Health impairment and conduct: a review of key cases

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A. INTRODUCTION

The Medical Board of Australia ('**Board**') has broad powers which it may exercise when a medical practitioner practices whilst impaired.

Having regard to this context, I have undertaken a review of cases that deal with how the Tribunals and Courts have dealt with medical practitioners who are impaired and the factors that have been considered when determining what an appropriate sanction ought to be in those circumstances.

In exploring this topic this paper firstly sets out in summary form the legislative scheme of the Health Practitioner Regulation National Law (**National Law**) as it applies to impairments for health practitioners. The various mechanisms of dealing with conduct or issues arising out of an impairment are briefly discussed. Secondly, a review of key cases is undertaken with a focus on identifying the factors that the Tribunals and Courts consider when coming to an appropriate determination. Finally, having regard to the cases and the legislative scheme, concluding observations about the matters arising out of the cases are made.

B. LEGISLATIVE SCHEME - HEALTH PRACTIONER REGULATION NATIONAL LAW

Key definitions

There are key definitions that are important to have regard to when considering the provisions of the National Law in the context of impairments.

The first definition to consider is the actual definition of an impairment which is set out in Section 5 of the National Law, which defines an impairment as follows:

> *"**impairment**, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect —*
>
> *(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or*
>
> *(b) for a student, the student's capacity to undertake clinical training —*
>
> - *(i) as part of the approved program of study in which the student is enrolled; or*
> - *(ii) arranged by an education provider."*

Having regard to the definition of an impairment, it is relevant to observe that the definition of impairment is wide, and encapsulates a number of physical, mental, and cognitive matters which might go to a person's capacity to practice in the profession.

The definitions of unprofessional conduct and professional misconduct are also necessary to observe in the context of the definition of impairment set out above. They are set out in section 5 of the National Law as follows:

> ***professional misconduct**, of a registered health practitioner, includes—*
>
> *(a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and*
>
> *(b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and*

(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

***unprofessional conduct**, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes—*

(a) contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and
(b) a contravention by the practitioner of—
(i) a condition to which the practitioner's registration was subject; or
(ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and
(c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession; and
(d) providing a person with health services of a kind that are excessive, unnecessary, or otherwise not reasonably required for the person's well-being; and
(e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and
(f) accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider; and
(g) offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner; and
(h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

It is relevant to observe that professional misconduct involves a *substantial* departure from the standards expected of a medical practitioner. This is to be contrasted with the standard of conduct required to trigger a finding of unprofessional conduct, which having regard to the definition above involves conduct of a *lesser* standard expected of that medical practitioner.

It is also of note that definitions of professional misconduct and unprofessional conduct are interrelated. Specifically, multiple instances of unprofessional conduct may give rise to professional misconduct and both definitions are inclusive rather than exhaustive definitions. These characteristics of the definitions allow the National Law to capture a broad range of conduct for the purpose of regulating medical practitioners.

Processes under the National Law

Notifications

Having regard to the key definitions above, it is relevant to understand the ways in which an impairment might come to the attention of the regulator. Usually, an impairment of a practitioner is likely to come to the attention of a regulator by way of a notification.

A notification may be made to AHPRA either verbally or in writing and must include particulars of the basis on which it is made. In cases involving an impairment, it not unusual to have details

which suggest an impairment along with some aspect of inappropriate conduct which has given rise to the concern raised by the notifier.

There are two types of notifications that can be made, voluntary notifications and mandatory notifications.

Voluntary notifications

A voluntary notification may be made by anyone who believes that a ground for voluntary notification exists.

Section 144 of the National Law sets out a number of grounds for making a voluntary notification, relevantly:

> *"(1)(a) that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;*
>
> *…*
>
> *(d) that the practitioner has, or may have,* ***an impairment****;*

Usually, there will be a nexus between the conduct of the medical practitioner and the impairment which has given rise to, or contributed to, the conduct giving rise to the notification.

Mandatory notifications

There are also mandatory notifications which arise by reason of notifiable conduct. Section 140 of the National Law defines notifiable conduct in relation to a registered health practitioner as including:

….

(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment.

….

Whilst there are separate obligations on health practitioners, employers and education entities in relation to mandatory notifications, the thrust of the obligation is that each of these types of entities must report notifiable conduct to the regulator.

C. KEY CASES

Lindsay v Health Care Complaints Commission [2010] NSWCA 194

Lindsay concerned a medical practitioner who was the subject of six separate complaints. The complaints included threatening behaviour by Dr Lindsay towards colleagues, patients, and a member of the public, failing to keep proper records and failing to listen to patients.

