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MEDICAL PROFESSIONALS CONVICTED OF ACCESSING CHILD PORNOGRAPHY – PRESUMPTIVE LIFETIME PROHIBITION ON PAEDIATRIC PRACTICE? HEALTH CARE COMPLAINTS COMMISSION v WINGATE

Health Care Complaints Commission v Wingate [2007] NSWCA 326 concerns an appeal from the New South Wales Medical Tribunal regarding its findings on professional misconduct outside the practice of medicine in relation to a doctor convicted of possessing child pornography. The latest in a number of cases on this issue in Australia, it highlights the complexity of such decisions before medical tribunals and boards, as well as the diversity of approaches taken. Considering both this case and the recent Medical Practitioners Board of Victoria case of Re Stephanopoulos [2006] MPBV 12, this column argues that Australian tribunals and medical boards may not yet have achieved the right balance here in terms of protecting public safety and the reputation of the profession as a whole. It makes the case for a position statement from Australian professional bodies to create a presumption of a lifetime prohibition on paediatric practice after a medical professional has been convicted of accessing child pornography.

INTRODUCTION

Increasingly, medical registration bodies within Australia and the United Kingdom are faced with difficult decisions relating to the registration of health care professionals convicted of child pornography offences. While recent high-profile cases in both countries have brought this issue to the media's attention, the laws, policies and disciplinary strategies utilised and adopted by the various bodies involved show that we are still far from finding a consistent approach to addressing this complex issue. The case of *Health Care Complaints Commission v Wingate* [2007] NSWCA 326 (*Wingate*), appealed to the New South Wales Court of Appeal from the New South Wales Medical Tribunal (NSWMT), is the most recent example. The issue of public confidence in the medical profession is a constant feature of the media attention paid to cases of this nature.[1] The adverse nature of the comments made suggests the right regulatory balance has yet to be achieved.

THE FACTS AND DECISION OF WINGATE

This case, on appeal from the New South Wales Medical Tribunal by the Health Care Complaints Commission (HCCC), concerned the NSWMT's decision against Dr Wingate in relation to a conviction under s 578B of the *Crimes Act 1900* (NSW) (since repealed), the charge being the possession of child pornography involving "66 images of boys apparently under the age of 16 years".[2] These images were chosen from a total of 600 found on the practitioner's external hard drive. Subsequently, 10,000 more images were found on the internal hard drive of his personal computer; however, no additional charges were made. He was fined $6,000, ordered to pay court costs and put on a good behaviour bond for a period of three years under the supervision of the New South Wales Probation and Parole Service.

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[1] For example, see, after the *Wingate* NSWMT case, AAP, "Child Porn Doctor to Continue Practising", *Sydney Morning Herald* (5 April 2007), http://www.smh.com.au/news/national/child-porn-doctor-keeps-job/2007/04/05/1175366385203.html viewed 26 February 2008; and in response to *Re Stephanopoulos* see O'Neil P, "Child Porn Doc Could Work On", *Herald Sun* (27 July 2005), http://www.news.com.au/heraldsun/story/0,21985,16062949-2862,00.html viewed 26 February 2008.

[2] *Re Wingate* [2007] NSWMT 2 at [2].

After the conviction, the Medical Board had to consider, within the framework of the *Medical Practice Act 1992* (NSW), whether any restrictions should be placed on Dr Wingate's right to practise, or whether he should be left on the register at all. Similar cases in other jurisdictions, as will be discussed below, typically approach this question initially through the concept of professional misconduct. However, s 36 of the *Medical Practice Act* (which deals with "unsatisfactory professional conduct") restricts its definition to "conduct relating to the practice or purported practice of medicine" which, if of a sufficiently serious nature, will then fall under "professional misconduct" in s 37. The NSWMT found (and this was upheld on appeal) that the particular offence of accessing child pornography in private fell outside these sections, as it did not directly relate to the practice of medicine.[3] This, it will be argued, is a highly contentious and erroneous conclusion.

