

TOWARDS COMPASSION: STATUTORY POWERS TO REGULATE IMPAIRED DOCTORS IN VICTORIA, 1844–2016

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I INTRODUCTION

The community relies on medical practitioners to treat the sick, but doctors' own illnesses can compromise their capacity to care for patients.¹ This is not an unlikely circumstance. The high incidence of mental health issues in particular within the medical profession is well documented,² and doctors are apparently more inclined than many other professionals to continue working when sick, and avoid or delay seeking medical treatment.³ Consequently, powers granted to regulators of the medical profession ('regulators') to manage medical practitioners whose ill health impairs their capacity to practise medicine – described in this article as 'impaired doctors' – have critical ramifications not only for the doctors, but for the public, too.

Remarkably, although the Medical Board for the District of Port Phillip was established in 1844 to regulate the Victorian medical profession, it was not until 1933 that its successor, the Medical Board of Victoria ('Board'), obtained any power to manage impaired doctors. Moreover, at that time, the Board was authorised to impose only one regulatory measure in response to one illness: the

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- 1 Peter Schattner, Sandra Davidson and Nathan Sherry, 'Doctors' Health and Wellbeing: Taking Up the Challenge in Australia' (2004) 181 *Medical Journal of Australia* 348, 349; Danielle Clode, 'Emotional Health: The Conspiracy of Silence Among Medical Practitioners: A Review of the Literature for the Royal Australian College of General Practitioners' (Royal Australian College of General Practitioners, July 2004) 4–5, 26.
- 2 Beyondblue, 'National Mental Health Survey of Doctors and Medical Students' (October 2013) <http://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdms-full-report_web> 2–4, 7; Schattner, Davidson and Sherry, above n 1, 348; Clode, above n 1, 5–6, 14–18.
- 3 Beyondblue, above n 2, 7; Clode, above n 1, 5, 19–23; Benedicte Ingstad and Vigdis Moe Christie, 'Encounters with Illness: The Perspective of the Sick Doctor' (2001) 8 *Anthropology & Medicine* 201, 203, 209; Australian Medical Association, *Health and Wellbeing of Doctors and Medical Students – 2011* (5 April 2011) <<https://ama.com.au/position-statement/health-and-wellbeing-doctors-and-medical-students-2011>>.

Board could erase from its register of ‘legally qualified medical practitioners’ the name of a doctor who was classified as an ‘inebriate’ for his or her addiction to alcohol or narcotic drugs.⁴ By contrast, today, the Medical Board of Australia (‘MBA’), which regulates Victorian doctors, has a variety of regulatory options to manage doctors who experience any health problem that falls within the broad definition of an ‘impairment’ in the *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) (‘2009 Act’), namely: ‘a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect’ the doctor’s ‘capacity to practise’ medicine.⁵ In addition, the MBA is specifically empowered to support doctors’ treatment and rehabilitation services.⁶

As these differences suggest, there have been dramatic shifts in the powers that successive Victorian legislatures have granted to regulators to manage impaired doctors. Part II of this article examines the significant changes to those statutory powers from 1844 to the present day. While members of Parliament (‘MPs’) consistently strove to protect the public in empowering regulators to manage impaired doctors, their conceptions of the best means of achieving this objective evolved over time. The article analyses parliamentary debates that reveal legislators’ intentions and the influences on them, including: growing medical knowledge about the impact of illnesses on human functioning; developments in medical treatments; changing social constructions of illness and the sick; lobbying by regulators, doctors’ representative bodies, and consumers of health services; and individual doctors’ circumstances.

Part III critically evaluates the major changes that MPs have made to regulators’ powers to manage impaired Victorian doctors. It argues that parliamentarians have increasingly empowered regulators to adopt a flexible, personalised and empathic regulatory approach that has the potential to support impaired doctors to practise medicine safely and is therefore beneficial for the doctors and the community. Nevertheless, notwithstanding MPs’ intentions in passing the *2009 Act* – the latest relevant legislation – in certain circumstances, impaired doctors may still experience regulation that seems punitive and unsupportive. The article recommends that parliamentarians change regulators’ powers further by encouraging them to manage these doctors in particular with greater compassion and thereby improve their prospects of practising medicine safely in the future.

4 *Medical Act 1933* (Vic) s 4, inserting *Medical Act 1928* (Vic) s 7(1)(b); *Inebriates Act 1928* (Vic) s 3 (definition of ‘inebriate’).

5 *Health Practitioner National Law (Victoria) Act 2009* (Vic) sch ss 5 (definition of ‘impairment’), 156, 178, 181.

6 *Health Practitioner National Law (Victoria) Act 2009* (Vic) sch ss 5 (definition of ‘health program’), 35(1)(n).

II SIGNIFICANT CHANGES TO STATUTORY POWERS TO REGULATE IMPAIRED DOCTORS IN VICTORIA

A *Medical Act 1933 (Vic)*

For 89 years after the Board was established, no Victorian statute referred to impaired doctors. Therefore, for almost a century, once the Board had declared a person to be a ‘legally qualified medical practitioner’, he or she retained unencumbered registration to practise medicine irrespective of any illness that made his or her healthcare unsafe (unless the doctor was also convicted of a felony or misdemeanour, or was found to have obtained his or her registration ‘irregularly or fraudulently’).⁷ For many years, parliamentarians had resisted pressure from the Board and doctors’ professional societies to grant the Board various powers.⁸ Legislators were influenced by a pervasive disrespect for doctors, which was attributable to the infancy of medical knowledge and rivalries within the Victorian medical profession, and distrust of the Board to exercise its authority appropriately.⁹ By 1933, however, many of those professional conflicts had resolved;¹⁰ there had been major advances in doctors’ capacity to treat illnesses;¹¹ and two medical practitioners – Sir Stanley Argyle, the Premier of Victoria, and Dr Clive Shields¹² – were able to convince their fellow parliamentarians that the Medical Bill 1933 (Vic), the first Victorian legislation to deal explicitly with impaired doctors, was ‘for the benefit of the public, and not ... the profession’, and the Board comprised respectable men.¹³

MPs may have been persuaded to pass the *Medical Act 1933 (Vic)* (*‘1933 Act’*) also because it focused on an issue of concern, namely, the doctor who fell within the definition of an ‘inebriate’ in the *Inebriates Act 1928 (Vic)*: ‘a person who habitually uses alcoholic liquors or intoxicating or narcotic drugs to excess’.¹⁴ While alcohol had been the most common source of addiction (though its consumption fell somewhat during the Depression), dependence on drugs, such as opiates, cocaine, morphine and heroin, had risen especially among doctors who had access to them.¹⁵ Despite an emerging ‘medical view’ of

7 *Medical Act 1906 (Vic)* s 6; *Medical Act 1915 (Vic)* s 8.

8 Gabrielle Wolf, ‘A Delayed Inheritance: The Medical Board of Victoria’s 75-Year Wait to Find Doctors Guilty of “Infamous Conduct in a Professional Respect”’ (2015) 22 *Journal of Law and Medicine* 568, 569–75.

9 *Ibid* 570, 575–7.

10 *Ibid* 577.

11 *Ibid*.

12 A G L Shaw, ‘Argyle, Sir Stanley Seymour’ in Bede Nairn et al (eds), *Australian Dictionary of Biography* (Melbourne University Press, 1979) vol 7, 92; Geoff Browne, ‘Shields, Clive’ in Geoffrey Serle et al (ed), *Australian Dictionary of Biography* (Melbourne University Press, 1988) vol 11, 593.

13 Wolf, above n 8, 577–8; Victoria, *Parliamentary Debates*, Legislative Assembly, 23 August 1933, 1005 (Sir Stanley Argyle, Premier and Treasurer), 1005–6 (Clive Shields).

14 *Medical Act 1933 (Vic)* s 4, inserting *Medical Act 1928 (Vic)* s 7(1)(b); *Inebriates Act 1928 (Vic)* s 3 (definition of ‘inebriate’).

15 Milton Lewis, *Managing Madness: Psychiatry and Society in Australia 1788–1980* (Australian Government Publishing Service, 1988) 170–1, 173–5.

addiction as a somatic, hereditary disease that could be treated and even cured,¹⁶ the perception that it was a moral weakness was still commonly held.¹⁷ Indeed, MPs believed that substance-dependent doctors had wilfully succumbed to vice and needed to be penalised, in Shields' words, 'for the protection of the public' and the retention of its 'confidence ... in the medical profession'.¹⁸

Pursuant to the *1933 Act*, the Board could erase from its Medical Register of Victoria ('register') the name of a doctor whom it found to be an 'inebriate', once it had given the doctor an opportunity to provide an explanation personally or in writing and held a 'full inquiry into the matter'.¹⁹ MPs explained the impact of this sanction, which they regarded as fitting for those doctors whom they described as 'a menace to the community'²⁰ – the 'drunken medical man' (whom they also considered to be a 'disgrace' to the medical profession),²¹ and the doctor who 'yielded to the temptation which peculiarly affects [doctors] in handling narcotic drugs'.²² Shields emphasised, 'when it de-registers a man ... [the Board] deprives him of the rights and privileges which registration gives',²³ while James Murphy MP observed: 'the professional life of a doctor who has been de-registered is ruined until he is given a fair opportunity to redeem his professional character'.²⁴ Parliamentarians granted the Board discretion to restore to the register the names of doctors who overcame their addiction,²⁵ if the doctors proved that they had, as MPs described it, 'turned over a new leaf',²⁶ or 'been sufficiently punished'.²⁷

B *Medical Act 1959 (Vic)*

Following the *1933 Act*, the *Medical Act 1959 (Vic)* ('*1959 Act*') – which amended the *Medical Act 1958 (Vic)* that had in turn repealed the *1933 Act*²⁸ – effected the next significant change to the Board's powers to regulate impaired doctors. It provided that, if a doctor was an involuntary patient of an institution for the treatment of the mentally ill, his or her registration to practise medicine

16 Ibid 167–8; Stephen Garton, "'Once a Drunkard Always a Drunkard": Social Reform and the Problem of "Habitual Drunkenness" in Australia, 1880–1914' (1987) 53 *Labour History* 38, 46–8; Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (HarperCollins, 1997) 704; Caroline Clark, 'Contrasting Medical Models of Alcohol Problems in Victoria around 1900' (2012) 107 *Addiction* 1756, 1756–9.

17 Garton, above n 16, 49–51; Lewis, *Managing Madness*, above n 15, 26, 167–8, 174.

18 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 August 1933, 1003, 1008 (Clive Shields).

