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Regulation in Need of Therapy? Analysis of Regulatory Decisions Relating to Impaired Doctors from 2010 to 2020

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Doctors' mental wellbeing is a critical public health issue. Rates of depression, anxiety, and substance use are higher than in the general population. Regulating unwell doctors who pose a public risk is challenging, yet there is little research into how medical regulators balance the need to protect the public from harm against the benefits of supporting and rehabilitating the unwell doctor. We analysed judgments from Australia, New Zealand, Ireland, United Kingdom, Ontario, and Singapore between 2010 and 2020 relating to impaired doctors. We found similarities in how decision-makers conceptualise impairment, how they disentangle impairment from associated conduct or performance complaints, and how regulatory principles and sanctions are applied. However, compared to other jurisdictions, Australian courts and tribunals tended to prioritise deterrence above the rehabilitation of the impaired doctor. Supporting impaired doctors' recovery, when appropriate, is critical to public protection and patient safety.

Keywords: *comparative law; doctors' health; impairment; medical regulation; patient safety; public interest*

I. Introduction

Poor mental health is common among doctors and, in some circumstances, can impair a doctor's capacity to deliver optimal patient care safely.[1] Australian doctors report substantially higher rates of psychological distress, anxiety, depression, and suicidal thoughts compared to the general population or other professionals.[2] Poor doctor health is therefore not just a problem for doctors, but also for their patients and the wider community. Risk factors for poor doctor health include high-intensity work situations, long working hours, vicarious trauma, and a culture of invincibility and blame within the medical profession.[3] Doctors are more likely to continue working when sick; more likely to avoid or delay seeking medical treatment; and more likely to self-diagnose and self-treat.[4] This can spiral into mental illness or substance abuse.[5] Doctors face barriers in accessing care and may avoid seeking medical

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[1] R Horton, "Physician Burnout: The Need to Rehumanise Health Systems" (2019) 394 *The Lancet* 1591.

[2] Beyond Blue, *National Mental Health Survey of Doctors and Medical Students* (2019) <https://medicine.uq.edu.au/files/42088/Beyondblue%20Doctors%20Mental%20health.pdf>.

[3] SK Brooks, C Gerada and T Chalder, "Review of Literature on the Mental Health of Doctors: Are Specialist Services Needed?" (2011) 20 J Ment Health 146.

[4] M Henderson et al, "Shame! Self-stigmatisation as an Obstacle to Sick Doctors Returning to Work: A Qualitative Study" (2012) 2 *BMJ Open* e001776.

[5] LJ Merlo et al, "Reasons for Misuse of Prescription Medication among Physicians Undergoing Monitoring By a Physician Health Program" (2013) 7(5) J Addict Med 349 <https://doi.org/10.1097/ADM.0b013e31829da074>.

help because they lack insight into their impairment, or because they fear criticism, letting patients and colleagues down, stigma, loss of control, breaches of privacy,[6] or regulatory repercussions.[7] However, when doctors themselves become patients, they are equally deserving of appropriate care and support, just like the rest of society.

Medical regulators are afforded wide-ranging powers to maintain professional standards and to ensure that only fit and proper doctors are registered to practise medicine. This includes regulating doctors whose capacity to practise medicine may be impaired because of a physical or mental health condition. In Australia, medical practice has been regulated since 1837.[8] However, it was not until 1933 that the Victorian medical regulator first acquired the power to cancel the registration of a doctor who fell within the definition of an "inebriate".[9] In 1938, the New South Wales regulator was given the power to deregister doctors who had become "incapable" within the meaning of the *Lunacy Act 1898* (NSW),[10] and their name was only reinstated to the roll of practitioners if they could demonstrate that they had "recovered their sanity".[11] By 1981, the definition of impairment was broadened in Victoria to include other mental or physical conditions.[12] New South Wales followed in 1992.[13]

Today, a uniform National Scheme exists for the registration and regulation of health practitioners in Australia, including doctors. The Australian Health Practitioner Regulation Agency maintains a national register of health practitioners and investigates and refers notifications about the health, conduct and performance of health practitioners (except in Queensland and NSW)[14] to the Medical Board of Australia ("the Board") for determination under the *Health Practitioner Regulation National Law Act 2009* (Qld) ("the *National Law*"). The *National Law* gives the Board broad powers to sanction or refuse registration to doctors, including those who may be impaired due to a health condition[15] and, in so doing, protects the public and maintains standards of healthcare quality and safety in Australia. Similar schemes exist in New Zealand,[16] the United Kingdom,[17] the Republic of Ireland,[18] Ontario,[19] and Singapore.[20]

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[6] SA Schneck, "'Doctoring' Doctors and Their Families" 280(23) (1998) JAMA 2039 <https://doi.org/10.1001/jama.280.23.2039>.

[7] Federation of State Medical Boards, *Physician Wellness and Burnout* (2018) <https://www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>.

[8] A Reid, "To Discipline or Not to Discipline? Managing Poorly Performing Doctors" (2006) 23(2) *Law in Context* 91. The article appears in a special issue in the above journal titled *Regulating Health Practitioners* edited by Dr Ian Freckelton. It also appears in a book: I Freckelton (ed), *Regulating Health Practitioners* (Federation Press, 2006).

[9] *Medical Act 1933* (Vic) s 4, inserting *Medical Act 1928* (Vic) s 7(1)(b); *Inebriates Act 1928* (Vic) s 3 (definition of "inebriate").

[10] *Medical Practitioners Act 1938* (NSW) s 30.

[11] *Medical Practitioners Act 1938* (NSW) s 104.

[12] *Medical Practitioners (Amendment) Act* 1981 (Vic) s 8, amending *Medical Practitioners Act 1970* (Vic) s 17(4).

[13] *Medical Practice Act 1992* (NSW).

[14] In Queensland, notifications are investigated in conjunction with the Office of the Health Ombudsman pursuant to the *Health Ombudsman Act 2013* (Qld). In New South Wales, notifications are received and investigated by the Medical Council of NSW in conjunction with the Health Care Complaints Commission, pursuant to the *Health Practitioner Regulation National Law Act 2009* (NSW) and the *Health Care Complaints Act 1993* (NSW).

[15] In New South Wales, the Medical Council of New South Wales ("the Council") wields some additional powers under a slightly different version of the National Law – the *Health Practitioner Regulation National Law Act 2009* (NSW).

[16] Doctors are regulated by the Medical Council of New Zealand under the *Health Practitioners Competence Assurance Act 2003* (NZ) ("the *NZ Act*"). As in Australia, the *NZ Act* regulates multiple health professions under a single unifying legislative framework that replaced occupation-specific laws and tribunals.

[17] The *Medical Act 1983* (UK) regulates doctors in the United Kingdom. The General Medical Council receives and investigates allegations that a doctor may be impaired. The Medical Practitioners Tribunal then determines whether the doctor is impaired and, if so, what sanction should be imposed.

[18] *Medical Practitioners Act 2007* (Ireland).

[19] Ontarian doctors are regulated by the College of Physicians and Surgeons of Ontario under the *Regulated Health Professions Act*, SO 1991, c 18, Sch 2 (*Health Professions Code*). As in Australia, this Act also regulates multiple other health professions, each with its own occupation-specific College.

[20] The Singapore Medical Council regulates doctors under the provisions of the *Medical Registration Act* (Singapore, cap 174, 1997), which is largely modelled on the UK legislation.

The regulation of impaired doctors can create tension between the public interest in maintaining standards of safety, the private interests of the impaired doctor, and the health workforce interest in supporting doctors to remain in practice in whom many years of education and training have been invested. It is understandably disconcerting for the public to learn that doctors may be affected by a medical condition that could adversely affect their ability to provide safe patient care. On the other hand, regulatory processes are stressful and paradoxically can lead to a vicious circle of worsening burnout, depression, anxiety, insomnia, and malfunctioning.[21] Therefore, overly draconian and punitive regulation can harm the public by creating fear, anxiety, and avoidance of help-seeking among the medical profession.

To better understand how medical regulators approach this tension, we conducted a comparative analysis of the legal framework and outcomes of disciplinary cases relating to impaired doctors in Australia, New Zealand, the Republic of Ireland, the United Kingdom, Ontario, and Singapore. Our aims were to examine how courts define impairment, disentangle impairment from professional misconduct allegations, and determine disciplinary sanctions for impaired doctors. We also explored whether access to legal representation was associated with particular types of impairment and whether it impacted disciplinary outcomes.

II. Method and Descriptive Statistics

In this study, we examined published court and tribunal decisions relating to impaired doctors between 2010 and 2020, in Australia and in comparable jurisdictions. Similar prior studies have focused on cases of misconduct only (to the exclusion of impairment cases), or only examined cases involving substance abuse[22] in a single Australian jurisdiction.[23] In most jurisdictions, hearings of medical regulators are held in private and decisions relating to impaired doctors are not published. In addition, medical regulators inconsistently publish information in their annual reports about the number, type, or outcome of cases involving impairment. Therefore, we looked to appellate court and tribunal decisions to obtain information about the regulatory response to allegations of impairment. One limitation with this approach is that the number of cases available for analysis at the court or tribunal level is small and may not be representative of the majority of cases decided by first-instance medical regulators. However, one advantage of this approach is that each published judgment allows for a more comprehensive textual analysis of the written reasons for decision.

