In Whose Interest? Recent Developments in Regulatory Immediate Action against Medical Practitioners in Australia

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"Immediate action" is a powerful regulatory tool available to Medical Boards. It protects the public from harm by restricting a medical practitioner's registration after allegations have been made, but before wrongdoing is proven. This article charts the development of these coercive powers in Australia and examines the legal, socio-political and ethical justification for supplementing a well-defined "public risk" test with a broad and controversial "public interest" test that leaves medical practitioners vulnerable to inconsistent decision-making. Compared to overseas jurisdictions, immediate action powers in Australia offer fewer procedural protections. The regulatory response to perceived threats to public trust and confidence in the medical profession needs to be proportionate, transparent, effective, and consistent, to protect the public while also being fair to practitioners.

Keywords: *Medical regulation; immediate action; public interest; patient safety*

I. Introduction

Allegations of serious misconduct against medical practitioners can result in intense media scrutiny and pressure on medical regulators to react swiftly. The Medical Board of Australia (Medical Board) has broad and far-reaching powers to protect the public. It can immediately suspend, or impose conditions on, the registration of a medical practitioner before serious allegations have been investigated and prosecuted and before the facts are known. This raises a dilemma for decision-makers. Failing to take immediate action in response to serious allegations may erode public confidence in the profession and expose patients to preventable harm. For example, in Australia, gynaecologist Dr Emil Gayed continued to provide clinical care to patients while the Medical Council of New South Wales investigated complaints against him which were subsequently upheld.[1] Conversely, taking immediate action in response to unfounded allegations that are ultimately refuted can inflict irreparable damage to a practitioner's reputation and derail their career, even if they are ultimately absolved. Immediate action can precipitously disrupt professional connections with patients, colleagues and employers. Even if the practitioner is later exonerated, re-establishing those relationships can be difficult. This has led some to describe immediate action colourfully as "regulatory capital punishment before trial".[2]

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[1] G Furness, "Review of Processes Undertaken by the Medical Council of NSW Pursuant to Part 8 of the Health Practitioner National Law (NSW) with respect to Dr Emil Gayed" (2018).

[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 is part of the medical regulatory toolbox in many countries, including the United Kingdom (UK),[3] Ireland,[4] New Zealand,[5] Canada,[6] Singapore,[7] Malaysia,[8] South Africa,[9] France,[10] Nigeria,[11] India[12] and the United States.[13] It is not unique to medical or health practitioners. Similar powers exist in Australia in relation to legal practitioners,[14] police officers,[15] judges,[16] pilots,[17] teachers,[18] tax agents[19] and unregistered health practitioners.[20] Despite the weight, scope and ubiquity of immediate action powers, they are rarely studied. This gap in the academic literature provides an opportunity to ask important questions about how society can best protect the public from harm, while ensuring adequate procedural safeguards for practitioners.

In this article, we explore the development and current legal application of immediate action powers in Australia. We examine the two grounds for immediate action: the narrow "public risk" test and the broader "public interest" test. We explore how these tests have been applied in Australia and compare their use to other jurisdictions. Finally, we argue that the regulatory response to perceived threats to public trust and confidence in the medical profession needs to be proportionate, transparent and consistent. We also believe that the regulatory framework for urgent intervention would be enhanced through greater procedural protections and concerted efforts to establish the effectiveness of interim interventions.

II. The Evolution of Immediate Action Powers in Australia

In 2010, the Governments of Australia's Commonwealth, States and Territories effected a National Registration and Accreditation Scheme (the National Scheme) for uniform health practitioner regulation, to facilitate movement of practitioners across Australian jurisdictions and to reduce health workforce shortages and inequalities.[21] The scheme now covers 15 health professions, each of which has its own National Board supported by a cross-profession agency called the Australian Health Practitioner

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

[4] *Medical Practitioners Act 2007* (Ireland) s 60.

[5] *Health Practitioners Competence Assurance Act 2003* (NZ) ss 39, 48, 69, 93.

[6] *Health Professions Act*, RSBC 1996, c 183, s 35(1); *Medical Profession Act 1981*, SS 1980–81, c M-10.1, s 48; *Regulated Health Professions Act,* SO 1991, c 18, s 25.4; *Health Professions Act,* RSA 2000, cH-7, s 65(1); *Regulated Health Professions Act 2009*, CCSM, c R138, s 110; *Professional Code*, CQLR c C-26, ss 52(1), 122.0.1; *Medical Act*, SNB 1981, c 87, s 56.1; *Medical Act*, SNL 2011, c M-4.02, s 44(6)(c); *Medical Act*, SNS 2011, c 38, s 45; *Medical Act*, RSPEI 1988, c M-5, s 32.5; *Medical Profession Act*, SNWT 2010, c 6, s 50; *Medical Profession Act*, RSNWT 1988, c M-9, s 42.

[7] *Medical Registration Act* (Singapore, cap 174, 1997) s 59.

[8] *Medical Act 1971* (Malaysia) s 29A.

[9] *Health Professions Act 1974* (South Africa) s 19A(1)(e).

[10] *Loi No 2019-774 du 24 juillet 2019 – Art 77(V). Code de la santé publique, Article L4113-114 (Modifié par Ordonnance no 2018-20 du 17 janvier 2018 – Art 14*).

[11] *Medical and Dental Practitioners Act 2004* (Nigeria, cap M8) s 15(2)(c).

[12] *Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations 2002* (India) reg 8.5.

[13] See, eg, Cal Gov Code § 11529(a) (West 2008); Va Code Ann § 54.1-2408.1; NCGS § 150B-3(c); Md Code Ann § 10-226(c)(2); NM Stat § 61-6-15.1(A) (2008).

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

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

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

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

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

[19] *Cassaniti v Tax Agents' Board (NSW)* (2009) 179 FCR 1; [2009] FCA 619.

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

[21] *Intergovernmental Agreement for National Registration and Accreditation Scheme for the Health Professions* (2008) <https://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f36&dbid=AP&chksum=Nwgoo Gtzxb6JjNBIEP9Lhg%3d%3d>.

Regulation Agency (AHPRA).[22] AHPRA (or the Office of the Health Ombudsman in Queensland and the Health Professional Councils Authority in New South Wales) receives and investigates notifications about the health, conduct or performance of health practitioners on behalf of the National Boards. National Boards are then charged with making decisions about these notifications.

The National Law protects the public and maintains standards of healthcare quality and safety by allowing National Boards to sanction health practitioners. They can caution,[23] reprimand[24] or suspend[25] practitioners, impose conditions[26] or accept undertakings.[27] However, the most coercive power is immediate action. Immediate action authorises suspension or restriction of a practitioner's registration at any time before a notification has been fully investigated.[28] It operates on an interim basis and is designed to prevent or ameliorate further harm from arising if a practitioner continues to practise pending the outcome of an investigation or disciplinary process. This means that National Boards often have to make difficult decisions with incomplete information. Striking the right balance can be challenging for National Boards.

A. The Narrow Test of Immediate Action – The Public Risk Test

Section 155 of the National Law defines immediate action, in relation to a registered health practitioner, as:

> (a) the suspension, or imposition of a condition on, the health practitioner's … registration; or
> (b) accepting an undertaking from the health practitioner; or
> (c) accepting the surrender of the health practitioner's registration.

At the inception of the National Scheme, s 156(1) of the National Law stated (in all States except New South Wales) that a National Board may take immediate action in relation to a registered health practitioner if:

> (a) the National Board reasonably believes that –
>
> (i) because of the registered health practitioner's conduct, performance or health, the practitioner poses a serious risk to persons; and
> (i) it is necessary to take immediate action to protect public health or safety…

(hereafter referred to as the "**public risk**" test for immediate action).

In New South Wales, the test for immediate action also included a public interest test that allowed for the suspension or imposition of conditions on a practitioner's registration if:

> satisfied that it is appropriate to do so the protection of the health or safety of any person or persons … or … is otherwise in the public interest.[29]

This became the impetus for what we later refer to as the "**public interest**" test.

Section 156(2) stipulates that a National Board may only take immediate action against a health practitioner if it provides the practitioner with written or verbal notice of the proposed immediate action and invites the practitioner or student to make a written or verbal submission to which the Board must have regard.

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[22] B Bennett et al, "Australia's National Registration and Accreditation Scheme for Health Practitioners: A National Approach to Polycentric Regulation" (2018) 40 *Sydney Law Review* 159.

[23] *Health Practitioner Regulation National Law Act 2009* (Qld) ss 178(2)(a), 191(3)(c).

[24] *Health Practitioner Regulation National Law Act 2009* (Qld) s 191(3)(c). A performance and professional standards panel may reprimand a health practitioner.

[25] *Health Practitioner Regulation National Law Act 2009* (Qld) s 191(3)(b). A health panel may suspend a health practitioner's registration.

[26] *Health Practitioner Regulation National Law Act 2009* (Qld) s 191(3)(a).

[27] *Health Practitioner Regulation National Law Act 2009* (Qld) s 178(2)(b).

[28] *Health Practitioner Regulation National Law Act 2009* (Qld) s 156.