19 *Medical Act 1933 (Vic)* s 4, inserting *Medical Act 1928 (Vic)* ss 7(1), (3)–(4).

20 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 August 1933, 1004 (Sir Stanley Argyle, Premier and Treasurer), 1007 (Clive Shields).

21 Ibid 1007 (Clive Shields).

22 Victoria, *Parliamentary Debates*, Legislative Council, 29 August 1933, 1065 (Harold Cohen).

23 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 August 1933, 1005 (Clive Shields).

24 Ibid 1013 (James Murphy).

25 *Medical Act 1933 (Vic)* s 6.

26 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 August 1933, 1008 (Clive Shields).

27 Victoria, *Parliamentary Debates*, Legislative Assembly, 27 July 1933, 576 (Ian Macfarlan, Chief Secretary); Victoria, *Parliamentary Debates*, Legislative Council, 29 August 1933, 1066 (Harold Cohen).

28 *Medical Act 1958 (Vic)* s 2(1), sch 1.

would be automatically suspended.²⁹ The Board could revoke the suspension if the doctor's 'mental health' was 'adequate to enable him [or her] to carry out the duties and functions of a legally qualified medical practitioner'.³⁰

This statute reflected MPs' acknowledgment that mental illnesses other than addiction might also impair doctors' medical care, but that doctors suffering from a mental illness could recuperate and resume safe medical practice. Indeed, the Bolte Government assumed that suspensions of registration would be imposed temporarily to protect the community until doctors were 'cured' of their mental illnesses.³¹ Ewen Cameron, Minister of Health, indicated that individual doctors' circumstances had precipitated the drafting of the Medical Bill 1959 (Vic). Cameron alluded to 'cases in which ... unfortunate gentlemen, not having recovered from [mental illnesses], have caused difficulties and ... danger to the public', though the Government did not satisfy the Opposition's request for particulars of those matters.³² According to the minutes of the Board's meetings in 1954, after receiving advice from the Crown Solicitor confirming that it did not have statutory power to suspend a doctor who had been certified as insane and was a patient at Mont Park Mental Hospital, the Board requested the parliamentary draftsman to prepare a draft provision to give it this authority.³³

Other influences on parliamentarians to make this change to the Board's powers to regulate impaired doctors may have included growing public recognition of the prevalence of mental illnesses, but also the development of effective treatments for them during the first half of the 20th century. Psychiatrists exposed that many people could have mental health problems ranging in severity, and, as Roy Porter, respected medical historian, observed, 'mental abnormality began to be seen as part of normal variability'.³⁴ The stigma that had attached to mental illness and assumptions that it was rarely overcome were diminishing in response to investigations into its neuropathological and psychological bases.³⁵ Early trials of therapies (inspired initially by interest in eugenics, 'mental hygiene', and soldiers' 'shell shock' in World War I),³⁶ including physical treatments for depression, schizophrenia and 'general paralysis of the insane' ('GPI') – a condition that developed after infection with syphilis – had limited

29 *Medical Act 1959* (Vic) s 2, inserting *Medical Act 1958* (Vic) s 12A(1); *Mental Hygiene Act 1958* (Vic) s 3(1) (definition of 'patient').

30 *Medical Act 1959* (Vic) s 2, inserting *Medical Act 1958* (Vic) ss 12A(2)–(3).

31 Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 1959, 3697 (John Bloomfield); Victoria, *Parliamentary Debates*, Legislative Council, 17 March 1959, 2539 (Ewen Cameron, Minister of Health).

32 Victoria, *Parliamentary Debates*, Legislative Council, 17 March 1959, 2539 (Ewen Cameron, Minister of Health); Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 1959, 3706 (John Bloomfield), 3697–8 (Valentine Doube).

33 Medical Board of Victoria, 'Board Minutes' (Public Record No VPRS 16389/P1, Public Record Office of Victoria, 14 September 1954, 12 October 1954).

34 Porter, above n 16, 521.

35 Lewis, *Managing Madness*, above n 15, 9, 13, 44, 48, 50–1, 75, 123.

36 *Ibid* 39; Catharine Coleborne and Dolly Mackinnon, 'Psychiatry and Its Institutions in Australia and New Zealand: An Overview' (2006) 18 *International Review of Psychiatry* 371, 374; Ruth Rae, 'An Historical Account of Shell Shock during the First World War and Reforms in Mental Health in Australia 1914–1939' (2007) 16 *International Journal of Mental Health Nursing* 266, 266–8.

success.³⁷ From the late 1930s, however, mental health workers increasingly practised psychotherapy effectively,³⁸ and electroconvulsive therapy began to be used successfully to treat depression in the 1940s.³⁹ A ‘psychopharmacology’ emerged that was similarly promising.⁴⁰ Insulin and cardiazol were used to treat schizophrenia and depressive psychosis,⁴¹ and after John Cade discovered in 1949 that lithium could be an anti-manic agent,⁴² psychotropic drugs were created in the 1950s, which also assuaged psychiatric disorders, and antibiotics cured GPI.⁴³

Pursuant to the *1959 Act*, if substance-dependent medical practitioners were certified, their registration was suspended, so the Board would not have needed to cancel those doctors’ registration in order to protect the public. In allowing for this circumstance, where the Board would not feel compelled to deregister substance-addicted doctors, it appears that MPs responded to the urging of doctors and others to accept the medical construction of alcoholism in particular as an illness that could be treated,⁴⁴ as well as to evidence supporting this view. While pharmacists’ supply of narcotic drugs was tightly controlled at this time, which limited access to them,⁴⁵ the incidence of alcoholism and admissions of alcoholics to psychiatric institutions in Australia was high.⁴⁶ Nevertheless, effective therapies were introduced, management services for alcoholics were established in public hospitals, and some of those discharged from psychiatric institutions began working with Alcoholics Anonymous and the Victorian Foundation on Alcoholism and Drug Dependence, which helped bring to public attention the potential for rehabilitating alcoholics.⁴⁷

C *Medical Practitioners Act 1970 (Vic)*

In 1959, Victorian parliamentarians did not contemplate that doctors who were ‘voluntary boarders’ at ‘mental hospitals’ might pose a risk to public safety.⁴⁸ Valentine Doube MP, for example, opined, ‘if a person is sufficiently sane to seek help for some particular mental disability by voluntarily entering a hospital, there is no fear that he [or she] will really offend against the community’.⁴⁹ This attitude was perhaps engendered by public health strategies

37 Lewis, *Managing Madness*, above n 15, 41, 43, 55; Porter, above n 16, 686.

38 Lewis, *Managing Madness*, above n 15, 29, 53, 75; Porter, above n 16, 521–2; Coleborne and Mackinnon, above n 36, 374.

39 Lewis, *Managing Madness*, above n 15, 43, 56; Coleborne and Mackinnon, above n 36, 374.

40 Porter, above n 16, 521.

41 Lewis, *Managing Madness*, above n 15, 43, 56.

42 Graham D Burrows and John W Tiller, ‘Cade’s Observation of the Antimanic Effect of Lithium and Early Australian Research’ (1999) *Australian and New Zealand Journal of Psychiatry* S27, S27, S29, S31.

43 Lewis, *Managing Madness*, above n 15, 55, 57, 76; Porter, above n 16, 520, 715.

44 Lewis, *Managing Madness*, above n 15, 175–6.

45 *Ibid* 174.

46 *Ibid* 178; James G Rankin, ‘From Scrubland to Vintage Wine: Australia’s Response to Substance-Related Problems in the Last 40 Years’ (2003) 22 *Drug and Alcohol Review* 255, 255–6.

47 Lewis, *Managing Madness*, above n 15, 175–6, 182; Rankin, above n 46, 256.

48 Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 1959, 3703 (Keith Sutton).

49 *Ibid* 3698 (Valentine Doube).

that sought to erode the stigma of mental illness further and encourage those who needed help to access it.⁵⁰ By passing the *Medical Practitioners Act 1970* (Vic) ('1970 Act') – which repealed the *Medical Act 1958* (Vic)⁵¹ – 11 years later, however, MPs demonstrated their appreciation that doctors who were not certified might nonetheless suffer from mental illnesses that compromised their capacity to practise medicine safely and fail to recognise their impairment. The 1970 Act substituted the automatic suspension of a certified doctor's registration with a broad discretion for the Board to suspend any registrant, regardless of whether or not the doctor was certified, if it deemed the doctor's 'mental health' to be 'such that he [or she] cannot satisfactorily carry out the duties and functions of a legally qualified medical practitioner'.⁵²

The Opposition raised concerns that this legislation might lead to the Board unnecessarily suspending doctors; discourage impaired doctors from seeking treatment because they feared that it could result in suspension of their registration; and/or worsen doctors' health.⁵³ Nevertheless, the Bolte Government considered that the legislation was needed to 'safeguard patients',⁵⁴ and some expressed confidence that the Board would defer to expert advice in deciding whether to exercise its power.⁵⁵ John Rossiter, Minister for Health, explained: 'the [B]oard's hands have been tied in a number of cases where it considered that the registration of a medical practitioner should be suspended because of his mental state' and the doctor was 'admitted on a voluntary basis' to a 'mental institution' or was 'obtaining treatment privately or as an out-patient'.⁵⁶ Walter Jona MP similarly observed: 'many practitioners ... are not in a state of mind which would warrant their certification, but their mental condition is such that they should not be practising medicine'.⁵⁷

These legislators' observations and their empowerment of the Board to suspend any doctor whose mental illness impaired his or her ability to practise medicine, and revoke a suspension if a doctor satisfied the Board that his or her mental health was 'adequate' to perform a doctor's 'duties and functions',⁵⁸ appear to reflect the impact on MPs of a shift in attitudes towards and treatments of mental illnesses. New antipsychotic and antidepressant drugs were produced that assuaged symptoms of mental illnesses.⁵⁹ The profile of psychiatry had risen, too, with the transformation of the Australasian Association of Psychiatrists into

50 Lewis, *Managing Madness*, above n 15, 40.

51 *Medical Practitioners Act 1970* (Vic) s 2(1).

52 *Medical Practitioners Act 1970* (Vic) s 18(1).

53 Victoria, *Parliamentary Debates*, Legislative Assembly, 26 November 1970, 2616, 2618, 2621 (Valentine Doube), 2611, 2617, 2620 (Alan Lind), 2613–14 (Thomas Mitchell).

54 *Ibid* 2617 (John Rossiter, Minister for Health).

