NOT BLACK AND WHITE?: DISCIPLINARY REGULATION OF DOCTORS CONVICTED OF CHILD PORNOGRAPHY OFFENCES IN AUSTRALIA

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Between 2006–19, eight doctors who were registered to practise medicine in Australia were convicted of child pornography offences. Despite finding that those medical practitioners' conduct was extremely serious, disciplinary decision-makers permitted seven of them to continue or, after a period of suspension of their registration, return to practising medicine, albeit subject to conditions. The decision-makers whose reasons for decision are published indicated that they strove to achieve the appropriate objective of protecting the public, but they reached their determinations to some extent in different ways from one another and, in some instances, on the basis of matters that were unhelpful in identifying which determinations would best safeguard the community. Further, they did not all provide thorough, cogent reasons for their decisions. This article analyses the matters to which these decision-makers had regard. It then recommends that Australian legislatures and regulators of the medical profession provide guidance regarding decision-making in disciplinary proceedings where doctors have committed child pornography offences. These proposals seek to ensure that disciplinary decision-makers safeguard the community in a consistent manner, and assure the public and the medical profession that they have done so.

I INTRODUCTION

While visiting his newborn baby at Geelong Hospital in 2012, a man found a USB stick on the floor of the birthing unit.[1] When he and his partner plugged it into a

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1 Karen Matthews, 'Ex-Geelong Hospital Heart Doctor Guilty of Possessing Child Porn', *Geelong Advertiser* (online, 23 April 2014) <www.geelongadvertiser.com.au/news/exgeelong-hospital-heart-doctorguilty-of-possessing-child-porn/story-fnjuhori-1226892686039>.

computer, child pornography appeared on the screen.[2] The couple took the USB to police, who also discovered on it documents traceable to Dr Alexander Black.[3] A specialist cardiologist, Black was the founder and then, at 59 years of age, head of Barwon Health's cardiology unit.[4] Another USB in Black's office and computers at his home stored the rest of his collection of child pornography, which totalled 45 images and 67 movies of child exploitation, featuring penetration, sadism and bestiality.[5] In 2014, Black pleaded guilty and was convicted in the Magistrates' Court at Geelong of two charges of knowingly possessing child pornography.[6] The doctor entered a two-year undertaking to be of good behaviour and his name now appears on the Register of Sex Offenders.[7] In disciplinary proceedings in June 2016, a panel of the Victorian Civil and Administrative Tribunal ('VCAT') determined to reprimand Black, suspend his registration to practise medicine for three months, and impose conditions on his registration, requiring him to continue treatment with his psychiatrist, and forbidding him from consulting and/or treating anyone under 18 years of age.[8]

Members of the public may be surprised, if not alarmed, that, on 1 October 2016, when the suspension of his registration expired, Black could resume working as a cardiologist.[9] VCAT's decision not to deregister Black seems counter-intuitive. It is most likely out of step with community expectation that registered medical practitioners, in whom people invest their trust at their most vulnerable — when they are unwell — do not spend their leisure or, indeed, in Black's case, work time accessing material that, according to the definition of 'child abuse material' in the *Crimes Act 1958* (Vic), 'depicts or describes … a person who is, or who appears or is implied to be, a child … engaged in, or apparently engaging in, a sexual pose or sexual activity'.[10] Moreover, the panel concluded that Black had engaged in 'professional misconduct', defined as 'conduct of the practitioner … that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession'.[11]

2 Ibid.

3 Ibid.

4 Ibid; Shane Fowles, 'Former Head of Barwon Health Cardiology Unit Dr Alexander "Sandy" Black Suspended over Child Porn', *Geelong Advertiser* (online, 10 June 2016) <www.geelongadvertiser.com.au/news/crime-court/former-head-of-barwon-health-cardiology-unit-dr-alexander-sandy-black-suspended-over-child-porn/news-story/1c30a7b69dd9c22b40bed8ff025cc4f0>.

5 Matthews (n 1).

6 *Medical Board of Australia v Black* [2016] VCAT 892, [16] (Presiding Member Wentworth, Member Fabris and Member Shanahan) ('*Black*').

7 Ibid.

8 Ibid 1–2.

9 Ibid.

10 *Crimes Act 1958* (Vic) s 51A (definition of 'child abuse material').

11 *Black* (n 6) [20] (Presiding Member Wentworth, Member Fabris and Member Shanahan), quoting *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic) sch s 5(c) (definition of 'professional misconduct') ('*National Law (Victoria)*').

Despite the apparent idiosyncrasy of VCAT's decision not to cancel Black's registration, it had six precedents in Australia in the preceding decade. Doctors Abraham Stephanopoulos, William Fitzgerald, Richard Wingate, Alex Simring, Clem Bonney, and a doctor whose name was subject to a suppression order and who was referred to as 'K',[12] were convicted of accessing, possessing and/or copying child pornography. The panels of one regulator and five tribunals who presided over disciplinary proceedings concerning these six doctors between 2006–16 determined that they could continue or, after a period of suspension of their registration, return to practising medicine, albeit subject to conditions. Ironically, in Stephanopoulos's case, a panel of the Medical Practitioners Board of Victoria ('MPBV') stated, '[i]t would be only in rare circumstances that a Panel of this Board would contemplate permitting a medical practitioner convicted of possession of child pornography to return to practice'.[13]

Since Black's case, Western Australia's State Administrative Tribunal ('WASAT') has departed from this pattern. In 2018, 'to give effect to the agreed terms of settlement' of a proceeding between the Medical Board of Australia ('MBA') and Aaron Voon, another medical practitioner who was convicted of child pornography offences, the panel disqualified Voon from applying for registration for three years.[14] At first blush, one might assume that, in the preceding cases, the panels' determinations to maintain the doctors' registration to practise medicine were ill-considered and favoured the interests of the practitioners over those of the community. Yet some of the panels' reasons for decision, and especially those in *Re Dr Abraham Stephanopoulos* ('*Stephanopoulos*')[15] — which ran to 182 paragraphs — reflected careful, balanced analyses of a range of considerations, and referred to relevant decisions of Australian and overseas health practitioner regulators, professionals' disciplinary tribunals, courts that conducted judicial reviews of regulators' and tribunals' decisions, and courts that imposed sanctions

12 Order of President Ardlie, Dr Wagner, Dr Allen and Member Smith in *K v Medical Board of Australia* (South Australian Health Practitioners Tribunal, 30 March 2015) ('*K*'); Andrew Hough, 'Senior Health Practitioner's Name and Profession Suppressed Despite Conviction for Child Pornography', *The Advertiser* (online, 4 May 2015) <www.adelaidenow.com.au/news/south-australia/senior-health-practitioners-name-and-profession-suppressed-despite-conviction-for-child-pornography/news-story/801597d49549eb61243dd9d994842de1>. Although Hough states that the practitioner's 'profession' was suppressed, it is apparent that the practitioner was a doctor from the following facts. The Medical Board of Australia ('MBA'), which registers and regulates the medical profession, was a party to the proceedings. The Minutes of Order place conditions on the practitioner's practice of medicine. Two of the four members of the panel that heard the matter were medical practitioners: see Australian Health Practitioner Regulation Agency, *Register of Practitioners* (Web Page) <www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>. Sections 10 and 15 of the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) require that the tribunal for the hearing of a proceeding should be constituted by the President or a Deputy President of the tribunal, two members of the panel of persons from the regulated health professions, who are of the same profession as the person to whom the proceeding relates, and one member of the panel that represents consumers of health services.

13 *Re Dr Abraham Stephanopoulos* [2006] MPBV 12, 3 (Dr Freckelton, Dr Mukhtar and Mr Russell) ('*Stephanopoulos*').

14 *Medical Board of Australia and Voon* [2018] VR 155 ('*Voon*'). Voon had failed to renew his registration as a medical practitioner so he was not registered when the matter came before the tribunal: at sch A [2].

15 *Stephanopoulos* (n 13).

for child pornography crimes.[16]

The panels whose decisions were published indicated that they strove to protect the public, thereby pursuing an appropriate objective of professionals' disciplinary proceedings. Nevertheless, with considerable discretion about how to safeguard the community, these panels reached their decisions to some extent in ways that were different from one another, though they imposed similar determinations. Differences between their reasoning may have been attributable partly to the material that the parties provided to them. In certain instances, however, the panels also referred to matters that were unhelpful in identifying the determinations that would best protect the public, which they could have disregarded if the parties drew their attention to them. Further, not all of the panels provided as thorough and cogent reasons for decision as *Stephanopoulos*;[17] the briefest reasons for decision — *Medical Board of Australia v Bonney* ('*Bonney*')[18] — are only nine paragraphs long (though this matter was decided on the papers and the panel made the orders that the parties jointly proposed).[19]

Specifically, while all the panels took into account the nature of the doctors' offences, they characterised them and assessed their seriousness in different ways from one another. Each of the panels also contemplated the risk of the doctors reoffending, but they did not all refer to the same matters that could help predict their likelihood of recidivism. Only some of the panels had regard to the doctors' behaviour after their offences were detected, and they did not always provide reasons, or the same explanations as one another, for the relevance of this matter to their determinations. Certain panels' references to the doctors' virtues and demand for their services did not assist them in ascertaining which determinations were necessary to safeguard the community. The only matter that all of the panels considered and to which they took a consistent approach was their capacity to protect the public by imposing conditions on the doctors' registration.

This article maintains that doctors' child pornography offences constitute a distinctive category of professional misconduct, and it would be helpful if Australian legislatures and regulators of the medical profession provided guidance regarding decision-making in disciplinary proceedings concerning doctors who have committed them. While the doctors' crimes may not harm anyone with whom they have had direct contact, they are abominable, foster the commission of more offences to satisfy demand for this material, and could indicate their propensity to commit 'contact' sexual offences particularly against young people. The panel in *Medical Board of Australia v Black* ('*Black*')[20] described the

16 See, eg, *Stephanopoulos* (n 13) [94]–[95], [120]–[145] (Dr Freckelton, Dr Mukhtar and Mr Russell).

17 *Stephanopoulos* (n 13).

18 [2010] QCAT 549 ('*Bonney*').

19 Ibid [9] (Deputy President Kingham).

20 *Black* (n 6).

devastating effects of the production of child pornography that is not computer-generated: '[it] involves young children being overborne by adults who subject them to degrading and distressing experiences, which necessarily impact on their development, self-esteem and happiness. And … their very prospects of survival into functional adulthood'.[21] Several of the panels observed that possessing and accessing such material 'involves facilitation and encouragement of the corruption and violation of children';[22] '[e]ach viewing of a child is … an act of abuse',[23] because it increases the market for more pornography and thus 'further exploitation and abuse of children's innocence'.[24]

Part II of this article explains the legal framework within which disciplinary determinations were made regarding the doctors. Part III analyses the main factors to which the panels had regard in reaching their decisions in all of the cases except *William Joseph Fitzgerald and Medical Board of Queensland*[25] and *K v Medical Board of Australia*,[26] for which no written reasons for decision were published, and *Medical Board of Australia and Voon*,[27] as the panel in that matter adopted the parties' statement of agreed facts rather than producing its own reasons for decision.[28] Finally, Part IV proposes changes to Australian legislation and the introduction of guidelines by regulators of the medical profession to assist parties in preparing for, and disciplinary panels in their decision-making in, cases where doctors have committed child pornography offences. Ideally, this guidance would clarify that protection of the public is the principal objective of disciplinary proceedings and determinations, and explain the meaning of this goal; articulate a suite of pertinent matters to which decision-makers could have regard in seeking to protect the public; and suggest that decision-makers document their consideration of these factors in their reasons for decision. These recommendations attempt to ensure that disciplinary decision-makers safeguard the community in a consistent manner, and assure the public and the medical profession that they have done so.

This article uses medical practitioners as a case study because they have a high public status and, potentially, access to especially vulnerable patients. Consequently, doctors who commit child pornography offences and disciplinary

21 Ibid [35] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

22 *Stephanopoulos* (n 13) [94] (Dr Freckelton, Dr Mukhtar and Mr Russell). See also *Health Care Complaints Commission v Simring* [2010] NSWMT 7, [48] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger) ('*Simring*').

23 *Simring* (n 22) [48] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

24 *Stephanopoulos* (n 13) [94] (Dr Freckelton, Dr Mukhtar and Mr Russell). See *Black* (n 6) [36] (Presiding Member Wentworth, Member Fabris and Member Shanahan), citing *Stephanopoulos* (n 13) [3]; *Re Dr Richard Wingate* [2007] NSWMT 2, [64] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier) ('*Wingate*').

25 Order of Richards DCJ in *William Joseph Fitzgerald and Medical Board of Queensland* (District Court of Queensland, Health Practitioners Tribunal, D2390/05, 27 April 2006) ('*Fitzgerald*').

26 *K* (n 12).

27 *Voon* (n 14).

28 Ibid.

decisions concerning them can have a significant impact on the community and the medical profession. The observations in this article might, nonetheless, apply to practitioners in other health professions who commit child pornography offences, too, and to health practitioners who are convicted of other heinous crimes.

The cases discussed in this article appear to be the only published Australian disciplinary decisions concerning medical practitioners who have been convicted of child pornography offences during the time period considered. This constitutes a small group of decisions, some of which were made under different legislation from others, including pursuant to statutes that have now been repealed. Nevertheless, only one inconsistency between the decisions — which relates to the panels' consideration of the nature of the doctors' offences — may have been partly due to differences in the legislation that the panels applied. Moreover, the decisions continue to be instructive because current legislation does not provide greater direction than its antecedents for decision-making in disciplinary matters concerning doctors who have committed children pornography offences,[29] and no guidelines yet exist for panels' exercise of their discretion in such cases.

II LEGAL FRAMEWORK FOR DISCIPLINARY PROCEEDINGS

Before 1 July 2010, when the National Registration and Accreditation Scheme ('NRAS') commenced operation, different entities in each Australian state and territory registered and regulated doctors within their jurisdictions, conducted disciplinary hearings themselves and also referred doctors to tribunals for this purpose.[30] Thus, the Medical Board of Queensland initiated disciplinary proceedings against Fitzgerald in the Health Practitioners Tribunal in Queensland in 2006, a panel of the MPBV undertook a 'formal hearing'[31] into Stephanopoulos's conduct also in 2006, and the Health Care Complaints Commission ('HCCC') brought complaints against Wingate and Simring before the New South Wales Medical Tribunal ('NSWMT') in 2007 and April 2010 respectively.