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

Section 3(3) of the National Law sets out the objectives and guiding principles of the National Law, which guides National Boards in the exercise of their functions under Section 156. They include:

> (a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
> …
> (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

B. A Broader Test for Immediate Action – The Public Interest Test

In 2017, the Medical Board and AHPRA commissioned an Independent Review by Professor Ron Paterson into the appropriateness of using chaperone conditions as a form of immediate action to protect patients while allegations of sexual misconduct against medical practitioners were being investigated (the Paterson Review).[30] While much of the Paterson Review is outside the scope of this article, it elucidated problems with the use of immediate action under the National Law. The Paterson Review observed that immediate action conditions:

- last too long (20 months, on average);[31]
- do not always prevent patient harm;[32]
- may undermine informed consent and mutual trust between patients and medical practitioners;
- may be inappropriate in personal and sensitive settings, such as psychotherapy;[33]
- are inconsistently applied across jurisdictions;[34]
- should not be used if a medical practitioner cannot be trusted to see patients without a chaperone.[35]

The Paterson Review recommended that the public risk test be broadened to also encompass a public interest test, to best protect patients.[36] The Paterson Review cited a South Australian case involving Dr Gregory Wilson, who remained registered despite being convicted of two counts of indecent assault against a child patient because a risk to the public was not identified. However, following further criminal convictions for unlawful sexual intercourse with an under-age patient, the *Medical Practice Act 2004* (SA) was urgently amended to enable immediate action to be taken if "desirable … in the public interest".[37] The Medical Board of South Australia then suspended Dr Wilson because it would "shock the public conscience" to allow him to continue practising, despite … strict conditions and undertakings.[38] However, Australian and overseas cases discussed below, reveals that similar conduct has clearly prompted immediate action on the basis of the public risk test, without the need to resort to a public interest test.

The Paterson Review concluded that:

> Patients, practitioners and the public deserve prompt, thorough, fair and consistent action in the interim period while the truth of sexual misconduct allegations is examined. Interim restrictions must be workable, acceptable to patients, and adequate to protect the public. Sexual advances or sexual assault by a health practitioner is a harm that society will not tolerate.[39]

In 2017, a Queensland Government Parliamentary Committee ("the Committee") endorsed an Independent Review commissioned by the Australian Health Ministers' Advisory Council.[40] The

[30] R Paterson, *Independent Review of the Use of Chaperones to Protect Patients in Australia* (2017).

[31] Paterson, n 30, 33.

[32] Paterson, n 30, 8.

[33] Paterson, n 30, 46.

[34] Paterson, n 30, 76.

[35] Paterson, n 30, citing *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630, 639F.

[36] Paterson, n 30, 12, 23, 31.

[37] *Medical Practice Act 2004* (SA) s 59(2)(b).

[38] *Medical Board v Wilson* (Unreported, SASC, Kelly J, 5 April 2007), cited by Paterson, n 30, 31.

[39] Paterson, n 30, 6.

[40] Australian Health Ministers' Advisory Council, Parliament of Queensland, *Independent Review of the National Registration and Accreditation Scheme for Health Professions: Final Report* (2014) <http://www.coaghealthcouncil.gov.au/Projects/Independent-Review-of-NRAS>.

Committee recommended changes to immediate action laws, as part of a broader overhaul of the National Scheme and National Law to improve efficiency, effectiveness and accountability.[41] It stated that the current threshold for immediate action may "constrain a National Board from taking swift action where it is warranted to protect public health, public safety or the public interest".[42] It suggested that a public interest test would ensure public confidence in health practitioners would not be eroded by knowledge that a practitioner had been allowed to continue practising while serious allegations were being resolved. It referred to the following example:

> [I]f a practitioner has been charged with a serious crime, and the relationship between the crime and the practitioner's practice is not yet well established, the "public interest" may require a National Board to constrain the practitioner's practice until the criminal matter is resolved, both for the protection of the public and for the public confidence in the health profession.[43]

The Committee referred to examples of when immediate action might be taken in the public interest, including:

1. Where there are serious criminal charges not directly related to the practitioner's practice
2. Historical issues uncovered after the passage of time
3. A pattern of repeated conduct, none of which individually may meet the threshold, but which is suggestive of an underlying issue.

The Queensland Government responded by enacting the *Health Practitioner Regulation National Law Amendment Bill 2017* (Qld).[44] In his Explanatory Speech, the Queensland Minister for Health also stated:

> The current grounds on which a National Board may take immediate action have been found to be problematic in some cases, such as the failures at Djerriwarrh Health Services in Victoria. In that case, the National Board was unable to take immediate action because the material before the Board did not meet the threshold set out in the National Law. In this context, I would like to draw attention to the recent report by Professor Ron Paterson [which] strongly endorses the approach taken in the Bill to apply the "public interest" test to immediate action for health practitioners.[45]

There was broad support for the Bill from advocacy groups and academics.[46] However, disquiet was expressed by groups supporting medical practitioners. Avant is Australia's largest medical indemnity insurance provider. In its submission on the Bill,[47] Avant raised concerns about the lack of clarity in the interpretation of the term "public interest" and recommended that the proposed amendments include a provision requiring the power be exercised in a way that is proportionate to the risk posed. This did not eventuate. Likewise, the Queensland Branch of the Australian Medical Association objected on the basis that the proposed public interest test was too broad and subjective, such that "anything could be in the public interest".[48]

In response, the Committee noted that a public interest test is used in other legislative schemes that licence and register professionals who occupy positions of trust within the community, such as legal practitioners. It went on the say that court and tribunal decisions provide guidance as to the legal meaning of "public interest" such that it is not necessary for the Bill to define it. However, as we explore below,

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[41] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017* (2017) 42.

[42] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, n 41, 22.

[43] Explanatory Notes, *Health Practitioner Regulation National Law Amendment Bill 2017* (Qld).

[44] Council of Australian Governments Health Council, *Summary of the Draft Health Practitioner Regulation National Law Amendment Law 2017* (2017) <http://www.coaghealthcouncil.gov.au/Projects/Health-Practitioner-Regulation-National-Law>.

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

[46] See Paterson, n 30.

[47] Avant Insurance, *Review of the National Registration and Accreditation Scheme for Health Professionals – Avant Submission* (10 October 2014) <https://avant.org.au/News/News-Resources/NRAS-submission/>.

[48] Shaun Rudd, Public Hearing Transcript, 17 July 2017, submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, n 41, 42, 15.

the public interest is an illusory concept. Of the few decisions in Australia considering the public interest test for immediate action, there is remarkable divergence of opinion.

On 1 March 2018, the new s 156(1)(e) of the National Law[49] commenced operation:

> (e) the National Board reasonably believes the action is otherwise in the public interest.
>
> Example of when action may be taken in the public interest –
>
> 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.
>
> (hereafter referred to as the "**public interest**" test for immediate action).

These legislative amendments are consistent with Australia's regulatory principles. AHPRA's *Service Charter* outlines its obligations to health practitioners, employers and the public and commits to regulating the health professions "in the public interest".[50] Likewise, the values espoused in AHPRA's *Regulatory Principles for the National Scheme* seek to uphold professional standards and maintain public confidence.[51] By broadening the grounds upon which immediate action may be taken to include a public interest test, Australian policy-makers have affirmed the paramountcy of public protection over the interests of medical practitioners and the medical profession.

III. Judicial Consideration of Immediate Action in Australia

Hearings of medical boards are closed to the public and their reasons for decision are not publicly available. Therefore, it is difficult to determine how the Medical Board decides the majority of cases where immediate action is considered. We know that disparities have been observed in how National Boards apply the National Law[52] and there is likely to be variation in how immediate action decisions are determined by National Boards across jurisdictions.[53] In the absence of publicly reported decisions of the Medical Board, we are reliant on decisions of the courts and tribunals to understand how these powers have been applied in Australia.

A. Cases Applying the Public Risk Test

Over the last ten years, numerous cases have considered the public risk test set out in s 156(1)(a) of the National Law. In *Nitschke v Medical Board of Australia*,[54] a story on ABC television[55] revealed that Dr Philip Nitschke, a well-known euthanasia advocate, was advising people how to import Nembutal into Australia, which they were using to end their lives. Voluntary assisted dying was not lawful in any Australian jurisdiction at that stage. The Medical Board received a number of complaints from mental health advocates and the Australian Medical Association about this. The Immediate Action Committee of the Medical Board in the Northern Territory imposed an immediate suspension on the basis that Dr Nitschke inappropriately advised a 45-year-old man about methods of suicide, knowing the man was not terminally ill, was likely to be suffering from depression and intended to take his own life. The Medical Board noted that Dr Nitschke regularly promoted "advice on methods of suicide" to people who were not terminally ill. It found that a doctor–patient relationship existed and that Dr Nitschke failed to: assess the patient for any underlying medical condition (including depression); provide any treatment

[49] *Health Practitioner Regulation National Law Amendment Act 2017* (Qld).

[50] AHPRA, *Service Charter* <https://www.ahpra.gov.au/documents/default.aspx?record=WD12%2F8645&dbid =AP&chksum=k5o4ABqyMZfC9TjiK31OAg%3D%3D>.

[51] AHPRA, *Regulatory Principles for the National Scheme* (2015) <https://www.ahpra.gov.au/AboutAHPRA/Regulatory-principles.aspx>.

[52] J Millbank, "Serious Misconduct of Health Professionals in Disciplinary Tribunals under the National Law 2010–17" (2019) 44(2) *Australian Health Review* 190.

[53] Paterson, n 30.

