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RECENT DEVELOPMENTS

Professional Conduct and Making Decisions for Minors

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Unprofessional Conduct and Professional Misconduct of Health Care Professionals

The regulatory framework of health care professionals in Australia was, until 2010, a matter of individual state and territory discretion. In 2006, the Council of Australian Governments (COAG) reached an agreement, and all jurisdictions began to move toward a national regulatory scheme (see ch 15 in White, McDonald, and Willmott 2010). This scheme is now a reality[1] and some recent tribunal activity has provided valuable insight into the expectations of professional conduct (and misconduct) under the national scheme. These decisions are worth consideration, as they draw a distinction between unprofessional conduct and professional misconduct and provide guidance on the role of the professional boards and tribunals under the national scheme.[2]

In a recent decision of the Queensland Civil and Administrative Tribunal (QCAT), the definition of professional conduct and professional misconduct under the National Act was considered. *Pharmacy Board of Australia v The Registrant* [2012] QCAT 515 required the Tribunal to consider the actions of the registrant, a well-established pharmacist, with regards to the record-keeping and distribution of pseudoephedrine (PSE). PSE is a Schedule 3, Pharmacists only Poison under the *Health* (*Drugs and Poisons*) *Regulation 1996* (Qld) ([13]) and is therefore subject to strict controls on the amount that is kept by the pharmacy at any one time (this was exceeded) and to specific requirements on the keeping of a register and reporting of access (neither of these was done appropriately). The registrant did not dispute any of this and accepted that he had not acted in an appropriate or professional manner. The point to be drawn from this decision is the discussion regarding what constitutes professional misconduct

[1] Each jurisdiction has adopted the national law as contained in Schedule 1 of the Queensland Act. South Australia is the only jurisdiction to introduce separate, mirror legislation, which is found in Schedule 2 of the South Australian Act: *Health Practitioner Regulation National Law Act 2010* (ACT) s 6, *Health Practitioner Regulation* (*Adoption of National Law*) *Act 2009* (NSW) s 4, *Health Practitioner* (*National Uniform Legislation*) *Implementation Act 2012* (NT) s 4, *Health Practitioner Regulation National Law Act 2009* (Qld) Schedule 1, *Health Practitioners Regulation National Law* (*South Australia*) *Act 2010* (SA) Schedule 2, *Health Practitioner Regulation National Law* (*Tasmania*) *Act 2010* (Tas) s 4, *Health Practitioner Regulation National Law* (*Victoria*) *Act 2009* (Vic) s 4, *Health Practitioner Regulation National Law* (*WA*) *Act 2010* (WA) s 4.

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[2] The national scheme comes under the umbrella of the Australian Health Practitioner Regulation Agency (AHPRA), and there are currently 14 health care professions covered: Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental, medical, medical radiation, nursing and midwifery, occupational therapy, optometry, osteopathy, pharmacy, podiatry, and psychology.

and/or unprofessional conduct under the National Act. In presenting the decision, the QCAT pointed to potential inconsistencies in the wording of the Act, and these are worth considering here.

Under the National Law Act, professional misconduct is defined as including "unprofessional conduct by the practitioner that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience," and unprofessional conduct is "conduct that is of a lesser standard than that which might reasonably be expected of the Registrant by the public and professional peers" (*Health Practitioner National Law Act 2009* (Qld), s 5; this wording is consistent across all jurisdictions). The Tribunal described the difference in the wording of the expected standard of professional conduct and professional misconduct as "curious" [36] and suggested that "it is unlikely the legislature was intended to create two standards of measure" [39]. It was suggested that the reason for the difference was historical, with the Queensland Act (*Health Practitioner* (*Professional Standards*) *Act 1999* (Qld)) only providing "one category of conduct which applied to disciplinary action—unsatisfactory professional conduct" [40]. The wording of unsatisfactory professional conduct is now mirrored in the National Law Act. Under the Professional Standards Act, there was no definition of professional misconduct, and therefore courts were required to turn to the common law, with previous tribunals adopting the definition from *Adamson v Queensland Law Society Incorporated* (1991) QR 498:

> The test to be applied is whether the conduct violates or falls short of, to a substantial degree, the standard of the profession of good repute and competency (507).

The Tribunal in this instance pointed to three separate categories of conduct that would act as potential grounds for sanction:

1. Unsatisfactory professional performance,
2. Unprofessional conduct, and
3. Professional misconduct [42].

The conclusion reached was that, whilst there are differences in wording, the import of these differences is minimal or, in the words of the Tribunal, "inconsequential" [43]. From a practical point of view, the expectations of the public and peers would be "ascertained by reference to those in the profession with equivalent training and experience and by the rules, codes, regulations and guidelines of the profession" [43]. Thus, the two apparently different standards can be seen as two ways of stating the same test.

Of more import than the different wording of the test was the inclusion, in the definition of misconduct, of the term "substantially below" [46]. The Tribunal turned to the Oxford and Collins dictionaries and concluded that, to be substantially below the expected standard (and therefore to amount to misconduct), the registrant's conduct must be "shown to be, to a high degree, below the standards expected of a registrant with equivalent training and experience" [49]. In this instance it was concluded that, whilst the behaviour was clearly below the expected standard of care (and therefore amounted to unprofessional conduct), it was not substantially below and therefore did not constitute professional misconduct.

