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REPORT OF INVESTIGATION INTO THE SUSPENSION OF DR PAUL MCGINITY BY THE MEDICAL COUNCIL OF TASMANIA

JULY 2012

INVESTIGATION INTO THE SUSPENSION OF DR PAUL MCGINITY BY THE MEDICAL COUNCIL OF TASMANIA

1. Introduction

1.1. Dr Paul McGinity is a general practitioner, practising in three towns in North East Tasmania - Scottsdale, Derby and Bridport.

1.2. In 2009, the Medical Council of Tasmania took action under s55 of the *Medical Practitioners Registration Act 1996* (the MPR Act), on two occasions, to suspend Dr McGinity's registration as a medical practitioner under that Act. The first decision to suspend (the first suspension) was taken by the Executive Committee of the MCT on 26 March 2009, purportedly under powers delegated by the MCT and in reliance upon ss 55(1)(f) and (g) of the Act, and took effect on 27 March 2009. This suspension was quashed by Porter J of the Supreme Court of Tasmania on 14 May 2009.[1] The second decision to suspend (the second suspension) was made by the MCT itself on 15 May 2009, in reliance on s55(1)(g) of the Act, and took effect on 18 May. The decision to suspend was made by teleconference on each occasion.

1.3. Section 55(1)(f) of the Act gave the MCT the power to suspend the registration of a medical practitioner for a period of not more than 12 months if it reasonably considered the suspension to be

> *... necessary for the purposes of investigating a complaint made against that medical practitioner or investigating on its own motion a matter that could be the subject of a complaint against that medical practitioner.*

Section 55(1)(g) provided a similar power to suspend on the ground that "the Council considers that it is in the public interest to suspend the registration".

1.4. The Act expressly provided at s55(3) that –

> *If the Council decides to suspend a medical practitioner's registration under this section it may afford that medical practitioner an opportunity to be heard but is not required to do so.*

1.5. The second suspension was subsequently lifted by the MCT, after Dr McGinity had provided certain undertakings. Those undertakings were given on 12 June 2009.

1.6. The power of the MCT to suspend a practitioner should be viewed in the context of the functions of the MCT, as stated in s7 of the Act, which included supervising the practice of medicine in the State, and monitoring the

[1] See *McGinity v Medical MCT of Tasmania* [2009] TASSC 31

standard and provision of medical services in the State. It should also be viewed in the context of s9 of the Act, which stated –

> *The Council must perform its functions and exercise its powers under this Act so as to –*
>
> *(a) ensure that medical services provided to the public are of the highest possible standard*
>
> *(b) ensure that persons practise medicine according to the highest possible standards; and*
>
> *(c) guard against unsafe, incompetent and unethical medical practices.*

1.7. The MPR Act was repealed by the *Health Practitioner Regulation National Law (Tasmania) Act 2010*, with effect from 1 July 2010, as part of national arrangements for the registration of practitioners in a range of health professions, including medical practitioners. The Australian Health Practitioners Regulation Agency (AHPRA) is central to these arrangements. The MCT ceased to exist with the repeal of the MPR Act, and the functions which it performed are ones which now fall to AHPRA and the Medical Board of Australia.

1.8. Dr McGinity continued to be registered, and to practise under the undertakings put in place in 2009. It appears that concerns about his practice of medicine evidently existed, as proceedings were commenced against him before the Health Practitioners Tribunal in respect of his treatment of eight patients. These were matters which had previously been before the MCT, and which AHPRA then handled under transitional provisions in the *Health Practitioner Regulation National Law (Tasmania) Act*.

1.9. The Tribunal handed down its determination on 3 July 2012, in which it approved a manner of resolving the referrals agreed to by AHPRA and Dr McGinity at a mediation session held in December 2011. This resolution allows Dr McGinity to continue to practice, subject to certain conditions, which conditions are to be reviewed in 12 months. A copy of the Tribunal's determination is Attachment A to this report.

1.10. Judging from the public response to the suspension of Dr McGinity's registration by the MCT, he is held in high regard by a large number of patients. Following the first suspension, my predecessor Mr Simon Allston received letters and formal complaints from many of his patients, asking him to investigate the suspension. Mr Allston declined to do so, since Dr McGinity had appealed the suspension to the Supreme Court. Mr Allston then received further letters and complaints in relation to the second suspension. After receiving one of these complaints, from one of his patients, Mr Allston wrote to Dr McGinity asking whether he supported the investigation of the matter. Meanwhile the time for Dr McGinity to appeal the second suspension had passed, without him lodging any appeal.

1.11. Dr McGinity told Mr Allston that he supported the investigation of the matter, and Mr Allston wrote to the then President of the MCT, Dr Peter Sexton, on 4 June 2009, informing him of his intention to investigate what he then described as being "the processes leading up to the suspension which took place on 18 May, leaving aside any issues relating solely to the first suspension".

1.12. Under the circumstances, it was not possible to investigate the processes leading up to the second suspension without investigating all issues relating to the first. The information which founded the first suspension was taken into account in deciding the second suspension, and the second suspension was effected in the shadow of the Supreme Court decision quashing the first.

1.13. This investigation has taken far longer than I or my predecessor Mr Allston would have liked, and I apologise to all involved, particularly to Dr McGinity (although he is not directly a party), for the fact that it has taken so long to complete.

1.14. It might be thought that the completion of the investigation is of no value, because the MCT no longer exists. I disagree; the suspension of Dr McGinity became such a subject of controversy, with vocal public criticism of the action taken by the MCT, that the completion of the task is in my view important.

1.15. A draft of this report was distributed to the following individuals in August 2011, and their responses have been taken into account in completing the report –

Dr George Cerchez

Dr Peter Sexton

Dr Fiona Joske

Ms Annette McLean-Aherne

Mr Philip Jackson

1.16. With limited exceptions, the responses received did not question the accuracy of the evidence laid out in the draft report, or add to that evidence. The responses had more to do with the interpretation and analysis of the evidence.

1.17. Both my and my predecessor's investigations have largely involved analysis of documentation on the MCT's files. No interviews were conducted. I note in this respect that none of the responses received to the draft report indicated that, in deciding to make the first suspension, the Executive Committee of the MCT was acting on information which was not in the documentary record.

1.18. The response of Drs Sexton and Joske included the submission that it would be undesirable for this final report to be made public until all of the matters against Dr McGinity which were before the Health Practitioners Tribunal had been heard and determined. This submission was more expansively made in an earlier letter to my predecessor from Matthew Hardy, the Director, Notification and Legal Services for AHPRA in Tasmania. Mr Hardy submitted that publication of the report could unduly influence the decision making process in relation to those outstanding matters.

1.19. I delayed publication of the report in view of this submission. As the Health Practitioners Tribunal reached a decision on outstanding matters on 3 July 2012, I now publish my report.

2. The factual background

2.1. The events involving the MCT which gave rise to Dr McGinity's suspension commenced on 25 January 2008. On that date, a meeting took place between Dr George Cerchez (Medical Advisor, Primary Health, Department of Health and Human Services (DHHS), Pip Leedham (Director of Community and Rural Health Reform), Dr Michael Hodgson (the then President of the MCT), Matthew Healy (Legal Officer with the MCT) and Annette McLean-Aherne (Registrar and CEO of the MCT). I have seen handwritten notes of this meeting, made by the Registrar. The meeting followed email contact by Dr Cerchez with the Registrar, in which Dr Cerchez referred to the purpose of the meeting as being "to discuss the problems we are experiencing with qualified privilege".