Section 64 sets out the situations in which the NSWMT could suspend or deregister the practitioner:

> (1) The Tribunal may by order suspend a person from practising medicine for a specified period or direct that a person be deregistered if the Tribunal is satisfied (when it finds on a complaint about the person):
> (a) that the person is not competent to practise medicine, or
> (b) that the person is guilty of professional misconduct, or
> (c) that the person has been convicted … and the circumstances of the offence render the person unfit in the public interest to practise medicine, or
> (d) that the person is not of good character.

As Basten JA noted in *Health Care Complaints Commission v Wingate* [2007] NSWCA 326 (at [19]):

> Having abandoned its challenge to the failure to characterise the conviction as falling within the terms of s 64(1)(c), the Commission could only succeed in obtaining an order for deregistration if it made good its complaint that the practitioner was not of good character, within s 64(1)(d). (It was not suggested that paragraph (a) was engaged and no appeal was brought against the dismissal of the first complaint, which might have engaged paragraph (b).)

Regarding the possession of the images, Basten JA stated (at [13]):

> As might have been expected, there was no case presented before the Tribunal to suggest that the private possession on a home computer of child pornography said anything about the knowledge, skill or judgment possessed, or care exercised by the practitioner in the practice of medicine. Rather, the case presented was that the possession of child pornography constituted improper or unethical conduct "relating to" the practice of medicine.

The NSWMT formed the view that the relevant conduct did not fall within the definition of "unsatisfactory professional conduct" in s 36 of the *Medical Practice Act* and therefore could not constitute professional misconduct under s 37 of the Act. The Court of Appeal upheld the reasoning of the tribunal in this regard (at [14]):

> The reasoning of the Tribunal in that respect was that s 36 did not deal with "a matter that is unconnected in any way with the practice of medicine", and that the practitioner's conduct "is not professional conduct at all" … Although the definition of "unsatisfactory professional conduct" included conduct that results in the practitioner being convicted of certain specified offences, the Tribunal correctly noted that the offence in question was not one of those specified in s 36(1)(d) of the *Medical Practice Act*: indeed, no crime specified in the *Crimes Act* fell within that part of the definition.

The remaining two challenges which arose on the appeal (at [20]) concerned the orders made by the NSWMT:

> (1) that Dr Wingate's practice be restricted in that he must not attend upon a person of less than 18 years of age without the presence of a nurse or other person approved by the Medical Board;
> (2) that Dr Wingate continue in treatment with a clinical psychologist or psychiatrist of his choosing at a frequency determined by the therapist and for Dr Wingate to consent for the therapist to notify the Board of termination of treatment. Such treatment is to continue until it is reviewed by the Board;
> (3) that Dr Wingate be reprimanded in respect of his downloading of pornographic images of children in the period 1998-2004;

[3] *Re Wingate* [2007] NSWMT 2 at [12]; *Health Care Complaints Commission v Wingate* [2007] NSWCA 326 at [14].

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(4) that Dr Wingate be reprimanded for his failure to provide the Medical Board with accurate information concerning his sexual orientation and the nature of the offences which he committed;
(5) that Dr Wingate pay the costs of the hearing.

The only order which was challenged was order (1). The HCCC sought a blanket prohibition on attendances upon a person of less than 18 years of age. It complained that the tribunal denied the parties procedural fairness in failing to indicate an intention to make some other order and provide them with an opportunity to address in relation to it. Secondly, the HCCC asserted error on the part of the tribunal in apparently taking into account as a mitigating factor that the practitioner had been subjected to punishment under the criminal law.

This meant that the issues for determination on appeal were:

(i) whether the Tribunal erred in dismissing the complaint that the Respondent was not of good character;
(ii) whether the Tribunal misdirected itself by taking account of the fact that the Respondent had been "dealt with by the criminal law"; and
(iii) whether there was error in permitting the Respondent to continue to treat persons under 18 years of age while requiring a "chaperone".

