

Volume 2  
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## President's Message

As I write this, my last column as President of this Board, I am reflecting on the past eight years, on what has changed and what remains the same.

The legislation under which the Board operates has changed significantly, first by a series of amendments and then by a new Act. Board membership has changed. Only Bob Adler, the incoming President, was on the Board in 2000. Most members now serve for three or six years. The organisation has changed in response to the heavier and more complex workload. There are more notifications to be investigated, more scope in the Board's investigative powers and a much greater need for Board reasoning to be made explicit at all stages of investigations and hearings.

The new legislation in Victoria and the prospect of the national registration scheme have led to a much higher level of interaction and co-operation between the regulated health professions and with the medical boards in other states and territories. The Register is available online and the Board's website is increasingly being used as a resource by doctors and the community.

The Board's role has not changed – protecting the community in Victoria by regulating the medical profession. The Board recognises that it is accountable to the community and that its effectiveness relies on it being seen as a credible and trustworthy agency.

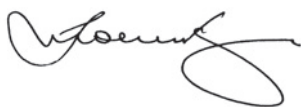
Most doctors, most of the time, have little to do with the Board's processes. They readily take on their professional responsibility to act in the patient's best interests by practising ethically and competently. Patients' expectations have not really changed – they continue to place their trust in their doctors and when they come to the Board they do so mostly because, if something has gone wrong for them, they want to ensure that it doesn't happen to anyone else.

Things will go wrong; sometimes there is no one at fault, sometimes a doctor will have behaved badly or failed to maintain professional standards. The Board's job is to ensure that doctors know what is expected of them and then to act promptly, robustly and fairly when there is evidence of a breach of professional standards.

# Welcome and Farewell

I have learned a great deal in the past eight years, from my patients, my colleagues, the Board staff and my fellow Board members. It is never dull at the Board. Each week brings new issues and opportunities to make us think about what we are here to do.

Despite the stresses and challenges, practising medicine is an intensely engaging and satisfying activity. I feel privileged to have played a part in the process of ensuring that doctors continue to merit the trust that is placed in them.



Dr Joanna Flynn  
President

## New President

Dr Bob Adler has been appointed President of the Board from 1 July 2008, succeeding retiring President Dr Joanna Flynn. Deputy President since 2005, Dr Adler works as a part-time psychiatrist in the Adolescent Forensic Health Service at the Melbourne Youth Justice Centre. Dr Adler is also in private practice with a specific interest in the forensic aspects of child and adolescent psychiatry. Dr Adler was Chairman of the Royal Children's Hospital Mental Health Service, and Professor/Director of Child and Family Psychiatry in the Departments of Paediatrics and Psychiatry at the University of Melbourne from 1985 to 1998. Since becoming a member of the Board in 1998, he has served on the Health, Professional Conduct and Sexual Misconduct Committees and has chaired the Health Committee. He is a member of the Audit Committee, and the Finance and Administration Committee.

Well respected by his peers, Dr Adler is known for his compassion, sense of fairness and considered approach to the complex issues the Board faces. Dr Adler is acutely aware of the core value of trust in the doctor-patient relationship and how crucial this is in providing effective patient care. The Board welcomes his appointment and looks forward to his leadership in the years ahead.

## New Appointments

The Board welcomes two new members:

### **Dr Peter Dohrmann**

Dr Peter Dohrmann has been appointed to the Board effective from 1 July 2008. He studied medicine at Monash University, graduating in 1977, and trained in neurosurgery at the Alfred Hospital.

In 1984 he obtained a neurosurgery fellowship position at the University of Texas Health Science Center at Dallas, specialising in trauma and cerebrovascular neurosurgery. In 1985 he worked in London as a Neurosurgery Registrar at the London Hospital and at the Hospital for Sick Children, Great Ormond Street.

Since 1986, Dr Dohrmann has been in private practice in neurosurgery at Melbourne's Epworth Hospital. He has also held senior appointments at a number of Melbourne teaching hospitals, including the Alfred and Royal Melbourne Hospitals. Dr Dohrmann was appointed Executive Medical Director of Epworth Hospital in 2002.

Away from neurosurgery, Dr Dohrmann is closely involved with the Melbourne Football Club and is a Board member of Open Family Australia.

### **Dr Felicity Hawker**

Dr Felicity Hawker was appointed to the Board in April 2008 to replace retiring member Dr Hadia Haikal-Muhktar. An intensive care physician, Dr Hawker has been the Director of the Intensive Care Unit at Cabrini Hospital since 1995. She is also an Honorary Senior Lecturer at the Monash University Medical School, Department of Surgery. She is a past Dean and is currently the Director of Professional Affairs of the Joint Faculty of Intensive Care Medicine of the Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicians, and a member of the Intensive Care Advisory Committee for the Department of Human Services. Dr Hawker holds a number of senior advisory roles within the Cabrini organisation, including membership of the Ethics Committee and the Clinical Outcomes Committee. Dr Hawker graduated from the University of Tasmania Medical School in 1972, later training at the Alfred Hospital in Melbourne, the Western Infirmary in Glasgow and Sydney's Westmead and Royal Prince Alfred Hospitals, where she was the Co-Director of the Intensive Care Unit from 1985 –1995.

### **Dr Mitchell Chipman, Mr Sean Lusk and Dr Bernadette White**

The Board is delighted that current members Dr Mitchell Chipman, Mr Sean Lusk and Dr Bernadette White have each been reappointed for further three-year terms.