2.2. Interpreting the Registrar's notes in the light of later correspondence, it is apparent that the DHHS personnel who were at the meeting told the MCT personnel about an ageing, solo, rural practitioner whose competence was in question. They did not name the practitioner, because of their concerns about "qualified privilege". This appears from subsequent information to be qualified privilege which they saw as attaching to the proceedings of a committee in Primary Health known as the Primary Health Credential and Clinical Privileges Committee (the PHCCPC).[2] The notes record some discussion about whether the MPR Act needed amendment to address difficulties arising from such privilege – presumably impediments to reporting information of concern about medical practitioners which came to light in the work of such committees.

2.3. Dr Cerchez and Ms Leedham told the MCT personnel that there were two Coroner's cases involving the practitioner of whom they were speaking, and

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[2] Qualified privilege is the term commonly used to describe the protection given by s 4 of the *Health Act 1997* to, amongst other things, information arising in the course of the performance by a quality assurance committee of its functions. To attract the protections given by the section, a committee must be declared by the Minister to be "an approved quality assurance committee": s4(1). To be so declared, the functions of a committee must include "the assessment and evaluation of the quality of health services provided by the State, a health service establishment [as defined] or by members of a professional association including the review of the clinical practices or clinical competence of persons providing those services".

that an audit of the practitioner's cases would be conducted over the next two weeks. It is recorded in the notes that they said that they would report the results of the audit to the MCT, if considered appropriate.

2.4. It would seem that no further contact was made with the MCT about this particular medical practitioner until the following December, some 10 months later.

2.5. In an email to the Executive Committee of the MCT on 2 December 2008, reporting on a telephone conversation that day with Dr Cerchez, the Registrar briefly described the meeting just mentioned, in the following terms:

> *Dr Cerchez and Pip Leedham (DHHS) met with Dr Hodgson and I some months ago now in relation to a matter that was the subject of two Coronial inquiries. We were not informed of the name of the practitioner in question (because of the confidentiality associated with the first Coronial matter – subject to qualified privilege) and did not receive any further details until now. The second Coronial matter is not yet concluded.*
>
> *I am now aware from my discussion with George that the practitioner is Dr Paul McGinity from Scottsdale ...."*

The Registrar then outlined the contents of her telephone conversation with Dr Cerchez, giving the following brief overview of the situation:

- *Dr McGinity has "resigned from the Department" (I presume in his VMO capacity at Scottsdale);*
- *The Clinical Privileges and Credentialing Committee ("CPCC") made up of "5 senior rural doctors" has agreed "not" to renew his hospital privileges;*
- *Dr McGinity has "appealed to a Quality Committee";*
- *Dr McGinity " ...is totally isolated; doesn't communicate with the other 5 doctors in Scottsdale; by own admission works 14 hour days; doesn't take holidays; has no insight into his problems; a short-term locum ... had significant concerns with what she saw in his private practice (he had a two week holiday in Scotland – apparently the first holiday in 10 years – George also mentioned something about " ... only internet access ... I didn't quite catch what he said – it was probably relating to information access being limited to the internet); and*
- *Second matter before the Coroner (ongoing).*

2.6. On that same day, 2 December 2008, Dr Cerchez followed up on this conversation by sending the Registrar a letter setting out his concerns about Dr McGinity. The letter fleshed out the concerns which the Registrar had briefly noted. In brief, the letter from Dr Cerchez stated that:

- In early 2007, the root cause analysis of an incident involving the death of a patient at the North East Soldiers Memorial Hospital (NESMH) at Scottsdale had identified significant issues surrounding the medical management of the patient, and that this matter had been referred to the PHCCPC.

- The PHCCPC had commissioned an independent review of the case and, in acting on the findings from that review, had recommended that Dr McGinity be required to update his clinical skills, to work "safe hours", and to engage in clinical interaction with other medical practitioners at the NESMH.

- These recommendations had been communicated to Dr McGinity.

- Several other cases had come to the attention of Dr Cerchez, which demonstrated a "pattern of clinical assessment and management" which in his view was "clinically unsound". These were also cases at the NESMH, involving "deteriorating patients", and involving "compromised care" which in his view "could have been avoided by transfer to specialist care at the LGH".

- Two of these cases had been reported to the Coroner, and one of them was the subject of a [then] current coronial investigation.

- Dr McGinity had resigned from his position of visiting rural medical practitioner at the NESMH when it had become "necessary to intervene in the care of yet another patient and transfer the patient to the Launceston General Hospital", citing as his reason for resigning that he did not wish "to work in an atmosphere of continually worrying when his medical decisions were going to be overridden ...". It was said by Dr Cerchez that the decision to transfer the patient only occurred after discussions with Dr McGinity by the Director of Nursing and by himself, asking for further intervention by Dr McGinity, and that Dr McGinity had "declined to act in what was a potentially life threatening clinical situation".

- Dr McGinity had reapplied to the PHCCPC to have his clinical privileges at the NESMH restored, and that the application had yet to be finalised (there is no mention in the letter of what the Registrar had recorded in her email about the application having been refused, and being under appeal).

2.7. Dr Cerchez went on to say this –

> *The reason for notifying the Medical Council of this situation at this stage is the concern for public safety. DHHS only has jurisdiction over the management of public patients at the hospital, but following a number of anecdotal communications from colleagues, there is significant concern surrounding his management of his private general practice patients.*

Dr McGinity has shown no insight or willingness to modify his practice despite a very personal representation to him, at his Scottsdale practice, by two senior members of the PHCCPC. There are aspects of his practice which have emerged through investigation of the Coroner's and the other cases which have been brought to my attention, which indicate that he may need significant guidance and support to recognise his failure to practice contemporary clinical medicine of a standard in keeping with his peers. His lack of insight and acknowledgement of a need for change, would suggest that he is a doctor who may be suffering significant "burn out". He admits to working 13 to 14 hours a day, is on call for his patients 7 days a week and only infrequently takes holidays. His failure to have any meaningful communication with the other five general practitioners in the town, his long working hours, covering the towns of Derby, Bridport and Scottsdale, and his acquiring of all of his continuing medical education from the internet, when face to face learning opportunities are available, would suggest a pattern of isolation which would make it hard for him to have an understanding of the issues with which he has been presented.

I would be grateful if the Medical Council would consider these issues, in confidence, as I am seriously concerned that the public safety is at risk.

2.8. The Registrar subsequently wrote to Dr Cerchez by email on 4 December, asking him to reconsider his request that the issues be considered in confidence. She said –

It is highly unlikely that the Council will be able to take this matter up, even of its own motion, if it is unable to refer to the notification received and the concerns that the notification raises.

...

So that Council can properly consider this matter, are you able to reconsider the basis on which you have provided the information to Council? That is, procedural fairness would dictate that Dr McGinity is made aware of the concerns and the source of those concerns. It is far simpler to be able to provide relevant correspondence to him."

