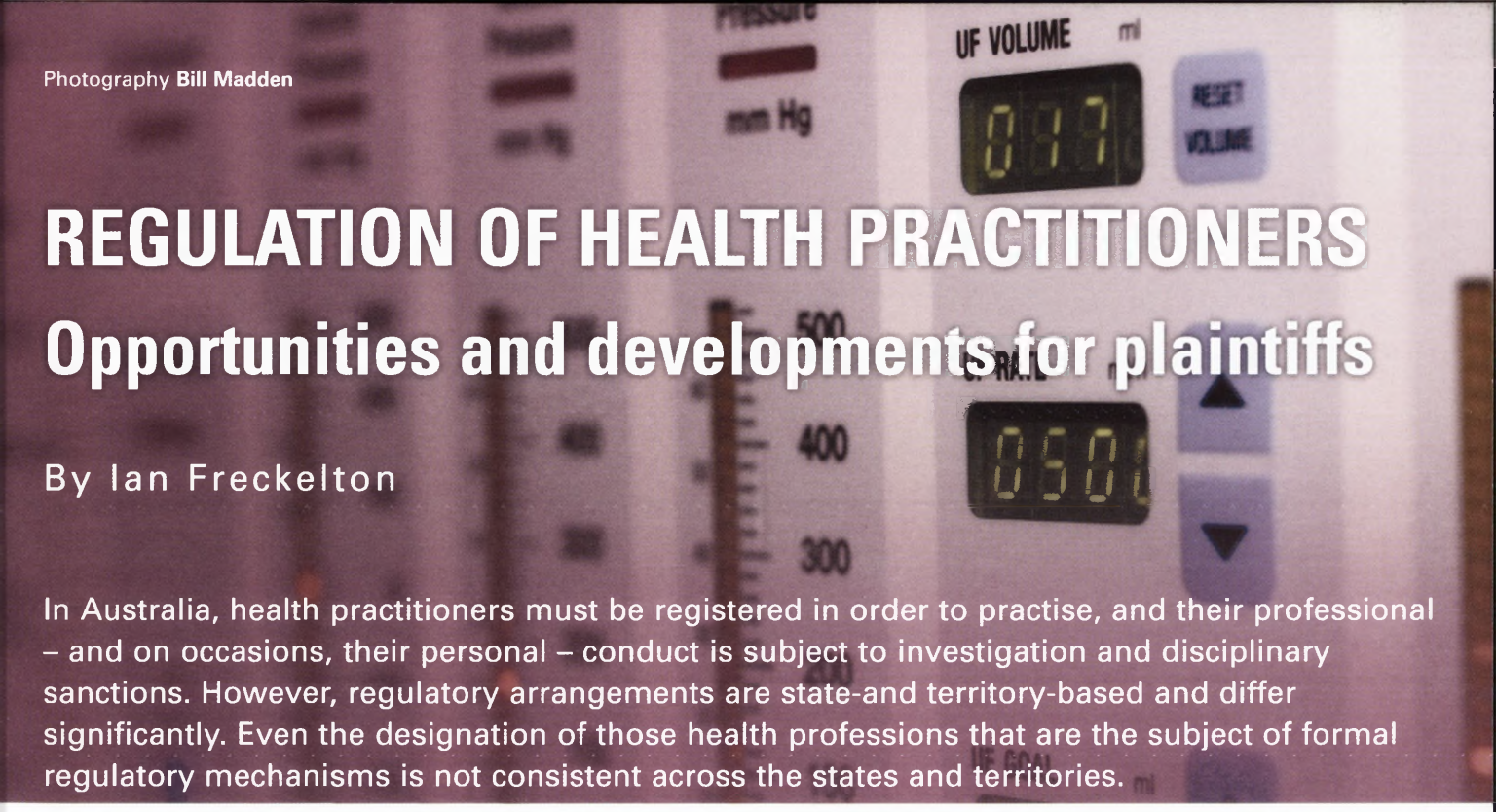

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REGULATION OF HEALTH PRACTITIONERS

Opportunities and developments for plaintiffs

By Ian Freckelton

In Australia, health practitioners must be registered in order to practise, and their professional – and on occasions, their personal – conduct is subject to investigation and disciplinary sanctions. However, regulatory arrangements are state-and territory-based and differ significantly. Even the designation of those health professions that are the subject of formal regulatory mechanisms is not consistent across the states and territories.