## Dr Joanna Flynn: A Huge Contribution

Dr Joanna Flynn is retiring after 19 years service to the community and the medical profession through her membership of the Medical Practitioners Board of Victoria. She has made a remarkable contribution.

Since 1989, when she was one of the first women appointed to the Board, through eight years as President, Dr Flynn has worked hard to protect the interests of the community and uphold medical professional standards.

As a leader of the Board and of the profession, she has ensured the Board's mandate to protect the community has been balanced with the need for fair and transparent processes, built on the principles of natural justice. Through membership and chairmanship of many Board committees and disciplinary panels, she has achieved a great deal.

Her role in developing a code of professional conduct, *Good Medical Practice*, demonstrates her strong personal commitment to setting clear professional standards for all registered medical practitioners in Victoria. This legacy is now being extended nationally, through her chairmanship of a team that is now developing a national code of professional conduct.

Under her leadership, the Board has become more outward looking and now leads the way in stakeholder consultation and engagement in the regulatory sector. The Board's establishment of a Community Consultative Committee to better understand and reflect the needs of ordinary Victorians is a lasting contribution. She has advocated for better ways for the Board to manage the health of doctors whose health problems could impact on their ability to practise medicine safely.

Another very significant contribution has been her advocacy for the proper assessment, supervision and support of International Medical Graduates in Victoria and her recognition of the important role that they play in Victoria's medical workforce.

Dr Flynn has made a substantial contribution nationally through a period of significant change. As President of the Australian Medical Council, she has been a clear advocate for professionally led medical regulation and has been instrumental in guiding the profession – and successive governments, Federal and State – through the difficult terrain, where demand for and of doctors can compete with the community's right to safe medical care.

Through her work in medical education, a generation of Victoria's general practitioners has benefitted from her guidance. Dr Flynn has earned a reputation for wisdom, integrity, decisiveness and compassion. These have been important attributes for a person faced many times daily with the need to strike a balance between competing, valid interests. The Board she leaves is stronger, clearer and more robust for her contribution. Her insight, intellectual rigour, leadership and humour will be sorely missed.

## Update to the Profession – Sexual Offences

On Friday 14 March 2008, Dr David Wee Kin Tong, a Victorian medical practitioner, was sentenced to eight years and four months imprisonment with a non-parole period of five years and six months after pleading guilty to seven counts of rape and seven counts of indecent assault involving 14 patients.

At the time, the case was the subject of intense media scrutiny and public debate, but not all that was reported about the case, the Board's management of it and disclosure of what the Board knew and when, was accurate. In managing the issue in the media, the Board was also constrained by confidentiality provisions in its legislation.

The case demonstrates the scope of the challenge the Board faces when distinguishing between inappropriately conducted intimate examinations and sexual assault, particularly when no allegations of assault have been made.

In 2005 and 2006, the Board received complaints from two women who were concerned about the way Dr Tong had conducted a medical examination. The incidents were alleged to have occurred in 2005 and 2004 respectively. The Board investigated the notifiers' concerns as, on the information before it, there did not appear to be any evidence of sexual assault. If the Board had believed at the time that Dr Tong had committed criminal offences, it would have encouraged the women to inform the police.

The Board investigates concerns about doctors' conduct and examines whether they have acted ethically and professionally. The Board does not investigate allegations of rape. This is the role of the police. The Board advises anyone who believes that a doctor has committed a criminal offence to inform the police.

The Board did not have access to information from or about any other women who were concerned about Dr Tong's conduct until after he had been charged by the police. When Dr Tong was charged, the Board immediately suspended his medical registration and later cancelled it.

Board President, Dr Joanna Flynn, has said publicly that the Board is extremely

sorry about the distress suffered by these women as a result of the conduct that led to Dr Tong's convictions.

The Board has taken seriously the lessons it learned from the case since Dr Tong was charged by police, and among other things:

- has amended the information sheet provided to notifiers about the importance of considering notifying police in relation to matters that may be criminal offences (e.g. sexual assault, assault and drug related allegations)
- Investigating Officers routinely advise notifiers/potential notifiers of their right to take a matter to the police (when this is appropriate) and advise them that lodging a complaint with the Board is not the same as initiating police action
- has developed guidelines to assist staff in determining which notifications may be dealt with by the police (e.g. fraud, assault, sexual assault, indecent exposure).

The Board collects confidential personal and health information in its investigations. It is not able to release this information to other agencies, except as authorised by law. In circumstances like these, the Board is obliged to ask a court to determine what information should be released to other agencies, including the police. The standard procedure is for the requesting agency to use a search warrant. The court then balances competing public interests and determines what information can be released.

The relevant part of the law of sexual offences is summarised below, drawn from sections 35, 36, 38 and 39 of the *Crimes Act 1958* (Victoria). It is not difficult to see how, in some circumstances, a medical procedure could constitute sexual assault. The intention of the Board in publishing this information is not to frighten practitioners or to discourage clinically indicated and appropriate physical examinations. Physical examination is a critical part of the medical consultation. The intention of summarising the law is to guide the profession and to reinforce the importance of doctors explaining to patients the reasons for an examination and obtaining the patient's permission before proceeding. The Board draws your attention to the definition of 'vagina' and the last dot point below.

## Sexual offences

Sexual penetration is defined in section 35(1)(a) and (b) of the *Crimes Act 1958* as the introduction (to any extent) by a person of his penis into the vagina, anus or mouth of another person, whether or not there is emission of semen; or the introduction (to any extent) by a person of an object or a part of his or her body (other than the penis) into the vagina or anus of another person, other than in the course of a procedure carried out in good faith for medical or hygienic purposes. 'Vagina' is defined as including the external genitalia and a surgically constructed vagina.

