Nitschke v Medical Board of Australia [2015] NTSC 39

PARTIES:	NITSCHKE Philip v MEDICAL BOARD OF AUSTRALIA
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING APPELLATE JURISDICTION
FILE NO:	LA 1 of 2015 (21502811)
DELIVERED:	6 July 2015
HEARING DATES:	1 and 2 April 2015
JUDGMENT OF:	HILEY J

CATCHWORDS:

APPEAL – decision of Health Professional Review Tribunal to take immediate action under *Health Practitioner Regulation National Law* s 156 – no evidence that conduct alleged could be proscribed by the Code of Conduct for Doctors in Australia – misconstruction of clause 1.4 of Code of Conduct for Doctors in Australia – no basis for reasonable belief required for s 156(1) – error of law – appeal allowed

HEALTH PRACTITIONERS – medical practitioners – *Health Practitioner Regulation National Law* s 156 – immediate action taken by Health Professional Review Tribunal to suspend practitioner's registration – appeal to Health Professional Review Tribunal from decision of Medical Board of Australia – misconstruction of clause 1.4 of Code of Conduct for Doctors in Australia – no evidence that conduct alleged proscribed by the Code of Conduct for Doctors in Australia – no basis for reasonable belief required for s 156(1) – appeal allowed – suspension quashed

ADMINISTRATIVE LAW – vocational regulation – medical practitioners – suspension of appellant's registration as a medical practitioner by immediate action taken by Health Professional Review Tribunal – *Health Practitioner Regulation National Law* s 156 – need to identify conduct relied upon – expansion of conduct subject of the appeal from the Medical Board of Australia to Health Professional Review Tribunal– appellant not given reasonable opportunity to respond – procedural fairness – irrelevant consideration – error of law – appeal allowed

Health Practitioners Act 2004 (NT) ss 63, 99; *Health Practitioner Regulation National Law Act* 2009 (Qld); *Health Practitioner Regulation National Law* ss 3(2)(a), 3(3); 3A; 5; 23; 25(a); 31(1); 35(1); 39; 40; 148(1); 156(1); 158; 160(1); 193; 199(1)(h); *Health Practitioner Regulation (National Uniform Legislation) Act 2010 (*NT) s 4; *Medical Practitioners Act 1938* (NSW), s 27.

Bernadt v Medical Board of Australia [2013] WASCA 259; *Chief Executive Officer Department for Child Protection v Hardingham* (2011) 214 A Crim R 259; *Coppa v Medical Board of Australia* (2014) 291 FLR 1; *Dekker v Medical Board of Australia* [2014] WASCA 216; *Kozanoglu v The Pharmacy Board of Australia* (2012) 36 VR 656; *R and Medical Board of Australia* [2013] WASAT 28; applied.

Australian and Overseas Telecommunications Corporation Ltd v McAuslan (1993) 47 FCR 492; *Bernadt and Medical Board of Australia* [2012] WASAT 185; *Beaumont v Beesley* [1973] 2 NSWLR 341; *Breen v Williams* (1996) 186 CLR 71; *Commissioner for Australian Capital Territory Revenue v Alphaone Pty Ltd* (1994) 49 FCR 576; *Cranley v Medical Board of Western Australia* (Unreported, Supreme Court of Western Australia, Ipp J, 21 December 1990); *Genco and City of Melbourne v Salter and Building Appeals Board* [2013] VSCA 365; *George v Rockett* (1990) 170 CLR 104; *Hoile v Medical Board of South Australia* (1960) 104 CLR 157; *I v Medical Board of Australia* [2011] SAHPT 18; *Lindsay v New South Wales Medical Board* [2008] NSWSC 40; *Marten v Royal College of Veterinary Surgeons Disciplinary Committee* [1966] 1 QB 1; *MLNO v Medical Board of Australia* [2012] VCAT 1613; *Pearse v Medical Board of Australia* [2013] QCAT 392; *Qidwai v Brown* [1984] 1 NSWLR 100; *Reeve v Aqualast Pty Ltd* [2012] FCA 679; *Liddell and Medical Board of Australia* [2012] WASAT 120; *Re Refugee Review Tribunal and Anor; Ex parte Aala* (2000) 204 CLR 82; *Re Minister for Immigration and Multicultural Affairs; Ex parte Miah* (2001) 206 CLR 57; *Reyes v Dental Board of South Australia* (2002) 83 SASR 551; *Roylance v General Medical Council No. 2* [2000] 1 A.C. 311; *Shahinper v Psychology Board of Australia* [2013] QCAT 593; *Solomon v AHPRA* [2015] WASC 203; *Stead v State Government Insurance Commission* 161 CLR 141; *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215; *The Tasmanian Board of the Pharmacy Board of Australia v Balzary* [2011] TASHPT 2; *S v Crimes Compensation Tribunal* [1998] 1 VR 83, referred to.

REPRESENTATION:

Counsel:

Appellant:	R Niall SC
Respondent:	L Chapman SC

Solicitors:

Appellant:	Fitzpatrick Legal
Respondent:	Australian Government Solicitor

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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Nitschke v Medical Board of Australia [2015] NTSC 39
No. LA 1 of 2015 (21502811)

BETWEEN:

NITSCHKE Philip
Appellant

AND:

MEDICAL BOARD OF AUSTRALIA
Respondent

CORAM: HILEY J

REASONS FOR JUDGMENT

(Delivered 6 July 2015)

Introduction

[1] On 8 July 2014 the SA Notification Committee A of the Medical Board of Australia ("the Medical Board" or "Board") made a decision under s 160 of the *Health Practitioner Regulation National Law*[1] ("the National Law") to investigate Dr Philip Nitschke, the appellant.[2]

[1] The *Health Practitioner Regulation National Law* is the Schedule to the *Health Practitioner Regulation National Law Act (Qld)* 2009.
[2] Appeal Book (*AB*) 894.

[2] On 23 July 2014, the Immediate Action Committee ("IAC") of the Medical Board decided to suspend the appellant's registration as a medical practitioner pursuant to s 156 of the National Law.[3] The appellant appealed against that decision to the Health Professional Review Tribunal ("the Tribunal") pursuant to s 199(1)(h) of the National Law. That appeal was conducted by way of a hearing de novo.[4]

[3] On 22 December 2014 the Tribunal confirmed the decision of the Immediate Action Committee suspending the registration of Dr Nitschke, and provided written reasons for doing so ("the Reasons").

[4] The appellant has appealed against that decision, pursuant to s 99 of the *Health Practitioners Act 2004* (NT), which permits such an appeal to this court but only on a question of law.

