Medical Board of Australia v Siow **[2016] SAHPT 1**

HEALTH PRACTITIONERS TRIBUNAL OF SOUTH AUSTRALIA

MEDICAL BOARD OF AUSTRALIA

v

SIOW, Dr James Chon Fatt

JURISDICTION: Health Practitioners

FILE NO: 4977 of 2012

HEARING DATE: 2 October 2015

DECISION OF SA HEALTH PRACTITIONERS TRIBUNAL
constituted by: President M Ardlie
Dr K Allen
Dr L Rose
Mr M de Rohan

DELIVERED ON: 2 October 2015

REASONS FOR DECISION PUBLISHED ON: 22 January 2016

CATCHWORDS:

*Complainant alleges that the respondent behaved in a way that constitutes professional misconduct - Complaint alleged ten grounds of professional misconduct - Respondent admits professional misconduct in respect of each of the grounds set out in the complaint - The respondent consulted with a patient who had been diagnosed with a terminal illness - Despite an awareness of the patient's terminal illness and prognosis the respondent devised a nutritional and detoxification program and referred the patient to other medical practitioners - The respondent so conducted himself and made statements to the patient and his family members that continued to engender an unreasonable expectation on their part as to a positive outcome for the patient contrary to the prognosis - **Held**: The conduct set out in the complaint constitutes professional misconduct - The Tribunal is satisfied that appropriate public protection and discipline are achieved by: A reprimand - Payment of a fine of $12,000 - Conditions imposed on the respondent's registration - The respondent will not consult, interview, examine, treat, advise or see any patient he knows to be suffering from cancer or a terminal illness - The respondent will engage in a professional mentoring program with a mentor approved by the complainant or its delegate - The respondent will*

maintain for review by the mentor a duplicate patient file - The respondent will submit to a practice audit at his practice in Melbourne to be undertaken by the mentor or an auditor approved by the Board - The respondent will complete an education course conducted by the Cognitive Institute within six months of being advised of the imposition of these conditions - The respondent will attend a psychiatrist at a frequency to be determined by the psychiatrist and comply with the recommended treatment plan - The respondent will ensure that the complainant receives a report from his psychiatrist every six months and within fourteen days of any request from the complainant or its delegate - The respondent will provide the name and address of the respondent's treating psychiatrist to the complainant within seven days of being advised of the imposition of these conditions - The respondent will provide a copy of these conditions to the respondent's present and any future treating psychiatrist - The respondent will remove and do all things necessary to facilitate the removal from all publications made by him or on his behalf containing any reference to his qualifications, education, training, experience or achievements which in any way represent or give rise to an imputation that he is a specialist other than a general practitioner - Review period for the conditions imposed is twelve months - All costs associated with the conditions imposed are the responsibility of the respondent - The respondent is to pay the complainant's costs of and incidental to these proceedings as agreed between the parties - Ss 193, 195, 196 Health Practitioner Regulation National Law (South Australia) Act 2010.

Craig v Medical Board of South Australia (2001) 79 SASR 545
Pharmacy Board of Australia v Jattan [2015] QCAT 294
NW Frozen Foods Pty Ltd v Australian Competition and Consumer Commission (1996) 71 FCR 285
Minister for Industry, Tourism and Resources v Mobil Oil Australia Pty Ltd [2004] FCAFC 72

REPRESENTATION:

Counsel:
Complainant: Mr S Ward
Respondent: Mr M Griffin QC
Solicitors:
Complainant: Piper Alderman
Respondent: Avant Mutual

Introduction

1 The complainant pursuant to the provisions of s 193 of the *Health Practitioner Regulation National Law (South Australia) Act 2010* ("National Law") alleged that the respondent behaved in a way that constituted professional misconduct.