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

[55] C Gribbin and D Owens, "Euthanasia Advocate Philip Nitschke Criticised over Support for 45-year-old Who Committed Suicide", *ABC News*, 5 July 2014 <https://www.abc.net.au/news/ 2014-07-03/nitschke-criticised-over-45yo-mans-suicide/5570162>.

of that condition (if he considered one existed); or refer him for assessment, specialist care or treatment. Dr Nitschke appealed to the Health Practitioners Tribunal of the Northern Territory (the HPT), which upheld the Committee's decision.

Dr Nitschke then successfully appealed to the Northern Territory Supreme Court (the NTSC), which set aside the immediate suspension. The NTSC found that the Medical Board and the HPT had erred by applying the wrong test in deciding to impose immediate action. Under s 156 of the National Law, the Medical Board and HPT should have considered whether they "reasonably believed" that, because of Dr Nitschke's conduct, he posed "a serious risk to persons" and it was "necessary to take immediate action to protect public health or safety". Instead, the Medical Board and HPT had incorrectly found that Dr Nitschke's conduct constituted professional misconduct or unprofessional conduct. That question was only to be determined at a later date after full consideration on the merits.[56] By considering a much broader range of conduct than required under s 156 of the National Law, the Medical Board and HPT considered irrelevant considerations[57] and therefore Dr Nitschke was denied procedural fairness.[58]

The Court provided useful instruction for deciding when National Boards should take immediate action under the National Law. The health practitioner, not their conduct, must pose a serious risk to persons, although the conduct will be relevant in determining that question.[59] Immediate action can be taken in relation to conduct where no treating relationship exists or where there is no connection to the practice of the profession.[60] However, 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 against the practitioner's registration.[61] 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.[62] However, where the alleged conduct relates to acts or omissions in relation to a person who is not a patient, "one would normally require expert evidence about the relevant duty to act, if the duty is not clearly identified elsewhere".[63]

Other Australian judgments also delineate the evidentiary requirements and proper approach for imposing immediate action.[64] According to these judgments, immediate action requires urgent action to protect public health and safety and is often based on "incomplete information".[65] It does not require a detailed enquiry, nor does it require proof of conduct. Instead, the existence of a "reasonable belief" that the medical practitioner poses a serious risk enlivens the power to take immediate action.[66] It is necessary to identify with precision what is the subject of the reasonable belief.[67] A reasonable belief might be based on material that would not usually be considered evidentiary.[68] For example, the mere fact and seriousness of complaints or charges, supported by untested witness statements might be sufficient evidence of a risk. Any material available should be carefully scrutinised in order to determine the weight to be attached to it. A complaint that is trivial or misconceived on its face should clearly not be given weight.

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[56] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [5]; [2015] NTSC 39.

[57] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [107], [109]; [2015] NTSC 39.

[58] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [110]; [2015] NTSC 39.

[59] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [88]; [2015] NTSC 39.

[60] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [92]; [2015] NTSC 39.

[61] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [93]; [2015] NTSC 39.

[62] *Nitschke v Medical Board of Australia* (2015) 36 NTLR 55, [89]; [2015] NTSC 39.

[63] *Dekker v Medical Board of Australia* [2014] WASCA 216, [73].

[64] *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; *Liddell v Medical Board of Australia* [2012] WASAT 120.

[65] *Tasmanian Board of the Pharmacy Board of Australia v Balzary* [2011] TASHPT 2, [4]–[5].

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

[67] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [65].

[68] *Pearse v Medical Board of Australia* [2013] QCAT 392.

Therefore, the nature of the allegations is highly relevant to whether immediate action is justified. The National Board should be able to identify and particularise the factors that make the risk serious; identify the persons to whom a practitioner poses a serious risk; and demonstrate the appropriateness of the immediate action to protect the identified persons from the serious risk.[69] The relevant facts do not need to be proven on the balance of probabilities. However, there must be proven objective circumstances sufficient to "justify a reasonable belief"[70] or to "induce the belief in a reasonable person".[71] As with cases involving pre-trial discovery in civil proceedings, there must be some "tangible support" beyond mere belief or assertion by an applicant.[72]

The purpose of immediate action is the protection of the public only on an interim basis. It is a means to an end, not an end in itself. The practitioner's suitability to practise will be revisited following further investigation and a full hearing on the merits, based on all of the available material.[73] However, 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".[74] Whilst the protection of the public is the paramount consideration, the impact of immediate action on a health practitioner must be considered[75] and the safety of the public "should be secured with as little damage to the practitioner as is consistent with its maintenance".[76] When a National Board takes immediate action, it must be the least onerous possible.[77]

> [B]ecause 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.[78]

Clearly, immediate action creates unique challenges for decision-makers, who must balance competing public and private considerations. While the National Law clearly makes public protection the paramount aim of the National Scheme, the courts require this to be tempered to the extent possible in view of the impact that immediate action can have on practitioners. The impasse that this creates is amplified when new and imprecise concepts such as "public interest" are introduced into the decision-making calculation.

B. Cases Applying the Public Interest Test

Unlike the public risk test, judicial consideration of the public interest test for immediate action remains inchoate. We will examine two recent decisions of the Victorian Civil and Administrative Tribunal (VCAT) involving alleged egregious conduct outside the practice of medicine. Both cases were the subject of police investigations and criminal proceedings that were in their infancy and the medical practitioner had not yet been found guilty. In both cases, VCAT agreed that the allegations were serious and would cause concern to the public if it learned that the medical practitioners continued practising while criminal proceedings were on foot. However, VCAT reached opposite decisions on how to apply these considerations to unproven and untested facts where the impact on the practitioner would be immense.

1. Farshchi v Medical Board of Australia

The first case in Australia to consider s 156(1)(e) was *Farshchi v Medical Board of Australia* (*Farshchi*).[79] Dr Farshchi was a medical practitioner who worked as a trainee in rural Victoria. He trained in Iran, was

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[69] J Owen, *Immediate Action, Not Reaction: A Practical Guide to Health Boards When Making Immediate Action Decisions* (2014) MCW In Focus <http://www.mcw.com.au/content/Document/News/Immediate%20Action%20Not%20Reaction.pdf>.

[70] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [66].

[71] *Bernadt v Medical Board of Australia* [2013] WASCA 259, [173].

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

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

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

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

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

[77] *Shahinper v Psychology Board of Australia* [2013] QCAT 593, [23].

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

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

active in Victoria's Iranian community and owned a business with his wife. Between July 2015 and March 2017, he allegedly forced an Iranian refugee (the victim) to work in his business 14 hours per day without pay or rest breaks. When the victim questioned this arrangement, Dr Farshchi allegedly threatened to have a bag placed over his head and throw him in the ocean, send him back to Iran, have him returned to immigration detention and dissolved in acid. The victim was allegedly terrified of Dr Farshchi, vomited from stress and was fearful of facing the death penalty if sent back to Iran because he had converted to Christianity.

Dr Farshchi admitted to prescribing medications for the victim in May and June 2017, including the opioid suboxone, for severe back pain. He admitted that he was aware of the victim's history of opioid use and did not document this in the record. It was alleged that Dr Farshchi's clinical care of the victim was inadequate in that his records did not reveal a therapeutic justification for the use of suboxone. It was also alleged that the victim collapsed at work after taking suboxone and that when Dr Farshchi was notified about this by other employees, he told them not to call an ambulance but to bring the victim to his office.

On 24 January 2018, Dr Farshchi was arrested and charged with forced labour offences.[80] He was released on $200,000 bail and the Medical Board was notified of the charges. On 6 February 2018, the Medical Board took immediate action against Dr Farshchi pursuant to s 156(1)(a) of the National Law to protect public health and safety. Section 156(1)(e) had not yet been enacted and was unavailable to the Medical Board at the time of their decision. They imposed conditions on his registration that required him to be supervised by another registered medical practitioner and that the supervisor was "required to take direct and principal responsibility for each individual patient, and must be physically present at the workplace at all times when [Dr Farshchi] is providing clinical care".

On 19 March 2018, Dr Farshchi applied to VCAT for review of the Medical Board's decision on the grounds that it was harsh, intrusive, excessive, prohibitive and unduly onerous and that there were no grounds to reasonably believe that such immediate action was necessary. He also contended that his bail conditions already prevented him from having contact with the informant and that, as he was not a fellow of his specialty college, he was already subject to supervisory conditions, albeit less stringent than those imposed by the Medical Board.

On 23 and 24 August 2018, VCAT dismissed the appeal. It noted that the evidence was unsworn, second-hand and untested.[81] It noted that Dr Farshchi "strenuously" denied the allegations, was entitled to a presumption of innocence and that no adverse inference should be drawn from him not giving evidence.[82] It also noted that a final hearing of the matter would not occur for a considerable period of time.[83] However, VCAT also noted that a police summary of the victim's statement referred to "corroborating evidence from a range of sources", but that the Australian Federal Police could not share that evidence with other agencies.[84]

VCAT held that immediate action should be taken in the public interest pursuant to s 156(1)(e) because the allegations against Dr Farshchi were serious and involved prolonged exploitation, abuse and human rights breaches of a vulnerable individual.[85] It held that these allegations undermine public confidence in the medical profession and raise serious questions about his ethical suitability to practise and his capacity to provide culturally safe medical care. It held that immediate action was necessary to give effect to the Medical Board's Code of Conduct and emphasised "the principles which lie behind registration in the health professions", including respect, compassion, integrity, trustworthiness, dependability and candour.[86] It noted that the Code of Conduct requires medical practitioners to promote the health of individuals and the community and to avoid caring for people with whom they are in close personal relationships.

[80] *Criminal Code Act 1995* (Cth) s 270.6A.

