ACT CIVIL & ADMINISTRATIVE TRIBUNAL

MEDICAL BOARD OF AUSTRALIA v MELHUISH (Occupational Discipline) [2016] ACAT 29

OR 36/2014

Catchwords: **OCCUPATIONAL DISCIPLINE – MEDICAL PRACTITIONER** – professional misconduct – medical research – information and health privacy principles – health records – personal health information

Legislation cited:
Australian Capital Territory Government Service (Consequential Provisions) Act 1994 (Cth) s 7
Freedom of Information Act 1989 (ACT) s 6
Health Act 1993 (ACT)
Health Practitioner Regulation National Law (ACT) ss 5, 196 456
Health Records (Privacy and Access) Act 1998 (ACT) s 4, sch 1
Legislation Act 2001 (ACT) s 184A
Privacy Act 1988 (Cth) s 14

Cases cited:
Cranley v Medical Board of Western Australia Unreported, Supreme Court of Western Australia, Ipp J, (21 December 1990)
Nitschke v Medical Board of Australia [2015] NTSC 39
Philip Nitschke and Medical Board of Australia [2014] NTHPRT 5
Re a Solicitor (2004) 216 CLR 253

List of Texts/Papers cited:
ACT Health Research Practice Policy
Australian Code for Responsible Conduct of Research 2007 cl 2.6, 2.7
Good Medical Practice: A Code of Conduct for Doctors in Australia cl 1.4, 11
National Statement on Ethical Conduct in Human Research

Tribunal: Senior Member P Spender
Member G Wright

Date of Orders: 13 April 2016
Date of Reasons for Decision: 13 April 2016
Date of Further Orders: 16 August 2016

AUSTRALIAN CAPITAL TERRITORY)
CIVIL & ADMINISTRATIVE TRIBUNAL) OR 36/2014

BETWEEN:

MEDICAL BOARD OF AUSTRALIA
Applicant

AND:

NICHOLAS MELHUISH
Respondent

TRIBUNAL: Senior Member P Spender
Member G Wright

DATE: 13 April 2016

ORDER

The Tribunal Orders that:

1. Upon deciding that the respondent has behaved in a way that constitutes professional misconduct, the matter is to be listed for further hearing to decide what action should be taken pursuant to section 196(2) of the *Health Practitioner Regulation National Law* (ACT) (the question of penalty).

2. The matter is to be listed for further directions on a date to be advised to consider the question of penalty and the applicant's application for costs.

……*Signed*……..
General President L Crebbin
for and on behalf of the Tribunal

AUSTRALIAN CAPITAL TERRITORY)
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BETWEEN:

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Applicant

AND:

NICHOLAS MELHUISH
Respondent

TRIBUNAL: Senior Member P Spender
Member G Wright

DATE: 16 August 2016

ORDERS

1. By consent, the Tribunal makes the following orders pursuant to section 196(2) of the *Health Practitioner Regulation National Law (ACT):*

   (a) that the respondent be reprimanded for his conduct;

   (b) that the following conditions be imposed on the respondent's registration:

      (i) The respondent must not practise as a medical researcher for a period of 12 months from the date of these orders;

      (ii) The respondent is to undertake and successfully complete a program of education, approved by the Medical Board of Australia (the Board) and provide the Board with a reflective practice report, in relation to the following topics: medical research ethics, privacy law, and Clause 11 of the Good Medical Practice: A Code of Conduct for Doctors in Australia;

      (iii) The respondent may not have any non-clinical communication with any persons, or relatives of persons, included in medical research projects the respondent was involved in, (the participants); and

      (iv) After the period of 12 months, referred to in condition b)(i), has been served, the respondent may not have any non-clinical

communication with any persons included in medical research projects the respondent may be involved in the future (the participants).

(c) that the respondent comply with the further conditions (Implementation Conditions), to be imposed on the respondent's registration, as set out below**.**

2. By consent, the respondent will pay the applicant's costs of these proceedings.

3. The applicant's application dated 2 May 2016 for a further order pursuant to section 39 of the *ACT Civil and Administrative Tribunal Act* is dismissed.

Implementation Conditions

Provision of information and acknowledgement

1. Following the making of these orders, the respondent, within 14 days of receipt by him or his solicitor of a form provided by AHPRA:

(a) is to provide to AHPRA on that form:

(i) the contact details of the Director of Medicine or other senior person at each and every current place of where he practises and written confirmation those persons are aware AHPRA will contact them to obtain reports on a six monthly basis or at other times as required by AHPRA or the Medical Board that the respondent has not practised as a medical researcher for a period of 12 months from the date of these orders;

(ii) the details of any and all places of his practice, together with confirmation from the Director of Medicine or senior person at each and every place of practice that they have sighted a copy of these conditions.

(b) is to provide to AHPRA written acknowledgement that AHPRA will contact and obtain reports from the Director of Medicine or senior person nominated in paragraph (a)(i) above on a six monthly basis or at other times as required by AHPRA or the Medical Board or where the Director of Medicine or senior person holds a concern, or becomes aware of a concern, that the respondent may have breached an order of the Tribunal that he not practise as a medical researcher for a period of 12 months or is otherwise concerned about his conduct.

2. For a period of 12 months from the date of these orders with each and every subsequent place of practice the respondent must, within seven days of the commencement of practice, provide to AHPRA the details of the subsequent place of practice together with written confirmation, where relevant, from the senior person at each and every subsequent place of practice that they have sighted a copy of these conditions.

Undertaking of further education

3. Within 14 days of the date of this order, the respondent must nominate to the Board for approval, in writing, an education course, assessment or program (the education) addressing the topics in order (b)(ii) of the Tribunal. The respondent must ensure:

   (a) The nomination includes a copy of the curriculum of the education.

   (b) The education consists of a minimum of 3 hours online or face to face training.

4. The respondent must complete the education within 12 months of the notice of AHPRA's approval of the education.

5. Within 14 days of the completion of the education, the respondent is to provide:

   (a) Evidence of successful completion of the education.

   (b) A reflective practice report to the Board demonstrating, to the satisfaction of the Board, that the respondent has reflected on the issues that gave rise to this condition and how the respondent has incorporated the lessons learnt in the education into the respondent's practice, including research, and confirmation that the respondent has not included this education or the preparation of this written report to satisfy his continuing professional development requirements.

6. The respondent must not use the education and/or reflective practice report undertaken in compliance with these restrictions to satisfy his CPD requirements.

Prohibition on communication with medical research participants

7. For the purposes of these conditions 'non-clinical communication' means direct communication or indirect communication through a third party and includes telephone, text message, messaging services, email, electronic communication through social media or written communication that does not relate to the actual observation and treatment of patients.

Costs of compliance

8. All costs associated with compliance with these orders are at the respondent's own expense.

……..
General President L Crebbin
for and on behalf of the Tribunal

REASONS FOR DECISION

The reasons below explain why the Tribunal has made the orders set out above.

1. On 13 April 2016 the Tribunal handed down a decision where it found that the respondent engaged in professional misconduct as defined in section 5 of the *Health Practitioner Regulation National Law (ACT)* (the National Law) because of various breaches of the *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Doctors' Code of Conduct), the National Health and Medical Research Council (NHMRC) *Australian Code for Responsible Conduct of Research 2007* (the NHMRC Code) and the ACT Health Research Practice Policy, which are explained below.

2. In a hearing on 4 July 2016, the Tribunal considered a joint submission by the parties about the penalty that should be imposed. After questioning the representatives of the parties, the Tribunal was satisfied with the orders proposed in the joint submission. The orders are within the power of the tribunal to make and are appropriate in the context of the Tribunal's findings about the respondent's conduct. By consent, the Tribunal has made the orders set out above pursuant to section 196(2) of the *Health Practitioner Regulation National Law (ACT).*

3. For ease of reference, the Tribunal has published the orders regarding the finding of professional misconduct and penalty together. The reasons given to the parties on 13 April 2016 are modified to incorporate the Tribunal's decision about penalty and its decision regarding publication of its reasons following the application made under section 39 of the *ACT Civil and Administrative Tribunal Act*.

4. In the reasons below, a reference to 'ACAT' or 'tribunal' refers to the ACT Civil and Administrative Tribunal generally, whereas 'Tribunal' refers to the current panel.

The application

5. In its amended application filed 24 April 2015, the applicant sought the following orders:

(a) That the respondent has engaged in conduct which constitutes professional misconduct or in the alternative unprofessional conduct.

(b) That the Tribunal take action in relation to the respondent pursuant to section 196(2) of the National Law.

(c) That the respondent pay the applicant's costs of and incidental to this application.[1]

6. The grounds or allegations relied upon were as follows:

(a) On 23 June 2013, on or around 15 January 2014 and on 30 January 2014, the respondent engaged in misconduct by writing letters to four former patients at the Canberra Hospital claiming, that as a result of research undertaken at the Canberra Hospital, medical treatment details, identifiable as belonging to them, were available to persons and organisations outside the hospital, without any evidence that this allegation was true.

(b) The respondent breached Principle 9 of the *Health Records (Privacy and Access) Act 1998* (ACT) (the Health Records Act), the NHMRC Code, the ACT Health Research Practice Policy and acted inconsistently with Information Privacy Principle 11 of the *Privacy Act 1988* (Cth) (the Privacy Act) by disseminating information he was provided with as a result of his involvement in a research project to persons and/or entities outside the project research team.

(c) The respondent persisted in the conduct of writing to patients making allegations that their medical treatment details were being made available outside the hospital and accessing patient records without authorisation despite his employer's direction not to do so after he wrote the first letter.

7. The allegations were particularised by a statement in support of the application for disciplinary action. The Tribunal will discuss the particulars of the allegations interstitially in the reasons below.

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1 Amended application 24 April 2015

Background

8. Between late 2011/early 2012 and 30 April 2012, the respondent assisted another Visiting Medical Officer (VMO) in anaesthesia, Dr James French, in a research project at the Canberra Hospital (TCH). Dr French was the lead researcher and the respondent assisted Dr French with the project.[2]

9. The project was to compare clinical outcomes for patients treated with blood transfusions while being airlifted to TCH by the Snowy Hydro SouthCare Rescue Helicopter with outcomes of similar patients who had not received a transfusion before being admitted.