What type of behaviour then will meet the "substantially below" test? Some insight can be found through examination of a series of four Tribunal reports addressing the conduct of a registered psychologist (Whyte) in his dealings with a patient both during and after a clinical relationship.[3] There were seven listed particulars, which ranged from disclosure of his mobile phone number through inappropriate medical advice and disparaging comments about professional colleagues to inappropriate social contact via the dating site RSVP and the development of a social and sexual relationship.

The process of the enquiry was a meticulous and detailed examination of the history of the relationship between the complainant and the respondent. It was clear from the outset that the complainant was exceptionally vulnerable and that the Tribunal felt that Whyte's conduct fell below the expected standard of a health care professional. The Tribunal concluded that the disclosure of personal information by the respondent, the provision of inappropriate treatment advice for her arthritis, derogatory comments about a colleague's failure to refer her to another psychologist,

[3] *HCCC v Whyte* (*No 1*) [2012] NSWPST 2 (1 Feb), *HCCC v Whyte* (*No 2*) [2012] NSWPST 4 (15 Feb) (interim orders), *HCCC v Whyte* (*No 3*) [2012] NSWPST 5, (16 Oct) (final orders), *HCCC v Whyte* (*No 4*) [2012] NSWPST 6 (8 Nov) (reasons for final orders).

and the disclosure of personal information about other clients all amounted to unsatisfactory professional conduct. It was the significant personal intrusion of pursuing the complainant on RSVP and establishing social and later sexual relations that constituted professional misconduct under the relevant Act.

Professional misconduct is therefore clearly more serious than unsatisfactory professional conduct and involved, in this instance, a significant intrusion into the complainant's life. What then is the role of the Tribunal in such situations? Does it punish the respondent, send messages to the professional community warning against such behaviour, or endeavour to retrain the respondent? It would appear that it is a combination of all of these, and the *Whyte* decisions provide some insight into the role and responsibility of the tribunals under the national scheme.

The Tribunal in *Whyte* was somewhat scathing of the respondent, describing his evidence in the following terms: "inconsistent, contradictory and lacking in credibility … evasive, self-justifying and at times implausible" (*Whyte No 1*, [195] and [198]). It was also clear that his interactions with the complainant were inappropriate and well outside of acceptable professional behaviour, and his conduct was described as "an abuse of the therapeutic relationship" (*Whyte No 1*, [215]). The Tribunal went on to note its grave concerns "regarding the conduct of the Respondent. The vulnerability of this client did not appear to register at any level with him. … His personal approach to her in the circumstances of her life story, could be characterised as utterly thoughtless, opportunistic and/or cruel" (*Whyte No 1*, [242]). Despite this strong condemnation of the respondent's attitude and behaviour, the Tribunal emphasised its "mandate to be protective and not punitive in orders it makes" ([241]) and therefore the interim orders delivered in February 2012 did not include suspension. The focus was on "redeeming" the respondent and the orders included: a mental health plan, remaining under the care of a general practitioner, the setting of clear boundaries around interactions with clients, open disclosure to all clients of the Tribunal findings, and supervision (details set out in *Whyte No. 2*). However, 8 months later, when the time came to issue final orders, the view of the Tribunal had shifted. The respondent had failed to comply with the interim orders and, despite once again reiterating its protective jurisdiction and emphasising the fact that cancellation of registration is "not an inevitable outcome" (*Whyte No 4*, [93]), the Tribunal elected to cancel the respondent's registration and prohibit his ability to apply for review for 18 months (the orders are set out in detail in *Whyte No. 3*).

The reasoning behind the Tribunal's adoption of a hard line was a combination of two key factors. The first was the respondent's noncompliance with the interim orders, which was seen as being indicative of his "lack of insight" (*Whyte No. 4*, [108] and [118]) regarding the severity of his actions and his "failure to fully comprehend the import of the Tribunal's findings" (*Whyte No 4*, [108]). The second factor was the role and authority of the Tribunal, both of which were challenged by the respondent's noncompliance. The Tribunal went to great lengths to explain that the "orders of a Tribunal are not mere guidelines or suggestions or prescribing some optimal position, they are to be strictly complied with" and the final orders were designed to "act as a deterrent for any practitioner considering not complying with conditions placed upon their registration" (*Whyte No 4*, [113]). The Tribunal thus extended its protective role to adopt a more disciplinary and potentially punitive position. Each therapeutic relationship is different, but the cases considered here clarify some important aspects of professional standards. The key points to take away are that unsatisfactory professional conduct involves falling below the standard expected by the public and one's peers. Professional misconduct is measured in a similar manner but involves falling substantially below the expected standard and is perhaps most likely to be found where there has been a violation of personal boundaries. A final point to draw from this is the role of the Tribunal. Suspension of registration is clearly not automatic and is perhaps something the Tribunal will resist. However, if the registered health care professional is resistant or shows a lack of respect, then the Tribunal will respond and send out a cautionary message.