[5] Although many of the submissions on appeal related to the conduct of the appellant and whether or not it might constitute professional misconduct or unprofessional conduct under the National Law, it was not a function of the Tribunal (when making its decision under s 156 of the National Law) and is not a function of this court in this appeal, to decide whether or not the Appellant has behaved in a way that

[3] AB 1156.
[4] Cf *Kozanoglu v The Pharmacy Board of Australia* (2012) 36 VR 656 (*Kozanoglu C/A*) at [95] – [96] and [98] – [119].

constitutes professional misconduct. That question is to be considered and determined by the Tribunal under s 193 of the National Law at some later date after full consideration on the merits.[5]

[6] Rather, the question before the Tribunal was whether it "reasonably believe[d] that," because of the appellant's conduct, he "pose[d] a serious risk to persons" and "it [was] necessary to take immediate action to protect public health or safety".[6]

Statutory context

[7] The statutory focus of these proceedings is s 156 of the National Law. Section 156(1) includes the following:

> A National Board may take immediate action in relation to a registered health practitioner or student registered by the Board if –
>
> (a) the National Board reasonably believes that –
>
> (i) because of the registered health practitioner's conduct, performance or health, the practitioner poses a serious risk to persons; and
>
> (ii) it is necessary to take immediate action to protect public health or safety.

[5] See for example *Lindsay v New South Wales Medical Board* [2008] NSWSC 40 (*Lindsay*) at [77]; *I v Medical Board of Australia* (*I*) [2011] SAHPT 18 at [26]; *Liddell and Medical Board of Australia* [2012] WASAT 120 (*Liddell*) at [21]; *Bernadt and Medical Board of Australia* [2012] WASAT 185 (*Bernadt*) at [2]; *R and Medical Board of Australia* [2013] WASAT 28 (*R*) at [23] – [28] and [104] – [107]; *Bernadt v Medical Board of Australia* [2013] WASCA 259 (*Bernadt C/A*) at [151].

[6] s 156(1).

[8] The National Law applies to the Northern Territory, and to medical practitioners who practice in the Northern Territory, by force of s 4 of the *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT).[7] It also applies to other States and the ACT by force of similar adopting legislation. It has been summarised in detail in other decisions such as the decision of the Western Australian Court of Appeal in *Bernadt v Medical Board of Australia*[8] (*Bernadt C/A*) and the decision of this court in *Coppa v Medical Board of Australia (Coppa).*[9]

[9] The National Law establishes a national registration and accreditation scheme for health practitioners. A person who practices the profession of medicine is a *health practitioner*. As part of the registration and accreditation scheme a person is registered as a *registered health practitioner*. A person who is registered under the National Law in the medical profession is referred to in the National Law as a *medical practitioner*.

[10] A convenient summary of the relevant scheme as it applies to Northern Territory health practitioners and medical practitioners in particular is set out by Barr J in *Coppa*[10] at [5] – [8]:

> [5] The National Law establishes a national registration and accreditation scheme for the regulation of health practitioners.

[7] See e.g. *Coppa v Medical Board of Australia* (2014) 291 FLR 1 (Barr J).
[8] [2013] WASCA 259.
[9] (2014) 291 FLR 1.
[10] (2014) 291 FLR 1.

One of the objectives of the national scheme is to protect the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.[11] The main principle for administering the National Law is now stated in terms that the health and safety of the public are paramount.[12] The "guiding principles" of the national registration and accreditation scheme include the principles that "the scheme is to operate in a transparent, accountable, efficient, effective and fair way" and that "restrictions on the practice of a health profession are to be imposed only if it is necessary to ensure that health services are provided safely and are of an appropriate quality".[13]

[6] The many health professions recognized under Part 5 of the National Law include medical, nursing and midwifery, occupational therapy, pharmacy, physiotherapy and psychology. National Boards are established for each of the recognized health professions. The defendant Medical Board of Australia is established as the National Board for the medical profession.[14] Each National Board is a body corporate. The functions of a National Board include assessment and investigation of matters referred to it by the Australian Health Practitioner Regulation Agency ("AHPRA")[15] about registered health practitioners; the establishment of panels to conduct hearings about health and performance and professional standards matters in relation to persons in the health profession; and the monitoring of conditions, undertakings and suspensions imposed on the registration of health practitioners.[16]

[7] The National Law requires all members of National Boards to act impartially and in the public interest in the exercise of their functions. The National Law expressly provides that a member of a National Board is to put the public interest before the interests of particular health practitioners or any entity that represents health practitioners…

[8] The functions of a National Board do not include the actual receipt of complaints (or "notifications" as they are called). Rather, notifications are made to AHPRA, which undertakes preliminary assessments and investigations on behalf of the

[11] National Law, s 3(2)(a).
[12] National Law, s 3A.
[13] The guiding principles are set out in the National Law, s 3(3).
[14] National Law, s 31(1).
[15] A body corporate established by s 23 of the National Law.
[16] National Law, s 35(1)(g), (h) and (j).

relevant National Board. The functions of AHPRA include providing administrative assistance and support to the National Boards in exercising their functions.[17] Subject to exceptions which are not presently relevant, AHPRA must as soon as practicable refer any notification it receives to the relevant National Board.[18] AHPRA must refer notifications about registered health practitioners in the medical profession to the defendant Medical Board of Australia.

[11] Part 7 of the National Law relates to registration of health practitioners. It enables the National Board to assess eligibility, qualifications and suitability for registration and to make decisions about registration including to impose conditions. Categories of registration include general registration, specialist registration and non-practising registration. Registration needs to be renewed every year.[19]

[12] Part 8 of the National Law is entitled "Health, performance and conduct". Divisions 2, 3 and 4 relate to the making of a "notification" to the National Agency (AHPRA).

[13] Any person or body who believes that a ground on which a "voluntary notification" may be made exists in relation to a medical practitioner may make such a notification. Section 144 sets out a wide range of grounds on which a person may make a voluntary notification, including grounds relating to the practitioner's professional conduct,[20]

[17] National Law, s 25(a).
[18] National Law, s 148(1).
[19] See for example ss 56, 61, 76 and 107-112.
[20] s 144(1)(a).

standard of knowledge, skill or judgment,[21] impairment,[22] and contravention of registration conditions[23] or of the National Law.[24]

[14] Another ground is that "the practitioner is not, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession."[25] As counsel for the respondent pointed out there have been many cases where a person has been found unsuitable to be or remain registered within a particular profession on account of conduct that did not occur in the course of the practice of the profession.[26]

[15] Following its receipt of a notification, the National Agency (AHPRA) is required to refer the notification to the relevant National Board. The National Board (here the Medical Board) must conduct a preliminary assessment and make various decisions.[27] It is open to the National Board to take no further action in certain circumstances.[28] In most cases the National Board must provide written notice of the notification to the practitioner.[29]

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[21] s 144(1)(b).
[22] s 144(1)(d).
[23] s 144(1)(f).
[24] s 144(1)(e).
[25] s 144(1)(c).
[26] See for example *Reyes v Dental Board of South Australia* (2002) 83 SASR 551 and cases referred to therein at [33] – [39].
[27] s 149.
[28] s 151.
[29] s 152.