The tribunal had identified two risks of concern regarding Wingate's fitness to practise. These were the risk of Dr Wingate re-offending, and the risk "of interference or inappropriate sexual advances being made to a patient".[4] Evidence was taken from psychiatrists who agreed that there was a low risk of a hands-on offence, based on an absence of any past hands-on offences. They also gave the opinion that his risk of re-offending was low to moderate, as he had previously overcome an alcohol addiction. The tribunal also accepted evidence that Dr Wingate was not a paedophile, but had "hebephilic" interests. The distinction was described as follows:

> The term "paedophilia" is used by the medical profession to indicate sexual interest in children who do not have secondary sexual characteristics, ie who are pre-pubescent … The term "hebephilic" describes a sexual interest in pubescent and post-pubescent young males and females. Hebephilia is not categorised as a psychiatric condition but a psychologist may describe the interest (provided it is acted upon) as a dysfunctional disorder.[5]

There was also evidence before the tribunal that Dr Wingate was indulging his hebephilic interests through more than just child pornography, by photographing young males and inviting them home (though there was no evidence of sexual interactions).

When considering the complaint of good character against Dr Wingate, the tribunal considered the paramount issue to be the protection of the public from harm, focusing on the specific conduct (whether it occurred once or was ongoing), as well as broader considerations such as "good fame and character, and service to the community past and present".[6] The tribunal considered that Dr Wingate practised as a specialist ophthalmologist, and thus dealt mostly with adults and elderly patients, and that no complaint had ever been made in relation to his work.

Consequently, the tribunal summarised the factors for and against his continued registration. The factors for included:[7]

(3) he pleaded guilty to the offences with which he was charged;
(4) he appears to now be very much aware of the seriousness of what he has done and the risk to his ability to practise;
(5) he now accepts that his conduct was immoral and abhorrent … and disgraceful …
(6) he has shown an ability to overcome alcoholism by strong will, which encourages confidence that he will overcome temptation to re-offend;
(7) the very positive commendations of a number of his colleagues, referring doctors and patients;
(8) his pro bono work.

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[4] *Re Wingate* [2007] NSWMT 2 at [70].

[5] *Re Wingate* [2007] NSWMT 2 at [57].

[6] *Re Wingate* [2007] NSWMT 2 at [73].

[7] *Re Wingate* [2007] NSWMT 2 at [86].

The factors against were stated as:

(1) the serious nature of the offences;

(2) the persistent nature of his downloading, ie it was clearly over an extended period and involved in excess of 10,000 images;

(3) the misleading information provided by Dr Wingate to delegates of the Board and Dr Allnutt, which we have detailed, in an attempt to minimise seriousness of the offence, minimise the extent of his offending behaviour, which was not the subject of charges, and to hide the true nature of his sexual proclivities.

Consequently, the tribunal did not find that Dr Wingate was unfit to practise medicine, nor that he was not of good character. The orders described above were imposed, and all but order (1) (the "chaperone condition"), were upheld by the New South Wales Court of Appeal. The tribunal was concerned about the imposition of such a condition in light of the case of *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 where the imposition of a condition requiring a chaperone when seeing a female patient was seen as indicating that the practitioner could not be trusted in relation to a fundamental aspect of professional conduct, and thus should have been de-registered. The Court of Appeal warned against applying such reasoning too generally, and noted that conditions are often necessary and appropriate. It held that the tribunal should have imposed a condition preventing Dr Wingate from treating persons under 18 years of age, and amended his registration accordingly. The court also found that with regard to the period of his registration as a sex offender, Dr Wingate would be a "prohibited person" under the relevant legislation, this should have been considered in the imposition of the condition. The court also found that a major reason for the condition was public confidence (at [66]):

> One legitimate purpose is maintenance of confidence of the public, both in the particular doctor and in the profession generally. As Dr Baron was at pains to point out in the course of his evidence, he might have a high degree of confidence in sending a six year old son to see the practitioner, but that confidence might not be shared by other members of the public who did not have his knowledge of the nature of the risk or the character of the practitioner. Relevant public concerns may thus justify the imposition of a condition where the risk is thought to be minimal.

Accessing child pornography: Relation to competence, fitness to practise and professional misconduct?

