Complementary Health Practitioners Disciplined for Misconduct in Australia 2010-2016

Jenni Millbank, Miranda Kaye, Anita Stuhmcke, David Sibbritt, Isabel Karpin and Jon Wardle*

This article examines disciplinary proceedings brought against complementary medicine (CM) practitioners in Australia at tribunal level since the inception of the Health Practitioner Regulation National Law. The article looks at all 32 such cases and identifies trends in the kinds of misconduct established, and the orders imposed. These findings are compared with earlier and more sizable studies of tribunal-level outcomes for disciplinary proceedings against doctors in Australia and New Zealand. While there are some clear comparisons – such as the gender ratio of respondent practitioners and the most common type of misconduct, ie sexual misconduct – there were also notable differences. Specifically, the rate of removal from practice, either by suspension or cancellation of registration, of CM practitioners was found to be significantly higher than that reported in earlier studies of cases against doctors. More research needs to be done to explore the reasons for this apparent disparity.

INTRODUCTION

The use of complementary medicine (CM) practitioners and products has been increasing over the past few decades. As a result, it now constitutes a sizeable part of the Australian health care sector. Given this, there are calls to increase the regulation and accountability of CM.[1] Despite a push to regulate CM practitioners in the same way as conventional practitioners, little is known about whether the kinds of disciplinary issues faced by both groups are comparable.

On 1 July 2010, the Australian Health Practitioner Regulation Agency (AHPRA) became the single national oversight agency for health professional regulation in Australia. Ten National professional boards were established, requiring mirror legislation in each State and Territory. The original 10 boards in the scheme regulated 10 health professions: Chiropractic, Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology. Four more boards joined the scheme on 1 July 2012. These were Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Medical Radiation Practice and Occupational Therapy. Therefore there are now three boards that directly regulate and register practitioner groups considered complementary medicine: Chinese Medicine, Chiropractic and Osteopathy – which together are referred to as the "CM Boards" in the remainder of this article. As at June 2015, there were 4,494 Chinese medicine practitioners, 4,998 chiropractors and 2,000 osteopaths registered across Australia.

* Jenni Millbank, Distinguished Professor, Faculty of Law, University of Technology Sydney and Senior Member, Occupational Division, NCAT (The views expressed here are personal to the author and do not represent NCAT); Miranda Kaye, Senior Lecturer, Faculty of Law, University of Technology Sydney; Anita Stuhmcke, Professor, Faculty of Law, University of Technology Sydney; David Sibbritt, Professor of Epidemiology, Faculty of Health, University of Technology Sydney; Isabel Karpin, Distinguished Professor, Faculty of Law, University of Technology Sydney; Jon Wardle, Lecturer, Faculty of Health, University of Technology Sydney. Thanks to UTS Faculty of Health and UTS:Law for funding support and Cindy Lam for her invaluable research assistance.

Correspondence to: jenni.millbank@uts.edu.au.

[1] J Wardle et al, "Is Health Practitioner Regulation Keeping Pace with the Changing Practitioner and Health-Care Landscape? An Australian Perspective" (2016) 4 *Frontiers in Public Health* 91.

Disciplinary hearings are one mechanism through which the legal system can provide accountability for unsafe services or products.[2] In an earlier article, we examined the outcomes of board decisions on complaints made against CM practitioners regulated by the *Health Practitioner Regulation National Law* (National Law): chiropractors; osteopaths; and Chinese medicine practitioners.[3] This article continues our examination of how CM practitioners are regulated under the National Law.[4] The focus of this article, however, is trends and outcomes of disciplinary tribunal hearings brought against CM practitioners under the National Law. While the hearing outcomes do not reveal the prevalence of the various kinds of misconduct and behaviours,[5] the data provide a snapshot of the legal response to the most serious matters which proceed to hearing.

In this article we examine 32 publically released legal decisions made by tribunals dealing with CM practitioners regulated under the National Law over a six-year period from 2010 to 2016 in which an adverse finding was made. Our findings are compared with recent research by Elkin et al involving 485 disciplinary decisions against doctors in Australia and New Zealand tribunals.[6] In particular, we utilise the typology of misconduct developed by Elkin et al in their analysis.[7] Elkin et al reported on trends and outcomes of tribunal proceedings concerning misconduct by doctors in the period 2000 to 2009 (inclusive) including the characteristics of the doctors involved, the main misconduct at issue and the case outcomes. Utilising this typology is useful to provide a point of comparison for recent tribunal decisions concerning CM practitioners under the National Law in the context of what was already known about medical practitioners, prior to the advent of the National Law.[8] However, the comparison is limited. In addition to the different timeframe of our study from previous studies and variable legal regimes in place, we have adapted the typology to highlight issues that may be unique to CM. Specifically, we included, under a separate head of inappropriate medical care, the failure to refer to "conventional" medical practitioners.

Complaints

In Australia, health care complaints are made to statutory bodies. Such bodies are vested with discretionary powers to determine how to investigate, dismiss or initiate disciplinary proceedings in relation to the complaint.[9] In all States and Territories except New South Wales (NSW), complaints

[2] I Freckelton, "Unscientific Health Practice and Disciplinary and Consumer Protection Litigation" (2011) 18 JLM 645, 647 lists other methods as: interventions by Health Services Commissioners; coronial inquiries; consumer affairs and fair trading actions; therapeutic goods actions; civil actions and criminal prosecutions.

[3] D Sibbritt et al, "How are Complementary Health Professions Regulated in Australia?: An Examination of Complementary Health Professions in the National Registration and 'Accreditation Scheme'" (under submission).

[4] *Health Practitioner Regulation National Law Act 2009* (Qld).

[5] As Elkin et al note, "the figures … are … a function of three interrelated elements; the underlying rate of misconduct, the rate at which misconduct is reported to tribunals, and how boards and tribunals react to such reports". See K Elkin et al, "Doctors Disciplined for Professional Misconduct in Australia and New Zealand" (2011) 194(9) MJA 452, 455.

[6] See K Elkin et al, n 5; K Elkin et al; "Removal of Doctors from Practice for Professional Misconduct in Australia and New Zealand" (2012) 21 BMJ Qual Saf 1027. See also for further analysis: K Elkin, "Medical Practitioner Regulation: Is It All About Protecting the Public?" (2014) 21 JLM 682. See also other studies which include: M Bismark, M Spittal and D Studdert, "Prevalence and Characteristics of Complaint-Prone Doctors in Private Practice in Victoria" (2012) 195 MJA 25; K Elkin, M Spittal and D Studdert, "Risks of Complaints and Adverse Disciplinary Findings against International Medical Graduates in Victoria and Western Australia" (2012) 197(8) MJA 197; H Kiel, *Problem Doctors in Disciplinary Tribunals: Who Do Protective Orders Protect? An Analysis of Australian Tribunal Decisions from 2010 – 2013* (PhD Thesis, UTS, 2016); D Mendelson, "Disciplinary Proceedings for Inappropriate Prescription of Opioid Medications by Medical Practitioners in Australia (2010-2014)" (2014) 22 JLM 255; L Surgenor et al, "New Zealand's Health Practitioners Disciplinary Tribunal: An Analysis of Decisions 2004-2014" (2016) 24 JLM 239.