We identified, downloaded, analysed, and interpreted court and tribunal decisions relating to the regulation of impaired doctors over a 10-year period to obtain descriptive data about the frequency, type and outcomes of notifications relating to impairment.[24] We selected these dates to correlate with the inception of the *National Law* in Australia. We selected New Zealand, the United Kingdom, Singapore, Ireland, and Ontario, as comparable jurisdictions as they are common law jurisdictions with broadly similar systems of medical training, modern regulatory frameworks, and decisions that are written in English. It was not feasible within the scope of this project to include all Canadian jurisdictions, so we selected Ontario as a representative jurisdiction because it is the most populous province in Canada.

All data were derived from published decisions. For data extraction purposes, the practitioner was treated as the unit of analysis. Accordingly, where two decisions were issued regarding a single practitioner in relation to the same fact situation, they were treated as one decision. This approach has previously been described and adopted in analyses of disciplinary decisions.[25] Data were available for all Australian jurisdictions, except Tasmania. This is because decisions of the former Tasmanian Health Practitioners Tribunal were not published during this period.

[21] AF Templaar, "The Problem Doctor as an Iatrogenic Factor: Risks, Errors, Malfunctioning and Outcomes" in P Lens and G van der Wal (eds), *Problem Doctors: A Conspiracy of Silence* (IOS Press, 1997).

[22] D Mendelson, "Disciplinary Proceedings against Doctors Who Abuse Controlled Substances" (2015) 23(1) J Law Med 24.

[23] H Kiel, "Regulating Impaired Doctors: A Snapshot from New South Wales" (2013) 21(2) J Law Med 429.

[24] In Australia, a Tribunal may determine matters relating to impairment, pursuant to the *Health Practitioner Regulation National Law Act 2009* (Qld) ss 6, 190, 193, 196, or the *Health Practitioner Regulation National Law Act 2009* (NSW) ss 5, 35, 175, 175C.

[25] J Millbank, "Serious Misconduct of Health Professionals in Disciplinary Tribunals under the National Law 2010–17" (2020) 44(2) Aust Health Rev 190 <https://doi.org/10.1071/AH18239>.

We obtained cases by searching publicly available databases. Exact search terms were adapted to different jurisdictions. We used the name of the medical regulator in the case name and then refined our search according to whether decisions included key phrases used in each jurisdiction to describe doctors with an impairment. Austlii and Lexis Advance were used to search for published and unpublished Australian cases. Potentially relevant cases were identified by searching for case names that included the phrase "Medical Board", "Medical Council", "Health Care Complaints Commissioner" or "Health Ombudsman". Cases were then further refined by searching for the key phrases "impairment", "health condition" or "health committee" within each judgment. Each case was then read in detail to determine if it was relevant for inclusion. A similar search strategy was used for the other jurisdictions as shown in Table 1.

Cases were included in this study if they specifically considered whether the doctor had an impairment, described the nature of the impairment, and considered the relevant regulatory sanction. Cases were excluded if they mentioned the presence of an impairment only in passing, were appealed on unrelated legal grounds, or if insufficient information was available to code the cases. Once relevant cases (hereafter referred to as "impairment cases") had been identified and included, they were read and coded for key parameters, including: the nature of the impairment; demographic information relating to the doctor; the nature of any prior regulatory action taken; whether there was an associated conduct complaint; legal representation; and regulatory sanctions imposed.

As all cases were derived from public documents, institutional ethics committee approval was not required.

TABLE 1. Search Strategy Employed to Retrieve Relevant Cases

Jurisdiction	Database(s) Used	Primary Search By Case Title	Secondary Search By Exact Phrase	Impairment Cases
Australia	AHPRA AustLII	"Medical Board" or "Medical Council" or "Health Care Complaints Commission" or "Health Ombudsman"	"Impairment" or "health condition" or "health committee"	89
New Zealand	NZ Health Practitioner Disciplinary Tribunal NZLII	"Medical Council" or "MCNZ" or "Health Practitioner Disciplinary Tribunal" or "HPDT"	"Mental or physical condition", "impairment", "health condition"	21
Ontario	CanLII WestlawNext Canada Lexis Advance	"College of Physicians and Surgeons" or "College of Physicians & Surgeons"	"incapacit" or "fitness" or "mental" or "ailment" or "physician health"	22
United Kingdom	GMC BAILII Westlaw UK	"General Medical Council" or "GMC"	"Adverse physical or mental health"	9
Singapore	SMC website CommonLII Lexis Advance	"Medical Council" or "SMC"	"Impairment" or "Physical or mental condition" or "Fitness to Practise" or "Fitness to Practice"	2
Hong Kong	MCHK website HKLII	"Hong Kong Medical Council" or "Health Committee"	"Physical or mental condition" or "fitness" or "health committee"	1
Republic of Ireland	BAILII IRLII	"Medical Council"	"relevant medical disability"	1
Malaysia	MMC website CommonLII Lexis Advance	"Malaysian Medical Council" or "Majlis Perubatan Malaysia"	"Medical Review Panel" or "impairment" or "Fitness to Practise" or "Fitness to Practice"	0

In Australia, we identified 89 impairment cases, comprising 45 (51%) in New South Wales, 27 (30%) in Victoria, seven (8%) in Queensland, five (6%) in South Australia, two (2%) in the Australian Capital Territory, two (2%) in Western Australia, and one (1%) in the Northern Territory. Sixty cases (67.4%) involved male doctors. The average age of doctors was 54 years.[26] Cases most commonly related to General Practitioners (34%), Psychiatrists (13%), Doctors in Training (8%), Surgeons (7%), and Anaesthetists (6%). All but five cases involved associated allegations of substandard professional performance or conduct.

In New Zealand, we identified 21 published decisions of the New Zealand Health Practitioners Disciplinary Tribunal (NZHPDT) or the High Court of New Zealand relating to doctors' health. None were primarily concerned with impairment, and all primarily dealt with associated professional conduct or performance issues. 57% were male practitioners and most involved General Practitioners, locums and medical officers. In Ontario, we identified 22 decisions of the College of Physicians and Surgeons of Ontario (CPSO) Disciplinary Committee relating to allegedly incapacitated doctors. 86% involved male doctors. The most commonly represented specialty was General Practice (45%). We only identified nine decisions of the High Court of England and Wales, and no cases from Scotland or Northern Ireland. All but two cases involved associated professional conduct concerns, most commonly refusal to undergo a health assessment.[27] Doctors were predominantly male (78%) and either anaesthetists or house officers. We identified two impairment cases from Singapore (both doctors were male) and one impairment case from Ireland involving a male doctor.

III. Types of Impairment and Their Judicial Interpretation

In Australia, *impairment* is defined by the *National Law* as "a physical or mental impairment, disability, condition, or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect…capacity to practise the profession".[28] In New South Wales, a doctor is also deemed not to have sufficient physical or mental capacity to practise medicine if they fail, without reasonable excuse, to comply with a notice directing a health assessment.[29] Examples of conditions deemed to meet the definition of an impairment by Australian courts and tribunals include: mood disorders (such as depression, anxiety or bipolar disorder);[30] psychotic disorders (such as schizophrenia);[31] substance use disorders (including alcohol abuse);[32] cognitive disorders;[33] and personality disorders.[34] However, while it is necessary to "identify a present impairment to find a complaint proven",[35] "it is not necessary to define that condition with a high level of precision, or in terms of narrow diagnostic labels".[36] It is sufficient that the presentation or symptoms are "prejudicial to the orderly conduct of her [or his] mental and physical duties as a … practitioner".[37]

[26] Where disclosed in decision. This may not be accurate, as only about half of published decisions contained information about age or year of birth.

[27] *Ali v General Medical Council* [2017] EWHC 741 (Admin); *The Queen on the Application of General Medical Council v Dr Plavelil Abraham George* [2008] EWHC 1337 (Admin).

[28] *Health Practitioner Regulation National Law Act 2009* (Qld) s 5. The same definition applies in New South Wales under the *Health Practitioner Regulation National Law Act 2009* (NSW) s 5.

[29] *Health Practitioner Regulation National Law Act 2009* (NSW) s 152B.

[30] *Medical Board of Australia v RTF* [2018] QCAT 323.

[31] *Medical Board of Australia v Wong* [2016] QCAT 112; *Medical Board of Australia v Zebic* (*Review and Regulation)* [2015] VCAT 139.

[32] *WD v Medical Board of Australia* [2013] QCAT 614; *Health Care Complaints Commission v DAC* [2017] NSWCATOD 98.