55 *Ibid* 2619 (Norman Billing).

56 Victoria, *Parliamentary Debates*, Legislative Assembly, 19 November 1970, 2212 (John Rossiter, Minister for Health). Details of those cases are not available, as the minutes to the Medical Board of Victoria's meetings after 1965 are closed to the public: see Public Record Office Victoria <<http://prov.vic.gov.au>>.

57 Victoria, *Parliamentary Debates*, Legislative Assembly, 26 November 1970, 2617 (Walter Jona).

58 *Medical Practitioners Act 1970* (Vic) s 18(2).

59 Joan Lawrence et al, 'Reflective Accounts of Psychiatry in Australasia, 1963–2000' (2013) 21 *Australasian Psychiatry* 97, 98, 100.

the Australian and New Zealand College of Psychiatrists in 1963, and the increasing practice of psychiatry outside institutions with the aim of rehabilitating patients.⁶⁰ Rossiter noted, ‘more than three-quarters of all persons admitted to mental institutions are admitted these days on a voluntary basis, and persons who at one time would have been admitted to mental institutions are encouraged to stay in the community’.⁶¹ Psychiatrists disagreed about whether mental illness was a biological or psychological phenomenon, and an anti-psychiatry movement maintained that mental illness was merely a label.⁶² Yet these arguments further normalised mental illness and some were consistent with the view that it was not necessarily an unchanging, permanent condition.⁶³

D *Medical Practitioners (Amendment) Act 1981 (Vic)*

During the parliamentary debates that preceded the passage of the *1959 Act* and the *1970 Act*, Doube highlighted that a doctor’s ‘physical diseases [could] render him [or her] incapable of carrying out his [or her] functions, but there is nothing in [the legislation] to prevent him [or her] from practising [medicine]’.⁶⁴ Finally, Victorian legislators responded to this risk, and the *Medical Practitioners (Amendment) Act 1981 (Vic)* (*‘1981 Act’*) – which amended the *1970 Act* – empowered the Board to suspend doctors’ registration if either their ‘physical or mental health’ prevented them from ‘satisfactorily’ carrying out a medical practitioner’s ‘duties and functions’.⁶⁵

It is ironic that parliamentarians first enabled the Board to protect patients from the threat posed by doctors whose physical illnesses or disabilities impaired their ability to practise medicine at a time when treatments for many ailments were more effective than ever before. From the late 19th century, advances in, inter alia, scientific experimentation, bacteriology, pharmacology and surgery led to important developments in medical knowledge and production of antitoxins to immunise against diseases.⁶⁶ Nevertheless, in 1933, when the legislature empowered the Board to regulate substance-addicted but not physically ill or disabled doctors, the severe impact of major infectious diseases –

60 Ibid 97; Lewis, *Managing Madness*, above n 15, 76, 134; Coleborne and Mackinnon, above n 36, 375; Royal Australian & New Zealand College of Psychiatrists, *Our History* (2013) <<https://www.ranzcp.org/About-us/About-the-College/Our-history.aspx>>.

61 Victoria, *Parliamentary Debates*, Legislative Assembly, 19 November 1970, 2212 (John Rossiter, Minister for Health).

62 Lewis, *Managing Madness*, above n 15, 57; Porter, above n 16, 522.

63 Lewis, *Managing Madness*, above n 15, 124.

64 Victoria, *Parliamentary Debates*, Legislative Assembly, 26 November 1970, 2618 (Valentine Doube).

65 *Medical Practitioners (Amendment) Act 1981 (Vic)* s 9(1), amending *Medical Practitioners Act 1970 (Vic)* s 18(1)(b).

66 Milton J Lewis, ‘Medicine in Colonial Australia, 1788–1900’ (2014) 201(1) (Supplement) *Medical Journal of Australia* S5, S10; Porter, above n 16, 306, 315, 320, 333–4, 367, 370, 374, 381, 428; Guenter B Risse, ‘Medical Care’ in W F Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine* (Routledge, 1993) vol 1, 45, 65–7, 71; Paul Weindling, ‘The Immunological Tradition’ in W F Bynum and Roy Porter (eds), *Companion Encyclopedia of the History of Medicine* (Routledge, 1993) vol 1, 192, 192–3, 197; Catherine E Storey, ‘A Brief History of the Specialties from Federation to the Present’ (2014) 201(1) (Supplement) *Medical Journal of Australia* S26–S27.

including tuberculosis, measles and poliomyelitis – was yet to be overcome.⁶⁷ Each succeeding decade, however, witnessed significant advances in medical treatments for physical illnesses and the production of more vaccines. From the 1940s, penicillin and then antibiotics cured many serious bacterial infections, while synthetic drugs reduced inflammatory conditions and high blood pressure, and vaccines prevented certain viral diseases.⁶⁸ The 1950s saw the advent of transplant surgery, and hospital technology improved.⁶⁹ In the 1960s, vaccines and antibiotics further reduced the impact of communicable diseases and suffering from other physical conditions was assuaged by new medication and surgery.⁷⁰

The reason why Victorian MPs decided in 1981 to empower the Board to regulate doctors whose physical illnesses impaired their capacity to practise medicine was that the Board and doctors alerted them, if indirectly, to the need to do so. The Australian Medical Association (‘AMA’) – Australian doctors’ peak representative body – advised Victorian MPs of its receipt from the Consumer Affairs Bureau of a high volume of complaints about doctors,⁷¹ which presumably included allegations about the medical practice of impaired doctors. William Borthwick, Minister of Health, considered that the Board under the leadership of its then President, Dr Bernard Neal, had been proactive in regulating the medical profession, but the Board had identified that it required more authority to take action when doctors’ medical care was substandard, and therefore sought this amendment to its governing legislation.⁷²

The *1981 Act* made other noteworthy alterations to the Board’s authority to regulate impaired doctors that the Board also requested.⁷³ It provided that, if the Board considered that a doctor’s physical or mental health was ‘such that he [or she could] satisfactorily carry out some, but not all, of the duties and functions of a legally qualified medical practitioner’, and ‘the gravity of the [doctor’s] condition [was] ... not so severe as to warrant the suspension of his registration’, the Board could instead impose ‘conditions, limitations or restrictions’ on the doctor’s practice (and ‘at any time revoke’ them).⁷⁴ To ascertain the likely impact of doctors’ ill health on their medical practice, and determine the least restrictive regulatory measure that was necessary to impose in order to protect patients of impaired doctors, the *1981 Act* authorised the Board to require doctors to

67 Porter, above n 16, 401–2, 442, 458, 685; Yvonne E Cossart, ‘The Rise and Fall of Infectious Diseases: Australian Perspectives, 1914–2014’ (2014) 201(1) (Supplement) *Medical Journal of Australia* S11, S11–S12.

68 Porter, above n 16, 457, 459, 685, 696, 711; Lewis, *Managing Madness*, above n 15, 55; Cossart, above n 67, S11–S12; Risse, above n 66, 67.

69 Porter, above n 16, 617, 623, 626; Risse, above n 66, 68.

70 Risse, above n 66, 68; Cossart, above n 67, S11; Porter, above n 16, 460, 583–4, 686, 715.

71 Victoria, *Parliamentary Debates*, Legislative Assembly, 9 December 1981, 4632 (Thomas Roper).

72 *Ibid* 4641 (William Borthwick, Minister of Health).

73 *Ibid*.

74 *Medical Practitioners (Amendment) Act 1981* (Vic) s 9(2), inserting *Medical Practitioners Act 1970* (Vic) s 18(1A).

undergo medical examinations so that it could obtain reports about their ‘physical and mental condition’.⁷⁵

With these changes, parliamentarians helped the Board to embrace a compassionate regulatory approach that was adapted to doctors’ particular health issues. Borthwick emphasised: ‘the power to impose conditions, limitations or restrictions is not seen as a penalty provision and it is the hope of the Government that the [B]oard will exercise the power responsibly and sympathetically in appropriate cases’.⁷⁶ Community awareness of advances in medical knowledge and treatments of illnesses probably accounted for parliamentarians’ appreciation that it might be sufficient and appropriate to constrain the practice of a physically or mentally ill doctor without suspending his or her registration. It was apparent that illnesses’ severity and their impact varied, and ever more symptoms of ailments could be controlled and alleviated.⁷⁷ Public investment in training doctors to meet the demand for medical care possibly also encouraged MPs to authorise the Board to permit impaired doctors to continue working with safeguards.

The *1981 Act* also introduced a significant change to the Board’s powers to regulate doctors who were ‘addicted to a drug of dependence’ or ‘repeatedly intoxicated’: the Board could impose conditions, limitations or restrictions on their practice as well as reprimand them.⁷⁸ The MPs who passed this statute did not share their forebears’ attitudes that substance-dependent doctors should be punished. Moreover, they intended to empower the Board to support such doctors to remain in practice if it could ensure that patients were not thereby endangered. Borthwick stated that the Board’s new regulatory options were not ‘a penalty[,] but ... a means of enabling the [B]oard to help a medical practitioner who ... may have an alcohol or drug problem’, and could give the Board ‘considerable flexibility when ... suspension or cancellation of registration may be too draconian’.⁷⁹ Borthwick envisaged that, ‘without preventing [a substance-addicted doctor] from continuing to practice [sic]’, the Board could ‘restrict the [doctor’s] right to prescribe drugs’ or ‘transfer [the doctor] to some other branch of medicine where he [or she] would not come into contact with drugs’.⁸⁰

In light of contemporary developments, it may have seemed feasible for substance-addicted doctors who were receiving treatment to engage in some medical practice safely if they were subject to certain constraints. Research into and public education about substance addiction reinforced that it was a treatable illness, and facilities for treating and rehabilitating alcoholics and drug-dependent

75 *Medical Practitioners (Amendment) Act 1981* (Vic) s 9(2), inserting *Medical Practitioners Act 1970* (Vic) ss 18(1E), (1G).

76 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 September 1981, 940 (William Borthwick, Minister of Health).

77 Porter, above n 16, 459–60, 583–4, 686, 715; Cossart, above n 67, S11; Lawrence et al, above n 59, 100.

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

79 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 September 1981, 939 (William Borthwick, Minister of Health).