Pursuant to the NRAS and the *Health Practitioner Regulation National Law* ('*National Law*'), the MBA now registers all Australian doctors to practise medicine. Under an 'applied laws' model, Queensland initially passed the

29 Several studies have investigated responses to complaints/notifications made about registered health practitioners including pursuant to the *Health Practitioner Regulation National Law*, as enacted in each state and territory, which governs the regulated health professions at present. See, eg, Mary Chiarella et al, 'Survey of Quasi-Judicial Decision-Makers in NSW and the National Registration Scheme for Health Practitioners' (2018) 25(2) *Journal of Law and Medicine* 357; Matthew J Spittal et al, 'Outcomes of Notifications to Health Practitioner Boards: A Retrospective Cohort Study' (2016) 14(1) *BMC Medicine* 198.

30 For a discussion of the NRAS, see Gabrielle Wolf, 'Regulating Health Professionals' in Anne-Maree Farrell et al (eds), *Health Law: Frameworks and Context* (Cambridge University Press, 2017) 73; Gabrielle Wolf, 'Sticking Up for Victoria?: Victoria's Legislative Council Inquires into the Performance of the Australian Health Practitioner Regulation Agency' (2014) 40(3) *Monash University Law Review* 890.

31 *Stephanopoulos* (n 13) [1] (Dr Freckelton, Dr Mukhtar and Mr Russell).

National Law,[32] and the other states and territories adopted and applied it as a law of their jurisdictions, though some modified it. The most significant changes to the *National Law* were made in New South Wales ('NSW') (from 2010) and Queensland (from 2014), and they follow a 'co-regulatory model'; health profession boards and health complaints bodies share regulatory responsibility in those states, whereas the MBA exclusively handles matters pertaining to doctors' conduct in the other jurisdictions (except the Australian Capital Territory in which the health complaints entity contributes to decisions about management of disciplinary matters).[33] Notwithstanding these differences, when doctors have been convicted of child pornography offences, the MBA, or in NSW the Medical Council of NSW or the HCCC and in Queensland the MBA or the Health Ombudsman, need to refer such matters to the administrative tribunal in the jurisdiction in which the conduct occurred.[34] The Queensland Civil and Administrative Tribunal therefore heard Bonney's case in 2010, while VCAT presided over Black's matter, the South Australian Health Practitioners Tribunal decided K's matter in 2015, and WASAT dealt with Voon's case in 2018.

Statutory requirements for the composition of the panels that heard the doctors' disciplinary matters varied. For instance, one judicial member heard Bonney's case;[35] a judge alone heard Fitzgerald's matter;[36] two doctors and a lawyer were required to hear Black's matter;[37] at least one lawyer and one registered doctor needed to sit on the panel for Stephanopoulos's hearing;[38] and a judge of the Supreme Court or District Court, two registered doctors and a layperson were required to hear Simring's and Wingate's cases.[39] Nevertheless, the nature of the panels' power was the same and, as primary decision-makers in these cases, they all had 'considerable discretion'.[40] Regulators of the medical profession and health complaints entities, though parties to the proceedings,[41] played a non-adversarial

32 *Health Practitioner Regulation National Law Act 2009* (Qld) sch ('*National Law*').

33 Wolf, 'Regulating Health Professionals' (n 30) 76, 78–92.

34 *National Law* (n 32) ss 5 (definitions of 'professional misconduct' and 'unprofessional conduct'), 193(1)(a)(i), (2); *Health Practitioner Regulation National Law Act (NSW) 2009* (NSW) s 145D ('*National Law (NSW)*'); *Health Practitioner Regulation National Law Act 2009* (Qld) s 50 ('*Health Practitioner Regulation National Law Act*'), inserting *National Law* (n 32) ss 193, 193A–B; *Health Ombudsman Act 2013* (Qld) s 103(5) ('*Health Ombudsman Act*').

35 *Health Ombudsman Act* (n 34) s 97; *Queensland Civil and Administrative Tribunal Act 2009* (Qld) sch 3 (definition of 'judicial member') ('*QCAT Act*').

36 *Health Practitioners (Professional Standards) Act 1999* (Qld) s 27 ('*Health Practitioners (Professional Standards) Act*').

37 *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 64(2)(b), sch 1 cl 11AJ ('*VCAT Act*').

38 *Medical Practice Act 1994* (Vic) s 47(1) ('*Medical Practice Act* (Vic)'), as repealed by *Health Professions Registration Act 2005* (Vic) s 163(1)(d) ('*Health Professions Registration Act*').

39 *Medical Practice Act 1992* (NSW) ss 147(3), 148(1), (9) ('*Medical Practice Act* (NSW)'), as repealed by *Health Practitioner Regulation Amendment Act 2010* (NSW) sch 3 ('*Health Practitioner Regulation Amendment Act*').

40 Roger Douglas and Margaret Hyland, *Administrative Law* (LexisNexis Butterworths, 3rd ed, 2015) 162. See also Douglas and Hyland (n 40) 6, 9.

41 See, eg, *National Law* (n 32) s 194(b).

role of providing information to the panels to assist in their decision-making,[42] while the panels had investigative and inquisitorial powers.[43] The panels could inform themselves about any matters and in any ways they deemed appropriate,[44] call witnesses (including experts) of their own motion,[45] and inquire into expert witnesses' credit.[46] Further, most of the panels were free to make no determination at all or alternately to impose one or more of a range of sanctions, including deregistration.[47]

The panels' discretion was, nonetheless, subject to the rule of law, and they needed to comply with their governing legislation and common law administrative law principles.[48] The panels were thus 'bound by the rules of natural justice',[49] and the two rules of procedural fairness that underlie it:[50] 'the hearing rule' (before making decisions that could adversely affect the doctors, the panels needed to provide them with notice of the allegations and a fair opportunity to respond to them);[51] and 'the rule against bias' (the panels needed to bring 'an impartial and unprejudiced mind' to the cases).[52]

The panels had to avoid committing other errors of law that, like denial of natural justice, would have constituted a ground of judicial review.[53] They needed to take into account 'relevant matters' that legislation mandated them to consider and disregard 'irrelevant matters' that legislation forbade them from considering.[54]

42 Douglas and Hyland (n 40) 60.

43 Ibid 59; Gabrielle Appleby, Alexander Reilly and Laura Grenfell, *Australian Public Law* (Oxford University Press, 2nd ed, 2014) 224; JRS Forbes, *Justice in Tribunals* (Federation Press, 4th ed, 2014) 188.

44 Forbes (n 43) 188–9; *VCAT Act* (n 37) s 98(1)(c); *QCAT Act* (n 35) s 28(3)(c); *Health Practitioners (Professional Standards) Act* (n 36) s 219(1)(d); *Medical Practice Act* (NSW) (n 39) s 161(1), as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3; *Medical Practice Act* (Vic) (n 38) s 52(1)(c), as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d).

45 See, eg, *VCAT Act* (n 37) sch 3 cl 7; *QCAT Act* (n 35) ss 98(1)(a), 110(1), 111.

46 Forbes (n 43) 188–9.

47 See, eg, *Medical Practice Act* (Vic) (n 38) s 45A, as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d); *National Law* (n 32) s 196; *Medical Practice Act* (NSW) (n 39) ss 60–4, as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3. Cf *Health Practitioners (Professional Standards) Act* (n 36) s 241(1)–(2), applied by the panel in *Bonney* (n 18), which required the tribunal to impose at least one sanction.

48 Forbes (n 43) 2; Douglas and Hyland (n 40) 6, 9, 38, 162; Geoffrey de Q Walker, *The Rule of Law: Foundation of Constitutional Democracy* (Melbourne University Press, 1988) 3, 42.

49 *VCAT Act* (n 37) s 98(1)(a); *Medical Practice Act* (Vic) (n 38) s 52(1)(d), as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d). See, eg, *QCAT Act* (n 35) s 28(3)(a); *Health Practitioners (Professional Standards) Act* (n 36) s 219(1)(a); *Civil and Administrative Tribunal Act 2013* (NSW) s 38(2).

50 Douglas and Hyland (n 40) 193; Justice James Edelman, 'Why Do We Have Rules of Procedural Fairness?' (2016) 23(3) *Australian Journal of Administrative Law* 144, 144–5, 153.

51 Appleby, Reilly and Grenfell (n 43) 224; Judith Bannister, Gabrielle Appleby and Anna Olijnyk, *Government Accountability: Australian Administrative Law* (Cambridge University Press, 2015) 459, 482; Forbes (n 43) 5, 98, 129, 131; Douglas and Hyland (n 40) 63, 218–19.

52 Bannister, Appleby and Olijnyk (n 51) 494; Forbes (n 43) 98, 260, 262–4, 266; Douglas and Hyland (n 40) 229, 232–3.

53 Bannister, Appleby and Olijnyk (n 51) 459; Forbes (n 43) 99; Douglas and Hyland (n 40) 163, 192.

54 Bannister, Appleby and Olijnyk (n 51) 541–2; Robin Creyke, John McMillan and Mark Smyth, *Control of Government Action: Text, Cases and Commentary* (LexisNexis Butterworths, 4th ed, 2015) 579–80.

While not bound by the rules of evidence,[55] the panels had to ensure that some evidence underlay their decisions,[56] and that, even if hearsay, it met the standard of proof on the balance of probabilities or 'reasonable satisfaction',[57] which Dixon J explained in *Briginshaw v Briginshaw*[58]

> is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[59]

Relying on evidence that met this standard would help prevent the panels from reaching decisions that were 'so unreasonable that no reasonable person could have reached [them]'.[60] As the panels were required to provide reasons for their orders,[61] and, therefore, also to 'set out the findings on material questions of fact and refer to the evidence or other material on which those findings were based',[62] they thereby demonstrated whether they had complied with the law.[63]

The panels were bound to follow judicial decisions, but not other tribunals' decisions.[64] It was, however, appropriate for the panels to regard as very persuasive precedents[65] other disciplinary matters involving professionals who had committed child pornography offences, given that consistent treatment of similar cases is fundamental to the rule of law.[66]

55 See, eg, *VCAT Act* (n 37) s 98(1)(b); *QCAT Act* (n 35) s 28(3)(b); *Health Practitioners (Professional Standards) Act* (n 36) s 219(1)(c); *Medical Practice Act* (Vic) (n 38) s 52(1)(c), as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d).

56 Bannister, Appleby and Olijnyk (n 51) 568; Forbes (n 43) 88–9; Douglas and Hyland (n 40) 66–7, 181.

57 Forbes (n 43) 178, 213.

58 (1938) 60 CLR 336.

59 Ibid 362.

60 Forbes (n 43) 87, citing *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 ('*Wednesbury*'). This error of law is termed 'Wednesbury unreasonableness', following *Wednesbury* (n 60).

61 See, eg, *VCAT Act* (n 37) s 117(1); *Health Practitioners (Professional Standards) Act* (n 36) s 245(2)(b); *Medical Practice Act* (NSW) (n 39) s 165(2)(c), as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3; *Medical Practice Act* (Vic) (n 38) s 56(1), as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d).

62 *Acts Interpretation Act 1901* (Cth) s 25D.

63 Forbes (n 43) 234–5.

64 Appleby, Reilly and Grenfell (n 43) 225; Forbes (n 43) 250; Douglas and Hyland (n 40) 11.

65 Appleby, Reilly and Grenfell (n 43) 225, citing *Re Littlejohn and Secretary, Department of Social Services* (1989) 17 ALD 482, 486 [9] (Deputy President Thomson).

66 Appleby, Reilly and Grenfell (n 43) 225; Bannister, Appleby and Olijnyk (n 51) 313–14; Douglas and Hyland (n 40) 11; Walker (n 48) 3, 19, 42; *Medical Practitioners Board of Victoria v Kaur* [2010] VCAT 364, [68] (Deputy President McNamara, Member Collopy and Dr Molloy), quoted in *Black* (n 6) [33] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

III MATTERS THAT THE PANELS TOOK INTO ACCOUNT

Legislation that was relevant to the disciplinary hearings concerning the doctors who had committed child pornography offences referred to the protection of the public.[67] Yet the *Health Practitioners (Professional Standards) Act 1999* (Qld) — which applied to Bonney's and Fitzgerald's matters — was the only statute that stated explicitly that this was the aim of disciplinary proceedings and action.[68] None of this legislation indicated what protection of the public entails or specified matters for the panels to take into account to ensure that their determinations achieved this goal. The panels did not refer to any guidelines produced by regulators of the medical profession to glean such instruction either.

As relevant statutes did not require the panels to take into account or disregard any matters in particular in seeking to protect the public, the panels did not err in law by ignoring 'relevant considerations' or referring to 'irrelevant considerations'.[69] Nevertheless, it was not in the interests of the doctors who were the subjects of these cases, the public or the medical profession that there were inconsistencies between the panels' consideration of various factors and that some of them did not document clearly how and why they took those matters into account. This Part of the article analyses the panels' approaches to the objective of protecting the public and the matters to which they had regard in attempting to achieve it through their determinations.

A *Protection of the Public*

For guidance, the panels referred to a long line of judicial decisions, which have treated the goal of protecting the public as fundamental to professionals' disciplinary proceedings and determinations.[70] Those decisions and the panels expressed different conceptions of this objective. Some of the decision-makers interpreted it as meaning literally protecting patients' health and safety, which

67 *Medical Practice Act* (Vic) (n 38) s 1(a), as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d); *National Law* (n 32) s 3(2)(a); *Medical Practice Act* (NSW) (n 39) s 2A(1), as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3; *Health Practitioners (Professional Standards) Act* (n 36) s 123(a).

68 *Health Practitioners (Professional Standards) Act* (n 36) s 123: this statute provided that upholding the standards of practice and maintaining public confidence in the medical profession were other purposes (in addition to the protection of the public) of disciplinary proceedings and action.

69 Bannister, Appleby and Olijnyk (n 51) 542–3, 549; *Lo v Chief Commissioner of State Revenue* (2013) 85 NSWLR 86, 89 (Basten JA), quoted in Creyke, McMillan and Smyth (n 54) 580; Douglas and Hyland (n 40) 167.