[7] Elkin et al, n 5.

[8] Jon Wardle undertook a similar exercise comparing registered and unregistered health providers during 2008-2013 using the NSW HCCC "issue categories". See J Wardle, "Holding Unregistered Health Practitioners to Account: An Analysis of Current Regulatory and Legislative Approaches" (2014) 22 JLM 350. For the reasons stated by Elkin et al, n 5, 453, we have decided to use the Elkin typology in this article rather than those used by the NSW HCCC or any of the medical boards.

[9] Each State and Territory has a Health Complaints Commission (HCC) set up as a statutory body independent of the health system to which complaints can be made. However, complaints can also be made to the 14 national professional health boards

are referred to the professional registration boards for consideration and/or investigation.[10] The most serious cases that could result in suspension or cancellation of registration are referred to tribunals for determination.[11] The health boards' professional standards committees investigate complaints concerning unsatisfactory professional performance or impairment. In NSW, complaints are handled via a co-regulatory model: complaints can be made to either the Council or the NSW Health Care Complaints Commission (HCCC), which consult to determine who investigates and handles the complaint.[12] As with other States, if it is decided that the complaint may amount to professional misconduct,[13] then the matter is referred to the tribunal for determination.

The CM Cases

We examined the available legal decisions made by tribunals dealing with CM practitioners over the six-year period from 1 July 2010 to 1 July 2016.[14] This period was chosen to coincide with the introduction on 1 July 2010 of the National Law, as in force in each State and Territory, and the creation of AHPRA under the National Registration and Accreditation Scheme. In relation to Chinese medicine practitioner cases, we searched all cases brought by the Chinese Medicine Registration Board of Victoria (CMRBV) from 2010 and then all cases brought by the Chinese Medicine Board of Australia (CMBA) from 2012. We focused only on tribunal decisions, therefore excluding practitioner cases that were diverted within the regulatory system to a non-disciplinary "health" or impairment pathway or a "performance" pathway.[15] In total we identified 32 cases.

- *Chinese medicine practitioners*: There were 10 disciplinary cases brought by the CMRBV from 2010.[16] Since the inclusion of Chinese medicine practitioners in the national scheme, there have been six cases brought by the CMBA: five cases in Victoria and one in Queensland.

as well as directly to a service provider. The Australian complaints system is further complicated by the fact that there are now three models of complaint handling running in Australia: in most States, the professional boards and AHPRA jointly administer complaint arrangements; in NSW complaints are made to the New South Wales Health Care Complaints Commission (NSW HCCC); in Queensland, complaints are made to the Office of the Health Ombudsman (OHO). State legislation varies with respect to the grounds for a complaint, the statute of limitations on a complaint and differences in the information required in the HCCs' reports to respective Parliaments. See M Walton et al, "Health Complaint Commissions in Australia: Time for a National Approach to Data Collection" (2012) 11 *Australian Review of Public Affairs* 1, 7.

[10] When comparing numbers of investigations, it is important to note that in NSW the HCC is mandated to investigate matters that raise significant issues of public health and safety: *Health Care Complaints Act 1993* (NSW) s 23. In 2009-2010, NSW had twice the number of investigations as the other HCCs combined: Walton et al, n 9, 13. In other States, the HCC is not compelled to investigate serious complains, although in Queensland the Ombudsman may issue an interim prohibition order where there is serious risk and, if such an order is issued, must then take relevant further action: see *Health Ombudsman Act 2013* (Qld) ss 68, 75.

[11] See K Forrester, "A New Beginning for Health Complains in Queensland: The Health Ombudsman Act 2013" (Qld) (2013) 21 JLM 273. The composition of a tribunal is similar to that under the former State and Territory laws. For example, in Queensland, the Tribunal consists of a judicial member, an assessor from the public panel of assessors and two assessors from the professional panel of assessors. In NSW, the Tribunal composition is similar, but the word "member" is used rather than "assessor".

[12] See *Health Practitioner Regulation National Law 2009* (NSW) s 144C, 145A, 145D. For further discussion of the similarities and differences for complaints/notifications handling between the national scheme and the co-regulated NSW scheme, see C Satchell, et al, "Approaches to management of complaints and notifications about health practitioners in Australia" (2016) 40 *Australian Health Review* 311.

[13] *Health Practitioner Regulation National Law (NSW) 2009* (NSW) s 139E.

[14] This case set excluded all non-disciplinary cases. To align with Elkin et al, n 5, it also excluded all cases where all aspects of the complaint were dismissed, thus focusing only on cases where a complaint of unsatisfactory conduct or professional misconduct was proved or conceded. We have counted as one case where the same practitioner has appeared more than once before a tribunal in relation to the same complaints even though the matter may have been reported on more than one occasion. All of the searches were conducted on Austlii <http://www.austlii.edu.au> using search terms that combined the name of the relevant board or HCCC in conjunction with the terms "Chiropractor", "Osteopath" and "Chinese Medicine".

[15] H Kiel, "Regulating Impaired Doctors: A Snapshot from New South Wales" (2013) 21 JLM 429, 430.

[16] On cases brought by the CMRBV between 2003 and 2007, see V Lin and D Gillick, "Does Workforce Regulation Have the Intended Effect? The Case of Chinese Medicine Practitioner Registration" (2011) 35 *Australian Health Review* 455. We have listed cases referred to the Tribunal by the CMRBV before July 2012 under CMRBV cases even if the CMBA was in operation

- *Osteopaths*: There were seven cases nationally: five of these were from NSW, with four of those cases being brought by the HCCC in the NSW Tribunal against the practitioner (one case was an appeal by a practitioner against the decision of the Osteopathy Council of NSW to suspend the practitioner's registration);[17] and two cases were from Victoria.
- *Chiropractors*: There were nine cases nationally: five NSW cases; two Queensland cases; one Victorian case; and one case from South Australia.

TYPES OF MISCONDUCT

In order to place the cases in context and to compare them with outcomes for professional misconduct in cases concerning medical practitioners, the Elkin typology was adapted to categorise the CM cases. Elkin et al highlight the fact that "professional misconduct is often multilayered rather than confined to a single, isolated breach".[18] This was very much the case in most of the CM decisions examined, the majority of which concerned numerous heads of misconduct as secondary issues such as billing irregularities or failures of record keeping (those common in Chinese medicine cases[19] were "failure to label and dispense herbs properly" or "failure to maintain basic infection control") which were only uncovered when the initial breach was investigated.