A person commits rape if:

- he or she intentionally sexually penetrates another person without that person's consent while being aware that the person is not or might not be consenting or while not giving any thought to whether the person is not consenting or might not be consenting; or
- after sexual penetration he or she does not withdraw from a person who is not consenting on becoming aware that the person is not consenting or might not be consenting.

Consent means free agreement. Free agreement is not present if the person:

- submits because of force, the fear of force or the fear of harm of any type to that person or someone else
- submits because she or he is unlawfully detained
- is asleep, unconscious, or so affected by alcohol or another drug as to be incapable of freely agreeing
- is incapable of understanding the sexual nature of the act
- is mistaken about the sexual nature of the act or the identity of the person
- mistakenly believes the act is for medical or hygienic purposes.

Indecent assault is defined in section 39(2) of the *Crimes Act 1958*. It is assault of a person in indecent circumstances, while:

- being aware that the person is not consenting or might not be consenting; or
- not giving any thought to whether the person is not consenting or might not be consenting.

Assault is unlawful contact or an apprehension of unlawful contact. A touch without consent can be an assault.

Indecent circumstances are not defined in the *Crimes Act 1958*, but are measured in light of the prevailing community morals and standards.

The issue of consent is explained above and medical practitioners' attention is drawn to the final dot point under 'consent'.

## Medical Certificates

The Board has received a number of expressions of concern about the validity of medical certificates issued by registered medical practitioners. Recent concerns relate to employees or patients who have been certified as being too unwell to work, but later discovered by the employer to be well enough to engage in other employment or recreational activities.

A medical certificate is an important document. The Board reminds practitioners that they are responsible for obtaining and making a record of sufficient factual information, by taking a thorough history and examination before they issue any form of certificate. A medical practitioner should feel confident that the patient has a medical condition that requires time off work. It is not acceptable for the doctor to provide a certificate on request and without justification.

If a medical practitioner does not find sufficient clinical evidence of any condition, they should consider offering patients the option of writing a letter detailing the reported symptoms, instead of providing a certificate. Practitioners can also suggest that the patient completes a statutory declaration.

Further information about medical certificates can be found in the Board's Medico-Legal Guidelines that are published on the Board's website at [www.medicalboardvic.org.au](http://www.medicalboardvic.org.au)

# Communications Research – How Can We Do Better?

We advised in the March 2008 newsletter that the Board had commissioned independent research to evaluate the effectiveness of its communication with the medical profession in Victoria.

The first, qualitative stage of the research is now complete. It aimed to ensure that the subsequent survey addresses the key communication issues identified by the profession. Thanks to those who participated in the first phase.

During June, the Board will be sending an email to all registrants for whom we have an email address. The email will contain a link to the website on which the survey is being hosted by independent research agency, Market Access, which the Board has commissioned to undertake this project. You will be able to complete the survey online. We will be selecting a random sample of registrants for whom the Board has no email address and providing a hard copy of the survey by mail.

The research aims to identify the issues medical practitioners want the Board to address in its communications, how you want the Board to communicate with you (mail, email etc) and how frequently you want the Board to communicate with you about specific issues. It will provide an opportunity for you to inform the Board about what you think of its current communications, what communications you would like to see retained and what communications you would like to see changed.

Participation in the survey is voluntary and anonymous. The results of the research will inform future Board communication with the profession and the Board will be grateful to those who are able to make time to participate.

# MABEL – Improving Your Working Life

MABEL (Medicine in Australia: Balancing Employment and Life) is a national longitudinal survey of doctors. If you receive a letter inviting you to participate, the authors encourage you to respond. If, however, you are not included in the random sample of doctors asked to participate and would like to be included, you can register to participate by going to the MABEL website: [www.mabel.org.au](http://www.mabel.org.au)

MABEL is being led by Professor Tony Scott of the Melbourne Institute at the University of Melbourne in collaboration with the Faculty of Medicine, Nursing and Health Sciences at Monash University. It is funded by the NHMRC.

# Working with Children Legislation – Implications

*This article has been prepared  
by the Department of Justice*

The Working with Children (WWC) Check is a scheme that helps protect children (under 18 years) from physical and sexual harm, by preventing those who pose a risk to the safety of children from working with them. The WWC Check does not apply to everyone who has contact with children.

The *Working with Children Act 2005* requires a person who works or volunteers in connection with certain types of 'child-related work' to apply for and pass a WWC Check.

Under the Act, you are undertaking 'child-related work' if:

- you are doing paid or unpaid (volunteer) work; and
- your work is in connection with one of the 20 occupational fields listed in the Act; and
- your work usually involves, or is likely to usually involve, regular and direct contact with a child, where that contact is not directly supervised by another person.

For doctors, the relevant occupational field in the Act is 'counselling and other support services'. People working in connection with this field need to apply for a WWC Check by 30 June 2008.

Some doctors may have children as patients. If you do this without direct supervision (e.g. by a parent) on a regular basis this is likely to be considered 'child-related work'. If you rarely consult with children who are not supervised, then you are unlikely to be considered to be doing 'child-related work'.

The check involves a national police records check; it considers relevant findings from disciplinary bodies (currently the Victorian Institute of Teaching) and involves ongoing monitoring of cardholders. Unlike a police record check, the WWC Check only considers some offences. Broadly speaking, the sorts of offences taken into consideration are serious sexual, violent and drug offences.