Whether, if a doctor is proven to be regularly accessing child pornography, this should be viewed as adversely impacting on the skills, knowledge and judgment required for competent medical practice was a major threshold issue in *Wingate*. Surely other medical professionals rationally could argue that the private possession by a medical practitioner on a home computer of child pornography says a considerable amount about the (inadequate) knowledge, skill or judgment possessed, or care likely to be exercised by that practitioner in the practice of medicine. This must be so unless a very limited, outdated and mechanistic view of contemporary medical practice is taken (that it involves, eg, merely technical aspects of diagnosis and treatment). Accessing child pornography suggests, eg, that the practitioner has a woefully poor knowledge of the adverse impact of such pornography on the health of its participants, or the victims (often) of those who watch it. It suggests the medical practitioner has a substandard understanding of the legislation criminalising child pornography and those involved in producing or exploiting children by this means and requiring mandatory reporting of potential victims to the relevant authorities. It likewise suggests that the practitioner has major flaws in the type of judgment required to sensitively interact with a wide variety of patients who may have suffered health problems as a direct or indirect result of persons accessing or participating in such pornography. It is hard to understand why a registrar or resident, eg, found to be accessing child pornography would not have that recorded on his professional evaluation record if the dominant purpose of such a record is to ensure high-quality care and public safety.

The authors also believe that both the New South Wales Medical Tribunal and the New South Wales Court of Appeal interpreted professional misconduct too narrowly, particularly in respect of what issues "relate to the practice of medicine".

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Possession of child pornography is a criminal offence in all jurisdictions in Australia.[8] When a medical professional is convicted of this crime, the status of their membership in the profession (through their registration or conditions placed upon it) is also called into question. While exclusion, and thus deregistration, may seem to the victims, their relatives, friends and related advocacy groups the only acceptable option, it deprives the community of all the future contributions that medical professional may offer. Yet, such a consideration must be balanced against the damage to the reputation of the profession as a whole, the risk of recidivism, as well as the protection of the public through possible harm to patients. As the Privy Council noted in the seminal case of *Bolton v Law Society* [1994] 1 WLR 512 at 519, which has been referred to in cases concerning medical professionals:

> The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.[9]

In practice, however, the public may have some justification in considering that medical boards and tribunals as well as the courts, as a best case scenario have been over-emphasising consideration for the individual medical professional's individual circumstances, and at a worst case involve secret sharers in, or sympathisers about, this criminal activity who are reluctant to take too strong a stand against it for fear of creating a rod that will break one day upon their own backs. It is an outrageous perversion of professional standards with a high likelihood of eroding public confidence that *Wingate* resolved into a debate about whether what occurred constituted "bad character".

Debate as to the meaning and scope of professional misconduct can be seen in cases concerning both legal and medical professionals. While, as seen in the New South Wales legislation, it has traditionally concerned conduct directly related to the profession, there is increasing acceptance within the common law that it may also have a broader effect. For example, in the Privy Council case of *Roylance v General Medical Council (No 2)* [2000] 1 AC 311, it was noted (at 331):

> [S]erious 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 … What is important … is not only the fact that disgraceful behaviour remote from the carrying on of a professional practice may constitute serious professional misconduct, but also that the duty of a doctor to himself, if not to his profession, exists outwith the course of his professional practice. One particular concern in such cases of moral turpitude is that the public reputation of the profession may suffer and public confidence in it may be prejudiced.

The case of *Childs v Walton* (unreported, NSWCA, 13 November 1990, BC9001755) also provides support for the broader interpretation of professional misconduct. This case concerned a psychiatrist who was found guilty of professional misconduct after initiating sexual encounters with patients after the termination of the doctor-patient relationship. Although the incident occurred outside of the "practice of medicine" which was required by the legislation, it was found (at p 9):

> The phrase "in the practice of medicine" does not have a temporal meaning, but rather a qualitative or descriptive character … The conduct must be such as to demonstrate the lack of a quality … necessary in the practice of medicine … It need not be conduct which occurs in the course of treating the patient.

