

**IN THE COURT OF APPEAL
SUPREME COURT OF QUEENSLAND**

APL 4611/05

HELEN TSIGOUNIS

**(Applicant for Leave to
Appeal/Appellant)**

and

MEDICAL BOARD OF QUEENSLAND

(Respondent)

OUTLINE OF ARGUMENT FOR MS TSIGOUNIS

OVERVIEW

1. At a meeting held on 28 May 2002, the Medical Board of Queensland (“**the Board**”) granted Helen Tsigounis (“**the Appellant**”) general registration with internship conditions pursuant to ss 57 and 59 of the *Medical Practitioners Registration Act 2001* (Qld) (“**the Act**”) as a general registrant with probationary internship conditions. At a meeting held 11 June 2002, the Board resolved that the Appellant complete a prescribed internship of six months, with a minimum period of 12 weeks in surgery.¹ The Board’s decision and reasons were provided to the Appellant in an Information Notice dated 21 June 2002 (Vol 11 A2755).
2. The concept of “*prescribed internship*” appears in s 57(1) of the Act concerning the “*Imposition of Internship Conditions*”. Section 57(1) applies if:
 - (a) the board decides to register an applicant for general registration who has successfully completed a medical course stated in section 44(a) as a general registrant; and
 - (b) the applicant has not started or, to the board's satisfaction, completed—
 - (i) the internship, for the profession, that is prescribed under a regulation (the prescribed internship) ...
3. Regulation 4 of the *4 Medical Practitioners Registration Regulation 2002* (“**the Regulation**”) provides that for s 57(1)(b)(i) of the Act, the prescribed internship:
 - (a) consists of at least 52 weeks in 1 or more accredited intern training programs or accredited intern training secondment programs; and

¹ Vol 11 A2748, A2753.

- (b) must include at least 10 weeks practical experience and training in each of the following—
 - (i) medicine, other than emergency medicine;
 - (ii) surgery;
 - (iii) emergency medicine.
- 4. From 11 June 2002, the Appellant was employed at Townsville District Hospital as an intern.
- 5. On 2 January 2003, the Board received a Notification of Completion of Internship from the Appellant. On 14 January 2003, the Board resolved that it was not satisfied that the Appellant had completed the period of 12 weeks experience in surgery, and extended the probationary conditions on her registration for a further period of three months. On 16 May 2003, the Board received a further Notification of Completion of Internship from the Appellant.
- 6. At a meeting held on 10 June 2003, the Board resolved that it was not satisfied that the Appellant had satisfactorily completed the internship program or could satisfactorily complete it during the prescribed period.² The Board further resolved that the Appellant be given a Show Cause Notice pursuant to s 85 of the Act inviting her to make a submission as to why the Board should not cancel her general registration – internship conditions. The Appellant responded to the Notice, but her registration expired on 30 September 2003 before the Board further considered the matter. On 16 December 2003, the Appellant applied for restoration of her registration, and on 27 January 2004 the Board resolved that her general registration be restored effective 27 January 2004 subject to the probationary conditions. At its meeting of 10 February 2004, the Board adopted resolutions in similar terms to those of 10 June 2003.³
- 7. On 23 March 2004, the Board resolved pursuant to s 88(3) of the Act to cancel the conditional registration of the Appellant as a medical practitioner.⁴
- 8. Pursuant to s 239 of the Act, the Appellant appealed to the District Court against the Board’s decision.
- 9. By decision delivered 11 May 2005 (Vol 16 A4172), Judge Wall QC allowed the appeal against the Board’s decision of 23 March 2004 to cancel the Appellant’s conditional registration as a medical practitioner, and set aside the decision to cancel her conditional registration. However, the judge confirmed the Board’s decision that the Appellant had not satisfactorily completed her internship, and directed the Board to extend the probationary conditions imposed on her registration for a period of one year by requiring her to undertake all of the prescribed internship.
- 10. The judge added at A4238 [298]:

² Vol 11 A2844.

³ Vol 11 A2979.

⁴ Vol 11 A3025.

“If the Board has power to vary the Appellant’s probationary conditions I consider it should be directed to do so by imposing additional conditions to the effect that during the prescribed internship the Appellant should submit to and undergo such psychiatric treatment as is considered appropriate by the Board with regular reporting to the Board by the treating psychiatrist/s and that during the prescribed internship there be such mentoring and supervision as is considered appropriate by the Board, together with contemporaneous advice to the Appellant of any perceived deficiencies in the performance of her internship and definitive assessment of her progress.”

11. The judge then adjourned the further hearing of the appeal to allow further submissions as to any directions to be given to the Board under s 240(1)(d) of the Act. Section 240(1) provides that in deciding an appeal against a decision of the Board, the District Court may:
 - (a) confirm the original decision; or
 - (b) amend the original decision; or
 - (c) substitute another decision for the original decision; or
 - (d) set aside the original decision and return the issue to the board with the directions the court considers appropriate.
12. By decision delivered 21 June 2005 (Vol 16 A4332), the judge ordered the Board to pay 15% of the Appellant’s costs of and incidental to the appeal. By decision delivered 12 July 2005 (Vol 17 A4342), the judge confirmed the orders made 11 May 2005, with an additional direction to the Board pursuant to s 240(1) (d) of the Act that the Appellant undertake the prescribed internship at a hospital other than Townsville Hospital.
13. The Appellant contends that whilst the judge at [27]-[31] (A4181) recognised that that the requisite standard of proof was that articulated by the High Court in *Briginshaw v Briginshaw* (1938) 60 CLR 336 (A4181)⁵, his Honour failed to apply that standard given the approach he took to:

⁵ In *Briginshaw v Briginshaw* Dixon J at 362 – 363 said: “Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of the given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters ‘reasonable satisfaction’ should not be produced by inexact proofs, indefinite testimony, or indirect inferences. Everyone must feel that, when, for instance, the issue is on which of two dates an admitted occurrence took place, a satisfactory conclusion may be reached on materials of the kind that would not satisfy any sound and prudent judgment if the question was whether some act had been done involving grave moral delinquency ... It is often said that such an issue as fraud must be proved ‘clearly’, ‘unequivocally’, ‘strictly’ or ‘with certainty’ ... This does not mean that some standard of persuasion is fixed intermediate between the satisfaction beyond reasonable doubt required upon a criminal inquest and the reasonable satisfaction which in a civil case may, not must, be based on a preponderance of probability. It means that

- 13.1. the seriousness of the allegations made, and the gravity of the facts to be proved, by the Board;
 - 13.2. the resolution of contested issues of fact in favour of the Board, in numerous instances the dispute being one of the Appellant's word against the uncorroborated word of another;
 - 13.3. the resolution of contested issues of fact, including expert opinion, adversely to the Appellant with inadequate explanation for the preference given to some experts over others; and
 - 13.4. the inherent unlikelihood of the Board's account having regard to the uncertain and inexact status of material factual allegations.
14. The Appellant submits that the evidence before the judge did not permit him to be satisfied that the Board has established its case to the *Briginshaw* standard of proof. In many instances, his Honour accepted evidence that was imprecise and vague, and drew indirect inferences without adequate explanation to justify what was thereby a failure to observe *Briginshaw*. This was an error of law.
15. Because of the importance of the matter to the Appellant, it was essential that the evidence of the Board be placed under the most careful scrutiny. Once that evidence is given the requisite scrutiny, it is plain that it had elements of unreliability which make the decision of the Board and that of judge decision unsafe. As the Supreme Court of Western Australia observed in *Hewett v Medical Board of Western Australia* [2004] WASCA 170:
- "The consequences to a medical practitioner of being found guilty of infamous conduct are extremely serious. In this case the Board took the view that the proper penalty was to remove the appellant's name from the Register of Medical Practitioners. No greater penalty could be suffered by a medical practitioner."*
16. The observations of Fitzgerald AJA in *Sinha v Health Care Complaints Tribunal* [2001] NSWCA 206 at [23]-[25] are to like effect.
17. The Appellant further submits that there was no basis in the evidence for the judge to direct the Board to impose additional conditions to the effect that during the prescribed internship she submit to and undergo such psychiatric treatment as considered appropriate by the Board with regular reporting to the Board by the treating psychiatrist/s.
18. Further, the decision of the judge to require the Appellant to commence the hearing without legal representation, and to appear unrepresented for the first three days of the hearing, 23- 25 August 2004, amounted to a serious denial of procedural fairness.

the nature of the issue necessarily affects the process by which reasonable satisfaction is attained. When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon other civil issues ... but, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected." See also *Rejfeek v McElroy* (1965) 112 CLR 517.