Whilst there were a number of matters considered as part of this appeal, one of the issues specifically considered by the Tribunal was in relation to Dr Lindsay's mental impairment itself and of its possible conflation with his competency to practice.

The NSW Court of Appeal, in considering submissions that the Health Care Complaints Commission had confused the concept of an impairment with a practitioner's competency to practice, rejected that proposition and noted that the existence of an impairment of itself does not necessarily lead to the conclusion that a medical practitioner is unable to practice medicine.

Whether a medical practitioner lacks competence to practice in the profession will depend on considerations such as:

- the nature and likely duration of the impairment,
- the kind of practice carried on by the medical practitioner,
- the extent to which the impairment interferes with the practitioner's judgment;
- the communication skills and clinical ability of the medical practitioner, and
- any other relevant circumstances.

Ultimately Dr Lindsay's appeal against the decision of the Tribunal cancelling his registration was unsuccessful.

Observation: the existence of an impairment will not of itself mean that a medical practitioner is unable to practice medicine.

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

Tung concerned a medical practitioner with paranoid personality disorder who in the context of no clinical concerns, engaged in a pattern of behaviour which made it clear that the medical practitioner had difficulty in negotiating relatively straight forward inter-personal conflict, and which created difficulties for her when under stress.

The appeal by the medical practitioner was argued on five grounds, including that the Tribunal lacked the power of deregistration, the medical practitioner was not afforded procedural fairness, the Tribunal failed to give adequate reasons, the Tribunal failed to consider other remedies and an impairment was not open for a reasonable Tribunal to find.

In Tung's case, although the Court of Appeal accepted that Dr Tung was suffering from an impairment, it held that the Tribunal did not have power to make the deregistration order which it had when there were no clinical concerns raised in relation to Dr Tung. The reasoning for this was that although Dr Tung had experienced some communication issues with other staff, there had been no complaints made about her clinical care and that this did not itself give rise to a power to deregister her.

The Court of Appeal cited that the error that the Tribunal fell into at first instance was by looking into the future and forming the view that her impairment could affect her ability to practice medicine where there had been no present clinical concerns raised. Specifically, it was not open to the Tribunal to find that Dr Tung was not competent to practice medicine because there were no clinical concerns raised against her in the present time.

In this regard, the Court of Appeal opined that, whilst there is room for some futurity in the concept of competence to practice medicine, the practice of medicine itself can be seen as existing on a continuum. On one end of this continuum is a practitioner whose physical or mental deterioration will inevitably and soon make them incapable of practicing medicine and on the other end is the practitioner who is competent to practice with no issues. In Dr Tung's case, a likelihood of clinical concerns at an indefinite future time was not sufficient to establish lack of capacity to practice medicine.

Ultimately, the appeal against the findings relating to Dr Tung having an impairment was dismissed, but the matter was remitted to the Tribunal for re-consideration noting that the Tribunal did not have the initial power to make the de-registration order which it had originally made where there were no clinical concerns.

Observation: Competence to practice medicine exists in a continuum. Future concerns about competence to practice must be considered in light of present clinical concerns.

***Medical Board of Australia v Zebic (review and regulation*) [2015] VCAT 139**

Dr Zebic was found face down on the computer keyboard at her desk in her consulting room while at work. It appears Dr Zebic had been alone in the consulting room for approximately 30 minutes before being found. After being roused, she was initially disoriented and incoherent. She had left sided facial weakness.

Dr Zebic was suspended on 3 June 2010 after having been found in that state. It is noted that this suspension occurred in the context of previous suspensions for drug use in May 1999 following self-notification, February 2000 following self-notification, and in August 2004 for failure to comply with a urine screening protocol.

It was whilst serving a period of suspension for this matter that Dr Zebic failed to comply with drug testing conditions and forged prescriptions.

Both the Board and the solicitors for Dr Zebic submitted that she should be able to practice medicine but being subject to strict conditions. This was ultimately accepted by the Tribunal.

Relevantly it was submitted by both the Board and Dr Zebic that her health had improved to such a point that registration subject to conditions was appropriate.

In this regard, Professor Bruce Singh, a consultant psychiatrist, reported to the Medical Practitioners Board of Victoria that Dr Zebic had a complex history including suffering an eating disorder during adolescence and early adulthood, a diagnosis of schizophrenia and borderline personality disorder in the context of long standing narcotic abuse. In this context it was opined that it was likely Dr Zebic's use of narcotics caused the incident and this thereby affected her ability to practice medicine either because of her physical or mental health.