[33] *Medical Board of Australia v Ferguson* [2015] QCAT 511.

[34] *Health Care Complaints Commission v Quach* [2015] NSWCATOD 2.

[35] *Tung v Health Care Complaints Commission* [2011] NSWCA 219, [58], [60].

[36] *Qasim v Health Care Complaints Commission* [2015] NSWCA 282, [64].

[37] *Grant v Health Care Complaints Commission* [2003] NSWCA 73, [12] (Meagher JA).

In *Health Care Complaints Commission (NSW) v McGregor*,[38] the Tribunal said that an impairment need not be a recognised DSM-V diagnosis.[39] However, there must be expert evidence to confirm the presence of impairing symptoms. In that case, "impaired reality testing" leading to "entrenched misinterpretations" was sufficient to find impairment. In *Medical Board of Australia and L*,[40] reduced impulse-control was found to impair the doctor's ability to practise medicine. Similarly, in *Medical Board of Australia v Ferguson*,[41] "deficient executive functioning" caused impairment because the doctor lacked insight into their repeated poor performance and conduct. On the other hand, in *Orchard v Medical Board of Australia*,[42] the Tribunal held that a psychiatrist's narrow focus on, and over-diagnosis of, ADHD to the exclusion of alternative diagnoses, was evidence of cognitive rigidity and a deficiency of attitude but did not amount to an impairment.

The mere existence of an impairment is insufficient to warrant disciplinary sanctions. Instead, the impairment must detrimentally affect, or be likely to detrimentally affect, the doctor's capacity to practise medicine. This will depend on various factors, including: the nature and likely duration of the impairment; the kind of practice carried on by the doctor; and the extent to which the impairment interferes with the practitioner's judgment, concentration, trust, communication, and clinical ability.[43] For example, a doctor with a narcissistic personality disorder was found to be impaired because he demonstrated consistent communication problems with patients and peers and inflexibility in dealing with others, especially concerning queries about diagnosis and appropriate treatment raised by patients, supervisors, auditors and delegates of the Council:[44]

> Overall, the evidence is indicative that the respondent suffers from an impairment in his cognitive and logical reasoning ability that is likely to detrimentally affect his clinical practice, and the capacity to be supervised effectively over a period of time longer than a few months to maintain him in safe clinical practice.[45]

Impairment may extend to disabilities, conditions, or disorders which, when controlled by treatment, result in no immediate detrimental effect on the practitioner's capacity to practise. For instance, a doctor with ongoing substance dependence may continue to have an impairment, even when sober, abstinent or in remission.[46] Likewise, a person with schizophrenia may still have an impairment when their illness is controlled by treatment.[47] In these cases, Tribunals may require ongoing treatment and monitoring to protect the public. However, Tribunals also distinguish *remission* from *recovery.* In *Health Care Complaints Commission v Tan*,[48] the Tribunal said that it is a matter of degree and judgment as to whether a "vulnerability" to ongoing drug use or mental illness is so real and serious that it should be classified as an impairment. For instance, a doctor in the early stages of remission who has recently used drugs may still have an impairment:[49]

> With the further passage of time, and continuation of the program of assistance and rehabilitation that he has now embarked upon, the point may be reached where it is reasonable to conclude that he no longer has such impairment, even though his vulnerability remains.

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[38] *Health Care Complaints Commission (NSW) v McGregor* [2020] NSWCATOD 13.

[39] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, 2013).

[40] *Medical Board of Australia and L* [2011] WASAT 98.

[41] *Medical Board of Australia v Ferguson* [2015] QCAT 511.

[42] *Orchard v Medical Board of Australia* [2013] VCAT 1729.

[43] *Health Care Complaints Commission (NSW) v Liprini* [2020] NSWCATOD 94.

[44] *Health Care Complaints Commission v Quach* [2015] NSWCATOD 2, [416], citing *Health Care Complaints Commission v Liprini* [2020] NSWCATOD 94.

[45] *Health Care Complaints Commission v Quach* [2015] NSWCATOD 2, [417]–[418].

[46] *Health Care Complaints Commission v Von Marburg (No 3)* [2019] NSWCATOD 91, [17]–[18].

[47] *Medical Board of Australia v Wong* [2015] QCAT 439, [71]–[73].

[48] *Health Care Complaints Commission v Tan* [2016] NSWCATOD 147, [98]–[101].

[49] *Health Care Complaints Commission v Tan* [2016] NSWCATOD 147, [99].

The likelihood of future clinical concerns or relapse must be sufficient to establish a lack of capacity to practise medicine[50] and Tribunals place great emphasis on psychiatric evidence of current stability or remission.[51] Where a doctor's impairment was due to circumstances that are no longer present and unlikely to recur, then the doctor cannot be said to be suffering from an impairment for the purposes of the *National Law*. On the other hand, where a doctor's condition relapses despite treatment and monitoring, Tribunals are more likely to find that the impairment could detrimentally affect the doctor's future capacity to practise medicine.[52]

Ultimately, the question of fitness to practise is determined as at the date of the hearing, not the date of the conduct.[53] An impaired doctor who is struck off the register and who seeks reinstatement of their registration bears a heavy burden of demonstrating that they are no longer impaired. In *Reimers v Medical Council (NSW)*,[54] the Tribunal held that this burden can only be discharged if there is evidence which corroborates remission or recovery, including consistently negative urine drug screening results. The currency of an impairment may be demonstrated by evidence of a prior deficiency, combined with the absence of evidence of improvement since that time.[55]

Outside Australia, we found few publicly available judgments in which the definition of impairment was judicially considered. In *Medical Council of New Zealand v T*,[56] the NZHPDT held that a finding of impairment in relation to cannabis abuse requires direct observation in a clinical setting to determine whether the condition adversely impacts on the practice of medicine. This is in contrast to Australia, where Tribunals routinely infer the presence of an impairment, based on a "likely" detrimental impact on the practice of medicine. Table 2 summarises the statutory definitions of "impairment" in each jurisdiction studied.

TABLE 2. Comparative Statutory Definitions of Impairment

Jurisdiction	Legislation	Regulator	Terminology	Definition of Impairment
Australia	*Health Practitioner Regulation National Law Act 2009* (Qld) s 5	Medical Board of Australia	Impairment	Physical or mental impairment, disability, condition, or disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, …the person's capacity to practise the profession.
New Zealand	*Health Practitioners Competence Assurance Act 2003* (NZ) ss 4(3)(c), 16(d), 27(1)(e), 45(2), 48(1), 49(1), 50(3)(a), 118(h)	Medical Council of New Zealand	Mental or physical condition	*Any mental or physical condition or impairment, including a condition caused by alcohol or drug abuse* (section 5). The regulator has disciplinary powers if the doctor is *unable to perform the required functions of their profession because of some mental or physical condition*
Republic of Ireland	*Medical Practitioners Act 2007* (Ireland) s 2	Medical Council of Ireland	Relevant medical disability	A physical or mental disability (including addiction to alcohol or drugs) which may impair the practitioner's ability to practise medicine or a particular aspect thereof.

[50] *Tung v Health Care Complaints Commission* [2011] NSWCA 219.

[51] See, eg, *Health Care Complaints Commission (NSW) v Liprini* [2020] NSWCATOD 94; and *Health Care Complaints Commission v Baraz* [2015] NSWCATOD 39, [219].

[52] *Health Care Complaints Commission v Von Marburg (No 3)* [2019] NSWCATOD 91, [17]–[18].

[53] *A Solicitor v Council of the Law Society of New South Wales* (2004) 216 CLR 253, [21]; [2004] HCA 1; *Supreme Court Prothonotary (NSW) v P* [2003] NSWCA 320.

[54] *Reimers v Medical Council (NSW)* [2015] NSWCATOD 38, [54].

[55] *Health Care Complaints Commission v Wang* [2010] NSWNMT 9, [93].

[56] *Medical Council of New Zealand v T* [2020] NZHPDT 1097, [97].

TABLE 2. continued

United Kingdom	*MedicalAct 1983* (UK) s 35C(2)	General Medical Council	Adverse physical or mental health	A medical practitioner's fitness to practise shall be regarded as "impaired" by reason of … adverse physical or mental health
Singapore	*Medical Registration Act* (Singapore, cap 174, 1997) ss 28(3)(c)(i), 37A(1)(a), 39(1)(d), 41(2)(a), 44(5), 46(1), 52(1), 58(1))	Singapore Medical Council	Physical or mental condition	Fitness to practise is impaired by reason of his physical or mental condition
Ontario	*Regulated Health Professions Act*, SO 1991, c 18, Sch 2 (*Health Professions Code*), s 1.	College of Physicians and Surgeons of Ontario	Incapacitated	A physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practise.
Malaysia	*Medical Act 1971* (Malaysia) – ss 19(1)(c), 24(2)(b), 36(2)(aa)*	Malaysian Medical Council	Physical or mental disability	Unable to fulfil professional or personal responsibilities and consequently is unable to practise medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive substance use or abuse.
Hong Kong	*Medical Registration Ordinance* (Cap. 131) (Hong Kong) – ss 20V(1)(a), 21A. *Medical Practitioners (Registration and Disciplinary Procedure) Regulation* (Cap 131 sub leg E) (Hong Kong), r 6(2)(b)	Hong Kong Medical Council	Physical or mental condition	Fitness to practise is impaired by reason of a physical or mental condition: *Dr Q v The Health Committee of the Medical Council of Hong Kong* [2014] HKCFI 184.