LEAVE TO APPEAL

19. Section 118(3) of the *District Court Act 1967* provides that leave is required for the proposed appeal. The Appellant submits that the proposed appeal involves error of law, and is one of considerable gravity, raising an important question of justice: *Johns v Johns* [1988] 1 Qd R 138 at 142; *Jiminez v Jayform Contracting Pty Ltd* [1993] 1 Qd R 610 Davies and McPherson JJA at 612.
20. The errors of law are found in the judge's consistent misapplication of the correct standard of proof, and in the denial of procedural fairness in requiring the Appellant to commence the hearing unrepresented and unprepared.
21. The gravity of the case and the important question of justice lie in the impact of the decision of the judge upon the Appellant's ability to pursue her career as a medical practitioner. The adverse findings of the judge in relation to the Appellant's professional competence are infected by an erroneous approach to the proper standard of proof, in a case in which the consequences to the Appellant are extremely serious.

COMPLAINTS/INCIDENTS

22. In opening (Vol 1 A12-17), the Board identified seven "*key incidents*" underlying the decision to cancel the Appellant's registration as a medical practitioner. These can be summarised as follows:
 - 22.1. the "*meningitis patient*" — 27 January 2003 (Judgment A4200);
 - 22.2. the cannulation of children:
 - 22.2.1. 2 September 2002 - Nurses Bailey and Haley (Judgment A4196);
 - 22.2.2. September 2002- Nurse Steer (Judgment A4196);
 - 22.2.3. about October - Dr Hodges (Judgment A4197);
 - 22.2.4. 28 October 2002 - 31 January 2003 — Dr Elcock, Nurses Maloney and Buldo (Judgment A4198)
 - 22.3. the lumbar laminectomy patient/diuretic incident - 20 February 2003 - Dr Lucas (Judgment A4187);
 - 22.4. the blood coagulation profile incident — 24 February – 9 March 2003 - Dr Balanathan (Judgment A4189);
 - 22.5. the phone order for potassium — 24 February – 9 March 2003 - Dr Balanathan (Judgment A4190);
 - 22.6. drug administration/intubation incident - mid January 2003 - Dr Gelhaar (Judgment A4199); and
 - 22.7. the morphine/Maxalon incident – 23 April 2004 – Nurse Margaret Weber (Judgment A4210).
23. The Appellant submits that there is a proper distinction to be made between complaints in relation to "*key incidents*" and other complaints

which cannot of themselves provide a bar to general registration. An illustration of complaints falling within this latter category are the various “*medication incidents*” referred to in the judge’s reasons of 11 May 2005. Where established to the requisite standard of proof, matters of this type are properly characterised as errors or mistakes which do not evidence a lack of minimum standard of knowledge or competency to prevent general registration as a medical practitioner: *Pillai v Messiter* (1989)16 NSWLR 197 per Kirby P at 202.

24. In relation to each of the “*key incidents*”, the Appellant submits that the Board failed to establish its case to the *Briginshaw* standard of proof, and that the proper order would have been to the effect that the Appellant had satisfactorily completed the internship conditions in accordance with the Information Notice dated 21 June 2002.

THE “MENINGITIS PATIENT”

25. Before the judge, the Board identified the management of patient Jarrod Young (“**JY**”), otherwise referred to as the “*meningitis patient*”, as the most serious of the incidents involving the Appellant (Vol 1 A12, 14.8). The incident formed the focal point of the Board’s case in relation to competency.
26. The Appellant submits that the judge erred in finding (A4200) that:
 - 26.1. JY in fact had meningitis;
 - 26.2. the Appellant should have performed a lumbar puncture; and
 - 26.3. the Appellant discharged JY without first presenting him to a Registrar or consultant.

Whether JY had meningitis

27. The evidence as to whether JY had meningitis was in conflict, Dr Cooksley expressing the view that JY had meningitis (Vol 4 A714), with both Dr Small (a witness for the Board) (Vol 2 A306.50) and Dr Papagelis (a witness for the Appellant whose evidence the judge generally accepted - Vol 16 A4230 [260]) (Vol 5 A1079.35) saying he did not.
28. The evidence was that following discharge in a range of what JY described as “8 to 9 o’clock (Vol 2 A284.35), JY went home, slept, suffered a recurrence of headache, and returned to the Emergency Department at about 3 pm (Ex40 Vol 12 3081 page 13). On his readmission, a lumbar puncture was performed some time after 5pm (Vol 2 A274, Vol 12 A3124). The lumbar puncture provides the basis for Dr Cooksley’s opinion (Vol 4 A714), a diagnosis made by him in part on hearsay evidence and without having examined the patient (Vol 9 A2141 para 9.2), and without having read the whole patient notes (Vol 4 A715.28).
29. Following readmission and lumbar puncture, Dr Gelhaar, the Registrar supervising the Appellant at the time (Vol 9 A2265.2266), was unable to put the diagnosis any higher than “*query meningitis*” (Vol 1 A74.10),

and stated there was never any evidence to support bacterial meningitis, the more serious form of the disease.

30. Dr Small, Director of the Emergency Department, gave evidence for the Board that following readmission and lumbar puncture there were no signs of meningitis, and that the lumbar puncture test would not have been significantly altered by antibiotics previously prescribed by the Appellant (Vol 2 A306.50). The view of Dr Small was supported by observations of various witnesses that the presentation of JY lacked the “*classic indicators*” of meningitis, which include high white blood cell count and fever. See for example:
 - 30.1. Dr Cooksley (Vol 4 A695.30, 697.30, 698.5, 699.27, 700.25, 703.40, 704.25, 706.20);
 - 30.2. Dr Papagelis (Vol 5 A1079.30-30. A1080.20); and
 - 30.3. Professor Dewan (Vol 4 A913.15-.50 914.10-.30, 916.40); and
31. The finding that JY had meningitis is incompatible with the equivocal evidence of Dr Gelhaar, and contradicted by Dr Small whose opinion was supported by Dr Papagelis and Professor Dewan.
32. It is submitted that the opinion of Dr Cooksley is unreliable as it is based on errors of fact. His statement to the Board dated 5 February 2004 is predicated on JY being an “*acute bacteria meningitis patient*” (Vol 9 A2148, A2154). The doctor incorrectly assumed that the Appellant diagnosed acute bacterial meningitis, performed a lumbar puncture and discharged the patient; who was then recalled (Vol 9 A2154). In an email to Dr Pugh dated 5 December 2003 (Vol 9 A2150), Dr Cooksley made errors concerning JY being a “*woman*” and a diagnosis of bacterial meningitis having been made. In cross-examination, Dr Cooksley admitted to errors in his statements (Vol 4 A702.30, A708.10), A71339, A704.30, A707. 10). The erroneous statements made by Dr Cooksley were conveyed to Dr Yuen who investigated the Appellant on behalf of the Board (Vol 4 A712.20), leading to Dr Yuen repeating the same errors (Vol 4 A712.60, A713.30) relating to “*JYs symptoms and treatment regime*”.
33. The opinion of Dr Small that JY did not suffer from meningitis was powerful evidence, Dr Small being the Board’s witness and well qualified to express an opinion, being the head of the Emergency Department. He described the incident as no higher than “*patient mismanagement with potentially significant outcomes to the patient*” (Vol 2 A305.30). Despite having being informed of the incident, Dr Small did not make a formal complaint (Vol 13 A3393, Vol 9 A2170), and asked Dr Lucas, who admitted JY on his re-presentation, not to discuss the matter with the Appellant (Vol 7 A1579 para 7). Dr Small’s description of the Appellant’s management of the patient, his opinion that the patient did not have meningitis, and his failure to institute any action combine powerfully to suggest that Dr Small did not regard the incident as significant.