Each case was classified into a category under the "primary misconduct type"; this was the "behaviour of most concern to the tribunal".[20] In keeping with the method used by Elkin et al, this was determined through close reviews of the case reports, focusing on express comments by the tribunal and the weight of attention given to each misconduct type at issue. It should be noted that varying levels of detail provided within the tribunal reports in relation to both fact finding and reasoning, and that in many cases the facts relied on by the tribunal were agreed upon by the parties, introduce further constraints to the data. Table 1 outlines the matrix of main misconduct categories.

TABLE 1 Types of misconduct in tribunal cases

I. Sexual misconduct towards patient
a. Relationship with patient
b. Inappropriate sexual contact
II. Inappropriate medical care
a. Treatment (inappropriate or inadequate)
b. Failure to refer to medical practitioner or hospital or call ambulance
c. Diagnosis (missed, delayed or incorrect)
III. Misconduct not in relation to patient
a. Inappropriate conduct not in relation to patient
b. Criminal offence

by the time of the hearing. The reason for this is that due to the transitional provisions, such cases are still named as brought by the CMRBV and were heard under the *Health Professions Registration Act 2005* (Vic), as opposed to the National Law; for example, see *CMRBV v Li (Review and Regulation)* [2013] VCAT 463.

[17] *Burton v Osteopathy Council of NSW* [2015] NSWCATOD 150.

[18] Elkin et al, n 5, 455.

[19] For example, see *CMRBV v Jiang (Occupational and Business Regulation)* [2010] VCAT 1227; *CMRBV v Eskander (Occupational and Business Regulation)* [2011] VCAT 1387; *CMBA v Ghaffurian (Occupational and Business Regulation)* [2012] VCAT 478; *CMBA v Lim (Occupational and Business Regulation)* [2012] VCAT 1614; *CMBA v Yang (Occupational and Business Regulation)* [2012] VCAT 1615; *CMRBV v Huang (Occupational and Business Regulation)* [2012] VCAT 1903; *CMRBV v Li (Review and Regulation)* [2013] VCAT 463; *CMBA v Teo (Review and Regulation)* [2014] VCAT 1587.

[20] Elkin et al, n 5, 453.

TABLE 1 *continued*

IV. Other misconduct
a. Non-sexual misconduct towards patient
b. Breach of registration conditions
c. Failure to obtain informed consent
d. Failure to maintain adequate records
e. Breach of privacy
f. Supervision of others
V. Illegal or unethical prescribing*
* This category is in the Elkin typology and, indeed was the primary issue in 21% of their cases. The prescription of medication is unlikely to be central to the practice of CM providers and so is a less important category in this area. However, as noted above, there were a number of cases where there were minor breaches of labeling assurances in relation to Chinese herbal medicine and breach of prescription assurances in relation to Chinese herbal medicine. In no case was this the major head of misconduct.

There is some fluidity in the terms utilised in the case law to describe conduct so that one category could cover a wide variety of conduct. For example, the term "boundary violations"[21] is frequently utilised in cases, but the practitioner conduct in question might include a sexual relationship with a patient, sexual or indecent assault of a patient, or conduct (such as texting or hugging)[22] that is not sexual. In such cases, the tribunal may not make an express finding that the violation is sexual misconduct as opposed to general professional misconduct and so we have had to make this determination upon our reading of the facts.[23]

In 34% (11 of 32) of the CM cases examined, sexual misconduct was the main type of misconduct established.[24] Our finding that sexual misconduct is the most common offence aligns with the findings of previous studies of medical practitioners. The Elkin study found the primary issues in medical practitioner cases were sexual misconduct (24% of cases), illegal or unethical prescribing (21%) and inappropriate medical care (20%). This is consistent with a much smaller and earlier study in NSW by Kiel that found that the most common reasons for doctors being deregistered involved inappropriate prescribing and sexual misconduct.[25] Similarly, a more recent study by Kiel, found that between 1 July 2010 and 1 July 2013, 128 Australian doctors had findings of unprofessional conduct

[21] See S Bird, "Managing Professional Boundaries" (2013) 42 *Australian Family Physician* 666, where she describes the wide range of behaviours that may be included within "boundary issues".

[22] See, eg *HCCC v Woods (No 1)* [2012] NSWHCT 2; *HCCC v Woods (No 2)* [2013] NSWCHT 2.

[23] For example, a "boundary violation" case where there was no apparent sexual misconduct, but the behaviour, such as frequently ringing the patient, inviting her on outings and having her stay in the practitioner's house could be read as on the "slippery slope" to more dangerous, possible sexual, boundary violations as in *CMRBV v Whiter (Occupational and Business Regulation)* [2012] VCAT 348. We classified this case as non-sexual misconduct towards the patient; importantly, however, the Tribunal recognised that the non-sexual boundary violations may still harm a patient by undermining the therapeutic process and could lead to exploitation.

[24] In one decision, *HCCC v Maher* [2013] NSWCHT 1, there were allegations of sexual misconduct, being inappropriate sexual contact with a male patient. However, the particulars were not established to the requisite standard of proof and the grounds of unsatisfactory professional conduct were found in relation to inadequate record keeping, inadequate information and lack of informed consent. Hence we have categorised the decision under the main head of misconduct of inadequate records.

[25] H Kiel, *Doctors in Disgrace: Issues and Criteria in the De-registration and Re-registration of Doctors in New South Wales* (LLM Honours Dissertation, University of Sydney 2000), cited in Kiel, n 15, 430. Similarly, Kiel n 6, found that between 1 July 2010 and 1 July 2013, 128 Australian doctors had findings of unprofessional conduct or professional misconduct made against them and, "the most common form of misconduct involved sexual misconduct and then inappropriate medical care. Inappropriate prescribing was also common".

or professional misconduct made against them, and "the most common category of misconduct was sexual misconduct, of which there were 34 such cases".[26] This appears to be similar to other studies of health practitioners. Wardle examined prohibition orders and public statements by the NSW HCCC relating to unregistered health practitioners during the years 2008-2014.[27] He also found that sexual misconduct was the most common category of misconduct. Notably 31% (10 of 32) of the CM cases involved inappropriate medical care.