Having eight versions of health practitioner regulation and inconsistent models, tests and administrative arrangements defy commonsense. However, in 2005 the Council of Australian Governments (CoAG) endorsed a major move towards national registration and a national system of regulation for medical practitioners, nurses, psychologists, dentists, physiotherapists, optometrists, podiatrists, chiropractors, osteopaths and pharmacists as of July 2008,[1] with uniform tests for what constitutes conduct deserving of censure, and consistent procedures across Australia and health disciplines.

The ambit of health practitioner regulation is spreading in order to reduce the incidence of charlatans passing themselves off as health practitioners; to restrict advertising that is false, misleading and deceptive; to institute compulsory insurance for health practitioners; and to reduce the risks of inadequate health services, including from complementary health practitioners. A model can be found in Victoria, where Chinese medicine practitioners, who are defined as persons who employ acupuncture, as well as those who use or dispense Chinese herbs (as defined),[2] have been the subject of formal regulation by the Chinese Medicine Registration Board since 2001.[3] Also in Victoria, medical radiation therapists[4] are in a similar category and naturopaths[5] may well follow. However, given the numbers and diversity of regulatory arrangements, this article refers principally to the regulation of medical practitioners.

It is not just the clinical work of health practitioners that can be the subject of disciplinary regulation. Administrative,[6] forensic[7] and even personal conduct[8] can come within the umbrella of regulatory investigation and, on occasion, sanction.

Finally, a change in regulatory style is occurring internationally, with a significant shift in focus away from whether a particular instance of inappropriate conduct occurred, to ascertaining the causes of such conduct so that they can be addressed – preferably, in a collaborative way. This can include assessment of systemic issues, health problems and performance or competency issues.

Health practitioner regulation is therefore an area of administrative law and practice that is changing rapidly. It overlaps in important ways with civil litigation against health practitioners – regulatory investigations and hearings have the potential to provide significant strategic and evidentiary assistance to plaintiffs. In addition, plaintiff lawyers can help regulatory authorities to protect the community against dangerous practitioners – often an issue that particularly motivates clients. Thus health regulation should be well understood by plaintiff lawyers. This article summarises the processes involved in complaint investigation and disciplinary determination, highlighting issues of particular relevance for those representing patients in civil actions against health practitioners.

COMPLAINTS

Grievances about the quality of service provided by health practitioners are variously termed 'complaints' and 'notifications'. Regulatory bodies generally prefer such grievances to be communicated in writing, promptly and with as much specific detail as possible about the interaction between the practitioner and the patient; what it is said that the practitioner did wrongly; and providing assistance so that investigators can pursue corroborating evidence. This highlights a tension that can exist at an early phase for patients – whether to report their grievances to regulatory bodies while their civil litigation is on foot – potentially to assist it, or to protect others – or to wait until it is concluded. Generally, early reporting is most advantageous for litigants, as well as for the prospects of an adverse disciplinary finding against a health practitioner. >>

Plaintiff lawyers can help to protect the public from dangerous practitioners.

In general, the bodies that receive complaints are the registration boards (in Tasmania, the Medical Council) for the health practitioners. In jurisdictions such as NSW, the body that receives and investigates complaints (the Health Care Complaints Commission) is separate from the body that determines serious matters. The Health Services Commissioner can also investigate minor complaints and facilitate the payment of compensation in a number of jurisdictions. Investigators can generally decline to investigate matters that are vexatious or lacking in any substance. This rarely occurs. Once a decision is made to investigate, the practitioner will be told of the complaint and asked for their response. This can be a tense time for complainants, as they often fear retribution from the practitioner.[9]

Complaints about practitioners are numerous and cover many subjects. In NSW, for instance, the Health Care Complaints Commission in 2005–2006 received 2,573 complaints and finalised 438 investigations. The average time for finalisation was a little short of a year. It referred 66 matters for consideration for disciplinary proceedings. More than half of the complaints (56%) related to treatment; about one in six (17.5%) to professional conduct; and about one in twelve (7.8%) to communication issues.[10] In Victoria, the Medical Practitioners Board received 582 notifications during the year.[11] Of these, 347 were referred to preliminary investigation, of which 48% related to clinical care; 20% to conduct or behaviour; 8% to medical reports or certificates; 7% to ethical matters; 5% to practice management; 4% to sexual conduct; 2% to personal conduct and 1% to criminal offending. Thirty-one matters were referred to formal hearing and 99 to informal hearing.

