Doctors disciplined for professional misconduct in Australia and New Zealand, 2000–2009

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ABSTRACT

Objectives: To describe professional discipline cases in Australia and New Zealand in which doctors were found guilty of professional misconduct, and to develop a typology for describing the misconduct.

Design and setting: A retrospective analysis of disciplinary cases adjudicated in five jurisdictions (New South Wales, Victoria, Queensland, Western Australia and New Zealand) in 2000–2009.

Main outcome measures: Characteristics of the cases (setting, misconduct type, patient outcomes, disciplinary measure imposed), characteristics of the doctors involved (sex, specialty, years since qualification) and population-level case rates (by doctor characteristics).

Results: The tribunals studied disciplined 485 doctors. Male doctors were disciplined for misconduct at four times the rate of their female colleagues (91 versus 22 cases per 100 000 doctor-years). Obstetrics and gynaecology and psychiatry were the specialties with the highest rates (224 and 178 cases per 100 000 doctor-years). The mean age of disciplined doctors did not differ from that of the general doctor population. The most common types of offences considered as the primary issue were sexual misconduct (24% of cases), illegal or unethical prescribing (21%) and inappropriate medical care (20%). In 78% of cases, the tribunal made no mention of any patient having experienced physical or mental harm as a result of the misconduct. Penalties were severe, with 43% of cases resulting in removal from practice and 37% in restrictions on practice.

Conclusions: Disciplinary cases in Australia and New Zealand have features distinct from those studied internationally. The recent nationalisation of Australia's medical boards offers new possibilities for tracking and analysing disciplinary cases to improve the safety and quality of health care.

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Disciplinary cases brought against doctors by professional regulatory bodies are poorly understood in Australia and New Zealand, and have not been analysed as a group. Information about them comes primarily from the intense media coverage that surrounds selected "scandals". Several published studies[1-6] have profiled cases such as these, but all are from the United States.

We analysed cases adjudicated by medical disciplinary tribunals in Australia and New Zealand over a 10-year period. We focused on cases in which a doctor was found guilty of misconduct. Our goal was to describe the characteristics of the doctors involved, the misconduct at issue and the case outcomes. In addition, because a robust typology for organising this information does not exist, we aimed to develop one.

METHODS

Context

Until 1 July 2010, when a national medical board commenced operation, separate medical boards operated in Australia's eight states and two territories. Our sample was drawn before this amalgamation of boards. The Medical Council of New Zealand has long had national jurisdiction. These agencies bring disciplinary charges in tribunals against doctors suspected of committing various forms of professional misconduct.

The term "tribunal", for the purposes of this study, refers to the disciplinary body in each jurisdiction with the power to remove a doctor from practice other than on an interim basis. These bodies are known by various names, and in some jurisdictions were historically constituted as subcommittees of medical boards, but by the end of our study period all jurisdictions had transferred this function to independent tribunals.

Sample

Our sample was taken from all disciplinary cases adjudicated by tribunals in Australia's four most populous states (New South Wales, Victoria, Queensland and Western Australia) and New Zealand between 1 January 2000 and 30 September 2009. These jurisdictions cover about 85% of Australian doctors and all New Zealand doctors.[7] After excluding cases in which the tribunal dismissed all charges ($n = 65$) and those exclusively concerned with non-disciplinary matters such as practitioner impairment ($n = 138$), our study sample consisted of 485 cases.

The Human Research Ethics Committee, University of Melbourne, approved the study.

Data sources

Our data came from two main sources. First, we gathered the written determinations associated with all sampled cases. Determinations contain detailed information about the case, including the nature of the charge, the evidence considered, submissions from the doctor concerned, the tribunal's decision and the reasons for and details of any penalties imposed. The texts of these documents ranged in length from a couple of paragraphs to 110 pages. For 80% of cases, the full texts of the determinations were available; for the rest (essentially cases from Victoria in 2000 and early 2001 and cases from WA), only summaries of the determinations were available.