Gender of Practitioner

Of the CM cases examined, only 12.5% (4 out of 32) of the disciplined practitioners were women, with 87.5% being male practitioners.[28]

These findings are strikingly similar to studies concerning established complaints against doctors.[29] In the Elkin study of tribunal outcomes only 9% of the doctors were female. In Kiel's more recent study, less than 15% of the disciplined doctors were women.[30] Elkin et al state that "the standard explanation [for this gender differential] is that female doctors tend to display more of the attributes that 'underpin a good doctor-patient relationship' leading to fewer complaints against women doctors and reduced exposure to disciplinary processes".[31] We note that the high level of sexual misconduct complaints, and close correlation with male practitioners of this kind of misconduct, may also explain the overall gender disparity.

Outcomes and Protective Orders

Once a complaint is proven and before any determination is made about appropriate protective orders, the tribunal will consider whether the conduct is unprofessional[32] or amounts to misconduct. The tribunal may consider a range of protective orders when a complaint is proved. These protective orders are not intended to be punitive but rather to protect the public.[33] Orders may include conditions such as mentoring, training or restricted practice, a reprimand, caution, suspension or cancellation of registration.

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[26] Kiel, n 6, 227.

[27] Wardle, n 8, 364.

[28] All four of the disciplined female practitioners were Chinese medicine practitioners. This is not because Chinese medicine has a higher percentage of female practitioners than the other CM disciplines as there are very similar proportions of female osteopaths as there are Chinese medicine practitioners. See AHPRA, *Annual Report 2013/14* (2014) 246-247, Table A6: in 2014, 53% of Chinese medicine practitioners were female; 53% of osteopaths were female. By comparison, the chiropractic profession remains more male dominated: 37% of chiropractors were female in the most recent figures. See further M Leach, "Profile of the complementary and alternative workforce across Australia, New Zealand, Canada, United States and United Kingdom" (2013) 21(4) *Complementary Therapies in Medicine* 364.

[29] Unwin et al note that overrepresentation of male medical practitioners in disciplinary proceedings is replicated by studies across the rest of world. See E Unwin et al, "Disciplined Doctors: Does the Sex of a Doctor Matter? A Cross-Sectional Study Examining the Association Between a Doctor's Sex and Receiving Sanctions Against Their Medical Registration" (2014) *BMJ Open*, fns 4, 6-11 <http://bmjopen.bmj.com>. However, this should be compared with studies of health practitioners where the workforce is female dominated, such as nurses: see, eg Surgenor et al, n 6, 246.

[30] Kiel, n 6, 120.

[31] Elkin et al, n 5, 454.

[32] In NSW referred to as unsatisfactory professional conduct: *Health Practitioner Regulation National Law 2009* (NSW) s 139B.

[33] Ian Freckelton has noted: "On the one hand it is accepted that disciplinary tribunals must not punish. However, they can dispense sanctions (including substantial fines) that are perceived by practitioners as punishment so long as tribunals do so avowedly to protect the public by deterring the practitioner from like conduct or to discourage other practitioners from comparable conduct." See I Freckelton, "Regulation of Health Practitioners: Grappling with Temptations and Transgressions" (2004) 11 JLM 401, 407.

Elkin et al found that 43% of the 485 tribunal cases they examined involving doctors resulted in the removal of the doctor from practice: two-thirds effected this by deregistration and one-third through a time-limited suspension of registration.[34] In 37% of cases, there were restrictions on practice and in 19% non-restrictive sanctions.[35]

By comparison, in the 32 cases against CM practitioners between 2010 and 2016, 72% of cases (23 of 32) resulted in removal of the practitioner from practice, with a fairly even split of deregistration (13 cases) versus suspension (10 cases). Of the CM cases, a further 22% of orders involved restrictions on practice and 6% resulted in non-restrictive sanctions (see Table 2).

TABLE 2 Disciplinary measures imposed

	n (%)
Removal from practice[*]	23 (71.88)
– Deregistration	10[#]
– Suspension	13
Restrictions on practice	7 (21.88)
– Education program	3
– Counselling	0
– Supervision	4
– Other conditions	5
Non-restrictive sanction	2 (6.25)[§]
– Reprimand	2
– Fine	1
– Costs	0

[*] Parent categories of disciplinary measures (removal from practice, restrictions on practice and non-restrictive sanctions) were mutually exclusive with overlaps resolved according to a hierarchy that follows the descending order of parent categories shown. Within parent categories, subcategories were not mutually exclusive at the case level.
[#] The deregistration figures include three cases where the practitioner was no longer registered but the tribunal ordered that the practitioner be prohibited from reapplying for period of time.
[§] The non-restrictive sanction figures include one case in which both a reprimand and a fine were ordered.

Although the pool of cases in question is much smaller, the figure of 72% of CM practitioners being removed from practice is significantly higher than either the Elkin or the Kiel studies of cases involving doctors. With only a small data set and outcomes of cases over different time periods to compare, the causes of this apparent differential must necessarily remain speculative.

In another article addressing discipline at professional board level, we suggested that a finding of apparently strict responses by professional boards to CM practitioners could arise from the desire of peer regulatory bodies to set high standards for the newly regulated practice areas of CM.[36] However such an explanation is less likely to be applicable at generalist disciplinary tribunal stage. Another

[34] This was similar in the Kiel study. Kiel found removal from practice in 40% of cases: with deregistration in 23% of matters and suspension in 17 % of cases. In Kiel's study, the most common protective order was the imposition of conditions upon a doctor's registration in 44% of cases. See Kiel, n 6, 132.

[35] K Elkin et al, "Removal of Doctors from Practice for Professional Misconduct in Australia and New Zealand" (2012) 21 BMJ 1027, 1030. It should be noted that Elkin et al were not only considering the main conduct at issue in that article.

[36] Sibbritt et al, n 3.

possible explanation for disparities in outcomes could be that medical practitioners tend to have higher levels of legal representation compared to other practitioners.[37]

Elkin has observed that there is a public interest in the rehabilitation of doctors (in order to keep them in practice) that does not exist to the same extent for other professionals whose high skills and scarcity of skills may be less valued by regulators, or less in demand by the public (eg lawyers).[38] In NSW, jurisprudence on the role of "protective orders" sometimes explicitly refers to the interest of the public in having access to the special skills of the practitioner as a dimension of protecting the health and safety of the public.[39] In the case of CM practitioners, it is possible there may not be the same level of public interest or the notion of investment by the community in their training and skills in comparison with doctors. This is part of an interesting debate about whether "high status" health professionals are generally sanctioned more or less severely than "low status" health professionals (such as nurses and CM professionals). For example, Surgenor et al, found that in New Zealand, "[n]urses were significantly more likely to be deregistered when compared with medical practitioners".[40] Further work is needed to illuminate factors involved in removal rates across all health practitioner groups in Australia, in order to place these established, but outdated, findings about medical practitioners and our initial recent findings about CM practitioners in the broader contemporary context of the National Law.

Removal from Practice Rates, By Case Characteristics

The removal from practice rate (including both deregistration and suspension), in relation to the main type of misconduct, is presented in Table 3.