10. In April 2012, the respondent expressed concerns with Dr French's proposed analysis and made allegations of research misconduct against Dr French to the Director of the Department of Anaesthesia. The respondent left the project on 30 April 2012.[3]

11. On 27 August 2012, the respondent formally complained about research misconduct on the part of Dr French to the Director-General of the ACT Health Directorate.[4]

12. In September 2012, Professor David Brewster, the Director of Research at TCH, appointed ACT Health Epidemiologist, Dr Bruce Shadbolt, to investigate the complaint. After interviewing both the respondent and Dr French, Dr Shadbolt provided a mediation report[5] to Professor Brewster which concluded there was no evidence of misconduct and, accordingly, Professor Brewster dismissed the complaint in November 2012.

13. Professor Brewster advised the Director-General, by letter dated 14 November 2012, that the respondent's application was dismissed.[6]

14. On 29 November 2012, the respondent complained about research misconduct on the part of Dr French by way of a 'second report'.[7]

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2 Amended application, 24 April 2015, Attachment A at [2]
3 Amended application, 24 April 2015, Attachment A at [3]
4 Exhibit R1, 4 March 2105, NM1-9, Tab 9
5 Exhibit A7, 13 August 2014, Tab 3 pages 16-19
6 Exhibit A7, 13 August 2014, Tab 4 pages 20-21

15. On 3 December 2012, Professor Brewster replied to the 'second report' rejecting all allegations.[8]

16. In December 2012, Dr French gave a presentation about his research to the Pre Hospital and Retrieval Quality Assurance Committee of the Capital Region Retrieval Service (Quality Assurance Committee).[9]

17. From January 2013, the respondent contacted a number of agencies and individuals, including the ACT Chief Minister (also the Health Minister), the ACT Opposition Leader and the ACT Health Services Commissioner alleging patients in the datasets could be identified. [10] Attached to his letter to the ACT Health Services Commissioner was one of the project datasets.[11]

18. In February 2013, Dr French submitted and then withdrew an abstract entitled 'Pre-Hospital Blood Transfusion: A retrospective cohort study' to the Australian and New Zealand College of Anaesthetists (ANZCA) Annual Scientific Meeting.[12]

19. In March 2013, Professor Frank Bowden was designated as lead officer within ACT Health to resolve the matter of dissatisfaction with the handling of the complaint and the research project generally with the respondent. On four occasions the respondent was invited to meet with Professor Bowden and the Deputy Director-General, Canberra Hospital and Health Services to resolve the matter but no such meeting eventuated.[13]

20. In early April 2013, the respondent lodged a formal complaint with the ACT Health Services Commissioner about the conduct of the TCH investigation into

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7 Exhibit R1, 4 March 2105, NM1-11, Tab 11
8 Exhibit R6(ii) - letter from NHMRC's Ron Brent to respondent dated 18 December 2013, page 2
9 Exhibit A2, 21 January 2015 at [19]
10 Exhibit R1, 4 March 2105 at paras 42 – 43; Transcript of Proceedings 1 May 2015, page 34, lines 10-27; Exhibit A10 Tab 6 page 2
11 Transcript of Proceedings 1 May 2015, page 34, line 27
12 Exhibit A2, 21 January 2015 at [20]
13 Amended application, 24 April 2015, Attachment A at [6]

his complaint of research misconduct and re-identifiable data, enclosing information from project datasets.[14]

21. Subsequently, on 14 May 2013, the respondent requested that the Australian Research Integrity Commission (ARIC) review the conduct of the investigation into his complaint to TCH and his complaint as to the failure to de-identify data.[15]

22. On 21 June 2013, the respondent wrote to the CEO of Snowy Hydro SouthCare claiming that medical details of patients were now available to a considerable number of people outside the hospital system as a result of the research project.[16]

23. On 23 June 2013, the respondent wrote to a 94-year-old former patient of the hospital (Patient 1) to inform him "that some of your medical treatment details have been included on a research file without removing information that identifies you personally. As a result, these details are now available to a number of government organizations outside the hospital, as well as a number of other people in various academic, insurance and legal organizations" and suggested that if Patient 1 was concerned he should write to the ACT Chief Minister.[17]

24. On 28 June 2013, a notification about the respondent's conduct was sent to the Australian Health Practitioner Regulation Agency (AHPRA) by Professor Bowden, the Acting Executive Director of Medical Services, Canberra Hospital and Health Services. This was followed on 4 July 2013 by a statement in support by Professor Bowden (referred to together as 'the first notification').[18]

25. The first notification alleged that the respondent had sent Excel files containing patients' particulars to unidentified agencies/persons in Sydney and Melbourne. It also alleged that the respondent had written to Patient 1 alleging that

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14 Exhibit A10, Tab 1, attachment to Human Rights Commission Complaint Form
15 Exhibit A11; Transcript of Proceedings 1 May 2015, page 35 at 35-39; Exhibit R1, 4 March 2105 at [45]
16 Exhibit R1, 4 March 2105, NM1-24, Tab 24
17 Exhibit A7, page 26
18 Exhibit A7, pages 1 to 15

Patient 1's medical treatment details had been included on a research file without removing identifying information and that as a result the details were available to a number of people and organisations outside the hospital.[19]

26. The first notification alleged that sending the letter to Patient 1, raising untrue allegations, had the potential to cause unnecessary distress to Patient 1 and his family, constituted professional conduct that may be of a lesser standard than that which might reasonably be expected of the respondent by the public and his professional peers, and demonstrated that the respondent's professional judgement is, or may be, below the standard reasonably expected.[20]

27. A response from the respondent's legal representatives, dated 6 September 2013, stated that the respondent:

    (a) denied having access to Patient 1's clinical file;
    (b) stated he found the identity and contact details of Patient 1 by entering his age and the date of his helicopter transfer to the hospital into an internet search engine; and
    (c) reserved his right to write to other former patients.[21]

28. Between 21 August and 15 October 2013, the respondent corresponded several times with the ARIC about his concerns and asked for a review of the research misconduct investigation.[22] On 18 December 2013, ARIC sent the respondent a copy of its report which concluded that the complaint should be dismissed.[23]

29. In September 2013, the respondent wrote to 45 anaesthetists and the CEO of Snowy Hydro SouthCare attaching a draft version of the abstract submitted, then withdrawn[24], by Dr French to the ANZCA Annual Scientific Meeting.[25]

30. On 4 October 2013, the Director-General of ACT Health Directorate (Director-General) advised the respondent that his correspondence to Patient 1 was

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19 Exhibit A7, pages 12 to 13
20 Exhibit A7, pages 1 to 15
21 Exhibit A7, pages 27-30
22 Transcript of Proceedings 1 May 2015, page 39
23 Exhibit R1, 4 March 2105, NM1-13, Tab 13
24 Exhibit A2, 21 January 2015 at [20]
25 Exhibit R1, 4 March 2105 at [60]-[61]

considered to be a breach of Principle 9 of the Health Records Act.[26] Principle 9 is extracted below.

31. The Director-General also advised the respondent that his conduct would amount to a breach of his contract in accordance with clause 17.2(13) of the *Sessional and FFS Agreement* (the Agreement) that the respondent entered into with the ACT on 15 December 2007.[27] The Director-General also directed the respondent to cease engaging in such unlawful conduct in accordance with clause 17.2(12) of the Agreement.[28]

32. On 10 January 2014, a Canberra Times reporter wrote to ACT Health raising the respondent's concerns and two days later an article 'Doctor "harassed" after he complained about flawed report' was published in the Canberra Times.[29]

33. On 15 January 2014, the respondent advised the ACT Chief Minister that he had written to two former patients (Patient 2 and Patient 3) whose information was included in the project's datasets to tell them that medical treatment details identifiable as belonging to them were available to a number of organisations and people outside the hospital. He further stated that these records were likely to become available to more people outside the hospital in the near future.[30]

34. Subsequently, on 24 January 2014, the Director-General wrote to the respondent stating her belief that his correspondence to Patients 2 and 3 constituted:

    (a) a further breach of Principle 9 of the Health Records Act; and

    (b) a serious breach of the respondent's contract in accordance with clause 17.2(13) of the Agreement.[31]

35. The Director-General also requested copies of all correspondence from the respondent to Patients 2 and 3.

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26 Exhibit A7, pages 33-34
27 Exhibit R2
28 Exhibit A7, pages 33-34
29 Exhibit A10, Tabs 2-3
30 Exhibit A7, pages 33-34
31 Exhibit A7, pages 33-34

36. On 30 January 2014, the respondent wrote a letter, similar to those he wrote to Patients 2 and 3, to another person (Patient 4).[32]

37. On 18 February 2014, the respondent wrote to the Federal Assistant Minister for Health identifying Patient 4 by name and further identifying him by stating that Patient 4 is the son of one of her former colleagues. In his letter, the respondent listed pathology test results which he said were those of Patient 4.[33]

38. A second notification to AHPRA about the respondent's conduct was made by Professor Bowden on 26 May 2014. In this second notification Professor Bowden raised the fact that the respondent had written to Patients 2, 3 and 4. Professor Bowden also raised concerns about the respondent's mental health and the likelihood of it detrimentally affecting his capacity to practise his profession.[34]

39. In June 2014, the respondent wrote to AHPRA twice. Firstly, stating that he had forwarded the project datasets to "many more people"[35] and secondly providing the names of patients he alleged were identifiable from the datasets and he attached an extract from the datasets.[36]

40. On 30 June 2014, the respondent wrote to the Australian Health Ethics Committee of the NHMRC seeking an opinion on research ethics and attached information from the datasets and the names of patients he claimed to have identified from the datasets.