2.9. Dr Cerchez replied by email on 5 December. He said that Dr McGinity had accused both Ms Leedham and Dr Cherchez of bias, and did not appear to understand the situation. He went on to say that the decision of the PHCCPC (not to renew Dr McGinity's credentialing at the NESMH) was "going through due process", and was under appeal. He observed that the timing of the approach to the MCT had not been ideal, and that they "would be concerned if anything were to jeopardise" the due process being followed. His email then contains the suggestion that it would be better to hold any further investigation by the MCT until the outcome of the appeal was known.

He said that he would proceed with the notification to the MCT, this time not in confidence, if the findings of the PHCCPC were upheld.

2.10. The next contact between Dr Cerchez and the MCT in relation to Dr McGinity appears to have been his letter of 2 March 2009. Enclosed with this letter was an email he had received from the NESMH's Acting Director of Nursing (A/DoN) dated 26 February 2009. The A/DoN briefly gave two examples of concerns related to Dr McGinity's management of patients.

- The first involved a named patient who had presented at the NESMH as pre-eclamptic, with high and rising blood pressure. The patient had been treated with medication for her hypertension, by a medical practitioner at the hospital, and transferred to the LGH amid concerns that she might fit. The patient had been seen by Dr McGinity the previous day and the day before that, but he had allegedly done nothing.

- The second patient, with a known history of cardiac disease, had presented at the NESMH with chest pain. His family had previously called Dr McGinity, who had instructed them to take the patient to the LGH without having seen him. Due to the severity of the pain the family brought the patient to the NESMH where he was diagnosed with a myocardial infarction. He was transferred to the LGH, but died the next morning. The A/DoN named the patient and indicated that because he had died before being admitted to the LGH, the matter might become a coroner's case.

2.11. In his letter, Dr Cerchez referred to another case that had been brought to his attention that day by one of the doctors at the NESMH. This case concerned a patient who had been transferred to the LGH on 27 February 2009. The patient had suffered a cardiac arrest in the ambulance on the way to the LGH, and Dr Cerchez advised that he was waiting for Dr Andrew Hughes, the State Retrieval Coordinator, to provide advice on whether the case had been appropriately managed prior to the admission of the patient to hospital. The patient was not named, and the gender of the patient was not given. It is implied in the letter that this person had been in the care of Dr McGinity, but this was not expressly stated. Nothing was said about whether the patient survived.

2.12. Dr Cerchez completed his letter by stating –

> *As Dr McGinity is now only working in a private capacity pending his appeal for clinical privileges for the NESMH, it is difficult for the public health system to influence his practice. The state Quality and Safety Appeal Committee is about to conduct a review of the Primary Health Credentialing Committee's decision, but this will not be completed till the end of this month.*
>
> *I remain very concerned for the safety of the Scottsdale community under his care irrespective of this committee's decision as it can only have jurisdiction in the public hospital system.*

2.13. The Registrar emailed Dr Cerchez on 5 March 2009, thanking him for his letter, and reminding him of his previous advice to the effect that he would proceed with an open notification to the MCT if the findings of the PHCCPC were upheld. She asked if he was now prepared to allow the MCT to accept his written concerns and the email from the A/DoN as a formal notification that, in her words, "we can take up with Dr McGinity". In this regard, she said –

> *I need to know what documentation we can provide to Dr McGinity or what information we can release by way of seeking an explanation from him.*
>
> *Can you please let me know urgently whether this information is now "formal" notification?*

2.14. No reply had been received from Dr Cerchez by 23 March 2009, when the Registrar sent an email on that date to Dr Fiona Joske, a member of the MCT (and a general practitioner) – and, as I later explain, a member of the committee which later decided on the first suspension of Dr McGinity. The email was copied to Dr Cerchez, and said -

> *As briefly discussed this morning, I have attached the documentation I have received (and sent) to date.*[3]
>
> *I am still awaiting a response from Dr George Cerchez to my email of 5 March 2009.*

Dr Joske replied on the same day, in these terms –

> *Hopefully George will now provide a response. If you don't get something that Council can act on from either him or Dr S1 (the one who said that she was sending you a complaint by registered mail) then I think we need to press them as it is not right to just let this drift.*

There is nothing on the file to indicate when Dr S1 had said that she was sending in a complaint, or to whom she had said this.

2.15. Dr Cerchez replied by email on 24 March 2009 and advised the Registrar that he wished to discuss the matter with her further before making a formal notification.

2.16. Dr Cerchez sent another email to the Registrar at 12:28 pm on 26 March 2009. The body of the email said only this -

> *I am writing to inform you that the investigation by independent investigators for the State wide Quality and Safety Committee has*

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[3] The information was sent in a pdf file, and there is nothing on the MCT file (apart from the text of the email, as here set out) to indicate exactly what was in the pdf file.

> *now concluded. A report will be handed to the Committee by the end of the month for their consideration.*
>
> *Further reports of inappropriate treatment which would suggest a failure to practice in accordance to accepted clinical guidelines has been reported to me which I enclosed* [sic]. *I am making the Medical Council aware of these cases on behalf of the Department of Health and Human Services in the interests of public safety.*
>
> *An investigation of the circumstances surrounding the ambulance transfer of the latest case is being conducted by Primary Health DHHS, with the assistance of the Northern Superintendent of the Ambulance Service ....*

The second of these quoted paragraphs is the closest that Dr Cerchez came to making the "formal notification" which the Registrar had been saying that she needed from him if the MCT was to act. There is no suggestion in the email that urgent action by the MCT was thought by Dr Cerchez to be necessary.

2.17. The attachments to the email included an email to Dr Cerchez from Dr Andrew Hughes dated 4 March 2009, in relation to the patient who had suffered a cardiac arrest in transit from the NESMH to the LGH – see para 2.11 above. The email commenced by saying that the patient had died "on Monday following our conversation". Dr Hughes identified the issue of concern as being that the patient had been transferred directly to the LGH in an ambulance crewed by volunteers, and the possible reason for having decided to proceed with the transfer in those circumstances as being a failure to recognise the severity of the situation. The email said –

> *It is difficult to ascertain from the referral note* [impliedly from Dr McGinity] *and the Scottsdale ambulance report whether there was appreciation of the life-threatening nature of the episode. The patient was talking and moving enough to be wheezy when assessed by the doctor. Clearly, by all objective measures however, this patient was in severe respiratory distress. With an underlying hypoxic lung condition this should have been recognised as life threatening.... In my view this patient should have been sent to the NESMH for attempted stabilisation with on-transfer if improved or retrieval if not.*

Dr Hughes suggested that peer review of the management of the patient would be of benefit, but noted that it was unlikely that the patient would have survived irrespective of his management.

2.18. Also attached to the email from Dr Cerchez was an incident report dated 16 March 2009 in relation to an incident that had allegedly occurred on the morning of 16 March 2009 to a patient named in the report. The report recorded the view of the Acting Nurse Unit Manager at the NESMH that the wrong treatment had been provided to the patient, presenting a factual description which was impliedly critical of treatment provided by Dr McGinity prior to the transfer of the patient to the NESMH.