TABLE 3 Types of misconduct and removal rates

Types of misconduct	Cases, n (% of all cases)	Cases resulting in removal from practice, n (category %)
Sexual misconduct towards patient – relationship with patient	5 (15.63)	4 (80.0)
Sexual misconduct towards patient – inappropriate sexual contact	6 (18.75)	6 (100.0)
Inappropriate medical care – treatment (inappropriate or inadequate and failure to refer)	10 (31.25)	8 (80.0)
Inappropriate medical care – diagnosis (missed, delayed or incorrect)	0 (0)	0 (0)
Misconduct not in relation to patient – inappropriate conduct not in relation to patient	2 (6.25)	1 (50.0)
Misconduct not in relation to patient – criminal offence	1 (3.13)	0 (0)
Other misconduct – non-sexual misconduct towards patient	1 (3.13)	0 (0)
Other misconduct – failure to obtain informed consent	0 (0)	0 (0)
Other misconduct – breach of privacy	0 (0)	0 (0)
Other misconduct – inadequate or inappropriate medical certificates or records	4 (12.5)	2 (50.0)

[37] Surgenor et al, n 6, 250, found that in New Zealand disciplinary cases medical practitioners were far more likely to have legal representation than nurses.

[38] Elkin (2014), n 6.

[39] See, eg *HCCC v King* [2013] NSWMT 9, [26]-[27]; *Re Parajuli* [2010] NSWMT 3, [32].

[40] Surgenor et al, n 6, 250.

TABLE 3 *continued*

Types of misconduct	Cases, n (% of all cases)	Cases resulting in removal from practice, n (category %)
Other misconduct – breach of registration conditions	3 (9.38)	2 (66.67)
Illegal or unethical prescribing	0 (0)	0 (0)

Elkin et al found that "the odds of removal [for doctors] were very high in cases involving sexual relationships with patients (81%) and moderately high in cases involving inappropriate sexual conduct (53%), commission of criminal offences, and forms of inappropriate conduct unrelated to patients".[41] In the cases involving CM practitioners, we observed high levels of removal rates for most types of misconduct: 80% for sexual relationship with patient; 100% for inappropriate sexual contact; and 80% for inadequate treatment. Generally the rates of removal for misconduct in relation to this small number of CM practitioners are higher than in relation to doctors, except misconduct involving a sexual relationship with a patient where the rate is very similar. In contrast to Elkin et al, we found that there was a higher rate of removal of CM practitioners for inappropriate sexual contact with a patient than for having a sexual relationship with a patient.

Analysis of Most Common Types of Misconduct among CM Practitioners

All the case reports were examined in detail to determine what issues the tribunals considered most important in relation to removal from practice. Details of some of the cases, in relation to the most common types of misconduct, are provided below. The attitude of the practitioner in relation to the investigation by the relevant board and in response to the allegations was frequently mentioned as central to the tribunal's decision about orders. This was particularly so in sexual misconduct cases, where the tribunal usually commented on the practitioner's remorse or lack thereof, lack of insight into the impact of their behaviour and commitment to change behaviours. Elkin et al suggested that:

> Tribunals in Australia … tend to remove doctors from practice for behaviours indicative of character flaws and lack of insight, *rather than* behaviours exhibiting errors in care delivery, poor clinical judgement or lack of knowledge.[42]

We suggest that this conclusion might be better expressed as *in addition to*, not *rather than*. In cases involving sexual misconduct in CM, other failures of care were often regarded as secondary, but were present as related or incidental findings. Lack of insight in cases of removal from practice also properly reflects the protective and forward-looking nature of the jurisdiction, in which the risk of recurrence must be considered specifically in relation to the practitioner but also more generally in relation to deterrence of like conduct in the profession, to setting standards of professionalism and maintaining the confidence of the public.[43]

Sexual Misconduct

Manning has suggested that there are three distinct kinds of sexual misconduct: romantic attachment cases where an ongoing relationship develops between the practitioner and the patient; "exploitation" cases where the practitioner is in a position of dominance and exploits a vulnerable patient in a temporary or situational sexual relationship; and sexual or indecent assault cases where there is no

[41] Elkin et al, n 35, 1030.

[42] Elkin et al, n 35, 1027 (emphasis added).

[43] *HCCC v Do* [2014] NSWCA 307, [35].

consent to the sexual contact (which may often occur under a pretext of clinical care).[44] The Elkin typology puts the first two categories under the one heading of "Relationship with the Patient". In our analysis here we have done the same, given that any sexual relationship between a practitioner and patient is a clear breach of professional boundaries, potentially exploitative and likely to compromise the standard of care to the patient. However, it is possible that close and comparative analysis of such cases may reveal a different approach to orders when the relationship between patient and practitioner is ongoing at the time of hearing, or regarded as equal in terms of power relations. We have placed the assault cases under the heading of "inappropriate sexual contact" noting that the physical violation of the patient is at the forefront of these decisions.

The tribunal decisions we examined emphasise that CM practitioners should be held to the same standards in relation to sexual relationships with patients as other health practitioners. In the case of *CMRBV v Antoniades*,[45] the Tribunal cited the case of *Wilks v Medical Practitioners Board (Vic)*[46] when explaining why sexual relationships between practitioners and patients were always inappropriate:

> Medical practitioners are placed in a position of trust in the community and have available to them intimate knowledge of their patients' physical and psychological wellbeing. This places the practitioner in a position to exploit the trust that has been given to them. The community expects that when they attend a medical practitioner, they will not be regarded as potential sexual parties nor that their relationship with the doctor will be sexualised. Likewise the profession expects its members to refrain from using the consulting room as a means of establishing sexual relationships with patients. To do otherwise brings the profession into disrepute by reducing the trust that the community has in the profession.[47]

The Tribunal commented that "[a]lthough these observations were made in the context of misconduct by a medical practitioner, they are equally apposite to the conduct of a Chinese Medicine practitioner".[48] Similar comments are made in cases brought against practitioners from other complementary health professions. Indeed, in the NSW case of *HCCC v Brush*,[49] the Tribunal pointed out that the Code of Conduct was the same for all registered health professionals.[50]

Sexual Relationship with Patient

In cases of a practitioner having a sexual relationship with a patient, an assessment of the extent of the power imbalance, the nature of the sexual relationship, the patient's vulnerability and the practitioner's insight into the conduct were identified as key issues in the tribunals' decision-making, particularly in relation to the decision whether to suspend or cancel registration. In one case, the Tribunal, while finding that the dating and sexual relationship of a female Chinese medicine practitioner with her patient was inappropriate, made explicit findings that it was consensual and did not involve actual exploitation of the patient.[51] The Tribunal made a finding of professional misconduct but reprimanded the practitioner and ordered her to continue a mentoring arrangement for eight months. By way of comparison, in *CMRBV v Antoniades*, a male Chinese medicine practitioner engaged in a sexual relationship with a patient. The Tribunal noted that the patient had previously disclosed to the practitioner matters of intimate personal history and emotional significance that made her particularly

[44] J Manning, "Changing Disciplinary Responses to Sexual Misconduct by Health Practitioners in New Zealand" (2014) 21 JLM 508.