2 The complainant alleged ten grounds upon which the allegation of professional misconduct was based namely:

> "The GROUNDS upon which this Referral is made are that:
>
> 1. between 23 March 2009 and 25 April 2009, the Respondent caused his patient [Name][1] ('the Deceased') and the Deceased's family to have an unreasonable expectation of beneficial treatment and prolongation of his life despite the Deceased suffering from an already diagnosed advanced terminal illness ('Terminal Illness').
>
> 2. between 23 March 2009 and 8 April 2009 the Respondent failed, either adequately or at all, to consult with the medical practitioners who had been treating the Deceased prior to 23 March 2009 as to his condition; treatment undertaken; expectation of life and medical needs;
>
> 3. between 23 March 2009 and 8 April 2009, the Respondent failed to give any, or due, weight, in devising, or thereafter modifying, a treatment plan for the Deceased, to the seriousness of the Terminal illness;
>
> 4. between 23 March 2009 and 8 April 2009, the Respondent provided to the Deceased:
>
> 4.1 treatment;
>
> 4.2 substances and medicines; and
>
> 4.3 referrals to other medical specialists:
>
> which were unnecessary, futile, of no beneficial effect and/or not reasonably required and caused the Deceased to incur excessive and unnecessary expense in relation to 4.1 and 4.2 above.
>
> 5. between 23 March 2009 and 8 April 2009, the Respondent failed to prescribe proper beneficial treatment for the Deceased namely palliative care;

[1] The Tribunal has decided not to publish the name of the deceased.

6. between 23 March 2009 and 8 April 2009, the Respondent failed to make and keep adequate patient records of and concerning the Deceased.

7. between 23 March 2009 and 8 April 2009, the Respondent failed to obtain a properly informed consent from the Deceased for the treatment he proposed to administer to the Deceased;

8. from 18 April 2009 until 25 April 2009 the Respondent, whilst in Thailand, engaged in an improper email dialogue with the Deceased when he knew or ought to reasonably have known that the Deceased was in a deteriorated condition in palliative care in Lyell McEwin Hospital ('LMH') but seeking to rely on him and thereby:

    8.1 interfered with the provision by LMH medical staff of appropriate medical treatment;

    8.2 further engendered in the Deceased an unreasonable expectation of beneficial treatment and prolongation of his life; and

    8.3 caused distress and unnecessary pain to the Deceased and distress to the Deceased's family and LMH staff.

9. Between 23 March 2009 and 25 April 2009 the Respondent failed to recognise and manage the unrealistic expectations of the Deceased and the consequent distress pain and inconvenience to the Deceased; and distress and inconvenience to his family and LMH staff.

10. On 23 March 2009 and thereafter, the Respondent:

    10.1 held himself out as a medical specialist; and/or

    10.2 used the words or title 'medical specialist' to describe himself and/or the services he provides; and/or

    10.3 took or used words or descriptions namely 'medical specialist', and 'Board certified' in relation to his qualifications as a medical practitioner which (or each of them) could reasonably be understood to indicate he was a specialist medical practitioner or authorised or qualified to practise other than in general practice.

When, at all times prior to 1 July 2010, he held no specialty registration and, since 1 July 2010, he has been registered as a general practitioner only."

3 The respondent filed an answer to the complaint. Since filing the answer the respondent made further admissions.[2]

4 The Statement of Agreed Facts contained admissions and acceptance by the respondent that each of the alleged ten grounds of professional misconduct amounted to professional misconduct. Counsel for the respondent advised the Tribunal that the respondent admits professional misconduct in respect of each of the grounds set out in the complaint.[3]

The hearing – Summary of submissions made by counsel for the complainant

5 The complaint issued on 16 November 2012 alleged ten grounds against the respondent.

6 The ten grounds concerned the conduct of the respondent as regards the patient who came into his care on 23 March 2009. The patient, a male born on 26 April 1978, as at 23 March 2009 had been diagnosed with and continued to suffer from a terminal illness namely S1 Nerve Sheath Sarcoma which had metastasised to his lungs. The terminal illness was first diagnosed in February 2008.

7 The patient was under the care of a general practitioner, a neurosurgeon and an oncologist (Dr Antonio Michele).

8 On 20 March 2009 Dr Michele advised the patient in the presence of his parents that on the basis of his examinations of the patient and having seen a CT Angiogram Report his prognosis was poor, he had only months to live and the most appropriate treatment was palliative care. Dr Michele referred the patient to the Lyell McEwin Hospital Palliative Care Department for the management of the terminal illness. The patient died of the terminal illness in the Lyell McEwin Hospital on 25 April 2009.