[16] Then follows Division 7 which enables the National Board to take "immediate action" in certain circumstances. If a National Board is proposing to take immediate action that consists of suspending the registration of a registered health practitioner it must give the practitioner notice of the proposed immediate action and invite the practitioner to make a submission to the Board.[30] Immediately after deciding to take immediate action in relation to the practitioner, the Board must provide written notice of the Board's decision. The notice must state the reasons for the decision and advise the practitioner that he or she may appeal the decision.[31] An appeal against a decision by the National Board to suspend the person's registration may be brought to "the appropriate responsible tribunal for the appellable decision",[32] in this case the Health Professional Review Tribunal established by s 63 of the *Health Practitioners Act 2004* (NT).

[17] Meanwhile, the National Board may investigate the practitioner. The Board must then decide whether or not to take further action in relation to the matter.[33]

[18] If a National Board "reasonably believes, based on a notification or for any other reason" that "the practitioner has behaved in a way that constitutes professional misconduct" it must refer the matter to a

[30] s 157.
[31] s 158.
[32] s 199.
[33] Division 8.

responsible tribunal, namely the Health Professional Review Tribunal.[34]

[19] In other situations, for example where a National Board "reasonably believes, because of a notification or for any other reason" that "the way a registered health practitioner … practices the health profession, or the practitioner's professional conduct, is or may be unsatisfactory" the Board may take actions itself including imposing conditions on the registration,[35] or refer the matter to a panel established under Division 11.

[20] If a matter has been referred to a panel and the practitioner asks for the matter to be referred to a responsible tribunal under s 193, or if the subject of the hearing is a registered health practitioner and the panel reasonably believes the evidence demonstrates the practitioner may have behaved in a way that constitutes professional misconduct, the panel is obliged to stop hearing the matter and to require the Board to refer the matter to a responsible tribunal under s 193.[36] Otherwise the panel can make one or more decisions including that the practitioner has behaved in a way that constitutes "unsatisfactory professional performance" or "unprofessional conduct".[37] In such circumstances the panel may decide to impose conditions on the practitioner's

[34] s 193(1)(a)(i).
[35] s 178.
[36] s 190. See too s 191(1)(b)(iv).
[37] s 191(1)(b). These terms are defined in s 5.

registration and, if it is a health panel, may suspend a practitioner's registration.[38]

[21] Appeals against such decisions of the Board or panel can be made to the appropriate responsible tribunal pursuant to s 199.

[22] Where a matter about a registered health practitioner has been referred to and heard by a responsible tribunal the tribunal has a wide range of powers. If the tribunal decides that the practitioner has behaved in a way that constitutes unsatisfactory professional performance, unprofessional conduct, or professional misconduct, it may caution or reprimand the practitioner, impose conditions on the practitioner's registration, require the payment of a fine up to $30,000, suspend the practitioner's registration for a specified period, or cancel the practitioner's registration. If it decides to cancel a person's registration the tribunal may also decide to disqualify the person from applying for registration as a registered health practitioner for a specified period or prohibit the person from using a specified title or providing a specified health service.[39]

Immediate action regime

[23] The purpose and operation of the immediate action regime established under Division 7 has been discussed in several decisions, some being

[38] s 191(3).
[39] s 196(2) and (4).

decisions of the appropriate responsible tribunal following an appeal from a decision by a National Board,[40] others being decisions of a Court following an appeal against a decision by a responsible tribunal.[41]

[24] Immediate action taken under s 156 is of an interim nature, and may well be taken on the basis of incomplete information. Such action will usually be taken urgently in order to protect the public, pending further investigations and ultimately a full hearing on the merits by a health panel under Division 11 or a responsible tribunal under Division 12.[42]

[25] Per the Victorian Court of Appeal in *Kozanoglu v The Pharmacy Board of Australia*[43] (*Kozanoglu C/A*) at [107]:

> While the purpose of the immediate action provisions is the protection of the public … only interim protection is envisaged. The practitioner's suitability to practice is then revisited, on all the material, before the panel or responsible tribunal [after a hearing on the merits under Division 12].

[26] In most of the cases to date the immediate action has been taken in order to protect patients of a medical practitioner, or people in a

[40] *I* at [26]; *Liddell* at [26]; *Bernadt* at [29] – [34]; and *R* at [23] – [28] & [104] – [107].
[41] *Kozanoglu C/A* at [59] – [61], [95] – [96] and [126] – [128]; *Bernadt C/A* at [14] – [40], [42] – [60], [62] – [68], [136] – [138], [152] -]153], [166], [170] – [174], [273] – [278].
[42] *Kozanoglu C/A* at [28] & [107] and *The Tasmanian Board of the Pharmacy Board of Australia v Balzary* [2011] TASHPT 2 at [4] – [5] & [9] referred to in *Kozanoglu C/A* at [115] – [116]. See too *Lindsay* at [79]; *I* at [26]; *Liddell* at [21] and *R* at [23] – [28] & [104] – [107]. Cf *Bernadt C/A* at [49].
[43] (2012) 36 VR 65.

contractual relationship with a medical practitioner such as customers of a pharmacist[44].

[27] Immediate action may well bring significant consequences for the practitioner, particularly if it involves suspension of the practitioner's registration, the most serious action that can be taken under Division 7.[45]

[28] In considering the necessity of taking immediate action the relevant tribunal will need to carefully consider the protection of the public on the one hand and the impact upon the practitioner on the other.

[29] As stated in *MLNO v Medical Board of Australia*[46] at [5] and repeated in *Pearse v Medical Board of Australia*[47] at [19]:

> Whilst the protection of the public is and must remain the paramount consideration, the impact of immediate action on a health practitioner cannot be overestimated.

[30] And more recently in *Kozanoglu C/A* at [126] and quoted in *Bernadt C/A* at [60]:

> … while the safety of the public must necessarily be the prime concern, that safety should be secured with as little damage to the practitioner as is consistent with its maintenance.

[44] *Kozanoglu C/A*.
[45] See e.g. *Kozanoglu C/A* at [28] – [29], [126] – [128].
[46] [2012] VCAT 1613.
[47] [2013] QCAT 392. See too *R v Medical Board of Australia* [2013] WASAT 28 at [105].