In most jurisdictions, the body that decides whether unprofessional conduct has occurred is an administrative tribunal separate from the registering and investigating body. For instance, in NSW, serious matters are dealt with by the Medical Disciplinary Tribunal, in Western Australia by the State Administrative Tribunal and in Queensland by the Health Practitioners Tribunal. On 1 July 2007, the new *Health Professions Registration Act* 2005 (Vic) will transfer responsibility for decision-making about serious matters from the Medical Practitioners Board of Victoria to the Victorian Civil and Administrative Tribunal (VCAT).[12]

REGULATORY TERMINOLOGY

Conduct potentially the subject of an adverse finding in disciplinary proceedings is defined differently in different jurisdictions.[13] In general, there are three levels of unacceptable conduct on the spectrum of severity; namely, unsatisfactory (or unprofessional) conduct, professional misconduct, and infamous conduct. An example of the first is rudeness or insensitivity to privacy issues. Professional misconduct generally requires a significant departure from accepted standards, disgraceful, dishonourable conduct, or conduct of which peers would be highly critical.[14] Professional misconduct is exemplified by sexualisation of the therapeutic relationship, conflicts of interest, serious breaches of confidentiality and dishonesty. Infamous conduct in a professional respect, which generally results in cancellation of registration, is typically found to have occurred when a practitioner has persuaded a patient to engage in sexual penetration in the course of a consultation.

In NSW, s36 of the *Medical Practice Act* 1992 (NSW) defines 'unsatisfactory professional conduct' and s37 defines 'professional misconduct'.[15] The sections are sufficiently broad that a wide variety of conduct may fall under either definition. The principal yardstick in s36(a) is peer-based: the standard reasonably expected of a practitioner of an equivalent level of training or experience.

By contrast, s3 of the *Health Professions Registration Act* 2005 (Vic) (which defines 'unprofessional conduct')[16] makes the yardstick of 'unsatisfactory' conduct the reasonable expectations of both peers and members of the public.

A serious error, whether or not it has disadvantageous consequences or causes harm to a patient, may constitute unprofessional conduct or even professional misconduct. The question for disciplinary purposes is not whether the practitioner has breached their duty of care; it is framed within statutory provisions such as those cited above from NSW and Victoria. However, the considerable degree of overlap between the civil and the disciplinary tests is such that it is rare for a practitioner to be found to have engaged in unprofessional conduct or unsatisfactory professional conduct, and not to be civilly liable.

On occasions, error will not constitute unprofessional conduct.[17] It will depend on the circumstances, in particular on the error and the extent to which the error departed from accepted standards from the perspective of other practitioners of good repute and competency,[18] a familiar test from the civil decision of *Whitehouse v Jordan*.[19] As Morris J put it in the important Victorian disciplinary decision of *Vissenga v Medical Practitioners Board*:[20]

> 'neither the public nor the peers of a medical practitioner expect perfection at all times. Human frailty visits every person, including those who are medical practitioners. Reasonable members of the public, and the reasonable peers of medical practitioners, understand this. Reasonable people are tolerant of occasional lapses, particularly if these lapses do not form a consistent course of conduct or, if taken separately, are insufficiently serious to warrant intervention by those charged with acting on behalf of the State.'

THE FOCUS OF DISCIPLINARY PROCEEDINGS

Personal injury and malpractice practitioners should remember that the regulatory jurisdiction is directed towards protecting the public. Even if a patient suffers only minor harm, the results for the health practitioner can be severe; similarly, a patient can suffer a severe, or even catastrophic

outcome, but the culpability of a practitioner may be determined to be low – with no finding of unprofessional or unsatisfactory conduct and only a modest sanction is imposed.

When imposing 'penalties', regulators consider not so much whether a practitioner has breached a duty of care or the consequences for a patient, as whether the practitioner poses an ongoing risk to the community or the profession. Regulatory sanctions are imposed not to punish, but to protect. However, this includes protecting both the general community and the standards of the profession in the eyes of the community.[21] Thus, in Queensland, s123 of the *Health Practitioners (Professional Standards) Act* 1999 (Qld) provides that the purposes of disciplinary hearings are: '(a) to protect the public; (b) to maintain public confidence in the health professions; and (c) to uphold standards of practice within the health professions'. These objectives can be accomplished, depending on the jurisdiction, by the imposition of reprimands, cautions, mandated further education, supervised practice, coerced change to practice, conditions, limitations or restrictions on practice, suspension of practice or cancellation of the right to practice. Deterrence of both the individual practitioner and of others who might behave similarly is often a potent consideration when a 'penalty' is imposed.[22]

Any interference with registration is generally on the public record and able to be identified either on internet registration records or by inquiry. Less substantial decisions by bodies often termed 'professional standards panels' are not so readily ascertained.