This interpretation of professional misconduct was also accepted in the recent case of *Health Care Complaints Commission v Gillet* [2007] NSWNMT 7 in the Nurses and Midwives Tribunal, which concerned a nurse found guilty of possessing child pornography. Relying on both *Roylance* and *Childs v Walton*, it was found (at [5]) that:

> [T]he nurse's conduct is of a sufficiently immoral, outrageous and disgraceful character to make the determination that he does not possess the requisite knowledge or judgment expected of him as a nurse … The tribunal is also satisfied that there is no need for the conduct to occur in the clinical context of the practice of nursing.

In Victoria, the definition of "misconduct" has been accepted from both *Roylance* and from *Re Solicitor* [1960] VR 617 which adopted the English definition from a case about a solicitor, *Myers v*

[8] For example, see *Crimes Act 1900* (NSW), s 91H; *Crimes Act 1958* (Vic), s 70.

[9] Quoted in *Gupta v General Medical Council* [2002] 1 WLR 1691 at [21].

Elman [1940] AC 282. In the latter case, it was found (at 288-289) that professional misconduct (in relation to the legal profession) includes conduct "which would reasonably be regarded as disgraceful or dishonourable by solicitors of good repute and competency".

The Australian Medical Association (AMA) Code of Ethics is also a useful instrument in defining professional conduct in Australia.[10] Section 2.1, which concerns Professional Conduct, includes the duties to:

> b. Recognise that your personal conduct may affect your reputation and that of your profession.
>
> …
>
> d. Report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body.
>
> f. Accept responsibility for your psychological and physical well-being as it may affect your professional ability.

These authorities and guidelines show a trend towards a broader definition of professional misconduct to include conduct which occurs outside of the strict practice of the profession. Therefore, the possession of child pornography, even if considered unrelated directly to the practice of medicine (a proposition which the present authors would contest), can nevertheless constitute professional misconduct. In all cases, it is accepted that regardless of whether the images were paid for, or obtained from free sites, the act of accessing the images fuels the criminal market for their creation. For example, in the Victorian case of *Re Provan* [2005] PRBD (Vic) 3 the board stated:

> The possession of child pornography involves facilitation and encouragement for the corruption and violation of children. The preparedness of persons such as Mr Provan to purchase child pornography creates a market which encourages the further exploitation and abuse of children's innocence.

As acknowledged in many of these cases, the individuals involved are intelligent, well-educated members of society who cannot claim ignorance to this fact, understanding that their behaviour encourages a market in which children are exploited and abused. It can be seen that to some extent this is incongruous with their role as medical professionals who care for, and are trusted by, vulnerable individuals (often including children) as an integral part of their profession. Furthermore, as recognised in *Gillet*, there is an inevitable conflict of interest arising for medical professionals who have a legislative duty to report exploitation of vulnerable groups, including children. To reiterate, all States except Western Australia have legislative requirements for doctors to report suspected child sexual abuse.[11] Where a duty exists to notify authorities in relation to child pornography, a conflict of interest would necessarily arise as the treating doctor would have a fear of being exposed. These issues illustrate that, even if it be held (on an outdated and ill-informed understanding of the nature of contemporary medical practice) that this activity does not directly relate to the practice of medicine, it can nevertheless fall within the realm of professional misconduct.

The cases stress that it is not the role of medical boards to punish those who transgress the law. Those who come before it in these cases have already been convicted, and are serving or have served their sentence. As recognised in *Ha v Pharmacy Board (Vic)* (2002) 18 VAR 465; [2002] VSC 322 at [72], "The Board, when imposing a penalty after a finding of professional misconduct, is not concerned with punishment. The penalty powers are there primarily for the protection of the public and to protect the reputation of the profession itself."

The recent Medical Practitioners Board of Victoria (MPBV) case of *Re Stephanopoulos* [2006] MPBV 12 is useful to consider alongside *Re Wingate*. This case involved a neurosurgical trainee convicted of knowingly possessing child pornography after large amounts of images (over 1,400, as well as movie clips and web pages) were found on his work computer, a CD-ROM in his car, and his home computer. He was sentenced to five months imprisonment wholly suspended for 15 months, and fined $5,000.