**Medical Act 1971* (Malaysia) ss 19(1)(c), 24(2)(b), 36(2)(aa). However, guidance provided by the Malaysian Medical Council suggests a broader definition that includes "the inability to practise medicine with reasonable skill and safety due to physical or mental illness, including deterioration through aging, loss of motor skill, or substance use" (Malaysian Medical Council, *Managing Impaired Registered Medical Practitioners* (MMC Guideline 001/2010) <https://mmc.gov.my/wp-content/uploads/2019/11/MANAGING-IMPAIRED-MED-PRACTITIONERS.pdf>

Across the jurisdictions studied, substance abuse and mood disorders were the most common impairments, with many doctors suffering from more than one impairment. For example, all 21 impairment cases in New Zealand related to a substance use disorder, including addiction to opioids, benzodiazepines, alcohol, cannabis, methamphetamine, or propofol. Some cases involved comorbid mental health disorders. Table 3 sets out our findings, which are consistent with prior research that substance use disorders are the most common type of impairment among doctors, followed by depression and anxiety.[57] A 2008 report

[57] TD Gunter, "Physician Impairment and Safety to Practice Medicine" in KJ Brower and MB Riba (eds), *Physician Mental Health and Well-being* (Springer, 2017) 107. H Kiel, "Regulating Impaired Doctors: A Snapshot from New South Wales" (2013) 21(2) JLM 429.

revealed that two-thirds of referrals to the Texas Medical Association Committee on Physician Health and Rehabilitation involved substance use disorders, 10% involved other mental health disorders, 4% physical disorders, 2% involved cognitive disorders, and the remaining 18% of the referrals were reports of disruptive behaviour.[58] Likewise, between 1 July 2015 and 31 June 2020, referrals to the Irish Medical Council's Health Committee comprised 39% for substance abuse, 56% for mental disabilities and 5% for physical disabilities.[59]

TABLE 3. Types of Impairments Disclosed in Judgments*

Jurisdiction	Total Cases	Mood Disorder	Psychotic Disorder	Substance Use Disorder	Personality Disorder	Cognitive Impairment	Not Specified/ Physical/ Other
Australia	89	47%	6%	44%	11%	8%	18%
New Zealand	21	52%	-	81%	5%	10%	24%
United Kingdom	9	33%	22%	22%	-	-	33%
Singapore	2	-	-	100%	-	-	-
Ontario	22	28%	17%	72%	28%	6%	33%
Hong Kong	1	100%	-	100%	-	-	-
Ireland	1	-	-	100%	-	-	-

* Some practitioners may have more than one type of impairment. For example, in Hong Kong, the single case identified related to both depression and substance abuse. Therefore, this was counted in both categories.

In summary, health "impairment" is consistently defined across the jurisdictions studied, and extends to physical and mental health conditions, substance abuse and disorders of behaviour or personality that result in a reduction in the doctor's capacity to practise medicine at the time of the hearing. However, outside of Australia, there are few publicly available decisions. While a strict diagnostic classification is not required to conclude that a doctor is impaired, there must be expert evidence of impairment, which in Australia can be inferred, but in New Zealand may have to be observed. The primary limitation of the regulatory response to impairment is that it necessarily treats impairment as binary (ie, impaired or unimpaired) and ignores the reality that symptoms of illness and the potential impact of those symptoms on functional abilities exist on a spectrum and will often wax and wane over time.[60]

[58] Texas Medical Association Committee on Physician Health and Rehabilitation, *Ethical Considerations in Physician Aging and Retirement* (2008) <http://materials.legalspan.com/texmed/product/d1ac1e54-3eb7-4640-b525af1d0309e8d1/Course%20%20Ethical%20Consideratins%20in%20Physician%20Aging%20and%20Retirement.pdf>.

[59] Irish Medical Council, *Annual Report 2016* (<https://www.medicalcouncil.ie/news-and-publications/reports/annual-report-and-financial-statements-2016.html>); Irish Medical Council, *Annual Report 2017* (<https://www.medicalcouncil.ie/news-and-publications/reports/annual-report-and-financial-statements-2017.html>); Irish Medical Council, *Annual Report 2018* (<https://www.medicalcouncil.ie/news-and-publications/reports/medical-council-annual-report-and-financial-statements-2018-.pdf>); Irish Medical Council, *Annual Report 2019* (<https://www.medicalcouncil.ie/news-and-publications/reports/annual-report-2019.pdf>); Irish Medical Council, *Annual Report 2020* (<https://www.medicalcouncil.ie/news-and-publications/reports/annual-report-2020.pdf>).

[60] Gunter, n 57, 107–127.

IV. Sanctions Imposed on Impaired Doctors

A. Statutory Powers Available to Regulators

Concerns about impaired doctors may come to the attention of regulators by way of voluntary[61] or mandatory[62] notifications from third parties, self-notification[63] by the doctor, or an own-motion investigation initiated by the regulator.[64] As the source or manner of the notification was often omitted from published reasons, it was not possible to draw conclusions about the relative frequency of notification types. However, others have studied this in Australia.[65] Once a notification is received and investigated, the Board may: refuse to grant registration;[66] accept an undertaking or impose conditions on the doctor's registration;[67] require the doctor to undergo a health assessment;[68] or refer the doctor to a health panel[69] or Tribunal.[70] In New South Wales, the Council may also: caution, reprimand, order treatment, or suspend the registration of an impaired doctor.[71] Similar powers exist in New Zealand. The MCNZ can: refuse to grant registration[72] or renewal of an annual practising certificate;[73] take immediate action to suspend or impose registration conditions;[74] impose final conditions on, or suspend, registration;[75] require a medical examination;[76] or refer to the health committee.[77] Similarly, the Irish Medical Council (IMC) to

[61] *Health Practitioner Regulation National Law Act 2009* (Qld) ss 144, 145. *Health Practitioner Regulation National Law Act 2009* (NSW) Pt 8 (other than in relation to mandatory notifications).

[62] *Health Practitioner Regulation National Law Act 2009* (Qld) ss 140–143. *Health Practitioners Competence Assurance Act 2003* (NZ) s 45(2): if a health practitioner or employer believes that a health practitioner is unable to perform the functions required for the practice of medicine because of some mental or physical condition, the person must promptly notify the Registrar of the MCNZ. *Regulated Health Professions Act*, SO 1991, c 18, Sch 2 (*Health Professions Code*), s 85.5(1): employer must notify the College of Physicians and Surgeons of Ontario if the doctor's employment is terminated, revoked, suspended, or restricted due to an incapacity.

[63] *Health Practitioner Regulation National Law Act 2009* (Qld) s 130; *Health Practitioner Regulation National Law Act 2009* (NSW) s 130.

[64] *Health Practitioner Regulation National Law Act 2009* (Qld) s 160(1)(b).

[65] MM Bismark et al, "Mandatory Reports of Concerns about the Health, Performance and Conduct of Health Practitioners" (2014) 201(7) Med J Aust 399 <https://doi.org/10.5694/mja14. 00210>.

[66] *Health Practitioner Regulation National Law Act 2009* (Qld) s 55: for general registration. *Health Practitioner Regulation National Law Act 2009* (Qld) s 60: for specialist registration.

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

[68] The Board may require a doctor to undergo a health assessment before deciding an application for registration (*Health Practitioner Regulation National Law Act 2009* (Qld) s 80) or at any time if believes that the practitioner has, or may have an impairment (*Health Practitioner Regulation National Law Act 2009* (Qld) s 169). A health assessment includes a medical, physical, psychiatric or psychological examination or test of a person to determine whether they have an impairment (*Health Practitioner Regulation National Law Act 2009* (Qld) s 5).

[69] *Health Practitioner Regulation National Law Act 2009* (Qld) s 181. A health panel may then decide to: take no further action; make a finding that the practitioner has an impairment; impose conditions (with a review date) on the practitioner's registration; suspend (with a reconsideration date) the practitioner's registration; or refer the matter should be referred to a Tribunal (*Health Practitioner Regulation National Law Act 2009* (Qld) s 191). In NSW, the Council may refer a matter to an Impaired Registrants Panel (*Health Practitioner Regulation National Law Act 2009* (NSW) s 173).

[70] *Health Practitioner Regulation National Law Act 2009* (Qld) s 196. A Tribunal may then decide to: take no further action; caution or reprimand the practitioner; find that the practitioner has an impairment; fine the practitioner; or impose conditions (with a review date) on, suspend for a specified period, cancel, or disqualify for a specified period, the practitioner's registration.