ACCESSIBILITY OF EVIDENCE AND DECISIONS

When a matter goes to a major hearing (in Victoria a 'formal hearing' held by the Medical Practitioners Board itself, and elsewhere before administrative tribunals), it generally takes place in public, unless the hearing body decides that matters of a particularly personal nature are being covered and the hearing ought to be closed, in full or in part. The decisions of a number of the bodies are now available on the internet.[23]

The decisions of first instance-tribunals tend to be extensive, with summaries and analysis of evidence. Tribunals generally consist of a cross-disciplinary hearing panel, including at least one practitioner of the discipline concerned and at least one medical practitioner. However, there are occasions in Victoria, when on appeal to VCAT, the matter has been heard by a lawyer member alone. But after 1 July 2007, when the *Health Professions Registration Act* 2005 (Vic) comes into force, decisions in serious matters will be heard at first instance by a VCAT panel, which must include at least two members of the relevant profession.

OBTAINING INFORMATION

Regulatory health boards are subject to freedom of information legislation. However, exemptions relating to confidentiality, ongoing investigations and in-house notes and legal advice can impede access to information about a complaint. Boards vary in their resort to exemptions to prevent access to their files. In principle, though, negative decisions about practitioners that have not interfered with their registered status – for example, decisions by a Professional Standards Committee in Western Australia – should be accessible via a freedom of information application.

In Victoria, freedom of information access to and third-party discovery of documents that could be relevant to civil litigation have been the subject of inconsistent appellate decisions.

The status of the ageing decision of Beach J in *ZZZ v JX*[24] is unclear. ZZZ instituted civil action against Dr JX, a psychiatrist, for damages arising out of an improper relationship between doctor and patient. Previously, ZZZ had lodged a complaint about the sexual relationship with the then Medical Board of Victoria, which upheld the complaint and suspended the practitioner for nine months. ZZZ sought a copy of the transcript of the formal hearing and any documents relevant to the disciplinary proceedings by way of non-party discovery. This was resisted by the Board on the grounds of confidentiality and public interest immunity. Beach J (in the Practice Court) held that it was in the public interest that there be the fullest possible disclosure to regulatory boards of information and material relating to the behaviour and actions of registered practitioners, to enable them to make optimal decisions about complaints. However, other considerations applied where a person was seeking non-party discovery of the documents relating to the proceedings of regulatory boards: >>

> 'if witnesses and medical practitioners whose behaviour and actions are under investigation knew that their statements could be given to others and used for a different purpose, that objective might well be frustrated. Medical practitioners might well be deterred from making statements which would found civil actions against them and complainants and witnesses might be less willing to offer free and truthful cooperation in investigations under the Act if their statements were liable to be disclosed in subsequent civil proceedings.'

This led Beach J to reject the application for non-party discovery.

By contrast, *Medical Practitioners Board of Victoria v Sifredi*[25] enunciated the more likely modern approach of the courts and tribunals. The Medical Board sought unsuccessfully to protect on public interest grounds both the responses given by the doctor to a complaint and various communications made by other doctors obtained as part of the investigation into his conduct. It contended that disclosure of the information would be reasonably likely to impair the Board in obtaining similar information in the future, an argument very similar to that accepted in the related context of *ZZZ v JX*. Neither MacNamara DP in VCAT[26] nor Hedigan J on appeal were persuaded on the evidence that the operations of the Board would be likely to be prejudiced by the release of such information, thereby giving a fillip to such requests. Hedigan J held that:

> 'the question of whether a disclosure is reasonably likely to impair the ability of an agency to obtain similar information in the future ought to be taken on a case-by-case basis as the context, background or evidence may be more or less influential on the body charged with making a decision in different cases.'[27]

The ramifications of the two decisions are not entirely straightforward. It may be that in the aftermath of *Sifredi* a more robust approach to the application of public interest immunity will be taken than that of Beach J in *ZZZ v JX*. However, the outcome of both a non-party application for production and applications under freedom of information legislation will depend on the circumstances of the case and the soundness of any claims of potential risk to the operation of regulatory bodies in the specific case. The precedent of the *Sifredi* and *Zacek* decisions is likely in most circumstances to lead to successful freedom of information applications for investigation files, including practitioners' responses and expert assessments.

PERFORMANCE AND HEALTH INVESTIGATIONS

One of the trends in regulation is that less emphasis is being placed on whether a practitioner has engaged in a particular act of unprofessional conduct and more on what factors might give rise to unacceptably poor conduct. This can result in findings not so much about whether a practitioner has behaved in an untoward way on particular occasions (the main focus of a civil case), but upon whether they lack adequate knowledge or competency in a given procedure, or whether they have a psychiatric, psychological, physical or other condition that impairs their capacity to practise competently. The issues in relation to performance and health are distinct but can overlap.