In considering how the determination powers should be exercised the Tribunal had regard to *Honey v Medical Practitioners Board (Vic) [2007] VCAT 526* at para 14 VCAT which states:

> *It is of prime importance in assessing the appropriate sanction that we bear in mind that the purpose of the determination is not to punish ... Our aim must be to protect the public, and we achieve that aim by imposing sanctions aimed at regulating professional performance of the particular individual under consideration and also by way of general deterrence to the profession as a whole.*

Having regard to the above, whilst finding that Dr Zebic engaged in professional misconduct, the Tribunal noted that they were are aware that neither the Board nor Dr Zebic was not guaranteeing an outcome but accepted the evidence that the negative consequences of the risk that Dr Zebic posed could be addressed through implementation of the strict conditions.

Observation: The purpose of imposing a sanction is not to punish a medical practitioner but to protect the public.

***Health Care Complaints Commission v McGregor* [2020] NSWCATOD 13**

Dr McGregor was a psychiatrist who graduated from the University of New South Wales in 1996 and was first registered as a medical practitioner in 1997. In 2015, he opened his practice at Northern Beaches Psychiatrist and Psychologist Family Medical Practice.

A colleague who practised in the same building as Dr McGregor complained to AHPRA about Dr McGregor's behaviour which including hiring a private detective to investigate him because Dr

McGregor thought that this colleague was having an affair with his wife. Dr McGregor had initially framed this complaint to the regulator as a '*mandatory notification*'.

The Board having had concerns about the nature of the complaint made by Dr McGregor and of potential mental health issues started an own motion investigation. As part of this investigation a blog on Dr McGregor's website was discovered; including an extract as follows:

> *When the infant torture, rape and satanic rites cannibalism by elites is provided by Trump on tape — seek the comfort of others.*

Despite Dr McGregor refusing to participate in any psychiatric assessment, the Tribunal found evidence to support a finding that Dr McGregor has a psychiatric impairment, disability, condition or disorder, these being 'impaired judgment, affective instability, a belligerent and ineffective approach to conflict resolution and a strong and public adherence to beliefs that are bizarre and possibly overvalued'.

In coming to its conclusion, the Tribunal relied upon expert evidence which found that Dr McGregor had impaired reality testing. In this regard the Tribunal opined that:

> *it is not necessary to identify a diagnosis in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM — 5) or otherwise. It is sufficient to note that we agree with Dr Wright that he has impaired reality testing.*

Having regard to its finding that Dr McGregor was impaired the Tribunal found that he did not have sufficient mental capacity to practise medicine. The persistence of impaired reality testing that leads to entrenched misinterpretations of Dr McGregor's perceptions and his inability to modify his interpretation of external events produced an impairment sufficient to preclude confidence that Dr McGregor could practise safely.

The impaired judgment and lack of insight displayed by Dr McGregor in the Tribunal's view, demonstrated the need for public protection while the impairment persisted.

The Board ultimately found that Dr McGregor was impaired and

(1) cancelled his registration

(2) prohibited Dr McGregor from applying for review for 12 months; and

(3) ordered Dr McGregor is to pay the Board's costs.

<u>Observation:</u> A finding of a psychiatric impairment, disability, condition or disorder does not rely on a diagnosis but will likely require an expert to establish its existence in a particular case.

***Medical Board of Australia v POS (Review and Regulation) (Corrected)* [2019] VCAT 1678**

POS was a medical practitioner who had been employed at a clinic as a paediatric fellow. POS was severely depressed and had:

- been exposed, at a young age, to depression and the attempted or actual suicide of close family members in the context of a staunchly religious family that regards such matters as a mortal sin;
- dealt with a medical matter by herself, at the age of 18 and while still studying, due to her family's strict religious convictions;
- been subjected to a breakdown of her first marriage due to infidelity; and
- been subjected to the breakdown of her second marriage, after only 9 months.

The issues of concern which gave rise to the notification about POS were that:

- POS had tried to cover up her attempted suicide and falsely claimed to employees at Clinic P that she had breast cancer;
- POS used that false medical condition to claim sick leave to which she was not entitled , including leave donated by other employees of Clinic P; and
- after she returned to work, POS sought to cover up her deception by submitting a number of false medical certificates and a false letter from a foreign health practitioner.

It was alleged by the Board in relation to these matters that POS engaged in professional misconduct.

The Tribunal observed the comments of Maxwell P in *Quinn v Law Institute of Victoria Limited*[1] (**Quinn**) that, in disciplinary hearings, it is necessary to consider if the existence of a medical condition (in that case, a history of depression) which reduces a person's culpability for the offending.