Second, we extracted information on doctors from medical registers. For the jurisdictions and time period covered by our study, this information was publicly accessible online.

Study instrument and variables

We developed an instrument for recording case descriptors (eg, the jurisdiction, decision date, setting of misconduct, number of patients affected, patient outcome and disciplinary measure imposed) and doctor descriptors (eg, sex, specialty and years since qualification).

We also sought to code misconduct type, but a literature review identified substantial limitations in existing typologies. Limitations included too few categories, non-

1 Characteristics of 485 tribunal cases

Characteristic	n*
Jurisdiction	
Victoria	157 (32%)
New South Wales	130 (27%)
Western Australia	87 (18%)
New Zealand	71 (15%)
Queensland	40 (8%)
Decision date	
2000–2002	175 (36%)
2003–2005	160 (33%)
2006–2008	116 (24%)
To 30 Sep 2009	34 (7%)
Setting of misconduct*	
Clinical	293 (66%)
Clinic	217 (49%)
Hospital inpatient	76 (17%)
Mixed clinical/non-clinical	99 (22%)
Non-clinical	14 (3%)
Not applicable	35 (8%)
Patients affected*†	
0	75 (16%)
1	240 (51%)
2+	155 (33%)
Patient outcome*‡	
Death	36 (8%)
Physical injury	41 (9%)
Psychiatric injury	28 (6%)
Drug dependency	66 (14%)
Upset to patient	126 (26%)
Risk to patient	72 (15%)
No consequence	24 (5%)
Not applicable	75 (15%)
Disciplinary measure*‡	
Removal from practice	209 (43%)
Restrictions on practice	179 (37%)
Non-restrictive sanction	93 (19%)

* Percentages were calculated with the number of available observations used as the denominator. Data were missing for event setting (44 cases [9%]), number of patients (15 cases [3%]), patient outcome (17 cases [3.5%]) and disciplinary measures (4 cases [0.8%]). † Number of patients mentioned in tribunal's decision as having been affected by the doctor's conduct. ‡ For cases in which multiple patient outcomes and disciplinary measures apply, the most severe is reported. Both are shown in descending order of ostensible severity. ◆

specific categories, and conflating types of misconduct (eg, misprescribing) with the underlying reasons for the misconduct (eg, incompetence or criminality).

We therefore developed a new typology, using a standard coding methodology.[8-10] We began with a draft typology derived from merging the categories used by two medical boards (Victoria[11] and Queensland[12]) with relatively comprehensive typologies. Two investigators (KE and DE) independently reviewed a random sample of 100 determinations, applying the draft typology to the misconduct in the cases, and adding and modifying categories as appropriate. We then compared and discussed the results of this review to determine a final set of five misconduct categories (inappropriate medical care, sexual misconduct towards a patient, illegal or unethical prescribing, misconduct not in relation to a patient and other misconduct) and 12 subcategories.

The instrument allowed coding of up to four misconduct types, but directed reviewers to select a primary type in cases with more than one type. The primary misconduct type was defined as the behaviour of most concern to the tribunal. We determined this through close reviews of the determinations, focusing on express comments by the tribunal and the weight of attention given to each misconduct type at issue.

Data collection and reliability testing

Between September and December 2009, we reviewed the determinations for all sampled cases. Data from these reviews were supplemented with basic sociodemographic data on the doctors involved, collected from medical registries.

To test the reliability of the decisions regarding the coding of misconduct types, 5% of cases ($n = 24$) were re-reviewed by a second reviewer who was blinded to the first review. Reliability testing on these reviews showed excellent agreement between reviewers for the determinations of primary misconduct type (agreement, 86%; κ, 0.85; standard error, 0.05) and any misconduct type (agreement, 96%; κ, 0.96, standard error, 0.08).