[31] In *Bernadt* the Western Australian State Administrative Tribunal said, at [27], that in immediate action review proceedings:

> … because a practitioner's reputation or their capacity to earn a livelihood in their registered vocation is at stake, the Tribunal must feel an actual persuasion of the occurrence or existence of the relevant facts, under the *Briginshaw* principle or approach, in order to form a reasonable belief under s 156 of the National Law …

[32] However in its later decision in *R and Medical Board of Australia*[48] the Western Australian State Administrative Tribunal distinguished *Bernadt* and did not consider that the *Briginshaw* approach was appropriate.[49] Although the Tribunal's decision in *Bernadt* was appealed (by Dr Bernadt) the Court of Appeal did not refer to this question in *Bernadt C/A*. In *Shahinper v Psychology Board of Australia*[50] the Queensland Civil and Administrative Tribunal agreed with the decision in *R and Medical Board of Australia* and said that the *Briginshaw* approach "is not what s 156 of the National Law calls for."[51]

[33] In *Dekker v Medical Board of Australia*[52] the Western Australia Court of Appeal considered it appropriate to have regard to the *Briginshaw* standard.[53] In *Solomon v Australian Health Practitioner Regulation*

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[48] *R v Medical Board of Australia* [2013] WASAT 28.
[49] [105] - [106].
[50] [2013] QCAT 593.
[51] At [16].
[52] [2014] WASCA 216 (*Dekker C/A*).
[53] [2014] WASCA 216 at [75] and [89]-[90].

Authority Mitchell J agreed that this standard is also applicable to the functions of a panel performing disciplinary functions under the National Law.[54] However, they were both matters involving final orders, not orders under s 156.

[34] The need for the relevant tribunal to form a reasonable belief as to each of the three components in s 156(1)(a) was discussed by each of the judges in *Bernadt C/A*. Per McLure P at [63] – [68]:

> [63] The Board (and SAT in the exercise of its review function) must believe, and have reasonable grounds for believing, the matters specified in s 156(1)(a)(i) and (ii): *Minister for Immigration and Multicultural Affairs v Eshetu* (1999) 197 CLR 611 [130] - [145].
>
> [64] The existence of a reasonable belief is a jurisdictional 'fact' that enlivens the power in s 156(1)(a) to take immediate action: *Eshetu* [130]; *Plaintiff M70/2011 v Minister for Immigration and Citizenship* [2011] HCA 32; (2011) 244 CLR 144 [57]; *Graham Barclay Oysters Pty Ltd v Ryan* [2002] HCA 54; (2002) 211 CLR 540 [183].
>
> [65] It is necessary to identify with precision what it is that must be the subject of the reasonable belief. There are three components in subpars (i) and (ii) of s 156(1)(a), one factual and two evaluative. They are:
>
> (i) (1) because of (that is, by reason of) the practitioner's conduct, performance or health
>
> (2) the practitioner poses a serious risk to persons; and
>
> (ii) it is necessary to take immediate action to protect public health or safety.
>
> [66] The 'reasonable belief' requirement applies, in my view, to the three components, including the factual substratum ((i)(1))

[54] [2015] WASC 203 at [138] – [139].

on which the evaluative assessments (in (i)(2) and (ii)) are to be made. That being so, the fact or facts directly in issue concerning a practitioner's conduct, performance or health do not have to be proven on the balance of probabilities: *George v Rockett* [1990] HCA 26; (1990) 170 CLR 104. However, there must be proven objective circumstances sufficient to justify the belief.

[67] The High Court in *Rockett* discussed the meaning of the statutory expression 'reasonable grounds for believing' in a provision relating to the issue of a search warrant. The provision relevantly provided 'If it appears to a justice, on complaint made on oath, that there are reasonable grounds for suspecting that there is in any house ... or place ... Anything ... as to which there are reasonable grounds for believing that it will of itself or by or on scientific examination, afford evidence as to the commission of any offence'. In that case the decision-maker did not have to entertain the relevant suspicion or belief. The question was whether the complaint and statutory declaration which supported it contained sufficient facts to found the reasonable suspicion and the reasonable belief. In that context, the majority said:

> Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture (116).

[68] For present purposes I will assume (it not having been the subject of any submissions) that this meaning of belief is of general application rather than context driven.

[35] At [173], after quoting from *George v Rockett*, Newnes JA said:

> A ‘reasonable belief’ similarly requires the existence of facts which are sufficient to induce the belief in a reasonable person.

[36] In *Coppa,* Barr J discussed *George v Rockett* and its application in *Bernadt C/A* and referred to what Yates J said in *Reeve v Aqualast Pty*

Ltd,[55] a case concerning pre-trial discovery in civil proceedings. At [55]:

> His Honour concluded that, although the notion of "reasonable belief" may set the threshold at quite a low level, there must be some tangible support that takes the existence of the alleged right beyond mere belief or assertion by the applicant.

[37] Unlike most of the other cases involving immediate action where the facts constituting the alleged conduct are disputed, most of the relevant facts in the present case are not in dispute.

[38] Rather the present matter concerned whether the conduct relied upon by the Board could be conduct within the scope of the National Law and whether because of that conduct the practitioner posed a serious risk and whether immediate action was necessary. The Tribunal needed to have a reasonable belief about each of these three components.

[39] The serious consequences of imposing immediate action required that the conduct asserted be clearly identified and that the practitioner be able to respond to those particular allegations. In *Shahinper v Psychology Board of Australia*[56] the Queensland Civil and Administrative Tribunal quoted the following passage from *R v Medical Board of Australia*[57]:

[55] [2012] FCA 679 at [65(g)].
[56] [2013] QCAT 593 at [15].
[57] [2013] WASAT 28 at [105].

> Obviously, the taking of immediate action, particularly when it comprises a suspension of the practitioner's registration, will have serious consequences for the practitioner's reputation and his capacity to earn a livelihood. He is, therefore, entitled to know the case sought to be made against him and to be given the opportunity to reply to it.

[40] Although at the time of taking immediate action the Board may still be in the process of investigating allegations and obtaining evidence in relation to the alleged conduct I consider that there does need to be some reasonable basis for holding the view that the alleged conduct is conduct that could ultimately be found to be in breach of the National Law.

Conduct

[41] An important issue that flows from the contentions made on behalf of the appellant is whether the conduct referred to in s 156(1)(a)(i) is confined to conduct occurring in the course of a doctor patient relationship or in connection with the practice of the profession.

[42] Counsel for the respondent contended that the conduct is not so confined. I agree.