—Bernadette Richards

Guardianship Decision to Consent to Kidney and Liver Transplant: *Auckland District Health Board v W* [2012] NZHC 1563

In June 2012, the New Zealand High Court ordered that a child be placed under guardianship for the purpose of consenting to a kidney and liver transplant. The child, known as M, was a 2-year-old girl who suffered from a congenital disorder, autosomal recessive polycystic kidney disease. Because of the disease, surgeons had

removed her kidneys and she was being kept alive by dialysis. Kidney transplantation was an option, but M also had portal hypertension, which meant that in addition to a kidney transplant M would also require a liver transplant.

M's parents were Jehovah's Witnesses and objected to M being given blood products. Because of the parents' objections, M could not be placed on the waiting list for organs as blood transfusions would very likely be necessary during a transplant procedure. The District Health Board applied to the Court to have M placed under guardianship. The Court as guardian could then consent to the transplant (and any consequential blood transfusions).

Using its powers under the *Care of Children Act 2004* (NZ), the Court ordered that the child be placed under the guardianship of the Court, because it was in the best interests of the child to do so. Two doctors were appointed as agents for the Court so that they would be able to provide consent to treatment should a suitable transplant become available. The parents were also appointed as agents for the Court for M's care in all respects other than medical treatment issues relating to the transplantation. Winkelmann J said at [23]:

> In putting to one side the religious objections of M's parents to the blood transfusion, I do not wish to minimise the role or importance of the views of M's parents since the parents' continued support and care of M is critical. They play an absolutely central role in her life. However, it is common ground between the parents and the medical professionals that it is in M's interests that she have the transplants recommended by the multi-disciplinary team. It is also common ground that it is in M's interests that this application be dealt with at this point so that she is in a position to be placed on the organ donor transplant list. By making the orders which are sought, this resolves for M's parents what must be an agonising conflict between their firmly held religious beliefs and the pressing needs of M.

—Cameron Stewart

Not for Resuscitation Orders and Children: *Re Natalie* [2012] NSWSC 1109

Natalie was a 10-year-old child who was profoundly disabled. Natalie suffered from a neurological condition called porencephaly. She also had been was diagnosed with severe hydranencephaly where more than 90 percent of her brain cortex had been replaced with cerebral spinal fluid. Her mother gave up caring for her soon after her birth and, initially, it was thought that Natalie would not survive for long. Her mental function at age 10 was that of a 6- to 12-week-old child. Natalie also had epilepsy, hypertension, and frequent seizures. Since she was 12 days old, Natalie was cared for by a woman who was made her adoptive parent in February 2012.

The Department of Community Services had created an End of Life Case Plan in July 2009, where it stated that an agreed objective was to ensure that Natalie has a dignified comfortable death with as little suffering as possible. As part of that plan, it was agreed that, in the event of cardiac pulmonary arrest, it would not be appropriate to provide cardiopulmonary resuscitation, intubation, or ventilation.

The Department asked the court to exercise its *parens patriae* powers to authorise her treating medical practitioners, paramedics, and nurse to withhold cardiopulmonary resuscitation, intubation, or ventilation and the administration of adrenalin unless they considered such treatment was appropriate given Natalie's prevailing clinical situation. The orders proposed by the Department stated that she be provided with all medical care and treatment directed toward the preservation of her life and the promotion of her health and welfare, up to the point of her suffering a cardiac arrest or respiratory arrest or another life-threatening event such as prolonged seizure or aspiration.

White J questioned whether this was necessary, as Natalie's adoptive mother had a clear right to authorise such a course of non-treatment as it was within her parental responsibility (*Re Baby D* (*No 2*) [2011] FamCA 176). Nevertheless, White J said there were two good reasons for exercising the court's powers:

> The first is that the medical practitioners may be in real doubt as to whether they should act on a decision of the second defendant authorising them not to resuscitate Natalie if she suffers a cardiac arrest or respiratory arrest or other lifethreatening event. They may consider in an emergency that they should not do so in the absence of an order from the Court making their position clear. In that respect the orders will clearly provide that they give an authority to medical practitioners and others not to take interventionist steps in the event

of cardiac arrest or respiratory arrest or other life-threatening event, unless they consider that treatment to be appropriate given Natalie's then prevailing clinical situation. In other words the orders provide an authority which is itself subject to those medical professionals' clinical assessment. They are not a direction as to how doctors and others must act.

The second reason why I think the jurisdiction ought to be exercised is that, as was put by counsel for Natalie, notwithstanding the second defendant has assessed it to be in Natalie's best interest that she not be resuscitated, her emotional attachment to the child might make it difficult for her to make that decision in Natalie's best interests when the time for decision arrives (at [23]–[24]).

White J found that the orders were appropriate given that the result of resuscitation efforts would be to cause Natalie increased suffering with no commensurate benefit.

—Cameron Stewart

Reference

White, B., F. McDonald, and L. Willmott, eds. 2010. *Health law in Australia*. Sydney: Thomson Reuters.