquiry for Dr Ler Teck Siang	Singapore	Falsifying blood tests, deceipt, breaching privacy, trafficking scheduled drugs	Conduct	Male	GP	No	Suspension	N/A
Medical Council v Dr Gerard Waters [2021] IEHC 252	Ireland	Providing incorrect information about COVID-19 and refusing to test or vaccinate patients.	Conduct	Male	General Practitioner	Yes	Referral to High Court	Suspension
Medical Council v FCM [2018] IEHC 616	Ireland	Lacking in basic medical knowledge and competence.	Performance	Male	Trainee	(Not stated in judgment)	Referral to High Court	Suspension
Lim v Medical Council of New Zealand [2016] NZHC 485	New Zealand	Charged with indecent assault of male patients while sedated	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Ahmad v Medical Council of New Zealand [2016] NZDC 21788	New Zealand	Convicted of indecent assault of female patients	Conduct	Male	General Practitioner	Yes	Suspension	Upheld
Fingerote v The College of Physicians and Surgeons of Ontario 2018 ONSC 5131	Canada (Ontario)	Sexually inappropriate comments and touching of breast.	Conduct	Male	Gastro-enterologist	Yes	Conditions	Overturned

APPENDIX 3. continued

Morzaria v College of Physicians and Surgeons of Ontario 2017 ONSC 1940	Canada (Ontario)	Charged with sexual assault. Inappropriate sexual touching of 13-year-old male patient	Conduct	Male	Paediatrician	Yes	Conditions	Upheld (split decision)
Kadri v College of Physicians and Surgeons of Ontario 2020 ONSC 5882	Canada (Ontario)	Lack of judgment and knowledge in care of patients	Performance	Male	Nephrologist	Yes	Conditions	Upheld
Kunynetz v College of Physicians and Surgeons of Ontario 2015 ONSC 6830	Canada (Ontario)	Alleged sexual misconduct during physical examination. Subsequent interim restrictions breached.	Conduct	Male	Dermatologist	Yes	Suspension	Upheld
College of Physicians & Surgeons of Alberta v Collett 2019 ABCA 461	Canada (Alberta)	Incapacitated due to physical or mental health condition (short term memory loss)	Health	Male	General Practitioner	Yes	Suspension	Overturned