[43] Counsel submitted that the apparent application of s 156(1)(a) to a broad range of conduct (irrespective of its nature) is curbed by the essential requirements in s 156(1)(a) that the Board reasonably believes that the practitioner poses a serious risk to persons because of the

conduct, and also that it is necessary to take immediate action to protect public health or safety.

[44] The main focus of the National Law is "unsatisfactory performance" by a health practitioner and to species of conduct by a health practitioner, namely professional misconduct and unprofessional conduct. This matter, and s 156(1)(a), relates to conduct. The word "conduct" is not defined in the National Law. However conduct is referred to in the definitions of *professional misconduct*, and *unprofessional conduct*. "Professional misconduct" as defined in s 5 of the National Law includes:

> (c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

[45] That conduct not occurring in connection with the practice of the relevant profession may amount to unprofessional conduct or professional misconduct is consistent with numerous other cases where doctors, dentists, lawyers and others have been dealt with in disciplinary proceedings for such conduct.[58]

[46] Although those cases and the definition of professional misconduct in s 5 of the National Law relate to the ultimate question as to whether or

[58] See for example *Hoile v Medical Board (SA)* (1960) 104 CLR 157; *Marten v Royal College of Veterinary Surgeons Disciplinary Committee* [1966] 1 QB 1; *Beaumont v Beesley* [1973] 2 NSWLR 341; *Roylance v General Medical Council No. 2* [2000] 1 A.C. 311; *Reyes v Dental Board of South Australia* (2002) 83 SASR 551.

not the practitioner is guilty of professional misconduct or unprofessional conduct, there is no reason to construe the meaning of the word differently and more narrowly when applying the immediate action provisions, in particular s 156(1)(a) of the National Law.

Relevant background

[47] Following a story aired on the ABC's *7:30* on 3 July 2014, the Board received six complaints,[59] including from members of the medical profession, the Australian Medical Association (WA) and mental health agency Beyond Blue. The Board had also received a complaint about Dr Nitschke in December 2012 from a member of the public whose 26-year-old son had accessed the Exit International online forums associated with Dr Nitschke, purchased Nembutal and taken his life.

[48] On 8 July 2014 an Out of Session meeting of the SA Notification Committee A of the Medical Board conducted by email decided to investigate Dr Nitschke under s 160(1) of the National Law. The record of the meeting[60] identified the following three "issues":

> 1. Whether Dr Nitschke inappropriately advised a 45-year-old man about methods of suicide, knowing that the man was not terminally ill, was likely to be suffering depression, and intended to take his life in two weeks.
>
> 2. Whether, in the circumstances, Dr Nitschke failed to refer the man to a general practitioner or psychiatrist.

[59] Dated between 4 and 11 July 2014.
[60] AB 894.

> 3. Whether Dr Nitschke inappropriately promoted and provided advice by his publication, 'the Peaceful Pill Handbook' on methods of suicide.

[49] Two reasons were stated for making the decision to investigate the appellant:

> 1. Dr Nitschke is currently being investigated by the Board in relation to the provision of advice about methods of suicide.
>
> 2. The Board believes that an investigation into the current matter is necessary and appropriate because Dr Nitschke's conduct is, or may be, unsatisfactory.

[50] By letter dated 9 July 2014 the Australian Health Practitioner Regulation Agency (AHPRA) notified Dr Nitschke of the investigation.[61] The letter stated that the Board decided on 8 July 2014 to investigate him "in relation to matters raised in a story aired on the ABC's *7.30* on 3 July 2014" and attached a transcript of the story. The letter then stated that "the issues currently identified are" the three issues listed in the record of the meeting of 8 July. The letter advised Dr Nitschke that he would have an opportunity to respond to the issues as the investigation progressed, that the investigation would be conducted in a timely way and that during the investigation he would be provided with progress updates. The letter required him to provide by 5pm Wednesday 16 July 2014 a number of documents including notes of communications between him, representatives of Exit International, Mr Brayley and Mr Waterman.

[61] AB 897.

[51] The South Australian Immediate Action Committee of the Medical Board of Australia met on the 14 July 2014. The record of that meeting[62] identified the following three issues:

> 1. Whether Dr Nitschke inappropriately promotes and provides advice on methods of suicide, including advocating for the right of a person to choose suicide even if not terminally ill.
>
> 2. Whether Dr Nitschke inappropriately discussed methods of suicide with Mr Nigel Brayley, knowing that he was 45 years old, was not terminally ill, was likely to be suffering depression, and intended to take his life in two weeks
>
> 3. Whether Dr Nitschke failed to take steps to obtain much, if any, information about Mr Brayley, assess any medical condition (including depression), provide any treatment of that condition or refer him for assessment, specialist care or treatment.

[52] Under the heading "Decision", the record stated that the members "formed a reasonable belief that Dr Nitschke poses a serious risk to persons and it is necessary to take immediate action to protect public health and safety" by "proposing to take immediate action under s 156(1) of the National Law by suspending Dr Nitschke's registration" and "inviting Dr Nitschke to make a written submission about the proposed immediate action by 12 noon Thursday 17 July 2014".

[53] The record stated that "the Board proposes to take immediate action for the reasons set out in the Immediate Action Agenda Paper", and "in particular" reasons which were then set out in four numbered

[62] AB 924 - 926.

paragraphs. The first paragraph stated that “Dr Nitschke overly promotes and provides advice on methods of suicide, including advocating for the right of a person to choose suicide even if not terminally ill” by various means including through the Exit International website and videos published on that and other websites, an online forum on that website, the Peaceful Pill Handbook and Exit Workshops. That information and material is made available to anyone and “advocates for the right of a person to choose suicide and goes beyond the voluntary euthanasia debate”. The second paragraph referred to the appellant’s email contact with Mr Brayley and included a statement that the “Board considers that Dr Nitschke was giving Mr Brayley advice as a medical practitioner” and that the “Board believes that Dr Nitschke did not exercise the care and skill expected of a medical practitioner”, as required by clause 1.4 of the Code. The third paragraph stated that “in the case of Mr Brayley, when considered against the backdrop of Dr Nitschke’s general advocacy for access to methods of suicide, Dr Nitschke’s strong personal view that people have the right to choose suicide has taken over from his responsibility as a doctor.” The fourth paragraph stated that “in this context it is very likely that what occurred with Mr Brayley will occur again and therefore the Board reasonably believes Dr Nitschke poses a serious risk to the health and safety of the public. This risk can only be addressed by taking the proposed immediate action.”

[54] By letter dated 14 July 2014 AHPRA gave notice to the appellant under s 158 of the National Law to show cause why the immediate action should not be taken to suspend his registration.[63] The letter advised Dr Nitschke that the Board was proposing to take immediate action by suspending his registration "because it reasonably believes that your conduct poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety for the reasons set out below."