41. In July 2014, the respondent wrote to the CEO of Snowy Hydro SouthCare twice in relation to the project.[37]

42. On 22 August 2014, AHPRA received a third notification about the respondent's conduct from Dr French. The third notification complained that:

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32 Exhibit A7, pages 33-34
33 Exhibit R3
34 Amended application, 24 April 2015, Attachment A at [22]
35 Exhibit A7, page 53
36 Exhibit R1, 4 March 2105, NM1-14, Tab 14
37 Exhibit A10, Tab 4

(a) the respondent failed to return the research dataset after he ceased with the project;

(b) the respondent used the de-identified dataset and combined it with information from other sources to identify patients whose particulars formed part of the dataset and then had written to those patients alleging their confidentiality had been breached thus causing the patients unnecessary confusion, anxiety and distress; and

(c) the respondent had breached a number of principles of the NHMRC Code.[38]

43. On 25 August 2014, the respondent wrote to the ACT Chief Minister with copies to journalists from the Canberra Times and the ABC.[39]

44. On 14 September 2014, the respondent wrote to 45 Canberra anaesthetists providing an amended data file and inviting them to re-identify patients.[40]

45. On 26 December 2014, the respondent wrote to the Medical Journal of Australia, copying Andrew Kefford of the ACT Public Service and the NHMRC, providing information about the project.[41]

46. On 27 January 2015, the ACT Auditor wrote to the Director-General of Health advising that the Audit Office had "received a disclosure from [the respondent] regarding his concerns about the security of government information." The respondent's concern was that "information which can be used to identify individuals, and thereby breach their confidentiality, is available to 'more than a hundred people…outside the hospital who are not involved in patient care and should not' have received the information."[42]

47. On 3 February 2015, the respondent wrote to interstate AHPRA offices including information extracted from the datasets.

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38 Amended application, 24April 2015, Attachment A at [24]
39 Exhibit A10, Tab 5
40 Exhibit A2, para 29 and Attachment G
41 Exhibit A10, Tab 7
42 Exhibit 10, Tab 8

48. On 19 March 2015, the respondent wrote to the ACT Chief Minister advising that he had made further contact with a patient.[43]

Was the respondent's conduct 'professional misconduct'?

49. A threshold issue is whether the respondent's conduct (which forms the subject matter of this proceeding) comes within the meaning of the term 'professional misconduct' for the purposes of section 5 of the National Law.

50. The relevant definitions in section 5 of the National Law are as follows:

> ***professional misconduct****, of a registered health practitioner, includes—*
>
> *(a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and*
>
> *(b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and*
>
> *(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.*
>
> ***unprofessional conduct****, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes—*
>
> *(a) a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and*
>
> *(b) a contravention by the practitioner of—*
>
> *(i) a condition to which the practitioner's registration was subject; or*
>
> *(ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and*
>
> *(c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession; and*

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43 Exhibit A10, Tab 9

(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being; and

(e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and

(f) accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider; and

(g) offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner; and

(h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

51. The applicant alleged that the respondent's conduct fell within subparagraphs (a) and (b) of the definition of 'professional misconduct' in section 5 of the National Law. The applicant expressly stated that it did not contend that the respondent's conduct was such as to make him unfit to hold registration in the profession and therefore did not rely upon paragraph (c) of the definition of professional misconduct.

52. Subparagraph (c) of the definition of professional misconduct relies upon the wider proposition that the practitioner's conduct, "whether occurring in connection with the practice of the health practitioner's profession or not" is inconsistent with the practitioner being a fit and proper person to hold registration in the profession. Reliance upon this paragraph would not necessarily require that a connection be established between the conduct and professional practice. However, reliance upon subparagraphs (a) and (b) require that a nexus be established.

53. This proceeding does not involve actions taken by the respondent in dealing with his own patients. Rather, it concerns other conduct regarding a research project and the question is whether that conduct is connected to professional

practice. In *Philip Nitschke and Medical Board of Australia*[44] the Northern Territory Professional Review Tribunal held that, when scrutinising a medical practitioner's conduct, the issue is not so much whether there was a doctor/patient relationship but whether there was sufficient connection to the profession.[45] Although the decision of the Tribunal was overturned on appeal by the Supreme Court in *Nitschke v Medical Board of Australia*[46] (*Nitschke*) the decision regarding this finding was not.

54. In the Northern Territory Supreme Court in *Nitschke,* Hiley J made the following comments about the requisite connection:

> *[92] The appellant also contended that s 156 only applies to conduct that is undertaken in the capacity of medical practitioner or that occurs in the context of a doctor/patient relationship. For reasons similar to those stated above, I disagree with this contention. As with the other provisions in the National Law, s 156 is capable of applying to any registered medical practitioner irrespective of his or her particular relationship or capacity at the time of engaging in the conduct which is said to be professional misconduct or unprofessional conduct.*
>
> *[93] That is not to say that there does not need to be some connection between the practitioner and the medical profession in order for immediate action to be taken. Although the conduct itself may have nothing to do with the practice of medicine, in order to take immediate action the relevant body would have to hold a reasonable belief that because of that conduct there would be a serious risk to public health or safety unless immediate action was taken in relation to the person's registration as a medical practitioner. In this regard there does need to be a connection between the practitioner and the practice of medicine in which he or she was registered to engage.*[47]

55. The applicant in the present case argued that although the appeal in *Nitschke* was concerned with section 156 of the National Law, which deals with an immediate action decision, the court made it clear that the other regulatory provisions of the National Law apply to the conduct of registered medical practitioners regardless of the existence of a doctor/patient relationship. The first instance decision was not overturned on the basis that Dr Nitschke had no

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44 [2014] NTHPRT 5
45 [2014] NTHPRT 5 at [45]
46 [2015] NTSC 39; (2015) 301 FLR 122
47 [2015] NTSC 39; (2015) 301 FLR 122 at [92] - [93]

doctor/patient relationship with the person he advised. Rather, the appeal was allowed on the basis that there was no evidence to satisfy the court that there exists a generally accepted standard or duty or a relevant professional conduct rule requiring the appellant to take certain actions in respect of the person he was dealing with given that that person was not the appellant's patient.[48]

56. The Tribunal notes that Hiley J discussed the Doctors' Code of Conduct in *Nitschke* and made the following comments:

> *Although a major focus of the Code is directed and can only apply to doctors in the course of a doctor patient relationship (e.g. clauses 2 and 3) the Code also covers a wide range of other matters including working with other health care professionals and within the health care system (clauses 4 and 5), minimising risk and maintaining professional performance (clauses 6 and 7), professional behaviour (clause 8), ensuring doctors' health (clause 9), teaching, supervising and assessing (clause 10) and undertaking research (clause 11).*[49]

57. In the present case, the applicant submitted that the respondent's conduct clearly had a connection to his professional duties as a medical practitioner because the respondent had a contract to practise medicine in the hospital where the research was being carried out and that research had an effect on the patients of that hospital.[50]

58. The applicant argued that *Nitschke* is distinguishable because in the present case there are clear and generally accepted standards that apply to medical practitioners involved in research projects. In that regard, the applicant relied upon the expert evidence of Associate Professor Mitra and tendered relevant professional conduct rules which are referred to in the amended application. The applicant noted that Hiley J in *Nitschke* quoted with approval the case of *Cranley v Medical Board of Western Australia*[51] where Ipp J discussed the process to be adopted by a tribunal when making findings of fact about a medical practitioner's conduct:

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48 [2015] NTSC 39; (2015) 301 FLR 122 at [125]
49 *Nitschke* at [115]
50 Applicant's submissions 26 June 2015 at [6]
51 Unreported, Supreme Court of Western Australia, Ipp J, (21 December 1990)

> *[73] The conventional ways in which such facts would be proved ... would, generally speaking, involve, or include, the Medical Board calling expert evidence from a person of good repute and competence within the medical profession to attest to the existence of the generally accepted standard or duty and its content or to tender any relevant professional conduct rules.*[52]

59. The respondent submitted that the conduct that is the subject of these proceedings is not so connected to his practice as an anaesthetist as to amount to professional conduct.[53] The respondent argued that his involvement in the research project was as a statistician, as distinct from his practice as an anaesthetist. In this respect, the respondent relied upon the High Court decision in *Re a Solicitor*[54] where the High Court held that a serious breach of trust within a family environment was "so remote from anything to do with professional practice that the characterisation of the appellant's personal misconduct as professional misconduct was erroneous."[55] The respondent in the present case, whilst accepting the 'abstract principle' that a medical practitioner can be subject to discipline for conduct outside the scope of their professional duties, argued that the principle does not extend to all conduct outside the scope of their duties. The conduct has to have a clear connection with the way in which the practitioner is supposed to carry out their professional duties.[56]

60. The respondent submitted that the only connection between the respondent and the practice of medicine was that the research involved patients at TCH where he was a visiting medical officer. This was not a sufficient connection for the purposes of the regulatory provisions of the National Law. The critical issue is the nature of his role in the research project, which was to analyse the statistical data collected by Dr French. This role was that of a statistician and not in his capacity as an anaesthetist.[57] The respondent noted that after he ceased work on

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52 Unreported, Supreme Court of Western Australia, Ipp J, (21 December 1990) at [7]; applicant's submissions 21 August 2015 at [1] to [5]
53 Respondent's submissions 19 June 2015 at [14]
54 (2004) 216 CLR 253
55 *Re a Solicitor* at [34]
56 Respondent's submissions 19 June 2015 at [12]
57 Exhibit R1 at [11]

the research project he was replaced by a statistician from the ANU who is not a medical practitioner.[58]

61. Similarly, argued Counsel for the respondent, his conduct after he left the research project was not sufficiently connected to his role as an anaesthetist. The pursuit of his complaint about Dr French's research project to the hospital, the NHMRC and ARIC were made pursuant to his involvement as a statistician in the medical research.[59] Moreover, the respondent contended that various supplementary disclosures to, for example, patients, Federal and Territory ministers, the Medical Journal of Australia, the Health Services Commissioner, various anaesthetists and the CEO of Snowy Hydro SouthCare also arose out of his role as a statistician in a medical research project, not in connection with his practice of medicine.[60]

62. The respondent prompted the Tribunal to consider the application of relevant codes of conduct in deciding whether there is a sufficient connection between the conduct and the medical profession.