In Victoria, for instance, 'professional performance' is defined to mean 'the knowledge, skill or care possessed and applied by a registered health practitioner in the provision of regulated health services'.[28] Whether a practitioner's 'professional performance' has been unsatisfactory can be a focus of investigation, separate from whether s/he has engaged in 'unprofessional conduct' or 'professional misconduct' in a specific case.

This approach can be attractive to health practitioners, enabling issues to be addressed collaboratively without the same public stigma and the need for a hearing in relation to whether they have transgressed on a particular occasion. For the same reason, patients (and plaintiff lawyers) may not find that this approach meets their needs, and may be inclined to take civil action as a result of the failure of regulators to make an adverse finding against a practitioner.

However, the 'performance and health pathways' are attractive to regulators in that they recognise and respond to the reality that a particular adverse event may not be easy to prove, but it is likely to be the product of:

- a systems failure within, for example, a hospital or a practice, for which a particular practitioner may have limited responsibility;
- a deficit in knowledge or skill on the part of the practitioner;
- a practitioner's health condition, including a physical condition, a psychiatric disorder, cognitive deterioration, or a substance dependency; or
- a combination of these.

The NSW Medical Board, for instance, has constructed a program

> 'designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is properly protected. It is designed to address patterns of practice rather than one-off incidents, unless the single incident is demonstrative of a broader problem. The causes of poor performance are many and varied. Professional isolation and inattention to continuing professional development are common contributing factors. On occasions, doctors present with adequate knowledge, but an inability to apply it in their day-to-day practice. This may be due to external, "distracters" such as illness and financial stress which may influence practitioner performance in the short or longer term.'[29]

Regulators of medical practitioners in the Northern Territory,[30] New Zealand[31] and Victoria[32] have also been leaders in this regard.

In principle, performance and health problems can be remedied by employing constructive strategies between the regulator and the practitioner, possibly including conditions on registration for a time to protect against risks, until the identified flaw or condition is satisfactorily addressed.[33] It is worthwhile for plaintiff lawyers to check whether a practitioner's registration has been so affected. The fact that in jurisdictions such as NSW, in particular, increasing numbers

of investigations are routed into 'performance' and 'health' assessments means that less is on the public record. However, the relevant Board's file should record any performance and health assessments and reports. Again, though, there may be limitations in terms of a plaintiff's rights of access because of health privacy rights on the part of the practitioner.

ADVERSE DISCIPLINARY DECISIONS

The fact that a practitioner has been found to have engaged in any form of unprofessional conduct does not bind a court in a subsequent professional negligence action. First, decisions about unprofessional conduct are made by administrative tribunals. Secondly, disciplinary decisions have a different focus and the criteria are different, albeit often comparable.

However, an adverse finding in a conduct, performance or health context is likely to 'be revealed' during court proceedings and to be highly prejudicial for the health practitioner concerned. Accordingly, it constitutes a strong negotiating point pre-trial for plaintiff lawyers.

Panel decisions in hearings related to any serious allegations about a practitioner and the reasons for such decisions may well give an important indication of evidence that can be adduced against the practitioner in civil litigation. Statements made by practitioners in the course of an investigation by a regulatory agency may well be put to the practitioner as to credit, including as prior inconsistent statements. And plaintiffs may rely on reports procured by regulatory bodies. Evidence given in serious matters before regulatory panels is often recorded and transcribed.

CONFIDENTIALITY CLAUSES IN SETTLEMENTS

When civil litigation (or a coroner's inquest)[34] is on foot against a health practitioner, regulatory bodies will occasionally defer their investigations (save in circumstances of identified particular risk from the practitioner) until the litigation is concluded. On other occasions, the plaintiff may decide not to lodge a complaint until matters filed in court have been finalised.

Difficulties can emerge when a health practitioner is prepared to settle a claim on confidential terms, including an undertaking that the plaintiff will not lodge complaints or notifications with any regulatory body. It is likely that such a clause is unenforceable for reasons of public policy. Ethical issues arise for both plaintiff and defence lawyers about incorporating such a clause in light of its likely unenforceability. Regulatory bodies are also alert to the possibility that health practitioners will seek to dissuade patients from exercising their right to lodge a complaint or notification by 'buying them off'. Any improper pressures in that regard can also constitute professional misconduct on the part of the health practitioner and could prompt allegations of impropriety in relation to the role played by their legal representatives. Caution is necessary.