34. The evidence lacked the cogency required by the *Briginshaw* standard to support a finding that JY suffered from meningitis, and the judge erred in so finding.

Whether lumbar puncture should have been performed

35. Following the admission of JY at about 4.35am, the Appellant conducted a thorough examination as evidenced by the clinical notes (Vol 12 A3120 Exhibit 40). Testing, including pulse rate, temperature, and full blood count, was performed and medication provided (see translation of notes (Vol 1 A98.30 ff). Dr Papagelis described the Appellant's treatment as "*a very thorough workup*" (Vol 5 A1062), an assessment which was not challenged.
36. The issue remains whether despite consideration being given by the Appellant to a diagnosis of meningitis, which on her assessment was not appropriate as evidenced by notation "*exclude meningitis*" (Vol 12 A3123 Exhibit 40) and her actual diagnosis of "*viral infection*" a lumbar puncture should have been performed.
37. Dr Papagelis gave evidence estimating a low statistic of 0.01% of patients presenting with headache having meningitis (Vol 5 A1063.30), an element of risk associated with lumbar puncture (although relatively small) (Vol 5 A1063.20), and of not performing lumbar puncture on every patient who presents with bad headache. Professor Dewan gave evidence that conditions including migraine and viral infection can present with similar symptoms to meningitis, and that the other conditions are a more common presentation (Vol 4 A916.30-.50).
38. When the clinical picture recorded by the Appellant in the medical notes was put to Dr Coley in cross-examination (Vol 1 A94.40), the doctor conceded that he would "*really need to use my best judgment and may not immediately jump into a lumbar puncture*" (see also Vol 1 A101.40). Dr Coley stated that the decision to perform a lumbar puncture was affected by "*clinical subtleties*" (Vol 1 A101.15). In terms of the Appellant's diagnosis of "*viral illness*", Dr Coley agreed that viral illness with headaches was common (Vol 1 A101.30), more common than viral meningitis.
39. At the time of JY's presentation on 27 January 2003, the Appellant had available to her the clinical notes relating to JY's presentation in November 2000 (Vol 4 A788). On the assumption that the January 2003 presentation included "*aches and pains*", Dr Gelhaar agreed that the presentations were "*almost identical*" (Vol 1 A156.50).
40. The fact of the prior presentation with similar symptoms which were not meningitis was a factor which influenced the Appellant's decision to "*exclude meningitis*", and not proceed to lumbar puncture. That decision was supported on the evidence of Professor Dewan (Vol 4 A915, 917); Dr Rosenblum (Vol 5 A1141); and Dr Papagelis (Vol 5 A1079). Dr Papagelis opined that he would only proceed to lumbar puncture if he felt "*strongly that there was a possibility of meningitis*" (Vol 5 A1079). Professor Dewan gave evidence that having regard to JY's previous

presentation, he would regard lumbar puncture as dangerous (Vol 4 A915.10).

41. Moreover, the decision as to whether a lumbar puncture was to be performed did not rest solely with the Appellant. The patient remained in the Emergency Department until at least 8.35am, if not 9.01am (Vol 16 A4338), following the ward rounds, which the Appellant knew would be conducted at 8am involving a consultant and Registrar. The Appellant gave evidence that she had "*low suspicion of meningitis*" but thought it was most likely a viral infection with headache (Vol 4 A789, 807). It is submitted that the clinical presentation of JY, and contrary opinions, create sufficient doubt as to whether lumbar puncture should have been performed such that there was an insufficient evidentiary basis upon which the judge could have been satisfied, to the *Briginshaw* standard, that the Appellant ought to have performed lumbar puncture.

Whether JY discharged without presenting to Registrar or consultant

42. It is beyond dispute that JY had not been discharged from the Emergency Department whilst the ward round which began at about 8am was being conducted (Vol 12 A 3081 para 11). JY observed the group of doctors "*going from bed to bed speaking to patients*".
43. The evidence in relation to the ward rounds included the following:
- 43.1. Dr Ashley gave evidence that "*all patients present in the emergency department at 0800 hours were reviewed during the 0800 hours ward rounds*" (Vol 10 A2439).
- 43.2. The Appellant was present beside JY's bed during the ward round (Vol 12 A3081 para 10).
- 43.3. Dr Gelhaar, the most senior doctor in the Emergency Department during the Appellant's consultation with JY, accepts that the ward round was performed with the Appellant (Vol 9 A2266 para 18). Dr Gelhaar gave evidence as to the usual practice: "*we generally have some sort of discussion about every patient... especially for a patient who is still in the department*" (Vol 1 A134.20). This account was shared by Dr Papagelis who stated that "*each of the patients is viewed and discussed*" (Vol 5 A1056.55). From his experience, the absence of a note on the patient chart can be explained as it is "*often not practical*" (Vol 5 A1057.40).
44. The Appellant gave evidence that she at all times attempted to comply with the Emergency Department policy to seek advice and direction from the supervising doctor on duty (Vol 13 A3248). She gave evidence that she kept patient JY in the Emergency Ward "*overnight*" in order to present him at the 8 o'clock ward round, and to enable a decision to be made concerning lumbar puncture (Vol 4 A806.10-30). She gave evidence that she discussed the patient with Drs Coley and Gelhaar (Vol 4 A790.10, A806.30). It is relevant also that the Appellant gave evidence, which was not challenged, that by the time of the ward rounds JY's

minimal photophobia had resolved and he was watching television (Vol 4 A808.5)

45. It is submitted that it is highly unlikely that the patient JY was not reviewed by Dr Gelhaar and others conducting the ward round. This is particularly so having regard to the fact that the patient had not been discharged at the time of the ward round, the acknowledgement by Dr Gelhaar that she “*did a ward round with Helen*” (Vol 9 A2226 para 18), and the description by Dr Gelhaar of the practice that “*we generally have some sort of discussion about every patient*” (Vol 1 A134.20).
46. Dr Gelhaar attempted to explain not seeing the patient JY on the basis of her understanding of the chart notes discharge at 8am (Vol 9 A2267 para 21). However, the evidence is clear that JY was discharged, at the earliest, at 8.25am or about 9am. Accepting that JY was present whilst Dr Gelhaar conducted the ward round, having regard to her practice of reviewing every patient, the failure for that to occur remains unexplained. It is submitted that doubt must exist, and that doubt ought to have been resolved in favour of the Appellant.
47. The protocol for discharging a patient from the Emergency Department to which his Honour makes reference (A4200) states:

“Interns must present every case to a Registrar or Consultant prior to discharging a patient from the Emergency Department” (Vol 9 A2186)
48. It is submitted that the facts establish that the patient was “*presented*” in accordance with the Emergency Department manual. The account given by Dr Ashley gives rise to questions as to its reliability. Dr Ashley states that she observed from the chart “*probable meningitis*” without record of lumbar puncture (Vol 10 A2439 para 11.1.8), and that the patient was recalled to the Emergency Department. However, as discussed above, the evidence was that JY was not recalled but returned of his own volition. The inference from Dr Ashley’s statement is that the patient was recalled because of concerns she held on the basis of what was contained in the patient chart. This is inconsistent with the absence of any step being taken concerning the patient prior to his voluntary representation. It is submitted that the evidence does not establish to the requisite *Briginshaw* standard that JY was not presented in accordance with the procedure set out in the Emergency Manual.
49. It is further submitted that the volume of work undertaken by interns within the Emergency Department is a relevant consideration when evaluating performance. The Emergency Department Manual states that 43,300 patients presented to the Emergency Department for assessment in the year 2003 (Vol 9 A2188).