9 The patient consulted with the respondent between 23 March 2009 and 8 April 2009. On 8 April 2009 the respondent travelled overseas.

10 The complainant is critical of the respondent in that it asserts that the respondent's communications with the patient and his family did not adequately address their expectations for a cure and therefore the language used by him may not have sufficiently addressed the reality of the patient's prognosis. As at the date of the first consultation the respondent was aware of the patient's terminal illness including the prognosis.

---

[2] See Exhibit C2 – Statement of Agreed Facts.
[3] Tr 2.

11 The respondent at the time of the initial consultation was aware that the patient's condition was incurable and that death in a few months was inevitable. What the respondent did created an unreasonable expectation on the part of the patient and his family. The respondent put the patient on a nutritional and detoxification program at a cost of some $3,500. Medical opinion is unanimous that such a program had no known benefit as regards the treatment of the diagnosed illness.

12 The respondent made no contact with any of the treating doctors and also accepts that he did not do anything to dissuade the patient or his family from an expectation that there might be a positive outcome to the treatment that he had recommended.

13 A further factor that reinforces the expectation that things could be done that may assist was the referral of the patient by the respondent to other doctors. The respondent organised for Dr Michael Chia to undertake a bronchoscopy and sought Dr Chia's advice as to any treatment that was available for the deceased. The respondent also referred the patient to Professor David David, Plastic Surgeon, regarding a piece of metal which was embedded in the patient's nose.

14 On 6 April 2009 Dr Chia advised the patient in person and the respondent by telephone that the condition was terminal and that he could offer no treatment, that the patient had poor insight and unrealistic expectations and that the patient should undertake palliative care.

15 Despite the reinforcement from Dr Chia that palliative care was the appropriate course to take the respondent continued to administer the intravenous nutritional program that he had devised.

16 The respondent made no attempts to speak with treating medical practitioners involved with the patient nor did he communicate with the Lyell McEwin Hospital Palliative Care Unit.

17 The respondent travelled overseas on 8 April 2009 and prior to doing so made no arrangements for any of the treating doctors to continue or take over the care of the patient.

18 The respondent admits that at no time from the date of the first consultation with the patient up to and including the date of the patient's death did he consult with or make any enquiries of the patient's treating practitioners as regards the patient's medical management.

19 The respondent's conduct amounts to a breach of the Code of Professional Conduct which applied at the time. In particular Standard 3 of the Code which makes mention of working constructively with all

health care professionals and ensuring that patient treatment is covered during absence or unavailability. Further that a patient's care is coordinated and appropriate delegation and referral of care of a patient takes place.

20 As alleged in ground three, the respondent did not have due regard to the patient's weight loss of approximately six kilograms between 24 March 2009 and 7 April 2009, its medical significance and accordingly as to whether the treatment program introduced by the respondent was appropriate as regards the patient.

21 In this context the respondent agrees that he did not give any, or any adequate, heed to the opinions expressed by the patient's treating practitioners and that his conduct was substantially below the standard reasonably expected of a registered medical practitioner of an equivalent level of training or experience.

22 The treatment program set up for the patient by the respondent did not comply with a conventional treatment modality as understood and utilised by medical practitioners of an equivalent level of training or experience in the management of patients with a condition equivalent to the patient's terminal illness. In addition the respondent failed to ensure that the treatment program was properly communicated to other treating doctors and the patient to ensure that it was not pursued in isolation or to the detriment of other treatment modalities including palliative care. As a consequence the patient focussed on completing the treatment program, had an imperfect understanding of the need to have palliative care and delayed acceptance of the need for such palliative care.

23 The respondent did not provide counselling to the patient about his poor prognosis, options regarding palliative care or recommendations about related social issues. Although the treatment program devised by the respondent was to be an adjunct to mainstream practices the respondent did not ensure that this was understood by the patient, his parents or other medical advisors and did not ensure that that is how it was effected.