[45] *CMRBV v Antoniades (Occupational and Business Regulation)* [2010] VCAT 2132.

[46] *Wilks v Medical Practitioners Board (Vic)* [2007] VCAT 2439, [156]-[157].

[47] *CMRBV v Antoniades (Occupational and Business Regulation)* [2010] VCAT 2132, [26].

[48] *CMRBV v Antoniades (Occupational and Business Regulation)* [2010] VCAT 2132, [28].

[49] *HCCC v Brush* [2015] NSWCATOD 120.

[50] This Code has been developed by most national boards under s 39 of the National Law, as in force in each State and Territory. Section 8.2 of the Code deals with "professional boundaries".

[51] *CMBA v Russo (Review and Regulation)* [2015] VCAT 2024.

vulnerable. When the patient became concerned that Antoniades was developing a sexual attraction to her he dismissed this concern and refused her request for referral to another practitioner. The patient refused sexual advances, but eventually a sexual relationship did develop. The Tribunal stated that:

> the conduct in pursuing the sexual relationship, and the personal and social relationship which accompanied it was selfish, opportunistic and persistent. It put Mr Antoniades' interests in sexual gratification ahead of his professional responsibilities and obligations.[52]

The Tribunal further noted that "there was nothing … to indicate any appreciation of the harm which can be caused to a vulnerable patient" by such misconduct.[53]

Antoniades maintained his denial of any of the allegations until the first morning of the hearing, portraying himself as the victim of an unsolicited and unwelcome advance from the patient. He also had stated that he did not recall ever reading any board communication that seeing a patient socially was prohibited. The case illustrates that failure to refer or appropriately treat a patient may be a flow-on effect of an improper relationship. In that case, the Tribunal suspended registration for two years, together with a reprimand and a requirement to undertake ethics training and education.

A similar lack of appreciation of the impact of misconduct by a CM practitioner is seen in the case of *HCCC v Ryken*,[54] where the Tribunal noted that the "respondent [chiropractor] appeared to be remorseful, but it was not clear to the Tribunal that he genuinely now had insight into his conduct". The practitioner had engaged in a sexual relationship with one patient plus inappropriate relationships with two other patients including kissing those patients, engaging in intimate Facebook and text exchanges, and visiting their homes. The Tribunal suspended Ryken's registration for six months and added conditions on practice for the 18 months after suspension including working in a group practice and professional mentoring.

An order cancelling the registration of an osteopath was made by the Tribunal in the NSW case of *HCCC v Brush*. The practitioner was also disqualified from reapplying for registration for 18 months, and a prohibition order was made preventing him from working in the related fields of massage therapies or any alternative or healing therapy. Brush had entered into a sexual relationship with a patient. He had failed to refer her for psychological treatment when she threatened to overdose on pain medication. He continued both the treatment and the sexual relationship for several months even after forming the view that his patient was "unstable".[55] The Tribunal, in deciding that the sexual misconduct was sufficient to warrant cancellation of Brush's registration, noted the vulnerability of the patient with whom Brush had the relationship, the fact that Brush was aware of that vulnerability and that his submissions in relation to the proceedings revealed "a breathtaking lack of insight".[56] While the Tribunal accepted that he regretted the relationship, it commented:

> it is difficult not to conclude that the reputational and associated harm he has suffered is the main reason he regrets his actions. Mr Brush's evidence does not leave us with a sense of reassurance that he now recognises the impropriety of engaging in a sexual relationship with a patient, particularly one whom he believed to be "unbalanced". The comment the "hunter has become the hunted" suggests that Mr Brush feels aggrieved by the making of the complaint and its subsequent investigation and prosecution. This suggests he lacks a real understanding of the extent to which his actions transgress the standards that apply to his profession.[57]

Inappropriate Sexual Contact

Cases of inappropriate sexual contact encompass a wide range of inappropriate sexual conduct towards a patient where there is otherwise no sexual relationship between the practitioner and the patient. They fall within a range of indecent behaviours and sexual assault that could be considered

[52] *CMRBV v Antoniades (Occupational and Business Regulation)* [2010] VCAT 2132, [25].

[53] *CMRBV v Antoniades (Occupational and Business Regulation)* [2010] VCAT 2132, [45].

[54] *HCCC v Ryken* [2016] NSWCATOD 58, [69].

[55] *HCCC v Brush* [2015] NSWCATOD 120, [33].

[56] *HCCC v Brush* [2015] NSWCATOD 120, [89].

[57] *HCCC v Brush* [2015] NSWCATOD 120, [89].

criminal behaviour. Further research into the practical application of regulatory restrictions in this area is required to investigate how many CM practitioner cases were also prosecuted criminally and to place this data in context with doctors and other health practitioners.

There were a number of cases where the tribunal cancelled the registration of the practitioner and imposed a temporal period before an application for reregistration could be made. The longest such period was imposed in the case of *HCCC v Black*.[58] The practitioner had assaulted and committed acts of indecency on four female patients, including a 12-year-old girl, through an escalating pattern of clinically unjustified intimate touching. In making its decision, the Tribunal noted the breach of Osteopathy Council conditions on practice made after previous disciplinary proceedings, the particular vulnerability of the patients involved in this case, the grooming behaviour of the boundary violations, the pattern of repeating behaviour, the serious nature of the assaults and the attitude of Black who described himself as "peerless" and believed himself "superior in every way to all other osteopaths (and chiropractors)".[59] The Tribunal commented:

> Whilst the imbalance of power that exists between a patient and a treating practitioner creates a vulnerability in the patient, the female patients involved in this matter each had additional factors that escalated this vulnerability – for example as a result of being of tender years or suffering significant pain. The evidence before the Tribunal recorded that the Respondent engaged in what is generally described in a wider setting as "grooming" behaviour or in writings regarding professional settings as "slippery slope" behaviour where boundary violations escalated over time. These violations included inappropriate comments and touching. A common complaint made by patients was the inappropriate removal of underpants and touching in the genital region.[60]

The Tribunal made a raft of protective orders: disqualifying Black from reapplying for registration as an osteopath for 10 years and prohibiting Black from providing all health services. In its protective orders, the Tribunal expressly prohibited Black from providing in "any manner massage therapy and/or naprapathic[61] services".[62] The Tribunal clarified that the prohibition order included any services, whether paid or unpaid, where the Respondent touched a patient or instructed or supervised any other person to provide health services.