In POS, Dr Le Bas gave convincing expert evidence that notwithstanding POS' apparent ability to continue to function in a work context, that she in fact suffered from a severe depressive illness throughout the relevant period and remained at risk of suicide. He also gave convincing evidence that what may appear to a casual observer to have been a 'rational' response, to try and cover up the deception, was actually 'irrational' and further evidence of a lack of clear thought at the time.

In those circumstances the Tribunal found that POS' culpability was diminished and the Tribunal was not comfortably satisfied that POS' conduct, viewed through that lens, was 'inconsistent with [POS] being a fit and proper person'.

In this context it was further observed by the Tribunal that that while the power to make determinations is not intended to be punitive, specific and general deterrence and the facilitation of rehabilitation will be relevant. Relevant factors articulated by the Tribunal in this regard include:

- the nature and seriousness of the conduct,
- evidence of contrition,
- the need or otherwise for specific deterrence,
- other disciplinary findings,
- evidence of character,
- evidence of rehabilitation,
- any delay between the start of the investigation until the completion of the Tribunal hearing and other mitigating factors.
- Also relevant is the degree of insight that the practitioner has into his or her offending conduct.

The Tribunal ultimately found that POS' responsibility was diminished and whilst a period of suspension was sought by the Board the Tribunal declined to suspend POS and instead imposed a reprimand and conditions on POS' registration including mentoring.

<u>Observation:</u> Culpability in the context of an impairment will be assessed having regard to that impairment and the facts that surround that impairment.

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***LCK v Health Ombudsman* [2020] QCAT 316**

LCK is a medical practitioner who was a fellow of the Royal Australasian College of Physicians with a subspeciality of paediatric emergency medicine. He was employed by Queensland Health and was the clinical director of paediatric emergency medicine at a hospital.

On 10 October 2018 the LCK went with his wife to a shopping centre, where they went separate ways. He purchased a gift, and then as he wandered around in what he described as a dream-like state, he noticed an attractive young woman and decided to record her on video, using his phone. This was positioned so as to look up her skirt, and film her underwear. He repeated this, taking a video of a total of seven young women in such a way that none of them was aware that this was occurring. He was however noticed by a bystander, and as a result the police were alerted and they arrested him. At the time of his arrest his wife and the police reported that he was looking dazed, confused and sweaty, and was speaking gibberish. He was subsequently admitted to a psychiatric hospital.

LCK was subsequently treated by a psychiatrist and psychologist over nine occasions. LCK was subsequently diagnosed with Major Depressive Disorder. Expert reports were provided to the Tribunal which relevantly explained the offending as occurring at a time when LCK was psychologically disturbed and mentally unwell, because of an accumulation of chronic stressors.

LCK was subject to immediate action proceedings commenced by the Board. The issue of concern for the Board was his conduct in taking videos of the young women. The Medical Board sought to prevent LCK from practicing medicine on the basis of his conduct.

The Tribunal ordered that the conditions imposed by the Board as part of the immediate action proceedings be removed because there was no risk to the public and that there be no replacement conditions.

The Tribunal in coming to its decision commented that:

> *There will have to be a hearing in due course of the reference to the Tribunal, but in circumstances where the applicant has for practical purposes been unable to practice in his speciality, or virtually at all as a doctor, he is in much the same position as if his registration had been suspended for eighteen months.*
>
> *I doubt whether the Tribunal at a hearing would impose a greater sanction than that in view of all the circumstances of the case, but that will be a matter for the Tribunal then, and will no doubt take into account what happens from now on.*

In its reasons, the Tribunal ultimately accepted the proposition that, generally speaking, a mental disorder short of insanity may lessen the moral culpability of an offender and so reduce the claims of general or personal deterrence upon the sentencing discretion.

Relevantly, the existence of a psychiatric disorder which causes the conduct may be relevant if:

- The conduct would not have occurred had it not been for the cause.
- The conduct was an aberration, uncharacteristic of the way in which the legal practitioner would otherwise have acted.
- The cause has subsequently been removed.

In LCK's case, the evidence that the applicant's offending was caused by the mental health issues he had at the time was accepted and that but for this mental health issue the conduct giving rise to immediate action would not have occurred.

<u>Observation:</u> Where the cause of the offending is removed and there is no risk to the public a disciplinary sanction which may be punitive may not be an appropriate determination for a Tribunal.