If you would like to find out more please visit [www.justice.vic.gov.au/workingwithchildren](http://www.justice.vic.gov.au/workingwithchildren) or call the Information Line on 1300 652 879.

# Enhancing Medical Practice in Victoria's Public Hospitals

*This update on new work from the Department of Human Services has been prepared by Dr Grant Phelps, BM BS MBA FRACP, Clinical Leader, Department of Human Services, Statewide Quality Branch and Gastroenterologist, Ballarat*

To support the provision of safe, high quality health care services within Victorian hospitals, the Department of Human Services (the Department) has recently provided the policy document<sup>1</sup>: 'Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy handbook', to all Victorian public hospitals. The policy provides guidance to hospitals about the appointment and ongoing employment of senior medical staff.

The policy was developed by a project team, led by a senior physician working closely with the Statewide Quality Branch and an expert advisory group. It builds on excellent work done several years ago in the Department to establish a similar policy for rural and regional Victoria. All doctors appointed to Victorian public hospitals are now appointed and reappointed under this policy.

The policy recognises that doctors should work within a defined Scope of Clinical Practice that is consistent with the organisation's capabilities. A doctor's Scope of Clinical Practice may thus be different in the different hospitals at which he or she holds appointments.

In appointing a doctor to a given Scope of Clinical Practice, there is a clear onus on organisations to support the doctor in delivering that skill set. Thus, Credentialling and Defining the Scope of Clinical Practice must be about a collaborative approach between organisation and doctor, based on a shared commitment to patient care.

The Department is investigating a number of activities to support the greater engagement of senior medical staff in further developing Victoria's hospital system. The Credentialling and Scope of Clinical Practice policy strongly supports the development of medical leadership in hospital settings, recognising that, as recently demonstrated in the NHS<sup>2</sup>, engagement of senior doctors is critical to the successful delivery of patient care and organisational outcomes. The policy recognises that regular review of a senior doctor's Scope of Clinical Practice is critical to the ongoing relationship between the doctor and organisation, in that clinician skill sets and organisational capability may evolve with time.

There has been widespread support among senior clinicians and the broader hospital sector for the development of a consistent approach to the process of regular review, with a view to enhancing clinical practice. Other industry sectors have well-established processes to review and support the activities provided by employees. Those clinical groups that have established a regular review process describe significant benefits to both organisation and clinician. The Department sees this work as an opportunity to build on the outstanding work organisations are doing to bolster their Credentialling and defining Scope of Clinical Practice processes.

The Department is keen to assist organisations and clinicians as they undertake regular clinician review, and has supported the continued activity of the project team with a specific brief to consider the development of a consistent, statewide approach to this process. While there has been considerable work in other states and countries about managing poorly performing doctors, the Department is of the view that it is critical that all practitioners be supported in their efforts to provide excellent care.

Another area of work that the project team is undertaking involves developing a better understanding of the competency and supervision needs of junior doctors, aimed at ensuring safe and appropriate practice. This will be a critical issue in years to come, as the number of junior doctors in our hospitals increases dramatically. The project team would be delighted to hear from you if you have any comments or thoughts about this work, or if you would like to assist in the work as it develops. Please contact Ms Jeannette Bell on (03) 9096 9030 or email [jeannette.bell@dhs.vic.gov.au](mailto:jeannette.bell@dhs.vic.gov.au)

<sup>1</sup> [www.health.vic.gov.au/credentialling](http://www.health.vic.gov.au/credentialling)

<sup>2</sup> Castro P. et al (2008) "A healthier health care system for the United Kingdom", McKinsey Quarterly February 2008

# Secure Online Facilities for Medical Practitioners

Registered medical practitioners must supply the Board with an address that can be published on the Register of Medical Practitioners, which is accessible to the public on the Board's website. The Board encourages doctors to review the address published on the register to make sure it is accurate, current and that the preferred address is displayed. The Board advises registered medical practitioners not to provide *only* their residential address to the Board. If no other address has been supplied, the Board must publish this address on the Register. Registered medical practitioners can provide the Board with up to three addresses and explicitly nominate any address for use on the public register.

Using the Board's secure online facilities, you can:

- update your contact details, including:
  - addresses (store up to three addresses)
  - phone number/s
  - email address
- nominate an address for the Register of Medical Practitioners available to the public through the website
- nominate an address for correspondence from the Board
- change your login details
- print a receipt
- request a Certificate of Registration Status
- opt out of receiving a hard copy of the annual report
- renew your general registration (pursuant to section 6(1) of the *Health Professions Registration Act 2005* (HPRA)) or registration to practice within a specialty (pursuant to section 7(1)(f) HPRA) during the nominated registration period
- apply for provisional registration (available to Victorian medical school graduates during the nominated registration period).

The Secure Online Facilities are available at <https://secure.medicalboardvic.org.au/login/welcome.php>

If you have forgotten your username and password, reset them by clicking the 'Forgotten your Username and Password?' link on the *Login* screen. (*This requires the PIN number the Board has provided to you during the application process and a valid email address.*)

## No username and password?

If you do not have a username and password to the Secure Online Facilities, you can create one by going to the *Login* page and clicking 'Obtain Username and Password'. (*This requires the PIN number the Board will have provided you during the application process.*)

## Lost or forgotten your PIN?

If you do not know your PIN, go to the *Login* page and click 'Obtain Username and Password'. Then click the 'Forgotten PIN?' link and enter the requested information. Your PIN will then be emailed to you. (*This requires a valid email address.*)

# National Medical Registration – Update

At the end of March the Council of Australian Governments (COAG) signed an Intergovernmental Agreement (IGA) that paves the way for national registration of doctors and eight other health professions in Australia from 1 July 2010. There will be a national medical board that will establish uniform processes across the country under common legislation. Details of the IGA are available at [www.coag.gov.au](http://www.coag.gov.au). This Board and all of the medical boards around Australia support the move to national registration. The Boards are all eager to contribute to the process of developing the national scheme to ensure that it delivers an effective system of medical regulation.