Inappropriate Medical Care

The number of cases involved in this category of inappropriate medical care was almost as high as in the sexual misconduct category. We included failure to refer to a conventional medical practitioner or hospital, or to call an ambulance, under this parent category.

Inadequate or Inappropriate Treatment

This category includes cases where the patient was "over-treated" by ineffective treatment, particularly when it was, or should have been, obvious that the treatment was not improving the patient's condition and also cases where the treatment itself was inappropriate and/or dangerous. Additionally, the conduct of the practitioner may have been "predatory and deliberately exploitative" or sometimes misconceived on the part of a practitioner who "regard[ed] themselves as medical pioneers".[63] Thus this category includes deliberate and misguided or incompetent overservicing or sale of products that offered no clinical benefit (but caused no danger to heath per se) and cases that involved the provision of treatments that were actually dangerous to health. Failures to refer to another practitioner for clinically necessary treatment may be regarded as related, in the sense that the provision of

[58] *HCCC v Black* [2014] NSWCATOD 35; *HCCC v Black (No 2)* [2015] NSWCATOD 5; *HCCC v Black (No 3)* [2015] NSWCATOD 72.

[59] *HCCC v Black (No 3)* [2015] NSWCATOD 72, [70], [92].

[60] *HCCC v Black (No 2)* [2015] NSWCATOD 5, [7].

[61] "Definition of Naprapathy: a system of treatment by manipulation of connective tissue and adjoining structures and by dietary measures that is held to facilitate the recuperative and regenerative processes of the body". See <http://www.merriam-webster.com/dictionary/naprapathy>.

[62] *HCCC v Black (No 3)* [2015] NSWCATOD 72, Order 4.

[63] Freckelton, n 2, 645.

non-harmful treatments may be a factor in deterring patients from seeking other, necessary care, but the issue of failure to refer is dealt with under a separate heading below.

In the case of *CMBA v Mei*,[64] the patient was an elderly woman with post-stroke symptoms of severe incapacitation. Mei treated her on 46-48 occasions in the space of four months with little sign of improvement in patient's treatment. The practitioner did not review the treatment plan in light of limited effects of treatment and continued to provide acupuncture treatment two to three times per week and to prescribe Chinese herbs in circumstances where the treatment could no longer be clinically justified. The Tribunal reprimanded and cautioned the practitioner, fined her and put conditions on her registration in relation to auditing and mentoring. While we found that fines were a relatively uncommon outcome of proceedings, this case involved a significant fine of $15,000. It is interesting that this arose in a case involving overservicing. The Tribunal stated that the fine was intended to deter the practitioner from breaching her obligations as a health professional in future as well as act as a means of general deterrence for other health professionals.

In *Chiropractic Board of Australia v Hooper*,[65] the practitioner had provided a patient with cerebral palsy with a long course of hyperbaric oxygen treatment (HBOT) and Lokomat treatment,[66] costing approximately $50,000 without making a proper assessment of the patient before embarking on the treatment. He had also misrepresented the likely efficacy of treatment and failed to monitor or evaluate any measurable improvement in the patient's condition or his suitability for stem cell therapy. Further, the advertising in relation to such treatment was misleading and deceptive about the effectiveness of the treatment. The Tribunal made orders cancelling Hooper's registration and disqualified him from applying for reregistration for two years. When determining the orders, the Tribunal stated that "the public cannot be protected with anything less than a cancellation" given Hooper's lack of insight into his wrongdoing as the practitioner was "unable or unwilling to acknowledge that he was out of step with those with much greater knowledge and experience in the field of hyperbaric oxygen treatment". The case is reputed to be the longest disciplinary hearing in Australia, other than that involving Dr William McBride, and involved the detailed weighing of orthodox clinical assessment of the medico-scientific status of HBOT for cerebral palsy with Hooper's strongly held beliefs, anecdotal evidence and testimonies.[67] Interestingly, the Tribunal did not grant a prohibition order on Hooper providing HBOT during the cancellation period despite an application for such by the Chiropractic Board.[68]

Inadequate treatment might include the failure to communicate to the patient about the likely efficacy of the treatment. In *CMBA v Teo*,[69] the Chinese medicine practitioner did not take steps to communicate that she could not cure the condition and the patient formed the view that "she would die young of cancer if she stopped being treated by the respondent". Here the Tribunal suspended

[64] *CMBA v Mei (Occupational and Business Regulation)* [2012] VCAT 1875.

[65] *Chiropractic Board of Australia v Hooper (Occupational and Business Regulation)* [2011] VCAT 641; *Chiropractic Board of Australia v Hooper (Occupational and Business Regulation)* [2011] VCAT 2400; *Chiropractic Board of Australia v Hooper (Occupational and Business Regulation)* [2012] VCAT 1042; *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 236; *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 878; *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 1346.

[66] A Lokomat machine is a robotic walking device which supports the patient's body weight as the patient is harnessed into the Lokomat. The device moves the patient's legs through a normal gait cycle. See <https://www.hocoma.com/world/en/products/lokomat>.

[67] *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 1346, [20].

[68] In relation to more recent investigations involving Malcolm Hooper, see further <http://www.heraldsun.com.au/news/victoria/police-join-inquiry-into-south-yarra-hypermed-hyperbaric-death/news-story/cc2c852d8d7e54c193f127db4c27322c>; <http://www.dailymail.co.uk/news/article-3680934/South-Yarra-Chiropractor-involved-Essendon-doping-scandal-investigated-death-patient.html>

[69] *CMBA v Teo (Review and Regulation)* [2014] VCAT 1587.

Teo's registration as CM practitioner for three months, but noted that there was no power in Victoria to place limits on her practice as a naturopath during that time.[70]

Some of the cases revolve around what can only be described as the provision of extremely dangerous treatment as opposed to the provision of excessive but ineffective treatment. If the Tribunal considered the treatment sufficiently dangerous, the practitioner's registration was suspended or cancelled. For example, in the case of *Burton v Osteopathy Council of NSW*,[71] Mr Burton was appealing the decision of the Osteopathy Council of NSW decision to suspend his registration pursuant to s 150 of the National Law. The appeal was dismissed by the Tribunal. Burton had instructed a live-in patient at his health centre, who was suffering from chronic fatigue syndrome, to undertake a prolonged water-only fasting program. Burton claimed that he measured his patients' recovery and wellbeing by assessing anal and drinking reflexes. The Council did not understand the clinical significance of the tests, and were unconvinced by Burton's claims. There did not appear to have been any osteopathic manual therapy performed on the patient despite billing for such treatment for 25 days.[72]