[81] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [55].

[82] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [56].

[83] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [108].

[84] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [57].

[85] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [77].

[86] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [76].

VCAT disagreed with Dr Farshchi's submission that the allegations relating to his business behaviours were unrelated to his practice as a medical practitioner and that they lacked a sufficient link to the quality of medical care that he would provide to his patients. Instead, VCAT determined that good medical practice required the maintenance of therapeutic relationships based on mutual trust, and that Dr Farshchi's alleged business conduct, if proven, would run counter to the inherent qualities of a medical practitioner that are required to engender trust from patients and the public.[87] Therefore, VCAT believed that failure to take immediate action would erode public confidence because, until serious criminal charges are resolved, the public may be "gravely concerned" that he could hold exploitative attitudes and might have a proclivity towards abuse of a power imbalance.[88] Moreover, VCAT noted that, in this case, there was a connection between the alleged business conduct and the practice of his professions in that he treated the victim for symptoms resulting from the "stress and conditions of his work environment".[89]

VCAT also rejected Dr Farshchi's submission that the degree of supervision imposed by the Medical Board was disproportionate to the concerns raised and that only the minimum regulatory intervention should be applied. Instead, VCAT held that only the physical presence of a supervisor would give confidence to patients that the therapeutic relationship would not be undermined in any way.[90] In reaching its decision, VCAT considered the public interest in maintaining a regulatory system that responds fairly and proportionately, particularly where a matter is unlikely to finalise expeditiously;[91] the public interest in allowing health practitioners, particularly those in "areas of need", to practise;[92] and the public interest in only taking immediate action when necessary to do so.[93] It also considered the devastating impact that onerous conditions would have on Dr Farshchi's livelihood and that he might be unable to find a supervisor prepared to supervise him in the circumstances.[94] However, VCAT held that the stronger public interest is to safeguard patient well-being, confidence in the regulatory system and that "no shadow be cast" over the therapeutic relationship between health practitioners and vulnerable patients.[95]

2. CJE v Medical Board of Australia

The second case to consider s 156(1)(e) was *CJE v Medical Board of Australia* (*CJE*).[96] CJE was a single homosexual male, who worked as a specialist in private practice in Sydney. The complainant in this case was another single homosexual male medical practitioner. Evidence available to VCAT revealed that CJE and the complainant first met in 2010, following which they arranged dinner dates and kissed on a number of occasions. Although they first had sexual intercourse in 2012, they had little ongoing mutual contact between 2012 and 2017. In April 2017, they re-established communication by text message and CJE asked if he could stay with the complainant in Melbourne, as he was visiting for work.

On a Friday night in mid-June 2017, CJE and the complainant had dinner together. They discussed gay men's health and their views on pre-exposure prophylaxis (PrEP) medication, which is used to reduce the risk of HIV infection. CJE told the complainant that he was taking PrEP. The complainant said that he was not using PrEP because he was concerned about side effects and did not see PrEP as a substitute for wearing condoms. The two men returned to the complainant's house and had sexual intercourse. The complainant alleges that he checked several times to ensure that CJE was wearing a condom. CJE reassured him that he was and that the complainant could trust him. Later, the complainant saw a discarded condom on the bed and immediately stopped the intercourse. He asked CJE why he had

[87] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [96].

[88] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [114].

[89] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [93].

[90] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [110].

[91] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [74].

[92] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [73].

[93] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [75].

[94] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [118].

[95] *Farshchi v Medical Board of Australia* [2018] VCAT 1619, [122].

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

removed the condom and CJE told him that "it feels better". CJE allegedly told the complainant that he had unprotected sex with another man six weeks beforehand but sought to reassure the complainant that he had not jeopardised his health.

The following day, CJE and the complainant swapped further text messages, including one where CJE agreed, at the complainant's request, to send the complainant a copy of his most recent HIV test result. However, CJE never sent the result. On the Sunday, the complainant told a friend what had transpired. The friend counselled the complainant to attend an Emergency Department for advice and testing. The complainant did this and was prescribed post-exposure prophylaxis to reduce the risk of HIV infection. The complainant sent a message to CJE informing him of the outcome. CJE did not respond and blocked further messages from the complainant. In late June 2017, the complainant informed Victoria Police of the incident.

In September 2018, CJE was arrested and charged with one count of rape under s 38 of the *Crimes Act 1958* (Vic) and one count of sexual assault pursuant to s 40(1) of the *Crimes Act*. CJE gave a no-comment interview. In November 2018, the Medical Board suspended CJE's registration under s 156(1)(e) of the National Law. CJE appealed to VCAT, arguing that the suspension should be lifted. On 23 January 2019, VCAT heard the appeal.

By a majority of two to one, VCAT did not form the reasonable belief that immediate action was necessary in the public interest under the National Law. VCAT substituted the Board's decision to suspend CJE, with its decision not to impose immediate action. In reaching this decision, VCAT was unanimous that registered medical practitioners must at all times display integrity, truthfulness, dependability and compassion, and must maintain the highest standards of ethical and trustworthy conduct to protect and promote individual and public health.[97] Members were also unanimous that the alleged conduct of CJE was egregious and raised serious questions about the ethical suitability of CJE to practise medicine. They held that the conduct, if proven, involved a calculated disregard for the health, safety and medical welfare of another person in the context of sexual intercourse that led to fear and distress on the part of the complainant that he might contract HIV.[98] Interestingly, all three members considered the case of *Farshchi* and agreed that immediate action was necessary and appropriate in that case:

> [A]llegations against Dr Farshchi concern allegations of alleged reprehensible conduct such that, in our view they are rare situations where public knowledge of the allegations and that the doctors could continue to practise would highly likely adversely impact public opinion of the medical profession and its regulation, that being against the public interest.[99]

However, members were split on the question of what the public interest required them to do with these findings. Member Reddy (in dissent) found[100] that immediate action was necessary to give effect to the principles which lie behind the registration of medical practitioners.[101] She believed that the allegations were not "trivial or misconceived"[102] and involved allegations that CJE jeopardised the physical and/or psychological health of another person through non-consensual sexual conduct.[103] In these circumstances, she determined that if the public learned of the allegations against CJE, the public would seriously question his ethical suitability to practise as a medical practitioner and that failure to take immediate action would adversely impact on the reputation of the medical profession and would undermine the willingness of the public to seek appropriate treatment if they were aware of the charges against him.[104] She also agreed with the Medical Board that immediate action was necessary because CJE's alleged offending:

[97] *CJE v Medical Board of Australia* [2019] VCAT 178, [93]–[94].

[98] *CJE v Medical Board of Australia* [2019] VCAT 178, [96]–[99].

[99] *CJE v Medical Board of Australia* [2019] VCAT 178, [91].

[100] *CJE v Medical Board of Australia* [2019] VCAT 178, [123]–[133].

[101] *CJE v Medical Board of Australia* [2019] VCAT 178, [125].

[102] *CJE v Medical Board of Australia* [2019] VCAT 178, [127].

[103] *CJE v Medical Board of Australia* [2019] VCAT 178, [131].

[104] *CJE v Medical Board of Australia* [2019] VCAT 178, [130].

> [D]emonstrated a preparedness to exploit a relationship of trust, a failure to make ethical decisions that prioritise a person's bodily integrity and the safety of individuals and a failure to observe appropriate and requisite boundaries in his interactions with persons that accord with legal, professional and ethical standards.[105]

and is:

> [I]ndicative of decision-making and judgment so flawed that the public may not be assured that [he] would be able to make decisions consistent with … safe and appropriate care of his patients and the observation of appropriate boundaries of such care.[106]

She viewed the alleged conduct as so grave that nothing short of suspension would be appropriate.

On the other hand, despite agreeing with the reasons expounded in *Farshchi*, the majority reached a conclusion that was in stark contrast to that in *Farshchi*. The majority held that not taking immediate action against an individual practitioner in response to allegations of serious offending would be unlikely to have any material or lasting effect on the reputation of the medical profession and would not result in a loss of public confidence.[107] It held that the public would not judge the profession solely on allegations against a single medical practitioner, even if those allegations were of high concern, because the occurrence of such allegations against medical practitioners is rare.[108] The majority relied on the decision in *Medical Practitioners Board of Victoria v Lal*,[109] in which the Victorian Court of Appeal reached a similar conclusion with respect to a decision to register an individual practitioner.

In addition, the majority held that, while the public would rightly demand punishment for those found guilty of serious criminal offending, it would also understand the importance of the doctrine of the presumption of innocence.[110] CJE faces criminal charges in relation to which he is presumed innocent. Had Parliament specifically intended that patients not be treated by medical practitioners accused (but yet found guilty of) serious criminal offending, it could have specifically enacted legislation prohibiting medical practitioners facing serious criminal charges from practising until they were found not guilty.[111] It went on to say that significant public investment had been expended in training CJE and there was an inherent public interest in allowing him to continue practising while awaiting the outcome of the criminal charges.[112]

Finally, the majority noted that CJE has practised without any other allegations against him relating to inappropriate professional or personal conduct either before or after the alleged incident in June 2017.[113] It also noted a number of character references that spoke of his community service and "exemplary medical care" that was respectful, caring and compassionate. The majority also considered the likely lengthy duration of immediate action that was dependant on the finalisation of the criminal prosecution.[114]

The Medical Board unsuccessfully appealed VCAT's decision to the Supreme Court of Victoria.[115] On reading the decision, there are indications that the Court was not wholly supportive of VCAT's decision. However, the Court lacked jurisdiction to make findings of fact or substitute its own decision. Its jurisdiction was limited to questions of law. It found no error of law on four grounds of appeal. First, the Court rejected the Medical Board's submission that VCAT applied incorrect tests for gauging public confidence.[116] The Medical Board submitted that VCAT should have considered whether immediate

[105] *CJE v Medical Board of Australia* [2019] VCAT 178, [74].