24 The respondent diagnosed a magnesium deficiency in the patient and prescribed magnesium. The respondent failed to first conduct an objective assay of the patient's magnesium level by a serum magnesium level test. The case notes contain no record of any discussion by the respondent with the patient on this matter.

25 The respondent's referral of the patient to Professor David was not indicated in the circumstances of the patient.

26 The case notes of the respondent were inadequate. An examination of the case notes reveal very little record of any consultations, advice given, counselling, conclusions or a treatment plan. The case notes are quite inadequate and below what is expected in contemporary general practice.

27 The respondent failed to obtain proper informed consent. The consent form submitted to the patient did not adequately set out matters to give the patient capacity to make an informed consent.

28 The respondent journeyed overseas on 8 April 2009. The patient deteriorated significantly and presented to the Lyell McEwin Hospital on 15 April 2009 in a distressed state suffering from shortness of breath and coughing up large amounts of blood as a result of the cancer having further extended throughout his lungs. The patient was admitted to the Palliative Care Unit and remained there until his death on 25 April 2009. The cause of death was attributed to the nerve sheath sarcoma which had moved to the lungs.

29 At the time of the admission to the Palliative Care Unit the patient indicated a preference to stick with the nutritional program devised by the respondent to the exclusion or in preference of the advice that he was being given by the Palliative Care specialists in particular as to pain control.

30 The notes from the Palliative Care Unit indicated an ongoing debate between staff and the patient and his family as to the need for proper analgesic care.

31 The respondent gave the patient advice and recommendations by email as to the treatment he might accept from the Palliative Care Unit. In so corresponding with the patient whilst he was in Thailand the respondent failed to make due inquiries about the patient's condition and to appreciate its seriousness and intervened in the treatment prescribed by those able to assist the patient at the Palliative Care Unit. The intervention by the respondent in this way deflected the patient from accepting and concentrating on his realistic medical state and diverted him from taking the palliative care advice and thereby caused distress and unnecessary pain to the patient as well as distress to his family and the staff at the Palliative Care Unit.

32 The respondent's conduct in his treatment of the patient was a failure to recognise and manage the unrealistic expectations of the patient and the consequent distress, pain and inconvenience to the patient and to his family and palliative care staff.

33 As at 23 March 2009 the respondent held himself out by the words on his letterhead as having specialist qualifications and Board certified qualifications. The respondent in publications referred to himself as a specialist and being Board certified, such representations giving rise to a conclusion that the respondent was a medical specialist other than a general practitioner.

34 At all material times the respondent's registration as a medical practitioner has been in general practice.

35 The Supreme Court has considered the nature of disciplinary proceedings.[4] Essentially the purpose of disciplinary proceedings is to protect the public. The orders made by disciplinary tribunals prevent practitioners who are unfit from practising. Orders made by disciplinary tribunals assure the public that appropriate standards are being maintained.

36 There are essentially three levels of departure from the proper standards. Firstly there is the treatment phase, then the conduct when the respondent intervened in the management of the patient whilst in hospital when the respondent was overseas, and the fact of the respondent holding himself out as a specialist when he was not.

37 The parties have reached agreement upon the terms and conditions to be imposed save and except for the amount of the fine. It is accepted that it is the Tribunal's decision and not the parties. The Tribunal is asked to consider the Minutes of Order and impose discipline along the lines set out therein.

38 The Tribunal is dealing with disciplinary proceedings for the protection of the public and is not involved in a pecuniary penalty regime. The Tribunal is able to accept submissions put forward by the parties on discipline provided it is satisfied that it is reasonably within the normal boundaries and permissible range.[5]

39 As the Minutes of Order provide the respondent is to be reprimanded and fined. The respondent will no longer treat any cancer patient or any patient that he learns to be suffering from a terminal illness.

40 The respondent is to have a mentor and there is a regime set out as to how this will operate.

---

[4] *Craig v Medical Board of South Australia* (2001) 79 SASR 545.
[5] *Pharmacy Board of Australia v Jattan* [2015] QCAT 294, *NW Frozen Foods Pty Ltd v Australian Competition and Consumer Commission* (1996) 71 FCR 285 and *Minister for Industry, Tourism and Resources v Mobil Oil Australia Pty Ltd* [2004] FCAFC 72.