# Advertising Guidelines

After a lengthy consultation process, the Board is close to finalising the guidelines that control the advertising of medical services in Victoria. The proposed guidelines have changed since the initial draft circulated to the profession in 2007 to reflect feedback from the community, the profession and the industry received during the consultation process.

Under section 95 of the *Health Professions Registration Act 2005*, the final guidelines will be issued by the Governor in Council after being approved by the Minister for Health. The Board will publish the endorsed guidelines on its website and advise the profession and the community of the changes when they have been approved.

# IMGs – National Uniform Assessment from 1 July 2008

By national agreement, all Australian states and territories are introducing uniform assessment and registration pathways for International Medical Graduates (IMGs). A national process to assess IMGs has been described on the Board's website for the past three months. The uniform assessment and registration pathways for IMGs complement, and add to, the existing AMC examinations pathway and are:

1. Competent Authority pathway
2. Standard pathway
3. Specialist pathway

More information about national uniform assessment of IMGs, including an information sheet and Frequently Asked Questions, is published on the Board's website at [www.medicalboardvic.org.au](http://www.medicalboardvic.org.au)

# Hearings

The following case studies have been taken from matters heard by Informal Hearing Panels and Professional Standards Panels conducted by the Board under the *Medical Practice Act 1994* and the *Health Professions Registration Act 2005*. The Board publishes these cases to help guide the profession.

## Poor communication

A general practitioner referred his patient for a breast ultrasound, as she had been suffering from a painful axilla. The patient complained to the Board that during the ultrasound examination, the radiologist asked her to demonstrate how she examined her breasts herself. Feeling uncomfortable about this, the patient made a half-hearted attempt at the examination. The radiologist was critical of her examination, which upset the patient. The doctor then squeezed some gel onto the patient's breast and asked her whether it was easier to examine with the gel applied.

The doctor said that he routinely asked his patients to examine their breasts as a precursor to undertaking an ultrasound examination of the breast. He said he did this to locate any lumps or areas of tenderness, so he could better direct the ultrasound examination and examine the relevant area in greater detail.

At the informal hearing, the patient noted that the doctor did not provide her with an adequate explanation about what seemed to her to be an unusual request, and that he did not seem to have reflected on the consultation from the patient's perspective. However, she accepted that the doctor's behaviour was not sexually motivated and accepted the rationale for the request for self-examination, after it had been explained to her during the course of the Board's investigation.

The Panel found that asking patients to examine their breasts was not in itself inappropriate. However, it was inappropriate to do so without an explanation and without ensuring that the patient understood the reason for doing so. Making a negative comment about the self-examination in this circumstance was also inappropriate. The Panel said the doctor had failed to communicate the intent behind the request, which had caused the patient considerable distress. The patient had felt uncomfortable at the time of the examination, but was unable to say so because she felt vulnerable and the doctor was insensitive to her feeling of vulnerability. The doctor had failed to appreciate the power imbalance between a practitioner who is standing clothed and a patient who is lying down with her breasts exposed.

Before making her notification to the Board, the patient had written to the practitioner about her concerns. The doctor failed to respond to this letter. After a reminder letter from the patient, the doctor's response had been brief, inadequate and demonstrated a lack of sensitivity on his part. It is likely that the patient would not have made a notification to the Board if the doctor had understood the patient's concerns and had responded appropriately.

The Panel found that the doctor had engaged in unprofessional conduct and cautioned him to be sensitive to patients' need for information, particularly when undertaking an intimate examination or examinations that may not be expected by the patient. The Panel cautioned the doctor not to ask patients to demonstrate their breast self-examination technique without adequate explanation and required him to undertake a course in communication skills and complaint management.

## Consent for clinical photography

A medical practitioner had been asked to attend to a patient who lived in a residential unit for people with physical and intellectual disabilities. The unit's staff knew the doctor, as he looked after a number of residents at the time of the notification.

The patient was intellectually disabled and needed constant care in the supported residential setting. She was suffering from a genital rash that the doctor diagnosed to be vulvo-vaginal candidiasis. The doctor said that he decided to photograph the rash as a clinical record and asked the rostered carer permission for this. The rostered carer did not object. After taking the digital photograph, the doctor showed it to the carer and then showed the photograph to the House Manager.

The House Manager reported that she was shocked that the photograph had been taken and then shown to staff. She referred the matter to her superiors, as she considered that it violated issues of consent and privacy. A meeting was arranged with the doctor, and while it was accepted that the doctor's actions were in no way sexually motivated, it was believed that he lacked appreciation of the patient's consent requirements and her privacy.

A representative of the patient's carers explained to the Panel that he saw significance in the content of the photograph and considered there was a difference between photographs of patients' genitals and photographs of skin conditions involving other areas of the body. The need to show images to staff members who could observe the condition first hand when performing routine daily care was also questioned. However, it was noted that the doctor was considered to be competent and this was the only area of concern with his practice.