2.19. The factual description given described how the patient had been woken by chest pain at 3 am, and had called Dr McGinity, who had attended him for an hour at the patient's home. Dr McGinity had given the patient certain treatment, and had told the patient to attend his rooms in the morning. The patient did so, having suffered continuing severe chest pain until then. Dr McGinity had called the ambulance, some eight hours after the patient first woke with the pain, and there had been controversy about whether the patient should be taken direct to the LGH, as Dr McGinity had wished, or taken to the NESMH, in accordance with the instructions to the ambulance crew by the Visiting Medical Officer at the hospital. Details critical of Dr McGinity's management of the patient were provided. The report stated:

> *Mismanagement was reported to George Cerchez, for investigation.*

2.20. The Registrar forwarded Dr Cerchez' email and attachments to Drs Joske and Sexton for their information. Her email said:

> *This is FYI for now. I will prepare the relevant documentation for consideration by the Ex Comm.*

The time of her email is given as 12:38 pm, ten minutes after the timing of the email to her from Dr Cerchez. The reference to "the Ex Comm" is evidently a reference to the MCT's Executive Committee.

2.21. I interpolate at this point that, as revealed in the Supreme Court decision referred to in para 1.2 above, the Executive Committee of the MCT then only had two nominated members, Drs Sexton (as President of the MCT) and Joske. It was meant to have had three, being the number of members which the MCT had endorsed over time as being the Committee's membership. It was the deficiency in the number of members who determined on 26 March that Dr McGinity's registration should be suspended that brought that decision undone.

2.22. All I wish to note at this point, beyond the fact that the Registrar was now communicating with the members of the Executive Committee about the case, is that the Committee held a delegation from the MCT which empowered it to exercise the power of the MCT to suspend the registration of a medical practitioner under s55(1)(g) of the MPR Act. This, as mentioned earlier, was a power to suspend a practitioner if this was considered to be in the public interest.

2.23. On 26 March 2009 the MCT also received a letter signed by four medical practitioners from Scottsdale, Dr S1 and three others, in which they expressed their concerns about "life threatening medical decisions" being made by Dr McGinity. They said such decisions had increased over the last two months, and that they felt that they could not "stand by and allow significant mortality and morbidity to occur".

2.24. They gave two examples of the life threatening decisions to which they referred, being cases already reported to the MCT by Dr Cerchez, namely:

- Dr McGinity's suggestion that a family member take a patient with crushing chest pain – who had died as a result of his condition – directly to the LGH an hour away, rather than present at the NEMSH 15 minutes away – see the second case described in para 2.10.

- Dr McGinity's treatment of a patient suffering chest pains prior to an ambulance being called and the patient being transferred to the LGH – see paras 2.18 and 2.19.

2.25. The writers said that there were "many other similar examples". They said that there were two Coroner's cases "currently being investigated", and that Dr Cerchez had received "multiple incident reports from the DHHS regarding similar incidents over at least 3 years". They said that they were very concerned for public safety, and called for an urgent review of Dr McGinity's registration.

2.26. The Registrar sent a copy of the letter to Drs Sexton and Joske by an email which is recorded as having been sent at 2:14 pm on 26 March. Her email was headed "URGENT Advice sought please: DR PAUL McGINITY – NOTIFICATION FROM [Dr S1 and her three colleagues]", and contained the following –

> *The attached letter was received by registered post today. Given the seriousness of the matters outlined in the letter,* [Dr S1 and her three colleagues] *have asked the Council to urgently consider Dr McGinity's registration.*
>
> *Given what you've read so far from Dr Cerchez and the seriousness of the matters raised in the abovementioned letter, do you think Council has sufficient information to consider immediate suspension of Dr McGinity's registration (in the public interest) pending further enquiries? I could urgently provide Council with today's letter and the information from Dr Cerchez (out of session) and through the Ex Comm, a recommendation could be made to Council that Dr McGinity's registration be suspended with immediate effect.*
>
> *Whilst Council can provide an opportunity to be heard (prior to suspension), it is not required to do so. Council could then take up these matters as a complaint of their own motion and dependent upon the outcome, the suspension could either be revoked or remain in force.*
>
> *Of course, Dr McGinity would have a right of appeal to the Supreme Court against the suspension.*
>
> ...
>
> *I await your urgent advice.*

2.27. An hour later, at 3:18 pm, the Registrar emailed the MCT's legal adviser, Phillip Jackson, seeking advice. Her email was headed in the same way as the

email that she had just sent to Drs Sexton and Joske, also carried the text of that email, and attached two documents only – a copy of the letter from Dr S1 and her colleagues and a draft Notice of Suspension of Registration.

2.28. The Registrar asked for advice on "whether Council would be on safe ground (for want of a better term) in suspending Dr McGinity under the circumstances", and for advice on whether any changes to the text of the draft Notice were needed. She said that the MCT had not been able to take action earlier because of the matters before a Clinical Privileges and Credentialing Committee which were subject to qualified privilege. She said that further information had been received from DHHS, however, and that the Department now wanted the MCT to use that notification to take up a complaint of the MCT's own motion. She offered to provide Mr Jackson with copies of the material received from Dr Cerchez if he wished to see it before providing the advice sought.

2.29. Mr Jackson replied by an email sent at 5 pm that day which commenced –

> *I have no doubt that the Council has very good grounds to suspend registration in the public interest.*

He said that he thought that the Notice of Suspension needed amendment, and asked to see "the DHHS documentation" before doing so. He then sent a further email at 5.21 pm, attaching an amended Notice. He said he thought that this Notice could safely be served without him seeing any further documentation – *i.e.* the material from Dr Cerchez. He added –

> *In my opinion, the public interest ground is sufficient and the public interest in suspension is clearly established by the letter from Dr McGinity's colleagues, without more.*

I note, however, that the draft Notice attached to his email, which was used in suspending Dr McGinity, founded the decision that he should be suspended on both the letter from Dr S1 and her colleagues and "expressions of serious concern" from DHHS about Dr McGinity's clinical competence and performance.

2.30. At 9:45 am the following day, 27 March 2009, the Registrar sent an email to the members of the full Council setting out what had occurred the previous day and providing a copy of the letter from Dr S1 and her colleagues. She said that Drs Joske and Sexton, exercising "the Executive's delegated power of Council", had "agreed to suspend" Dr McGinity's registration pending the outcome of an own motion investigation into the allegations.

2.31. No indication was given as to when that decision had been taken – *i.e.* whether that had occurred on the evening before, or on that day – but it is fair to assume that it was made after Mr Jackson's advice had been received during that evening. The Registrar also said that she had chosen a six month suspension as an initial period, but that this could be revoked by the MCT at any time, if it thought this appropriate. She concluded the email by saying

that she would be arranging for service of the Notice upon Dr McGinity that day.

2.32. The Notice that was served stated that the resolution to suspend was by the Medical Council of Tasmania, and did not refer to the purported exercise of delegated power by the Executive Committee. It said that the resolution had been made pursuant to both ss 55(1)(f) and (g) of the MPR Act. It was served upon Dr McGinity's surgery in George Street, Scottsdale by fax at 11:10 am on 27 March 2009 under cover of a letter from the Registrar. The letter told Dr McGinity that he ceased to be a registered medical practitioner upon receipt of the Notice for the period of time specified in the Notice unless the suspension was revoked by the MCT or the Supreme Court. The letter also told him of his right to appeal to the Court within 14 days of service of the Notice. There is no reason to believe that Dr McGinity had any prior notice of the proposed suspension.