THE SURGICAL COMPONENT

Whether the Appellant had completed the requisite 12 week surgical component of her internship

50. It is submitted that the judge erred in finding that the Appellant had completed only 11 of the 12 weeks surgery component (Vol 16 A4186)

para 50) as required by the internship conditions imposed by the Information Notices dated 21 June 2002 (Vol 11 A2755) and 28 January 2003 (Vol 11 A2767). On 15 May 2003, the Appellant forwarded a letter and accompanying documents to the Respondent (Vol 11 A2774-A2799 Exhibit J018 in support of Notification of Completion of Internship (Vol 11 A2800 Exhibit J019). Amongst the supporting documents were Intern Assessment Forms concerning the Medical Rotation from Doctors Sheller (A2776), Aluana (A2777), Munasingh (A2780), the Emergency Department Rotation from Doctors Coley (A2782), Holland (A2784), and the Surgical Rotation from Doctors Almendi (A2786), Cu Tai (A2787) and Hafsa Yusuf (A2888). The Intern Assessment Forms covered all requisite areas of practice, and provided positive assessments of the Appellant.

51. On 20 January 2003, Dr Barry Hodges, Deputy Director of Medical Services at the Townsville Hospital, provided a Work Progress Report in which he “*recommended registration*” (Vol 1 1A2793). In a further document dated 29 January 2003 (Vol 11 A2795), Dr Hodges stated “*Dr Tsigounis’ performance has been considered satisfactory in all respects*”.
52. The material relied upon by the Board in determining whether the Appellant had completed the 12 week rotation in surgery contained a material misapprehension as to the significance of the fractured nature of her surgical rotation:
 - 52.1. Associate Professor Keary in a letter dated 20 May 2003 to the Board (Vol 11 A2832) advised “*eight weeks surgery as a fractured attachment*”.
 - 52.2. Dr Keary reinforced his concern about the fractured nature of the surgical rotation in a further letter dated 30 May 2003 (Vol 11 A2834).
 - 52.3. The significance attached by the Board to “*fragmented surgical experience*” is seen in the email from Robyn Scholl, Assistant Registrar of the Board, dated 27 May 2003 “*Re: Completion of internship*” (Vol 12A3273 Exhibit 51).
 - 52.4. Dr Keary in cross-examination conceded that the Appellant had “*possibly completed 12 weeks surgery*” (Vol 3 A564, A565). His assertion that three weeks must be “*consecutive*” (Vol 3 A565.5) was ultimately conceded by the Board to be an error, the Board’s counsel agreeing with the judge that a fractured surgical rotation would suffice (Vol 5 A1222.25).
53. It is submitted that his Honour erred in failing to find that the Appellant had completed the required 12 weeks surgical component of her internship. In determining the issue, the judge placed reliance on the hospital records, which his Honour said at Vol 16 A4184 at [42] “*leave much to be desired and I have some reservations about their accuracy and reliability*”.

54. The finding that the Appellant had completed only 11 of the 12 weeks surgery component (Vol 16 A4186 [50]) did not meet the *Briginshaw* standard which his Honour purported to apply (Vol 16 A4181), in circumstances in which the onus to prove that the 12 weeks had not been completed lay, and was accepted to lie, with the Board (Vol 5 A1205.20). This conclusion derives support from his Honour's own observation at [55] that if all that was preventing the Appellant gaining unconditional registration was one uncompleted week of surgery, he would be inclined to the view that the many weeks she worked in emergency medicine would qualify. Dr Hodges had given evidence that in the past and during the Appellant's employment at the Townsville Hospital, the Board was on occasions prepared to accept emergency medicine as surgery.

Whether the surgical component was completed to a satisfactory standard

Lumbar laminectomy patient/diuretic incident - 20 February 2003

55. The diuretic incident involving the lumbar laminectomy patient was identified by counsel for the Board in opening as the third of the key incidents. The judge found at [59] that the Appellant prescribed a diuretic (Lasix) over the telephone without reviewing the patient, thereby placing the patient at risk of dehydration and renal failure, and also that she failed to make any notes on the patient's chart.
56. Dr Lucas gave evidence that at his review of the patient at 8am, he was concerned about signs of dehydration (Vol 3 A484.50), and that he contacted Dr Hodges concerning the incident. The finding that the patient was at risk of "*dehydration and renal failure*" was not entirely supported by Dr Lucas whose evidence was that the dehydration was "*contributed to*" by the Appellant's action (Vol 3 A483.50). The affidavit of Dr Lucas (Vol 10 A2453 Exhibit 23) contains the relevant patient notes (Vol 10 A2463 PGL2) which show examinations of the patient by nursing staff at 1am, 2am, 3am, 4am, 5am, 6am and 8am, without any abnormality including dehydration being noted.
57. The Appellant's assertion that she reviewed the patient prior to prescribing Lasix (Vol 13 para A3362 184 Exhibit 56) was not challenged in cross-examination (Vol 5 A1 127-A1128). Dr Hodges accepted that the Appellant had satisfied him that she had "*actually seen the patients*" (Vol 3 A520.55). It is submitted that his Honour fell into error in rejecting the Appellant's evidence on this point, the Appellant being entitled to the doubt in accordance with the *Briginshaw* standard.
58. Following the complaint to Dr Hodges by Dr Lucas, the Appellant the next morning contacted Dr Hodges who discussed the incident with the Appellant and took no action (Vol 3 A521.20). Dr Lucas did not make a formal complaint, but rather provided a statement on 10 February 2004 (Vol 7 A1572) after being contacted by the solicitors for the Board (Vol 3 A489.15—30). Moreover, in his affidavit (Vol 10 A2452 Exhibit 23) Dr Lucas accepted that fifteen minutes after the 12.45am order for Lasix (para 4.4) the Appellant "*had the patient's chart in her possession and*

prescribed Temazepam and Stemetel (Vol 10 A2452 at para 4.9.2). Dr Lucas commented that “*it would be unusual to have the patient’s chart in your possession without reviewing the patient*”. It is submitted that these aspects of the evidence of Dr Lucas support the Appellant’s assertion that the patient had been personally reviewed by her prior to the prescription of Lasix. The Appellant should have been given the benefit of the doubt in respect of whether she reviewed the patient.

59. The Appellant acknowledged her failure to note the patient’s chart at the time she reviewed the patient as an unfortunate oversight on her part “*probably due to the work pressures during a busy overnight shift*” when she was the only resident on duty (Vol 13 A3362). Dr Lucas acknowledged (Vol 10 A2453, para 4.10) that during the night shift there was only one on call surgical registrar allocated to cover the three surgical wards (A2453).