41 There are audit provisions as regards the respondent's practice and case notes. The respondent is to undergo an education course in relation to doctor patient communications. The respondent is to attend a psychiatrist as required by that psychiatrist.

Summary of submissions made by counsel for the respondent

42 The respondent has been undergoing psychiatric treatment and this has reached the position where it is likely to be continuing treatment on an as needs basis. The treating psychiatrist does not see any immediate need for treatment to be on a regular basis. The treating psychiatrist has indicated a willingness to continue to be engaged and to provide reports to the complainant as required.

43 Any fine to be imposed by the Tribunal will be paid personally by the respondent.

44 The respondent commenced referring patients suffering from cancer or a terminal illness to other doctors and specialists such that as at January 2015 he no longer has any existing patients who fit that criterion. He has done this in recognition of the fact that in relation to the patient his conduct failed to meet the necessary standards. He has also come to appreciate that he had a real difficulty in controlling his communications with such patients.

45 By acknowledging that the breaches alleged in grounds one to ten amount to professional misconduct the respondent admits that his failure to handle the expectations of the patient and his failure to manage them has had a terrible impact on the patient and his family particularly in those stages towards the end of the patient's life. Following on from that having recognised the problems he consulted with a psychiatrist and engaged Dr Joyner as a mentor.

46 As a result of this professional contact the respondent has developed a much sharper insight into his own problems which in turn led him to lack the necessary capacity to bring the patient's expectations back to a realistic level. He has determined that the best way to move forward is to remove himself from contact with patients who might experience those comorbidities and to concentrate his services in the area of his particular interest of nutritional medication and metal toxicology.

47 As regards the mentoring program arrangements were put in place some time ago for Dr Joyner to evaluate and assess various aspects of the respondent's practice. This process continues. The respondent has developed a good rapport with Dr Joyner and has cooperated fully with Dr Joyner's involvement in his practice.

48 The respondent has completed a course conducted by the Cognitive Institute in the area of doctor-patient communications.[6]

49 The respondent has received a great deal of assistance from his treating psychiatrist over the past two years. His contact with his psychiatrist has identified a number of psychological factors that were at play.

50 The respondent graduated in medicine in 1986 and has practiced since that time.

51 The respondent was involved in endeavours to try and assist his father in the search for cures and treatment that might cure his father or prolong his life as his father was diagnosed with hepatic cirrhosis and liver cancer. His father died in 1991. His father implored him to use the opportunity that would arise following his death in his work as a medical practitioner to seek out cures and to try and save others from the pain and ordeal that the respondent's father had gone through leading to his death.

52 The respondent recognises that his intense desire to help people, such as the patient, had arisen from the type of death that his father experienced. He had devoted himself and was extremely driven in his pursuit of the benefits of nutritional medicine and in particular in terms of being able to assist people with their quality of life even if they were also undertaking traditional forms of treatment.

53 The respondent now accepts that he allowed himself to be overly influenced by the strong emotive forces that he felt to do something for the patient. He embarked on the regime of treatment without making sure that he informed the patient, the patient's wife and the patient's parents that what he was doing was not going to alter the end result.

54 The respondent is deeply apologetic to the patient's family. The furthest thing from his mind was to add to in any way the difficulties, the pain and the trauma that the patient and his family were going through at the time.

55 The respondent acknowledges that he did not communicate with the patient's treating practitioners and the staff of the Lyell McEwin Palliative Care Unit. He acknowledges that it was completely blinkered on his part to focus only on what the patient wanted and not to be dealing with the other practitioners.

56 He recognises that by not fully informing himself about the fact that the patient entertained unreasonable expectations about what might happen

[6] Exhibit R1 – Course completion certificates from Cognitive Institute dated 12 September 2015.

he allowed those expectations to continue without confronting them and addressing them with the patient.

57 The respondent indicates an understanding now that many of the expressions that he used in his dealings with the patient and his family were of the type that were overly optimistic. His realisation of this incorrect approach has come about due to his contact with his psychiatrist, Dr Joyner and from the course undergone by him at the Cognitive Institute.