70 See, eg, *Stephanopoulos* (n 13) [114] (Dr Freckelton, Dr Mukhtar and Mr Russell), quoting *Law Society of New South Wales v Bannister* [1993] NSWCA 157, 12 (Sheller JA) ('*Bannister*'); *Stephanopoulos* (n 13) [115], quoting *Craig v Medical Practitioners Board* (2001) 79 SASR 545, 554–5 [43], [46]–[48] (Doyle CJ) ('*Craig*'); *Stephanopoulos* (n 13) [147], quoting *Ha v Pharmacy Board of Victoria* [2002] VSC 322, [89]–[91] (Gillard J) ('*Ha*'); *Black* (n 6) [26] (Presiding Member Wentworth, Member Fabris and Member Shanahan), quoting *Craig* (n 70) 554 [41]; *Black* (n 6) [28], quoting *Dickens v Law Society of Tasmania* (Supreme Court of Tasmania, Cosgrove J, 23 September 1981) 15–16 ('*Dickens*').

they distinguished from other apparent aims of disciplinary proceedings that are repeatedly articulated in case law, but not legislation, namely, maintaining the good standing and reputation of the medical profession, this profession's ethical and professional standards, and public confidence in doctors.[71] Other decision-makers have, however, treated all of these objectives as fused under the umbrella aim of protecting the public.[72]

The main direction provided by case law on which the panels relied is that, in making determinations in disciplinary matters, protection of the public is not achieved by punishing professionals.[73] The panels described punishment as exclusively the purview of the criminal law,[74] which they contrasted with the object of disciplinary proceedings, repeatedly emphasising that the 'function' of determinations is protective and not punitive.[75] Yet it is disingenuous to maintain that disciplinary determinations never punish professionals, and some courts have recognised that they will have this effect.[76] Hearing the HCCC's appeal against the NSWMT's decision in *Health Care Complaints Commission v Wingate* ('*HCCC v Wingate*'),[77] Basten JA in the NSW Court of Appeal observed:

> Although the exercise of professional disciplinary powers may be seen as protective and not as involving punishment … there is undoubtedly a degree of overlap between the purposes served by each in their respective contexts … The fact that disciplinary orders are commonly characterised as 'protective' does not deny that they have punitive effects.[78]

Definitions of punishment vary, but most involve the infliction of suffering, pain,

71 See, eg, *Ha* (n 70) [89]–[91] (Gillard J), quoted in *Stephanopoulos* (n 13) [147] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Black* (n 6) [5], [25] (Presiding Member Wentworth, Member Fabris and Member Shanahan), citing *Ha* (n 70) [91], [97], *Medical Practitioners Board of Victoria v Grolaux (No 2)* [2009] VCAT 978 ('*Grolaux*') and *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630, 637 ('*Litchfield*').

72 See, eg, *Simring* (n 22) [112] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Craig* (n 70) 554 [41] (Doyle CJ), quoted in *Black* (n 6) [26] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Gayed v Walton* (New South Wales Court of Appeal, Mason P, Meagher and Stein JJA, 31 July 1997), cited in *Wingate* (n 24) [69] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Stephanopoulos* (n 13) [165] (Dr Freckelton, Dr Mukhtar and Mr Russell).

73 See, eg, *Black* (n 6) [25] (Presiding Member Wentworth, Member Fabris and Member Shanahan), citing *Ha* (n 70) [91], [97] (Gillard J), *Grolaux* (n 71) and *Litchfield* (n 71) 637; *Black* (n 6) [28], citing *Dickens* (n 70) 15–16 (Cosgrove J); *Stephanopoulos* (n 13) [113] (Dr Freckelton, Dr Mukhtar and Mr Russell), citing *Morris v Psychologists Registration Board* (Supreme Court of Victoria, Harper J, 19 December 1997) 23–4 ('*Morris*') and *Mullany v Psychologists Registration Board* (Supreme Court of Victoria, Gillard J, 22 December 1997) 17–18 ('*Mullany*'). See also *Clyne v New South Wales Bar Association* (1960) 104 CLR 186, 201–2; *New South Wales Bar Association v Evatt* (1968) 117 CLR 177, 183–4 ('*Evatt*').

74 See, eg, *Stephanopoulos* (n 13) [179] (Dr Freckelton, Dr Mukhtar and Mr Russell).

75 Ibid [113], citing *Morris* (n 73) 23–4 (Harper J) and *Mullany* (n 73) 17–18 (Gillard J); *Black* (n 6) [25] (Presiding Member Wentworth, Member Fabris and Member Shanahan), citing *Ha* (n 70) [91], [97] (Gillard J), *Grolaux* (n 71) and *Litchfield* (n 71) 637; *Simring* (n 22) [112] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Wingate* (n 24) [69] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

76 See, eg, *Medical Board of Australia v Cukier* [2017] VCAT 109, [88] (Members Wentworth, Collopy and Reddy) ('*Cukier*'); *Craig* (n 70) 554 [45] (Doyle CJ).

77 (2007) 70 NSWLR 323 ('*HCCC v Wingate*').

78 Ibid 336 [55], citing *Ziems v Prothonotary of the Supreme Court of New South Wales* (1957) 97 CLR 279, 286 (Dixon CJ), 289 (Fullagar J) ('*Ziems*').

hardship and/or deprivation in response to wrongdoing.[79] The criminal sanctions that the doctors discussed in this article received would have had this impact. In addition to Black's sentence, the following sanctions were imposed on the other doctors. Bonney, a general practitioner who accessed child pornography, received a 12-month prison sentence and, though he was released immediately, he was subject to a probation officer's supervision for 18 months.[80] Fitzgerald, a surgeon who possessed and copied child pornography, was fined.[81] Simring, a gastroenterologist who possessed and accessed child pornography, was sentenced to two terms of imprisonment, both of which were suspended.[82] Stephanopoulos, a neurosurgical trainee who possessed child pornography, was fined and sentenced to five-months' imprisonment, which was wholly suspended for 15 months.[83] Wingate, an ophthalmologist who possessed child pornography, was fined, ordered to pay costs and placed on a three-year good behaviour bond, supervised by the Probation and Parole Service.[84] K, who was convicted of possessing child pornography, but whose area of medical practice was not published, was sentenced to 16 months' imprisonment, suspended subject to a two-year good behaviour bond.[85] Voon, a child psychiatrist who produced and possessed child exploitation material, was sentenced to 27 months' imprisonment, but released on conditions that he be of good behaviour.[86]

The panels' determinations had a similarly punitive effect on the doctors. The orders for Simring, Fitzgerald, Wingate, Bonney, K and Voon to pay costs involved in the disciplinary proceedings,[87] were a significant pecuniary impost. As the panel in *Black* acknowledged, a reprimand, which Black as well as Stephanopoulos, Simring, Wingate, K and Voon received,[88] publicly denounces a practitioner and might thereby hamper his/her medical practice: 'A formal reprimand is not a mere "slap over the wrist". As Marks J observed in *Peeke v Medical Board of Victoria*, a reprimand, being a serious form of censure and condemnation … "has the potential for serious adverse implications for the

79 Mirko Bagaric, Lidia Xynas and Victoria Lambropoulos, 'The Irrelevance to Sentencing of (Most) Incidental Hardships Suffered by Offenders' (2016) 39(1) *University of New South Wales Law Journal* 47, 69–72.

80 *Bonney* (n 18) [1], [4] (Deputy President Kingham).

81 'Surgeon Convicted Over Child Porn', *Daily Mercury* (online, 13 November 2004) <www.dailymercury.com.au/news/apn-surgeon-convicted-over-child/78045/>.

82 *Simring* (n 22) [4], [9] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

83 *Stephanopouolos* (n 13) [11] (Dr Freckelton, Dr Mukhtar and Mr Russell).

84 *Wingate* (n 24) [2], [5], [76] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

85 Hough (n 12).

86 *Voon* (n 14) sch A [15].

87 *Simring* (n 22) [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Fitzgerald* (n 25) [10] (Richards DCJ); *Wingate* (n 24) 1 (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Bonney* (n 18) 4 (Deputy President Kingham); *K* (n 12); *Voon* (n 14).

88 *Stephanopoulos* (n 13) 1, [182] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Simring* (n 22) [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Wingate* (n 24) 1, [95] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Black* (n 6) 1, [14], [47] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

medical practitioner"'.[89]

The suspensions of Stephanopoulos's, Black's and K's registration to practise medicine, and the disqualification of Voon from applying for registration, fell within common definitions of punishments, too.[90] Deprivation of employment is a recognised punishment,[91] and Gillard J observed in *Mullany v Psychologists Registration Board*,[92] a judgment often quoted in disciplinary decisions regarding doctors, that '[t]o be deprived of the opportunity of working as a professional for a period … would have a devastating effect upon one's financial position, one's standing in the community, one's practice'.[93] In restricting their medical practice, conditions that were imposed on Stephanopoulos's, Fitzgerald's, Simring's, Black's and K's registration prohibiting them from providing treatment to minors,[94] and on Bonney's and Wingate's registration permitting them to treat minors only in the presence of a chaperone,[95] may have resulted in the diminution of their income and reputations, too.

None of the panels explicitly acknowledged that they had punished the doctors. As determinations are made for the purpose of protecting the public, rather than with the intention of penalising doctors, their imposition in disciplinary proceedings after practitioners have received criminal sentences does not contravene the rule against double jeopardy.[96] Nevertheless, as Basten JA cautioned in *HCCC v Wingate*, 'it may be important to recognise that disciplinary orders … have punitive effects and to take those effects into account in ensuring that the necessary protective purpose is achieved without unnecessarily imposing a degree of punishment exceeding that thought appropriate by the criminal court'.[97] This contention does not constrain disciplinary decision-makers' discretion to impose severe determinations, for it may be necessary for them to make determinations that are harsher than criminal sanctions that doctors have received where those penalties have not protected the public sufficiently. Beyond noting the doctors' sentences, the panels did not consider the extent to which the criminal penalties achieved this objective.

89 *Black* (n 6) [48] (Presiding Member Wentworth, Member Fabris and Member Shanahan), quoting *Peeke v Medical Board of Victoria* (Supreme Court of Victoria, Marks J, 19 January 1994) 6.

90 *Stephanopoulos* (n 13) 2, [182] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Black* (n 6) 1, [58] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *K* (n 12); *Voon* (n 14).

91 Bagaric, Xynas and Lambropoulos (n 79) 82.

92 *Mullany* (n 73).

93 Ibid 20.

94 *Stephanopoulos* (n 13) 1, [182] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Fitzgerald* (n 25) 1 (Richards DCJ); *Simring* (n 22) [58], [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Black* (n 6) 2, [51] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *K* (n 12).

95 *Bonney* (n 18) 1, [6] (Deputy President Kingham); *Wingate* (n 24) 1, [95] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

96 Forbes (n 43) 219; *Litchfield* (n 71) 635, citing *Re Weare* [1893] 2 QB 439 and *Bannister* (n 70) 7–8 (Sheller JA).

97 *HCCC v Wingate* (n 77) 336 [55].

In *Stephanopoulos*, the panel asserted that its 'role … is not to punish a person who has breached the criminal laws of Victoria. That is the responsibility of the criminal courts. The Panel's role is to take such measures as are necessary to protect the public'.[98] While this statement reflects the principal objectives of criminal sanctions and disciplinary determinations, criminal sanctions are designed to safeguard the public, too, and determinations may punish practitioners, even though it is not disciplinary decision-makers' 'role' to do so.[99] In relation to the doctors discussed in this article, courts attempted to achieve 'community protection' by imposing sentences that would thwart the production and consumption of child pornography.[100] Notwithstanding this function of the criminal sanctions, they did not address the interests of patients and the medical profession in particular, which the panels (unlike the courts) were responsible for prioritising in seeking to protect the public. For this reason, the panels may have needed to make determinations that had a punitive impact and one that was even greater than that of the criminal sanctions (though punishment was only a consequence of the panels' attempts to protect the public, rather than their objective). As JRS Forbes observes, 'the interests of the community … may justify a sanction more severe than any criminal penalty for the same conduct'[101] in order 'to safeguard the interests of the public' and 'protect the integrity of, and public confidence in' the medical profession.[102]

The courts' suspensions of the doctors' prison sentences, or immediate release of the practitioners from them,[103] were designed to encourage their rehabilitation and deter them from reoffending, while still punishing them.[104] In the meantime, however, as they were not incarcerated, the doctors could continue practising medicine and further injure the reputation of the medical profession, and lower its standards and public confidence in it. This would certainly have been the case if they reoffended and the panels could legitimately have deregistered the doctors to prevent them from committing further crimes while remaining representatives of the registered medical profession. Even if the doctors did not reoffend, and/or those who were given prison terms were required to serve them, the facts of their convictions, sentences and ongoing medical registration could have diminished the profession's public standing and community trust in it. Basten JA observed

98 *Stephanopoulos* (n 13) 3 (Dr Freckelton, Dr Mukhtar and Mr Russell).

99 Forbes (n 43) 183.

100 *Stephanopoulos* (n 13) [94] (Dr Freckelton, Dr Mukhtar and Mr Russell), quoting *R v Stroempl* (1995) 105 CCC (3d) 187, 191 (Modern ACJO) (Ontario Court of Appeal).

101 Forbes (n 43) 182, citing *Pratt v British Medical Association* [1919] 1 KB 244, 278 (McCardie J), *Byrne v Kinematograph Renters Society Ltd* [1958] 2 All ER 579, *Ziems* (n 78) 286 (Dixon CJ), *Evatt* (n 73) and *Craig* (n 70) 550–1 [23] (Doyle CJ).

102 Forbes (n 43) 217.

103 *Simring* (n 22) [9] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Stephanopoulos* (n 13) [11] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Bonney* (n 18) [1]; Hough (n 12); *Voon* (n 14) sch A [16].