Atrial fibrillation incident – 20 February 2003

60. The evidence of Dr Lucas (Vol 10 A2453) in relation to the atrial fibrillation incident is based on what he read from the patient records, and things “*told to him by nurses*” (Vol 10 A2454 para 5.4), and goes no higher than detailing the procedure which should have been followed prior to administering Digoxin (Vol 10 A2457 - Ex 23 “PGLI” para 2.2.5). It is no more than an assumption on the part of Dr Lucas that the ECG and patient were not reviewed prior to prescribing Digoxin. However, the judge at [61] accepted that assumption as being the fact, and made findings on that basis.
61. The patient records suggest that the Appellant did attend the ward at 1 am on 20 February 2003, at which time the prescription for Digoxin was entered on the Drug Chart, as evidenced by the Appellant’s signature (Vol 10 A2494). It is conceded that evidence was not given at the hearing in the District Court by the Appellant that it is her signature which appears at Vol 10 A2494, but the signature accords with that of the Appellant on other records: for example, Vol 12 A3123, Vol 9 A 2216, A2255, A2282. Accordingly, the Appellant asks the Court to infer that the notation at A2494 is her signature.
62. The judge found at [61] that the Appellant did not view the ECG results before prescribing Digoxin, but asked the nurse who called her to read out the result displayed on the top of the ECG over the phone (Vol 16 A4187). It is submitted that his Honour fell into error in so finding. There was no direct evidence to support the finding; the name of the nurse was not identified, nor any evidence adduced from any nurse to support the finding. The only evidence was a hearsay comment from Dr Lucas in his affidavit (Vol 10 A2458 para 2.2.3).
63. The Appellant was unable to specifically recall the incident, and could only give evidence of her usual practice to review ECG results herself (Vol 13 A3362). Acceptance that the Appellant was in attendance at the ward at 1am supports the inference that she did in fact review the ECG as was her usual practice. It is submitted that the complaint relating to this

incident has not been established to the requisite standard, and that the judge fell into error .

Vascular surgical ward - 24 February- 9 March 2003

64. His Honour at 4189-4190 identified four separate complaints in connection with the appellant's performance in the vascular surgical ward between 24 February and 9 March 2003:
 - 64.1. failure to advise of a patient's abnormal blood coagulation profile (major incident 4 identified by the Board in opening (Vol 1 A15.55), also referred to as the "INR incident");
 - 64.2. delay in carrying out tests as instructed ;
 - 64.3. failure to insert an IV cannula as instructed;
 - 64.4. ordering potassium for a patient before an operation (major incident 5 identified by the Board in opening).
65. These complaints were largely reliant on the evidence of Dr Sharmila Balanathan, the surgical registrar to whom the Appellant reported, and a relatively junior medical practitioner having graduated in 1999 (Vol 8 A2045, para 1). The judge referred at A4188 to Dr Hodges' belief that problems between Dr Balanathan and the Appellant "*commenced due to a personality conflict*". It is clear from the evidence that the relationship was tenuous from the outset. On the second morning of working together, Dr Balanathan required the Appellant to attend the ward rounds, notwithstanding that she had completed her rostered hours (Vol 1 A196.40-A197.10) The Appellant took exception, and contacted Dr Hodges (Vol 3 A513.10-A514.50). Dr Hodges forwarded an email to, *inter alia*, Rossato Reno (then Head of the Department of Surgery)⁶ (Vol 8 A 2042 Exhibit 3 "BADH2" concerning the demand that the Appellant return to the ward after she had completed her rostered hours, which demand struck him as "*monumental misuse of financial resources particularly when there is an evening ward call RMO rostered who could do the proper work for the reg*". The response from Reno Rossato (Vol 12 A3182 Exhibit 44) stated that the RMO was "*to be congratulated ... The Institute does NOT support this nonsense and it is NOT to be repeated*".
66. A relevant feature of the Appellant's rotation in surgery was that only two weeks were spent with Dr Balanathan. During the other 9-10 weeks, the Appellant worked with other registrars who provided favourable intern assessments - Dr Almendi, 17 December 2002 (Vol 8 A1855), Dr Cu Tai, 17 April 2003 (Vol 8 A1867), Dr Hafsa Yusuf, 6 March 2003 (Vol 8 A1863), Dr Kaushik, 28 March 2003 Vol 8 A1865 - incorrectly referred to at A201 as Dr Cofso — Vol 11 A2774, A2790) - which Dr Balanathan agreed were "*above average if not very good assessments*" of the Appellant (Vol 1 A202.30). Moreover, during the two week period spent with Dr Balanathan, the Appellant's time was divided with another

⁶ Vol 3 A 0158.55.

registrar, Dr Hafsa Yusuf, who provided a positive assessment (Vol 1 A204.10, Vol 8 A1863).

67. In contrast to the positive surgical assessments, the unfavourable report of Dr Balanathan was not prepared until 28 May 2003, and then only following discussions with Dr Yuen from the Board who attended Townsville Hospital on 15 and 16 May 2003 to discuss the Appellant's performance (Vol 1 A205.30). The assessment of Dr Balanathan was also contrary to the Work Progress Report of Dr Hodges dated 14 March 2003 (Vol 8 A2043 Exhibit 3 'BAJH3") and similarly that of Associate Professor Keary (Vol 8 A1871 Ex 2 "PJK1") dated 4 April 2003. Those reports supported the absence of concerns held by surgical registrars other than Dr Balanathan.
68. It is relevant also note that the Intern Assessment Form completed by Dr Balanathan dated 28 May 2003 (Vol 8 A2062) did not raise any specific incidents and simply commented: "*Helen has required substantial supervision during the time that she has worked for this unit. I have not found her to be reliable or dependable.*" It was this statement which was relied upon by the Board in the Show Cause Notice dated 11 June 2003 (Vol 11 A2845). The concerns belatedly raised by Dr Balanathan were inconsistent with evidence from Dr Hodges that Dr Balanathan advised in the second week of the Appellant's term under her supervision: "*Helen was making a greater effort to comply with her required duties*" (Vol 8 A2039 Ex 3 "BAJHI" para 20).
69. It is submitted that the judge erred at Vol 16 A4192 [78] in attaching particular weight to the evidence of Dr Balanathan in finding unsatisfactory performance in surgery, given the background of conflict with the Appellant, the contrary assessment of other registrars, and Dr Balanathan's failure to raise specific complaints with Dr Hodges, all matters reflecting adversely on the credit of Dr Balanathan.

Failure to advise of abnormal blood coagulation profile (A4189)

70. The basis of this complaint was that the Appellant failed to notify Dr Balanathan of an INR reading of 3.5 which should have been regarded as a "*significantly abnormal result*" (Vol 1 A196.20-30, Vol 8 A2046 Ex 4 para 10.1). The Appellant's evidence was that she called Dr Balanathan at 2 pm to tell her of the abnormal INR result of 3.5 (Vol 4 A0841.45).
71. Under cross-examination, Dr Balanathan gave evidence that she received a phone call at about 2pm whilst in theatre "*to let me know about the blood results of approximately five patients and whether I wanted anything done with - in response to these — some of these blood results.*" (Vol 1A223.10). Dr Balanathan also accepted that that the patient notes contained an entry made by the Appellant at 1400 hours documenting an INR of 3.5 amongst other blood test results (Vol 1 A242.20). However, despite this evidence, Dr Balanathan maintains that the very abnormal result was not notified to her (A242.30).
72. It is submitted that the evidence did not support a finding, established to the *Briginshaw* standard, that the Appellant failed to notify Dr Balanathan

of the abnormal result. In any event, Dr Papagelis gave evidence that it would not be uncommon for a mistake of this nature to be made (Vol 5 A1045.50). Dr Papagelis' opinion that a failure to report the INR was "forgivable" was not challenged in cross-examination (A1046.50).

Delay in carrying out tests as instructed (A4190)

73. This complaint by Dr Balanathan was not relied upon by the Board as a major incident. It is submitted that little weight would attach to it in evaluating the Appellant's level of performance. The delay of four hours in undertaking Arterial blood gas tests was explained by Dr Papagelis (Vol 5 A1052.60) in the context of the possibility of more ill patients needing attention, and the ultimate responsibility of the registrar.