58 He now recognises that following his departure for overseas, at a crucial time in the patient's care, inadequate steps were taken to make sure that the patient was being looked after by someone else. He assumed wrongly that if the patient needed further treatment that the patient would return to his previous treating doctors. He also acknowledges that he was wrong by providing advice to the patient through email without fully knowing the extent of what was happening, and without speaking with the staff at Lyell McEwin Hospital that the advice that he was offering was ill considered.

59 The respondent is a married man with children and following the death of his father has continued to care for his mother. He is a man devoted to his extended family.

60 The respondent has undertaken a great deal of additional training in Europe and America in the areas of nutritional therapy and toxicology particularly metal toxicology. He admits that he wrongly and incorrectly described himself on his letterhead as being Board certified.

61 Presently the vast majority of his patients are people who need to have their lifestyle and nutrition evaluated and worked on so that they can become healthier and avoid falling into being diabetic. In Melbourne, where he attends to work for one day a week, the patients that he sees are usually people who have been exposed to toxic substances in the workplace.

62 The respondent acknowledges the inadequacy of his case notes in relation to the patient. He accepts that he did not adequately set out in his case notes the details of the treatments that he was proposing and in particular the discussions he had with the patient or the patient's family. Nor did he properly identify and record what he was recommending and why.

63 The legal position as regards the principles involved when an agreed position has been reached and is put to the Tribunal is as expounded by counsel for the complainant. What is proposed in the Minutes of Order

is within reasonable bounds and contains a proper regime for the protection of the public interest. The public interest is properly served by all of those conditions because it allows the respondent to continue in general practice and provides the necessary safeguards to ensure that mistakes of this nature do not happen again.

64 The terms and conditions and penalties to be imposed amount to a significant imposition.

65 What happened occurred some six years ago and has obviously had an impact on the respondent and his family. During that period there has been growth and development of insight into his communication failings.

66 As an aside the impact of the awful situation with the patient and the patient's family has brought about a realisation on his part that his intense focus upon his patient has had a deleterious effect upon his personal relationships with his wife and within the family on occasions. This he has addressed through his psychiatrist and with Dr Joyner's help.

Consideration

67 The protection of the public is the paramount consideration when considering the purpose of the proceedings and the imposition of discipline on the respondent. For the protection of the public only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are entitled to be registered. The Full Court of the Supreme Court of South Australia when discussing the purpose of disciplinary proceedings had this to say:[7]

> "The purpose of disciplinary proceedings is to protect the public, not to punish a practitioner in the sense in which punishment is administered pursuant to the criminal law. A disciplinary tribunal protects the public by making orders which will prevent persons who are unfit to practise from practising, or by making orders which will secure the maintenance of proper professional standards. A disciplinary tribunal will also consider the protection of the public, and of the relevant profession, by making orders which will assure the public that appropriate standards are being maintained within the relevant profession.
>
> …
>
> In the case of a professional disciplinary tribunal, an obvious type of order protective of the public is an order cancelling the registration or recognition of a person as a member of a

[7] *Craig v Medical Board of South Australia* (2001) 79 SASR 545 Doyle CJ, Williams and Martin JJ in particular at pages 553-555 per Doyle CJ.

> profession. Such an order removes the right to practise in the profession, thereby protecting the public against a person found unfit to be a practitioner.
>
> …
>
> In other cases the protection of the public or the public interest may justify an order intended to bring home to the practitioner the seriousness of the practitioner's departure from professional standards, and intended to deter the practitioner from any further departure. A fine might well be imposed with this object. An order imposing a fine might look like a punishment imposed by a court exercising criminal jurisdiction, but in professional disciplinary proceedings it is imposed on a different basis. An order might also be made in professional disciplinary proceedings to emphasise to other members of the profession, or to reassure the public, that a certain type of conduct is not acceptable professional conduct. In the latter case the order is made in part to protect the profession, by demonstrating that the profession does not allow certain conduct. This, in the end, is also in the public interest."