104 Mirko Bagaric and Richard Edney, *Sentencing in Australia* (Thomson Reuters, 3rd ed, 2016) 641–2.

in *HCCC v Wingate*, 'where the penalty imposed under the criminal law is a period of imprisonment, there may be an incongruity between the status of the practitioner as a prisoner and his or her continued right to practise'.[105] Indeed, the panel in *Stephanopoulos* considered it 'appropriate' that the doctor — whom that panel believed would not reoffend — 'not return to practice while his suspended sentence is still current'[106] on the basis of the point made by Newman J in *Council for the Regulation of Health Care Professions v General Dental Council* that, in cases where a professional is serving a sentence for a 'serious criminal offence', 'good standing in a profession must be earned if the reputation of the profession is to be maintained'.[107]

The criminal sentences would have done little to restore the public's faith in the medical profession and its reputation if these doctors' convictions undermined them. By contrast, disciplinary determinations could have protected the public in this sense, but to do so, they may have needed to inflict some hardship on the doctors. The panels in *Black*, *Stephanopoulos* and *Health Care Complaints Commission v Simring* ('*Simring*')[108] observed that the practitioners' offences diminished the community's trust in the profession and its standards.[109] Through making determinations that had a punitive impact on the doctors, however, the panels' determinations conveyed that the practitioners had committed professional transgressions and betrayed the public, and reinforced the community and medical profession's expectations about doctors' proper behaviour. They thereby confirmed the medical profession's high ethical and professional standards and helped to rebuild community confidence in it. Doyle CJ noted in *Craig v Medical Board of South Australia*[110] (which the panel in *Stephanopolous* quoted) that, to protect the public, determinations can be made that 'might look like a punishment imposed by a court exercising criminal jurisdiction' in order 'to emphasise to other members of the profession, or to reassure the public, that a certain type of conduct is not acceptable professional conduct' and 'the profession does not allow' it.[111]

The courts sought to achieve specific deterrence (by deterring the doctors from reoffending) and general deterrence (by deterring other would-be offenders from committing child pornography crimes).[112] Most of the panels indicated

105 *HCCC v Wingate* (n 77) 336 [54].

106 *Stephanopoulos* (n 13) [177] (Dr Freckelton, Dr Mukhtar and Mr Russell).

107 Ibid [122], quoting *Council for the Regulation of Health Care Professions v General Dental Council* [2005] EWHC 87 (Admin), [54] (Newman J).

108 *Simring* (n 22).

109 Ibid [53] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Stephanopoulos* (n 13) [176] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Black* (n 6) [38] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

110 *Craig* (n 70).

111 Ibid 555 [47], quoted in *Stephanopoulos* (n 13) [115] (Dr Freckelton, Dr Mukhtar and Mr Russell).

112 Kate Warner, 'Sentencing for Child Pornography' (2010) 84(6) *Australian Law Journal* 384, 385.

that they, too, intended to protect the public by deterring the doctors and other medical practitioners from engaging in similar wrongdoing.[113] (Indeed, the fact that the suffering experienced by the doctors as a consequence of the panels' determinations constituted the disincentive for them and other practitioners to commit such offences belies the panels' understandings that they had not punished the doctors).[114] In *Stephanopoulos*, however, the doctor's counsel submitted that Stephanopoulos's sentence effected 'a significant measure of general deterrence' and it would be 'wrong' for the panel to make determinations 'directed toward achieving no more than an object already achieved by the criminal courts'.[115] The panel did not respond to this argument in its reasons for decision.[116] Yet it could have justified its imposition of harsh determinations on the basis that they supplemented the deterrent impact — particularly on Stephanopoulos and the medical profession — of the criminal sanctions that the doctor had received by virtue of the facts that they restricted his pursuit of his livelihood and, even if inadvertently, humiliated him before his colleagues (the medical profession was notified of the panel's decision).

B *The Nature of the Doctor's Offence*

A matter that was central to all of the panels' decision-making about which determinations they should make to protect the public was the nature of the doctors' offences. Nevertheless, there were inconsistencies in the ways in which the panels characterised the doctors' conduct and assessed its gravity, though they also ultimately made similar determinations. These inconsistencies were less attributable to significant differences between the content of the pornography that the doctors accessed and/or possessed than to: minor variations in the particular legislation that the panels were required to apply, though also their divergent interpretations of the same legislation; some of the panels' assessments of whether the doctors were sufficiently ethically upright to practise medicine; and the panels' discretion regarding how they reached determinations.

Variations in the terminology used in legislation to describe doctors' conduct that falls below professional standards, and warrants the imposition of determinations, account for some of the differences between the panels' findings about the

113 *Black* (n 6) [27] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Stephanopoulos* (n 13) [114], [178] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Simring* (n 22) [112] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Wingate* (n 24) [69] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

114 See *Quinn v Law Institute of Victoria Ltd* (2007) 27 VAR 13. '[T]he Tribunal's disciplinary orders are punitive as well as protective. The available sanctions are, by their nature, punitive, and the objectives of specific and general deterrence — which serve the protection of the public — depend upon the sanctions having punitive effect': at 7 [30] (Maxwell P); *Cukier* (n 76) [88] (Members Wentworth, Collopy and Reddy), citing *Stirling v Legal Services Commissioner* [2013] VSCA 374, [57].

115 *Stephanopoulos* (n 13) [102] (Dr Freckelton, Dr Mukhtar and Mr Russell).

116 Ibid [114].

doctors' behaviour. For instance, such inconsistencies resulted in the panel finding that Bonney had engaged in 'improper conduct and conduct discreditable to his profession' (one of the statutory definitions of 'unsatisfactory professional conduct'),[117] while, pursuant to other relevant legislation, the panels in *Black* and *Simring* concluded that the doctors had engaged in 'professional misconduct',[118] and Stephanopoulos's behaviour was found to constitute 'unprofessional conduct of a serious nature'.[119]

Two panels also reached different findings from one another about the doctors' conduct because they interpreted the same statute differently. The panel in *HCCC v Wingate* considered that the doctor's offences could not be classified as 'professional misconduct' under the *Medical Practice Act 1992* (NSW) ('*Medical Practice Act* (NSW)'), which defined it as 'unsatisfactory professional conduct … of a sufficiently serious nature to justify suspension' or cancellation of the practitioner's registration, and listed various forms of conduct that would constitute it, concluding with 'other improper or unethical conduct relating to the practice … of medicine'.[120] As Wingate did not commit his crimes at work, the panel believed that it could not describe them as falling within this final category.[121] Nevertheless, the panel in *Simring* subsequently found that Simring had engaged in 'professional misconduct' pursuant to this statutory provision even though he, too, committed the offences 'in his private life'.[122]

Other differences between the panels' findings about the nature of the doctors' offences resulted from some of them assessing whether the doctors exhibited the appropriate morality for medical practice. The panels in *Wingate* and *Simring* referred to case law that indicates that doctors' 'fitness to practice' and 'character' denote their 'moral standards, attitudes and qualities',[123] and found that the doctors

117 *Bonney* (n 18) [5] (Deputy President Kingham); *Health Practitioners (Professional Standards) Act* (n 36) s 124(1)(a).

118 *Black* (n 6) [20] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Simring* (n 22) [79] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger). See *National Law* (n 32) ss 5 (definition of 'professional misconduct'), 196(1)(b)(iii); *Medical Practice Act* (NSW) (n 39) s 37, as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3.

119 *Stephanopoulos* (n 13) [96] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Medical Practice Act* (Vic) (n 38) ss 3 (definition of 'unprofessional conduct'), 45A(1)(a), as repealed by *Health Professions Registration Act* (n 38) s 163(1)(d).

120 *Medical Practice Act* (NSW) (n 39) ss 36–7, as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3. See *Wingate* (n 24) [53] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

121 *Wingate* (n 24) [50]–[53] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Simring* (n 22) [65] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Medical Practice Act* (NSW) (n 39) s 36(1)(m), as repealed by *Health Practitioner Regulation Amendment Act* (n 39) sch 3.

122 *Simring* (n 22) [75] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger). See also *Simring* (n 22) [76]–[79].

123 *Wingate* (n 24) [73] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier), citing *Re Davis* (1947) 75 CLR 409, 420 (Dixon J), *McBride v Walton* [1994] NSWCA 199, 32–3 (Handley JA) ('*McBride v Walton*') and *Ex parte Tziniolis; Re Medical Practitioners Act* (1966) 67 SR (NSW) 448 ('*Tziniolis*'); *Simring* (n 22) [99] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger), quoting *Tziniolis* (n 123) 451–2 (Walsh JA).

were not unfit to practise medicine.[124] Black committed offences that were similar to the crimes committed by Wingate and Simring; all of these doctors possessed pornography that, inter alia, depicted young people involved in explicit sexual activity.[125] Yet the panel in *Black* found that this doctor had engaged in 'conduct … 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'.[126] This panel was quoting one of three definitions of 'professional misconduct' in the *National Law* (and found that the doctor's conduct fell within the other two definitions as well).[127] The panels in *Simring* and *Wingate* also found that the doctors were 'of good character',[128] while the other decision-makers did not seek to evaluate the practitioners' 'character'. Despite the panel of the NSWMT reaching this conclusion in *Simring* and finding that the doctor was 'not unfit to practise in the public interest',[129] it also stated that Simring's offences demonstrated 'an absence of qualities compatible with professional practice'.[130]

Some of these inconsistencies in the panels' decision-making demonstrate the difficulty of evaluating individuals' personal morality. Judges and disciplinary panels have assumed that professionals' conduct can reflect their 'fitness to practise' and 'character'.[131] Nevertheless, while it is possible to assess whether an individual's behaviour is immoral by referring to community standards concerning ethical and unethical conduct, it is problematic to infer from that behaviour that he/she is an immoral person. (The panel in *Stephanopoulos*

124 *Simring* (n 22) [61] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Wingate* (n 24) [91] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

125 *Simring* (n 22) [6]–[7] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Black* (n 6) [16] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Wingate* (n 24) [54] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

126 *Black* (n 6) [20] (Presiding Member Wentworth, Member Fabris and Member Shanahan), quoting *National Law* (n 32) s 5 (definition of 'professional misconduct'). The *National Law* (n 32) does not provide any test of fitness and propriety to hold registration.

127 *Black* (n 6) [20]–[22] (Presiding Member Wentworth, Member Fabris and Member Shanahan), discussing *National Law* (n 32) s 5 (definitions of 'professional misconduct' and 'unprofessional conduct'). 'Professional misconduct' is also defined in the *National Law* (n 32) as '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', and 'more than one instance of unprofessional conduct that, when considered together, amounts to [such] conduct'. The *National Law* (n 32) defines 'unprofessional conduct' as '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 provides a list of conduct that is covered by this definition, including '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' (which the panel in *Black* (n 6) considered applied to this doctor: *Black* (n 6) [21]).

128 *Simring* (n 22) [110] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Wingate* (n 24) [91] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

129 *Simring* (n 22) [61] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

130 Ibid [75].

131 See Ian Freckelton, '"Good Character" and the Regulation of Medical Practitioners' (2008) 16(3) *Journal of Law and Medicine* 488, 496–511; Gabrielle Wolf and Mirko Bagaric, 'Nice or Nasty?: Reasons to Abolish Character as a Consideration in Australian Sentencing Hearings and Professionals' Disciplinary Proceedings' (2018) 44(3) *Monash University Law Review* 567; *Wingate* (n 24) [73] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier), discussing *McBride v Walton* (n 123) [25]–[26] (Handley JA), [52] (Powell JA).

noted the 'immorality' of the doctor's conduct, but did not seek to assess his personal morality).[132] Issues such as — do we in fact have a moral character? If so, is it immutable or possible to change, and/or necessarily good or bad? What constitutes good and bad character? Which conduct definitively reflects one's character? And can we describe someone as immoral if he/she is mentally ill?[133] — are philosophical and psychological questions that have no right or wrong answers and inevitably elicit subjective, varied responses. As Ian Freckelton observes, 'the simplicity and artificiality of the dichotomy … between "good" and "bad" character' creates 'conceptual problems'[134] and is 'a challenge for regulatory bodies and tribunals, as is the application of suitable yardsticks'.[135] In addition, Freckelton aptly comments, '[t]he last thing that one would want of regulators or disciplinary tribunals is that they function as roving moral police officers'.[136]

In any event, it is possible to characterise and assess the gravity of a doctor's offence on the basis of his/her crime alone. Some decision-makers have relied on the notion that professionals' wrongdoing 'manifest[s] the presence or absence of [moral] qualities which are incompatible with, or essential for, the conduct of [professional] practice' in order to classify it as professional misconduct where it occurs outside of their work.[137] Nevertheless, a doctor's offence is properly regarded as related to his/her medical practice and as professional misconduct, even where it is not committed at work, if it is so degenerate that it undermines the reputation and standards of the medical profession and community trust in it, and/or indicates that the doctor may pose a threat to patients' health or safety. The Privy Council expressed this point to some extent in *Roylance v General Medical Council (No 2)*[138] (which the panel in *Wingate* quoted, though it found that the *Medical Practice Act* (NSW) was 'not concerned' with this 'wider view of professional misconduct'):[139] 'serious professional misconduct may arise where the conduct is quite removed from the practice of medicine, but is of a sufficiently immoral or outrageous or disgraceful character', because 'the duty of a doctor to himself, if not to his profession, exists outwith the course of his professional practice' and, as a consequence of this behaviour, 'the public reputation of the

132 *Stephanopoulos* (n 13) [93] (Dr Freckelton, Dr Mukhtar and Mr Russell).

133 Freckelton (n 131) 499.

134 Ibid 511.

135 Ibid 509.

136 Ibid 510.

137 *Wingate* (n 24) [26] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier), quoting *New South Wales Bar Association v Cummins* (2001) 52 NSWLR 279, 289 [56] (Spigelman CJ). See also *Wingate* (n 24) [49]; *A Solicitor v Council of the Law Society of New South Wales* (2004) 216 CLR 253; *Simring* (n 22) [66]–[69] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); Freckelton (n 131) 499.

138 [2000] 1 AC 311 ('*Roylance*').

139 *Wingate* (n 24) [51] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

profession may suffer and public confidence in it may be prejudiced'.[140]

Certainly, though, it is appropriate for decision-makers to consider doctors' offences to be particularly serious if they occur at their workplaces and/or during medical practice. However, the panel in *Stephanopoulos* was the only decision-maker that appeared to take into account the location in which the doctor's crimes took place. For this panel, the fact that Stephanopoulos committed child pornography crimes at work exacerbated the gravity of his offences, indicating determinations that were required to protect the public.[141] Black also brought child pornography into his workplace, but the panel simply noted that he had done so without explicitly attaching weight to that fact.[142] While Bonney, Simring and Wingate seem to have confined their offending to the privacy of their homes, in evaluating the seriousness of their offences, none of the panels indicated whether they considered that these doctors' offences probably would have had less immediate impact on their colleagues and patients than if they had committed them at work.[143]

The panels differed from one another in further measures that they used to assess the nature of the doctors' crimes. The panels in *Black*, *Simring*, *Stephanopoulos* and *Wingate* — but not *Bonney* — noted that they considered whether the doctors' offences were a 'one-off lapse'[144] or an 'error of judgement',[145] and found that their commission of such crimes over a long time period warranted them receiving a particularly severe determination.[146]

The panel in *Stephanopoulos* also applied the so-called '*Oliver* scale' for measuring the degeneracy of child pornography in which the lowest level refers to 'images depicting erotic posing with no sexual activity', while material in the highest, fifth level portrays 'sadism or bestiality'[147] (though now superseded, the English Sentencing Advisory Panel recommended this scale, and the Court of Appeal in *R v Oliver*,[148] and then the United Kingdom's ('UK') General Medical Council's ('GMC') Fitness to Practise Committees, adopted it).[149] Finding that

140 *Roylance* (n 138) 332 (Clyde LJ), quoted in *Wingate* (n 24) [30] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

141 *Stephanopoulos* (n 13) [93], [159] (Dr Freckelton, Dr Mukhtar and Mr Russell).