[71] A Professional Standards Committee may exercise these powers under *Health Practitioner Regulation National Law Act 2009* (NSW) ss 146B, 146D.

[72] *Health Practitioners Competence Assurance Act 2003* (NZ) s 16.

[73] *Health Practitioners Competence Assurance Act 2003* (NZ) s 27.

[74] *Health Practitioners Competence Assurance Act 2003* (NZ) s 47. An interim order lasts up to 20 days to allow the doctor to undergo an examination and testing.

[75] *Health Practitioners Competence Assurance Act 2003* (NZ) s 50(3)–(4).

[76] *Health Practitioners Competence Assurance Act 2003* (NZ) s 49.

[77] This is not a statutory function but appears to be the practice of the MCNZ when dealing with impaired doctors. See Medical Council of New Zealand, *Health Concerns about a Doctor* <https://www.mcnz.org.nz/our-standards/fitness-to-practise/health-concerns-about-a-doctor/>.

investigate,[78] or impose conditions[79] on a doctor's registration in the interests of public safety, as a result of a relevant medical disability. It also allows the IMC to establish a Health Committee to support and monitor doctors with a relevant medical disability.[80] A Monitoring Committee then monitors compliance with any conditions imposed.

In the United Kingdom, a Medical Practitioners Tribunal (MPT) may suspend or impose conditions on,[81] but cannot erase,[82] the registration of a doctor whose fitness to practise is impaired by reason of adverse physical or mental health. The General Medical Council may direct a doctor to undergo a health assessment.[83] In Ontario, the CPSO may order a potentially impaired doctor to undergo a health assessment or suspend their registration until they submit to an assessment.[84] Upon receipt of an assessment report, the matter may be referred to a Fitness to Practise Panel[85] which, upon a finding of incapacity, may suspend, revoke, or impose conditions on the doctor's registration.[86] As in other jurisdictions, hearings of the Fitness to Practise Panel are closed to the public.[87] Similar processes and sanctions exist in Singapore,[88] Malaysia,[89] and Hong Kong,[90] with hearings also closed to the public.[91]

B. Principles of Disciplinary Sanctioning

Courts and tribunals have developed disciplinary principles to assist in determining disciplinary outcomes. These principles are particularly germane to cases where impaired doctors have also engaged in substandard professional conduct or performance. However, in contrast to professional conduct or performance allegations, impairment allegations are not concerned with moral blameworthiness.[92] An impairment may explain, or manifest as, professional misconduct.[93] However, while the presence of an impairment may reduce the culpability of a doctor who has engaged in unprofessional conduct,[94] it does

[78] *Medical Practitioners Act 2007* (Ireland) s 57.

[79] *Medical Practitioners Act 2007* (Ireland) s 53.

[80] *Medical Practitioners Act 2007* (Ireland) s 20(4)(a).

[81] *Medical Act 1983* (UK) s 35D.

[82] *Medical Act 1983* (UK) s 35D(2)(a).

[83] General Medical Council (Fitness to Practise) *Rules* 2004 (as amended) (UK) <https://www.mpts-uk.org/-/media/mpts-documents/ftp-rules---amended-november-2017-64002624.pdf>.

[84] *Regulated Health Professions Act*, SO 1991, c 18, s 59(2).

[85] *Regulated Health Professions Act*, SO 1991, c 18, s 61.

[86] *Regulated Health Professions Act*, SO 1991, c 18, s 69(1).

[87] *Regulated Health Professions Act*, SO 1991, c 18, s 68(1).

[88] Under the *Medical Registration Act 1997* (Singapore, cap 174, 1997), the Singapore Medical Council may refer matters to a Health Committee (ss 41(2), 49(2)). A Health Committee may then determine whether a doctor's practice is impaired by reason of a physical or mental condition (s 52) and, if so, it can suspend, erase or impose conditions on the doctor's registration (s 58).

[89] The Malaysian Medical Council may convene a Fitness to Practise Committee or Medical Review Panel to assess the doctor's condition, its impact on the practitioner's fitness to practise, and the doctor's insight and compliance with any treatment: see *Medical Act 1971* (Malaysia) s 36(2)(aa); and Malaysian Medical Council, *Managing Impaired Registered Medical Practitioners 2010* <https://mmc.gov.my/wp-content/uploads/2019/11/MANAGING-IMPAIRED-MED-PRACTITIONERS.pdf>.

[90] The Medical Council of Hong Kong may refer a matter concerning "the health or physical or mental fitness to practise of any registered medical practitioner" to a Health Committee to assess a doctor's health or physical or mental fitness to practise (*Medical Registration Ordinance* (Hong Kong) Cap 131, s 20V). A Health Committee may dismiss a notification (*Medical Practitioners (Registration and Disciplinary Procedure) Regulation* (Hong Kong) Cap 131 sub leg E, s 6(5)), or recommend that the doctor's registration be suspended or be subject to conditions (*Medical Registration Ordinance*, s 20V(3)–(4)). The MCHK has similar powers on appeal (*Medical Registration Ordinance* (Hong Kong) Cap 131, s 21A).

[91] *Medical Registration Ordinance* (Hong Kong) Cap 131, s 22(1B).

[92] *Medical Board of Queensland v DAP* [2008] QCA 44, [26].

[93] *Reimers v Health Care Complaints Commission* [2012] NSWCA 317, [14].

[94] *Quinn v Law Institute of Victoria* (2007) 27 VAR 1; [2007] VSCA 122, cited in *Medical Board of Australia v POS (Review and Regulation) (Corrected)* [2019] VCAT 1678.

not absolve the doctor from responsibility. For instance, it has been said that an eye surgeon who suffers seriously from uncontrolled Parkinson's disease may be unfit to practise as an eye surgeon even though they are morally blameless.[95]

Consistent across the jurisdictions studied is the mantra that disciplinary proceedings are primarily concerned with public protection, not punishment in the criminal law sense. Disciplinary tribunals protect the public by preventing unfit doctors from practising, and by making orders that maintain professional standards and uphold public confidence that professional standards are being maintained. In theory, denouncing misconduct operates both as a specific deterrent to the doctor concerned, as well as a general deterrent to the medical profession to refrain from engaging in unprofessional conduct.[96] In *Medical Board of Australia v Lee*,[97] VCAT identified the disciplinary principles at play when making disciplinary decisions in Australia. They should: protect the public; maintain ethical and professional standards; not be punitive; achieve specific and general deterrence; facilitate the doctor's rehabilitation; not consider personal matters, such as shame or financial difficulty; consider any ongoing risk posed by the doctor; consider the degree to which the doctor has acquired insight; and consider each case on its facts and not apply a rigid formula.

In *Reimers v Health Care Complaints Commission*,[98] a doctor with a substance use disorder argued that conduct resulting from an impairment could not be professional misconduct and that it was unreasonable to treat the conduct as warranting de-registration. The New South Wales Court of Appeal disagreed, saying that "gross, repeated, incompetent medical practice does not cease to be such because it is caused by an addiction to alcohol, heroin or other drugs", particularly where the practitioner was aware of his condition and its consequences. Similarly, in *Sherman v Medical Board of Australia*,[99] the Tribunal did not accept that the practitioner's behaviour was explicable or in any way excused by reason of bipolar affective disorder. As such, practising while intoxicated amounts to professional misconduct, even if driven by an underlying impairment, such as a substance use disorder.[100] Nevertheless, where conduct is largely driven by an impairment and a practitioner has insight into, and sought extensive treatment for, that impairment, then Tribunals will generally regard this favourably in mitigation.[101]

> There is no doubt that addiction is a condition which may, perhaps should, evoke sympathy. The degree to which a criminal offence is caused by a mental illness, including addiction, may properly be reflected in the sentence imposed …. But the underlying purpose of a disciplinary order … is not primarily punitive, but protective. That is not to impose some artificial dichotomy of punitive and protective orders …. Rather, it is to recognise the primary object [is] "to protect the health and safety of the public by providing mechanisms designed to ensure that ... medical practitioners are fit to practise medicine".

In terms of rehabilitation, the Tribunal in *Medical Board of Australia v VRT*[102] found it to be in the public interest that a doctor who has been unable to practise due to a medical condition, be able to do so if the medical condition can be addressed appropriately. However, many other Australian cases suggest that specific and general deterrence should override concerns about rehabilitation, especially when there are associated professional misconduct allegations. For example, in *Medical Board of Australia v KFM*,[103] the registration of a doctor with a substance use disorder who practised while intoxicated and lied to the Board about their addiction was cancelled. This was despite medical evidence that their offending resulted, at least in part, from their addiction, that they subsequently received treatment resulting in remission, and gained insight into their offending. This case sends a strong signal to the profession

[95] *Medical Board of Queensland v DAP* [2008] QCA 44, [26].

[96] *Health Care Complaints Commission v Do* [2014] NSWCA 307, [35] (Meagher JA).