Failure to insert an IV cannula as instructed (A4190)

74. The judge's findings that the cannula was inserted six hours later by a nurse, the Appellant did not respond to her pager, and that she was at the bank, were not established on the evidence, and his Honour fell into error (Vol 10 A4190). Dr Balanathan's evidence on this issue was hearsay, prejudicial and should have been rejected (Vol 1 A1 99.10-40). The Appellant did not recall the incident (Vol 1 A237.40, 238.35).
75. In any event, even if established, the incident is not of sufficiently grave a nature to support a finding that the Appellant has not satisfactorily completed her surgery rotation.

Ordering potassium for a patient before an operation (A4190-4192)

76. This incident was identified by the Board as number 5 of the major incidents. The Appellant acknowledged her mistake (Vol 5 A1104.50), expressed an apology (A1105.30), and accepted responsibility for the error (A1106.1). Her difficulty recollecting the event was explained in terms of the number of fluid orders given over the phone on a daily basis as an intern (Vol 5 A1105.50)
77. In terms of gravity, it was put to Dr Balanathan that the mistake concerning potassium was not "life threatening" having regard to the quantity which was administered (Vol 1 A240.55). Dr Balanathan's position was put no higher than stating that the potassium "shouldn't have been given to the patient" (A241.10). Dr Papagelis gave evidence that a mistake by an intern to recognise "high potassium" is not uncommon (Vol 5 A1 045.55).
78. It is submitted that the judge fell into error in finding that the Appellant's surgical performance was unsatisfactory on the basis of Dr Balanathan's evidence (Vol 16 A4192 at [78]). The finding fails to have regard to the many positive surgical assessments of the Appellant to which his Honour gave little consideration (Vol 10 A4193-4195).

PAEDIATRICS - SEPTEMBER AND OCTOBER 2002

Cannulation incidents (Vol 16 A4195)

79. The judge considered cannulation incidents on 2 September 2002 involving two patients, Patient DE (aged 4) and Patient SB (aged 6), in respect of whom evidence was given by Nurse Bailey, and a separate incident a few days later on involving an attempt to cannulate a child during which Nurse Steer was present (A4196). These incidents comprise the balance of the major incident number 2 identified by the Board, and which is otherwise dealt with under the heading “*EMERGENCY*” below.
80. The Appellant accepted that on occasions she experienced difficulty with cannulation. The issue is the weight which ought to have been placed on this aspect of the Appellant’s skills. Dr Papagelis gave evidence (Vol 5 A1048.50) that “*Cannulation is not something that a lot of people find easy and it’s not uncommon to come across interns who - who don’t have a very good cannulation technique.*”
81. The judge found that cannulation in the axilla was an “*inappropriate site*” (Vol 16 A4196 [95]). Dr Papagelis gave evidence that circumstances can arise where cannulation into the axilla would be appropriate (Vol A1051.18-.45), a proposition not challenged in cross-examination.
82. Dr Hodges spoke to the Appellant after the incident involving Nurse Bailey and stressed the hospital policy of no more than two attempts. Dr Hodges testified that “*as far as I am concerned you (the Appellant) complied with that advice thereafter.*” (Vol A510.20).

Dr Frischman - about October 2002 (Vol 16 A4197)

83. Dr Frischman, a visiting paediatrician, gave evidence of his direction to the Appellant that a child was “*not to receive a bowel wash-out*” (Vol 1 A162.20), and his discovery on his ward round the next day that the procedure had been performed. Whilst this was unnecessary and unpleasant for the patient, Dr Frischman did not consider it to be a harmful procedure (Vol 9 A2263). Dr Frischman stated that he spoke to Dr Hodges about the incident. Dr Hodges gave evidence that he spoke regularly by phone to Dr Frischman about a variety of issues, and that at one point Dr Frischman spoke to him about the Appellant, “*although it was really as a side issue. My recollection is that he raised issues more about her dress sense and personality than her clinical abilities*” (Vol 8 A2038 Exhibit 3 para 11). Dr Frischman first made a statement concerning the Appellant on 3 February 2004 (Vol 6 A1449).
84. The second incident in respect of which Dr Frischman gave evidence was the writing of a script for the drug Lanictal, which was incorrectly noted as “*Lanictal*” and without the dose being noted (Vol 1 A166.20). These incidents should be seen in the context of the Appellant undertaking a rotation of “*several weeks*” in paediatrics (Vol 1 A161.50, A163.50), less than a full term of three months which Dr Frischman considered preferable (Vol 1 A163.50-A164). It seems to have been accepted by Dr Frischman that during her internship the Appellant would on occasions work three consecutive days in paediatrics, charged with the sole care of patients with the exception of supervision at ward rounds (Vol 1

A165.30-.50). Dr Frischman described his concern in relation to the Appellant's performance as being one of "*short term memory*", which he confined to the two incidents, and did not consider should be turned into "*a life or death situation*" (A166.20).

85. The opinion of Dr Frischman regarding the Appellant's ability in paediatrics was contrary to the positive assessment of Dr Ian Shellshear in the Intern Assessment Form dated 22 October 2002 (Vol 10 A2600 Ex 30). Dr Shellshear assessed the Appellant's overall performance as "*good to excellent*" (Vol 10 A2602).
86. Despite these conflicting opinions, the judge made adverse findings concerning the Appellant's performance in paediatrics, preferring the opinion of Dr Frischman to that of Dr Shellshear, and notwithstanding that the complaints made by Dr Frischman could not fairly be regarded as serious. His Honour stated that the evidence was "*more consistent with Dr Frischman's opinion*" (Vol 10 A4198 para 106). It is submitted that such an approach to the evidence fails to satisfy the *Briginshaw* standard.

EMERGENCY— 28 OCTOBER 2002 — 31 JANUARY 2003 (4198)

Another cannulation incident

87. In connection with the Emergency Department rotation, the judge first considered another cannulation incident, being one of the three cannulation incidents identified by the Board as the second of the major incidents. His Honour placed sole reliance on the estimate of Nurse Maloney that there were five or six attempts to cannulate a child patient (Vol 7 A1611 para 9), despite Nurse Maloney having observed only one attempt to cannulate (Vol 7 A1610 para 6). This was inconsistent with the evidence of Nurse Buldo that the third cannulation was successful (Vol 1 A261.50). The Appellant gave evidence consistent with that of Nurse Buldo that there may have been three attempts (Vol 4 A795.15), but the difficulty in recall was explained by the 12 month delay in the complaint and the volume of cannulations, "*5 a day on average*" (A795.30-40).
88. Dr Elcock, an Emergency Department physician, agreed that three attempts was not unusual (Vol 1 A388.10), and that it is very difficult to cannulate children (A388.30). Dr Papagelis also gave evidence that three attempts for children was not unusual (Vol 5 A1087.15). Moreover, Dr Elcock testified that his discussion with the Appellant about the incident was "*pretty professional and non-confrontational*" (A398.50). Dr Elcock also noted that the child was "*quite settled*" following the incident (A398.30), evidence which provided no basis for his Honour's finding that the incident caused the patient "*distress*".
89. It is submitted that the totality of the evidence, including the delay in raising the incident with the Appellant (Vol 2 A795.30), did not support any particular weight being given to the incident. Rather, the preponderance of evidence concerning the Appellant's performance in Emergency was in her favour, including Intern Assessment Forms

completed by Dr Coley (Vol 11 A2814), Dr Munasingh (A2810), Dr Holland (A2822) and Dr Ashley (A2816).

90. Further, the incidents in Emergency should be viewed in the context of a lengthy period in that rotation (10 weeks at the date of Dr Ashley's assessment) (A2816), during which a great volume of work was undertaken.