142 *Black* (n 6) [1]–[2], [22] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

143 See *Bonney* (n 18); *Simring* (n 22); *Wingate* (n 24).

144 *Black* (n 6) [55] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

145 *Wingate* (n 24) [88] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

146 *Black* (n 6) [55] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Simring* (n 22) [107] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Stephanopoulos* (n 13) [166]–[167] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Wingate* (n 24) [88] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Bonney* (n 18).

147 *Stephanopoulos* (n 13) [118] (Dr Freckelton, Dr Mukhtar and Mr Russell).

148 [2002] EWCA Crim 2766. Courts in England and Wales now apply the Sentencing Council for England and Wales, 'Sexual Offences: Definitive Guideline' (Report, 12 December 2013) <www.sentencingcouncil.org.uk/wp-content/uploads/Sexual-offences-definitive-guideline-Web.pdf>.

149 *Stephanopoulos* (n 13) [118] (Dr Freckelton, Dr Mukhtar and Mr Russell); Warner (n 112) 386.

the pornography in Stephanopoulos's possession was 'at the lower end' of the *Oliver* scale, the panel was inclined to make a more lenient determination than deregistration.[150] The Magistrate who sentenced Simring applied the Combating Paedophile Information Networks in Europe ('COPINE') scale for classifying child pornography, which has ten categories and was adapted to create the *Oliver* scale.[151] Although the Magistrate found that 80% of the images that Simring possessed fell within categories 4 to 6 of that scale, and 20% fell within category 7,[152] the panel of the NSWMT did not indicate whether it took these assessments into account in deciding upon which disciplinary determinations to make. None of the other panels referred to the *Oliver* or COPINE scales, or to alternative taxonomies of child pornography that have been developed. Nevertheless, such assessments would have provided useful objective indicators of the seriousness of the doctors' offences and thus of determinations that were required to protect the public.

C *The Doctor's Virtues*

A matter that only two of the panels mentioned in their reasons for decision, and on which even those decision-makers may not have placed the same weight, was evidence of the doctors' virtues. The panel in *Stephanopoulos* quoted comments of the doctor's friends, acquaintances and colleagues, which attested to Stephanopoulos's trustworthiness, concern to help others and courteousness.[153] Although the panel did not indicate how it took those observations into account, its reference to them suggests that it may have considered them to be relevant to the determinations that it needed to make to protect the public. By contrast, the panel in *Wingate* explicitly stated that 'the very positive commendations of a number of [Wingate's] colleagues, referring doctors and patients' reflected Wingate's 'character' and 'support[ed] his continued registration'.[154] It is, however, unnecessary and unhelpful for decision-makers to have regard to evidence of the admirable traits of doctors who have committed child pornography offences in order to decide which determinations to make to safeguard the community. Those attributes do not render the doctors' crimes less odious, diminish their impact on the child victims of the pornography and on the reputation of and public confidence in the medical profession, or reliably indicate whether the doctors are likely to reoffend. The panel in *Wingate* interpreted evidence of the doctor's virtues as reflecting his 'good character', but, for the reasons discussed above, it is problematic for decision-makers to attempt to assess practitioners' personal

150 *Stephanopoulos* (n 13) [155] (Dr Freckelton, Dr Mukhtar and Mr Russell).

151 *Simring* (n 22) [5]–[6] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); Warner (n 112) 386.

152 *Simring* (n 22) [6] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

153 *Stephanopoulos* (n 13) [65]–[84] (Dr Freckelton, Dr Mukhtar and Mr Russell).

154 *Wingate* (n 24) [86] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier). See also *Wingate* (n 24) [90].

morality and to rely on those evaluations in order to determine how best to protect the public.

D *Risk of the Doctor Reoffending*

All the panels took into account the risk of the doctor reoffending,[155] which was an especially apposite consideration when deciding on determinations to make to protect the public. As Samuel JA aptly noted in *Buttsworth v Walton*[156] (which the panel in *Stephanopoulos* cited), 'the public interest in the [doctor's] continuing in practice must be weighed against the public interest in protecting patients from any repetition of the conduct'.[157] Given the doctors' apparent attraction to viewing sexualised images of young people, the likelihood of them committing child pornography offences again might reasonably be suspected to be high. It was also appropriate for the panels to consider whether there was a risk of these doctors acting out the images that they had viewed and committing contact sexual offences.[158]

It is difficult to investigate rates of recidivism amongst child pornography offenders because law enforcement authorities' data is unreliable (they do not detect and are uninformed about many child pornography and other sexual offences that are committed).[159] Nevertheless, the panels and expert witnesses who testified in the doctors' disciplinary proceedings observed certain characteristics of the practitioners that they considered — and, in some instances, which empirical research has identified — may indicate child pornography offenders' increased or decreased risks of reoffending.[160] Importantly, some of the witnesses also contemplated whether the impact on the doctors of the detection of their offences, their criminal and disciplinary hearings, and the consequences for the doctors that flowed from them, diminished the influence in their cases of factors that might otherwise enhance child pornography offenders' risk of recidivism. While it was reasonable for the panels to consider whether the doctors evinced these features, they did not refer to all of the same risk factors as one another, and some of them did not explain clearly in their reasons for decision how the evidence

155 Ibid [70]; *Stephanopoulos* (n 13) 3, [113] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Black* (n 6) [29] (Presiding Member Wentworth, Member Fabris and Member Shanahan), citing *Ha* (n 70) [101] (Gillard J); *Simring* (n 22) [30] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Bonney* (n 18) [2]–[3], [8] (Deputy President Kingham).

156 [1991] NSWCA 40.

157 Ibid 15, cited in *Stephanopoulos* (n 13) [113] (Dr Freckelton, Dr Mukhtar and Mr Russell).

158 Michael C Seto and Angela W Eke, 'Predicting Recidivism among Adult Male Child Pornography Offenders: Development of the Child Pornography Offender Risk Tool (CPORT)' (2015) 39(4) *Law and Human Behavior* 416; Michael C Seto, R Karl Hanson and Kelly M Babchishin, 'Contact Sexual Offending by Men with Online Sexual Offenses' (2011) 23(1) *Sexual Abuse* 124, 135; Kelly M Babchishin, R Karl Hanson and Heather VanZuylen, 'Online Child Pornography Offenders Are Different: A Meta-Analysis of the Characteristics of Online and Offline Sex Offenders against Children' (2015) 44(1) *Archives of Sexual Behavior* 45, 46.

159 Babchishin, Hanson and VanZuylen (n 158) 56; Seto, Hanson and Babchishin (n 158) 139–40.

160 Seto and Eke (n 158) 416–17.

about such matters supported their conclusions that the doctors were unlikely to reoffend. Each of the factors relating to the doctors' risk of reoffending that certain or all of the panels considered is now examined in turn.

1 *The Doctor's Criminal History*

The panel in *Wingate* concluded that the doctor's lack of a 'prior criminal record of any kind' supported his continued registration.[161] Seemingly relying on the evidence of a psychiatrist and a psychologist who examined Wingate, this panel considered that there was a low probability of the doctor committing a contact sexual offence, partly because he had not previously been convicted of one.[162] It was, however, erroneous for the panel to assume that Wingate had not committed a contact sexual offence on the basis of the fact that he did not have an official criminal record. Wingate could have offended in the past without detection and there was actually evidence that 'caused the Tribunal concern that Dr Wingate may have in fact been indulging his hebephilic inclinations in more than downloading child pornography', though that evidence did not definitively confirm 'any actual misconduct by Dr Wingate with any person'.[163]

It might nonetheless have been prudent for the other panels to have also considered whether the doctors had official criminal records. Some studies have demonstrated that child pornography offenders with prior convictions may be at risk of reoffending, especially if their previous crimes were contact sexual offences.[164] The panels would, however, have needed to bear in mind that this risk factor may apply to a lesser degree to doctors who have been disgraced professionally for their crimes and have come to recognise the incongruity between their vocation, which involves helping others, and the commission of such offences.

2 *The Doctor's Psychological Profile*

Each of the panels contemplated whether the doctor's propensity to reoffend may have been evident from his psychological profile. Although this investigation was appropriate, the panels did not all consider whether the doctors exhibited the same aspects of those profiles that could have indicated an increased or decreased risk of recidivism. Further, only some of the panels explained persuasively how expert evidence about the doctors' psychological profiles supported their findings regarding their likelihood of reoffending.

161 *Wingate* (n 24) [86] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

162 Ibid [70].

163 Ibid [82].

164 Seto and Eke (n 158) 417, 427; Seto, Hanson and Babchishin (n 158) 137; Angela W Eke, Michael C Seto and Jennette Williams, 'Examining the Criminal History and Future Offending of Child Pornography Offenders: An Extended Prospective Follow-Up Study' (2011) 35(6) *Law and Human Behavior* 466, 466–7, 475.

The panel in *Stephanopoulos* was alone amongst the decision-makers in regarding the doctor's 'empathy for the victims of the makers of the images with which he became preoccupied' (which Stephanopoulos apparently demonstrated to his treating psychiatrist and to the panel) as a factor that indicated his 'very low risk of reoffending'.[165] The panel in *Simring* noted that a psychologist whom the doctor consulted testified that '[h]er treatment plan for him was to … develop victim empathy' and Simring 'was responsive and compliant with the therapy', but it did not indicate whether it made any inferences from this evidence about the doctor's likelihood of recidivism.[166] Whether the doctors had empathy for the young people who were abused to produce the pornography may, however, have been an important predictive measure of their risk of reoffending, as studies have shown that child pornography offenders' empathy for those victims can represent a 'barrier' to them committing contact sexual offences.[167]

The panels in *Wingate* and *Stephanopoulos* referred to evidence of the doctors' self-control,[168] while the panel in *Simring* noted the opinion of the doctor's treating psychiatrist that it was vital for him to continue receiving psychiatric treatment 'as a reminder to him of the consequences of a lapse in self-control'.[169] It may have been useful for the other panels also to have considered the extent of the doctors' self-control. Research has found that child pornography offenders' self-control may constitute another obstacle to them reoffending.[170]

All the panels did refer to expert evidence about whether the doctors were sexually interested in young people. It was appropriate for the panels to place weight on this aspect of the doctors' psychological profiles given the witnesses' expertise and the findings of research that many child pornography offenders have a strong sexual interest in children, which motivates their offending,[171] and admission or diagnosis of such attraction can be associated with child pornography offenders who reoffend[172] (including by committing contact sexual offences against children, particularly where they have opportunity to do so).[173] Some of the expert witnesses in these cases also considered whether the consequences for the doctors of the detection and prosecution of their offences may have prevented

165 *Stephanopoulos* (n 13) [173] (Dr Freckelton, Dr Mukhtar and Mr Russell). See also *Stephanopoulos* (n 13) [20], [60].

166 *Simring* (n 22) [22] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

167 Babchishin, Hanson and VanZuylen (n 158) 46–7, 51.

168 *Wingate* (n 24) [78], [86], [90] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Stephanopoulos* (n 13) [40] (Dr Freckelton, Dr Mukhtar and Mr Russell).

169 *Simring* (n 22) [32] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

170 Babchishin, Hanson and VanZuylen (n 158) 46–7.

171 Ibid 46, 54, 58; Seto and Eke (n 158) 416–17; Michael C Seto, Lesley Reeves and Sandy Jung, 'Explanations Given by Child Pornography Offenders for Their Crimes' (2010) 16(2) *Journal of Sexual Aggression* 169, 170, 176–7; Seto, Hanson and Babchishin (n 158) 140.

172 Seto and Eke (n 158) 427.

173 Babchishin, Hanson and VanZuylen (n 158) 46, 55–6; Seto, Reeves and Jung (n 171) 178.

them from pursuing their attraction to young people through committing further child pornography crimes or contact sexual offences.[174]

Nevertheless, not all of the panels indicated clearly in their reasons for decision how the experts' evidence about the doctors' sexual interests, alternative possible motivations for their offending, and the extent of the doctors' rehabilitation, substantiated their conclusions that the doctors were unlikely to reoffend. Although it was reasonable for these decision-makers to seek to maintain the doctors' privacy, they also needed to reassure the public that it would be protected in circumstances where they permitted the doctors to continue practising medicine.