[97] *Medical Board of Australia v Lee* [2019] VCAT 311.

[98] *Reimers v Health Care Complaints Commission* [2012] NSWCA 317, [11]–[14].

[99] *Sherman v Medical Board of Australia* [2012] VCAT 47, [38].

[100] *Medical Board of Australia v KFM* [2021] VCAT 1479.

[101] See, eg, *Health Care Complaints Commission (NSW) v Carayannis* [2021] NSWCATOD 81.

[102] *Medical Board of Australia v VRT* [2018] VCAT 83, [17].

[103] *Medical Board of Australia v KFM* [2021] VCAT 1479.

that courts and tribunals will not tolerate attempts to mislead the regulator. It also highlights that, while a practitioner's offending may be a product of their impairment, it does not excuse the conduct and regulators will still pursue professional misconduct allegations. Cases have been similarly decided in New Zealand,[104] Canada,[105] and the United Kingdom.[106] Indeed, in one Ontarian case, the tribunal determined that a doctor who engaged in professional misconduct for the purpose of using drugs of addiction was even more "directly culpable for his prolonged and flagrant misconduct" because he was not addicted to the substances he was misappropriating.[107]

While the principles adopted by courts and tribunals in New Zealand for imposing sanctions are akin to those in Australia,[108] rehabilitation is afforded greater deference. In *Professional Conduct Committee appointed by the Medical Council of New Zealand v S*,[109] the NZHPDT held that allowing the doctor to continue to practise would facilitate her rehabilitation, despite prescribing large quantities of medications in the names of family members for personal use. Similarly, in *Farr*,[110] the NZHPDT held that the offending (stealing of drugs and needles from their employer) was related to an underlying addiction and that rehabilitation was an important factor in imposing conditions, rather than suspending the doctor from practice. The high-water mark in prioritising safe return to practice over punishment is *Ontario (College of Physicians and Surgeons of Ontario) v Jamal*,[111] where a Discipline Committee held that "the reputation of the profession does not suffer from, and is in fact enhanced by, recognition of the successful rehabilitation of a physician who has demonstrated that she is ready to return to practise". This contrasts starkly with the approach adopted in Australia.

C. Sanctions Imposed

In Australia, all but five cases identified involved associated complaints of substandard professional conduct or performance. As such, the disciplinary sanctions imposed were often targeted to those allegations, and the presence of an impairment was argued in mitigation.[112] We found that the most common professional conduct complaints were related to doctors attempting to access prescribed medications to which they were addicted. This included: fraudulently obtaining drugs of dependence (by either forging colleagues' signatures, using their prescription pads, or prescribing for patients or relatives for the purpose of self-administration);[113] breaching registration conditions, such as by failing to submit

[104] *Farr* [2018] NZHPDT 976; *N* [2016] NZHPDT 812; and *Professional Conduct Committee appointed by the Medical Council of New Zealand v Harypursat* [2018] NZHPDT 975.

[105] *Roberts v Ontario (College of Physicians and Surgeons of Ontario)*, 2018 ONCPSD 2.

[106] *Udom v General Medical Council* [2009] EWHC 3242.

[107] *Ontario (College of Physicians and Surgeons of Ontario) v Guirguis*, 2018 ONCPSD 47.

[108] In *Roberts v Professional Conduct Committee* [2012] NZHC 3354, Collins J at [44]–[51] identified eight factors as relevant whenever the Tribunal is determining an appropriate penalty. "The Tribunal is bound to consider what penalty: (a) most appropriately protects the public and deters others; (b) facilitates the Tribunal's important role in setting professional standards; (c) punishes the practitioner; (d) allows for the rehabilitation of the health practitioner; (e) promotes consistency with penalties in similar cases; (f) reflects the seriousness of the misconduct; (g) is the least restrictive penalty appropriate in the circumstances; and (h) looked at overall, is the penalty 'fair, reasonable' and proportionate in the circumstances."

[109] *Professional Conduct Committee appointed by the Medical Council of New Zealand v S* [2018] NZHPDT 994.

[110] *Farr* [2018] NZHPDT 976.

[111] *Ontario (College of Physicians and Surgeons of Ontario) v Jamal*, 2020 ONCPSD 23.

[112] See, eg, *Medical Board of Australia v Wong* [2016] QCAT 112.

[113] See, eg, *Medical Board of Australia v Dr I* [2014] SAHPT 18; *Medical Board of Australia v Dr "C"* [2012] SAHPT 4; *Medical Board of Australia v Stark* [2016] QCAT 175; *Mukherjee v Medical Council of New South Wales* [2018] NSWCATOD 124; *Goh v Medical Council (NSW)* [2016] NSWCATOD 92; *Health Care Complaints Commission v Azizi* [2016] NSWCATOD 94; *Health Care Complaints Commission v Tan* [2016] NSWCATOD 147; *WD v Medical Board of Australia* [2013] QCAT 614; *Medical Board of Australia v Sarfraz (Occupational Discipline)* [2015] ACAT 20; *Health Care Complaints Commission v Baraz* [2015] NSWCATOD 39; *Health Care Complaints Commission v Geary* [2018] NSWCATOD 15; *Health Care Complaints Commission v Street* [2014] NSWCATOD 124.

urine or hair drug testing or prescribing drugs of dependence contrary to conditions;[114] or misleading the regulator or treating practitioners about the existence or extent of substance use.[115]

The most commonly imposed conditions specifically relating to an impairment, included conditions requiring: abstinence from use of illicit drugs, drugs of dependence or alcohol; abstinence from self-medication; drug monitoring; psychiatric treatment; treatment from a general practitioner and/or addiction specialist; monitoring from the Impaired Registrants' Panel (in New South Wales) or the Victorian Doctors' Health Program; and attendance at Alcoholics Anonymous or a similar support group, such as the Doctors in Recovery Group.[116] Factors leading to more onerous conditions, or periods of suspension or disqualification, included: non-compliance with treatment; repeated breaches of health monitoring and treatment conditions; lack of insight into the impairment and its impact on safe practice; practising while unwell; and behaviour that put the doctor or the public at risk when unwell.[117] Nevertheless, where conditions can satisfactorily mitigate risk to the safety and welfare of the public, this will be preferred over suspension or cancellation.[118]

Similarly, all 21 New Zealand cases involved an associated professional conduct charge. As in Australia, the most common conduct charges related to unlawful or unethical means of acquiring drugs of dependence, including: prescribing drugs of dependence for family members or patients with the intention of self-administration;[119] stealing drugs of dependence from health services;[120] forging the signature of other doctors when prescribing for themselves;[121] or misleading the MCNZ or the NZHPDT about the existence of substance misuse.[122] In these cases, the NZHPDT censured the doctor and either suspended or imposed conditions on the doctor's registration for up to three years. The most commonly imposed condition was supervision by the MCNZ Health Committee, followed by mandated psychiatric or psychological treatment, drug monitoring, mentoring, prohibition on prescribing controlled drugs, limitations or work hours and practice settings, and various combinations of these conditions. Outcomes were less severe when the doctor showed remorse,[123] co-operated with the regulator,[124] had engaged with the Health Committee,[125] and had taken steps to rehabilitate themselves and seek treatment.[126] Where suspensions were ordered, the NZHPDT commonly cited public protection and, interestingly, rehabilitation as the reason for this. Unlike in Australia, the NZHPDT frequently imposed a short period of suspension to allow the impaired doctor to undergo treatment, such as in a residential detox programme, before allowing them to return to practice.[127]

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[114] *Medical Board of Australia v Zebic (Review and Regulation)* [2015] VCAT 139; *Cakan v Health Care Complaints Commission* [2020] NSWCATOD 116; *Health Care Complaints Commission v Sun* [2016] NSWCATOD 80; *Health Care Complaints Commission v XC* [2015] NSWCATOD 9; *Barratt v Medical Board of Australia* [2012] NSWMT 22.

[115] *Smithson v Medical Council (NSW)* [2016] NSWCATOD 82; *Health Care Complaints Commission v Von Marburg (No 3)* [2019] NSWCATOD 91.

[116] See, eg, *Health Care Complaints Commission v Street* [2014] NSWCATOD 124.

[117] See, eg, *CWV v Medical Board of Australia* [2016] NSWCATOD 161.

[118] See further, *Lindsay v Health Care Complaints Commission* [2010] NSWCA 194 (Sackville AJA), [168]–[169] (Young, Giles JJA agreeing).

[119] *Craig* [2016] NZHPDT 844; *Professional Conduct Committee appointed by the Medical Council of New Zealand v N* [2017] NZHPDT 900; *Professional Conduct Committee appointed by the Medical Council of New Zealand v N* [2017] NZHPDT 934; *Professional Conduct Committee appointed by the Medical Council of New Zealand v A* [2019] NZHPDT 1046.

[120] *Farr* [2018] NZHPDT 976.

[121] *E* [2010] NZHPDT 345.