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[10] Australian Medical Association, *Code of Ethics* (2004, revised 2006), http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP, viewed 19 February 2008.

[11] See eg *Children, Youth and Families Act 2005* (Vic), s 200; *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 27.

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It is also important to note that in all of these cases, once convicted of child pornography offences, practitioners are placed on the Sex Offenders Register or equivalent. Dr Wingate was required to become registered on the Child Protection Register pursuant to the *Child Protection (Offenders Registration) Act 2000* (NSW) for a period of eight years, while Dr Stephanopoulos was placed on the Sex Offenders Register for eight years pursuant to the *Sex Offenders Registration Act 2004* (Vic). This in itself has various implications. For example, for this period Dr Wingate is also rendered a "prohibited person" under the *Commission for Children and Young People Act 2000* (NSW), meaning that he cannot be employed in a position involving the direct provision of health services to children, or employment in the wards of public or private hospitals in which children are patients.

DIFFERENCES BETWEEN THE AUSTRALIAN AND UNITED KINGDOM APPROACH

Recently, high-profile cases of a similar nature have also come before the United Kingdom General Medical Council (GMC). It is therefore interesting to compare the approaches taken. Historically, more United Kingdom cases have focused on preserving the reputation of the profession and thus the confidence of the public in the profession. In many recent cases of the GMC Fitness to Practise (FTP) Panel, including the case of *Oakley*,[12] the panel referred to *Bolton v Law Society* as well as the Privy Council case of Dr Gupta,[13] stating: "The panel considers that a profession's most valuable asset is its collective reputation and the confidence it inspires in the members of the public." Dr Oakley accepted a police caution for making and possessing indecent photographs of children, and was placed on the Sex Offenders' Register for two years, after which another 480 images were found on his home computer. He accepted responsibility for the images, and stated that he had been under considerable stress at the time due to a marriage breakdown. As well as accepting evidence from psychiatrists that Dr Oakley suffered from paedophilia,

> The Panel considers that any indecent image of a child represents abuse. Anyone who views such material helps to perpetuate a cycle of exploitation of children. The public expects appropriate standards of behaviour from doctors and is entitled to expect that a registered practitioner will conduct himself in a professional manner, even when the doctor's actions do not directly affect patients. Dr Oakley, through his actions, has fallen seriously below those standards and the Panel has no doubt that he has damaged the reputation of, and undermined the confidence in, the medical profession by his conduct.

All United Kingdom GMC decisions are also influenced by the GMC's *Indicative Sanctions Guidance for Fitness to Practise Panels*.[14] The Guidelines accept the following principle from the case of *Haikel v General Medical Council* [2002] UKPC 37 in relation to sexual misconduct (para 41 of S1-9):

> The public, and in particular … patients, must have confidence in the medical profession whatever their state of health might be. The conduct as found proved … undoubtedly undermines such confidence and a severe sanction was inevitable. Their Lordships are satisfied that erasure was neither unreasonable, excessive nor disproportionate but necessary in the public interest.

Following some high-profile cases, the Guidelines now deal specifically with convictions for child pornography offences. Paragraph 8 of S2-2 of states:

> Child pornography involves the exploitation or abuse of a child. Accessing, storing or distributing such material is illegal and regarded in society as morally unacceptable. For these reasons any involvement in child pornography by a registered medical practitioner raises the question whether the public interest demands that his or her registration be affected.

Paragraph 10 of S2-3 (emphasis in original) recognises that:

> Whilst the courts properly distinguish between degrees of seriousness, *the Council considers any conviction for child pornography against a registered medical practitioner to be a matter of grave*

[12] General Medical Council, Fitness to Practise (FTP) Panel, 2-3 April 2007, http://www.gmc-uk.org/concerns/hearings_and_decisions/ftp/20070403_ftp_panel_oakley.asp viewed 26 February 2008.

[13] *Gupta v General Medical Council* [2001] EWHC Admin 631.