GUIDELINES ISSUED BY REGULATORY BODIES

An important function of regulatory bodies is to issue guidance to practitioners. Such guidance can provide useful particulars for statements of claim, as it may identify what is expected of practitioners by their governing body. Examples of such documents are:

- the Medical Board of South Australia's *Good Medical Practice: Duties of a Doctor Registered by the Medical Board of South Australia*;[35]
- the Medical Council of Tasmania's *Policy on Disposal of Medical Records*;[36]
- the Victorian Board's *Medico-Legal Guidelines*;[37]
- the NSW Board's *Medical Certificates Policy*;[38]
- the ACT Medical Board's *Standards Statement: Medical Practitioners and Sexual Misconduct*;[39] and
- the Western Australian Medical Board's *Telemedicine Policy*.[40]

CONCLUSIONS

Awareness by plaintiff lawyers of the processes, policies and documentation generated by regulatory bodies against health practitioners should be a fundamental part of effectively representing patients and of strategic planning for malpractice litigation. Many a client is motivated most by wanting to take steps to ensure that other patients are not harmed in the way that they have been by a health practitioner. Assisting a client to formulate their complaint thoughtfully, accurately and in a timely way, giving them information about regulatory processes, and providing them with realistic expectations about disciplinary investigations >>

> Regulatory sanctions are imposed not to punish, but to protect.

and hearings, can constitute effective legal representation in this regard.

While there are important distinctions between the new statutory tests for professional liability for healthcare practitioners and the tests for unprofessional conduct, unsatisfactory professional conduct and professional misconduct, they still have much in common. This means that disciplinary decisions can give a helpful insight into the likely results of civil litigation, and into the likely performance of both a plaintiff and a health practitioner in the witness box. Complaints about healthcare practitioners often generate extensive and peer-informed investigations, knowledge of which can substantially assist litigation on behalf of patients. Documentation generated by regulatory bodies can shed important light on standards and expectations within the relevant profession and also on peer assessments of potential breaches of the duty of care by practitioners. This is so whether the focus of regulatory bodies is in respect of practitioners' conduct, performance or health. Similarly, access to the responses of health practitioners to allegations made against them can provide fertile material for cross-examination on behalf of plaintiffs.

While civil litigation and regulatory investigation and disciplinary hearings have a different focus, each can usefully assist the other. With the likely implementation of nationally consistent approaches to both registration and regulation of a range of health practitioners, plaintiff lawyers can draw upon the investigative and adjudicatory work of regulatory bodies to inform their litigation strategies against health practitioners. ■