2.33. The issue of whether Dr McGinity might be permitted to resume practice on the basis of giving undertakings which might protect the public arose very soon afterwards. Drs Sexton and Joske provided this information in their response to the draft of this report –

> *The first suspension took place with effect from Friday 27 March 2009. A scheduled Council meeting was held on Friday 3 April 2009 during which it was resolved to draft undertakings for Dr McGinity's perusal. If the terms of the undertakings were agreed to by the practitioner he would have been able to resume his practice forthwith.*
>
> *The first version of the undertakings was circulated amongst Council members before they were presented to the practitioner via his lawyer Ken Procter SC on Monday 6 April 2009. An amended version was prepared by Wednesday 8 April 2009 when Dr McGinity, and his lawyers, Ken Procter SC and Alison Hay met in person with the Council's President, the Registrar and its solicitor, Daniel Zeeman at the Council's offices in Hobart. They discussed the possibility of resolving the dispute subject to undertakings. Dr McGinity made it plain at that meeting that he was not prepared to agree to any undertakings at that time as he rejected the notion that he had been involved in any wrongdoing. Under the former Act the Council had no basis upon which to compel a practitioner to agree to conditions on their registration or to accept undertakings.*
>
> *Accordingly, the Council was prompt in its efforts to reinstate the practitioner's registration, subject to undertakings. The first attempt occurred within one business day of the Council meeting and six business days after the first suspension.*

2.34. The MCT appointed an internal investigator, Greg Roberts, to investigate the allegations against Dr McGinity. Mr Roberts sent an initial letter to Dr McGinity on 6 April, seeking his response to the allegations that preceded

the first suspension. The letter did not name particular cases in respect of which a response was sought. Dr McGinity subsequently replied to this letter by sending the MCT a 22-page document entitled "Response to Comments and Suggestions", dated 22 April 2009, with many attachments. His response dealt with four specific cases that had been raised in the allegations forwarded to him, and also addressed more general allegations in that material.

2.35. Further allegations came in to the MCT in April, from three of the signatories to the letter from Dr S1 and her colleagues and from Dr Cerchez, and Mr Roberts sent a further letter to Dr McGinity on 6 May, giving him an opportunity to respond to the additional matters. This letter raised allegations in respect of 19 further patients, 11 of whom were named. By this time, therefore, there were allegations about the management by Dr McGinity of 23 patients.

2.36. As mentioned, the first suspension of Dr McGinity's registration was quashed by the Supreme Court on 14 May. This result must have been anticipated, for the Registrar wrote to the members of the MCT on 7 May, saying that she was doing so at Dr Sexton's request, in anticipation of a proposed Special Meeting of the Council to be held by teleconference at a time to be fixed on 14 May. She said that the meeting was to consider two matters only – the terms of reference of the Executive Committee, and the suspension of Dr McGinity. Attached to the email were:

- documents relating to the first suspension
- the new information received against Dr McGinity since the first suspension;
- Mr Roberts' first letter to Dr McGinity, of 6 April;
- Dr McGinity's response of 22 April; and
- what the Registrar described as "Council approved and unapproved Undertakings (from the registration file and rejected by Dr McGinity)".

Thus, negotiations had already taken place with Dr McGinity in relation to undertakings which, if made, might satisfy the MCT that the public interest no longer required the suspension of his registration.

2.37. The second suspension took place at a meeting of the MCT held at 9.30 am on 15 May, the day after the Supreme Court decision was handed down. Six of the members of the MCT were present, with one of them absenting herself after about 75 minutes. Four were absent.

2.38. Aside from a resolution regarding the minutes of the previous meeting of the MCT, on 12 May, the MCT passed three resolutions at this meeting –

1. *That Dr Paul Michael McGinity's registration be suspended pursuant to s55(1)(g) of the Medical Practitioner's Registration Act 1996 ('the Act') in the public interest.*

2. *That Dr Paul Michael McGinity not be afforded the opportunity to be heard.*

3. *That the Medical Council is prepared to consider the revocation of the suspension of Dr McGinity in the event that he agrees to enter into undertakings as approved by the Medical Council.*

2.39. The minutes record that the MCT had considered all of the documents listed in para. 2.36 at its previous meeting – except for any mention of the letter from Mr Roberts to Dr McGinity and his response of 22 April[4] - and "based on this information determined that Dr McGinity is a risk to public safety". The decision that his registration should be suspended on this basis was said to have been demonstrated by his –

1. *Failure to exercise reasonable clinical judgement;*

2. *Failure to correctly diagnose life threatening medical conditions; and*

3. *Failure to correctly manage life threatening medical conditions.*

The minutes continue –

> *The Registrar advised that Council is unable to impose conditions on Dr McGinity's practice (at this time) that would protect the public, and therefore the Council determined that Dr McGinity's registration should be suspended immediately.*

2.40. The minutes record that the considerations which were taken into account in deciding that Dr McGinity would not be given an opportunity to be heard included the following –

- *That based on the information as listed in Appendix item 6.1, the need for suspension was urgent, in the public interest;*

- *Information provided by Dr McGinity in relation to the complaints currently under investigation;*

- *That Dr McGinity and his legal counsel (Mr Ken Procter SC and Ms Alison Hay) met with the President, the Registrar and Mr Daniel Zeeman during his previous period of suspension;*

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[4] It is obvious however, as noted in para 2.40, that the Council had considered those submissions in coming to its second resolution, so must be presumed to have also had them in mind when it came to the first.

- *That the Medical Council is currently awaiting a response from Dr McGinity in relation to a further 11 patients (as per Council's letter to Dr McGinity of 6 May 2009.*

2.41. Thus, the submissions which Dr McGinity had made in his document of 22 April were taken into account by the MCT – not, expressly, in advance of the decision to suspend, but in the decision that it was not appropriate to give him a further opportunity to be heard.

2.42. As for the issue of undertakings, the minutes include the following, prior to recording the resolution on this subject to which I have already referred:

> *The members discussed the previously approved proposed undertakings and the unapproved proposed undertakings.*
>
> *The Medical Council agreed that public safety concerns may be addressed by Dr McGinity agreeing to enter into appropriate undertakings relating to his clinical practice.*

As earlier stated, Dr McGinity entered into such undertakings on 12 June 2009, and thereafter regained registration and resumed medical practice.

3. Analysis – the task

3.1. My task is to measure these events and, specifically, the two suspensions, against the various bases for action that are listed in s28(1) of the *Ombudsman Act 1978*. That section states –

> *(1) Where, as a result of an investigation carried out under this Act, other than an investigation carried out pursuant to a reference made under section 15 or section 16, the Ombudsman is of the opinion that the action to which the investigation relates–*
>
> *(a) appears to have been taken contrary to law;*
>
> *(b) was unreasonable, unjust, oppressive, or improperly discriminatory;*
>
> *(c) was in accordance with a rule of law or a provision of an enactment or a practice that is or may be unreasonable, unjust, oppressive, or improperly discriminatory;*
>
> *(d) was taken in the exercise of a power or discretion and was so taken for an improper purpose or on irrelevant grounds or on the basis of irrelevant considerations;*
>
> *(e) was a decision that was made in the exercise of a power or discretion and the reasons for the decision were not, but should have been, given;*
>
> *(f) was based wholly or partly on a mistake of law or fact; or*

(g) was wrong–

he shall take such action specified in subsection (1A) or subsection (2) as in the circumstances of the case he thinks fit.