Statistical analysis

We report counts and percentages for characteristics of the tribunal cases. For doctor sex and specialty, we calculated rates of disciplinary cases at the population level. Specifically, we used registration data and relevant medical workforce reports[7,13-15] to estimate the total number of doctors registered in each jurisdiction and year, summed them to create denominators consisting of registered doctor-years, and then applied the disciplinary case counts as numerators. For the comparison of rates by sex, we adjusted the denominator for female practitioners to allow for their lower mean working hours per week relative to males (38 hours versus 47 hours per week[7,13]). The registration and medical workforce data also allowed calculation of mean years since qualification, for doctors in the wider population (using mean age minus 24 years) during the study period, which we compared with the corresponding mean in the study sample. All analyses were conducted using Stata, version 10 (StataCorp, College Station, Tex, USA).

2 Characteristics of doctors in 485 tribunal cases

Characteristic	n*	Rate†
Sex		
Men	440 (91%)	91
Women	42 (9%)	22
Specialty		
General practice	285 (65%)	131
Psychiatry	43 (10%)	178
Surgery	32 (7%)	95
Obstetrics/gynaecology	24 (6%)	224
Hospital generalist	19 (4%)	65
Other specialty	14 (3%)	53
Anaesthesiology	13 (3%)	15
Registrar	6 (1%)	15

* Percentages were calculated with the number of available observations used as the denominator. $n = 482$ for sex; data were missing for three cases (1%). $n = 436$ for specialty; data were missing for 49 cases (10%). † Rate per 100 000 doctor-years. ◆

RESULTS

Tribunals in Victoria, NSW, Queensland, WA and New Zealand heard 550 disciplinary cases against doctors between January 2000 and September 2009. In 88% of all those cases (range, 76% to 93%), the doctor concerned was found guilty of misconduct and disciplined accordingly. The discipline rate was 6 per 10 000 doctors per year.

Characteristics of cases

Location and timing

About one-third of the cases occurred in Victoria and just over one-quarter occurred

3 Application examples of the developed typology for classification of misconduct

Example	Classification
A 19-year-old patient on medication for depression presented to a general practitioner with a urinary tract infection. The GP performed an unnecessary breast examination then and at several subsequent appointments.	Other sexual misconduct
A GP supplied pethidine to an inpatient without following prescribing procedures and after having been told that the patient was drug-dependent.	Illegal or unethical prescribing
A surgeon performed otoplasty on two patients (a father and his son), then bandaged the wounds too tightly, causing serious necrosis of flesh and scarring. No information was given to the patients about possible complications or postoperative pain.	Treatment; failure to obtain informed consent
A GP was given $260 000 in a series of gifts by an older couple who were his patients. This was in exchange for "free care" from the doctor.	Non-sexual misconduct towards patient
An anaesthetist took a used syringe home with drugs in it, and when nurses queried this, he said it was for training, and tried to persuade them not to report his actions.	Inappropriate conduct not in relation to patient
A doctor had drug testing conditions imposed on her registration due to her drug addiction. Over a period of 18 months, she breached the conditions 71 times by returning positive results or failing to attend for urine testing.	Breach of registration conditions
A GP prescribed excessive Rohypnol (flunitrazepam) to a patient, without due regard for the patient's wellbeing. The doctor also failed to keep proper records of his prescribing, which compromised the patient's treatment.	Illegal or unethical prescribing; treatment; inadequate medical certificates/records

in NSW (Box 1), even though there are more doctors registered to practise in NSW than there are in Victoria.[7,13] The case rate decreased over the study period, from 175 in 2000–2002 to 116 in 2006–2008. The misconduct at issue occurred in a clinical setting in two-thirds of cases, with most clinical cases (217/293 [74%]) occurring in non-inpatient settings.

Harm to patients

Physical harm to patients occurred in 9% of cases and patient death in 8%. However, the most prevalent outcome for affected patients was being upset at what had occurred and, in 78% of cases (380/485), there was no mention in the tribunal determination of physical or psychiatric harm to the patient as a result of the misconduct.