80 *Ibid.*

people had increased.⁸¹ Parliamentarians were nonetheless also concerned about a rising problem of ‘drug abuse’ in the community to which doctors had contributed by supplying and self-prescribing narcotic drugs.⁸² Authorising the Board to reprimand those doctors was, Borthwick explained, ‘part of the legislative programme of the Government to curb the illicit drug traffic in [Victoria]’.⁸³ MPs were influenced by a medical staff group at the Wangaratta District Base Hospital, which advised them that a reprimand could usefully serve as a ‘warning’ to doctors that, ‘if the offence is repeated’, the Board could impose a harsher regulatory measure.⁸⁴

E *Medical Practitioners (Amendment) Act 1983 (Vic)*

Through the *Medical Practitioners (Amendment) Act 1983 (Vic)* (‘1983 Act’), which amended the 1970 Act, parliamentarians made another significant alteration to this statute that the Board sought.⁸⁵ The amendment authorised the Board to impose a condition, limitation or restriction on a doctor’s practice in response to the doctor’s request to do so where the ‘medical practitioner believes that his physical or mental health is such that he cannot satisfactorily carry out all or some of [a doctor’s] duties and functions’.⁸⁶ The Board envisaged that this provision would ‘encourage a sick doctor to seek treatment and to voluntarily accept such limitation on his practice that may be desirable because of his physical or mental disability’, and thereby protect ‘the community from the harm that might be done by doctors whose mental or physical health is impaired’.⁸⁷

MPs may have been receptive to the Board’s suggestion because giving impaired doctors opportunities to contribute to decision-making about their regulation was congruent with contemporaneous societal attitudes towards the sick. A broad, anti-authoritarian social movement that had emerged in the 1970s advocated liberating minorities – including patients – from oppression, and a ‘self-help’ movement at this time supported patients’ ‘rights’ to be treated not as helpless victims, but as responsible agents in their rehabilitation.⁸⁸ The notion that patients should be empowered to help themselves possibly gained greater traction in response to rising awareness that lifestyle choices affect one’s health.⁸⁹

81 Lewis, *Managing Madness*, above n 15, 176–7, 179, 183, 186–7; Rankin, above n 46, 255–9.

82 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 September 1981, 939 (William Borthwick, Minister of Health); Victoria, *Parliamentary Debates*, Legislative Assembly, 9 December 1981, 4641 (William Borthwick, Minister of Health); Lewis, *Managing Madness*, above n 15, 186–7.

83 Victoria, *Parliamentary Debates*, Legislative Assembly, 23 September 1981, 938 (William Borthwick, Minister of Health).

84 Victoria, *Parliamentary Debates*, Legislative Assembly, 9 December 1981, 4640 (Milton Whiting).

85 Victoria, *Parliamentary Debates*, Legislative Council, 15 June 1983, 2907–8, 2911 (David White); Victoria, *Parliamentary Debates*, Legislative Council, 16 June 1983, 2962 (Geoffrey Connard). The Medical Board of Victoria made recommendations for the amendment of its governing legislation in its second annual report of 1981/82.

86 *Medical Practitioners (Amendment) Act 1983 (Vic)* s 7, inserting *Medical Practitioners Act 1970 (Vic)* s 18(1AA).

87 Victoria, *Parliamentary Debates*, Legislative Council, 15 June 1983, 2911 (David White).

88 Lewis, *Managing Madness*, above n 15, 61–3, 91, 188.

89 Porter, above n 16, 585.

F *Medical Practitioners (Amendment) Act 1991 (Vic)*

Legislation passed before 1991 had required the Board, except in an emergency, to hold a ‘full inquiry’ into impaired doctors’ health before imposing any regulatory measure, even if the Board had requested the doctors to have medical examinations.⁹⁰ Pursuant to the *Medical Practitioners (Amendment) Act 1991 (Vic)* (‘1991 Act’) (which amended the *1970 Act*), however, the Board could choose, instead of holding the inquiry, to use an informal process to determine the likely effects of doctors’ illnesses on their medical practice, and then endorse doctors’ ‘voluntary action’ to constrain their practice or undergo treatment.⁹¹

Parliamentarians empowered the Board to appoint a medical practitioner (who could be one of its members) to undertake a ‘preliminary assessment’ of information that a doctor’s ‘fitness to practise’ was ‘seriously impaired because of his or her physical or mental condition’.⁹² (The *1991 Act* was the first relevant Victorian statute to use the word ‘impaired’ to describe the impact of doctors’ ill health on their capacity to practise medicine). If the assessor decided that the information indicated that the doctor may not have been fit to practise, the assessor was required to invite the doctor to undergo a medical examination to assess the doctor’s fitness to practise, and the examining medical practitioner needed to report to the assessor on the doctor’s physical and/or mental condition.⁹³ The Board could then approve an agreement between the assessor and doctor that the doctor would give an ‘undertaking’ to the Board to limit his or her practice, cease practising for a period, and/or receive medical treatment.⁹⁴

This change to the Board’s powers was significant because, as Minister for Health Maureen Lyster observed, the informal process ‘provide[d] a more sympathetic and less draconian alternative to ... dealing with sick medical practitioners’ than an inquiry.⁹⁵ The Explanatory Memorandum to the *Medical Practitioners (Amendment) Bill 1991 (Vic)* also described the new process as ‘less complex, and legalistic’.⁹⁶ The AMA, the Board and the Health Issues Centre (which supported consumers of health services) approved of the legislation,⁹⁷ possibly in part because it was consonant with an increasingly

90 Victoria, *Parliamentary Debates*, Legislative Council, 15 May 1991, 1683 (Maureen Lyster, Minister for Health); *Medical Practitioners (Amendment) Act 1981 (Vic)* s 9, inserting *Medical Practitioners Act 1970 (Vic)* ss 18(1C)–(E), (1J).

91 *Medical Practitioners (Amendment) Act 1991 (Vic)* s 11, inserting *Medical Practitioners Act 1970 (Vic)* s 18E.

92 *Medical Practitioners (Amendment) Act 1991 (Vic)* s 11, inserting *Medical Practitioners Act 1970 (Vic)* s 18B(1).

93 *Medical Practitioners (Amendment) Act 1991 (Vic)* s 11, inserting *Medical Practitioners Act 1970 (Vic)* ss 18C–18D.

94 *Medical Practitioners (Amendment) Act 1991 (Vic)* s 11, inserting *Medical Practitioners Act 1970 (Vic)* s 18E(3).

95 Victoria, *Parliamentary Debates*, Legislative Council, 15 May 1991, 1683 (Maureen Lyster, Minister for Health).

96 Explanatory Memorandum, *Medical Practitioners (Amendment) Bill 1991 (Vic)* 2.

97 Victoria, *Parliamentary Debates*, Legislative Council, 27 August 1991, 34 (Marie Tehan); Victoria, *Parliamentary Debates*, Legislative Council, 15 May 1991, 1683 (Maureen Lyster, Minister for Health); Health Issues Centre, *About Us* <<http://www.healthissuescentre.org.au/about-us/>>.

popular ‘holistic’, ‘humanistic’ model of medical care that viewed patients as ‘partners’ in their treatment, and investigated environmental factors that affected their illnesses.⁹⁸

G *Medical Practice Act 1994 (Vic)*

In the context of growing patient litigation against doctors and health consumers’ concerns about how the Board – established as the Medical Practitioners Board of Victoria (‘MPBV’) by the *Medical Practice Act 1994 (Vic)* (‘*1994 Act*’)⁹⁹ – dealt with complaints about doctors, MPs sought to address the interests of those making complaints and practitioners who were the subjects of their allegations.¹⁰⁰ By passing the *1994 Act*, which repealed the *1970 Act*,¹⁰¹ parliamentarians made two important changes to the Victorian regulator’s powers to manage impaired doctors that they considered would ‘protect the public’ (which was one of the stated ‘main purposes’ of this statute),¹⁰² and ‘strike a balance between the rights of the medical practitioner and the good of the general public’.¹⁰³ First, the *1994 Act* expanded the Victorian regulator’s powers to regulate impaired doctors in emergency situations. Since the *1981 Act* came into operation, the Board had power to suspend a doctor immediately, before holding an inquiry, if the ‘gravity’ of the practitioner’s ‘physical or mental condition’ warranted this action.¹⁰⁴ In the *1994 Act*, legislators gave the MPBV an alternative regulatory option to suspending an impaired doctor’s registration in a situation that it believed constituted an emergency: the MPBV could, instead of suspending the doctor, choose to seek and accept a written agreement from the doctor ‘to alter the way in which she or he practises medicine’.¹⁰⁵ Second, parliamentarians removed the MPBV’s authority to deregister and reprimand a doctor who was an alcoholic or drug-dependent.

With the latter change, parliamentarians acknowledged that substance-addicted doctors were ill, and encouraged the MPBV to recognise the doctors’ wishes to continue pursuing their livelihood, but also ensure that they did not endanger patients. The MPBV and a panel that the MPBV established to conduct a ‘formal hearing’ into a doctor’s ability to practise were required to regulate substance-addicted doctors in the same ways as they managed practitioners who experienced other mental and physical health problems. The Board could enter into agreements with the doctors to alter the way in which they practised medicine, and the Board and formal hearing panel could permit such doctors to

98 Risse, above n 66, 70.

99 *Medical Practice Act 1994 (Vic)* s 65(1).

100 Victoria, *Parliamentary Debates*, Legislative Assembly, 24 March 1994, 544–5 (Alan Brown); Victoria, *Parliamentary Debates*, Legislative Council, 4 May 1994, 480, 489 (Caroline Hogg), 490 (Geoffrey Connard), 494 (Louise Asher).

101 *Medical Practice Act 1994 (Vic)* s 100.

102 *Medical Practice Act 1994 (Vic)* s 1(a).

103 Victoria, *Parliamentary Debates*, Legislative Council, 4 May 1994, 489 (Caroline Hogg).

104 *Medical Practitioners (Amendment) Act 1981 (Vic)* s 9(2), inserting *Medical Practitioners Act 1970 (Vic)* s 18(1A).

105 *Medical Practice Act 1994 (Vic)* s 27(5)(a), as inserted by *Health Practitioner Acts (Further Amendments) Act 2002 (Vic)* s 11.

practise medicine subject to restrictions or suspend their registration.¹⁰⁶ MPs may have been influenced to make this change to the regulator's powers by the expansion of services to treat substance abuse and its formal classification as a 'mental disorder' by the World Health Organisation (in *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*) and the American Psychiatric Association (in its *Diagnostic and Statistical Manual of Mental Disorders*).¹⁰⁷

H Health Professions Registration Act 2005 (Vic)

The *Health Professions Registration Act 2005 (Vic)* ('2005 Act'), which repealed the *1994 Act*,¹⁰⁸ introduced a common regulatory system for 12 Victorian health professions,¹⁰⁹ and also made significant changes to the MPBV's powers to manage impaired doctors. While some of those amendments could encourage regulators to support an impaired doctor to remain in or return to safe medical practice, others had the potential – for the first time since the *1994 Act* removed the regulator's power to cancel the registration of a substance-addicted doctor – to result in an impaired doctor's deregistration.