[14] General Medical Council, *Indicative Sanctions Guidance for Fitness to Practise Panels* (2005), http://www.gmc-uk.org/concerns/hearings_and_decisions/sanctions_referrals_guidance.asp viewed 20 February 2008.

> *concern because it involves such a fundamental breach of patients' trust in doctors* and inevitably brings the profession into disrepute. It is therefore highly likely that in such a case the only proportionate sanction will be erasure …

Although noting that other sections allow for the consideration of proportionality, the Guidelines make clear that no doctor registered as a sex offender should have unrestricted registration, and that it is likely that in most cases, absent particular or unique circumstances, such a conviction will result in erasure.

As a result of the federal nature of the legal system in Australia, each State has its own, different legislation and professional regulatory bodies, making it far more difficult to create a national standard or statement such as the Guidelines produced by the GMC. Furthermore, as discussed earlier and recognised in *Wingate*,[15] the legislation regarding "professional misconduct" differs quite significantly from State to State.

As a consequence, the Australian boards and tribunals approach the issue more on a case-by-case basis, balancing the risks of recidivism, possible harm to the community, and the insight of the practitioner into their actions. While the principles of *Bolton* are mentioned, there appears to be less focus on the reputation of the profession and public confidence. As seen in the cases of *Re Stephanopoulos* and *Wingate*, the psychiatric evidence of the practitioners' chances of re-offending and state of mind was critical, if not determinative of the final result. The contributions both practitioners would be precluded from making to the community if deregistered were a significant consideration, which is generally given more weight in Australian cases compared with those in the United Kingdom.

The complex and well-reasoned decision of the board in *Re Stephanopoulos* demonstrates the value of taking a case-by-case approach, as many of the factors are unique to each case. The Panel considered evidence from a large number of witnesses, including psychiatrists, forensic psychologists and professional colleagues, as well as the practitioner himself. The board found (at [113]):

> The public interest in the practitioner's continuing in practice must be weighed against the public interest in protecting clients from any repetition of the conduct exhibited in this case. The question of the likelihood of repetition is central to the imposition of an order.

The board in *Re Stephanopoulos* also reproduced (at [128]) the General Medical Council statement in *Re Watson* (unreported, 11 November 2005) that:

> The public expects appropriate standards of behaviour from doctors and is entitled to expect that a registered practitioner will conduct himself in a professional manner, even when the doctor's actions do not directly affect patients … The Panel considers that a profession's most valuable asset is its collective reputation and the confidence it inspires in members of the public.

The panel in *Re Watson* took such a view based on the GMC Indicative Sanctions Guidance, of which there is no equivalent in Australia. In *Re Stephanopoulos* [2006] MPBV 12, more evidence regarding the practitioner's state of mind was considered, including how he confronted the issue, his understanding into his own condition, and therefore the risk of re-offending, which was found to be low. In relation to the evidence he gave before the panel, "He exhibited a sophisticated understanding of why he had fallen into patterns of pornography addiction … In short, his insight was of a high level" (at [169]). Evidence from health professionals that Dr Stephanopoulos was not strictly a paedophile was also a major factor in the decision, as it was accepted that his behaviour was in response to stress and pressure at work and would be unlikely to occur again. While the panel made clear that such a response to any external pressures is never justified or condoned, the evidence that he was not found to be a paedophile was nevertheless significant.

CONCLUSION: WHERE THE CONSEQUENCES OF RECIDIVISM ARE TOO GREAT

Both *Re Stephanopoulos* and *Wingate* emphasise the current trend of taking a case-by-case approach, and thus considering the individual and particular risks the practitioners may pose. Yet, while it is relevant to consider the practitioner's individual circumstances to determine the risks of recidivism or

[15] *Re Wingate* [2007] NSWMT 2 at [50].