Drug administration/intubation incident - mid January 2003 (Judgment A4199)

91. The evidence in relation to the "intubation" incident, identified by the Board as major incident number 6, was contained in the statement and affidavit of Dr Gelhaar dated 4 February 2004 (Vol 6 A1453 para 4) and 1 July 2004 (Vol 9 A2265 paras 8 and 9). The allegation of Dr Gelhaar was that contrary to instructions as to the order in which the drugs were to be given - sedative, anaesthetic, then muscle relaxant - , the Appellant "*picked up the syringe with the muscle relaxant first*" (A2265 paras 8 and 9).
92. The Appellant's evidence was that the intubation proceeded without incident (Vol 13 A3352 para 126). The evidence of Dr Gelhaar was uncorroborated. The patient was not identified (A146.8), the incident was not noted in the records (A147.25), and the relevant clinical files could not be located (A146. 10). Dr Gelhaar made no formal complaint (A146.30). The alleged error was inconsistent with the Appellant's experience in anaesthetics in Greece (Vol 13 A3516, A3329 para 13).
93. The uncorroborated evidence of Dr Gelhaar was accepted by the judge, who found that the Appellant was "*too casual and was not paying attention to the instructions given to her*" (Vol 16 A4200 [116], without providing any reasons for rejecting the Appellant's account. It is submitted that much more is required for the tribunal of fact to be satisfied to the requisite standard that the incident was established. In terms of degree, Dr Gelhaar gave evidence that it was "*unlikely that any damage would have happened*" as a result of the alleged incident (Vol 1 A72.15). Thus, even if established, the incident was not of such a magnitude as to warrant any restriction upon the Appellant's registration.

CARDIOLOGY — 14-30 APRIL 2003 (4209)

94. The judge acknowledged that work performed by the Appellant in cardiology was not performed as part of her internship (Vol 16 A4221 [223]). The evidence established that during the two week period in cardiology, the Appellant had RMO status, having been promoted to the position RMO on 19 January 2003 (Vol 3 A509.10, A654, Vol 11 A2795, Vol 12 A3178). It is submitted that his Honour fell into error in having regard to evidence in relation to the Appellant's performance in cardiology in determining whether she had satisfactorily completed the internship pursuant to s 94 of the Act.
95. If, however, the Court considers incidents in cardiology to be relevant for the purpose of a decision under s 94 of the Act, it is relevant that in the

proceedings before the judge the Board placed reliance on only the “*morphine maxalon incident*” on 23 April 2003 , being number 7 of the major incidents identified by the Board.

Cardioversion Incident (A4210)

96. The evidence did not suggest that serious consequences attached to the manner in which the Appellant used the charged paddles in the course of a demonstration as to their use by Nurse Neil (Vol 3 A 459.30. Nurse Neil conceded that she did not discuss the “*error*” in the use of the paddles with the Appellant (Vol 3 A453.46-47). Nor was there any evidence of notification or complaint in relation to the incident. Professor Dewan gave evidence that it would be “*extremely unusual*” to expect cardio—version of an intern(Vol A920.10).

Morphine — Maxalon incident 23 April 2003 (A4210)

97. The Appellant was hampered in her capacity to respond to this complaint, given the delay in the making of the allegation by Nurse Weber (Vol 13 A3364 para 201). The Appellant’s affidavit response was frank, referring to her usual practice, a response not challenged in cross-examination. The judge found that no harm came to the patient.

Frusamide magnesium patient (A4211)

98. In respect of the prescription of Lasix, the judge preferred the evidence of Nurse Doe that a higher dose was not warranted (cf the Appellant’s evidence at Vol 5 A1018.40-.80. Dr. Papagelis gave evidence supportive of an increase in dosage (Vol 5 A1082.20, 1082.30). The judge did not refer to the evidence of Dr Papagelis on this point.
99. The Appellant accepted that the transcription “*supp*” was misleading (Vol 5 A1017.52), as it may have been mistaken for suppository. It is submitted that the incident was minor, and should be given no weight. It occurred at a time when the Appellant was in her first and only week in cardiology (Vol 5 A1018.20-.30). A mistake of this type is of the kind referred to by Kirby P referred in *Pillar v Messiter* (1989) 16 NSWLR 197 at 202.

Consent for cardioversion (A4211)

100. This involved a balancing of what was alleged by Nurse Lawty and the Appellant’s denial of the incident. It is submitted that when faced with the evidence of the two witnesses, the judge’s preference for the evidence of Nurse Lawty - “*I am satisfied that I can act on what Nurse Lawty said happened*” (A4212.1) - falls short of the *Briginshaw* standard. In any event, even if accepted, the incident would be regarded as so minor in nature as not to impact upon the Appellant’s ability to gain general registration.

Angiogram consent (4212)

101. The Appellant repeats the submission above concerning the minor nature of this incident

Another cannulation incident (A4214)

102. The evidence on this further cannulation incident was conflicting. Nurse Darr gave evidence that the cannula was inserted outside of the vein in the tissue (Vol 2 A403. 17). In contrast, Nurse Doe gave evidence that the cannula must have been inserted in the vein (Vol 2 A434.50), her concern being that it had been left “*uncapped and undressed*” (A434.30). It is submitted that the incident, although minor in nature, was not established to the requisite standard of proof, and that his Honour fell into error in finding the incident established.

Various medication errors (A4216)

103. The various medication errors discussed by his Honour at [197]-[213] were of a minor nature, and ought not impact upon the Appellant’s eligibility for general registration. In dealing with the medication issue, the judge placed reliance on evidence which was hearsay, and unreliable. For example, Dr Paul Martin’s opinion in relation to “*repeated errors*” was based in part on “*reports from nursing and medical staff*”, without any details as to nurse names, patient names, or dates provided. Nonetheless, the judge was prepared to accept what Dr Martin said (Vol 16 A4217 [201]). See also A 4217[202] 7).

Anginine S/L

104. Whilst his Honour rejected this complaint (A4220 [210]), reliance on it by the Board is indicative of the trivial and overzealous nature of some of the allegations made against the Appellant. A complaint as to potential confusion between handwriting “S/L” (sublingually) and “S/C” (subcutaneously) cannot be treated seriously in circumstances in which the drug is only prescribed in tablet form (A4219 para 10.3). Dr Papagelis gave evidence (Vol 4 A1081.20):

“You don’t give Anginine subcutaneously. Anyone with any sort of experience knows that. It sounds like the L and the C were misinterpreted. That sort of nurse needs a talking to — I mean how, could you even think that that is the case?”

Lasix stat order

It is submitted that no weight should be afforded to the transcription error. Dr Papagelis did not attach any significance to the notation (Vol 5 1083): “*What’s wrong with that. That just means... please give immediately.*” Professor Dewan gave evidence that a single dose, which is understood to mean “*stat dose*”, is not an uncommon mode of prescription (Vol 5 A919.34).

Lasix PRN order

105. The Appellant concedes that the notation “*Lasix PRN*”, meaning “*as required*”, was misleading. When she became aware that the nurses were confused by the terminology, she changed the drug chart herself (A4218 para 7.3).

Temazepam IV order

Again, the Appellant acknowledged this transcription error (A422 0[211]). As Dr Papagelis opined, mistakes of this nature occur in teaching hospitals (Vol 5 A1070.1), especially having regard to the volume of medications noted by an intern during the year, which Dr Papagelis estimated in terms of “*thousands*” (Vol 5 A1069.10).

106. Dr Papagelis did not regard mistakes of this type to be unusual for interns (A 1084.2, A1085.10). Dr Papagelis gave evidence of various other medication transcriptions which he regarded as minor mistakes which he would have expected the nurses to have detected (A1083.20-1085).