The panel's reasons for decision in *Wingate* indicate that the expert witnesses did not in fact support its finding that, despite the doctor's sexual interest in young people, he would be disinclined to reoffend.[175] The panel stated that it accepted health professionals' 'evidence' that Wingate 'is unlikely to commit a hands-on offence in the context of his medical practice',[176] but also noted that those practitioners warned the panel against making such an assessment on the basis of the available evidence.[177] This panel's conclusion is especially troubling given that it recognised that the doctor 'had a strong hebephilic interest'[178] and downloaded child pornography for 'sexual gratification',[179] and, as noted above, was concerned that he 'may have in fact been indulging his hebephilic inclinations in more than downloading child pornography'.[180]

It was reasonable for the panel in *Black* to rely on several health professionals' testimonies to find that this doctor was 'not a paedophile'[181] and his attraction to child pornography was attributable to a 'distorted preoccupation' with his experiences as a victim of child sexual abuse and the psychological harm it caused him.[182] Nevertheless, the panel did not indicate whether, and if so how, it reconciled the experts' views that Black's experience of further psychiatric treatment for these issues would 'have the important protective effect of reducing any likelihood of repetition of the conduct',[183] with the fact, about which it expressed 'some concern', that Black's 'offending occurred after he had already

174 *Stephanopoulos* (n 13) [29], [37] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Simring* (n 22) [27] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

175 *Wingate* (n 24) [82], [89] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

176 Ibid [89].

177 Ibid [83].

178 Ibid [82]. See also ibid [57].

179 Ibid [88].

180 Ibid [82].

181 *Black* (n 6) [11] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

182 Ibid [10].

183 Ibid [50]. See also ibid [16], [54].

received a period of counselling'.[184]

The expert evidence in *Bonney* similarly indicated that the doctor 'presented a minimal risk of recidivism' because psychological disturbances other than the doctor's sexual interest in young people accounted wholly for his offending. (In the context of 'a history of moderate depression', Bonney was said to have 'developed compulsively-driven usage of internet sites including those displaying pornographic images' that 'at no time provided [him] with any sexual arousal or gratification').[185] Yet, in contrast to the other panels, to reach a prediction about the doctor's likelihood of reoffending, the panel seemingly relied on the testimony of only one health professional — Bonney's 'consultant psychologist' — and did not indicate if he had expertise in treating and assessing sexual offenders.[186] Further, the panel did not clarify whether, and if so how, this witness's evidence supported its apparent assumption that Bonney's continued receipt of psychological or psychiatric treatment for the issues that drove him to commit child pornography offences could ensure that he did not reoffend.[187]

Only the panels in *Simring* and *Stephanopoulos* reassured readers of their reasons for decision that the expert evidence — comprising testimonies from multiple health practitioners in each case, some of whom were called as witnesses specifically for their expertise in assessing sexual offenders — about the doctors' sexual interests and other motivations for their offending strongly supported their predictions that the doctors would probably not reoffend.[188] The panel in *Simring* acknowledged that the experts believed that the doctor had an ongoing 'hebephilic interest, an interest in pubescent girls',[189] and 'still fantasises about young, adolescent girls'.[190] Nevertheless, it noted the opinion of a psychiatrist whom Simring consulted that the doctor's sexual interest was 'behavioural rather than reflective of a psychiatric illness',[191] so 'any risk of [him] re-offending depends on whether he can curb his behaviour'.[192] This panel referred also to the testimony of Simring's treating psychologist who confirmed that the doctor 'had used the internet to access pornography as a means of dealing with anxiety and symptoms of depression',[193] but, through therapy, had acquired the capacity to avoid a recurrence of this conduct: he had 'learned techniques to reduce triggers

184 Ibid [55].

185 *Bonney* (n 18) [3] (Deputy President Kingham).

186 Ibid.

187 Ibid [3], [5]–[6].

188 *Simring* (n 22) [27], [31], [49]–[50] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Stephanopoulos* (n 13) 3, [161], [173] (Dr Freckelton, Dr Mukhtar and Mr Russell).

189 *Simring* (n 22) [28] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

190 Ibid [50].

191 Ibid [28].

192 Ibid [27].

193 Ibid [23].

that might lead to his accessing pornography'.[194]

The panel in *Stephanopoulos* noted the 'uncontradicted and unanimous evidence from highly reputable mental health professionals … that Dr Stephanopoulos is not a paedophile'.[195] Yet, as it was concerned that Stephanopoulos's sexual interest in young people had motivated his offending and could indicate his potential to reoffend, this panel outlined the lengths it went to in order to satisfy itself that the witnesses were thoroughly 'cross-examined … about [their] tests … clinical examinations … the methodology that underlies their opinions and alternative inferences that could be drawn from the data'.[196] Disbelieving Stephanopoulos's claim that he had never been sexually interested in children, the panel documented that it recalled Stephanopoulos's treating psychiatrist to explain why he was convinced — as was Stephanopoulos's treating psychologist and a forensic psychologist who examined him — that the doctor was unlikely to reoffend despite his sexual interest and denial of that interest.[197] The panel also referred to those practitioners' explanations of how strategies that Stephanopoulos had developed could prevent him from reoffending.[198]

3 *The Doctor's Insight*

In *Stephanopoulos*, *Black*, *Simring* and *Wingate*, though not in *Bonney*, the panels interpreted evidence (which in *Stephanopoulos* and *Simring* was provided by expert witnesses) of the doctors' recognition of factors that led to their offending, their need for treatment, and the seriousness of their offences and their impact — which the first three of those decision-makers described as 'insight' — as another sign of the practitioners' low likelihood of reoffending and a reason to maintain their medical registration.[199]

It is plausible that the doctors' understandings of the reasons for their offending, and of the potential for mental health professionals to help them resist any urge to reoffend, reflected the success of psychological and/or psychiatric treatment in reducing their probability of recidivism, as well as their capacity for further rehabilitation. In addition, the experience of having their offences uncovered and publicised may have prompted the doctors to recognise the depravity of their crimes, their effects on the child victims of pornography, and the dissonance between such offending and their professional role. The doctors' acquisition of

194 Ibid [24].

195 *Stephanopoulos* (n 13) [161] (Dr Freckelton, Dr Mukhtar and Mr Russell).

196 Ibid [173].

197 Ibid [23]–[24], [33], [41], [61]–[64], [153], [171]–[172].

198 Ibid [51]–[53], [57]–[58], [170]–[173].

199 Ibid 3, [37], [39]–[40], [51], [53], [63], [125], [169]; *Black* (n 6) [11], [16], [31], [54] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Simring* (n 22) [24], [29]–[30], [106], [110] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); [29]–[30], [106], [110]; *Wingate* (n 24) [86], [89] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Bonney* (n 18).

insight in this sense could also have assisted with their rehabilitation and reduced their likelihood of reoffending. The practitioners probably appreciated the nature of their crimes at least to some degree when they committed them, but during their offending may have convinced themselves that their crimes were victimless. In seeking to predict the doctors' risk of recidivism, it seems that the panels took into account the doctors' insight alongside evidence of their responses to psychological and/or psychiatric treatment. It was important for them to do so, given that, as Stephanopoulos's treating psychiatrist testified, 'as we see with other forms of addictive behaviour, awareness [of the criminality of behaviour] doesn't necessarily guarantee that people will avoid engaging in [it]'.[200]

4 *The Doctor's Remorse*

Another reason for the panels' conclusions in *Black* and *Stephanopoulos* that the doctors had a low likelihood of recidivism, and therefore that they did not need to deregister them to protect the public, was their assessments that they had demonstrated 'remorse'.[201] Yet it was not apparent why the panel in *Black* inferred from the facts that Black 'self-reported to the Board [after he had been charged with possession of child pornography], made early admissions in both the criminal and the disciplinary proceedings and cooperated with the Board' that the doctor was remorseful.[202] A more compelling interpretation of this behaviour is that Black hoped thereby to lessen the severity of sanctions that he would receive. The panel included within its reasons for decision the parties' agreed statement of facts, which noted that a psychologist who conducted two assessments of the doctor 'reported that Dr Black expressed to him a deep sense of remorse … for his conduct'.[203] That psychologist also reported that '[h]e felt that Dr Black was a low risk of re-offending'.[204] Nevertheless, the panel did not indicate whether the psychologist in fact believed that Black was remorseful, if this influenced his opinion that Black was unlikely to reoffend, or whether the panel relied on the psychologist's report in finding that Black was remorseful.

The panel in *Stephanopoulos* found that this doctor was remorseful based on evidence provided by Stephanopoulos's friends and associates, and its own impressions of him.[205] There are, however, no reliable measures to draw on to assess whether an offender is genuinely remorseful, feigning this emotion, feeling sorry for having his/her crimes detected rather than for committing them, or

200 *Stephanopoulos* (n 13) [60] (Dr Freckelton, Dr Mukhtar and Mr Russell).

201 Ibid [80]–[81], [83], [169], [173]; *Black* (n 6) [54] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

202 *Black* (n 6) [54] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

203 Ibid [16].

204 Ibid.

205 *Stephanopoulos* (n 13) [80]–[81], [83], [169], [173] (Dr Freckelton, Dr Mukhtar and Mr Russell).

exhibiting some other emotion altogether.[206] Indeed, some research suggests that it is easy to misinterpret an offender's shame — which can actually be associated with an increased risk of reoffending — as being a sign of his/her remorse, and therefore make an inaccurate prediction about his/her likelihood of recidivism.[207]

E *The Doctor's Behaviour Following Detection of His Offences*

A further variation between the panels' decision-making was that only those who presided over the hearings in *Black*, *Wingate* and *Simring* attached significance to the doctors' behaviour following law enforcement bodies' detection of their offences.[208] These panels did not always give reasons, or the same explanations as one another, for the relevance of this matter to their consideration of which determinations were required to protect the public. Moreover, some of the reasons that they did provide were unconvincing.

It is unclear why the panel in *Black* regarded the doctor's abstention from reoffending between the time that the police investigated his crimes and his matter came before it as a factor weighing against the need to deregister him.[209] Black's behaviour was possibly motivated at least in part by his concern about his pending disciplinary proceeding and his awareness of the scrutiny of him at that time. Consequently, this conduct did not definitively indicate Black's likelihood of reoffending and should have been irrelevant to the panel's consideration of which determinations it needed to make to protect the public. The panel's assumptions that Black's admission of his crimes and compliance with criminal and disciplinary processes reflected his 'insight and remorse',[210] and were thus factors supporting his continued registration,[211] were also questionable. These matters do not appear to have demonstrated Black's insight in the sense that he appreciated the gravity of his conduct — beyond the fact that he had committed

206 Susan A Bandes, 'Remorse and Criminal Justice' (2016) 8(1) *Emotion Review* 14, 15–17; Michael Proeve and Steven Tudor, *Remorse: Psychological and Jurisprudential Perspectives* (Ashgate, 2010) 48–9; Mirko Bagaric and Kumar Amarasekara, 'Feeling Sorry?: Tell Someone Who Cares' (2001) 40(4) *Howard Journal of Criminal Justice* 364, 365; Rocksheng Zhong et al, 'So You're Sorry? The Role of Remorse in Criminal Law' (2014) 42(1) *Journal of the American Academy of Psychiatry and the Law* 39, 43, 46; Rocksheng Zhong, 'Judging Remorse' (2015) 39(1) *New York University Review of Law and Social Change* 133, 134.

207 Bandes (n 206) 15, 17. The role of remorse as a mitigating factor in sentencing decisions has in fact been criticised for these reasons and because it has been found that judges do not all look for the same indicators of remorse as one another, they define the emotion of remorse in different ways from each other, and insufficient research has been conducted to determine whether there is a correlation between any apparent signs of offenders' remorse and their probability of reoffending: Proeve and Tudor (n 206) 92; Bagaric and Amarasekara (n 206) 364, 371–2, 375; Zhong (n 206) 135–7, 145, 163, 172; Zhong et al (n 206) 43, 46; Bandes (n 206) 14–16.

208 *Black* (n 6); *Wingate* (n 24); *Simring* (n 22).

209 *Black* (n 6) [54] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

210 Ibid.

211 Ibid [12], [54].

crimes — and thus his reduced risk of reoffending. As discussed above, Black's desire to encourage decision-makers to impose only lenient penalties on him may have been a more likely explanation of this behaviour than his remorse. Under the *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic), Black was required to give the MBA written notice that he had been charged with and convicted of the offences,[212] so it also seems unjustifiable for the panel to have maintained his registration for the reason that he merely complied with this statutory requirement.

The panel in *Wingate* similarly attached weight to the extent of the doctor's candour and cooperation with authorities following the detection of his offences, but it did not articulate the same reasons for doing so as the panel in *Black*.[213] This decision-maker actually gave no reason for treating the fact that Wingate 'pleaded guilty to the offences with which he was charged' as a matter supporting his continued registration.[214] It would, however, have been prudent for this panel to have explained the relevance of this matter to its assessment of which determinations it needed to make to protect the public, especially given that there was seemingly no evidence that Wingate's plea reflected his diminished risk of reoffending. The panel may have sought to reward the doctor for his honesty because doing so could have encouraged other offenders to plead similarly and his plea relieved the prosecution of the need to prove its case. While it would help protect the public if the panel's determinations did in fact incite other doctors who commit child pornography offences to admit them, it was unnecessary for the panel to credit Wingate for saving the state any expense. Wingate's plea would already have been treated as a mitigating factor in his criminal proceeding,[215] and the HCCC did not need to establish whether or not Wingate committed the crimes with which he was charged because the court's finding was simply treated as evidence for the disciplinary proceeding.[216]

This panel did, however, provide a valid reason for its decision to reprimand Wingate 'for his failure to provide the Medical Board with accurate information concerning … the nature of the offences which he committed'.[217] (Wingate had lied to the Board and a psychiatrist to whom it referred him about the content and volume of pornographic material that he had downloaded).[218] The panel's determination could have helped to protect the public because it reinforced, as Basten JA described it on appeal, the 'public interest'[219] of a doctor's 'duty

212 *National Law (Victoria)* (n 11) ss 130(1), (3)(a)(i)–(ii).

213 *Wingate* (n 24); *Black* (n 6).

214 *Wingate* (n 24) [86] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

215 Bagaric and Amarasekara (n 206) 366.

216 Forbes (n 43) 215–16 [12.69].

217 *Wingate* (n 24) [95] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

218 Ibid [58], [60]–[61], [63].

219 *HCCC v Wingate* (n 77) 334 [45].

of full and frank disclosure of misconduct'.[220] The panel in *Wingate* stated, 'it would be highly undesirable if practitioners … who are under investigation … were to proceed on the basis that untruths can be told about the circumstances of offending … without such conduct itself having consequences should the contrary information come to light'.[221]

In *Simring*, the panel reprimanded the doctor for contravening his statutory obligation to notify the NSW Medical Board of his convictions.[222] This determination could have protected the public by encouraging other doctors to inform regulators of the medical profession promptly if they are convicted of crimes. The panel did not, however, articulate that this was its reason for reprimanding Simring.

Stephanopoulos and Bonney were also less than candid after their offences were detected, but the panels in these cases explained why they believed that they did not need to make determinations in response to this behaviour in order to protect the public. Stephanopoulos denied his sexual interest in young people, but, as noted above, the panel indicated that it was reassured by expert evidence that this did not reflect his increased risk of reoffending.[223] Although Bonney breached voluntary undertakings that he had made to the MBA, the panel stated that it accepted that those contraventions had been unintentional.[224]

F *Demand for the Doctor's Services*

The panels in *Wingate*, *Black* and *Stephanopoulos* considered that they needed to balance the objective of protecting the public with the community's demand for the doctors' services.[225] Matters that therefore convinced those decision-makers to maintain the doctors' registration included, respectively, that: Wingate worked in remote areas in a speciality of ophthalmology that benefited older patients and in a pro bono scheme for indigenous patients, and his colleagues and patients attested to his exemplary medical practice;[226] Black's colleagues wrote to the panel about 'his skill as a cardiologist, his teaching and research, the clinical services he has provided over many years … and his ongoing importance

220 Ibid 333 [43].

221 *Wingate* (n 24) [85] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

222 *Simring* (n 22) [11], [86], [94]–[96], [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

223 *Stephanopoulos* (n 13) [171] (Dr Freckelton, Dr Mukhtar and Mr Russell).