Under the *2005 Act*, one of the MPBV's explicit functions became 'to initiate, promote, support, fund or participate in programs that [it] considers will improve health practitioners' ability to practise'.¹¹⁰ The MPBV could therefore help impaired doctors to recuperate and practise medicine safely. The MPBV could still establish an inquiry – termed a 'health panel' in the *2005 Act* – to obtain information about doctors' conditions and determine appropriate regulation for them.¹¹¹ New regulatory measures that could be imposed at this hearing included: conditions that might assist with an impaired doctor's rehabilitation, such as undergoing counselling and attending upon a health practitioner for treatment;¹¹² and a requirement for the doctor to enter into an agreement with the MPBV.¹¹³

In contrast to those provisions, which could lead to impaired doctors continuing to practise medicine or resuming practice when they were sufficiently well to do so, other alterations to the MPBV's powers made by the *2005 Act* could result in an impaired doctor ceasing practice. With the agreement or upon the request of an impaired doctor, the MPBV was able to cancel the practitioner's registration.¹¹⁴ In addition, the *2005 Act* empowered the Victorian Civil and Administrative Tribunal ('VCAT') to cancel doctors' registration against their wishes.¹¹⁵ Under this statute, the MPBV could refer a matter concerning a

106 *Medical Practice Act 1994 (Vic)* ss 32, 34(2).

107 Rankin, above n 46, 260; Dan Lubman et al, 'Putting "Addiction" Back into Psychiatry: The RANZCP Section of Addiction Psychiatry' (2008) 16 *Australasian Psychiatry* 39, 41.

108 *Health Professions Registration Act 2005 (Vic)* s 163(1)(d).

109 Explanatory Memorandum, *Health Professions Registration Bill 2005 (Vic)* 1.

110 *Health Professions Registration Act 2005 (Vic)* s 118(1)(k).

111 *Health Professions Registration Act 2005 (Vic)* s 65.

112 *Health Professions Registration Act 2005 (Vic)* ss 67(3)(a), (d).

113 *Health Professions Registration Act 2005 (Vic)* s 67(2)(d).

114 *Health Professions Registration Act 2005 (Vic)* ss 39(1), 59(2)(d).

115 *Health Professions Registration Act 2005 (Vic)* s 77(4)(h).

doctor's 'ability to practise' to VCAT,¹¹⁶ and a health panel and a 'professional standards panel' (appointed by the MPBV to conduct a hearing into a doctor's professional performance or conduct) were required to refer a matter to VCAT if they considered that a doctor's ability to practise was affected to such an extent that it was reasonably likely that VCAT might cancel his or her registration.¹¹⁷

Unlike the MPs who in 1933 authorised the Board to deregister 'inebriates', in making these changes to regulators' powers, legislators did not intend that impaired doctors would be punished. In fact, most MPs did not envisage that the MPBV would refer matters pertaining solely to a doctor's health (and not his or her conduct) to VCAT,¹¹⁸ although the *2005 Act* permitted it to do so. Rather, parliamentarians focused on ensuring that doctors about whom complaints were made were, and were seen to be, regulated appropriately.

The AMA opposed much of the Health Professions Registration Bill 2005 (Vic) and one of its concerns was that VCAT hearings into complaints about doctors would increase the MPBV's costs, which would ultimately be borne by doctors (through their payment of registration fees) and patients.¹¹⁹ The Government nonetheless considered that this legislation would 'protect the public' and strike 'a better balance between the needs and interests of consumers – the Victorian community – and the rights and interests of practitioners'.¹²⁰ It heeded the recommendations of a research report, commissioned by the Department of Human Services, into consumer experiences of the complaints processes of Victorian health practitioner registration boards.¹²¹ The report found that many complainants believed that these regulators were biased and looked after practitioners at the expense of protecting patients.¹²² To develop a 'more consumer-trusted' system that appeared fair and impartial,¹²³ the report recommended separating the boards' investigation and prosecution functions from the hearing and determination of disciplinary matters, so that panels within the boards would hold informal hearings, while an independent tribunal would make decisions regarding serious complaints.¹²⁴ MPs might also have been influenced to pass the *2005 Act* by contemporaneous reviews of health

116 *Health Professions Registration Act 2005* (Vic) ss 41(2), 46, 53(2), 59(2)(g).

117 *Health Professions Registration Act 2005* (Vic) ss 64(2)(b), 68(2).

118 Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2005, 2101 (Hugh Delahunty), 2104 (Daniel Andrews), 2107 (Ann Barker).

119 Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2005, 2099 (Helen Shardey), quoting a submission of the Australian Medical Association; Victoria, *Parliamentary Debates*, Legislative Council, 24 November 2005, 2369–70 (Dianne Hadden); Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2005, 2101 (Hugh Delahunty).

120 Victoria, *Parliamentary Debates*, Legislative Council, 24 November 2005, 2366 (Carolyn Hirsh); Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2005, 2104 (Daniel Andrews).

121 Resolution Resource Network and Health Issues Centre, 'Bringing in the Consumer Perspective: Consumer Experiences of Complaints Processes in Victorian Health Practitioner Registration Boards' (Final Report, October 2004); Victoria, *Parliamentary Debates*, Legislative Council, 24 November 2005, 2363 (David Davis).

122 Resolution Resource Network and Health Issues Centre, above n 121, 7, 11, 49, 57.

123 *Ibid* 13.

124 *Ibid* 57–8.

practitioner regulation legislation in Western Australia ('WA'), Queensland and the Northern Territory ('NT').¹²⁵

I Health Practitioner Regulation National Law (Victoria) Act 2009 (Vic)

The *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) ('2009 Act') is the latest statute to change significantly regulators' powers to manage impaired Victorian doctors. This statute implemented the National Registration and Accreditation Scheme ('NRAS') by adopting and applying as a law of Victoria the schedule to the *Health Practitioner Regulation National Law Act 2009* (Qld).¹²⁶ (The *Health Professions Registration (Repeal) Act 2012* (Vic) subsequently repealed the *2005 Act*).¹²⁷ The amendments made by the *2009 Act* to regulators' authority reflect the impetuses for the creation of the NRAS.

Under the NRAS, National Health Practitioner Boards register practitioners in 14 health professions in all Australian jurisdictions and, with the exception of New South Wales ('NSW') and Queensland, handle matters relating to their health, performance and conduct.¹²⁸ The MBA regulates the Victorian medical profession. In 2006, the Council of Australian Governments ('COAG') agreed to create the scheme to 'improve safety and quality' in the health sector.¹²⁹ COAG was responding to a report that it had sought from the Productivity Commission, which described the former system for regulating Australian health practitioners – each health profession was regulated individually and at a state and territory level – as inflexible, inconsistent and costly.¹³⁰ COAG made its decision in the wake, too, of scandals in which public hospitals and medical boards had enabled doctors to continue practising medicine after grave allegations had been made about their professional conduct and performance.¹³¹ In one of those cases, a professional standards committee appointed by the Medical Board of NSW had also found that the practitioner, Dr Graeme Reeves, suffered from 'personality and relationship problems and depression that detrimentally [affected] his mental capacity to practise medicine'.¹³² Reeves was subsequently convicted of indecent assault and grievous bodily harm of patients.¹³³

125 Ibid 20.

126 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) s 4.

127 *Health Professions Registration (Repeal) Act 2012* (Vic) s 3.

128 New South Wales and Queensland follow a co-regulatory model whereby health professionals are regulated under both the *Health Practitioner Regulation National Law*, as in force in each state and territory, and other state legislation, and health profession boards share regulatory responsibilities with health complaints bodies.

129 Council of Australian Governments, 'Communique' (14 July 2006) 4; Council of Australian Governments, 'Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions' (Intergovernmental Agreement, 2008) cls 2.3, 2.5.

130 Productivity Commission, 'Australia's Health Workforce' (Research Report, 22 December 2005) iv, xiv, xix, xxxiv.

131 Gabrielle Wolf, 'Sticking Up for Victoria? Victoria's Legislative Council Inquires into the Performance of the Australian Health Practitioner Regulation Agency' (2014) 40 *Monash University Law Review* 890, 892–5.

132 New South Wales, Inquiry into the Circumstances of the Appointment of Graeme Reeves by the Former Southern Area Health Service, *First Report of the Special Commission of Inquiry* (2008) 10 [2.29].

Especially in light of these events, MPs were concerned to ensure that the NRAS protected the public.¹³⁴ Their promotion also of doctors' interests was recognised by the AMA, which considered that the legislative changes were timely.¹³⁵ Parliamentarians' intentions are apparent in provisions of the *2009 Act* that expand regulators' authority over impaired doctors' registration to some extent, but also require the MBA to give impaired doctors more opportunities to respond to proposals for their regulation than were available to them under preceding relevant legislation.

In contrast to the *2005 Act*, the *2009 Act* does not empower the MBA to refer matters that relate only to doctors' health, and not their conduct, to VCAT (which has retained its authority to deregister doctors).¹³⁶ Nevertheless, the MBA, unlike previous regulators of the Victorian medical profession, has power to refuse to grant a doctor registration or renew a doctor's registration on the ground that he or she is 'not a suitable person to hold registration' if the MBA believes that the doctor 'has an impairment that would detrimentally affect the individual's capacity to practise the profession to such an extent that it would or may place the safety of the public at risk'.¹³⁷ Further, the MBA can grant an impaired doctor registration or renew an impaired doctor's registration subject to conditions.¹³⁸

Before imposing a regulatory measure on a registered doctor, however, the MBA must undertake a 'show cause process' by giving the doctor written notice of its proposal and inviting the doctor to make a submission about it (unless the Board has already investigated the doctor or conducted a health assessment or performance assessment of him or her because the doctor will already have had a chance to make a submission in response to those processes).¹³⁹ This change extends previous regulators' obligations to permit doctors to make submissions to inquiries into their health that were held. Indeed, the *2009 Act* is the first Victorian statute to require a regulator, in a situation that it believes is an emergency, to seek an impaired doctor's response to a proposal to take regulatory action.

quoting *Reeves* (Unreported, New South Wales Medical Tribunal, Judge McGuire, Dr Atkinson, Dr Vamos and Dr Gleeson, 23 July 2004) 6.