[106] *CJE v Medical Board of Australia* [2019] VCAT 178, [75].

[107] *CJE v Medical Board of Australia* [2019] VCAT 178, [113].

[108] *CJE v Medical Board of Australia* [2019] VCAT 178, [116].

[109] *Medical Practitioners Board of Victoria v Lal* [2009] VSCA 109.

[110] *CJE v Medical Board of Australia* [2019] VCAT 178, [104], [117].

[111] *CJE v Medical Board of Australia* [2019] VCAT 178, [120].

[112] *CJE v Medical Board of Australia* [2019] VCAT 178, [106].

[113] *CJE v Medical Board of Australia* [2019] VCAT 178, [105].

[114] *CJE v Medical Board of Australia* [2019] VCAT 178, [104].

[115] *Medical Board of Australia v Liang Joo Leow* [2019] VSC 532.

[116] *CJE v Medical Board of Australia* [2019] VCAT 178, [66]–[102].

action was required to maintain public confidence in the profession, instead of considering whether its absence would result in *loss* of public confidence. However, the Court said that the majority's reference to *loss* of public confidence was synonymous with "no significant impact" on public confidence, which was an acceptable test to apply. Likewise, the Court disagreed with the Medical Board's submission that VCAT incorrectly interpreted the public interest as requiring immediate action to be taken only if a failure to do so would create "public outrage". Instead, the Court held that VCAT was referring to "public outrage" as an example of when immediate action could be taken.

Second, the Court held that it was not irrelevant for VCAT to consider that the public would foreseeably understand that serious allegations of this nature against medical practitioners are rare and that the profession would not be adversely judged by the public when serious allegations are made against one practitioner. The Court held that consideration of immediate action will inevitably view the alleged conduct of an individual practitioner through a wider public lens and that, where the decision is informed by questions of public confidence, the prevalence of allegations may be relevant. The Court also held that VCAT had correctly directed itself that untested criminal charges do not automatically require immediate action, that the nature of the charges will be relevant and that it is not necessary to make findings of guilt before immediate action can be taken.[117]

Third, the Court disagreed with the Medical Board's submission that, having found that the alleged conduct was *grave* and *egregious* and would be of *high concern* to the public, it was legally irrational or unreasonable for VCAT to set aside the suspension.[118] The Court recognised that this was a difficult case in which there was a large area of "decisional freedom" due to the expansive public interest criterion. The facts did not command a particular decision. Finally, the Court held that VCAT did not fail to give adequate reasons for its decision. It identified the factors that it considered in reaching a decision and its path of reasoning was sufficiently disclosed.[119]

C. The Present Situation in Australia

It is difficult to reconcile the disparate outcomes in *Farshchi* and *CJE*. Both cases involved untested allegations of egregious conduct that contravened the fundamental qualities of a medical practitioner, which include respect, integrity, trustworthiness, and candour. In both cases, the conduct, if proven, was unethical, exploitative and potentially harmful to the physical and emotional well-being of the victims. One factual difference was that Dr Farshchi was an international medical graduate and trainee, whereas *CJE* was an Australian-trained specialist with a favourable reputation amongst his peers. The majority in *CJE* narrowly interpreted Parliament's intentions, saying that if Parliament had intended for immediate action to be taken, it could have defined offences that would preclude a medical practitioner from practising while awaiting trial. However, this approach is clearly contrary to the intention that a public interest test be broad in scope and flexible in application. Indeed, VCAT went further. It suggested that rather than being perturbed by the alleged egregious conduct of a single practitioner, the public would be disturbed to learn that a medical practitioner had been prevented from practising despite the absence of a finding of guilt. The similarities between the two cases and the difference in final outcome make it challenging to draw meaningful conclusions about how future Tribunals or National Boards might apply immediate action powers. This is problematic in view of the important role that consistency plays in maintaining public confidence in the regulation of the profession.

In November 2019, the Council of Australian Governments Health Council (the Ministerial Council) issued binding policy directions[120] to AHPRA and the National Boards pursuant to s 11 of the National

[117] *CJE v Medical Board of Australia* [2019] VCAT 178, [103]–[114].

[118] *CJE v Medical Board of Australia* [2019] VCAT 178, [115]–[121].

[119] *CJE v Medical Board of Australia* [2019] VCAT 178, [50]–[65].

[120] Council of Australian Governments Health Council, *Policy Direction 2019-1. Paramountcy of Public Protection When Administering the National Scheme* (2019) <https://www.ahpra.gov.au/documents/default.aspx?record=WD20%2f29447&dbid=AP&chksum=zAwX6DuV0pz9ombMcgfkpQ%3d%3d>.

Law.[121] These directions may assist in reconciling the divergent outcomes in *Farshchi* and *CJE*. They require AHPRA and National Boards to:

- act in the interest of public protection, patient safety and support safety and quality of healthcare;
- consider the potential impact of the practitioner's conduct on the public;
- consider the extent to which deterring other practitioners from participating in similar conduct supports the protection of the public and engender confidence in the regulated profession;
- give at least equal weight to the expectations of the public as well as professional peers with regards to the expected standards of practice by the registered practitioner;

Most importantly, the Ministerial Council directed that "the risk that a practitioner poses to the public and the need for effective deterrence must outweigh consideration of the potential impacts upon the practitioner from any regulatory action".[122] While these directions may assist National Boards, it is unclear whether they apply to responsible tribunals when considering immediate action appeals. As observed in *Vo v Medical Board of Australia*,[123] the directions do not specifically refer to responsible tribunals that exercise their "own functions" on appeal[124] and appear to "stray into the territory of legislative amendment" by requiring additional factors to be considered.[125] The directions also disappointed the Australian Medical Association, which was critical of the lack of "public and transparent consultation on these particular reforms with the whole medical profession" and called for "consistent laws based in evidence to ensure that all doctors and medical students can have the utmost confidence in the regulator. It will be important that these new policy directions do not conflate public expectations with real evidence and best practice medicine".[126] Clearly, AHPRA and the Medical Board face a growing challenge winning and retaining the hearts and minds of medical professionals, who increasingly perceive regulators as organs of government engaged in a political process.

IV. International Experience

While many countries have enacted statutes that provide for a public risk test for immediate action, only a handful (including the United Kingdom,[127] Singapore,[128] Malaysia,[129] and the Canadian provinces of Québec[130] and New Brunswick[131]) allow for a public interest test. The threshold for taking immediate action under the public risk test varies considerably between countries. Most jurisdictions are silent as to duration of interim sanctions. However, some impose strict time limits that force regulators to finalise matters expeditiously. This varies from 20 days in Hawaii[132] to five months in France,[133] without the option of further extension. In the United Kingdom, Singapore and Malaysia, there are requirements for regulator review and the option of applying for extension. The regulatory matrix in each jurisdiction entails unique thresholds, processes and protections. These are summarised in Table 1.

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[121] *Health Practitioner Regulation National Law Act 2009* (Qld) s 11(6).

[122] Council of Australian Governments Health Council, n 120.

[123] *Vo v Medical Board of Australia* [2020] VCAT 1072.

[124] *Health Practitioner Regulation National Law Act 2009* (Qld) s 199.

[125] *Vo v Medical Board of Australia* [2020] VCAT 1072, [30]–[34].

[126] P Durham, "COAG Tells AHPRA: Public Safety Comes First", *The Medical Republic*, 22 January 2020 <http://medicalrepublic.com.au/coag-tells-ahpra-public-safety-comes-first/24802?utm_source=TMR%20List_&utm_campaign=f16d5b5190-Newsletter_May_18_05_20&utm_medium=email&mc_cid=f16d5b5190&mc_eid=77fb056232>.

[127] *Medical Act 1983* (UK).

[128] *Medical Registration Act* (Singapore, cap 174, 1997).

[129] *Medical Act 1971* (Malaysia).

[130] *Professional Code*, CQLR c C-26, ss 52.1, 122.0.1.

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

[132] Haw Rev Stat § 436B-23 (2011).

[133] *Loi No 2019-774 du 24 juillet 2019 – Art 77(V). Code de la santé publique, Art L4113-114 (Modifié par Ordonnance no 2018-20 du 17 janvier 2018 – Art 14*).