[55] The letter provided those reasons under two subheadings. Under the subheading "General Advocacy" the letter stated that "you overtly promote and provide advice on methods of suicide, including advocating for the right of a person to choose suicide even if not terminally ill." That part of the letter then referred in some detail to a number of matters of the kind set out in the first paragraph of the record of the Board's meeting of 14 July including his association with the Exit International website, online forums and Exit Workshops.

[56] The second part of the letter had the subheading "Mr Nigel Brayley" and referred to what Dr Nitschke had said about his contact with Mr Brayley during the ABC's *7.30* on 3 July and email communications between him and Mr Brayley. The letter stated that "the Board considers that you were in a patient/doctor relationship with

[63] AB 928 and following pages.

Mr Brayley, or at least giving Mr Brayley advice as a medical practitioner."

[57] The letter went on to point out that the Board had not made a final decision in relation to the ongoing investigations but that "at this stage the Board is only considering whether or not immediate action should be taken in relation to your registration." Dr Nitschke was requested to provide a written submission about the proposed action by 12 noon on Thursday 17 July.

[58] Dr Nitschke responded to the show cause notice by providing written submissions and materials on 21 July 2014. He did seek further particulars and additional time to respond to some matters but this was refused.

[59] The IAC met on 22 and 23 July 2014. Under the heading "Decision" the record of that meeting[64] states that:

> The IAC reasonably believes that:
>
> 1.1 Dr Nitschke failed to appropriately discharge professional obligations as a registered medical practitioner in his interactions with Mr Nigel Brayley. Mr Brayley was a 45-year-old resident of Perth, Western Australia, who took his own life on or about 2 May 2014 by consuming a lethal dose of Nembutal.
>
> 1.2 Dr Nitschke's actions amount to 'conduct' for the purpose of s 156(1)(a)(i) of the National Law,

[64] AB 1156 - 1160.

1.3 because of that conduct, Dr Nitschke poses a serious risk to persons, and

1.4 it is necessary to take immediate action to protect public health or safety.

[60] The record of that meeting states that in reaching its decision the IAC attached particular weight to the unedited video interview with Dr Nitschke, an edited version of which was broadcast on the ABC's *7.30* program.

[61] The record includes 'Reasons' and used three subheadings. Under the subheading 'Conduct' the record states:

> Having regard to the material before the IAC … the IAC reasonably believes that, in Dr Nitschke's interactions with Mr Brayley, he had professional responsibilities as a registered medical practitioner which he failed to appropriately discharge.
>
> It was apparent from various remarks that Dr Nitschke made in the unedited video that he formed a clinical judgment about Mr Brayley's capacity to make a decision to suicide.

[62] The record then quotes from three emails, namely an email sent by Dr Nitschke to Mr Brayley at 1.01pm on 15 April 2014, a reply by Mr Brayley, and a further reply by Dr Nitschke at 11.31am the next day. Mr Brayley replied to that email at 1.11pm on 16 April. The record then states:

> Having regard to Dr Nitschke's email communications with Mr Brayley, the IAC reasonably believes that he:

- failed to respond in an appropriate manner to Mr Brayley's stated intent to take his own life within two weeks, knowing that Mr Brayley was 45 years old, not terminally ill and had described himself as suffering.

- failed to take steps to obtain much, if any information from Mr Brayley, assess any medical condition (including depression), provide any treatment of that condition (if Dr Nitschke considered one existed) or refer Mr Brayley to assessment, specialist care or treatment,

- did not exercise the care and skill expected of a registered heath practitioner, in particular having regard to cl 1.4 of 'Good Medical Practice: A Code of Conduct for Doctors in Australia, (March 2014), which relevantly provides that Dr Nitschke has a responsibility to protect and promote health of individuals and the community.

[63] Under the subheading "Serious risk to persons" the record states that "the IAC reasonably believes that because of Dr Nitschke's conduct with Mr Brayley, Dr Nitschke poses a serious risk to persons." It then goes on to say that in forming the belief the IAC has also had regard to certain other "general background material relating to Dr Nitschke's promotion of, and advice given to persons about, end of life choices."

[64] By letter dated 23 July 2014 AHPRA provided Dr Nitschke with a "Notice of decision to take immediate action" (referred to in the Reasons as the "Notice of Immediate Action").[65] Under the heading "Decision" the letter set out the IAC's decision (set out in [59] above). It stated that the decision would take effect from 12am 24 July 2014, and would continue to have effect until the decision is set aside on

[65] AB 1162-1167.

appeal or the suspension is revoked by the Board. Under the heading "Reasons", the letter repeated the reasons contained in the record of the IAC's decision which I have already referred to and quoted in paragraphs [61] to [63] above.

[65] Following the Board's decision Dr Nitschke appealed to the Tribunal on 30 July 2014. As it was agreed that the appeal should be conducted de novo, the Board provided detailed written submissions entitled "Respondent's Outline of Submissions" on 17 October 2014.[66] The appellant provided detailed written submissions entitled "Outline of Appellants Submissions" dated 27 October 2014.[67]

[66] The appeal was heard by the Tribunal on 10-12 November 2014. On 10 November the appellant sought to tender a folder containing various articles and correspondence described as 'a collection of professional journal articles [that] touch on the issue of rational suicide.'[68] For convenience I marked that folder as Exhibit A2 in this proceeding. The Tribunal refused to accept those materials as evidence, primarily because it considered that they were not relevant. On 14 November the appellant provided the Tribunal with detailed written submissions, which for convenience I marked as Exhibit A1 in this proceeding. They included an addendum which summarised the contents of Exhibit A2.

[66] AB 219-235.
[67] AB 27-37.
[68] Transcript of Proceedings, *Philip Nitschke v Medical Board of Australia* (Darwin, HPRT 1/2014) Currie P, 10-11 November 2014 (*Transcript of Tribunal Proceedings*) p 23; AB 264.

The Tribunal accepted the main submissions in Exhibit A1 (pages 1-65) but not the addendum.

[67] On the 21 November 2014 the Western Australian Court of Appeal delivered its decision in *Dekker v Medical Board of Australia* [2014] WASCA 216, upholding an appeal against an earlier decision of the State Administrative Tribunal (WA). The Board informed the Tribunal of the decision and provided written submissions entitled "Respondent's Further Outline of Submissions".[69] The appellant provided the "Appellant's Further Submissions re Dekker" dated 2 December 2014.[70]

[68] The Tribunal provided its decision and reasons on 22 December 2014.[71]

Appeal to this Court

[69] The appellant appealed against that decision to this court by Notice of Appeal dated 15 January 2015. The Notice of Appeal was amended by leave at the hearing.