63. The Tribunal accepts the respondent's submission that professional misconduct based on breaches of clause 1.4 of the Doctors' Code of Conduct must fail. Clause 1.4 of the Doctors' Code of Conduct states the following:

> *Doctors have a duty to make the care of patients their first concern into practice medicine safely and effectively. They must be ethical and trustworthy.*

64. Hiley J in *Nitschke* commented upon clause 1.4 as follows:

> *[117] In my opinion the clause 1.4 paragraph does not impose an obligation, standard or duty the breach of which would constitute professional misconduct or unprofessional conduct. Such an obligation, standard or duty needs to be found elsewhere in the code or shown to be an obligation, standard or duty generally accepted within the medical profession at the relevant time. …*
>
> *[119] The clause 1.4 paragraph is expressed in very general and aspirational terms. It is not couched in imperative terms and does not*

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58 Transcript of Proceedings 30 April 2015 page 42, lines 5 to 6
59 Respondent's submissions 28 August 2015 at [7]
60 Respondent's submissions 28 August 2015 at [7]

> *prescribe and identify any specific obligations. It has no clearly identifiable content. …*
>
> *[121] Other provisions of the code, primarily those in clauses 2 and 3, do impose such obligations where the person is a patient of the doctor. There is no reason to suppose those provisions necessarily apply where there is no doctor patient relationship.*[61]

65. The Tribunal agrees with the respondent's analysis of clause 1.4 of the Doctors' Code of Conduct and does not consider that it creates a standard that could constitute professional conduct.

66. However, in this case there are other provisions in codes of conduct that prescribe and identify specific obligations and are couched in sufficiently imperative terms.[62] These provisions operated in the arrangement that was entered into between the respondent, Dr French and ACT Health. It is necessary to consider the broader professional context of these arrangements, that is, the conduct of research at TCH. For example, the link between medical research and medical practice/professional conduct is created by clause 11 of the Doctors' Code of Conduct. Clause 11 of the Doctors' Code of Conduct is entitled 'Undertaking research' and it states the following:

> *11.1 Introduction*
>
> *Research involving humans,…or their health information, is vital in improving the quality of health care and reducing uncertainty for patients now and in the future, and in improving the health of the population as a whole. Research in Australia is governed by guidelines issued in accordance with the National Health and Medical Research Council 1992. If you undertake research, you should familiarise yourself with and follow, these guidelines.* [63]
>
> *…*
>
> *11.2 Research ethics*
>
> *Being involved in the design, organisation, conduct or reporting of health research involving humans brings particular responsibilities for doctors. These responsibilities, drawn from the NHMRC guidelines, include*
>
> *11.2.1 According to participants the respect and protection that is due to them.*

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61 [2015] NTSC 39; (2015) 301 FLR 122 at [117] – [121]

62 *Nitschke v Medical Board of Australia* [2015] NTSC 39; (2015) 301 FLR 122 at [119]

63 Doctor's Code of Conduct 11.1

11.2.2 Acting with honesty and integrity.

67. Chapter 11 of the Doctors' Code of Conduct recognises that doctors undertake research from time to time therefore, prima facie medical research is contemplated by professional conduct. The nature of the obligations are more specific than the broadly-worded, aspirational statements that were referred to by Hiley J in the *Nitschke* case when discussing clause 1.4. The Tribunal considers that the reference to 'protection' in clause 11.2.1 includes privacy and data protection that is the subject of the wider regime for the protection of personal information which is referred to in the amended application and is discussed below.

68. The nature of the obligations that may be connected with professional conduct are further refined by the obligations under the NHMRC guidelines, which are expressly incorporated by clause 11 of the Doctors' Code of Conduct. The NHMRC Code[64] defines research broadly as "original investigation undertaken to gain knowledge, understanding and insight."[65] The relevant provisions of the NHMRC Code place very specific responsibilities upon researchers and the relevant provisions state as follows:

> ***2.6 Manage storage of research data and primary materials***
>
> *Researchers must manage research data and primary materials in accordance with the policy of the institution. To achieve this, researchers must:*
>
> *2.6.1 Keep clear and accurate records of the research methods and data sources, including any approvals granted, during and after the research process.*
> *2.6.2 Ensure that research data and primary materials are kept in safe and secure storage provided, even when not in current use.*
> *2.6.3 Provide the same level of care and protection to primary research records, such as laboratory notebooks, as to the analysed research data.*
> *2.6.4 Retain research data, including electronic data, in a durable, indexed and retrievable form.*
> *2.6.5 Maintain a catalogue of research data in an accessible form.*
> *2.6.6 Manage research data and primary materials according to ethical protocols and relevant legislation.*

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64 NHMRC Australian Code for the Responsible Conduct of Research: https://www.nhmrc.gov.au/guidelines-publications/r39

65 NHMRC Australian Code for the Responsible Conduct of Research, page 1

2.7 Maintain confidentiality of research data and primary materials

> *Researchers given access to confidential information must maintain that confidentiality. Primary materials and confidential research data must be kept in secure storage. Confidential information must only be used in ways agreed with those who provided it. Particular care must be exercised when confidential data are made available for discussion.*

69. The Tribunal considers that the obligations under clauses 2.6 and 2.7 of the NHMRC Code applied to the respondent both independently as a researcher and as a doctor because they are incorporated into Chapter 11 of the Doctors' Code of Conduct when he undertook research in a medical context.

70. There are other provisions in the NHMRC Code that regulate the responsible communication of research findings in the public arena. The Tribunal notes that clause 4.1.2 of the NHMRC Code states as follows:

> *4.12.1 Discussing research findings in the public arena should not occur until the findings have been tested through peer review. In discussing the outcomes of a research project, special care should be taken to explain the status of the project — for example, whether it is still in progress or has been finalised.*

71. However, the Tribunal notes as a factual matter that Associate Professor Mitra considered that the respondent had not breached clause 4.12.1 and therefore the Tribunal gives no further consideration to this obligation.

72. Another relevant code of conduct is the National Statement on Ethical Conduct in Human Research (the National Statement). The National Statement was discussed by Associate Professor Mitra in his evidence.[66]

73. Further, the Tribunal adopts the applicant's submission that the ACT Health Research Practice Policy applies by operation of clause 2.6 of the NHMRC Code. As quoted above, clause 2.6 of the NHMRC Code requires that researchers must manage research data and primary materials in accordance with the policy of the institution. In the present case, the ACT Health Research Practice Policy applies to:

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66 Witness statement of Associate Professor Mitra dated 7 April 2015 at [15]

> *all individuals in ACT Health engaged in research including any person paid by, under the control of, or affiliated with ACT Health, such as scientist, trainees, technicians and other staff members, students, fellows, guest researchers, or collaborators in ACT Health, as well as those using ACT Health premises and/or resources*.[67]

74. The ACT Health Research Practice Policy clearly applied to the activities undertaken by the respondent that are the subject of these proceedings, for example because the respondent was paid by and/or under the control of ACT Health.[68] The operation of the policy is discussed in more detail below.

75. Therefore the Tribunal concludes that the nature of the obligations placed upon the respondent when conducting research within a medical context sufficiently imbued that conduct with the quality of professional conduct. This is due to the operation of Chapter 11 of the Doctors' Code of Conduct, the NHMRC code and the ACT Health Research Practice Policy.

76. There is a further factual element that adds weight to the conclusion that the impugned conduct fell within the ambit of professional conduct. The respondent alleged that he was only requested to undertake the research in his capacity as a biostatistician. The respondent therefore argued that his role in the project was purely as a statistician and not as an anaesthetist. The Tribunal notes the point made by the respondent that when he left the project he was replaced by a statistician from the ANU. However, the evidence indicates that there was some overlap between the respondent's role as statistician and as a medical practitioner in the communications between himself and Dr French.

77. The evidence given by Dr French indicated that the research collaboration arose because he and the respondent were both anaesthetists and visiting medical officers at TCH. Dr French explained that he discussed the research with his fellow anaesthetists and knew the respondent as an anaesthetic colleague. He also knew that the respondent had "some qualifications in statistics".[69] The discussions between Dr French and the respondent at the early stages of the research demonstrate that Dr French relied to some extent on the respondent's

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67 ACT Health Research Practice Policy, Exhibit R6 item (l) pages 2 to 3

68 Sessional and FFS agreement dated 15 November 2007 between ACT and Dr Melhuish – Visiting Medical Officer (Individual), Exhibit R2

69 Dr French witness statement 21 January 2015 at [8]

clinical expertise as well as his skill as a statistician. For example, the discussions between Dr French and the respondent referred to "clinically relevant points of comparison" that could be used to frame the research project. The language and acronyms used in the communication indicates that Dr French relied upon the respondent's strong familiarity with the clinical management of patients as well as the institutional framework of the practice of medicine.[70]

78. At this stage of the research, Dr French was asking some fundamental research questions that drew upon the respondent's clinical knowledge as well as his statistical expertise. The nature of this interaction was characterised effectively in the witness statement of Dr Shadbolt as follows:

> *the process of research often involves many players who support but [are] not necessarily part of the final research especially in health service/case series type research of retrospective data.*[71]

79. Therefore, the Tribunal finds that when the respondent was invited to join the research team, it was not exclusively because of his skill as a statistician, it was also because of his skill as a medical practitioner. His skill as a medical practitioner included his familiarity with the clinical management of patients and the broader institutional framework of the practice of medicine.

80. The Tribunal concludes that the Doctors' Code of Conduct and the NHMRC Code contemplate that research forms part of the activities that are contemplated by medical practice. The Tribunal finds that there is a connection between the conduct of the respondent alleged in the amended application and the practice of medicine which is sufficient to amount to professional misconduct as defined in section 5 of the National Law. The obligations imposed by the relevant codes and their connection to professional conduct continued after the respondent had left the research project because the nature of the obligations persisted after he had ceased to be involved in the research project.