[122] *Professional Conduct Committee appointed by the Medical Council of New Zealand v Emmerson* [2017] NZHPDT 887.

[123] *R* [2015] NZHPDT 681.

[124] *Dr I* [2014] NZHPDT 641.

[125] *N* [2016] NZHPDT 812.

[126] *Hodgson* [2015] NZHPDT 740.

[127] *Streat* [2014] NZHPDT 630.

A broad sweep of Ontario cases suggests that, in the absence of particularly aggravating features, an impaired practitioner who engages in professional misconduct to obtain drugs for their addiction might expect a reprimand, a suspension, or the imposition of conditions on their practising certificate. It is clear from numerous cases that doctors with substance use disorders are subject to voluntary undertakings to comply with monitoring conditions managed by the Ontario Medical Association's Physician Health Program.[128] Again, the most common conditions relating to the doctor's impairment include: treatment, monitoring, mentoring, prescribing restrictions, and work limitations.

There were too few cases to draw any meaningful conclusions about the application of disciplinary principles to United Kingdom or Singapore cases. However, we note that the two cases from Singapore[129] involved doctors convicted of possession and use of prescribed and illicit drugs. Both were censured and required to undergo rehabilitation and addiction counselling. Despite a relaxation of Singapore's criminal penalties for individuals caught with small quantities of drugs for personal use,[130] the SMC Disciplinary Tribunal characterised the doctors as having a "defect in character" because they engaged in professional misconduct that "eroded the faith and confidence of the public in the medical profession".[131] Nevertheless, the Tribunal supported the rehabilitation and reintegration of these young doctors with "promising career[s]" ahead of them into their profession, to re-build "the confidence of, and to show good faith to, [their] colleagues and the public".[132] Despite harsh criticism, rehabilitation remained central to the disposition of both cases.

In summary, we found that the disciplinary powers available to, and the sanctions imposed by, the various medical regulators are broadly similar across the jurisdictions studied. However, we noted divergence between Australia and the other jurisdictions in the relative priority given to deterrence and rehabilitation.

V. Impact of Legal Representation

The relationship between impairment, legal representation, and disciplinary outcomes is complex. Severe health impairment may diminish a doctor's capacity to instruct lawyers or understand the benefits of representation, and the absence of legal representation may increase the stressors which contribute to impairment.[133] In Australia, the *National Law* prevents doctors from practising medicine unless they are covered by "appropriate professional indemnity insurance arrangements".[134] Prior research shows that Australian doctors are more likely to be legally represented in disciplinary hearings involving serious misconduct compared to other registered health practitioners and that legally represented health practitioners are less likely to be removed from practice.[135] Similarly, in the United Kingdom, doctors without legal representation appear to face tougher regulatory sanctions from the MPT than those who enjoyed legal representation.[136] Specifically, nearly 80% of doctors erased from the register were unrepresented, whereas 80% of those who escaped sanctioning were represented. With this in mind,

[128] See, eg, *Ontario (College of Physicians and Surgeons of Ontario) v Thavanathan*, 2020 ONCPSD 14; *Ontario (College of Physicians and Surgeons of Ontario) v McArthur*, 2018 ONCPSD 58; *Ontario (College of Physicians and Surgeons of Ontario) v Dhanoa*, 2020 ONCPSD 28; *Williams v Ontario (College of Physicians and Surgeons of Ontario)*, 2018 ONCPSD 70.

[129] *In the Matter of Dr Yeo Eng Hui Damian* [2019] SMCDT 6; and *In the Matter of Dr Lim Lok Houw Mervin* [2014] SMCDT 4.

[130] *Misuse of Drugs (Amendment) Act 2019* (Singapore).

[131] *In the Matter of Dr Yeo Eng Hui Damian* [2019] SMCDT 6, [27].

[132] *In the Matter of Dr Yeo Eng Hui Damian* [2019] SMCDT 6, [49].

[133] 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" (2015) 5 *BMJ Open* e006687.

[134] *Health Practitioner Regulation National Law Act 2009* (Qld) s 130.

[135] J Millbank, "Serious Misconduct of Health Professionals in Disciplinary Tribunals under the National Law 2010-17" (2020) 44(2) *Australian Health Rev*iew 190 <https://doi.org/10.1071/AH18239>.

[136] Doctors without legal representation face tougher regulatory sanctions from MPTS hearings. Medical Protection, *Doctors without Legal Representation Face Tougher Sanctions from MPTS Hearings* <https://www.medicalprotection.org/uk/articles/doctors-without-legal-representation-face-tougher-sanctions-from-mpts-hearings>.

the final part of our study examined impairment cases to see if there was any association between legal representation and either the type of health impairment or the disciplinary sanction imposed.

We found that doctors were legally represented in 80% of impairment cases in Australia, although this was only 69% in New South Wales. This compares to 86% in New Zealand, 91% in Ontario, and 100% in Singapore, but only 44% in the United Kingdom. Of those unrepresented Australian doctors, 83% were male, and one-third involved applications for reinstatement of previously cancelled medical registration in New South Wales.[137] In all New South Wales cases, the registration of unrepresented doctors was either cancelled or not reinstated. We found no other clear association between legal representation and either the type of impairment suffered by the doctor or the disciplinary outcome reached, although non-appearance at a disciplinary hearing was often criticised by Tribunals because it prevented them from gaining a meaningful or reliable impression of the impaired doctor's insight or contrition in relation to admitted misconduct:[138]

> his failure to [give evidence before this Tribunal] should be appropriately criticised and the tribunal should be entitled to draw inferences adverse to the interests of the respondent in those areas of controversy where the Tribunal would have benefited from the evidence of the respondent that he had failed to give.[139]

There are several reasons why doctors may not be legally represented during a regulatory hearing. First, some impaired doctors may be too unwell to arrange legal representation or face the prospect of a disciplinary hearing. Second, medical indemnity insurers may only cover doctors who are registered and who are defending or responding to a regulatory investigation. Therefore, requests for assistance in relation to reinstatement of registration or removal of registration conditions may not always be covered.[140] Likewise, most insurers exclude coverage for doctors who practise in breach of registration conditions.[141] Perhaps most significantly, recent legislative changes now allow medical indemnity insurers to refuse to enter into a contract of professional indemnity insurance with a doctor if the practitioner places the public at risk of substantial harm in their private practice because they have an impairment within the meaning of the National Law.[142] Collectively, these policies and legislative reforms may disadvantage doctors with the most severe impairments who cannot access legal representation when seeking to reinstate their registration, thus creating further barriers for impaired doctors seeking to re-enter the profession.

VI. Discussion

The problem of impaired doctors is a serious public health issue affecting not only the doctors themselves, but also their family, peers, patients, and the wider community. In this study, we examined how courts and tribunals across multiple jurisdictions define impairment and separate it from associated conduct or performance issues. We also examined the powers available to medical regulators, and analysed the regulatory sanctions imposed on impaired doctors in various settings. Our analysis revealed several key findings. First, we found that the definition of impairment included physical and mental health conditions and substance use disorders in all jurisdictions. In Australia, this also includes personality disorders and disruptive behaviours that do not invite simple diagnostic classification. To impose sanctions on impaired doctors, the impairment must detrimentally impact on the practice of medicine. In most jurisdictions,

[137] *Bahramy v Medical Council of New South Wales* [2017] NSWCATOD 146; *Mukherjee v Medical Council of New South Wales* [2018] NSWCATOD 124; *Hanna v Medical Council of NSW* [2019] NSWCATOD 139; *Barratt v Medical Board of Australia* [2012] NSWMT 22; *CWV v Medical Board of Australia* [2016] NSWCATOD 161.

[138] *Health Care Complaints Commission v Reader* [2016] NSWCATOD 152, [134].

[139] *Health Care Complaints Commission v Quach* [2015] NSWCATOD 2, [52].

[140] See, eg, MIGA, *Medical Indemnity Insurance Policy 1 July 2022*, clause 5.31(g) <https://www.miga.com.au/MIGA/media/MIGA/Policy%20Documents/doctor-policy-wording.pdf>.

[141] See, eg, Avant, *Practitioner Indemnity Insurance Policy v5.1*, clause 14.2(b) <https://www.avant.org.au/WorkArea/DownloadAsset.aspx?id=27917289735>; MDA National, *Professional Indemnity Insurance Policy v.13*, clause 26.6 <https://www.mdanational.com.au/-/media/pdf-files-download-section/mdan209-13_piip__f_rev-20210628.pdf>; MIPS, *Indemnity Insurance Policy 1 July 2022*, clause 31.6(b) <https://support.mips.com.au/home/handbook>; MIGA, n 140, clause 5.26(b).

[142] *Medical Indemnity Act 2002* (Cth) s 52A(b).

including Australia, this can be inferred. In others, such as New Zealand, it may have to be observed to be found proven.