3.2. I deal first with the second suspension, since this is the most straightforward to address.

4. Analysis – the second suspension

4.1. I do not criticise the second suspension. I am satisfied that the Council had the power to suspend, that it had material before it on which it could justifiably reach the conclusion that the suspension was necessary in the public interest, and that under all of the circumstances Dr McGinity should not be given the opportunity to be heard before it decided on the suspension.

4.2. There had clearly been considerable engagement with Dr McGinity about the facts of the matter by that time; the Council had a written response from him about the allegations made prior to 6 April; and the suspension took place in a setting in which the MCT was flagging that it would let him practise provided that he agreed to make undertakings that would satisfy it that the public interest would be sufficiently protected. From this perspective, the conclusion that Dr McGinity was a "risk to public safety" was drawn on the basis that he would present such a risk if he were registered to practise without the protection of undertakings.[5] And, since he had refused to that point to give undertakings of the kind which the MCT saw as necessary to protect the public interest, the MCT effectively had no option but to suspend.

4.3. In making these comments, I am essentially commenting upon the processes followed by the MCT in deciding on this suspension. I do not comment on the merits of the various allegations that the MCT had before it at this time, beyond saying, as I have in the previous paragraph, that I am satisfied that the MCT had material before it on which it could justifiably reach the conclusion that suspension was necessary in the public interest. The allegations were later the subject of detailed investigation, with a number of them being dismissed. Some of them were dealt with by AHPRA and the Medical Board of Australia, as mentioned earlier, and are now the subject of a determination of the Health Practitioners Tribunal.

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[5] Various provisions in the MPR Act referred to the possibility of undertakings. Most relevantly to Dr McGinity's situation at this time, the Act empowered the MCT to suspend the registration of a medical practitioner if he or she failed to honour an undertaking given to it (s55(e)), or to remove a practitioner's name from the register on that ground (s40(1)(a)(iv)).

5. Analysis – the first suspension

5.1. As explained earlier, the first decision to suspend was made by a committee of two people, which believed that it was a duly formed Executive Committee, with delegated power to take this action.

5.2. Scrutiny therefore necessarily falls upon the information which was before this committee when it took that decision. It also falls on the process which the Committee followed in coming to its decision. These are the principal administrative aspects of the case upon which I have focussed. Again, I say nothing about the merits of the various allegations which led to this decision to suspend.

5.3. While there is nothing on the MCT file which records exactly what Drs Sexton and Joske had been given, the Registrar purportedly sent Dr Joske all of the information that the Registrar had received from Dr Cerchez up to 23 March (see para 2.14). In addition, Dr Sexton was the President of the MCT, and presumably had been kept well-informed by the Registrar as the matter developed. I am prepared, therefore, to assume that, at the time that they made their decision, Drs Sexton and Joske were aware of all the information that had come to the Registrar from Dr Cerchez.

5.4. In responding to the draft report, Drs Sexton and Joske told my predecessor that they were acting on "the concerns of four medical practitioners from Scottsdale in addition to the concerns of Dr Cerchez", but said that "the receipt of the letter from [Dr S1 and her colleagues], who had firsthand experience with Dr McGinity's practice, was a tipping point". They added –

> *A good deal of information, anecdotal or otherwise, had accumulated over the previous twelve months, which suggested a genuine concern in the local medical community for the safety of the Scottsdale public.*

5.5. Thus it is clear that the letter from Dr S1 and her colleagues was particularly influential in satisfying Drs Sexton and Joske that immediate suspension, without notice, was necessary in the public interest. The letter from Dr S1 and her colleagues was much more transparent about what was being sought than Dr Cerchez had been in his email, in that the doctors expressly sought an urgent review of Dr McGinity's registration, and thereby his right to practise. That being said, however, the letter raised nothing new. The two cases which they gave as examples were ones that Dr Cerchez had otherwise brought to attention (para 2.23); one of these had been mentioned by Dr Cerchez in his letter to the Registrar of 2 March (para 2.10); the two Coroner's cases had been mentioned at the initial meeting between DHHS and MCT personnel in January 2008 (para 2.5, first italicised paragraph); and otherwise the letter referred generally to multiple incident reports received by Dr Cerchez "over at least 3 years".

5.6. In other words, when analysed, the letter from Dr S1 and her colleagues added nothing to the material already received from Dr Cerchez, other than expressions of concern, and a clear request that action be taken with respect

to Dr McGinity's registration. I acknowledge, however, that one of the cases mentioned was one which Dr Cerchez had only raised with the MCT on 26 March himself, and it was new in that respect – para 2.18.

5.7. Why then, was the situation considered to be so urgent that summary suspension, without notice to Dr McGinity, was thought to be necessary? The exercise of the power to terminate a person's right to practise their livelihood without warning and without giving them any opportunity to answer the allegations against them, and so point out error or negotiate a different outcome, can only be justified on the basis of urgency. The implication is that there is no time to consult with the practitioner if the public is to be protected, that on the information received there is a real chance of significant harm occurring in the time that it would take to consult, and that the risk of harm is so great as to outweigh the ordinary obligation to be fair.

5.8. The Registrar certainly perceived no such urgency when she wrote to Dr Cerchez on 5 March, and spoke of releasing information to Dr McGinity "by way of seeking an explanation from him" – para 2.13. But she did see the situation as urgent by 26 March – para. 2.26. What happened in the meantime?

5.9. I also observe that Dr Cerchez never at any time expressed a need for urgency in his written communications with the MCT. I note in this respect:

- the delay of 10 months between the meeting of DHHS and MCT personnel on 25 January 2008 and Dr Cerchez' next contact with the MCT about the matter in his email of 2 December 2008 – paras 2.1 to 2.5;
- the delay by Dr Cerchez in making a formal notification to the MCT, which persisted through to his email to the Registrar of 26 March 2009, despite being pressed by the Registrar about the MCT's perceived need for a formal notification in her emails to him of 4 December 2009 and 5 March 2010 – paras 2.8 and 2.13;
- the lack of any action by Dr Cerchez to progress the matter with the MCT between his email of 5 December and his letter of 2 March – paras 2.9 and 2.10;
- the lack of any response by Dr Cerchez to the Registrar's email of 5 March (inviting a formal notification) until 24 March, when he was prompted to reply by receiving a copy of the Registrar's email to Dr Joske – paras 2.14 and 2.15;
- the materials that Dr Cerchez sent to the Registrar on 26 March had come to him on 26 February and 16 March – paras 2.10 and 2.18;
- the muted way in which Dr Cerchez wrote to the Registrar on 26 March, just "making the Medical Council aware of" the two cases of which he then provided details – para 2.16; and

- the fact that the report of Dr Hughes, received by Dr Cerchez on 4 March, was not forwarded to the MCT until 26 March – see para 2.17.

5.10. The answer to the question as to why the situation with Dr McGinity was suddenly treated as urgent seems to lie in the apparently serious nature of the three specific cases raised with the MCT on 26 March (by Dr Cerchez' email and the letter from Dr S1 and her colleagues, in combination), as well as, the call for urgent action contained in the latter.

5.11. Looking at the two cases in the letter from Dr S1 and her colleagues, the Committee had no detail on the first. Dr McGinity's submissions to the MCT of 22 April indicate that this case occurred on 22 February, but all the Committee could have known from the information before it was that the case was recent.