Penalties

In 43% of cases, the doctor was removed from practice, either temporarily (via suspension) or permanently (via deregistration). In 19% of cases (93), the only disciplinary measure imposed was a non-restrictive sanction (for example, a caution, reprimand or fine) which did not interrupt the doctor's immediate or long-term ability to practise.

Characteristics of doctors

Male doctors accounted for 91% of the cases and were disciplined at over four times the rate of female doctors (91 versus 22 cases per 100 000 registered doctor-years) (Box 2). Nearly two-thirds of the cases were against general practitioners, who had the third-highest case rate (131 per 100 000 registered doctor-years), behind obstetrician–gynaecologists (224) and psychiatrists (178). Disciplined doctors gained their primary medical qualification a mean of 21.4 years before committing the misconduct (range, −4 to 55 years; standard deviation, 9.8 years), which is identical to the estimated mean years since qualification for the wider doctor population in the relevant jurisdictions.

Types of misconduct

Box 3 shows several examples of types of misconduct and how these behaviours were coded in our typology.

The leading type of misconduct was sexual misconduct towards a patient, which was the primary issue in 24% of cases (Box 4). This type of misconduct occurred almost exclusively among male doctors (110/114, 96%). Two-thirds of the sexual misconduct involved sexual relationships with patients as opposed to other inappropriate sexual contact (eg, unnecessary examination and touching of sexual organs).

Illegal or unethical prescribing (the primary issue in 21% of cases) was the next most common type of misconduct, followed by inappropriate medical care (20%), which was split between treatment problems (73%, 69/95) and diagnostic errors (27%, 26/95).

Other types of misconduct for which doctors were disciplined were breaches of registration conditions that had already been imposed (primary issue in 7% of cases), inadequate or inappropriate issuing of medical certificates or keeping of medical records (5%), failure to obtain informed consent (5%), and criminal offences unrelated to patients (4%). Expanding the analysis beyond the primary issues to include all issues in the cases (Box 4) dramatically increased the prominence of two types of misconduct: problems with medical certificates or records (5%–26% of cases) and treatment issues (14%–36%).

DISCUSSION

This study showed that male doctors were disciplined for misconduct at four times the rate of their female colleagues. Among specialties, obstetrics and gynaecology and psychiatry had the highest rates. The most common types of offences were sexual misconduct (particularly intimate relationships with patients), illegal or unethical prescribing and substandard treatment. In nearly two-thirds of cases, no patient experienced physical or psychiatric harm as a result of the misconduct. The penalties were severe: 81% of cases led to either deregistration or restrictions on practice.

The finding that male doctors are more often sanctioned by medical tribunals than female doctors echoes findings from the US.[2-6,16,17] The standard explanation is that female doctors tend to display more of the attributes "that underpin a good doctor–patient relationship",[16] thereby provoking fewer patient complaints and reduced exposure to disciplinary processes.[5,17]

The markedly high rates of disciplinary cases observed against psychiatrists and obstetricians and gynaecologists also resonate with previous US research.[1-6] The explanation is contested. Provider factors may play a role, with disproportionate selection into these specialties by individuals with personal characteristics that put them at elevated risk of disciplinary action. A rival

4 Type of misconduct* in 485 tribunal cases

Type of misconduct	Primary issue n*†	Any issue n†
Sexual misconduct towards patient	114 (24%)	123 (26%)
Relationship with patient	76 (16%)	79 (17%)
Inappropriate sexual contact	38 (8%)	47 (10%)
Illegal or unethical prescribing	102 (21%)	119 (25%)
Inappropriate medical care	95 (20%)	184 (38%)
Treatment (inappropriate or inadequate)	69 (14%)	175 (36%)
Diagnosis (missed, delayed or incorrect)	26 (5%)	38 (8%)
Misconduct not in relation to patient	52 (11%)	97 (20%)
Inappropriate conduct not in relation to patient	34 (7%)	79 (16%)
Criminal offence	18 (4%)	18 (4%)
Other misconduct	117 (24%)	277 (58%)
Non-sexual misconduct towards patient	32 (7%)	71 (15%)
Breach of registration conditions	32 (7%)	60 (13%)
Failure to obtain informed consent	22 (5%)	54 (11%)
Inappropriate medical certificates or records	26 (5%)	127 (26%)
Breach of privacy	3 (1%)	11 (2%)
Supervision of others	2 (0.5%)	10 (2%)