133 *R v Reeves* (Unreported, District Court of New South Wales, Woods DCJ, 1 July 2011); *Reeves v The Queen* [2013] NSWCCA 34.

134 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 3(2)(a); Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 1; Victoria, *Parliamentary Debates*, Legislative Assembly, 15 October 2009, 3695 (Daniel Andrews, Minister for Health); Victoria, *Parliamentary Debates*, Legislative Council, 27 November 2009, 5836 (Khalil Eideh); Victoria, *Parliamentary Debates*, Legislative Assembly, 11 November 2009, 3895 (Judith Graley).

135 Victoria, *Parliamentary Debates*, Legislative Assembly, 11 November 2009, 3896 (Peter Crisp); see Australian Medical Association, Joint Submission to the Australian Health Workforce Ministerial Council, *Exposure Draft of the Health Practitioner Regulation National Law*, 21 July 2009 <https://ama.com.au/system/tdf/documents/AMA_Joint_Submission_to_Government.pdf?file=1&type=node&id=37154>.

136 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 196(2)(e).

137 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 55(1)(a), 82(1)(c)(i)(C), 112(2)(a).

138 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 83(1).

139 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 157, 179; Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 100.

The MBA can take ‘immediate action’, by imposing a regulatory measure on a doctor without holding an investigation or hearing before doing so, if it ‘reasonably believes that ... because of the registered [doctor’s] ... health, the practitioner poses a serious risk to persons; and ... it is necessary to take immediate action to protect public health or safety’.¹⁴⁰ Prior to taking immediate action, however, the MBA must initiate a ‘show cause process’.¹⁴¹ The purpose of this process, according to the Explanatory Notes to the Health Practitioner Regulation National Law Bill 2009 (Qld), is ‘to afford the practitioner ... natural justice’.¹⁴² This is achieved through giving the doctor notice of the proposed immediate action and inviting him or her to make a written or verbal submission to the MBA, which the MBA must consider in deciding whether to take immediate action.¹⁴³ Nevertheless, the show cause process is ‘not intended’ to ‘delay or impede’ the MBA from ‘taking immediate action, when it is warranted’.¹⁴⁴ In such circumstances, the MBA is also empowered to encourage impaired doctors to contribute to decision-making about their regulation. The immediate action can constitute the imposition of conditions on or suspension of registration, but may involve the MBA accepting the doctor’s undertaking or surrender of registration, too.¹⁴⁵

III EVALUATING THE SIGNIFICANT CHANGES TO STATUTORY POWERS TO REGULATE IMPAIRED DOCTORS IN VICTORIA

In parliamentary debates and legislation, MPs who empowered regulators to manage impaired doctors in Victoria repeatedly emphasised that their paramount objective was to protect the public. Particularly in the last few decades, legislators have indicated, too, their concern to respect impaired doctors’ interests, as patients (in making decisions about their treatment) and as practitioners (in seeking to continue working in the profession for which they have trained). MPs often implied that there was an inherent tension between the community’s needs and impaired doctors’ ‘rights’, which they had to balance when deciding on powers to grant to regulators. If impaired doctors seriously endanger patients, their continued pursuit of their livelihood is unjustifiable. Yet it is in everyone’s interests if doctors, whom the community has devoted resources to educate so that they can meet the public’s need for medical care, can be supported to practise medicine safely.

Many changes that parliamentarians have made over the years to regulators’ powers to manage impaired doctors have enabled and encouraged them to support doctors’ safe medical practice. As legislators’ conceptions of the best

140 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 156(1)(a).

141 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 157.

142 Explanatory Notes, *Health Practitioner Regulation National Law Bill 2009* (Qld) 93.

143 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 157.

144 Explanatory Notes, *Health Practitioner Regulation National Law Bill 2009* (Qld) 93.

145 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 155.

means of protecting the public have evolved in response to various influences, they have empowered regulators to adopt an ever more flexible, personalised and empathic regulatory approach. This style of managing impaired doctors has the potential to achieve optimal outcomes for practitioners and the community, namely, that impaired doctors continue working but with modifications to ensure that they do not imperil patients, or return to medical practice when they are sufficiently well to do so.

Notwithstanding the considerable shift in legislators' intentions, there are circumstances in which impaired doctors today may still experience regulation that appears punitive and that does not support them to practise medicine safely. For the benefit of the doctors and ultimately the community, future legislators could change regulators' powers further by encouraging them to manage these practitioners in particular with greater compassion and thereby enhance their chances of practising medicine safely in the future.

A Regulators' Powers to Support the Safe Medical Practice of Impaired Doctors

One change to regulators' powers that has manifestly encouraged them to promote impaired doctors' safe medical practice is that, since 2005, they have been given discretion to assist with practitioners' recuperation. One of the MBA's current statutory 'functions' is 'to provide financial or other support' for doctors' 'health programs',¹⁴⁶ which can include 'education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders'.¹⁴⁷ In 2009, Minister for Health Daniel Andrews confirmed that the Brumby Government intended to enable the MBA to continue supporting health programs that had proven 'essential to the ongoing good health and working ability of the health workforce'.¹⁴⁸

Another alteration to regulators' powers that has enhanced their capacity to support more impaired doctors to practise medicine safely has been the expansion of the forms of ill health experienced by doctors for which regulators can manage them. In 1933, the Board could only regulate doctors whose medical practice was impaired by excessive use of alcohol or drugs. Over time, parliamentarians passed statutes that empowered regulators to constrain the medical practice of doctors who suffered from other illnesses. Today, regulators can impose regulatory measures on doctors who suffer from any type of sickness, condition, disability or disorder, provided that it 'detrimentally affects or is likely to detrimentally affect' their 'capacity to practise' medicine.¹⁴⁹

By requiring regulators to give impaired doctors more opportunities to participate in decision-making about their regulation, MPs appeared to believe

146 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 35(1)(n).

147 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 5 (definition of 'health program').

148 Victoria, *Parliamentary Debates*, Legislative Assembly, 15 October 2009, 3697 (Daniel Andrews, Minister for Health).

149 *Health Practitioner National Law (Victoria) Act 2009* (Vic) sch ss 5 (definition of 'impairment'), 156, 178, 191(3).

that they thereby increased the probability that those doctors would practise medicine safely. While there is no evidence to confirm whether this is the case, it seems likely that, if regulators permit impaired doctors to contribute to determinations about regulatory measures to be imposed, the practitioners will be more willing to comply with them. From 1983, regulators have been authorised to apply regulatory measures in response to an impaired doctor's request to do so and, from 1991, they have been able to reach agreements with impaired doctors regarding their practice and treatment. Currently, the MBA must also give impaired registered doctors a chance to respond to any proposal to impose a regulatory measure (unless the Board has conducted an investigation regarding or a health assessment or performance assessment of a doctor),¹⁵⁰ and the MBA is authorised to accept impaired doctors' undertakings.¹⁵¹

Parliamentarians have gradually introduced more effective processes for regulators to ascertain the nature of doctors' ill health and its likely impact on their practice of medicine. Such improvements have enabled regulators to customise their regulation to individual doctors' conditions and thereby better foster their safe practice. From 1933 until 1991, regulators were required to hold inquiries into doctors' health. The formality of those proceedings potentially intimidated doctors, and influenced them to withhold details of their ill health and its effects on their practice. From 1991, regulators have still been authorised to establish such hearings,¹⁵² but they are no longer required to do so and the inquiries (which since 2005 have been termed 'health panels') have become less formal. In the *1994 Act* and the *2005 Act*, MPs specified that these proceedings were to be 'conducted with as little formality and technicality as the requirements of [the statute] and the proper consideration of the matter permit'.¹⁵³

Since the passage of the *1991 Act*, regulators have been empowered to elicit information about doctors' health through more sensitive and efficient means than a hearing, namely, by: appointing individuals to assess doctors' ability to practise medicine; and/or arranging for doctors to undergo examinations of their health. Impaired doctors may disclose details of their conditions more readily to those conducting investigations or health examinations than to panels hosting inquiries, so that regulatory measures can be tailored to their particular needs. At present, if the MBA believes that a doctor has or may have an impairment, in addition to or instead of establishing a health panel, it can apply regulatory measures in response to the recommendations of an investigator whom it appoints to conduct an investigation,¹⁵⁴ or to the outcome of a 'health assessment' that it requires a doctor to undergo (which is potentially broader than the medical examination permitted under previous statutes, as it can encompass a psychological examination or test).¹⁵⁵

150 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 157, 179.

151 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 155(b), 178(2)(b).

152 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 181(1).

153 *Medical Practice Act 1994* (Vic) s 52(1)(b); *Health Professions Registration Act 2005* (Vic) s 69(1)(a).

154 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 156, 160, 166–7, 178.

155 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 5 (definition of 'health assessment'), 156, 168–9, 171(2)(a), 175, 177–8.

MPs have also empowered regulators to promote impaired doctors' safe medical practice by expanding the types of regulatory measures that they can apply. With increased forms of regulation available to them, regulators can personalise their management of impaired doctors, taking into account their specific conditions. In 1933, the Board had no alternative but to deregister an inebriate. Over time, MPs have authorised regulators to manage impaired doctors in different ways: from 1959, to suspend their registration; from 1981, to impose conditions, limitations and restrictions on their practice; and from 1991, to enter agreements with and/or accept undertakings from them, such as to receive treatment, limit or alter their practice of medicine, and (from 2005) to undergo counselling.

The culmination of these statutory changes is that regulators now have a variety of options for managing impaired doctors. If the MBA reasonably believes that doctors have or may have an impairment, it can take 'relevant action' including by cautioning them, accepting undertakings from them, and/or imposing conditions on their registration.¹⁵⁶ If the MBA takes immediate action, it can suspend or impose a condition on the impaired doctor's registration, and/or accept an undertaking from the doctor or surrender of the doctor's registration.¹⁵⁷ A health panel appointed by the MBA can also impose conditions on or suspend the registration of a doctor whom it decides has an impairment.¹⁵⁸

B Potential for Impaired Doctors to Experience Punitive and Unsympathetic Regulation

With its current powers to regulate impaired doctors, the MBA can tailor its management of them to their particular health issues and restrict their practice to the lowest extent necessary to safeguard patients. Although parliamentarians have empowered regulators to adopt this flexible, personalised management style, regulation of impaired doctors can still appear punitive and unsympathetic. This is especially likely in cases where: doctors are severely impaired; doctors are impaired to a lesser extent, but are unaware of the effects of their ill health on their medical practice; and impaired doctors engage in professional misconduct. Typically, in these circumstances, regulatory measures that are imposed on the impaired doctors will not help them to practise medicine safely in the future and, despite the MBA's power to support health programs, no specific assistance is offered to the practitioners.