68 The New South Wales Court of Appeal[8] had this to say:

> "The gravity of professional misconduct is not to be measured by reference to the worst cases, but by the extent to which it departs from the proper standards. If this is not done there is a risk that the conduct of the delinquents in a profession will indirectly establish the standards applied by the Tribunal."

69 The Tribunal is of the unanimous view that the conduct of the respondent as detailed in the complaint amounts to professional misconduct.

70 The Tribunal having heard submissions has some understanding of why the respondent dealt with the patient in the manner complained of. The respondent's experience with his father and the unfortunate death of his father no doubt prompted the respondent to embark upon an approach to treatment that was on the one hand completely dedicated but on the other lacking in any objectivity.

71 The Tribunal accepts that through the mentoring process and the contact with the treating psychiatrist the respondent has developed insight into what amounted to a significant departure from the proper standards as regards his treatment of the patient.

---

[8] *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 638 per Gleeson CJ, Meagher JA, Handley JA.

72 The parties prepared draft Minutes of Order for consideration by the Tribunal. The Tribunal after considering the draft Minutes of Order and hearing from counsel for the complainant and the respondent asked the parties to agree additional terms to be imposed on the respondent's registration which in effect required him to remove from electronic communications and websites and publications that appear on the internet any reference to his qualifications which might indicate a speciality. Following the hearing the parties agreed those terms and amended the Minutes of Order.

73 The Tribunal has considered the amended draft Minutes of Order which it adopts. The Minutes of Order included a reference to the fine of $12,000 which the Tribunal imposed upon the respondent.

74 The Minutes of Order are:

> **"AND UPON** our finding this day that the Respondent's conduct as pleaded in Grounds 1 – 10 inclusive of the Complaint herein is professional misconduct within the meaning of section 5 of Schedule 2 to the *Health Practitioner Regulation National Law (South Australia)* ('**National Law**') **IN ACCORDANCE WITH** section 196 of Schedule 2 to the National Law, the South Australian Health Practitioners Tribunal **ORDERS THAT**:
>
> 1. The Respondent is reprimanded;
>
> 2. The Respondent is to pay a fine of Twelve Thousand Dollars ($12,000.00) to the Complainant within thirty (30) days of this Order.
>
> 3. Pursuant to section 196(2)(b) of Schedule 2 to the National Law, the following conditions are imposed on the Respondent's registration:
>
> 3.1. The Respondent will not consult, interview, examine, treat, advise or see (collectively called '**Consul**t') any patient he knows to be suffering from cancer or a terminal illness. If the Respondent becomes aware that a patient is suffering from cancer or a terminal illness he must make arrangements to refer them to another registered medical practitioner and cease consulting that patient within two weeks of becoming aware that the patient is suffering from cancer or a terminal illness. Where the Respondent is already aware of

an existing patient with cancer or a terminal illness, he must transfer such patients to another registered practitioner within two weeks of being advised of the imposition of these conditions.

3.2. The Respondent will engage in a professional mentoring program with a mentor approved by the Board or its delegate ('**Mentor**') requiring:

(a) the Respondent to meet with the Mentor at least once every three months commencing no later than one month from the date of these conditions being imposed;

(b) the mentoring to focus on the areas of patient evaluation and treatment; record keeping; awareness of co-morbidities in patients; involvement of other practitioners in the care of a patient; improving communication with patients, their families and other practitioners and informed consent (including the manner in which that consent is obtained);

(c) the Mentor to provide a written report to the Board on the Respondent's progress in the mentoring program every three months or within 14 days of any request from the Board or its delegate;

(d) the Respondent to provide a reflective paper on the learning outcomes of the mentoring program and how these will be implemented into his practice as a medical practitioner within one month of completion of the mentoring.

3.3. The Respondent will submit the details and resume of a proposed Mentor to the Board within 14 days of being advised of the imposition of these conditions.

3.4. The Board and its delegate may communicate with any mentor proposed in accordance with condition 3.3 and any mentor approved in accordance with condition 3.2 in relation to the Respondent's

mentoring; progress; work performance and compliance with these conditions.

3.5. The Respondent will maintain, for review by the Mentor, a duplicate patient file (in a format approved by the Board) in his Adelaide place of practice for every patient whom he consults in any State or Territory of Australia other than South Australia.