Second, we found that the powers available to medical regulators to sanction impaired doctors are similar across the jurisdictions studied and included the imposition of conditions or suspension, or referral for a health assessment. Third, courts and tribunals are clear that, while an impairment may explain unprofessional conduct, it does not excuse it, although an impairment may reduce the severity of disciplinary sanctions, particularly where treatment of an underlying impairment leads to the development of insight and remorse. Fourth, Australian courts and tribunals appear more willing to prioritise the regulatory goals of specific and general deterrence above the facilitation of the impaired doctor's rehabilitation. Fifth, we found that most doctors were legally represented and there was no clear association between legal representation and either the type of impairment or the disciplinary outcome. Sixth, we found more publicly available impairment cases in Australia compared to other jurisdictions. This may reflect a greater willingness in Australia to hold such hearings in public or to make reasons publicly available. Finally, we found that in New Zealand and Ontario, most impairment cases resulted in registration conditions requiring ongoing treatment and follow-up from the Health Committee or the Ontario Physician Health Programs (PHP), respectively.

Presently, every Canadian province has its own PHP. The largest is the Ontario PHP.[143] These programs, like New Zealand's Health Committee, operate at arm's length from regulators and provide comprehensive treatment, including early intervention, referrals, rehabilitation, residential therapy, family therapy, case-managed return to work, advocacy services, and relapse contingency plans. Recovering doctors are placed on a mandatory treatment and monitoring contract, usually for five years. Although two-thirds of participants in Canadian PHPs are referred by Canadian regulators,[144] relapses are not routinely reported to the regulator unless the doctor is non-compliant with treatment or withdraws from the program while practising, thus maintaining barriers between therapy, monitoring, and reporting so that treatment can remain confidential.[145] In effect, Canadian PHPs divert impaired doctors away from regulatory processes and offer a therapeutic alternative to professional sanctions.[146]

On the other hand, Australian and United Kingdom PHPs remain inchoate. While the Victorian Doctors Health Program (VDHP) was established in 2001,[147] other Australian PHPs began operating in 2016,[148] while a United Kingdom practitioner health program for doctors in London was established in 2008.[149] In contrast to the Ontario PHP, a 2011 study found that only 17% of doctors managed by the VDHP were referred by the Medical Practitioners Board of Victoria.[150] Unsurprisingly, we found few Australian cases where courts or tribunals entrusted the ongoing management and monitoring of an impaired doctor to a PHP.[151] Instead, conditions are imposed on impaired doctors in Australia that usually mandate a fragmented suite of treatment and/or monitoring from multiple practitioners, each of whom

[143] Canadian Medical Association, *Physician Wellness Hub. Provincial Physician Health Programs* <https://www.cma.ca/physician-wellness-hub/resources/depression/provincial-physician-health-programs>.

[144] JM Brewster et al "Characteristics and Outcomes of Doctors in a Substance Dependence Monitoring Programme in Canada: Prospective Descriptive Study" (2008) 337 BMJ a2098 <https://doi.org/10.1136/bmj.a2098>.

[145] Federation of State Medical Boards, *Policy on Physician Impairment* (2011) <https://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf>.

[146] RJ Bonnie and J Monahan, "License as Leverage: Mandating Treatment for Professionals" (2004) 3 Int J Forensic Ment Health 131 <https://doi.org/10.2139/ssrn.1758874>.

[147] KJ Breen, "Doctors' Health: Can We Do Better under National Registration?" (2011) 194(4) Med J Aust 191 <https://doi.org/10.5694/j.1326-5377.2011.tb03768.x>.

[148] See Medical Board Ahpra, *New Doctors' Health Service Arrangements* <https://www.medicalboard.gov.au/news/2016-04-28-doctors-health.aspx>.

[149] C Gerada, "The Practitioner Health Programme: A Free and Confidential Health Service for Doctors and Dentists in London" (2008) 1(2) London J Prim Care 74 <https://doi.org/10.1080/17571472.2008.11493212>.

[150] C Wile, M Frei and K Jenkins, "Doctors and Medical Students Case Managed By an Australian Doctors Health Program: Characteristics and Outcomes" (2011) 19(3) *Australas Psychiatry* 202 <https://doi.org/10.3109/ 10398562.2011.561846>.

[151] One of the only examples we found was: *Medical Board of Australia v Zebic (Review and Regulation)* [2015] VCAT 139.

separately reports to the regulator. Thus, drug monitoring results are sent directly to the regulator and are not discussed with the impaired doctor first in a therapeutic setting. Regulators then make regulatory decisions, rather than therapeutic decisions, based on those test results.

Moreover, because Australian regulators often impose abstinence-based conditions on impaired doctors,[152] relapses or setbacks are reported to and managed by the regulator, rather than being left to the clinical acumen of a specialised multi-disciplinary PHP. Consequently, relapses of substance abuse that contravene abstinence-based conditions are treated as professional misconduct issues, rather than as primarily a health issue.[153] In other jurisdictions, these matters may not come to the attention of the regulator at all because PHPs would manage minor breaches or transient relapses themselves. Another disadvantage with a regulatory approach to the management of impairment is that regulatory bureaucracies can be less flexible or agile in responding to the sometimes rapidly changing nature of medical illness. For example, doctors may become seriously unwell before regulators act, while suspended doctors may have to wait many months after they have recovered before being allowed to re-enter the workforce. A case-managed approach through a PHP may be more responsive to the changing needs of the doctor's illness. Such an approach may better meet the doctor's therapeutic needs without endangering public protection.

We believe that there is a pressing need to embrace PHPs as an alternative to the inflexibility of regulators that may inadvertently jeopardise the health of impaired doctors and, paradoxically, may compromise public protection by inadequately supporting doctors' safe return to practice. At the very least, a co-management model could be adopted, as exists elsewhere.[154] This is particularly important given the growing evidence that the prognosis for impaired doctors managed by a PHP is better than for members of the general population managed by non-physician programs.[155] Moreover, doctors who successfully complete a program managed by a PHP were at lower risk of malpractice claims compared to a matched cohort.[156] Ultimately, we believe that specialist clinical services dedicated to the treatment and monitoring of impaired doctors are best placed to manage impaired doctors in tandem with regulators.

VII. Conclusions

Steady progress has been made in Australia over the last 20 years to recognise the problem of poor doctor health and wellbeing, and to provide early access to high-quality treatment and rehabilitation programs, like those in Canada. However, we believe that more could be done to co-ordinate the role of regulators and PHPs in Australia. Our study reveals that Australian courts and tribunals tend to prioritise deterrence above rehabilitation and rarely entrust the monitoring and treatment of impaired doctors to physician health programs. Instead, they often impose sanctions that require multiple independent practitioners to separately report to the regulator. Regulatory sanctions are often formulaic and there remains limited judicial understanding of current evidence in relation to addiction, relapse, or rehabilitation. As a result, relapses are often treated as professional conduct matters requiring sanction, rather than viewed through the lens of the doctor's recovery. Clearly, there are circumstances where restrictive sanctions are crucial for public protection, such as in the case of impaired doctors who have refused to follow the reasonable advice of treating clinicians and represent an unacceptable risk of harm to the public if they were to continue practising medicine without restrictions. However, in other circumstances, doctors may briefly relapse without compromising public safety. One reason why Australian courts and tribunals

[152] See, eg, *Health Care Complaints Commission v Noore* [2017] NSWCATOD 145; *Health Care Complaints Commission v Rixon* [2016] NSWCATOD 24; *Health Care Complaints Commission v Bester* [2016] NSWCATOD 140; *Health Care Complaints Commission v Baraz* [2015] NSWCATOD 39.

[153] See, eg, *Medical Board of Australia v DRP (Review and Regulation)* [2016] VCAT 2076; *Health Care Complaints Commission v Astor-Finn* [2016] NSWCATOD 73.

[154] See TB Bailey and CSG Jefferies, *Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients* (Health and Law Institute, 2012).

[155] RM Morse et al, "Prognosis of Physicians Treated for Alcoholism and Drug Dependence" (1984) 251(6) JAMA 743.

[156] E Brooks et al, "Physician Health Programmes and Malpractice Claims: Reducing Risk through Monitoring" (2013) 63(4) Occup Med 274 <https://doi.org/10.1093/occmed/kqt036>.

rarely utilise the expertise of PHPs may be due to a lack of a formal agreement. We recognise that the impairment cases in this study only represent a small proportion of total cases managed by medical regulators. However, these cases provide insights into how Australian courts and tribunals consider the more serious or contentious matters. We believe that an unwell doctor's interest in rehabilitation and recovery should be viewed as advancing, rather than hindering, public protection. Doctors who are well and have insight into their medical condition are more likely to exercise good clinical judgment and make safe clinical decisions, and the sooner doctors in recovery can successfully return to work, the better for the community. Supporting the wellbeing of doctors is therefore critical to maintaining a healthy workforce of doctors who can safely serve the public. This remains consistent with the *National Law*'s paramount guiding principle.[157]

[157] *Health Practitioner Regulation National Law Act 2009* (Qld) ss 3(2)(a), 3A.