The representative also discussed the issue of consent in this setting. He considered that in routine matters, the competence of the doctor was a key factor and he or she acted under an agreement with staff in an arrangement of mutual understanding. In more complex areas, such as intimate examinations or complicated procedures, formal consent was usually required and must be sought by the doctor.

The doctor informed the Panel that he saw little or no difference between photographs of genitals compared to photographs of other areas of the body and viewed all images purely as aids to clinical diagnosis and treatment. He usually transferred the images into the patient's file at his clinic and then deleted the photo from his camera. The doctor also said that he assumed that the carer could provide consent, although he had since discovered that the matter of consent was complex and needed to be requested formally.

The Panel was faced with two issues:

### **1. Clinical photography**

The Panel considered that taking and storing photographs of certain clinical conditions, notably skin conditions, could provide a valuable pictorial record to assist assessment and monitor progress. It viewed the doctor's practice of photography as appropriate in this regard. With modern electronic record keeping, digital images could easily be incorporated into the patient's health record for future reference. As such, the images form part of the patient record and are subject to the same considerations of confidentiality, privacy and security as any other part of the record. Practices need to have safeguards and procedures to meet appropriate legal and ethical standards concerning the privacy and security of patient records.

Doctors have a responsibility to respect and protect confidential information. Equally, the public reasonably expects that health records are maintained in a safe and secure manner and access to them is restricted only to health personnel directly involved in providing care. The public is increasingly concerned with matters of privacy and has a high level of awareness about the need to prevent digital images from reaching unauthorised sources who are then able to disseminate them widely.

This particularly applies to images in which the patient may be identified, or to images of areas of the body with particular privacy significance, such as genitals or breasts. Accordingly, practitioners need to take special care when photographing these areas and be aware of the need to obtain specific informed consent from the patient before taking any clinically warranted photograph. This consent process needs to include a clear explanation of the purpose of the photography and an explanation about the confidentiality, privacy and security of all images.

### **2. Informed consent, when the patient is disabled and not competent to provide consent**

The issue of informed consent in this setting was considered to be complex. Practitioners attending residential care facilities do so with the understanding that they are the recognised medical provider of patient care and are required to discharge their professional responsibilities accordingly, to fulfil their duty of care. Practitioners need to understand that they are in a team caring for the patient and, under these circumstances, are required to communicate fully with other care and support staff at the facility. To facilitate this professional team approach, practitioners are encouraged to cultivate a relationship with facility staff that is based on mutual respect and in which the interests of the patient are best served. History taking, examination and minor medical procedures are usually performed in a climate of understanding and reflect an unwritten agreement between doctor and staff, while bearing in mind the wishes of the patient and/or their next of kin. The public generally accepts this arrangement as being appropriate and practical.

However, in some circumstances, the facility staff identify that they have additional legal and moral responsibilities for resident welfare. Such circumstances include that of intellectually disabled residents who are not capable of understanding or appreciating the act of giving consent. If a patient cannot provide consent, the medical practitioner

can obtain consent from the 'person responsible'. The term 'person responsible' is defined in section 37 of the *Guardianship and Administration Act 1986* (Victoria). In the case of a resident in a care facility who is not competent to provide consent and has no recognised next of kin, guardian or power of attorney, the issue of consent is complicated. Current guidelines are published in the Department of Human Services (DHS) publication 'The Residential Services Practice Manual (July 2007)' available from the DHS website at <http://hnp.dhs.vic.gov.au>

The practitioner is expected to obtain consent from the appropriate authority in all matters other than routine medical care. This applies to unusual or relatively complicated medical procedures, invasive tests or matters of particular sensitivity, such as intimate examinations. The Panel sees the issue of photography of a patient's genitals as falling into this category and one in which special consent should be sought. It confirms that in such circumstances, it is the practitioner's professional responsibility to demonstrate awareness of these sensitive issues by considering the patient's right of consent. Practitioners are also required to respect and protect patient dignity and privacy. When there is any doubt about this, it is prudent that the doctor asks senior facility staff to assist with decision making before proceeding.

In this case, the Panel found that the doctor's only intent when photographing the patient was to obtain a clinical record of the patient's condition. However, by not informing senior staff of his intention to photograph the patient's genitals, the doctor failed to afford his patient or her representative adequate opportunity to withhold consent. Also, by showing a sensitive photograph to a third party in a setting outside of a consultation, the doctor violated his patient's privacy and right to confidentiality. The Panel found this to be conduct of a lesser standard than that which might reasonably be expected of a registered medical practitioner by the public and his peers. The Panel found that the doctor had engaged in unprofessional conduct.

The Panel was confident that the doctor had developed an understanding of the issues central to the notification and there was little prospect that the behaviour would be repeated. Therefore, the Panel did not require that the doctor undertake education or counselling. The Panel determined that the doctor be cautioned to ensure that he adequately and appropriately addressed issues of consent, privacy and confidentiality with his patients in the future.

### **Failure to assess**

A mother took her three-year-old child to a general practice when he had a moderately severe asthma attack. He had received salbutamol through a spacer at least two hours before presenting to the doctor.

The doctor saw the child promptly, examined him and entered her findings in the medical record. She recognised that the child was sick and recommended that he required immediate hospital care. She did not treat the child with salbutamol or oxygen.

The child's mother said that the doctor did not discuss with her the option of ambulance transport to hospital, while the doctor was adamant that she did discuss this option with her. The doctor said that she felt that transport by car to hospital would be safe and quicker than waiting for an ambulance. The doctor thought that the trip to hospital should have taken ten minutes. It actually took the mother about 30 minutes to travel to hospital. There was no other adult in the car and the mother also had a baby with her.