Notes: **1** CoAG Communique, 14 July 2006: http://www.coag.gov.au/meetings/140706/index.htm#health, accessed 6 March 2007; see further A-L Carlton, 'National Models for Regulation of the Health Professions' (2006) 23(2) *Law in Context* 21. **2** *Chinese Medicine Registration Act* 2000 (Vic). **3** See M Parker, 'Chinese Dragon or Toothless Tiger? Regulating the Professional Competence of Traditional Chinese Medicine Practitioners' (2003) 10 *Journal of Law and Medicine* 285; I Freckelton, 'Regulation of Chinese Medicine' (2000) 8 *Journal of Law and Medicine* 5. **4** *Health (Medical Radiation Technologists) Regulations* 1997 (Vic): see http://www.health.vic.gov.au/mrtb/, accessed 1 February 2007. **5** See Department of Human Services, *Regulation of Complementary Health Practitioners: Discussion Paper*, September 2002, http://www.health.nsw.gov.au/public-health/clinical_policy/complementary/compmed_paper.pdf, accessed 6 March 2007. **6** See I Freckelton, 'Health Practitioner Regulation' in B Bennett and G Tomossy, *Globalization and Health*, Springer, Netherlands, 2006. **7** See, for example, *General Medical Council v Meadow* [2006] EWCA Civ 1390; *James v Medical Board (SA)* [2006] SASC 267 at [84]; M Groves, 'Professional Disciplinary Proceedings Against Expert Medical Witnesses' (2007) 14 *Journal of Law and Medicine* 306; I Freckelton, 'Regulation of Health Practitioners' in I Freckelton and K Petersen (eds), *Disputes and Dilemmas in Health Law*, Federation Press, Sydney, 2006; I Freckelton, 'Insightlessness and an Unscientific Forensic Expert' (2006) 14 *Journal of Law and Medicine* 176. **8** See *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311. **9** See *R v McGrane* [2002] QCA 173 for an extreme example of such retribution, where a doctor murdered his patient. **10** Healthcare Complaints Commission of New South Wales, *Annual Report, 2005/2006*, http://www.hccc.nsw.gov.au/downloads/ar0506.pdf, accessed 1 February 2007. **11** Medical Practitioners Board of Victoria, *Annual Report, 2006*, http://medicalboardvic.org.au/pdf/AR_2006.pdf, accessed 6 March 2007. **12** See SL Middleton, TD Pearce, and MD Buist, 'The Rights and Interests of Doctors and Patients: Does the New Victorian *Health Professions Registration Act* 2005 Strike a Fair Balance?' (2007) 186 *Medical Journal of Australia* 192: http://www.mja.com.au/public/issues/186_04_190207/mid10955_fm.html, accessed 6 March 2007. **13** For a useful analysis, see J McIlwraith and B Madden, *Health Care and the Law*, 4th ed, Thomson, Sydney, 2006, pp400-3. **14** *Campbell v The Dental Board of Victoria* [1999] VSC 113 at [23]-[24]; *Qidwai v Brown* [1984] 1 NSWLR 100 at 105. **15** See Appendix. **16** *Ibid.* **17** See *Pillai v Messiter (No. 2)* (1989) 16 NSWLR 197 at 200. **18** See, for example, *Re Foo* [2006] MPBV 15 at [62]. **19** [1981] 1 All ER 267. **20** [2004] VCAT 1044 at [33]. **21** *Ha v Pharmacy Board of Victoria* [2002] VSC 322 at [97] per Gillard J. **22** See, for example, *Craig v Medical Board of South Australia* [2001] SASC 169. **23** For instance, formal hearing decisions of the Victorian Medical Practitioners Board (http://medicalboardvic.org.au/content.php?sec=106, accessed 1 February 2007); the Psychologists Registration Board (http://www.psychreg.vic.gov.au/store/page.pl?id=3262, accessed 1 February 2007); the Dental Practice Board (http://www.dentprac.vic.gov.au/publications.asp?doc=1, accessed 1 February 2007); the Chinese Medicine Registration Board (http://www.cmrb.vic.gov.au/board/board.html, accessed 1 February 2007); and of the VCAT (http://www.austlii.edu.au/au/cases/vic/VCAT/, accessed 1 February 2007) are all available on the internet. **24** Unreported, Supreme Court of Victoria, 25 November 1993, BC9300986. **25** [2000] VSC 33. **26** *Sifredi v Medical Practitioners Board* [1999] VCAT 87. **27** Subsequently, applying *Sifredi*, see *Zacek v Medical Practitioners Board of Victoria* [2005] VCAT 114. **28** *Health Professions Registration Act* 2005 (Vic), s3. **29** See http://www.nswmb.org.au/index.pl?page=6, accessed 1 February 2007. **30** See http://www.nt.gov.au/health/org_supp/prof_boards/medical/Performance%20Assessment%20Policy.doc, accessed 1 February 2007. **31** See http://www.mcnz.org.nz/Competence/Concernsaboutcompetence/tabid/76/Default.aspx, accessed 6 March 2007. **32** See http://www.medicalboardvic.org.au/content.php?sec=31, and http://medicalboardvic.org.au/pdf/AR_2006.pdf, accessed 6 March 2007. **33** See A Reid, 'To Discipline or Not to Discipline? Managing Poorly Performing Doctors' (2006) 23(2) *Law in Context* 91. **34** See I Freckelton and D Ranson, *Death Investigation and the Coroner's Inquest*, Oxford University Press, Melbourne, 2006. **35** http://www.medicalboardsa.asn.au/media/files/608.pdf, accessed 1 February 2007. **36** http:www.medicalcounciltas.com.au/pdfs/10505%20(policy%20no%205%20Disposal%20of%20medical%20records).pdf, accessed 1 February 2007. **37** http://www.medicalboardvic.org.au/pdf/Medico_Legal_Guidelines.pdf, accessed 1 February 2007. **38** http://www.nswmb.org.au/index.pl?page=68, accessed 1 February 2007. **39** http://www.medicalboard.act.gov.au/Standards%20Statements/docs/sexual%20misconduct.pdf, accessed 1 February 2007. **40** http://www.wa.medicalboard.com.au/pdfs/Telemedicine.pdf, accessed 1 February 2007.