CMRBV v Ghaffurian[73] involved a Chinese medicine practitioner who misrepresented his qualifications by letting patients believe he was a conventional medical practitioner. The practitioner told a patient suffering from sarcoidosis that "he could cure anything"[74] and gave injections to the patient that were not within the scope of his Chinese medicine practice including: undiluted vitamin C injections, light therapy, treatment for toxicity using a "bioresonance machine" and offering her stem cell injections from sheep and cattle. The Tribunal noted that there was:

> no published, evidence-based literature in peer reviewed scholarly journals which assess the [light therapy machine and/or bioresonance machines'] therapeutic or scientific effectiveness in treating or detecting any diseases in humans.[75]

The Tribunal cancelled Ghaffurian's registration and disqualified him from applying for three years and commented that this was necessary to protect the public due to "Mr Ghaffurian's demeanour when giving evidence before us, his apparent lack of insight into the gravity of his conduct and his unreliability as a witness" indicating little prospect that his behaviour would change.[76]

Failure to Refer to a Medical Practitioner or Hospital

Often what health practitioners do not do is of more consequence than what they do. A key risk associated with any health profession is the risk of omission caused by the failure to appropriately refer to another medical practitioner.[77] Inappropriate monopolisation of care can constitute unprofessional conduct. This is particularly important for CM practitioners who may not have diagnostic skills[78] or qualifications, or may possibly have an ideological opposition to conventional medicine. These cases can overlap with cases of excessive treatment in that the practitioner does not stop treating the patient when it should have been evident that the patient was not responding to the

[70] In NSW, this power would be available under s 149C(5) of the *Health Practitioner Regulation National Law* (NSW). This case is an interesting example of the power of the safety net capacity of negative licensing regimes, currently available in NSW, South Australia and Queensland. See Wardle, n 8.

[71] *Burton v Osteopathy Council of NSW* [2015] NSWCATOD 150.

[72] *Burton v Osteopathy Council of NSW* [2015] NSWCATOD 150, [76]. "Fasting and resting" treatments are still offered at Arcadia Health Centre, despite the death of Dr Burton. See <http://www.arcadiahealthcentre.com.au>.

[73] *CMRBV v Ghaffurian (Occupational and Business Regulation)* [2012] VCAT 478; *CMBA v Ghaffurian (No 2) (Occupational and Business Regulation)* [2012] VCAT 1944.

[74] *CMRBV v Ghaffurian (Occupational and Business Regulation)* [2012] VCAT 478, [14].

[75] *CMRBV v Ghaffurian (Occupational and Business Regulation)* [2012] VCAT 478, [40].

[76] *CMBA v Ghaffurian (No 2) (Occupational and Business Regulation)* [2012] VCAT 1944, [43].

[77] J Wardle, "The National Registration and Accreditation Scheme: What Would Inclusion Mean for Naturopathy and Western Herbal Medicine? Part II: Practice Implications" (2011) 23 *Australian Journal of Medical Herbalism* 18, 21.

[78] Or who may have a diagnostic paradigm that does not align with conventional medical theory and practice.

particular treatment, and a referral to a conventional medical practitioner should have been made. However, in one of the cases,[79] the failure was literally a failure to call emergency services when a patient undergoing chiropractic treatment began convulsing and lost consciousness. The delay deprived the patient of resuscitative medical care that might have prevented his death from cardiac arrest later in hospital.

A case of continuing to treat when it should have been evident that a referral should have been made is *CMBA v Lim*,[80] where the patient "repeatedly presented" to the practitioner with rectal bleeding, excessive bowel movements, haemorrhoids, stomach pain and warm feet. The practitioner conceded that he should have referred to a medical practitioner or hospital for further investigation of the bowel condition.

CONCLUSION

In this pool of 32 cases concerning osteopaths, chiropractors and Chinese medicine practitioners, we found very low tolerance for any sexual misconduct, but also strict standards in relation to inadequate delivery of care and treatment. Qualitative analysis of the decisions showed that tribunals were influenced in their decision to cancel or suspend registration by a practitioner demonstrating a lack of insight into their misconduct.[81] Mendelson has argued that cancellation or suspension in such cases may assist the practitioner from repeating behaviour by "facilitating their insight into the causes and consequences of their misconduct".[82] Determinations in disciplinary matters should protect the public, deter the individual and others, maintain professional standards and are not to punish practitioners.[83] However, protective orders can be punitive in effect, particularly when the practitioner is deregistered, suspended or fined.[84] Punitive consequences are justified if removal protects the public and also gives the practitioner opportunity to gain insight into their misconduct.

Although the case set under examination is small, this article presents findings from the first six years of tribunal determinations for misconduct of CM practitioners under the National Law in Australia. We found some clear similarities between disciplinary outcomes concerning CM practitioners and those from previous much larger studies concerning medical practitioners. In particular, such similarity exists in relation to the gender of the practitioners and the most common types of misconduct. However, we found that rates of removal from practice either by suspension or cancellation of registration of CM practitioners were significantly higher than in earlier reported studies of medical practitioners. This area requires more detailed research, addressing removal rates and types of misconduct across all the health professions to ensure consistency of approach. While tentative, our findings confirm a pressing need for further research into the regulation of CM practitioners within the context of the National Law.

[79] *Chiropractic and Osteopathy Board of South Australia v Forte* [2012] SAHPT 2.

[80] *CMBA v Lim (Occupational and Business Regulation)* [2012] VCAT 1614, [77].

[81] See in particular the cases: *HCCC v Black* [2014] NSWCATOD 35; *HCCC v Black (No 2)* [2015] NSWCATOD 5; *HCCC v Black (No 3)* [2015] NSWCATOD 72; *HCCC v Woods (No 1)* [2012] NSWHCT 2; *HCCC v Woods (No 2)* [2013] NSWCHT 2; *HCCC v Ryken* [2016] NSWCATOD 58; *HCCC v Brush* [2015] NSWCATOD 120; *Chiropractic Board of Australia v Hooper (Occupational and Business Regulation)* [2011] VCAT 641; *Chiropractic Board of Australia v Hooper (Occupational and Business Regulation)* [2011] VCAT 2400; *Chiropractic Board of Australia v Hooper (Occupational and Business Regulation)* [2012] VCAT 1042; *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 236; *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 878; *Chiropractic Board of Australia v Hooper (Review and Regulation)* [2013] VCAT 1346.

[82] Mendelson, n 6, 264.

[83] National Law, s 3(2)(a). In NSW and Queensland, the health and safety of the public are the "paramount" consideration: see *Health Practitioner Regulation Act 2009* (NSW) s 3A; *Health Ombudsman Act 2013* (Qld) s 4(1).

[84] Elkin (2014), n 6, 693.