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70 Dr French witness statement 21 January 2015 at Annexure B

71 Witness statement of Dr Shadbolt dated 31 March 2015 at attachment A, page 2

Ground 1 – Writing to Patients 1 to 4

81. The applicant alleged that one of the grounds of misconduct was that the respondent had written to and caused potential distress to Patients 1 – 4 by stating that medical treatment details identifiable as belonging to them were available to persons and organisations outside the hospital as a result of the research project, without any evidence that this was true and in circumstances where he was the only person who had distributed the patients' medical treatment details outside the research project.[72] The applicant also alleged that he had persisted in the conduct of writing to patients making allegations that their medical treatment details were being made available outside the hospital despite his employer's direction not to do so.[73]

82. Patients 1 to 4 were all patients who were included (or might eventually be included) in the dataset because they had been airlifted by helicopter as a consequence of an incident causing severe trauma. The respondent admitted that he wrote to Patients 1 to 4. The language of the letters was as follows, or words to a similar effect:

> *As a result of the use of your medical records in research some of your medical treatment details including pathology test results which are identifiable as belonging to you are now available to several government and academic organisations outside the hospital as well as a number of other people in insurance and legal organisations.*
>
> *It is likely that your records will become available to more people outside the hospital in the near future.*[74]

83. The applicant submitted that the statements were untruthful because it was not as a result of the use of the medical records in research that the patient's treatment details, test results and medical records were given to anyone outside the hospital, it was as a result of the respondent's dissemination of those records after he left the research project.

84. The respondent alleged that he had re-identified certain patients by using the dataset and undertaking a simple Internet search. During cross-examination he

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72 Amended application dated 24 April 2015 at [25(b)]

73 Exhibit A7, page 2

74 Exhibit A7, Tabs 8 (Patient 2) and (Patient 3) and 12 (Patient 4), see similar language also at Exhibit A7, Tab 6 (Patient 1).

admitted that he had mistakenly identified one of the patients.[75] In oral evidence the respondent said that he was entitled to write to the mis-identified patient as he suspected that that patient would necessarily have been part of the final dataset that Dr French was going to use. The applicant argued that the respondent was disingenuous to say that he had written to the wrong patient because he suspected that that patient might be on a future dataset rather than because his 'simple' Internet set search had led him to mis-identify the patient. The Tribunal agrees with this assessment of the evidence.

85. The Tribunal also considers that, generally speaking, the respondent showed little insight into whether patients might be the distressed by his letters. For example, he was asked whether he had had considered the effect of his letter upon the welfare of a 94-year-old man who, like the other patients, had suffered a traumatic medical event requiring him to be airlifted and might be further distressed by an alleged disclosure of his personal information. The distress might be suffered by the patient himself or by a member of his family. The respondent replied that he applied an "open disclosure policy" and that he considered the welfare of patients in writing to them as he was not of the view that they would become suicidal by obtaining that information.[76] The 94-year-old man was singled out because his advanced age was relevant to the reason why he could readily be identified from the dataset.[77] The respondent continued that he provided his employer with many opportunities to write to patients to advise them that their confidentiality had been breached before he wrote to patients but the employer did not accede to his request.[78]

86. The respondent's response to this question demonstrated that, prima facie, his behaviour fell short of his obligations to accord the respect and protection that is due to Patients 1 to 4 as research participants under clause 11.2.1 of the Doctors' Code of Conduct.

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75 Transcript of Proceedings 1 May 2015 pages 57-58
76 Transcript of Proceedings 1 May 2015 page 21, lines 35-41
77 Transcript of Proceedings 1 May 2015 page 21, lines 25 to 30
78 Transcript of Proceedings 1 May 2015 page 23, lines 19 to 24

Were the letters true?

87. Counsel for the respondent made the somewhat thorny argument that the letters were in fact true because the expert evidence indicated that the patients might be able to be re-identified and consequently the personal details had become available. The letter to Patient 1 dated 23 June 2013 read as follows:

> *This is to inform you that some of your medical treatment details have been included on a research file without removing information that identifies you personally. As a result, these details are now available to a number of government organisations outside the hospital as well as a number of other people in various academic, insurance and legal organisations.*[79]

88. The respondent submitted that the first sentence of that letter is clearly true in light of the expert evidence of both Associate Professor Mitra[80] for the applicant and Mr David Vaile[81] for the respondent. It was also true, the respondent contended, that the patients' details were available to organisations outside the hospital as well as "a number of other people in various academic, insurance and legal organisations."

89. The respondent's evidence was that he was concerned that the hospital was not taking the issue he had raised as to the breach of patient privacy seriously and as a result, he sent the datasets and patient information to people and organisations described by him in his statement of 4 March 2015.[82] Counsel for the respondent argued that it was an inevitable consequence of making a formal complaint of research misconduct to those people and organisations that they would have to look at the way the datasets had been set out in order to decide whether the respondent's complaint had substance. Those were the entities referred to by the respondent in the second sentence of his letter set out above.

90. Further evidence relied upon in support of the respondent's argument that the letters were true was that Dr French had made a presentation in December 2012 to the Quality Assurance Committee.[83] The attendees of the presentation were bound by the secrecy provisions in Part 8 of the *Health Act 1993* (the Health

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79 Letter to patient dated 23 June 2013, Exhibit A7, Tab 6
80 Exhibit Al at [8]
81 Exhibit R7 at [3], [22]
82 Exhibit R7 at [56]
83 Transcript of Proceedings 30 April 2015 page 43, lines 42 to 44

Act). However, the respondent relied upon the fact that Dr French had made a statement that it was an open presentation where those in attendance could take away the information and consider it for themselves.[84]

91. The Tribunal agrees with the applicant's submission that it was not as a result of the use of the medical records in research that patients' details were given to anyone outside the hospital, it was as a result of the respondent's dissemination of those records after he left the research project. The Tribunal does not consider that any statement by Dr French that consideration of information by people who are bound by a secrecy obligation can in any way amount to the type of disclosure that was represented by the respondent in his letter to Patients 1 to 4. The respondent sought to justify the dissemination of patients' details without recognising that the letters omitted a critical fact – that the dissemination had occurred due to the respondent's own acts. The submissions about justification will be discussed below.

92. Putting to one side the speculative comments about Dr French's presentation at the Quality Assurance Committee and further speculation about re-identification, no evidence was offered by the respondent of actual disclosure, other than by the respondent's own acts.

93. The Tribunal finds that the statements made to Patients 1 – 4 were therefore untrue due to the omission of a critical detail - that it was the respondent himself who was the cause of the dissemination of the information. In the alternative, even if the statements were literally true, they were nevertheless misleading. Upon either finding – untrue or literally true but misleading – the Tribunal considers that they demonstrate a clear lack of honesty and integrity under 11.2.2 of the Doctors' Code of Conduct.

94. Associate Professor Mitra gave evidence both in his written report and in oral evidence that the respondent was under an obligation to either return the dataset to the researcher or destroy it once he left the research project in April 2012.[85] The respondent did not destroy the data, and without the permission of the

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84 Transcript of Proceedings 30 April 2015 page 43, line 42 to page 44, line 11
85 Exhibit A1 at [20], Transcript of Proceedings 30 April 2015 page 24, line 10

ethics committee, disseminated the data and contacted patients who were the subject of critical care research and made what the applicant described as "misleading and potentially alarming statements" to them.[86] Associate Professor Mitra considered that it was improper for the respondent to make that contact particularly because it had the potential to traumatise them and their families.[87]

95. It is noteworthy that the respondent persisted in the conduct of writing to patients even though his employer wrote to him by letter dated 4 October 2013 advising him that that his correspondence breached Principle 9 of the Health Records Act and his contract of employment.[88] The Director-General directed the respondent to desist from such conduct. Despite this request, the respondent wrote to further patients.

96. The Tribunal concludes that the respondent has breached 11.2.1 and 11.2.2 of the Doctors' Code of Conduct. The findings above indicate that the respondent did not accord participants in the research the respect and protection that was due to them nor did he act with honesty and integrity. Further, the obligations imposed under 2.6 and 2.7 of the NHMRC Code (that is incorporated into the Doctors' Code of Conduct) have been breached by him failing to return the dataset upon leaving the research project. The respondent also breached clause 2.7 of the NHMRC Code, which required him to use confidential information only in ways agreed with by those who provide it. Although the agreement of the patients is inferred (due to the circumstances of the data collection), it cannot be assumed that any of the patients would have agreed to the dissemination of their personal health information to the recipients of the respondent's letters.

97. Although the applicant also alleged in the amended application that the respondent breached 1.4 of the Doctors' Code of Conduct by writing to Patients 1 to 4, as discussed above, the Tribunal has adopted the reasoning of Hiley J in *Nitschke* regarding clause 1.4 and therefore does not consider that it creates the

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86 Applicant's submissions 29 May 2015 at [30]
87 Witness statement of Associate Professor Mitra at [12], [41]
88 Exhibit A7, Tab 9

requisite obligation to support a finding of professional misconduct. The Tribunal will give no further consideration to clause 1.4.

98. The Tribunal is satisfied that the applicant has established Ground 1.

Ground 2 - Breach of Principle 9 of the Health Records Act and Acting Inconsistently with Information Privacy Principle 11 of the Privacy Act

99. This ground of alleged misconduct was particularised by the applicant in its amended application as follows:

> *Disseminating the datasets provided to him by Dr French for the purposes of the research project and identifying by name some of the patients whose particulars form part of the dataset used by Dr French in the research project to various persons and/or entities outside the research project such as Senator Fiona Nash, the Snowy Hydro SouthCare, the Chief Minister and Minister for Health (ACT) and the Opposition Leader (ACT) and 45 anaesthetists.*

100. It was alleged that by doing so:

> *the respondent breached Principle 9 of the Health Records Act and acted inconsistently with Principle 11 of the Information Privacy Principles (IPP) in s 14 of the Privacy Act which applied in the ACT via the Australia Capital Territory Government Service (Consequential Provisions) Act 1994 (Cth).*

101. The parties agreed that records dealing with personally identifying health information within ACT government agencies between mid-2012 and 12 March 2014 were regulated dually by:

(a) The Information Privacy Principles (IPPs) found in section 14 of the *Privacy Act 1988* (Cth) (Privacy Act), which applied to ACT agencies via the *Australian Capital Territory Government Service (Consequential Provisions) Act 1994* (Cth). The IPPs regulated dealings with personal information, which is defined in section 6 of the Privacy Act as:

> *Information or an opinion whether true or not, and whether recorded in a material form or not about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion*;

(b) The Health Privacy Principles (HPPs), in Schedule 1 to the Health Records Act which apply to personal health information defined (in section 4) as:

> *any personal information:*
>
> *(a) relating to the health, an illness or a disability of the consumer; or*
> *(b) collected by a health provider in relation to the health, an illness or a disability of consumer.*

'Personal information' is itself defined in section 4 of the Health Records Act as:

> *any information, recorded or otherwise, about the consumer where the identity of the consumer is apparent, whether the information is*
>
> *(a) fact or opinion or*
> *(b) true or false.*

102. As regards ACT government agencies, the parties also agreed that if the HPPs applied then their obligations under the IPPs were excluded.[89]

103. The HPPs apply to any person who has possession or control of a record containing personal health information[90] including the respondent, regardless of whether he was authorised by his employer to use the information.