* Reviewers judged primary type of misconduct from four or less misconduct types recorded per case (mean per case, 1.98; standard deviation, 0.86). Type of misconduct could not be coded in five cases due to missing information (1%). † Percentages were calculated with the number of available observations ($n = 480$) used as the denominator. ◆

explanation underlines the distinctive aspects of the clinical activities these specialists perform, and the patient populations they serve, as independent risk factors. Although such patient factors may play a role, they are unlikely to tell the whole story.

Several measures in our study highlight that serious harm to patients is not a prerequisite for serious disciplinary action against doctors. Forty-one per cent of cases involved only upset or risks to patients, 5% had no impact on the patient involved, and 15% involved misconduct unrelated to patients. Yet 43% of these non-injurious cases resulted in removal from or restrictions on practice for the offending doctor (the same as the removal rate for cases associated with patient injuries). Taken together, these findings indicate that boards and tribunals interpret their public protection mandate as extending to intervening in risky actions and behaviours, not merely reacting to circumstances where palpable damage has been done. A review of media reports about regulatory oversight in this area might incorrectly suggest otherwise.

Our study maps the frequency of specific types of misconduct among doctors in Australia and New Zealand for the first time. Sexual misconduct and illegal or unethical prescribing top the list. One-fifth of the cases from Australia and New Zealand involved illegal or unethical prescribing as the primary issue, which is close to figures from recent US studies[2,4,6] that have identified this as an issue in 11%–19% of disciplinary cases (though one must be cautious making such comparisons because some US studies include impairment findings, which we excluded). By contrast, sexual misconduct appears to feature as a far more prevalent misconduct type in Australia and New Zealand than in the US,[1,4-6] where it has been reported as an issue in only 4%–10% of cases.

Inappropriate medical care also features prominently in our sample, particularly when all misconduct types (not just the primary one) are considered. This result bucks traditional concepts of medical boards as self-regulators with a near-exclusive focus on sexual misconduct and substance misuse. We see clear evidence that they are also asserting their authority to address quality-of-care concerns.

Finally, misconduct in relation to inadequate or inappropriate issuing of medical certificates and maintaining of medical records warrants special mention. This was the primary issue in only one in 20 cases, but more than one-quarter of cases showed negative findings in this area. In other words, misconduct regarding medical certificates and records frequently coexisted with other forms of misconduct. This was because these breaches are often uncovered during an investigation for another breach. International research has identified the same phenomenon.[18] From a policy perspective, it highlights the fact that professional misconduct is often multilayered rather than confined to a single, isolated breach.

Our study has several limitations. First, in constructing descriptive variables, we relied on information contained in the tribunal determinations. Second, the rate statistics used data from the results of workforce surveys which were not sent to some classes of registrants in Queensland. However, the statistical properties of the fractions (small numerators and very large denominators) make them robust against slight-to-moderate variations in the population-level counts. Third, our rate comparisons on doctors' sex and specialty do not adjust for the possible interaction of these variables. However, we do note that the three specialties with the highest complaint rates (psychiatry, obstetrics and gynaecology, and general practice) are no more male dominated than medicine generally, suggesting that these high rates are not the artefact of an underlying sex effect.

Fourth, context is important in interpreting findings from this study. We analysed a select group of disciplinary cases: those at the upper level of the disciplinary process in which doctors were found guilty of misconduct. Further, the statistics we report, such as the prevalence of various misconduct types, should not be construed as direct indicators of the incidence of such behaviours in practice. Rather, the figures we report are, in theory, a function of three interrelated elements: the underlying rate of misconduct, the rate at which misconduct is reported to tribunals, and how boards and tribunals act on such reports. Our study observes the product of these interactions but cannot separate the independent role of any one of them in determining counts and rates of disciplinary action.