On arrival at the hospital, staff said that the patient was suffering from a severe asthma attack and was given emergency treatment: oxygen, inhaled salbutamol and corticosteroids. He was transferred to a specialist hospital with paediatric facilities after he was stabilised.

The Panel found that the doctor either underestimated the severity of the asthma attack or failed to appreciate how quickly a child with a moderate asthma attack could deteriorate. The Panel noted that severe asthma was regarded as a medical emergency and was potentially life threatening. The Panel felt that the public and the doctor's peers would expect that in the circumstances and on the basis of her examination, the doctor should have assessed the asthma attack as severe or alternatively have determined that the child was at risk of significant deterioration on the way to the hospital. The Panel felt that the doctor should have provided emergency treatment at the clinic and should have arranged for the child to be transported to hospital by ambulance. The Panel concluded that the doctor's conduct was unprofessional.

The Panel determined that the doctor be cautioned to be aware that moderate asthma was a potentially life threatening problem that required prompt management and close monitoring.

### **Failure to notify suspected abuse**

A psychiatrist was informed by his seven-year-old patient's mother that the patient had been observed sexually abusing his two-year-old sister. The child admitted that the abuse had been going on for a considerable time. The family was distraught about these events. The doctor confirmed his obligation to inform the Department of Human Services (DHS) about the abuse. He immediately arranged for the children to be separated, with the two-year-old being sent to live with her grandmother until the situation could be sorted out.

The children's mother was left with the impression that the doctor would be notifying DHS immediately. Though the doctor made attempts to contact DHS, it took five days for the notification to be made. In that five-day period, the doctor made a home visit to the grandmother who was caring for the abuse victim. The family did not understand the purpose of the visit, although the doctor explained to the Panel that it was intended to support the grandmother and to assess how the two-year-old was settling in.

The family complained that the doctor did not appropriately manage his notification to DHS and gave misleading advice about the notification to the children's mother. The family also complained that the doctor attended the grandmother's house to investigate the child's welfare and living arrangements without having proper authority to do so.

The Panel found that the doctor did not notify the DHS of the suspected child abuse of a two-year-old child in a timely manner and that he had not given accurate information to the mother about his notification.

The Panel said that it was mandatory for medical practitioners to report suspected child abuse under the *Children and Young Persons Act 1989*, which was in operation at the time, and stated that this should be done 'as soon as practicable'. In the Panel's view, the doctor had adequate opportunity to contact DHS over the five-day period and noted that he instead spent time making a home visit to the family.

The doctor told the Panel that an earlier notification to DHS would not have altered the management of the case, as the protection services relied on his case management recommendations. However, the Panel was not presented with any evidence to support this view. While child protection services may well rely on the advice and recommendations of a child psychiatrist in their management of a case, this did not remove the medical practitioner's obligation to notify the statutory body promptly.

In this case, the doctor assumed the responsibility for management of the abuse allegations, including removing a two-year-old child from her mother before contacting DHS. The Panel found this conduct was of a less standard than that which might reasonably be expected by the doctor's peers and the public, and the doctor was found to have engaged in unprofessional conduct.

In relation to the allegation about the home visit, the Panel accepted the doctor's reasons for the visit were motivated by his concern to support the family and to offer assistance in a crisis. The doctor had been involved with the family over many years and was affected by what had happened to the extent that he may not have been thinking as clearly as he otherwise might. While conducting a home visit was unwise in view of his failure to contact DHS sooner, and while he did not make his purpose for the visit clear to the family, under the particular circumstances, the Panel did not find that this amounted to unprofessional conduct.

The Panel cautioned the doctor to ensure that he complied with the legislative requirements for reporting suspected child abuse and that he familiarised himself with the avenues for contacting DHS, especially out of hours.

### **Failure to obtain consent and inadequate communication**

A patient had attended a surgeon for an opinion about a painful ano-rectal condition. She did not expect definitive treatment and had been treated by the surgeon for the same condition 15 years previously.

A friend who was present during the consultation accompanied the patient to the hearing. The friend gave corroborative evidence about the consultation to the Panel.

The doctor examined the patient and then performed a haemorrhoid banding procedure without first explaining details of the procedure to the patient and without seeking her permission to proceed. Everything the doctor said to her was while she was on her side with her bottom exposed to him. The patient found the procedure extremely painful and was very distressed by it.

The patient remained in severe pain for a couple of days. She had swelling at the site of the banding and there was a terrible smell that made her worry that she had an infection. After finding little black bands on the toilet paper, she telephoned the doctor's rooms. She believed that the doctor was abrupt with her and told her to return to his rooms.

The Professional Standards Panel found that the doctor did not take adequate time to explain his diagnosis or the options for treatment. He was insensitive to the patient's pain, did not spend adequate time explaining post-operative care, did not give the patient written information and did not explain what she might expect over the next few days.

The Panel found that the doctor was abrupt during the consultation, but there was inadequate evidence to conclude that he was rude to the point of being unprofessional. He could have been more sensitive to the patient's need for information and her evident pain and distress.

The doctor admitted that he did not explain what banding meant and took the patient's silence as consent. Without adequate information, the patient could not consent to the procedure. In this respect, the Panel found the doctor's conduct was unprofessional.

The Panel found that the doctor explained the bare minimum about post-procedure expectations and analgesia and did not tell the patient what she might experience over the next few days, including any possible sequelae or complications. She left the surgery distressed, with a poor understanding of what was likely to occur and limited information about analgesia and treatment other than to take Panadol or Panadeine and not aspirin. The Panel found that leaving a distressed patient without adequate explanation of these matters was unprofessional.