104. The applicant submitted that the datasets which Dr French created and provided to the respondent[91] comprised both personal information for the purposes of the Privacy Act and personal health information to the purposes of the Health Records Act. This is because at least some individuals were identifiable (or their identity could be reasonably ascertained) from the information. Other records created by the respondent did not contain personal health information, but did contain personal information.

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89 See *Australian Capital Territory Government Service (Consequential Provisions) Act 1994* (Cth) Schedule 3, inserting section 7(1)(c)(a) which picks up the Health Records Act exemption in section 6 of the *Freedom of Information Act 1989* (ACT)

90 Health Records Act, Dictionary (definitions of 'record-keeper' and 'health record'), *Legislation Act 2001*(ACT) section 184A

91 Attachment B to Exhibit A2

105. The applicant further submitted that where a record contained both personal information and personal health information the respondent could only be in breach of the HPPs by using it for unauthorised purposes.[92]

106. Where a record contains only personal information and does not contain personal health information, then the IPPs apply and the applicant submitted that the respondent had an obligation to act consistently with the IPPs. The applicant further submitted that the HPPs remained applicable past 12 March 2014 when the Privacy Act was amended replacing the IPPs with the Australian Privacy Principles (APPs). The applicant does not allege that the respondent disclosed any personal information after 12 March 2014 and the APPs are therefore not applicable to the current proceedings. However, the respondent used personal health information after 12 March 2014 and the applicant submitted that the HPPs were breached by him after that date.

107. The respondent agreed with the applicant's analysis of the relevant legislation, however his lawyers noted that only one allegation against the respondent concerned the Privacy Act, in particular Information Privacy Principle 11, (IPP 11), which arose out of three letters that the respondent wrote to the ACT Chief Minister/Minister for Health dated the 23 June 2013, 15 January 2014 and 30 January 2014.

108. The applicant created a table of the information provided by the respondent to entities outside the ACT Health Directorate for the purpose of ventilating his concerns about the methodology of the research project.[93] The applicant's table also stated the relevant paragraphs of the amended application that raise the breach, evidence of distribution and whether the applicant alleged there was an IPP or HPP violation. The respondent reproduced the table in its submissions and provided a further column that sets out the respondent's response to the alleged breach. The applicant's table is set out below as Table A in Annexure A. The respondent's table is set out below in Table B in Annexure B. The Tribunal thanks the parties for creating the tables. The Tribunal found them to be of great assistance.

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92 Applicant's submissions 29 May 2015 at [37]
93 Applicant's submissions dated 29 May 2015 at [39]

109. It is clear that the respondent circulated a 'corrupted' dataset to the persons shown in Table A. However the applicant alleged that the dataset nevertheless included personal health information despite the 'corruption'. This is because the dataset also allowed for the identification of some patients. The respondent argued that it is clear that the respondent knew this because in his email to the cohort of anaesthetists on 14 September 2014 he invited recipients to "identify 2 patients in the attached file."[94] He also invited the recipients of this email to do a simple Google search on the two italicised words in his email, *South Care* and *Scooter*. The applicant argued that corrupting the dataset by altering details or adding in false patients does not alter its status because the truth or falsity of the information is immaterial to the definitions in section 4 of the Health Records Act.

110. Further, argued the applicant, the respondent's email identified the patients in the dataset as SouthCare trauma patients and this was sufficient to comprise personal health information about them, regardless of its accuracy. Each dataset was subject to the HPPs, at least in relation to the identifiable patients.

111. HPP 9 restricts use of personal information, except where disclosure is authorised by that provision. HPP 9 limits the use of personal health information by a record keeper who has possession or control of a health record that was obtained for a particular purpose. It prohibits the use of that information for any other purpose unless:

    (a) the consumer has consented to use of the information for that other purpose; or

    (b) the record keeper believes on reasonable grounds that use of the information for that other purpose is necessary to prevent or lessen a significant risk to the life or physical, mental or emotional health of the consumer or another person; or

    (c) the use of the information for that other purpose is required or authorised by law or court order; or

    (d) the purpose for which the information is used is directly related to the purpose for which the information was obtained; or

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94 Attachment G to Exhibit A2

(e) *the use of the information is related to the management, funding or quality of the health service received by the consumer*.

112. None of the exempt disclosures under HPP 9 are relevant to the present situation.

113. The application of the IPPs to the respondent's professional responsibility is more complex. The applicant alleged that the respondent 'acted inconsistently' with IPP 11 and, more particularly, that the respondent should have supported the ACT Health Directorate's obligation under IPP 11 not to disclose personal information. The applicant said this is not a question of the respondent's personal liability for any disclosure that might occur in breach of IPP 11, rather it is question of his 'professional judgement'.[95]

114. Returning to HPP 9, the applicant alleged that the disclosures to Senator Nash, the Chief Minister/Minister for Health, the Leader of the Opposition, the CEO of Snowy Hydro SouthCare and 45 anaesthetists were all in breach of HPP 9 because there is no arguable basis to support the disclosure of the information made by the respondent in writing to those entities. The Tribunal notes the applicant's argument that the respondent was aware that at least some of patients on the corrupted list were identifiable when he invited the anaesthetists who had received the letter to attempt to re-identify them.[96] Similarly, said the applicant, the disclosure of personal information of patients, in the form of their names and addresses in the letters to the Chief Minister/Minister for Health were inconsistent with IPP 11.

115. The respondent argued that expert evidence provided on his behalf by Mr David Vaile proved that he had not breached the privacy laws. The Tribunal examines this evidence below, alongside the evidence led by the applicant.

The expert evidence

116. Mr David Vaile gave evidence on behalf of the respondent. Mr Vaile is the Executive Director of the Cyberspace Law and Policy Centre at the University of New South Wales Faculty of Law. He does not hold a formal academic

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95 Applicant's submissions 29 May 2015 at [43]
96 Exhibit A2, attachment G

appointment at the University of New South Wales.[97] Mr Vaile's expertise is in law. He is not an expert in medical research, having only been involved in about three to four clinical research projects that involved an application to an ethics committee.[98]

117. Associate Professor Mitra gave evidence for the applicant. He is a Fellow of the Australasian College for Emergency Medicine and holds the position of Consultant Emergency Physician at the Alfred Hospital, Melbourne and Adjunct Clinical Associate Professor of Critical Care at Monash University in Melbourne.[99] Associate Professor Mitra is a clinical researcher who is currently researching critical care and has been involved in over 60 research projects.[100]

118. Mr Vaile gave evidence that the respondent appears not to have breached the privacy of the data subjects because he had conducted further de-identification efforts, which were likely to have reduced or eliminated the risk of re-identification before the exposure of these records to third parties.[101] Associate Professor Mitra disagreed with this comment by Mr Vaile. He considered that on leaving the research team the respondent should have destroyed all research data. However the respondent used this confidential information to identify patients. Associate Professor Mitra considered that there was no means by which patients or the relevant ethics committee permitted the respondent to conduct identification of patients using the data that was provided. Associate Professor Mitra considered that in doing so and contacting the patients and their families, the respondent breached key principles of the National Statement.[102] Associate Professor Mitra considered that as a researcher conducting research with human participants the respondent had to follow the principles of the National Statement and in his opinion, once the respondent had expressed his

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97 Transcript of Proceedings 1 May 2015 page 81, line 19
98 Transcript of Proceedings 1 May 2015 page 82, lines 15 to 20
99 Witness statement of Associate Professor Mitra dated 30 March 2015 at [2] page 2, Exhibit A1
100 Transcript of Proceedings 30 April 2015 page 22, line 20
101 Witness statement of David Vaile dated 4 March 2015, Exhibit R6 at[3(b)]
102 Witness statement of Associate Professor Mitra dated 30 March 2015 at [40] – [41] page 2, Exhibit A1

disagreement with the research methodology and exited the research team, he should have destroyed all data pertaining to this research.[103]

119. The Tribunal considers that where there is any conflict between the evidence of Associate Professor Mitra and Mr David Vaile, the opinions of the Associate Professor should be preferred.

120. In general, the Tribunal considered that the evidence of Mr David Vaile should be given little weight. Mr Vaile's opinions about certain things were belied by the evidence. For example, he opined that the respondent had not breached the privacy of the data subjects because his de-identification efforts were likely to have reduced or eliminated the risk of re-identification before the exposure of these records to third parties.[104] This is belied by the clear disclosure of a patient's name, his father's name and information about the patient's health to Senator Nash. When asked what would happen if some of the data maintained sufficient integrity for re-identification to occur even in the corrupted dataset, Mr Vaile replied that that would be "unfortunate".[105] Similarly, Mr Vaile's opinion that the respondent's disclosures did not amount to public release because of the "strong secrecy provisions applicable to most or all of these contexts" was tenuous.[106] The applicant noted that some of the recipients of the letters, such as the Ombudsman and the Health Services Commissioner, would not be bound by "strong secrecy provisions".[107] Moreover, the Privacy and Health Records Acts do not confine themselves to regulating public release and the fact that a party is bound not to further disclose information does not authorise disclosure of the information to it.[108]

121. Mr Vaile inter-mingled legal and normative propositions in his statement and oral testimony. He gave evidence that the respondent's actions were justified as consistent with some type of public interest disclosure. The respondent expressly declined to rely on the provisions of the *Public Interest Disclosure*

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103 Witness statement of Associate Professor Mitra dated 30 March 2015 at [19] - [20], Exhibit A1
104 Witness statement of David Vaile, Exhibit R7 at [3(b)]
105 Transcript of Proceedings 1 May 2015 page 80, line 22
106 Exhibit R7 at [13]
107 Applicant's submissions 29 May 2015 at [49]
108 Applicant's submissions 29 May 2015 at [49]

Act 2012.[109] While the Tribunal recognises that there may be occasions when disclosures are required in the public interest, the Tribunal was not assisted by Mr Vaile's evidence. He admitted that he did not know much about ACT law and the relevance of his broader evidence was unclear, given that Dr French frankly agreed that the inclusion of the date of the relevant events on the dataset meant that patients could be re-identified, but that it was never intended that the dataset be circulated outside the research team.[110] Mr Vaile also made a broad argument that the respondent was motivated by patients' rights, but the respondent's motives are irrelevant to whether in fact he breached the applicable privacy laws. As the applicant submitted, "there is no public interest test in the HPPs or IPPs."[111] Mr Vaile also sought to justify the respondent's action by reference to the "prospect of publication" and the "unresolved risk of imminent publication" respectively.[112] There was no evidence of imminent publication either at the time the disclosures were made or even by the time of the hearing.