Medical Board of Australia and Pharmacy Board of Australia v Lee (Review and Regulation) (Corrected) [2019] VCAT 311 (Lee)

Dr Lee was an intern who had obsessive compulsive disorder and substance abuse dependence. In this context he misappropriated sedative medication and self-administered those medications. Dr Lee was sentenced in the Magistrates Court having entered a plea of guilty to criminal offences related to this offending behaviour.

In concluding that Dr Lee had engaged in professional misconduct the Tribunal summarised the principles that should be taken into account when determining an appropriate sanction in such a disciplinary matter. They include:

- the purpose of the imposition of determinations is to protect the public;
- determinations are intended to maintain proper ethical and professional standards for the protection of the public and also for the protection of the profession in the sense of maintaining stature and integrity in the eyes of the public;
- determinations should in no way be punitive;
- the objectives of determinations can be achieved by specific deterrence, that is, the deterrence of the person concerned from further inappropriate conduct; by general deterrence, that is, the deterrence of other practitioners minded to conduct themselves similarly; and by facilitation of rehabilitation on the part of the practitioner;
- personal matters such as shame, personal ordeal, and financial difficulty are of little relevance save insofar as they contribute to the specific deterrence of the practitioner;
- the likelihood of recidivism, or, put another way, an assessment of the ongoing risk posed by the practitioner, should be central to the imposition of a determination;
- the degree to which the practitioner has acquired insight into his or her conduct is relevant to the assessment of the continuing risk posed by the practitioner;
- insight can include an understanding of the nature of the conduct, an acceptance that the conduct was wrong, an appreciation of why the practitioner engaged in that conduct, empathy with the consequences, and/or a willingness to take measures to identify risk factors and to do that which is necessary to avoid further transgressions; and
- any form of official censure is of consequence. It has been observed by the Courts that a reprimand is a serious matter for a professional person and should not be considered a ‘slap over the wrist’.

Critically, what is emphasised is that the Tribunal’s protective function is paramount. Thus, where there is a choice of sanctions, it is to be expected that the Tribunal will choose that sanction which maximises the protection of the public.

Finally, it is observed that determinations cannot be reached according to a set formula, rather, every case must be determined on its own unique facts, including any mitigating circumstances recognising that there is a need to impose determinations which support rehabilitation and to give weight to periods of time already away from practice.

<u>Observation:</u> Where there is a choice of sanctions open to a Tribunal the sanction which maximises protection to the public will likely be selected.

D. CONCLUDING COMMENTS

Having regard to the cases which have been reviewed it is prudent to make the following five comments about the factors taken into account by a Tribunal when coming to a determination about a matter involving a medical practitioners' health impairment.

First, the Tribunal's disciplinary orders are punitive as well as protective. In arriving at an appropriate determination, the Tribunal's protective function is paramount. Thus, where there is a choice of sanctions, it is to be expected that the Tribunal will choose that sanction which maximises the protection of the public.

Second, appropriate determinations by a Tribunal cannot be reached according to a set formula, rather, every case must be determined on its own unique facts, including mitigating circumstances. In appropriate cases, the Tribunal also is required to recognise the need to impose determinations which support rehabilitation and give weight to periods of time already away from practice.

Third, there is no presumption that because you have an impairment you are not able to practice medicine. Whether an impairment will mean that a practitioner is unable to practice will ultimately depend on a number on factors such as

a. the nature and likely duration of the impairment,
b. the kind of practice carried on by the medical practitioner,
c. the extent to which the impairment interferes with the practitioner's judgment, communication skills and clinical ability; and
d. other relevant circumstances.

Fourth, a psychiatric disorder may provide an explanation for the relevant conduct but is not an excuse for the conduct itself, although it may be taken into account in relation to sanctions, in mitigation.[2]

Finally, while the power to make determinations by a Tribunal is not intended to be punitive, specific and general deterrence and the facilitation of rehabilitation will be relevant. In this regard, factors to be considered by the Tribunal include the nature and seriousness of the conduct, evidence of contrition, the need or otherwise for specific deterrence, other disciplinary findings, evidence of character, evidence of rehabilitation, any delay between the start of the investigation until the completion of the Tribunal hearing and other mitigating factors.

Also relevant is the degree of insight that the practitioner has into his or her offending conduct. Accordingly, a mental disorder may lessen the moral culpability of an offender and so reduce the claims of general or personal deterrence.

Jayr Teng

Aickin Chambers

3 May 2021

[2] *Nursing and Midwifery Board of Australia v Evans* [2016] QCAT 77 at [35], and in *Health Ombudsman v HSK* [2018] QCAT 419 at 28