THE PSYCHIATRIC ISSUE

107. The Appellant submits that there was no basis in the evidence for the judge to direct the Board - “*if the Board has power to vary the Appellant’s probationary conditions*” (A4238 [289]) - to impose additional conditions to the effect that during the prescribed internship she submit to and undergo such psychiatric treatment as considered appropriate by the Board with regular reporting to the Board by the treating psychiatrist/s.
108. The issues on the appeal were whether the Appellant had satisfactorily completed her internship, not her psychiatric fitness to practice. In any event, as the judge acknowledged (Vol 16 A4225 [248]), he did not have the benefit of oral evidence from the psychiatrists. Accordingly, he ought not have ventured any assessment of, or sought to impose any additional probationary conditions in relation to psychiatric issues.
109. During the hearing, it was accepted by the Board that the Appellant does not have a psychiatric illness (Vol 5 A1266.5) or a psychiatric condition that would disqualify her (A1266.32). That submission was supported by the medical evidence to which reference was been made by the judge at Vol 16 A4224-A4227. In a report dated 19 January 1999 (Vol 12 A3288), Dr Papagelis opined: “*This lady does not have any symptoms or signs of mental illness. She is naturally stressed regarding her loss of employment*”. In a report dated 23 December 1998 (A3290) Dr Scud similarly found no evidence of major psychiatric illness, with his conclusions going no further than “*a personality showing some evidence of being sensitive to criticism*” (A2291).
110. That view was shared by Dr Kippax who, in a report dated 24 April 2002 to the Board (Vol 11 A2379) did not note any major signs of psychiatric disorder but concluded that the Appellant meets the criteria for Paranoid Personality Disorder. It is of significance that that the opinion of Dr Kippax was based solely on one interview of 90 minutes duration. In a report dated 10 August 2004 (Vol 12 A3285) Dr Ouzas rejected the diagnosis by Dr Kippax of “*Paranoid Personality Disorder*”.
111. It is submitted that particular weight ought attach to the opinion of Professor John Allan, who was appointed by the Board and with whom the Appellant was consulting pursuant to the conditions attached to her probationary registration during the period of internship. Dr Allan’s opinion was based upon regular attendance by the Appellant which

included “*some supportive psychotherapy*” (A3287). Despite regular attendances as recently as 7 April 2003, Professor Allan did not consider that there was any need to prescribe medication and concluded: “*there are not significant issues at this point*”.

112. A further independent psychiatric assessment of the Appellant was undertaken by Dr John Shand on or about 17 February 2003 (Vol 12 A3289), during the period in which the Appellant was consulting Dr Allan. Dr Shand expressed a similar opinion to that of Dr Allan, also failing to detect “*any form of psychiatric disorder*”.

CONDUCT OF THE HEARING

Denial of legal representation

113. On day one of the hearing, 28 August 2004, Mr Franzese, a legal practitioner admitted in Victoria but not in Queensland (Vol 1 A8.10), appeared for the Appellant.
114. Mr Franzese was uncertain whether his professional indemnity insurance covered legal practice in Queensland, as required pursuant to s 74 of the *Legal Profession Act 2004* (Qld) (A8.30-40).
115. A grant of leave to appear to Mr Franzese pursuant to s 52 of the *District Court of Queensland Act 1967* was opposed by the Respondent (Vol 1 A10.20), and refused by the judge (A10.40). Thereafter the Appellant appeared in person, and did so for the first three days of the hearing. His Honour did not suggest to the Appellant that she make an application for an adjournment to enable her to engage legal representation. There was no enquiry as to the Appellant’s capacity or preparedness to represent herself matter.
116. It is submitted that having regard to the gravity of the complaints and the likely impact upon the Appellant’s livelihood and reputation, the judge ought to have informed the Appellant of the availability of an application for an adjournment in order to secure legal representation. Instead, the judge was involved in the following exchange with the Appellant (A11.10-20):

“But Ms Tsigounis, do you realise that you ‘ll have to conduct the case yourself.

Appellant: Well, I have no choice.

His Honour: Well, I don’t think you do. I — I don’t think you do have a choice.”

It is submitted that these remarks are tantamount to a refusal of an application for an adjournment.

117. The result was that the Appellant appeared in person on days 1, 2 and 3 of the hearing - 23 – 25 August 2004 - at which point the case was adjourned to a date to be fixed. The prejudice was significant and incurable. On days 1 and 2, the Board called Drs Gelhaar, Coley and

Ashley, whose evidence was central to the most serious of the complaints, that concerning the “meningitis patient”.

118. On day 1, at 4.01 pm the Board called Nurse Struthers out of sequence in the witness list (A60.50). The Appellant objected and sought an adjournment at least until the following morning on the basis that she did not know she would be “*acting as solicitor today, and I certainly haven’t prepared*” (61-30-40), the judge’s response was that the Appellant had “*to be ready for changes like this*” (A61.10). It is submitted that his Honour fell into error by rejecting an application for adjournment in respect of the evidence of Nurse Struthers.
119. On day 1, at the conclusion of the evidence of Nurse Struthers, the Board called Dr Gelhaar, again out of sequence. Again, the Appellant objected to Dr Gelhaar being called out of sequence, as she was having her solicitor attempt to engage counsel and was not prepared (A68.60-A69.50). It is submitted that his Honour fell into error by rejecting what was effectively an application for adjournment in respect of the evidence of Dr Gelhaar. The judge’s likely attitude to an adjournment application is seen in the following response to the Appellant’s objection to calling Dr Gelhaar out of sequence (A69.5):

“I hate to think what’s going to be counsel’s first request tomorrow morning, if you do get counsel.”
120. On day 3, evidence was called from Dr Balanathan, whose evidence was central to the INR incident (major incident number 4), and the potassium incident (major incident number 5). On day 1, evidence was given by Nurse Bailey, and on day 3 by Nurse Buldo, that evidence being central to complaints relating to the cannulation of children, the second of the Board’s major incidents.
121. The denial of legal representation not only had the result that the Appellant was unrepresented whilst evidence was adduced from some of the most critical witnesses for the Board. It also had the consequence that the judge formed an impression of the Appellant which exceeded an evaluation of her evidence, and was influenced by the manner in which she conducted the case as an unrepresented litigant, unfamiliar with court procedure, and lacking legal training and knowledge of evidence, a situation in which she was understandably overwhelmed.
122. The impressions which the judge gained of the Appellant from extensive contact spanning fourteen hearing days led to an assessment of her personality which approached psychiatric evaluation. This is apparent in his Honour’s references to “*a personality defect*” (A4222 [232]), a “*limited capacity for self examination and objective analysis of events and complaints*” (A4223 [238]), and the opinions of Professor Judd and Dr Kippax being “*also consistent with my own observations and assessment of the Appellant during the hearing of the appeal*” (A4227 [246]). It is submitted that his Honour’s assessment of the Appellant exceeded what could reasonably be concluded from her demeanour as a witness. It arguably goes beyond the capacity of a judge in a court of law

in the absence of expert evidence to make findings approaching the status of psychiatric diagnosis.

ORDERS

123. The Court should make the following orders pursuant to s 119(2)(b) of the *District Court of Queensland Act 1967*:

1. Leave to appeal granted.
2. Appeal allowed.
3. The orders of Judge Wall made 11 May 2005, 21 June 2005 and 12 July 2005 be set aside.
4. In lieu thereof substitute an order that there be substituted for the decision of the Board a decision that that the Appellant has satisfactorily completed the internship conditions in accordance with the Information Notices from the Medical Board of Queensland dated 21 June 2002 and 28 January 2003.
5. Costs.

3 January 2005

Bret Walker

Sarah Pritchard