122. The Tribunal does not consider that Mr Vaile's evidence established that the respondent did not breach the relevant privacy laws.

Falsity of the personal health information

123. Counsel for the respondent submitted that the material that was disseminated by him was so far removed from what was contemplated by the scope of the Health Records Act that it did not amount to a health record on any sensible understanding of that Act. The respondent relied upon the fact that what was sent to most of the people covered in the allegation was not the dataset that had been sent to him by the Dr French. Rather it was a dataset that looked as if it might be information about a real person, but the actual information was fictional.

124. The definitions of 'personal information' and 'personal health information' in the Health Records Act plainly state that the information may be fact or opinion or true or false. The respondent urged the Tribunal to read down the meaning of

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109 Respondent's submissions 20 August 2015 at [1]
110 Witness statement of Dr James French dated 30 March 2015 at [13], Exhibit A3
111 Applicant's submissions 29 May 2015 at [50]
112 Exhibit R7 at [22] and [41]

the term 'true or false' so that it means 'true or false due to a mistake'. Although the Tribunal agrees that the definition would encompass falsity due to mistake, the Tribunal also considers that information that has been deliberately falsified would also fall within the definition. The term 'true or false' is a reasonably plain term that does not yield to the narrow interpretation that was urged upon the Tribunal by the respondent.

125. The respondent relied upon the presentation speech made by the Chief Minister but the Tribunal does not consider that there is any ambiguity which requires recourse to secondary material. Further, the comments of the Chief Minister in the presentation speech do not shed light on the meaning of what is a relatively straightforward expression with a clear meaning. Importantly, not all of the information disseminated by the respondent was false. For example in the letter to Senator Nash, the respondent disclosed the true name of Patient 4. The emails to the anaesthetists invited them to re-identify patients, therefore 'true' information was embedded in the material.

126. Therefore, regardless of the truth or falsity of the material or why or how any falsities in the material arose, it was information recorded about the health of a consumer. Therefore, the Tribunal is satisfied that the material that was circulated by the respondent related to the health of the consumer or was collected by a health provider in relation to the health, illness or disability of the consumer. The information may have been true in some cases, false in others and may be a hybrid of true and false information but it was nevertheless captured by section 4 of the Health Records Act.

127. The respondent made a further argument that disclosure to certain people was not a breach of HPP 9 because these people assumed certain roles within the health sector. The Tribunal rejects this argument. The language of HPP 9 is clear – a record keeper who has possession or control of the health record must not use the information for any purpose other than the narrow stipulations under subparagraphs (a) – (e) that are quoted above. Therefore the respondent's argument that there is no breach of HPP 9 because the relevant recipient was "within the health sector" is irrelevant. HPP 9 does not contemplate any disclosure beyond the narrow stipulations contained within its exemptions.

Further, the Tribunal notes the point made above that regardless of whether the recipient of the information is under a secrecy obligation, HPP 9 contemplates that no disclosure will occur to that person at all unless it occurs under the narrow exemptions allowing disclosure.

Findings on the relevant disclosures

128. In this section, the Tribunal sets out its findings in relation to disclosures referred to in the tables in Annexures A and B below.

129. The Tribunal has discussed disclosures 1-4 (writing to patients 1-4) above.

130. The Tribunal rejects the respondent's arguments regarding disclosures 5, 6, 7, 8 9 and 12, because in relation to disclosures 5, 8, 9, 10 and 12, the fact that the recipients were "within the health sector" is irrelevant to the strict regime created by HPP 9.

131. In relation to disclosure 6 where the respondent provided information to the Medical Journal of Australia, Andrew Kefford and the NHMRC, the Tribunal repeats its finding that the strict regime imposed by HPP 9 does not contemplate this disclosure. Insofar as the respondent relied upon his disclosure to Mr Kefford in his role as ACT Public Service Commissioner as amounting to some type of whistleblowing, the respondent subsequently conceded that he did not rely upon the *Public Interest Disclosure Act 2012*. There is no evidence that the disclosure to the NHMRC was in the nature of the disclosure to provide advice about the ethical behaviour on the conduct of medical research.

132. In relation to disclosure 7, providing the information to AHPRA, the same arguments apply that the disclosure to the regulator is irrelevant to the strict regime created by HPP 9. Similarly, no evidence was led that the disclosure to AHPRA was to provide advice about the ethical conduct of medical practitioners or to other aspects of AHPRA's responsibilities under the National Law.

133. Regarding disclosure 10, the applicant does not allege that the respondent breached IPP 11, rather that he acted inconsistently with ACT Health's obligations to comply with that principle. The Tribunal adopts the applicant's

submission in relation to this disclosure and finds that the respondent acted inconsistently with ACT Health's obligation to comply with that principle, which demonstrates his poor judgement

134. Regarding disclosure 11, the evidence of Dr French established that Professor Myles was not part of the research team,[113] therefore the information still had to be managed in accordance with HPP 9. It was not so managed by the respondent.

135. Regarding disclosure 13, the Tribunal finds that HPP 9 was breached because the datasets circulated by the respondent constituted a 'health record' for the purposes of the Health Records Act and the circulation did not occur in accordance with the terms of HPP 9.

136. Regarding disclosures 14 and 15, the Tribunal agrees that clause 4.12 of the NHMRC Code has not been breached, however other breaches are established as discussed below.

137. In conclusion, the Tribunal finds that the respondent breached Principle HPP 9 of the Health Records Act and acted inconsistently with Principle IPP 11 of the Privacy Act.

Breach of the NHMRC Code for the Responsible Conduct of Research

138. As discussed above, clause 2.7 of the NHMRC code requires that researchers given access to confidential information must maintain that confidentiality. The datasets containing the patients' details provided by Dr French to the respondent clearly contained confidential information. In breach of clause 2.7, the respondent used the confidential information to engage in the exercise of re-identifying patients to prove his concern about the methodology of the research project and then disclosed information to the entities discussed above.[114]

139. Clause 2.6 of the NHMRC Code provides that researchers must manage research data and primary materials in accordance with the policy of the institution. The applicant alleged that the respondent breached the ACT Health

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113 Witness statement of Dr James French 31 March 2015 at [14]
114 Applicant's submissions 29 May 2015 at [55]

Research Practice Policy and therefore breached clause 2.6 of the NHMRC Code. This is discussed below.

140. The applicant also alleged a breach of clause 4.12 of the NHMRC code, however based on the evidence of Associate Professor Mitra, the Tribunal finds that there has been no breach of this provision.

141. The Tribunal has stated its findings above that the respondent breached principle HPP 9 of the Health Records Act and acted inconsistently with principle IPP 11 of the Privacy Act. The Tribunal further finds that the respondent has breached clauses 2.6 and 2.7 of the NHMRC Code.

Breach of the ACT Health Research Practice Policy

142. As discussed above, the ACT Health Research Practice Policy covers a wide ambit of people engaged in research in the health sector in ACT and clearly covered the relevant activities of the respondent. Clause 6.2 of the policy states the responsibilities of researchers. The relevant provisions state as follows:

> *6.2.1 Researchers have primary responsibility for the appropriate and secure management of data and records. …*
> *6.2.5 Researchers must manage their data so as to comply with relevant privacy legislation and protocols.*
> *6.2.6 Researchers are responsible for ensuring appropriate security of any confidential material.*
> *6.2.7 Researchers must make available for discussion data that form the basis of publications of any kind. Where confidentiality provisions apply (for example, where the researchers or institution have given undertakings to third parties, such as the subjects of the research), it is necessary for data to be kept in a way that reference to them by third parties can occur without breaching such confidentiality.*

143. The applicant submitted that if the respondent was entitled to pursue his complaint with third parties, it was incumbent upon him to do it without breaching patient confidentiality. The applicant contended that the respondent could, for example, have advised Dr French to de-identify the dataset further so that it became impossible for anyone outside the research team to identify the patients used in the research.[115] Dr French's evidence was that the respondent did not raise any issue of privacy or the identification of patients with him

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115 Applicant's closing submissions 29 May 2015 [61]

while the respondent was participating in the research project.[116] Similarly, the respondent did not raise any concerns about de-identification and privacy of patients when he first formally complained about the research project and Dr Shadbolt was appointed to investigate his complaint.[117]

144. The amended application also alleged that the respondent breached clause 4.2.11 of the ACT Health Research Practice Policy by disseminating information he gained by being a member of the research team to persons and entities outside the research team.

145. Clause 4.2.11 states as follows:

> *Confidentiality must be observed for data of a confidential nature, for example from individual patient records.*

146. The respondent submitted that the alleged breaches of the ACT Health Research Practice Policy raise similar issues to whether the respondent has breached the privacy laws.

147. The Tribunal has stated its findings above that the respondent breached principle HPP 9 of the Health Records Act and acted inconsistently with principle IPP 11 of the Privacy Act. The Tribunal further finds that the respondent has breached the relevant clauses of the ACT Health Research Practice Policy.