TABLE 1. Legislative Framework for Immediate Action Powers around the World

Jurisdiction	Legislation	Requirements	Decision-maker	Type of Immediate Action	Cases	Duration
UK	*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	*Bawa-Garba v General Medical Council* [2015] EWHC 1277 *GMC v Hiew* [2007] 1 WLR 2007; [2007] EWCA Civ 369 R (on the application of George) v General Medical Council [2004] Lloyd's Rep Med 33; [2003] EWHC 1124 (Admin)	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.
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	*Lim v Medical Council of New Zealand* [2018] NZHC 485 Ahmad v Medical Council of New Zealand [2016] NZDC 21788	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
IRELAND	*Medical Practitioners Act 2007* (Ireland) s 60	Necessary to protect the public	High Court (following *ex parte* application)	Suspension only	*Hermann v Medical Council* [2010] IEHC 414	Not stipulated. Usually until complaint or investigation is completed

TABLE 1. *continued*

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	*Singapore Medical Council v Dr Wee Teong Boo* [29 May 2019] Singapore Medical Council Interim Orders Committee Singapore Medical Council v Dr Lee Siew Boon Winston [2018] SMCDT 4	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.
MALAYSIA	*Medical Act 1971* (Malaysia) s 29A	- Necessary for the protection of members of the public; or - Is otherwise in the **public interest**; or - Is in the interests of the practitioner.	Disciplinary Board of the Malaysian Medical Council	Suspension or conditions	No case law	Up to 12 months. Must be reviewed at six months and then every three months. President of Malaysian Medical Council may extend for up to six months. No limit on the number of extensions.
FRANCE	*Code de la santé publique,* Art L4113-114	- In cases of emergency; or - Exposes patients to serious danger	National Disciplinary Chamber, Interregional Council, or Disciplinary Chamber of First Instance	• Suspension		Five months
CANADA						
British Columbia	**Extraordinary action to protect public** *Health Professions Act,* RSBC 1996, c 183, s 35(1)	Extraordinary action to protect the public	Inquiry Committee of the College of Physicians and Surgeons of British Columbia.	• Suspension • Conditions • Limitations	*Scott v College of Massage Therapists of BC* [2016] BCCA 180	Until no longer necessary

Ontario	**Interim suspension** *Regulated Health Professions Act*, SO 1991, c 18, Sch 2, ss 25.4, 51(4.2) and 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	*Rohringer v College of Physicians & Surgeons of Ontario* [2017] ONSC 6656	Until order is varied or matter resolves
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	*Youssef v College of Physicians & Surgeons of New Brunswick* [2012] NBQB 253	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	*Psychologues (Ordre professionnel des) c Lavoie* 2019 CanLII 20258 (QC OPQ)	Not specified Until the earliest date on which, the order is stayed or withdrawn, the practitioner is acquitted, or expiry of 120 days.
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

TABLE 1. *continued*

UNITED STATES						
California	Cal Gov Code §11529 (West 2008) Cal Gov Code §11460.10 (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. Immediate danger to the public health, safety, or welfare that requires immediate agency action.	Medical Quality Hearing Panel	• Suspension • Conditions • Limitations • Restrictions		Not specified
Hawaii	Haw Rev Stat § 436B-23	Immediate and unreasonable threat to personal safety.	Hawaii Medical Board	• Suspension • Restriction		20 days

The United Kingdom was the first jurisdiction to adopt a broad public interest test for immediate action in 2000. This was part of suite of regulatory reforms that followed high-profile scandals at the Bristol Royal Infirmary[134] and Alder Hey Hospital.[135] However, it was the scandal involving Harold Shipman that most fashioned current immediate action laws.[136] Shipman remained on the medical register after being convicted of the murder of 15 patients. The media condemned the UK's medical regulator, the General Medical Council (the GMC), for not immediately suspending Shipman after he was first charged.[137] Ensuing legislative reforms focused on fixing this perceived crisis of public confidence in medical regulation. The GMC's objective became "to protect, promote and maintain the health and safety of the public";[138] the Council for Health Care Regulatory Excellence was created to launch public interest appeals against GMC decisions regarded as "too lenient";[139] and the burden of proof in disciplinary investigations was lowered from the criminal standard requiring "proof beyond reasonable doubt" to the civil standard requiring proof of the allegations "on the balance of probabilities".[140] Lord Hunt described the role of the GMC as follows:

> The General Medical Council must exist to protect patients. It must be truly accountable. It must be guided at all times by the welfare and safety of patients. Recent scandals involving a number of incompetent doctors have shocked the public. That is why such urgent action is required. There is no doubt that the present systems have to be strengthened and changed. There are currently various gaps and loopholes in the GMC procedures which mean that doctors who may be a danger to patients can continue to practise. That is neither acceptable nor in the public interest … In future the GMC will be able to impose interim suspension or conditions in any circumstance, including cases of performance and health. The power will be sufficiently wide so that the GMC can act swiftly and more effectively in response to unforeseen circumstances, which if it was unable to act would place patients at risk or damage public confidence in the medical profession.[141]

Over the last 20 years, UK courts have grown increasingly comfortable imposing immediate action (particularly suspensions)[142] without clear evidence of public risk or urgency.[143] Initially, courts held that it would not typically be appropriate to apply interim sanctions simply to maintain standards of behaviour,[144] as that is the function of final sanctions. However, later cases show a willingness to apply them where medical practitioners act dishonestly, such as by fraudulently completing cremation certificates[145] or lying to hospital administration during an investigation.[146] Immediate action was used only four times between 1980 and 1996, but 455 times in 2009,[147] and 388 times in 2018.[148] However,

[134] I Kennedy et al, *The Inquiry into the Management of Care of Children Receiving Complex Heart Surgery at the Bristol Royal Infirmary 1984-1995* (Her Majesty's Stationery Office, 2001).

[135] J Keeling et al, *The Royal Liverpool Children's Inquiry: Report* (Her Majesty's Stationery Office, 2001).

[136] DJ Smith, *The Shipman Inquiry – Fifth Report: Safeguarding Patients: Lessons from the Past – Proposals for the Future* (Stationery Office, 2004).

[137] United Kingdom, *Parliamentary Debates*, House of Commons, 1 February 2000, Vol 343, Col 907 (Alan Milburn, Secretary of State for Health).

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

[139] *National Health Service Reform and Health Care Professions Act 2002* (UK) s 29.

[140] *Health Act 1999* (UK) s 60, as amended by *Health and Social Care Act 2008* (UK) s 112.

[141] United Kingdom, *Parliamentary Debates*, House of Lords, 7 July 2000, Vol 614, Col 1728 and 1729 (Lord Hunt of Kings Heath).

[142] See Paterson, n 30, 6.

[143] P Case, "Putting Public Confidence First: Doctors, Precautionary Suspension, and the General Medical Council" (2011) 19(3) *Medical Law Review* 339, 357.

[144] *Yeong v General Medical Council* [2010] 1 WLR 548, [61]; [2009] EWHC 1923 (Admin).

[145] *Sandler v General Medical Council* [2010] Med LR 491; [2010] EWHC 1029 (Admin).

[146] *Bradshaw v General Medical Council* [2010] Med LR 323; [2010] EWHC 1296 (Admin).

[147] *Bradshaw v General Medical Council* [2010] Med LR 323; [2010] EWHC 1296 (Admin).

[148] General Medical Council, *Our Annual Report* (2018).

strict time limits and review processes apply. An initial interim order may not exceed 18 months[149] and must be reviewed six-monthly.[150] The GMC may apply to the relevant court for an unlimited number of extensions of up to 12 months,[151] which must continue to be reviewed.[152]

Although legislation in Singapore largely mirrors that in the United Kingdom, courts have historically been more sympathetic to the interests of practitioners.[153] This may be changing following several recent cases where doctors continued to practise despite multiple allegations of sexual assault.[154] This is also occurring in New Zealand. In *Ahmad v Medical Council of New Zealand*,[155] for instance, an interim suspension was imposed on Dr Ahmad's registration only after he was convicted of indecently assaulting six patients. The media[156] criticised the regulator for failing to immediately suspend Dr Ahmad after he was charged.[157]

By contrast, in Ireland, only the High Court can suspend the registration of a medical practitioner and only if satisfied that the need for public protection outweighs the implied constitutional right[158] of citizens to earn a living.[159] Hearings before the High Court are usually closed and few such judgments are publicly available. There is no provision for referral on public interest grounds and there is no provision for interim conditions. Compared to other jurisdictions, the process in Ireland is cloaked in secrecy and generous to the interests of medical practitioners.

Canadian courts and regulators view immediate action as extraordinary and draconian and should be reserved only when absolutely necessary. The threshold for immediate action is high. "Actual, likely or probable harm"[160] to the public must result from not taking immediate action, rather than merely "possible harm". This must be based on a prima facie case involving serious allegations from a credible source. There is no public interest test, except in Québec[161] and New Brunswick.[162] Medical regulators must consider the impact of immediate action on the practitioner, which must not be disproportionate to the risk posed to the public if no interim order is granted. Before imposing an interim suspension, interim conditions must have been considered and deemed insufficient to protect the relevant interest. Interim suspensions are rare[163] and generally only permissible as a last resort "if necessary to protect the public and if no other less intrusive means is available to provide that protection".[164]

> [a doctor suspended on an interim basis] pays, on a daily basis, the same price of total suspension from practice that could arise if they 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.[165]

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

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

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

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

[153] *Singapore Medical Council v Dr Wee Teong Boo* (29 May 2019, Singapore Medical Council Interim Orders Committee).

[154] 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>.

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

[156] O Carville, "Predatory Health Professionals Still Practising", *Herald on Sunday*, 14 August 2016, cited in Paterson, n 30.

[157] O Carville, "Dodgy Doctors Continue to Practise", *The New Zealand Herald*, 15 August 2016, cited in Paterson, n 30.

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

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

[160] *Regulated Health Professions Act,* SO 1991, c 18, s 25.4.

[161] *Professional Code*, CQLR c C-26, s 52(1), 122.0.1.

[162] *Medical Act,* SNB 1981, c 87.

[163] Law Reform Commission of Saskatchewan, "Handbook on Professional Discipline Procedure" (2017) *CanLIIDocs* 207.