The Panel cautioned the doctor to provide patients with adequate information and to ensure that he gained informed consent for surgical procedures. It found he should not take silence as a sign of consent. He was required to provide clear information about what patients could expect after procedures. The Panel reminded the doctor that ensuring the effectiveness of communication was the responsibility of the doctor and not the patient.

## **Formal Hearings**

*It is Board policy not to publish in the Bulletin the names of doctors found to have engaged in unprofessional conduct, not of a serious nature, or those against whom allegations have not been proven, if the doctor has requested that his or her name is not published. Further details of the Board's Formal Hearing decisions are available on the website at [www.medicalboardvic.org.au](http://www.medicalboardvic.org.au)*

### **Dr Peter Ronald Eisen**

#### **Allegation**

The patient consulted Dr Eisen, a psychiatrist, between April 1983 and March 1984, attending at the doctor's rooms three times per week. It was alleged that at the conclusion of the final consultation, Dr Eisen told the patient that he would no longer treat her because he was attracted to her. Dr Eisen then asked the patient to dinner. Following the dinner, the patient and Dr Eisen engaged in sexual intercourse. Dr Eisen did not continue to see the patient subsequently.

The patient stated that the experience prompted her to suffer severe depression and suicidal thoughts. She stated that she no longer trusted psychiatrists. In an agreed statement of facts, Dr Eisen admitted the allegation and expressed that he was deeply ashamed of his actions.

#### **Finding and determination**

As the doctor admitted the allegation, the Panel found that the allegation was made out. In the Panel's opinion, the doctor-patient relationship had been exploited most inappropriately and in circumstances in which the patient was severely traumatised. In this particular case, the Panel took the view that Dr Eisen's conduct was 'shameful and disgraceful' and, taking into account all the circumstances, constituted infamous conduct in a professional respect.

In reaching a determination, the Panel was guided by the main purpose of the Board's legislation, which is to protect the public. One aspect of protection of the public is the maintenance of standards within the

medical profession. The Panel also took into account that the psychiatrist-patient relationship brought with it special duties in so far as the psychiatrist was concerned. The particular vulnerability of the patient was acknowledged when the Panel took into account the question of determination.

The Panel noted that Dr Eisen was not registered and had not been registered for approximately four years. Therefore, there was no registration that could be suspended or cancelled or which could otherwise be made subject to conditions. If Dr Eisen had been registered, then the Panel was of the view that a suspension period of two years would have been applicable. However, as he was no longer registered, the Panel felt that it was appropriate to reprimand him, noting that a reprimand was by no means a trivial penalty in the circumstances.

## **Dr Mohammed Mateen UI Jabbar**

### **Allegations**

The patient had attended Dr Jabbar for a skin check at a Skin Cancer Clinic. It was alleged that during the consultation Dr Jabbar:

1. asked the patient to remove all her clothing without offering her any privacy. He did not indicate to the patient that she could use a curtained partition in the examination room or offer her a gown or any other privacy while she undressed
2. palpated her breasts inappropriately, holding and lifting each breast when this was not necessary in the conduct of the skin examination
3. told the patient that she had sagging breasts. This comment was unsolicited and unrelated to his examination of the patient's skin
4. advised the patient that she could have cosmetic surgery to her breasts. He allegedly said that she could and/or should have a breast lift or breast implants. This advice was unsolicited and unrelated to the examination of the patient's skin.

Dr Jabbar said that he has had training in cosmetic surgery but ceased active practice in cosmetic surgery six months before the consultation with the patient. He said that he would have referred the patient to a plastic surgeon if she had requested it. The patient said that she thought Dr Jabbar was 'drumming up business for another practice' while he was examining her skin.

### **Findings and determinations**

The Panel heard evidence from the patient and from Dr Jabbar. There were some considerable inconsistencies noted in the evidence.

After hearing the evidence, the Panel concluded that there had been a misunderstanding between the patient and the doctor regarding the extent to which the patient was requested to undress for the purpose of the examination. The Panel accepted the evidence of the doctor that there was a curtain in the room that could have been available to the patient. The Panel accepted the patient's evidence that she did not observe the curtain and no mention of a curtain or other means of privacy was made by Dr Jabbar. The Panel was concerned that Dr Jabbar showed a lack of concern about this matter and suggested that in future, he should have more regard for the needs of patients in relation to privacy while undressing. However, the view of the Panel was that in the circumstances, this conduct was not unprofessional.

There was inconsistency in the evidence relating to whether Dr Jabbar palpated the patient's breasts. Dr Jabbar denied touching the patient's breasts. However, the Panel accepted the patient's evidence and found that the doctor's conduct had been unprofessional in this respect.

Dr Jabbar admitted that he told the patient that she had sagging breasts. He also admitted that he advised the patient that she could have mastopexy, but he did not admit to advising her to have breast implants. He agreed that the advice was unsolicited and unrelated to his

examination of the patient's skin. The Panel found that Dr Jabbar's conduct in providing unsolicited comments about the patient's breasts and advising her to have cosmetic surgery was unprofessional.

The Panel determined to reprimand Dr Jabbar and required him to undergo counselling about the issues that had arisen in this case. The counselling aimed to provide Dr Jabbar with an appreciation of the nature of the conduct, guide him about appropriate interaction between doctor and patient and prevent him repeating the behaviour that led to the complaint.