The recent nationalisation of Australia's disciplinary framework for health professionals, under the Australian Health Practitioner Regulation Agency, opens up new possibilities for tracking and learning from disciplinary matters. This study introduces new tools for pursuing this work; it also maps a basic epidemiology of cases in which Australian and New Zealand doctors have

been disciplined in the decade to 2010. Ultimately, the core goal of any rigorous empirical analysis of professional misconduct should be to assist regulators in ensuring Australians receive safe care at the hands of competent practitioners. However, improved public understanding of these cases is also important. Without that, anecdotes and media reports of particular "scandals" may produce a distorted perspective.

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COMPETING INTERESTS

None identified.

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REFERENCES

1 Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *JAMA* 1998; 279: 1883-1888.
2 Morrison J, Wickersham P. Physicians disciplined by a state medical board. *JAMA* 1998; 279: 1889-1893.
3 Morrison J, Morrison T. Psychiatrists disciplined by a state medical board. *Am J Psychiatry* 2001; 158: 474-478.
4 Clay SW, Conatser R. Characteristics of physicians disciplined by the State Medical Board of Ohio. *J Am Osteopath Assoc* 2003; 103: 81-88.
5 Kohatsu ND, Gould D, Ross LK, Fox PJ. Characteristics associated with physician discipline: a case–control study. *Arch Intern Med* 2004; 164: 653-658.
6 Khaliq AA, Dimassi H, Huang CY, et al. Disciplinary action against physicians: who is likely to get disciplined? *Am J Med* 2005; 118: 773-777.
7 Australian Institute of Health and Welfare. Medical labour force 2006. Canberra: AIHW, 2008. (AIHW Cat. No. HWL 42; National Health Labour Force Series No. 41.) http://www.aihw.gov.au/publication-detail/?id=6442468174 (accessed Mar 2011).
8 Glaser BG, Strauss AL. The discovery of grounded theory: strategies for qualitative research. New York: Aldine De Gruyter, 1967.
9 Constas MA. Qualitative analysis as a public event: the documentation of category development procedures. *Am Educ Res J* 1992; 29: 253-266.
10 Hall MA, Wright RF. Systematic content analysis of judicial opinions. *Calif L Rev* 2008; 96: 63-122.
11 Medical Board of Queensland. Annual report 2008–2009. Brisbane: Office of Health Practitioner Registration Boards, Queensland Government, 2009.
12 Medical Practitioners Board of Victoria. Annual report 2008. Melbourne: MPBV, 2008.
13 Australian Institute of Health and Welfare. Medical labour force 2003. Canberra: AIHW, 2005. (AIHW Cat. No. HWL 32; National Health Labour Force Series No. 32.) http://www.aihw.gov.au/publication-detail/?id=6442467747 (accessed Mar 2011).
14 Medical Council of New Zealand. The New Zealand medical workforce in 2003. Wellington: MCNZ, 2005. http://www.mcnz.org.nz/portals/0/publications/workforce_2003%20.pdf (accessed Mar 2011).
15 Medical Council of New Zealand. The New Zealand medical workforce in 2006. Wellington: MCNZ. http://www.mcnz.org.nz/portals/0/publications/workforce_2006.pdf (accessed Mar 2011).
16 Firth-Cozens J. Doctors with difficulties: why so few women? *Postgrad Med J* 2008; 84: 318-320.
17 Foreman SM, Stahl MJ. Chiropractors disciplined by a state chiropractic board and a comparison with disciplined medical physicians. *J Manipulative Physiolog Ther* 2004; 27: 472-477.
18 Post J. Medical discipline and licensing in the state of New York: a critical review. *Bull N Y Acad Med* 1991; 67: 66-98.

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