Ian Freckelton *is a barrister at Crockett Chambers in Melbourne. Between 1999 and 2006 he was also the lawyer member of the Victorian Medical Practitioners Board and of the Victorian Psychologists Registration Board.* **PHONE** *(03) 9225 7666*
EMAIL *I.Freckelton@vicbar.com.au*

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APPENDIX

In NSW, s36 of the *Medical Practice Act* 1992 (NSW) defines 'unsatisfactory professional conduct' to include:

'(a) Any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

(b) Any contravention by the practitioner (whether by act or omission) of a provision of this Act or the regulations.

(c) Any contravention by the practitioner (whether by act or omission) of a condition to which his or her registration is subject.

(d) Any conduct that results in the practitioner being convicted of or being made the subject of a criminal finding for any of the following offences:
  (i) an offence under section 204 of the Mental Health Act 1990,
  (ii) an offence under section 175 of the Children and Young Persons (Care and Protection) Act 1998,
  (iii) an offence under section 35 of the Guardianship Act 1987,
  (iv) an offence under section 128A, 128B, 129, 129AA or 129AAA of the Health Insurance Act 1973 of the Commonwealth,
  (v) an offence under section 46 of the Private Hospitals and Day Procedure Centres Act 1988,
  (vi) an offence under section 43 of the Nursing Homes Act 1988.
  ...

(e) Accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for:
  (i) referring another person to the health service provider, or
  (ii) recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter.

(f) Accepting from a person who supplies a health product (or from another person on behalf of the supplier) a benefit as inducement, consideration or reward for recommending that another person use the health product.

(g) Offering or giving any person a benefit as inducement, consideration or reward for the person:
  (i) referring another person to the registered medical practitioner, or
  (ii) recommending to another person that the person use any health service provided by the practitioner or consult the practitioner in relation to a health matter.

(h) Referring a person to, or recommending that a person use or consult:
  (i) another health service provider, or
  (ii) a health service, or
  (iii) a health product, when the practitioner has a pecuniary interest in giving that referral or recommendation (as provided by subsection (2)), unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

(i) Engaging in overservicing, as provided by subsection (3).

(j) Permitting an assistant employed by the practitioner (in connection with the practitioner's professional practice) who is not a registered medical practitioner to attend, treat or perform operations on patients in respect of matters requiring professional discretion or skill.

(k) By the practitioner's presence, countenance, advice, assistance or co-operation, knowingly enable a person who is not a registered medical practitioner (whether or not that person is described as an assistant) to:
  (i) perform any act of operative surgery (as distinct from manipulative surgery) on a patient in respect of any matter requiring professional discretion or skill, or
  (ii) issue or procure the issue of any certificate, notification, report or other like document, or to engage in professional practice, as if the person were a registered medical practitioner.

(l) Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another registered medical practitioner attends instead within a reasonable time.

(m) Any other improper or unethical conduct relating to the practice or purported practice of medicine.'

Section 37 defines 'professional misconduct' to mean 'unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register'.

In Victoria, s3 of the *Health Professions Registration Act* 2005 (Vic) defines 'unprofessional conduct':

'(a) conduct of a health practitioner occurring in connection with the practice of the practitioner's health profession that is of a lesser standard than a member of the public or the health practitioner's peers are entitled to expect of a reasonably competent health practitioner of that kind;

(b) professional performance which is of a lesser standard than that which the registered health practitioner's peers might reasonably expect of a registered health practitioner;

(c) infamous conduct in a professional respect;

(d) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for that person's well-being;

(e) influencing or attempting to influence the provision of health services in such a way that client care may be compromised;
  ...

(h) a finding of guilt of:
  (i) an offence where the health practitioner's suitability to continue to practise is likely to be affected because of the finding of guilt or where it is not in the public interest to allow the health practitioner to continue to practise because of the finding of guilt; or
  (ii) an offence under this Act or the regulations; or
  (iii) an offence as a health practitioner under any other Act or regulations;

(i) the contravention of, or failure to comply with a condition imposed on the registration of the health practitioner by or under this Act;
  ...

(k) the breach of an agreement made under this Act between a health practitioner and the responsible board that registered that practitioner.'

Professional misconduct in Victoria is defined to include:

'(a) unprofessional conduct of a health practitioner, where the conduct involves a substantial or consistent failure to reach or maintain a reasonable standard of competence and diligence; and

(b) conduct that violates or falls short of, to a substantial degree, the standard of professional conduct observed by members of the profession of good repute or competency; and

(c) conduct of a health practitioner, whether occurring in connection with the practice of the health practitioner's health profession or occurring otherwise than in connection with the practice of a health profession, that would, if established, justify a finding that the practitioner is not of good character or is otherwise not a fit and proper person to engage in the practice of that health profession.'