Grounds of appeal

[70] In his Amended Notice of Appeal the appellant contends that the Tribunal made the following errors of law:

[69] AB 236-8.
[70] AB 214-218.
[71] AB 6-26.

1. The Tribunal misconstrued the Code of Conduct for Doctors in Australia (the Code) in holding that it imposed an obligation on Dr Nitschke to promote or protect the health of Mr Brayley and to assess, treat or refer Mr Brayley in circumstances where Mr Brayley was not a patient of Dr Nitschke.

2. In making the decision the Tribunal denied Dr Nitschke procedural fairness by:

   2.1 expanding the conduct the subject of the application without giving Dr Nitschke a reasonable opportunity to respond in circumstances where the Board had deliberately confined its case;

   2.2 determining that suicide lacked "credibility" and that Dr Nitschke had sanctioned suicide and an alternative pathway that was impliedly illegitimate but precluded Dr Nitschke from advancing submissions and adducing evidence on the question of whether suicide might be rational and justifiable as an exercise of personal autonomy;

   2.3 concluding that Dr Nitschke had supported Mr Brayley to acquire and smuggle Nembutal into Australia without that allegation being distinctly and fairly put to Dr Nitschke or being part of the allegations against him.

3. The Tribunal based its conclusions on facts for which there was no evidence including:

   3.1 That Dr Nitschke had through his corporate entity supplied Mr Brayley with the *Peaceful Pill handbook;*

   3.2 That Dr Nitschke had supplied or assisted Mr Brayley acquire and smuggle into Australia Nembutal;

4. The Tribunal erred in the construction of the Code by holding that advocacy in relation to suicide and providing information to persons who might chose to end their own life was in breach of the Code.

Conduct relied upon by the Board before the Tribunal

[71] Much of this appeal concerns the proper identification of the particular conduct relied upon by the Board for the purposes of s 156(1)(a)(i),

namely the conduct because of which the Board reasonably believed the appellant posed a serious risk to persons. Grounds 1 and 4 concern the application of the Code to such conduct. Ground 2 concerns the way in which the Board is said to have wrongly taken other conduct into account.

[72] Counsel for the respondent submitted that because the appellant made broad assertions to the Tribunal that he had done nothing wrong and attempted to raise issues about rational suicide and other matters, the Tribunal was required to respond to those submissions, rather than proceed as a tribunal normally would proceed in an immediate action case. I disagree. In my opinion the Tribunal was required to consider and deal with the matters decided by the Board which led to its decision, which in turn was subject of the appeal to the Tribunal. The onus remained upon the Board to clearly identify the conduct alleged and to satisfy the Tribunal of the necessity for immediate action because of that conduct. The Tribunal would not have been entitled to engage in a wide-ranging unfocused consideration of other conduct on the part of the appellant just because he had introduced or attempted to introduce matters that were irrelevant to the Board's decision and hence the appeal before the Tribunal. The Tribunal did refer to those assertions made by the appellant at various stages within the Reasons, including under the headings "Appellant's Case" and "Discussion". But

this was after the Tribunal had set out the Board's case under the heading "Respondent's Case".

[73] In my opinion the only conduct asserted against the appellant and which the appellant was required to respond to and which the Tribunal was required and entitled to consider for the purposes of the first part of s 156(1)(a)(i) was the conduct clearly identified in [13] of the Reasons.

[74] From [12] to [16] of the Reasons the Tribunal stated the following under the heading "Respondent's Case":

> [12] The Medical Board set out a summary of the matters of concern in its outline of submissions in these terms:
>
> a. "At all relevant times, Dr Nitschke was a registered medical practitioner and a Director of Exit International, an organisation formerly known as the Voluntary Euthanasia Research Foundation and founded by the Appellant in 1997. According to Dr Nitschke, Exit International is an 'organisation which promotes individuals having choice at the end of life by using means to bring about their own peaceful death when they wish'. On the Exit International website, information can be obtained concerning these matters including about membership of Exit, the Peaceful Pill Handbook (co-authored by the appellant), newsletters, a forum and public workshops presented by the appellant.
>
> b. Mr Nigel Brayley was 45 years old. He was not terminally ill. He lived in Western Australia.
>
> c. On 2 February 2014, Mr Brayley purchased a copy of Dr Nitschke's Peaceful Pill Handbook over the internet.
>
> d. According to Dr Nitschke, he met Mr Brayley at a workshop in Perth in February 2014. In a media release on 3 July 2014,

Dr Nitschke stated he spoke to Mr Brayley on that day. Mr Brayley 'was interested in ensuring that he had access to the means of a peaceful and reliable death as a future contingency'.

e. On 27 February 2014, Mr Brayley purchased an Exit Dilution Purity Test Kit at the exitinternationalstore.com after obtaining Nembutal from China. These kits are available for purchase by the public to test the purity of Nembutal.

f. In mid April 2014, police executed search warrants at residences in Western Australia for possession of Nembutal. Mr Brayley's residence was searched.

g. On 15 and 16 April 2014, Dr Nitschke and Mr Brayley corresponded via email.

h. On 2 May 2014, Mr Brayley died after consuming Nembutal.

i. On 20 June 2014, Dr Nitschke was interviewed by a journalist for the 7.30 program (ABC) in relation to various matters including his contact with Mr Brayley.

j. On 4 July 2014, an interview with Dr Nitschke (an edited version of the interview on 20 June 2014) was broadcast on the 7.30 program (ABC) (edited interview).

Conduct

k. The conduct which formed the basis for the decision to take immediate action was the interaction between Mr Brayley and Dr Nitschke particularly Dr Nitschke's response, and failure to respond to Mr Brayley's stated intention to suicide within two weeks.

l. The Respondent repeats the matters set out under the heading of 'Conduct' in the Notice of Immediate Action provided to Dr Nitschke dated 23 July 2014.

m. In summary, Mr Brayley advised Dr Nitschke via email:-

    i. That he did not fit within the Exit charter of supporting a terminal illness;

    ii. 'I am suffering and have been now for some 9 months';

iii. ‘I have sought medical and other forms of assistance but they are unable to help’;

iv. ‘All recognise and accept that my life will never be the same and that it is only going to get worse and I am not prepared to risk my family’s financial security and happiness by continuing along the same path. I am 45 years old but have travelled and experienced more of this world than most people twice my age. I have a beautiful wife who is still young enough to move on and find happiness again and it’s this knowledge and my desire for this to happen that makes my decision so much more easier’;

v. ‘I will cc you into my final statement and if you wish to use any or parts of it once I have gone then feel free to’; and

vi. ‘I was planning to exit this Friday however I have readjusted this time table in light of the search warrant. You will however hear from me (final statement) within the next 2 weeks’.

n. Dr Nitschke’s response to that information was to reply to Mr Brayley via email:-

i. on the topic of the raids;

ii. about the need for a general email warning to members to ensure that they keep their Nembutal product ‘well hidden’ from the police; and

iii and to say ‘Thank you very much for your information, and I will be interested in your final statement’.

o. Following the broadcast of the edited interview on the 7.30 program on 4 July 2014, AHPRA received eight notifications all of which expressed concern that Dr Nitschke had failed to properly assess or refer Mr Brayley to a service that may assist him.