Since parliamentarians first authorised regulators to suspend impaired doctors' registration, they have also empowered them to revoke suspensions. A VCAT panel in *Honey v Medical Practitioners Board of Victoria* ('*Honey*') articulated the perceived distinction between deregistration and suspension of registration: 'Cancellation of registration sends a clear message of unsuitability to practice [sic]. Suspension may be thought to indicate confidence in the doctor's

156 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 178.

157 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 155–6.

158 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 191(3)(a)–(b).

future ability to practice [sic] once the period of suspension is served'.¹⁵⁹ Yet a suspension of registration may not be temporary, and a suspended doctor could be prevented from practising medicine indefinitely. If the MBA takes immediate action to suspend an impaired doctor's registration, the decision continues to have effect until the MBA revokes the suspension or a VCAT panel sets it aside on appeal,¹⁶⁰ but regulators may never receive evidence to justify ending a suspension of registration.

Indeed, the impact of suspension of registration on an impaired doctor, personally and professionally, may inhibit him or her from returning to medical practice, particularly if regulators do not provide any support to them. The suspension has no inherent rehabilitative effect. Moreover, to impaired doctors, being prevented from pursuing their livelihood for any length of time, however short, might feel like a punishment, and such an experience could lead to a deterioration in doctors' health and deter them from seeking medical treatment or resuming work. In the recent matter of *Medical Board of Australia v ZOF [No 2]* ('ZOF'), a VCAT panel acknowledged that suspension of registration could have the tangible punitive impact of harming a doctor's professional reputation.¹⁶¹ Additionally, the panel in *Honey* quoted Gillard J's observation in *Mullany v Psychologists Registration Board* that 'to be deprived of the opportunity of working as a professional for a period [of suspension of registration] would have a devastating effect on ones [sic] financial position, one's standing in the community, one's practice'.¹⁶²

Powers that the legislature has granted to regulators may also result in impaired doctors not being granted registration to practise medicine, or having their registration cancelled with or without their consent. Impaired doctors would probably experience these regulatory measures as being as punitive and draconian as a suspension of registration, and they are unlikely to support their rehabilitation or subsequent attempts to seek to practise medicine.

In addition to the MBA's powers to refuse to register doctors or renew doctors' registration if it believes that they have an impairment, the MBA can take immediate action by accepting impaired doctors' surrender of their registration.¹⁶³ According to Gavin Jennings MP, legislators who passed the *2009 Act* aspired 'to achieve an outcome where a practitioner voluntarily agrees to cease ... their practice so that they do not pose a risk to the public. Voluntarily withdrawing from their practice will enable them to receive assistance'.¹⁶⁴ Although doctors' surrender of registration is ostensibly voluntary, they may feel compelled to relinquish their livelihood to avoid the imposition of alternative

159 *Honey v Medical Practitioners Board of Victoria* [2007] VCAT 526, [43] (Judge Harbison and Member Davis).

160 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 159(2)(a)–(b), 199(1)(j), (2). This statute does not specify when a suspension of registration that is imposed by a health panel expires.

161 [2015] VCAT 379, [36] (Senior Member Proctor, Members Collopy and Shanahan).

162 *Honey* [2007] VCAT 526, [54] (Judge Harbison and Member Davis), quoting *Mullany v Psychologists Registration Board* (Unreported, Supreme Court of Victoria, Gillard J, 22 December 1997) [20].

163 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 155(c), 156(1)(a).

164 Victoria, *Parliamentary Debates*, Legislative Council, 27 November 2009, 5840 (Gavin Jennings).

regulatory measures (such as suspension of registration) and potential public humiliation, but subsequently regret their decision. Moreover, after relinquishing their registration, these doctors may feel too ashamed or despondent to seek any assistance.

A doctor may also be deregistered by a VCAT panel – which stands in the shoes of the regulator – if it decides that the doctor has an impairment, and the panel can disqualify the impaired doctor from applying for registration for a specified period.¹⁶⁵ The impact on impaired doctors of involuntary deregistration can be particularly severe and discourage them from obtaining treatment or attempting to practise medicine again. As Shields recognised in 1933, such cancellation of registration without the doctors' consent forcibly deprives them of the 'rights and privileges' of registration. Further, as the panel highlighted in *Honey*, it informs the practitioner and the public that the doctor is unsuited to practise medicine, and a deregistered doctor must reapply for registration with no guarantee of his or her application being granted.¹⁶⁶

Generally, VCAT will only hear matters that concern doctors' health (and not their professional conduct) in the first instance if doctors request a health panel or performance and professional standards panel to transfer their matters to the tribunal.¹⁶⁷ Nevertheless, if impaired doctors repeatedly breach conditions on their registration that the MBA or a panel have imposed, or undertakings that they have given to the MBA, the MBA might refer their matters to VCAT. A doctor's contravention of a condition or undertaking falls within the definition of 'unprofessional conduct' in the *2009 Act*, and this statute's definition of 'professional misconduct' includes '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 [doctor] of an equivalent level of training or experience'.¹⁶⁸ The MBA must refer a matter to VCAT if it or a panel it appoints believes that a doctor has engaged in professional misconduct or improperly obtained his or her registration, even if the doctor's ill health precipitated this behaviour.¹⁶⁹

Other determinations that a VCAT panel can make in relation to impaired doctors, while less restrictive of their registration than suspension of registration or deregistration, might also be perceived as draconian and unsupportive. For instance, if impaired doctors' matters are referred to VCAT, a panel can reprimand them or require them to pay a fine to the MBA.¹⁷⁰ Impaired doctors would probably interpret these regulatory measures as punishments. Indeed, in *Peeke v Medical Board of Victoria*, Marks J observed that a reprimand is not a

165 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 196(2)(e), (4)(a).

166 *Honey* [2007] VCAT 526, [42] (Judge Harbison and Member Davis).

167 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 190(a), 193(1)(b).

168 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 5 (definitions of 'unprofessional conduct' and 'professional misconduct'). In response to an impaired doctor's contravention of conditions or an undertaking, the Medical Board of Australia could also appoint a health panel or a performance and professional standards panel, vary the doctor's conditions, or take 'relevant' or 'immediate' action: at sch ss 126, 156, 178, 181–2.

169 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 190(b), 193.

170 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch ss 196(2)(a), (c).

‘trivial penalty’ and ‘to a professional person, has a potential for serious adverse implications’.¹⁷¹ Moreover, neither a reprimand nor a fine would assist an impaired doctor in any way to practise medicine safely in the future.

In 1981, Borthwick reinforced that the Thompson Government did not empower the Board to place conditions on impaired doctors’ registration in order to penalise them. Certainly, regulators’ imposition of conditions can support impaired doctors to practise medicine safely. Nevertheless, conditions, which the MBA, a health panel and the MBA can impose, may potentially have a punitive effect on impaired doctors if they prevent them from undertaking some practice that is essential to pursuing their medical speciality.¹⁷²

If impaired doctors engage in professional misconduct, even though their ill health was the catalyst for their behaviour, they may find themselves the subject of disciplinary proceedings at VCAT. While tribunal panels must address the impaired doctors’ conduct, their tendency to pursue goals that are not explicitly articulated in the *2009 Act* can lead to impaired doctors experiencing regulation that is punitive and that does not support their future safe medical practice.

The disciplinary powers of professional disciplinary tribunals are discretionary,¹⁷³ and, before and after the NRAS came into operation, many tribunal panels have applied longstanding common law notions of the purposes of disciplinary determinations to which the *2009 Act* does not refer.¹⁷⁴ For instance, tribunal panels have repeatedly indicated in their decisions regarding doctors’ conduct that they have interpreted regulators’ obligation to protect the public (which has repeatedly been expressed in relevant legislation) as involving objectives that these statutes have not articulated, such as maintaining proper professional standards and public confidence in the medical profession, as well as deterring the individual doctor and other practitioners from engaging in similar behaviour.¹⁷⁵ When VCAT panels make decisions regarding impaired doctors informed by these aims – even though they often emphasise that determinations are not to be used to punish practitioners¹⁷⁶ – their regulation can potentially have a penalising effect that is inappropriate. This may be the case particularly if the doctors have already recovered from illnesses that precipitated their behaviour and learned from their mistakes.¹⁷⁷ In fact, in *Honey*, the panel indicated that it could be reasonable and fitting to deregister a ‘miscreant doctor’, ‘even if there is no risk at all of repetition of the offending conduct’, because ‘protection of the public requires a strong message to be sent to other medical practitioners that the

171 *Peeke v Medical Board of Victoria* (Unreported, Supreme Court of Victoria, Marks J, 19 January 1994).

172 Danuta Mendelson, ‘Disciplinary Proceedings against Doctors Who Abuse Controlled Substances’ (2015) 23 *Journal of Law and Medicine* 24, 35–6.

173 *Walton v Gardiner* (1993) 177 CLR 378, 404 (Brennan J).

174 Danuta Mendelson, ‘Disciplinary Proceedings for Inappropriate Prescription of Opioid Medications by Medical Practitioners in Australia (2010–2014)’ (2014) 22 *Journal of Law and Medicine* 255, 255–6, 260–3, 267–8, 278.

175 *Ibid* 260–2, 264–5, 268.

176 *Ibid* 263. See, eg, *ZOF* [2015] VCAT 379, [9] (Senior Member Proctor, Members Collopy and Shanahan).

177 Mendelson, ‘Disciplinary Proceedings for Inappropriate Prescription’, above n 174, 264, 267–8, 270–1.

conduct in question is reprehensible, and to other patients that they will be protected from that conduct'.¹⁷⁸

C Recommendations for Future Statutory Changes to Regulators' Powers to Manage Impaired Doctors

So how can parliamentarians ensure that more impaired doctors will experience regulation that supports them to practise medicine safely? Arguably, they can make further changes to the powers of regulators (and the tribunals that stand in their shoes for the purpose of disciplinary matters) that encourage them to manage impaired doctors with greater compassion. Such changes are particularly necessary in circumstances where regulators must manage doctors who: are severely impaired; are impaired to a lesser degree, but lack insight into the impact of their ill health on their medical practice; or engage in professional misconduct.