224 *Bonney* (n 18) [7] (Deputy President Kingham).

225 *Wingate* (n 24) [76]–[77], [86], [90] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier); *Black* (n 6) [54] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Stephanopoulos* (n 13) [113], [164], [174], [181] (Dr Freckelton, Dr Mukhtar and Mr Russell).

226 *Wingate* (n 24) [76]–[77], [86], [90] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

to the community as a cardiologist';[227] and health professionals gave evidence of Stephanopoulos's outstanding clinical skills, commitment to his work as a neurosurgical registrar, and capacity 'to contribute [a great deal] to the health of the Victorian community'.[228]

The *National Law* states that one of the NRAS's objectives is 'to facilitate access to services provided by health practitioners in accordance with the public interest',[229] and there is clearly a public interest in ensuring that high level medical care is available to patients.[230] Nevertheless, it is appropriate that protecting the public is the principal aim of disciplinary proceedings and determinations and, as Katie Elkin observes, 'extreme caution should still be exercised in allowing supply considerations to influence disciplinary decision-making, lest we risk compromising the fundamental regulatory purpose of public protection'.[231] When disciplinary panels have regard to demand for the services of a doctor who has committed child pornography offences, they may fail to prioritise the protection of the public. Further, they could unfairly discriminate against: doctors who practise in well-serviced specialities or locations (regardless of the doctors' relative risk, a general practitioner might receive a harsher determination than a neurologist, for instance, because there are fewer neurologists than general practitioners); and patients who require care from a doctor who specialises and/or works in an area with few competitors. In any event, especially given that there are not major shortages of doctors in Australia,[232] it is difficult to argue persuasively that it is necessary to maintain the registration of doctors who have committed child pornography offences for the purpose of meeting patient demand.

G *Conditions on the Doctor's Registration*

All the decision-makers considered whether the public would be protected if they permitted the doctors to continue practising medicine, but imposed conditions on their registration. The panels believed they could achieve this objective, in the matters of *Stephanopoulos*, *Simring* and *Black*, by prohibiting the doctors from

227 *Black* (n 6) [17] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

228 *Stephanopoulos* (n 13) [174] (Dr Freckelton, Dr Mukhtar and Mr Russell). See also *Stephanopoulos* (n 13) [66]–[69], [72]–[73], [75], [77], [79].

229 *National Law* (n 32) s 3(2)(e). Although the panel in *Black* (n 6) applied the *National Law (Victoria)* (n 11), it did not refer to this provision when asserting that the apparent 'public interest in Dr Black continuing to practise … needs to be weighed in the balance of considerations in protecting the public': *Black* (n 6) [54] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

230 Katie Elkin, 'Medical Practitioner Regulation: Is It All About Protecting the Public?' (2014) 21(3) *Journal of Law and Medicine* 682, 695, 697.

231 Ibid 699.

232 Anna Patty, 'Doctor Oversupply Leads to Calls to Halt Imports', *The Age* (Melbourne, 7 January 2017) 3.

treating patients under 18 years of age,[233] and in Bonney's and Wingate's cases by allowing them to treat minors only in the presence of a chaperone.[234]

The Court of Appeal in *HCCC v Wingate* appropriately rejected the HCCC's argument that the need to impose this condition on the doctor's registration 'demonstrated a lack of faith in the practitioner's character and future conduct which was inconsistent with his continuing entitlement to practice [sic] medicine'.[235] That Court in fact varied the condition to prohibit Wingate from treating patients under 18 years of age in any circumstances,[236] but Basten JA explained that '[c]onditions may be imposed … for various purposes',[237] and not only to prevent a doctor's misconduct, including for 'maintenance of confidence of the public, both in the particular doctor and in the profession generally'.[238]

Indeed, the panels in *Simring* and *Stephanopoulos* imposed conditions on the doctors' registration preventing them from treating patients under 18 years of age, even though they believed it unlikely that they would reoffend (and they noted that the appearance of the doctors' names on sex offender and child protection registers respectively, as a consequence of their convictions, already effected the same prohibition).[239] The panel in *Simring* considered that its condition could help 'maintain public confidence in the profession' by reassuring 'a member of the public [who] being aware of [Simring's] convictions but not … the background details of the case may not feel as confident' as the health professionals who testified in the proceeding that Simring's 'risk of further offending' was low.[240] In *Stephanopoulos*, the panel asserted that 'it would be inappropriate … for [Stephanopoulos] to work with children', and considered the condition would send 'a firm message … to him and to any other medical practitioner minded to download … child pornography … that they will face condign consequences

233 *Stephanopoulos* (n 13) [182] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Simring* (n 22) [58], [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Black* (n 6) 2, [51] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

234 *Bonney* (n 18) 1, [6] (Deputy President Kingham); *Wingate* (n 24) 1, [95] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

235 *HCCC v Wingate* (n 77) 329 [26] (Basten JA). See also *HCCC v Wingate* (n 78) 338 [62], 339 [66]. In its appeal, the HCCC referred to *Litchfield* (n 71) 639, in which the NSW Court of Appeal stated that 'the necessity for imposing such conditions [prohibiting a doctor from treating female patients except in the presence of a female chaperone] on the [doctor's] registration demonstrated that he was unfit to practise medicine'. For a discussion of Basten JA's interpretation of *Litchfield* (n 71), see Kathy Shats and Thomas Faunce, 'Medical Professionals Convicted of Accessing Child Pornography: Presumptive Lifetime Prohibition on Paediatric Practice? Health Care Complaints Commission v Wingate' (2008) 15(5) *Journal of Law and Medicine* 704, 707.

236 *HCCC v Wingate* (n 77) 342 [78] (Basten JA). For an explanation of the Court of Appeal's decision to vary the panel's order in *Wingate* (n 24), see Freckelton (n 131) 508.

237 *HCCC v Wingate* (n 77) 338 [62].

238 Ibid 339 [66].

239 *Simring* (n 22) [9], [60] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Stephanopoulos* (n 13) [11], [175], [180] (Dr Freckelton, Dr Mukhtar and Mr Russell).

240 *Simring* (n 22) [59] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger).

from this Board … if they do so'.[241]

The panels in *Black*, *Bonney* and *Wingate* did impose conditions — in Black's case, prohibiting him from treating patients under 18 years of age and, in the other two cases, allowing them to treat minors only in the presence of a chaperone — to minimise the risk of the doctors committing contact sexual offences against young people[242] (though the panel in *Wingate* assessed this doctor's risk to be 'very small').[243] Maintaining the doctors' registration to practise medicine in these circumstances might only be justified if there were no opportunities for the doctors to breach the conditions. Yet Ron Paterson's 2017 review of the use of chaperone conditions found that they 'are not wholly effective to prevent patients being exposed to harm and, in some cases, sexually assaulted',[244] and '[p]redatory practitioners can evade chaperone conditions, causing harm to patients and loss of public confidence in health professions and their regulators'.[245]

These cases predated Paterson's report, but it was appropriate for the panels to have considered the risk of the doctors contravening the conditions. Although it is regulators' responsibility to monitor doctors' compliance with conditions, the panel in *Bonney* noted that it was reassured by the 'detailed information' that the MBA provided to the tribunal 'about how it [would] monitor the conditions'.[246] Nevertheless, other panels' wording of certain conditions could have heightened the risk to which the public was exposed where they permitted the doctors to continue practising medicine. One such example is the condition on Black's registration that permitted him to treat a minor 'in a case of a medical emergency', without specifying who assesses whether the situation constitutes a medical emergency and how this is determined.[247]

All of the panels also imposed conditions on the doctors' registration requiring them to undergo psychological or psychiatric treatment, which they believed

241 *Stephanopoulos* (n 13) [177] (Dr Freckelton, Dr Mukhtar and Mr Russell).

242 *Black* (n 6) [16], [51] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Bonney* (n 18) [2], [6], [8] (Deputy President Kingham); *Wingate* (n 24) [70]–[71], [89], [94] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

243 *Wingate* (n 24) [94] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

244 Ron Paterson, *Independent Review of the Use of Chaperones to Protect Patients in Australia* (Report, February 2017) <https://nhpopc.gov.au/chaperone-review/> 8.

245 Ibid 10. See also Tessa Hoffman, 'Call to Abolish "Failing" Medical Chaperone System', *Australian Doctor* (online, 3 August 2016) <www.australiandoctor.com.au/news/latest-news/calls-to-abolish-failing-medical-chaperone-model>; Helen Kiel, 'Drugs, Sex and the Risk of Recidivism: Psychiatry in the Witness Box' (2006) 13(1) *Psychiatry, Psychology and Law* 132, 139.

246 *Bonney* (n 18) [7] (Deputy President Kingham).

247 *Black* (n 6) 2 (Presiding Member Wentworth, Member Fabris and Member Shanahan). See also *Simring* (n 22) [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger) in which the panel imposed a condition permitting the doctor to treat a person under 18 years of age in a medical emergency, too, but sensibly provided in the condition that it would only apply 'where it is not possible or reasonable to have a patient with a serious or life-threatening or urgent condition treated by another medical practitioner or transferred to the nearest hospital'. This condition also required Simring to notify the NSW Medical Board within seven days if he treated a minor in these circumstances.

would protect the public,[248] for the reason that such treatment could rehabilitate the doctors, thereby reducing their risk of reoffending.[249] Health practitioners might have been able to assist the doctors to address the motivations for their offending, and develop and maintain strategies to avoid reoffending. Nevertheless, as noted above, it was not apparent that all the panels had obtained strong assurances from the expert witnesses that such treatment would most probably ensure that the doctors did not reoffend. For instance, there was no suggestion that Wingate had lost his sexual interest in young people and the expert witnesses could not confidently predict that he would refrain from acting on that attraction;[250] Black's receipt of counselling preceded some of his offending;[251] and the panel in *Bonney* (unlike the panels in *Simring* and *Stephanopoulos*) did not refer to any evidence suggesting that therapy could reduce Bonney's likelihood of reoffending.[252]

IV PROPOSAL FOR REFORM

This article proposes that Australian legislatures and regulators of the medical profession provide guidance to parties in preparing for, and disciplinary panels for their decision-making in, proceedings concerning doctors who have committed child pornography offences. The proposed advice would entail: a clear direction that protecting the public is the principal objective of disciplinary proceedings and determinations, and an explanation of that goal; specification of matters that decision-makers could take into account in seeking to achieve it in these cases; and a recommendation that decision-makers document their consideration of those factors in their reasons for decision.

A *Proposed Objectives of Disciplinary Proceedings and Determinations*

Although the *National Law* as enacted in each Australian jurisdiction refers to the protection of the public, it does not explicitly indicate that this is the central objective of disciplinary hearings and determinations.[253] The article proposes that this legislation be amended so that it states that this is the case and also that,

248 *Black* (n 6) [49]–[50] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Simring* (n 22) [113] (Ainslie-Wallace DCJ, Dr Anderson, Dr Sammut and Member Ettinger); *Stephanopoulos* (n 13) [180], [182] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Bonney* (n 18) 3, [6] (Deputy President Kingham); *Wingate* (n 24) [95] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

249 See, eg, *Stephanopoulos* (n 13) [180] (Dr Freckelton, Dr Mukhtar and Mr Russell); *Black* (n 6) [50] (Presiding Member Wentworth, Member Fabris and Member Shanahan); *Wingate* (n 24) [94] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

250 *Wingate* (n 24) [83] (Rein DCJ, Dr Giuffrida, Dr Ng and Member Napier).

251 *Black* (n 6) [55] (Presiding Member Wentworth, Member Fabris and Member Shanahan).

252 *Bonney* (n 18).

253 *National Law* (n 32) s 3(2)(a); *National Law (NSW)* (n 34) s 3A; *Health Practitioner Regulation National Law Act* (n 34) s 13, inserting *National Law* (n 32) s 3A.

encapsulated within this goal, are the aims of protecting patients from threats to their health and safety, and upholding the reputation and ethical and professional standards of the medical profession and public confidence in it. This change would reinforce that all of those objectives are important and intertwined, and that decision-makers must make determinations to achieve one or more of them.

In addition, guidelines produced by regulators of the medical profession could confirm that punishing doctors is not decision-makers' objective, but they are entitled to make determinations that have this effect if they are necessary to achieve the goal of protecting the public. Disciplinary panels could also be advised that it might only be in exceptional circumstances that a lenient determination would protect the public, according to the proposed definition of this objective of disciplinary proceedings, where doctors have committed child pornography offences.

B *Proposed Matters for Decision-Makers to Consider in Reaching Determinations to Protect the Public*

The article suggests that regulators of the medical profession specify matters to which decision-makers might have regard, as well as some factors on which they should probably place no weight, when identifying which disciplinary determinations they need to make to achieve the objective of protecting the public in cases where doctors have committed child pornography offences. If these guidelines are framed as recommendations, they will not artificially constrain decision-makers' discretion or result in undue difficulties if parties do not present material at a hearing that addresses all of the matters noted in them. Yet if disciplinary panels, in exercising their discretion, to a significant extent consider the same suite of factors that are germane to their aims, they will reach decisions that uphold the rule of law by virtue of their consistency, and protect the public. Importantly, application of these matters will help decision-makers ascertain whether the circumstances of a particular case are exceptional and more lenient determinations are warranted.

Specifically, the article recommends that decision-makers be advised that it is unnecessary for them to take into account evidence of the doctors' virtues and demand for their services because, for the reasons set out above, those matters will not help them decide which determinations are required to protect the public. The discussion below outlines factors that, the article proposes, parties and disciplinary panels could be encouraged to consider.

1 *The Doctor's Conviction and Sentence*

It is recommended that regulators of the medical profession advise disciplinary decision-makers to consider whether the fact of the doctors' convictions for child

pornography offences, the nature of the criminal penalties that the doctors have received and, if applicable, the inclusion of their names on sex offender registers, are incompatible with their continued unrestricted registration to practise medicine. They could also be directed to take into account the extent to which the doctors' sentences have already protected the public because this will assist them in identifying which further measures are still required to achieve that goal. Such guidance could reinforce that it may be legitimate for disciplinary decision-makers to impose harsh determinations where the doctors' criminal sanctions — for instance, a prison sentence — have ensured the community's safety, but not sufficiently upheld the reputation and standards of the medical profession and public confidence in it. Further, disciplinary panels might be advised that, if their determinations have an adverse impact on the doctors' careers, they could enhance the deterrent effect, especially on the doctors and the medical profession, of criminal penalties that the doctors have received.