5.12. The letter from Dr S1 and her colleagues provided no details of this case in its three-line description, and the only other information before the Committee was that provided in a five-line summary in the A/DoN's report mentioned in para. 2.10. The summary from Dr S1 added nothing to the other. Thus, the Committee had before it a bare allegation of mismanagement by Dr McGinity in telling the family of a patient with severe chest pain to take him direct to the LGH, without Dr McGinity having seen him, and information that the patient had subsequently died. It had no significant detail before it which might have enabled it to judge whether the allegation was accurate or whether there may have been extenuating circumstances.

5.13. The second case in the letter from Dr S1 and her colleagues was documented in the incident report mentioned in para 2.18, provided to the MCT with Dr Cerchez' email of 26 March. The report shows that the incident occurred on 16 March. The patient had suffered a heart attack, and so was clearly at risk of dying. More informative of course than the available descriptions of the first case, the incident report implied that Dr McGinity had failed to recognise the seriousness of the patient's condition. The patient had woken with chest pain at 3 am, but had been treated at home and later at the surgery, and not hospitalised until eight hours after the symptoms first presented. There was implied criticism of the failure to call an ambulance earlier, of Dr McGinity's request to the ambulance officers to take the patient direct to the LGH, of an alleged failure to give oxygen, and of an alleged failure to give medications which are normally administered in such a setting.

5.14. The letter from Dr S1 and her colleagues did not specify the criticisms being made of Dr McGinity's management of this case, but it seems that the doctors' concern was with failure to diagnose the heart attack earlier, overall delay in calling an ambulance, and seeking to have the patient taken to the LGH.

5.15. The third specific case before the Committee on 26 March was the one referred to in paras 2.11 and 2.17, in relation to which the Committee had the email to Dr Cerchez from Dr Hughes of 4 March. This case had

occurred on 2 March. In this case also, Dr McGinity had instructed the ambulance crew to take the patient direct to the LGH, rather than to the NESMH.

5.16. Dr Hughes' email of 4 March certainly gave cause for concern about this case. Dr Hughes' initial view, on the materials that he had seen, was that the case was suggestive of misjudgement by Dr McGinity – failure to recognise the severity of the situation, or an unwise failure to send the patient to the NESMH for stabilisation before the patient was transferred to the LGH. A possible failure to recognise the severity of the situation was evidenced by the limited information provided in Dr McGinity's referral letter, by the failure to accompany the patient in the ambulance, and by the failure to seek local medical assistance. Dr Hughes considered that the case required peer review.

5.17. All three cases contained the same theme – an ill-considered decision that the patient should go directly to the LGH, rather than to the nearby rural hospital, the NESMH. The backdrop to this, unstated in the letter from Dr S1 and her colleagues or in any of Dr Cerchez' communications with the MCT between December 2008 and March 2009, but manifest from the details in para 2.5 of the meeting of Dr Cerchez and Pip Leedham with MCT personnel in January 2008, was concern that Dr McGinity was deliberately avoiding the use of the NESMH, and compromising his patients, by sending them to the LGH, because of feelings of animosity towards practitioners at the NESMH. It is relevant to this that the issue of the restoration of Dr McGinity's clinical privileges at the NESMH was still unresolved.

5.18. The second and third of these cases also contained the theme of concern about Dr McGinity's clinical competence or performance (to use words from the Notice of Suspension of Registration that issued in relation to this suspension).

5.19. There was a fourth specific case of which the Committee had some knowledge. This was the case of the pre-eclamptic patient mentioned in para 2.10 - another case of allegedly poor clinical competence, with no issue about transfer to the LGH. In this case, the only detail available was the A/DoN's case summary of just over five lines.

5.20. Then there were the two Coronial cases, to which the letter from Dr S1 and her colleagues made reference. No detail about these cases was on the MCT's file when inspected by my officer, and I have no reason to believe that the Committee knew anything about them.

5.21. My strong view, after dissecting the facts in a way that could not have been possible in the rush to action which took place at the MCT on 26 March, is that the failure of the Committee to accord Dr McGinity procedural fairness before acting to suspend him, was, in the words of s 28(1) of the *Ombudsman Act*, unreasonable and unjust. I also consider that it was preceded by totally inadequate administrative preparation.

5.22. I make mention of these specific matters –

- The Committee acted in haste, deciding on the suspension in less than 24 hours of receipt of Dr Cerchez' final email and the letter from Dr S1 and her colleagues. It did so without any report from any MCT officer or any other person analysing the facts that were thought to justify such extreme action. In saying this, I note that the way the facts developed meant that the Committee may not have ever realised that only four specific cases had been raised, and that the evidence with respect to two of these was effectively limited to five lines each, so that they truly represented only bare allegations. As mentioned, one of these inadequately detailed cases was one of the two cases which lay at the centre of the letter from Dr S1 and her colleagues.

- For similar reasons, the Committee may never have appreciated how long it was since the McGinity case (then de-identified) was first raised with the MCT, and the full nature of the delays that had occurred in Dr Cerchez coming forward with a formal notification – as to which see para 5.9 above.

- For similar reasons also, the Committee may not have separated in its mind the two primary issues that the specific case brought forward – (1) inappropriately sending patients direct to the LGH rather than to the NESMH first, and (2) clinical competence. There were three cases in the first category, one of which was known only through a five-line summary, and there were only two cases in the latter. The first of these issues in particular was readily susceptible to being addressed by undertakings that the MCT could have sought to negotiate with Dr McGinity.

- No thought seems to have been given to the fact that Dr Cerchez had indicated that the Quality and Safety Appeal Committee had yet to report, and was expected to do so by the end of the month (para 2.16). The MCT would never have received details of the deliberations of the Committee, since they would have been covered by qualified privilege,[6] but the outcome of that review process would have become known and was very relevant to the decision that it was taking.

5.23. All in all, the suspension was inadequately thought through at officer and committee level, particularly for a step that would have such gross effects upon the practitioner, his family, his employees, his patients and the local communities in which he practised.

5.24. The peremptory removal of a person's right to practise their profession, without giving that person any prior notice or opportunity to be heard, has to be very cautiously used. Those who exercise such a power need to do so in full appreciation of the financial, reputational and other consequences that will and may flow for the individual whose right of practice is being taken away, and of the consequences for others who are connected with that

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[6] See footnote 2 above.

person, and whom that person serves. They need to do so in the firm and well-founded conviction that the circumstances which would appear to justify the exercise of the power are so clear that there is no reasonable alternative course of action.

5.25. Translating these observations into the context of this case, and repeating observations that I have made in para 5.7 above, the members of the Committee needed to be satisfied that the risk to public safety which it regarded Dr McGinity as presenting was so grave that immediate action had to be taken - and that immediate action had to be taken without any notice to him or any opportunity to answer the allegations, in order to prevent him from continuing to practise and thereby potentially causing harm. It therefore had to be satisfied that, weighing the public risk against the desirability of according procedural fairness in light of the extreme consequences that would flow for the practitioner and others, the summary removal of Dr McGinity's right of practice was the only proper course. There is no evidence that the matter was ever approached with the discipline called for by these considerations. Indeed, the timing and nature of the communications which passed between those involved on 26 March are clear evidence to the contrary.