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a hands-on offence, such as whether the practitioner is paedophilic or hebephilic, this is arguably irrelevant for the purposes of maintaining public confidence. Even if psychiatric evidence suggests that the risk of a hands-on offence is low, this may not make a difference for the patients themselves and creates an ad hoc standard that may be readily abused by these highly intelligent accused. For example, a mother taking a young child to see a doctor may consider his previous conviction for child pornography offences as a legitimate concern, regardless of how much insight he has, or claims to have, into his actions, his psychiatric evaluation, or whether there is a nurse present. Similarly, she is unlikely to know of his registration as a sex offender at the time or in the past. The New South Wales Court of Appeal addressed this in relation to how tribunals should approach the imposition of such conditions (at [67]):

> Public concerns as to the safety of young patients may be reasonable or irrational. They may be reasonable in the sense that possession of pornographic material may, for a group of people having particular characteristics, correlate with hands-on offences. The concerns may also be reasonable in that the offence of which the practitioner was convicted potentially covers both young (pre-pubescent) children and pubescent or post-pubescent teenagers. An indication of a true paedophilic interest might be treated more seriously than a hebephilic interest, but the public who knew of the conviction would have no way of knowing which was involved. On the other hand, there may be views held by members of the public concerning the risks in such circumstances, which views have no basis in the scientific or medical literature. The tribunal may well need to exercise caution in imposing conditions on a practitioner designed to meet views which are truly irrational prejudices. It might have little or no inhibition in imposing a condition which flowed from a rational concern, even though based on ignorance of the particular circumstances.

Such a patronising statement about what judges consider "irrational", if applied to jury verdicts, would be completely unacceptable. It comes across here as highly self-serving to the court and the practitioner and consequently as having a significant likelihood of diminishing public confidence in both professions. The public is rationally entitled not to be concerned with the fact that the practitioner committed the offence at a stressful period in his life, rather than in response to a particular sexual urge or preference. The public's concern is that every possible step be taken to reduce the risk that children will be abused by paedophiles. As stated by the Court of Appeal, even if the members of the public recognise pro-paedophilic conduct by a medical practitioner as a response to stress rather than ongoing paedophilic urges, they may nevertheless presume that any future stressful experiences may lead the practitioner to engage in different types of destructive or harmful behaviour.

These kinds of cases and associated publicity in the United Kingdom pushed the GMC to explicitly mention child pornography offences in its Indicative Sanctions Guidance. While the principles stated in the NSW Court of Appeal case of *Wingate* will become the law on this issue in that State, the other cases show that Australia still lacks consensus on the issue.

The present authors argue that a strong case can be made for a statement indicating that, unless a strong reason for the contrary exists, as a minimum requirement a condition restricting treatment of patients under 18 years of age should be imposed in all cases of child pornography convictions.

A nationwide system of registration of medical professionals is one option through which this could be achieved. However, while registration of medical professionals remains under State rather than federal control, there are nevertheless some options for the development of guidelines in Australia. For example, the AMA Code of Ethics could explicitly refer to this issue, or it could be addressed through a position statement. Alternatively, each medical board in Australia could adopt a position on the issue, either through a consultation body or the Australian Medical Council. The option of specific legislative reform in each State would achieve consistency; however, it would be difficult to formulate without stifling the ability of the boards and tribunals to consider each case individually – the importance of which has been illustrated through the cases discussed.

With increased policing of, and attention being paid to, the crime of child pornography, more cases of convictions across all professions are emerging both in courts and throughout the media. Public trust and confidence in the medical profession is paramount, and with growing public awareness of these cases, it is important for the profession to have a clear and consistent approach to the registration of convicted medical professionals. The case of *Wingate* provides a good, clear

statement supporting the imposition of conditions in such circumstances restricting access to patients under 18. It does, however, raise significant concerns about whether the right approach was taken in relation to medical practitioners convicted of child pornography offences and professional misconduct. As medical practitioners are influential members of society who should (if they possess the requisite professional knowledge and judgment) be well aware of the harm caused by child pornography, it presumptively suggests a fundamental erosion of their professional competence to access it. It is time that medical professional organisations in Australian prepare a consensus position statement under which conviction of a medical practitioner for accessing child pornography creates a presumption of a life-time ban from paediatric practice and findings of incompetence, lack of fitness to practise and professional misconduct, both in relation to the practice of medicine and through bringing the profession into disrepute.

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