2 *The Nature of the Doctor's Offence*

The article proposes that, in seeking to identify which determinations are necessary to protect the public, disciplinary decision-makers could be encouraged to take into account the nature of the offences that doctors have committed. It also recommends that they be guided to characterise such conduct consistently, and use the same measures as one another to assess its gravity.

As noted above, the definition of 'professional misconduct' in the *National Law*, as it is enacted in all Australian jurisdictions except NSW, includes 'conduct of the practitioner … that is inconsistent with the practitioner being a fit and proper person to hold registration'.[254] This definition will probably help improve consistency in findings about doctors who have committed child pornography offences to some extent. It does not require decision-makers to evaluate the doctors' personal morality, but rather to focus on whether their behaviour conforms to the expectations of the medical profession and the community about the appropriate conduct of a registered medical practitioner.

Decision-makers' focus on the seriousness of doctors' offences will also enable them to justify imposing harsher determinations particularly where doctors did not commit the crimes at work or during medical practice, and/or the practitioners are found to have a low probability of recidivism. Indeed, the panel observed in *Stephanopoulos*,

> there is little guidance for this Panel as to the determination it should impose where it is … satisfied that a practitioner is unlikely to offend and yet his or

254 *National Law* (n 32) s 5 (definition of 'professional misconduct'). Cf *National Law (NSW)* (n 34) ss 139B–C: the definition of 'unsatisfactory professional conduct' in this statute does not refer to a health practitioner's character or fitness to practise.

> her behaviour is grossly unacceptable by reference to contemporary community standards and has brought the profession into undeserved disrepute.[255]

Regulators of the medical profession might advise decision-makers that, to ascertain the gravity of a doctor's crime and thus fitting determinations to make, they could assess the degree of harm that it has caused to the child victims of the pornography, the medical profession and the community in general. They might also guide decision-makers to consider various aspects of a child pornography offence that may indicate the harm for which the doctor is responsible. For instance, decision-makers could be recommended to take into account matters that courts consider in sentencing for child pornography offences, including: the volume of images collected by a doctor, with a larger collection indicating a more grave offence;[256] the length of time for which the doctor possessed the material; and the frequency of the doctor's access to the material.[257]

Decision-makers could also be directed to consider the location/s in which a doctor possessed and/or accessed the child pornography. An offence might be deemed more serious if it was committed where others could witness it, and especially at a place where medicine is practised. Nevertheless, decision-makers could be advised to find that, even if the doctor's crime was not committed at work, it will have a sufficient connection to medical practice to warrant it being considered professional misconduct, and determinations being made in response to it, if it indicates a potential threat to patients' health or safety and/or undermined the reputation, standards and/or public confidence in the medical profession.

Particularly important may be that decision-makers are advised to have regard to any classification that courts have made of the degeneracy of material that the doctors accessed or possessed (they are entitled to consider the courts' records of evidence where relevant, and regard the courts' findings as evidence for their functions).[258] Where courts have not evaluated the heinousness of the pornography, decision-makers might be directed to apply an objective scale to assess this (some consider the *Oliver* typology 'more precise' than the COPINE scale, but other taxonomies have been developed more recently in Australia and overseas that could be drawn upon, such as the Child Exploitation Tracking System).[259] Regulators of the medical profession could guide decision-makers to consider specifically whether, according to these measures of the depravity of

255 *Stephanopoulos* (n 13) [150] (Dr Freckelton, Dr Mukhtar and Mr Russell).

256 Warner (n 112) 386, 388–9.

257 Ibid 386, 390.

258 Forbes (n 43) 215–16.

259 Warner (n 112) 386. See, eg, 'Sexual Offences: Definitive Guideline' (n 148) 76–7; the Child Exploitation Tracking System and Interpol categorisation system: Queensland Sentencing Advisory Council, *Classification of Child Exploitation Material for Sentencing Purposes* (Consultation Paper, March 2017) <www.sentencingcouncil.qld.gov.au/__data/assets/pdf_file/0020/512714/QSAC-CEM-consultation-paper.pdf> 29; Judicial College of Victoria, *Victorian Sentencing Manual* (Web Page, 13 March 2020) 336–7 [24.2.2.3] <https://resources.judicialcollege.vic.edu.au/article/669236>.

child pornography, the material that is the subject of the doctors' offences is so grossly immoral that they could not protect the public by maintaining the doctors' registration to practise medicine (because, to do so, would severely injure the reputation and standards of and public confidence in the medical profession).

3 *Risk of the Doctor Reoffending*

It is critical that decision-makers are advised to assess and take into account the risk of doctors who have been convicted of child pornography offences committing further child pornography crimes and contact sexual offences. Indeed, it would be reasonable for regulators of the medical profession to suggest to decision-makers that, if they believe that the likelihood of such a doctor's recidivism is high, prima facie, to protect the public, the necessary determination will be cancellation of the doctor's registration to practise medicine. The article recommends that decision-makers be encouraged to consider expert evidence concerning the particular doctors' risk of recidivism, inquire into those witnesses' credit, and call expert witnesses (which, as noted above, they are empowered to do) if they are not satisfied that the parties have presented sufficient evidence in this regard.

Panels could be advised that their reasons for decision may seem more cogent if they refer to the opinion of more than one health practitioner with expertise in assessing and treating sexual offenders, whose evidence examines particular matters. They might consider whether the doctors evince characteristics that have been associated with child pornography offenders' increased or decreased risks of recidivism (such as prior convictions, especially for contact sexual offences, and certain aspects of their psychological profiles, for instance, empathy for the victims of pornography, self-control, and sexual attraction to children). This evidence could also delve into the degree to which the impact of factors that have been linked to a greater likelihood of child pornography offenders reoffending may be reduced in the case of doctors due to the effect on their careers of the detection of their crimes, and the consequences that have flowed from this, and their realisation of the discord between the nature of their vocation and those offences. Expert evidence in such cases might deal with the reasons for the doctors' offending, including any psychological disturbances or illnesses that may have motivated it, and the extent to which the doctors demonstrate insight, in the sense that they understand the factors that led to their offending, their need for treatment, the seriousness of their crimes and their impact on the child victims of pornography. In addition, such evidence could consider whether the doctors have received psychiatric and/or psychological treatment, and if it has assisted with their rehabilitation by helping them to identify triggers for their offending and use strategies to prevent them from reoffending.

4 *The Doctor's Behaviour Following Detection of His/Her Offences*

The article recommends that regulators of the medical profession advise decision-makers that, in making determinations, it may be appropriate for them to take into account doctors' behaviour following detection of their crimes if they are able to indicate how doing so can help to protect the public. For instance, they could articulate that it is necessary for them to permit evidence of doctors' cooperation and candid communication with regulatory, disciplinary and judicial authorities, or lack thereof, to influence their choice of determinations in order to encourage other doctors to assist and be forthright with them, or to discourage practitioners from behaving otherwise. In addition, where decision-makers attribute doctors' uncooperativeness or dishonesty to their failure to understand, and/or incapability of fulfilling, their obligations to such authorities, the profession and/or the public,[260] they could justify making determinations to protect the public from the threat to it that the practitioners pose for that reason.

Decision-makers might, however, be guided to exercise caution in interpreting from doctors' abstention from reoffending during the period in which they are awaiting criminal sentences and disciplinary determinations that they have a low likelihood of recidivism, as practitioners will be conscious that they are under scrutiny and that any further offending by them will probably be detected. Conversely, evidence that the doctors have committed further offences at this time, and/or denied or minimised their offending, may indicate their propensity to offend again, especially if they have already received psychological and/or psychiatric treatment.[261] Indeed, decision-makers could be directed also to consider any evidence of the effectiveness of therapy that the doctors have undertaken after the detection of their offences in rehabilitating them and reducing their likelihood of reoffending.

5 *Conditions on the Doctor's Registration*

Disciplinary panels could be advised that they can consider whether they are satisfied that the public would be protected if the doctors were permitted to continue practising medicine subject to conditions. If there is no evidence that the doctors represent a risk of committing sexual offences against adults, such conditions might prohibit them from treating patients under 18 years of age, and/or compel the doctors to receive psychological and/or psychiatric treatment for the purpose of rehabilitation. It would, however, be appropriate for decision-makers to be directed to ensure that any conditions are worded carefully to minimise opportunities for the practitioner to contravene them. Disciplinary panels could also be encouraged to consider whether the conditions are practicable, which may

260 See, eg, *Legal Services Board v McGrath (No 2)* (2010) 29 VR 325, 341 [27] (Warren CJ).

261 Seto, Reeves and Jung (n 171) 170–1.

not be the case if, for example, the offending doctor is a paediatrician or works in another medical specialty that principally involves treatment of young patients, such as Voon's area of expertise. Further, guidelines could suggest to decision-makers that they should not be satisfied that a condition requiring a doctor to receive psychological and/or psychiatric treatment will protect the public unless they receive compelling evidence from reputable health professionals with expertise in assessing and treating sex offenders confirming that it is highly likely that the doctor will be rehabilitated.

C *Proposed Requirements for Disciplinary Panels' Reasons for Decision*

It is vital that guidelines produced by regulators of the medical profession direct disciplinary decision-makers to document clearly in their reasons for decision how they have taken into account various matters. Decision-makers should be guided to prepare such reasons carefully in order to maintain the doctors' privacy to the extent that it is possible to do so, while also reassuring the community and the medical profession that they have protected the public. Explanations for disciplinary panels' decisions will be especially important where, contrary to probable public expectation, decision-makers do not deregister the doctors.[262] Decision-makers could be advised in particular that if they rely on expert witnesses' testimony to conclude that doctors represent a low risk of reoffending and, for that reason, decide not to cancel their registration, that they convey in their reasons for decision how the evidence substantiates those conclusions.

V CONCLUSION

Possessing and accessing child pornography are atypical crimes because they cause harm indirectly and yet society considers them to be deeply abhorrent.[263] Victims of those offences, where the images are not computer-generated, are children who are abused to produce the pornography. The public responds with intense emotion, including outrage and disgust, to child pornography offences.[264] This reaction is especially heightened when doctors commit child pornography

262 See General Medical Council, *Sanctions Guidance: For Members of Medical Practitioners Tribunals and for the General Medical Council's Decision Makers* (Guidance, March 2016) <www.mpts-uk.org/DC4198_Sanctions_Guidance_March_2016.pdf_67114893.pdf> 42 [147] ('*Sanctions Guidance*'): the UK's General Medical Council sensibly advises, '[i]f the tribunal decides to impose a sanction other than erasure, it is important that it fully explains the reasons and the thinking that has led it to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.'

263 Warner (n 112) 384–5.

264 For a discussion of the appropriate role of disgust in law, see Dan M Kahan, 'The Progressive Approach of Disgust' in Susan A Bandes (ed), *The Passions of Law* (New York University Press, 1999) 63; Martha C Nussbaum, '"Secret Sewers of Vice": Disgust, Bodies, and the Law' in Susan A Bandes (ed), *The Passions of Law* (New York University Press, 1999) 17.

crimes, in particular due to the faith that patients necessarily invest in doctors and the unbalanced relative power of the parties to the therapeutic relationship: the patient is vulnerable in relation to and dependent on the medical practitioner who is responsible for the patient's healthcare.[265] The community and the medical profession can thus also suffer as a consequence of the doctors' offences. The GMC has produced sanctions guidance for UK decision-makers in which it aptly observes, 'any conviction for child pornography against a registered doctor is a matter of grave concern because it involves such a fundamental breach of the public's trust in doctors and inevitably brings the profession into disrepute'.[266]

For these reasons, some may argue that the registration to practise medicine of any doctor who commits child pornography offences should be cancelled automatically. It is important that disciplinary panels ascertain which regulatory measures are required to protect the public. As this article has argued, where doctors have committed child pornography offences, unless exceptional circumstances exist, the protection of the public — according to the article's proposed definition of this objective in the disciplinary context — will probably necessitate the imposition of severe determinations, and often deregistration.[267] Such determinations can protect the public by effecting general and specific deterrence, and impeding the doctors' access to vulnerable patients, though determinations that focus on the doctors' rehabilitation may also help to ensure public safety by addressing their risk of reoffending. Details of child pornography offences and the contexts in which they are committed will vary. It is therefore recommended that decision-makers take into account the various matters that this article suggests they consider, and that they have discretion to choose from a range of cascading determinations.[268]

Australian disciplinary panels require clear direction for their decision-making in cases where doctors have committed child pornography offences. From the published cases discussed in this article, it appears that the dearth of guidance has, to date, led to panels making decisions to some extent in different ways from one another (which, as noted above, may be partly due to the material that the parties presented) and, in certain instances, on the basis of matters that do not help identify which determinations will best protect the public. Further, in some cases, they have not thoroughly or cogently articulated the reasons for their decisions.

265 Shats and Faunce (n 235) 709; Joanna Manning, 'Changing Disciplinary Responses to Sexual Misconduct by Health Practitioners in New Zealand' (2014) 21(3) *Journal of Law and Medicine* 508, 509.

266 *Sanctions Guidance* (n 262) 42 [147].

267 Indeed, consistent with the panel's view in *Stephanopoulos* (n 13), the GMC advises decision-makers, '[i]t is … highly likely that, in these cases [where doctors have committed child pornography offences], the only proportionate sanction will be erasure [from the list of registered medical practitioners]': ibid.

268 Ibid 43 [152]: the GMC also emphasises, however, that '[e]ach case should be considered on its merits and decisions should be taken in the light of the particular circumstances relating to the case'.

This article has therefore proposed that amendments be made to legislation and regulators of the medical profession produce guidelines for disciplinary panels and parties involved in proceedings concerning doctors who have committed child pornography offences. These could confirm that protection of the public is the principal goal of disciplinary proceedings and determinations, and outline the meaning of this objective and matters to which decision-makers might have regard in such cases to achieve it (the article provides examples of factors that panels could take into account, but this list is not intended to be exhaustive). They could also advise decision-makers to document in their reasons for decision how they have applied those matters. Following these recommendations could increase the consistency between disciplinary panels' decisions, and ensure that they protect the public and assure the community and the medical profession that they have done so.