5.26. As it turns out, the MCT and now AHPRA, the Medical Board and the Health Practitioners Tribunal have since been satisfied that Dr McGinity should be allowed to continue to practise medicine, subject to certain undertakings. He has continued to practise under these arrangements since June 2009, albeit under the cloud of the continued investigation by AHPRA of a number of the cases raised against him in 2009. There is reason to believe, therefore, that the MCT could have achieved similar arrangements in March or April 2009, and avoided all of the upheaval that followed the decision of the Committee on 26 March 2009 to summarily suspend.

6. Submissions in response to draft report

6.1. This section of this report addresses some of the submissions made in response to the draft report. It does not deal with all of the points made, but that should not be taken as indicating that I have not considered the submissions in full.

6.2. The primary points made by Drs Sexton and Joske are that:

- their decision to suspend was influenced by the widespread community concern which surrounded the case of Dr Jayant Patel in Queensland, and by the belief that "Council might be criticised for failing to act quickly enough or for not being seen to take the complaints, which appeared to involve the deaths of some patients, sufficiently seriously";

- they chose to act as promptly as possible on the allegations because they might otherwise have been criticised as being tardy, and not having the welfare of the public as the paramount consideration;

- they considered that a delayed response could have potentially caused unnecessary and avoidable serious risk to the public;

- they were faced with extremely serious allegations from several medical practitioners who each had knowledge of Dr McGinity's practice, who considered that he might be causing avoidable deaths;

- the legislation under which they were operating did not, unlike the *Health Practitioner Regulation National Law Act 2009*, provide them with the power to impose conditions on Dr McGinity's practice to address the situation, or require him to give undertakings;

- the events had been deconstructed out of context and the draft report failed to consider whether any realistic alternative options were available to the MCT;

- they had acted decisively, in good faith and entirely in the public interest, to protect the public from potential harm in the best manner that they could;

- this type of action had been contemplated for some time, but the MCT was not able to act on the contact from Dr Cerchez because he was not able to fully disclose all the relevant details until March 2009;

- given the nature of the allegations, the length of time for the complaints to crystallize and the proportion of medical practitioners in Scottsdale demanding action, the Council felt compelled to act; and

- they had the clear power to suspend without according procedural fairness, and that this was the type of case where timely action was more important than procedural fairness.

6.3. The primary points made by Mr Jackson which I have not already addressed by adjustments to the report are that:

- the draft report did not give sufficient attention or weight to the contents of the letter from Dr S1 and her colleagues, including its request for urgent action by the MCT;

- the draft report misconstrued how and why it came about that urgent action had been taken following the letter from Dr S1 and her colleagues and Dr Cerchez' final email;

- seen in its correct factual context, the matter was not suddenly treated as urgent on 26 March 2009;

- the MCT was in fact "only waiting for the "green light" from Dr Cerchez which came with his final email, and that "it was not until the Council was in possession of tangible evidence, in the form of the letter from [Dr S1 and her colleagues], that colleagues of Dr McGinity held serious concerns about his competence and their

perception of the risks that he presented to members of the public who were his patients";

- the analysis in the report involved a "bureaucratic consideration of issues with the benefit of hindsight"; and

- hindsight also showed that it is unlikely that Dr McGinity would have agreed to undertakings, such that immediate suspension, without notice, was the only practical option.

6.4. Dr Cerchez asked for his submissions to remain confidential. I have made a number of adjustments to the report to take account of those submissions.

6.5. I make the following observations in response to the submissions which I have detailed.

6.6. I do not doubt that the Committee and those working with it acted in good faith, and with a sense of urgency driven by concern for protection of the public, with the possibility of a Patel-type situation in mind. I do not accept, however, that immediate suspension without notice was under serious consideration prior to late March 2009, because that is inconsistent with the Registrar's emails to Dr Cerchez of 4 December 2008 and 5 March 2009 (paras 2.8 and 2.13). As Drs Sexton and Joske admitted in their submissions, and as Mr Jackson also indicates, the receipt of the letter from Dr S1 and her colleagues was a tipping point. Here were four practitioners from the same community who were calling for the urgent review of Dr McGinity's medical registration, on the grounds of public safety. I think it safe to say that without the letter from Dr S1 and her colleagues, the Committee would not have acted to suspend in the way that it did.

6.7. As Mr Jackson says, the Committee now had the "green light" that it had been waiting for. It had long held concerns about Dr McGinity, as a result of the information that had come forward from Dr Cerchez, and now it had evidence that Dr McGinity's colleagues had serious concerns about his competence and about the potential risk to the patients.

6.8. Notwithstanding the Committee's concerns, the power to peremptorily remove a person's right to earn a living is an extraordinary power, which automatically calls for caution. The call for action by the four local doctors was significant, to be sure, but the Committee had to form its own judgement, and evaluate whether that call for action was well-founded, and whether the evidence before it was sufficient to justify the exercise of the power. As I have indicated, the MCT's files contain no analysis of the evidence which had come forward, to determine if it was sufficient. On analysis, that evidence was limited. Under the circumstances, it was easy to obtain the impression that the evidence was more extensive than it in fact was.

6.9. What alternative did the Committee have? The alternative was to formulate the sort of undertakings which were developed in the more considered circumstances which followed the Council meeting on 3 April, and put the

allegations and those undertakings to Dr McGinity, and demand a prompt response, under the threat of immediate suspension if the MCT could not be satisfied that the public interest was adequately safeguarded. It might have taken one to two weeks to bring matters to a head this way.

6.10. An obvious rejoinder to this is that the public would not have been safeguarded in the meantime, and the risk of harm to the public was too great to ignore. This is true – but the concerns about Dr McGinity had been long-standing, and one to two weeks in the scheme of things was not a significant period, particularly when the evidence against him was limited. It is not too strong to say that the Committee acted on evidence which needed substantiation.

6.11. Another rejoinder, put in the submissions above, is that later events indicate that it is unlikely that Dr McGinity would have given any undertakings, and that the Committee would have had to suspend him anyway. I acknowledge that this may have been the case – but, if things had developed in this way, Dr McGinity would have been accorded procedural fairness and would have had only himself to blame for the loss of any right to practise.

6.12. Finally, I think it important to comment that the delay by Dr Cerchez in bringing things to a head by his email of 26 March 2009 was not justified by the assertion that qualified privilege prevented him from providing detail until then. His email preceded the delivery by the Quality and Safety Appeal Committee of its report in any event, and s4 of the *Health Act 1997* did not prevent provision of evidence about the quality of Dr McGinity's practice, only evidence of what had taken place within the quality assurance committees which were involved. Dr Cerchez could have made his case to the MCT, as he eventually did, without any evidence of what had taken place within a quality assurance committee.

7. Concluding comments

7.1. As earlier indicated, I have completed this report so as to provide insight into the first and second suspensions, which caused such public controversy at the time. No legal consequences flow from my findings, and I make no recommendations for future action. I would have been making recommendations if the MCT had been in existence, but the advent of the national registration scheme for health professionals means that the task of considering the suspension of a health practitioner in circumstances such as those outlined in this report now falls to other organisations, under other laws. Perhaps, however, this report and the whole episode behind it will give rise to appropriate caution by health registration boards in future, when considering the summary suspension of practising rights.

Leon Atkinson-MacEwen
Ombudsman

27 July 2012

ATTACHMENT A

Determination of the Health Practitioners Tribunal delivered on 3 July 2012, available at the web address below.

www.austlii.edu.au/au/cases/tas/TASHPT/2012/4.html