Conclusion – Professional Misconduct

148. The Tribunal concludes that the respondent has engaged in conduct which constitutes professional misconduct as defined in section 5 of the National Law in that he has engaged in unprofessional conduct that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience by, inter alia:

    (a) breaching obligations in clause 11 of the Doctor's Code of Conduct (due to the concurrent operation of the NHMRC Code and the ACT Health Research Practice Policy) by writing to Patients 1 to 4; and

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116 Exhibit A2 at [21], Exhibit A3 at [8]
117 Witness statement of Dr Shadbolt dated 27 March 2015, Exhibit A6 at [3]

(b) breaching Principle 9 of the Health Records Act and acting inconsistently with the Information Privacy Principle 11 of the Privacy Act by disseminating information he was provided with as a result of his involvement in a research project to persons and/or entities outside the project research team. Principle 9 and Principle 11 were binding upon the respondent by the operation of clause 11 of the Doctors' Code of Conduct, the NHMRC Code and the ACT Health Research Practice Policy.

149. The Tribunal orders that the matter be re-listed for directions in relation to action that should be taken pursuant to section 196(2) of the National Law regarding the appropriate penalty and to consider the question of costs.

Conclusion – Penalty

150. Given the protective nature of the jurisdiction, the Tribunal has concluded that the orders regarding penalty proposed by the parties are within the Tribunal's power and appropriate for the Tribunal to make. The relevant orders (set out above) are accordingly made pursuant to s 196(2) of the *Health Practitioner Regulation National Law (ACT).*

……*signed*……..
General President L Crebbin
for and on behalf of the Tribunal

Annexure A – Summary of information provided by the respondent – Applicant's submissions dated 29 May 2015 at [39]

ALLEGED DISTRIBUTION	DATE	APPLICATION PARAGRAPH(S) RAISING BREACH	EVIDENCE OF DISTRIBUTION	IPP OR HPP VIOLATION
Writing to patients				
Writing to Patient 1	23 June 2013	25(b), 26	Exhibit A7, Tab 6	Not applicable
Writing to Patient 2	15 January 2014	25(b), 25(c), 26	Exhibit A7, Tab 8	Not applicable
Writing to Patient 3	15 January 2014	25(b), 25(c), 26	Exhibit A7, Tab 8	Not applicable
Writing to Patient 4	30 January 2013	25(b), 25(c), 26	Exhibit A7, Tab 12	Not applicable
Distributions of patient information including data-sets				
Writing to Senator Nash with information about Patient 4	18 February 2014	25(a), 26	Exhibit R3	HPP 9
Providing patient information to the Medical Journal of Australia, Mr Andrew Kefford and the NHMRC	26 December 2014	Letter to Minter Ellison dated 19 February 2014 (see Attachment A)	Exhibit A10, Tab 7	HPP 9
Providing patient information to Australian Health Practitioner Regulation Agency offices outside of the ACT	3 February 2015	Letter to Minter Ellison dated 19 February 2014 (see Attachment A)	Exhibit R6, attached to letter dated 24 February 2015	HPP 9
Data-sets given to the ACT Chief Minister/Minister for Health	27 January 2013	25(a), 26	Exhibit A10, Tab 1, p10	HPP 9
Data-sets given to the leader of the Opposition	22 February 2013	25(a), 26	Exhibit A10, Tab 6	HPP 9

ALLEGED DISTRIBUTION	DATE	APPLICATION PARAGRAPH(S) RAISING BREACH	EVIDENCE OF DISTRIBUTION	IPP OR HPP VIOLATION
Providing names and addresses of patients who were involved in research project to the ACT Chief Minister/Minister for Health	23 June 2013 15 January 2014 30 January 2014	26	Exhibit A7, Tab 6 Exhibit A7, Tab 8 Exhibit A3, Tab 13	IPP 11
Disseminating data-sets and other information to Professor Paul Myles (entity in Melbourne)	Unknown	26	Exhibit A7, Tab 7	HPP 9
Disseminating data-sets and other information to ACT Health Services Commissioner	7 April 2013	26	Exhibit A10, Tab 1	HPP 9
Disseminating data-sets to anaesthetists employed at the Canberra Hospital	14 September 2014	26	Exhibit A2, Attachment G	HPP 9
Discussing the research project before its conclusion				
Disseminating draft abstract and discussion of the research project to the CEO of SnowyHydro SouthCare	11 September 2013 21 June 2013 20 July 2014 27 July 2013	26	Exhibit A2, Attachment E Exhibit A10, Tab 4	Not applicable
Disseminating draft abstract and discussion of the research project to anaesthetists employed at the Canberra Hospital	11 September 2013 24 September 2013	26	Exhibit A2, Attachments E and F	Not applicable

Annexure B
Respondent's response to the summary of information – Annexure A of the respondent's submissions dated 19 June 2015

Medical Board of Australia v Dr Nicholas Melhuish

'Annexure A'

Alleged distribution	Date	Application paragraph(s) raising breach	Evidence of distribution	IPP or HPP violation	Response to alleged breach
Writing to patients					
1. Writing to Patient 1	23.06.2013	25(b), 26	Exhibit A7,Tab 6	Not applicable	No breach of the Code
2. Writing to Patient 2	15.01.2014	25(b), 25(c), 26	Exhibit A7, Tab 8	Not applicable	No breach of the Code
3. Writing to Patient 3	15.01.2014	25(b), 25(c), 26	Exhibit A7, Tab 8	Not applicable	No breach of the Code
4. Writing to Patient 4	30.01.2013 (sic) (2014)	25(b), 25(c), 26	Exhibit A7, Tab 12	Not applicable	No breach of the Code
Distributions of patient information including data-sets					
5. Writing to Senator Nash with information about Patient 4	18.02.2014	25(a), 26	Exhibit R3	HPP 9	HPP9 does not apply. If it does, not a health record as information was false. No breach as she Assistant Minister for Health so within

Alleged distribution	Date	Application paragraph(s) raising breach	Evidence of distribution	IPP or HPP violation	Response to alleged breach
					health sector.
6. Providing patient information to the Medical Journal of Australia, Mr Andrew Kefford and the NHMRC	26.12.2014	Letter to Minter Ellison dated 19 February 2014 (see Attachment A)	Exhibit A10, Tab 7	HPP 9	HPP9 does not apply. If it does, not a health record as contains false information. Appropriate to disclose to Mr Kefford in his role as ACT Public Service Commissioner authorised to receive public interest disclosures and to NHMRC as responsible for NHMRC Code and advice on ethical behaviour in the conduct of medical research.
7. Providing patient information to Australian Health Practitioner Regulation Agency offices outside of the ACT	03.02.2015	Letter to Minter Ellison dated 19 February 2014 (see Attachment A)	Exhibit R6, attached to letter dated 24 February 2015	HPP 9	HPP9 does not apply. If it does, no breach as AHPRA is national regulator.
8. Data-sets given to the ACT Chief Minister/ Minister for Health	27.01.2013	25(a), 26	Exhibit A10, Tab 1, p10	HPP 9	HPP9 does not apply. If it does, no breach as she was Minister for Health and so within health sector.

Alleged distribution	Date	Application paragraph(s) raising breach	Evidence of distribution	IPP or HPP violation	Response to alleged breach
9. Data-sets given to the Leader of the Opposition	22.02.2013	25(a), 26	Exhibit A10, Tab 6	HPP 9	HPP9 does not apply. If it does, no breach as did not send him Dr French's data-sets and as Shadow Minister for Health, within health sector so entitled to write to him.
10. Providing names and addresses of patients who were involved in research project to the ACT Chief Minister/ Minister for Health	23.06.2013 15.01.2014 30.01.2014	26	Exhibit A7, Tab 6 Exhibit A7, Tab 8 Exhibit A3, Tab 13	IPP 11	IPP11 does not apply as respondent not a 'record keeper'. If does apply, no breach as Minister for Health is within health sector.
11. Disseminating data-sets and other information to Professor Paul Myles (entity in Melbourne)	Unknown	26	Exhibit A7, Tab 7	HPP 9	HPP9 does not apply. If it does, no breach as Prof Myles within research team and respondent understood he was an intended author.
12. Disseminating data-sets and other information to ACT Health Services Commissioner	07.04.2013	26	Exhibit A10, Tab 1	HPP 9	HPP9 does not apply. If it does, no breach as ACT Health Services Commissioner within health sector.

Alleged distribution	Date	Application paragraph(s) raising breach	Evidence of distribution	IPP or HPP violation	Response to alleged breach
13. Disseminating data-sets to anaesthetists employed at the Canberra Hospital	14.09.2014	26	Exhibit A2, Attachment G	HPP 9	HPP9 does not apply. If it does, no breach as not 'health record' as data has been corrupted.
Discussing the research project before its conclusion					
14. Disseminating draft abstract and discussion of the research project to the CEO of SnowyHydro SouthCare	11.09.2013 21.06.2013 20.07.2014 27.07.2013	26	Exhibit A2, Attachment E Exhibit A10, Tab 4	Not applicable	No breach of 4.12 of NHMRC Code according to Assoc Prof Mitra – paragraph 23, Exhibit A1.
15. Disseminating draft abstract and discussion of the research project to anaesthetists employed at the Canberra Hospital	11.09.2013 24.09.2013	26	Exhibit A2, Attachments E and F	Not applicable	No breach of 4.12 of NHMRC Code according to Assoc Prof Mitra – paragraph 23, Exhibit A1.

HEARING DETAILS

FILE NUMBER:	OR36/14
PARTIES, APPLICANT:	Medical Board of Australia
PARTIES, RESPONDENT:	Dr N Melhuish
COUNSEL APPEARING, APPLICANT	Mr C Erskine SC instructed by Ms Plevey
COUNSEL APPEARING, RESPONDENT	Mr P Griffin instructed by Ms Kyprianou
SOLICITORS FOR APPLICANT	Australian Government Solicitor
SOLICITORS FOR RESPONDENT	Minter Ellison Solicitors
TRIBUNAL MEMBERS:	Professor P Spender Mr G Wright