[164] B Salte, *The Law of Professional Regulation* (LexisNexis, 2015).

[165] *Huerto v College of Physicians and Surgeons of Saskatchewan* 2004 SKQB 423, [22].

Similarly, in the United States, the threshold for taking immediate action is considerable. State licensing boards can only take immediate action in an emergency[166] or where there is "danger",[167] "clear and imminent danger",[168] or "substantial danger"[169] to public health and safety. In addition, occupational licences are constitutionally protected[170] by property and liberty rights and the standard of proof required to remove them is onerous ("clear and convincing evidence" standard).[171]

Clearly, the approach taken to regulatory immediate action varies across the world. While there has historically been less appetite for immediate action in Australia compared to the United Kingdom,[172] the enactment of the public interest test and recent clarifying directives from the Ministerial Council signals a policy shift. However, we believe that this should be accompanied by more robust procedural protections. Our comparative analysis demonstrates that in countries with lower thresholds for immediate action (principally the United Kingdom and Singapore), stricter time limits apply, while in jurisdictions without time limits (such as Ireland, Canada and the United States), more robust procedural and constitutional protections are afforded to medical practitioners.

V. Discussion

The enactment of broad immediate action powers can be seen as a political response to specific clinical governance failures. For much of the last century, society entrusted the medical profession to establish and enforce its own standards for training, practice and discipline. It was afforded freedom from government control in return for high standards of professionalism and service in the public interest.[173] More recently, numerous enquiries, reviews and media reports into medical malpractice scandals involving substantial patient harm have exposed self-serving, paternalistic and impervious regulatory mechanisms that shielded culpable medical practitioners from public scrutiny[174] and eroded public confidence in the effectiveness of self-regulation. Greater government control has been exerted through laws, ethical codes and regulatory agencies that increasingly promote surveillance, monitoring, risk management and public accountability. These increasingly stringent regulatory measures promise greater public safety but must be accompanied by a commitment to research that ensures regulators deliver on these promises.

There is little research into the use and outcomes of immediate action in Australia or overseas. We recently conducted a retrospective cohort study[175] that examined over 13,000 AHPRA complaints between 2011 and 2013 and tracked them to finalisation. This showed that only 4% of complaints resulted in immediate action, while 10% resulted in final restrictive outcomes, such as the imposition of conditions or suspension of practice. During the same period, the New Zealand Medical Council imposed immediate action in 4% of performance notifications and 10% of impairment notifications,[176] while in the same period in the United Kingdom, the GMC imposed interim sanctions in 25% of cases. In Australia, immediate action was most likely to be imposed following mandatory complaints initiated by employers and following complaints relating to substance misuse or sexual misconduct. However, we also showed that nearly

[166] Md Code Ann § 10-226(c)(2).

[167] Cal Gov Code § 11529(a).

[168] NM Stat § 61-6-15.1(A) (2008).

[169] Va Code Ann § 54.1-105(A).

[170] M Moody, "When Courts Do Not Protect the Public: How Administrative Agencies Should Suspend Professionals' Licenses on an Emergency Basis" (2008) 10 *Florida Coastal Law Review* 551.

[171] B Bennett, "The Rights of Licensed Professionals to Notice and Hearing in Agency Enforcement Actions" (2006) 7 *Texas Tech Administrative Law Journal* 205, 234.

[172] O 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.

[173] M Saks, *The Professions, State and the Market: Medicine in Britain, the United States and Russia* (Routledge, 2015).

[174] M Stacey, "The General Medical Council and Professional Accountability" (1989) 4(1) *Public Policy and Administration* 12.

[175] Bradfield et al, n 172.

[176] Medical Council of New Zealand, *Annual Report*, 2012 & 2013.

80% of cases resulting in a final restrictive sanction (such as suspension of registration or imposition of conditions) were not preceded by immediate action. Likewise, among notifications where immediate action was taken, 48% did not result in restrictive final action.[177] This discordance between immediate action and subsequent restrictive sanctions highlights the many challenges faced by National Boards when determining matters at an interim stage based on incomplete information. It also highlights the need for the National Law to incorporate statutory timeframes for regular review of immediate action orders, as circumstances change over time.

National Boards must make swift and sweeping decisions that have far-reaching implications. Although they can provisionally assess the reliability, plausibility and consistency of allegations, they cannot test evidence or conclude facts. They must delicately balance competing public and private interests. Taking immediate action at the earliest opportunity most effectively protects the public from future harm. Immediate action also creates an incentive for medical practitioners facing serious allegations to reflect, rehabilitate and remediate in the time between the incident giving rise to the complaint and the final hearing. Immediate action can preserve the legitimacy of a final sanction that may not be imposed until many years after an incident occurred or an allegation was raised.[178] On the other hand, taking immediate action where allegations are not later substantiated can have a devastating and enduring impact on the affected practitioner. Policy-makers and regulators ultimately bear the onus of proving that: significant community risk exists without the regulatory intervention; the proposed intervention is effective; and the costs justify the intervention.

Regulation that restricts professional freedoms, particularly before allegations are proven, must respond to risks (or protect interests) that are significant, rather than merely speculative, theoretical or remote.[179] Surveys consistently show that the medical profession enjoys high levels of public trust. A recent Roy Morgan Poll[180] showed that 89% of Australians rated medical practitioners "very high" or "high" for their "ethics and honesty" (up 3% from 2016).[181] In the United Kingdom[182] and New Zealand,[183] the medical profession was rated the most trustworthy. In the United States, 69% of respondents rated the honesty and integrity of medical practitioners as "high" or "very high".[184] High levels of public trust in the medical profession promulgate the trust required to initiate a mutually respectful and trusting therapeutic alliance with an individual practitioner.[185] The importance of trust within the doctor–patient relationship is unequivocal. A trusting doctor–patient relationship improves health outcomes.[186] Patients who trust their medical practitioner are more willing to disclose highly personal information, allow intimate physical examinations, undergo invasive investigations and procedures and consume potentially

[177] Bradfield et al, n 172.

[178] Case, n 143.

[179] L Gostin, *Public Health Law: Power, Duty, Restraint* (University of California Press, 2000).

[180] R Morgan, *Image of Professions Survey 2017: Health Professionals Continue Domination with Nurses Most Highly Regarded Again; Followed by Doctors and Pharmacists* (2017) <https://thompsonsaustralia.com.au/roy-morgan-image-of-professions-survey-2017/>.

[181] J Morris et al, "Health Complaints' Entities in Australia and New Zealand: Serving the Public Interest" in John Chamberlain and Mike Dent (eds), *Professional Health Regulation in the Public Interest: International Perspectives* (Policy Press, 2018).

[182] IPSOS/MORI Social Research Institute, *Veracity Index* (2017) <https://www.ipsos.com/sites/default/files/ct/news/documents/2017-11/trust-in-professions-veracity-index-2017-slides.pdf>.

[183] Chartered Accountants of Australia and New Zealand, *The Future of Trust – New Technology Meets Old-fashioned Values* (2019) <https://www.charteredaccountantsanz.com/-/media/9a59e4591204424fb4ab75128d954054.ashx>.

[184] Gallup Poll, *Honesty/Ethics in Professions* (5 December 2013) <http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx>.

[185] E Huang et al, "Public Trust in Physicians – Health Care Commodification as a Possible Deteriorating Factor: Cross-sectional Analysis of 23 Countries" (2018) 55 *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* 0046958018759174.

[186] 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.

toxic medications. Clearly, there is inherent value and virtue in public interest regulation that seeks to maintain and enhance the trustworthiness of the medical profession as this maximises the health, safety and well-being of society.[187]

Immediate action powers are not without costs. Governments seeking to expand their reach must justify that the purported regulatory objectives are worth these costs. Complaints against medical practitioners are increasing in Australia[188] and overseas.[189] Disciplinary proceedings are expensive and traumatic for medical practitioners.[190] They can lead to depression, anxiety and suicidal ideation[191] that persist long after a complaint resolves.[192] The risk of distress is highest for current or recent complaints, compared to past complaints. Medical practitioners identify the "threat" of regulatory action as their most serious work-related stressor.[193] In the United Kingdom, 28 doctors died by suicide while under regulatory investigation between 2005 and 2013. A subsequent report concluded these deaths may have been preventable and that regulators needed to take affirmative steps to protect the emotional and psychological health of medical practitioners during investigations.[194] In the United Kingdom, the medical profession responded to the report saying it had lost confidence in its regulator, which had cast a "noxious miasma" over the profession.[195] Similar criticisms have been levelled towards AHPRA and the Medical Board in Australia.[196]

In a substantial number of immediate action cases studied in the United Kingdom, the severity of the interim sanctions exceeded final outcomes.[197] Similar observations have been made in a criminal context, where pre-trial processes such as detention, legal costs and bail applications often exact greater hardship on defendants than the ultimate sentence.[198] Such an interventionalist style of regulation may impair professionalism and goodwill, by discouraging openness and candour,[199] encouraging mistakes to be concealed and unnecessarily removing good practitioners from practice.[200] This may paradoxically compromise good patient care and result in the "strictest laws becoming the severest injury" not just for practitioners but also for the public.[201] A balance must be struck whereby the public can be confident that

[187] Gostin, n 179, 95.

[188] N MacKee, *Regulator Acknowledges Tensions* (2014) MJA Insight, Issue 27 <https://insightplus.mja.com.au/_2014/27/regulator-acknowledges-tensions/>.