There are undoubtedly cases in which regulators consider it impossible to minimise the risk that impaired doctors pose to patients without curtailing their medical practice substantially. In the *2009 Act*, MPs set out broad directions for regulators to follow in exercising their discretion to manage impaired doctors. Regulators must attempt to realise the 'objective' of the NRAS 'to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered'.¹⁷⁹ Regulators are also required to heed the guiding principle of the NRAS that 'restrictions on the practice of a health profession are to be imposed ... only if it is necessary to ensure health services are provided safely and are of an appropriate quality'.¹⁸⁰ If doctors' impairments are acute or if their impairments are relatively mild, but they are unaware of the effects of their ill health on their practice – which might be reflected, for instance, in their contravention of conditions or undertakings – regulators may believe that it is necessary to impose considerable constraints on their practice to ensure that the public is not endangered.¹⁸¹

While not a Victorian case, the matter of *Van Dijk and Medical Board of Australia* demonstrates that a regulator may consider that it has no option but to preclude an impaired doctor from practising indefinitely in order to protect the community. Dr Van Dijk had inappropriately prescribed narcotic drugs for patients with whom he was in a close personal relationship, and in breach of relevant guidelines, and consumed the medication himself.¹⁸² The NT Health Professional Review Tribunal found that the doctor had attempted to 'thwart' the

178 [2007] VCAT 526, [44], [51] (Judge Harbison and Member Davis).

179 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 3(2)(a).

180 *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 3(3)(c).

181 Mendelson, 'Disciplinary Proceedings against Doctors', above n 172, 34, quoting Gregory Treverton-Jones et al, 'The Tribunal's Decision' in Gregory Treverton-Jones, Alison Foster and Saima Hanif (eds), *Disciplinary and Regulatory Proceedings* (Jordan Publishing, 8th ed, 2015) 265.

182 *Van Dijk and Medical Board of Australia* (Unreported, Northern Territory Health Professional Review Tribunal, Currie P, Community Member Martin, Special Members Giles, Omond and Toth, 28 October 2014) [13].

Board's investigation and exhibited no remorse, and there was no independent evidence to confirm that he was rehabilitated, or to help estimate whether treatment would be successful or when he might be fit to return to practice.¹⁸³ In these circumstances, the tribunal was sceptical that conditions on Van Dijk's registration would be 'effective if Dr Van Dijk were to return to practice' because 'the danger to the public would be substantial', and it reached what it described as 'the unavoidable conclusion' that his name should be removed from the register.¹⁸⁴

Yet it is for cases involving impaired doctors such as Dr Van Dijk that parliamentarians should encourage regulators to manage practitioners with greater compassion to improve their chances of practising medicine safely in the future. MPs might, for instance, require regulators to support individual impaired doctors to obtain treatment for their ill health where it is considered necessary to suspend or cancel their registration or refuse to grant them registration. Legislators could also prevent regulators from imposing regulatory measures on or making determinations in relation to impaired doctors that have a purely punitive effect, no rehabilitative impact and no protective function, including where the practitioners have engaged in professional misconduct. If a regulatory measure has some protective function, but there is an alternate means of ensuring that patients are not endangered that will not have the effect of punishing the impaired doctor, regulators should be obliged to apply this latter option. In addition, MPs could make it imperative for regulators and tribunal panels to take doctors' health into account when reaching determinations about how to address their professional conduct. In this respect, they would be formally authorising a practice that has already been applied by some tribunal panels.

Medical Board of Australia v Langton is an example of a case in which a tribunal panel imposed a milder sanction than the egregiousness of the doctor's misconduct might otherwise have warranted because the doctor's ill health was a stimulus for his behaviour. A panel of the State Administrative Tribunal of WA found that Dr Langton's severe depression 'played a significant part' in his engagement in professional misconduct (which included treating a patient with whom he was involved in an intimate relationship), it described his ill health as a 'mitigating factor', and it suspended rather than cancelled the doctor's registration.¹⁸⁵

IV CONCLUSION

Victorian parliamentarians, compared with legislators in other Australian states and territories, were initially slow to empower regulators to manage impaired doctors. For instance, Queensland regulators could deregister doctors

183 Ibid [23]–[26], [56], [58], [73] (Currie P, Community Member Martin, Special Members Giles, Omond and Toth).

184 Ibid [72], [77] (Currie P, Community Member Martin, Special Members Giles, Omond and Toth).

185 *Medical Board of Australia v Langton* (Unreported, Western Australia State Administrative Tribunal, Member Wallace, 22 October 2014) [50].

whom they judged to be guilty of ‘habitual drunkenness’ eight years before the Victorian Board could do so,¹⁸⁶ and they had discretion to suspend the registration of substance-dependent doctors 48 years ahead of Victorian regulators;¹⁸⁷ WA regulators could place conditions on the registration of substance-addicted doctors 15 years before the Victorian Board was granted equivalent authority;¹⁸⁸ and it was nine years before the Victorian Board obtained similar power to that of NSW regulators to impose regulatory measures on doctors whose physical illnesses impaired their ability to practise medicine.¹⁸⁹

Nevertheless, Victorian legislators were also unique for some time in denying regulators the authority to prevent doctors from pursuing their livelihood if their mental illnesses (other than substance addiction) or physical illnesses impaired their capacity to practise medicine. Victorian regulators never had the power of their counterparts in NSW, Queensland, South Australia (‘SA’), Tasmania and WA to deregister doctors whose mental illnesses impaired their capacity to practise medicine,¹⁹⁰ and the authority of NSW and SA regulators to cancel the registration of physically ill doctors.¹⁹¹ This foreshadowed the empathic style of managing impaired doctors that Victorian parliamentarians would empower regulators to adopt.

In light of Victorian parliamentarians’ initial tardiness in authorising regulators to manage impaired doctors, their eventual encouragement of regulators to lean away from a one-size-fits-all, draconian regulatory approach is especially notable. The Board had no authority to regulate impaired doctors a little over 80 years ago, and the first power that it was granted to do so was confined to deregistering an ‘inebriate’. Yet, in the succeeding eight decades, Victorian legislators expanded the regulatory options for managing impaired doctors, and today regulators can apply a variety of measures to regulate doctors who experience any health issue that detrimentally affects their capacity to practise medicine, and the MBA has specific discretion to support programs that help impaired doctors to recuperate.¹⁹²

186 *Medical Act 1925* (Qld) s 15(1)(ii).

187 *Medical and Other Acts Amendment Act 1933* (Qld) s 7, amending *Medical Act 1925* (Qld) s 15.

188 *Medical Act Amendment Act 1966* (WA) s 5, amending *Medical Act 1894* (WA) s 13.

189 *Medical Practitioners (Amendment) Act 1972* (NSW) s 5(u), amending *Medical Practitioners Act 1938* (NSW) ss 30(1)–(2).

190 *Medical Practitioners Act 1938* (NSW) s 30(1)(b)(ii), as inserted by *Medical Practitioners (Amendment) Act 1972* (NSW) s 5(u); *Medical Act 1939* (Qld) s 28(1), until replaced by *Health Legislation Amendment Act 1992* (Qld) s 118; *Medical Practitioners Amendment Act 1966* (SA) s 16, amending *Medical Practitioners Act 1919* (SA) s 26; *Medical Act (No 2) 1955* (Tas) s 16(10), as repealed by *Medical Act 1959* (Tas) s 2; *Medical Act Amendment Act 1945* (WA) s 10, amending *Medical Act 1894* s 13(3).

191 *Medical Practitioners Amendment Act 1966* (SA) s 16, amending *Medical Practitioners Act 1919* (SA) s 26; *Medical Practitioners (Amendment) Act 1972* (NSW) s 5(u), inserting *Medical Practitioners Act 1938* (NSW) s 30(1)(b)(ii).

192 Using this discretion, the Medical Board of Australia has committed to fund a network of nationally-consistent doctors’ health services. For this purpose, the Medical Board of Australia has partnered with the Australian Medical Association, which has created a company to administer the delivery of those health programs by service providers in each jurisdiction: Australian Medical Association, ‘New Doctors’ Health Service Arrangements’ (Media Release, 28 April 2016) <<https://ama.com.au/sites/default/files/documents/280416%20-%20New%20Doctors%27%20Health%20Service%20Arrangements.pdf>>; Medical Board of Australia, ‘Medical Board of Australia and AMA Join Forces on Doctors’ Health’

Inspiring this striking shift in powers granted to regulators of the Victorian medical profession have been parliamentarians' understandings of the best ways of protecting the public, the chief objective that they repeatedly expressed in parliamentary debates and legislation. Over time, Victorian MPs have steadily appreciated that empathic regulation of impaired doctors, applying measures that are customised to individual doctors' particular health issues, is more likely to support them to practise medicine safely. An ideal outcome for doctors and the community is that impaired doctors continue to pursue their livelihood subject to safeguards that protect their patients, or resume practice once they are sufficiently well to do so.

Such regulation of impaired doctors can, however, be difficult to achieve. Great advances in medical knowledge have led to increasingly effective treatments and cures for illnesses, and also prevented contraction of and eradicated some diseases. Nevertheless, new contagious diseases continue to appear, certain illnesses (such as cancer, diabetes and Alzheimer's disease) remain incurable, antibiotic-resistant bacteria are proliferating, and mental health problems, including substance addiction, have far from disappeared.¹⁹³ Doctors, like the rest of the community, are susceptible to the effects of sickness and, in practising their profession, impaired doctors can potentially harm other ill people. In the face of this challenge, despite contemporary legislators' intentions and their significant changes to regulators' powers to manage impaired doctors, vestiges of the past remain. Impaired doctors can still perceive their regulation as punitive, and it may not support them to practise medicine safely.

Importantly, however, this experience of regulation by impaired doctors is not inevitable. The significant changes that have been made to regulators' authority to manage impaired Victorian doctors highlight for future parliamentarians the value of a flexible, personalised and empathic regulatory approach. This history may also influence legislators to change regulators' powers further by encouraging them to manage with greater compassion impaired doctors who are most likely to experience draconian, unsupportive regulation, and thereby improve those doctors' prospects of practising medicine safely in the future.

(Media Release, 5 May 2015) <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD15%2f16746&dbid=AP&checksum=0IVpiXp6dvITx6Wzs4NmCg%3d%3d>>.

193 Porter, above n 16, 716; Cossart, above n 67, S12, S14.