3.6. The Respondent will submit to a practice audit at his practice in Melbourne to be undertaken by the Mentor or an auditor approved by the Board or its delegate to assess compliance with these conditions.

3.7. The Respondent will complete an education course conducted by the Cognitive Institute in the area of Doctor/patient communications within six months of being advised of the imposition of these conditions.

3.8. The Respondent will provide the Board with evidence of successful completion of the course referred to in condition 3.7 within one month of completion of the course.

3.9. The Respondent will attend a psychiatrist at a frequency to be determined by the psychiatrist and comply with the recommended treatment plan.

3.10. The Respondent will ensure that the Board receives a report from his psychiatrist every six months and within 14 days of any request from the Board or its delegate.

3.11. The Respondent will provide the name and address of the Respondent's treating psychiatrist to the Board within seven days of being advised of the imposition of these conditions and, if the Respondent should change his psychiatrist, the Respondent will notify the Board of his new psychiatrist within seven days of the Respondent's first appointment with that new psychiatrist.

3.12. The Respondent will provide a copy of these conditions to the Respondent's present and any future treating psychiatrist.

3.13. The Respondent will arrange for his psychiatrist's written confirmation acknowledging that these conditions have been sighted to be provided to the Board within 14 days of being advised of the imposition of these conditions, and within 14 days of his first appointment with a new treating psychiatrist.

3.14. The Board and its delegate may communicate with the Respondent's treating psychiatrist and any allied treating practitioners about the Respondent's health and these conditions.

3.15. The Respondent will remove, and do all things necessary to facilitate the removal, from all publications made by him or on his behalf ('**Publications**'), containing any reference to his qualifications, education, training, experience or achievements which in any way represent or give rise to an imputation (whether read in isolation or in combination with other Publications) that:

(a) he is, or at any time was, registered by the Board or its predecessor as a medical specialist in clinical metal toxicology; advanced integrative medicine; advanced longevity medicine and/or aesthetic medicine; or

(b) he is a specialist other than a general practitioner within the meaning of sections 5, 115 and 118 of Schedule 2 to the National Law; or

(c) he is 'Board certified'.

For the purposes of these conditions a reference to Publications includes any communication (whether in written, electronic, or oral form, or a combination of same) made, authorised or adopted by or on behalf of the Respondent in connection with the matters in 3.15 (a) –(c) above.

3.16. The Respondent will comply with the requirements of condition 3.15 within three months of the imposition of these conditions.

3.17. The Respondent will provide evidence of compliance with condition 3.15 within one month of completion.

3.18. The Respondent will not in the future in Publications, whether directly or indirectly, make any representation of the type described in condition 3.15 above.

3.19. As to condition 3.15, in the event that the Respondent has done all things necessary to remove Publications but a third party publisher of that information fails or refuses to remove same, the Respondent will report this fact, together with such details of his actions taken to remove such Publications as the Board may reasonably require, to the Board within 28 days of the failure or refusal and, in such a case where the Board indicates that it is satisfied with the actions taken, the Respondent will be taken to have satisfied his obligation under condition 3.15. Where the Board is not so satisfied, it may give the Respondent directions as to any further action to be taken by him to remove the Publications or ameliorate their effect.

3.20. The review period for these conditions is 12 months.

3.21. All costs of these conditions are the responsibility of the practitioner.

3.22. In the event that the Respondent changes his principal place of practice to New South Wales then the appropriate review body for conditions on registration is the Medical Council of New South Wales

Notes:

In these Conditions, a reference to the "Board" is a reference to the Complainant.

These conditions will remain in force until such time that they are set aside on appeal or the Board agrees to their amendment or removal.

A failure to comply with these conditions may constitute behaviour for which action may be taken under Part 8 of the *Health Practitioner Regulation National Law (South Australia).*

4. The Respondent is to pay, within 21 days of the date of this Order, the Complainant's costs of and incidental to these proceedings which have been agreed by the parties by exchange of correspondence being email from Piper Alderman dated 29 September 2015 and letter of Avant Mutual dated 1 October 2015."