[189] C White, "Complaints against Doctors Continue to Rise", *BMJ Careers* (30 September 2013) <https://www.bmj.com/content/347/bmj.f5925.full>.

[190] L Nash et al, "The Response of Doctors to a Formal Complaint" (2006) 14 *Australasian Psychiatry* 246.

[191] T Bourne et al, "The Impact of Complaints Procedures on the Welfare, Health and Clinical Practise of 7926 Doctors in the UK: A Cross-sectional Survey" 5(1) (2015) *BMJ Open* e006687. 16.9% of doctors with current/recent complaints reported moderate/severe depression (relative risk (RR) 1.77 (95% CI 1.48–2.13) compared to doctors with no complaints (9.5%)). 15% reported moderate/severe anxiety (RR = 2.08 (95% CI 1.61–2.68) compared to doctors with no complaints (7.3%)). Doctors with current/recent complaints were 2.08 (95% CI 1.61–2.68) times more likely to report thoughts of self-harm or suicidal ideation.

[192] C Martin et al, "Physicians' Psychological Reactions to Malpractice Litigation" (1991) 84 *Southern Medical Journal* 1300.

[193] P Schattner, "The Stress of Metropolitan General Practice" (1998) 169 *Medical Journal of Australia* 133.

[194] S Horsfall, "Doctors Who Commit Suicide while under GMC Fitness to Practice Investigation" (GMC Report, 14 December 2014) <http://www.gmc-uk.org/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf>.

[195] A Samanta et al, "Regulation of the Medical Profession: Fantasy, Reality and Legality" (2004) 97(5) *Journal of the Royal Society of Medicine* 211.

[196] K Breen, *Memoir of an Accidental Ethicist. On Medical Ethics, Medical Misconduct and Challenges for the Medical Profession* (Australian Scholarly Publishing, 2018).

[197] Case, n 143.

[198] J Earl, "The Process Is the Punishment: Thirty Years Later" (2008) 33(3) *Law & Social Inquiry* 735.

[199] K Checkland et al, "Re-thinking Accountability: Trust versus Confidence in Medical Practice" (2004) 13(2) *British Medical Journal Quality & Safety* 130.

[200] Case, n 143, 371.

[201] Institute for the Study of Civil Society (CIVITAS), *The General Medical Council: Fit to Practise?* (2014) 6 <https://www.civitas.org.uk/content/files/GMCFittoPractise.pdf>.

medical practitioners are competent and ethical without creating coercive regulation in which "the sword of Damocles permanently hang[s] over medical practitioners' heads".[202]

The public interest test can also create legal uncertainty. The expression "public interest" is one of the most used terms in the lexicon of law, regulation and public administration.[203] In Australia, its legal context includes "the public interest", "in the public interest", "contrary to the public interest", "inconsistent with the public interest", "necessary in the public interest", and "serve the public interest". In New South Wales alone, over 190 separate legislative Acts require consideration of the public interest.[204] Statutory public interest tests, including those in relation to immediate action, are often a "catch-all" clause, designed to give decision-makers discretion in complex situations where specific considerations cannot be exhaustively prescribed in legislation. For example, in the National Law, it is clear that the use of immediate action in the public interest is designed to capture cases where there is "otherwise" no identifiable risk to the public.

> "the public interest", when used in a statute, classically imports a discretionary value judgment to be made by reference to undefined factual matters, confined only "in so far as the subject matter and the scope and purpose of the statutory enactments may enable".[205]
>
> The indeterminate nature of the concept of "the public interest" means that the relevant aspects or facets of the public interest must be sought by reference to the instrument that prescribes the public interest as a criterion for making a determination.[206]

Despite its centrality in history, law and government, it has never been precisely defined by courts, legislators or academics.[207] It embraces matters for the "good order of society and for the well-being of its members",[208] as distinct from individual or personal interests. Nonetheless, the term has wide meaning and unsettled boundaries.[209] The categories of public interest are not closed.[210]

> [It] is as rich and variable as the legal imagination can make it according to the circumstances that present themselves to the policy maker.[211]

In a pluralistic society, there can be no single public interest and its lack of specificity and apparent pliability can render it elusive. A lack of statutory clarity may lead regulators to overuse powers that restrict an individual's liberty without sound grounds. Likewise, the underuse of powers may lead regulators to fail to respond to actual threats. It is unfortunate that the National Law does not provide greater clarity and guidance for decision-makers about how the public interest test is to be applied in cases of immediate action. As the Victorian cases described above aptly demonstrate, regulatory powers that rely on complex and ambiguous concepts may inadvertently produce inconsistent, uncertain and arbitrary policies, decisions and outcomes.

In the United Kingdom, the medical profession has argued that public interest regulation is subjective, politically motivated, ill-defined and is based on "public mood" rather than evidence.[212] It is apprehensive

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[202] Samanta et al, n 195.

[203] C Wheeler, "The Public Interest Revisited: We Know It's Important but Do We Know What It Means?" (2013) 72 *Australian Institute of Administrative Law Forum* 34.

[204] C Wheeler, "The Public Interest: We Know It's Important, but Do We Know What It Means?" (2006) 48 *Australian Institute of Administrative Law Forum* 22.

[205] *O'Sullivan v Farrer* (1989) 168 CLR 210, [217].

[206] *McKinnon v Department of Treasury* (2005) 145 FCR 70, [245]; [2005] FCAFC 142.

[207] J Johnston, *Public Relations and the Public Interest* (Routledge, 2016) 3.

[208] *DPP v Smith* [1991] 1 VR 63, [75].

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

[210] Senate Committee on Constitutional and Legal Affairs, Parliament of Australia, *Report on Draft Commonwealth Freedom of Information Bill* (1979) [5.28].

[211] G Robinson, "The Federal Communications Act: An Essay on Origins and Regulatory Purpose" in Max Paglan (ed), *A Legislative History of the Communications Act of 1934* (OUP, 1st ed, 1989) 16.

[212] H Williams et al, "A Turning Point for Medical Regulation" (2015) 350 *British Medical Journal* h284.

of the media's role in distorting perceptions and outcomes[213] by creating unrealistic expectations that medical practitioners will always be "superhuman paragon[s] of virtue" possessing a "conscience beyond reproach".[214] There is no doubt that the media appropriately shapes and informs public debate on issues of health regulation. Widespread news coverage about systemic failures within the health system can lead to independent enquiries, regulatory reform and safer care. Research also shows that active media coverage of legal proceedings improves judicial consistency and transparency.[215] On the contrary, in a criminal context, pre-trial publicity can negatively influence perceptions of the defendant by judges and jurors.[216] Interim regulatory decisions uninformed by concluded facts that rely on a malleable public interest test may be particularly susceptible to subconscious interference from media reports. Intense media interest may even elicit more severe interim sanctions,[217] but this remains to be empirically tested.

Clearly, the justification for enhancing public confidence in the medical profession is compelling. It leads to trust on an individual practitioner level that fosters better health outcomes. However, there are costs associated with the imprudent application of coercive regulatory powers. To temper these risks, we recommend amendments to the National Law that have been informed by our comparative analysis of international immediate action powers. Firstly, we propose strict timelines and requirements for regular review, in line with legislation in the United Kingdom, Singapore and Malaysia. Immediate action imposed on the basis of limited information may no longer be required upon receipt of further information, even if the criminal or disciplinary investigation is incomplete. Secondly, once National Boards impose immediate action, they should be required to reach a final determination following full investigation as expeditiously as possible, in line with legislation in Nova Scotia[218] and California.[219] The Paterson Review found that many interim conditions last too long (at least 20 months). Given the horrendous impact that immediate action can exact on the professional life of practitioners, the National Law should command greater accountability and responsiveness. Finally, the public interest test requires improved statutory definition to prevent inconsistent and arbitrary application. We believe that these amendments would better protect practitioners, and ultimately the public, from the widening reach of regulation in a modern Australia.

VI. Conclusions

Immediate action is the most vexed yet vital power at the disposal of National Boards. When first enacted in Australia, these powers were reserved for urgent situations to prevent harm to persons or the public. However, in response to perceived regulatory failures, National Boards have been granted wider powers. They can now suspend or impose conditions on a medical practitioner to protect public trust or confidence in the profession before evidence is tested and without identifiable and specific risk of harm to persons.

In this article, we critically scrutinised the assumptions that underlie these reforms. We showed that the public interest test for immediate action protects public trust and confidence in the profession. We argued that high levels of public trust in the profession may directly improve health outcomes by encouraging citizens to engage in a trusting therapeutic alliance with individual medical practitioners. In addition, early intervention in the form of immediate action can better protect the public than waiting until investigations have concluded. However, we also highlighted some of the problems with a broad public interest test. The elastic nature of the public interest concept can produce inconsistent outcomes. The combination of growing numbers of disciplinary hearings, increasingly coercive regulation, and

[213] CIVITAS, n 201.

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

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

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

[217] Case, n 143.

[218] *Medical Act*, SNS 2011, c 38, s 45(6)(b).

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

inconsistent outcomes may harm the emotional wellbeing of medical practitioners and damage trust in regulators. This may indirectly and paradoxically harm the public.

In response, we proposed legislative amendments, including: regular review of immediate action orders; strict timelines for the prosecution of matters to conclusion; strict time limits on the duration of interim orders and a clearer statutory definition of the "public interest". We believe that these procedural safeguards would engender greater confidence in the regulatory framework from the medical profession and the public.