[13] The Medical Board allege that having received Mr Brayley’s emails in mid April 2014, Dr Nitschke, as a registered medical practitioner:

a. Failed to respond in an appropriate manner to Mr Brayley’s stated intent to take his own life within two weeks, knowing

that he was 45 years old, not terminally ill and had described himself as suffering. Dr Nitschke's only response to Mr Brayley's stated intention to suicide in two weeks was 'I will be interested in your final statement'.

b. Failed to take steps to obtain any information from Mr Brayley to assess any medical condition (including depression), provide any treatment of that condition (if he considered one existed) or refer him to assessment, specialists care or treatment.

[14] The failure to obtain information from Mr Brayley to assess his medical condition is evident from the email correspondence itself but also from statements made by Dr Nitschke in the media:-

- On 20 June 2014, Dr Nitschke told the 7.30 program journalist (unedited interview) that he did not get any background from Mr Brayley, he did not know whether Nigel was 'tired of life' and 'there's a lot more going on in Nigel's background that I was unaware of'.

- On 17 July 2014 during a press conference, Dr Nitschke described Mr Brayley as a 'serial killer' with whom he had 'very brief contact'/'scant dealings with'/'very little communication'.

- On 24 July 2014, during an interview on 666 ABC Radio Canberra, Dr Nitschke described Mr Brayley as a 'serial killer' with whom he 'had almost no contact with'.

- On 24 July 2014 at his press conference, Dr Nitschke described Mr Brayley as a 'serial wife killer' but 'didn't know he was a killer' and said he had 'very brief involvement with this person'.

[15] In regard to non-referral for assessment/treatment, Dr Nitschke had stated that:-

- He does not think he 'had a duty of care to direct [Mr Brayley] to any particular other medical service'

- He 'didn't think it was appropriate' to refer Mr Brayley to 'go off and see a doctor'

- He believed that Mr Brayley made a 'very rational decision to end his life';

- ‘He’s able to put a very rational letter together there and make what he thinks are the right decisions for his life now. And he needs to be respected. Not come along and doing our little hypothetical medical judgment’.

[16] Did not exercise the care and skill expected of a registered health practitioner, in particular having regard to cl 1.4 of ‘Good Medical Practice: A code of Conduct for Doctors in Australia’ (March 2014), which relevantly provides that as a registered medical practitioner Dr Nitschke has a responsibility to protect and promote health of individuals and the community.”

[75] The conduct the subject of complaint was said to have been in contravention of the Code of Conduct, in particular cl 1.4.[72]

[76] Notwithstanding that the Board’s decision on 8 July to investigate the appellant, its proposal of 14 July to take immediate action, and its show cause notice of 14 July all referred to other conduct on the part of the appellant, namely that described under the subheading “General Advocacy”, it is clear that by the time the Board made its decision on 23 July 2014, and more relevantly at the time of the hearing before the Tribunal, the only conduct said to be conduct for the purposes of s 156(1)(a)(i) was that summarised in [13] of the Reasons.

[77] Although [12] contained a subheading “Conduct” which referred to “the interaction” between Mr Brayley and the appellant followed by detailed paraphrasing of the emails, I consider that the only purpose and effect of that paragraph was to summarise the relevant facts by way of background.

[72] Reasons [16] and [33].

[78] It was [13] of the Reasons which clearly identified the conduct relied upon by the Board as conduct relevant for present purposes and conduct which is said to have been in contravention of the Code. Although Mr Brayley had previously attended a workshop where Dr Nitschke spoke and he had a brief discussion with him on that occasion, it was the emails of 15 & 16 April 2014 which constituted the "interactions" referred to.[73] No oral communication between Mr Brayley and Dr Nitschke was there alleged.

[79] The succeeding paragraphs of the Reasons, [14] and [15], set out the basis for the factual assertions in [13(b)].

[80] In my opinion the only issues properly before the Tribunal and hence the only matters for it to determine were:

(a) whether the conduct alleged and summarised in [13] of the Reasons was conduct of the kind that could be in breach of the Code,[74] and in particular the fourth paragraph of clause 1.4[75] which provides that:

> Doctors have a responsibility to protect and promote the health of individuals and the community.

[73] This is consistent with submissions made to the Tribunal by counsel for the Board during the hearing. See for example the Transcript of Tribunal Proceedings at pages 5.9 (AB 246), 24.1 (AB 265), 26-7 (AB 267-8), 121.6 (AB 362), 126.9 (AB 367), 140.9 (AB 381) and 143.5 (AB 384).
[74] See Reasons [27], [28], [33], [54], [55] – [92] & [111].
[75] Reasons [16], [55], [65], [77] & [88].

(For convenience I shall refer to that as "the clause 1.4 paragraph")

(b) whether because of that conduct the Tribunal "reasonably believes" that:

(i) because of that conduct, Dr Nitschke poses a serious risk to persons; and

(ii) it was necessary to take immediate action to protect public health or safety.

[81] I will interrupt the discussion at this point to record that evidence of and references to other conduct on the part of the appellant, such as that referred to in [12], [46] and [49] – [52] of the Reasons, was accepted as relevant to the question as to whether the appellant posed a serious risk to persons other than Mr Brayley because of the likelihood of him continuing to engage in those activities including repetition of the conduct the subject of complaint.[76] The Tribunal also had regard to much of that material in the process of reaching the conclusion, at [54] of the Reasons, that "the interactions Dr Nitschke had with Mr Brayley had a sufficient connection with his profession and that in the course of that conduct Dr Nitschke was bound by the Code of Conduct." It also seems that both the appellant and the Board encouraged and or

[76] Submissions to the Tribunal by counsel for the Board on 10 November 2014, recorded at page 7 of the Transcript of Tribunal Proceedings (AB 248).

permitted the Tribunal to consider other issues, including the rights and wrongs of voluntary euthanasia, the ability to make rational decisions about ending one's life and the likelihood of such a person having depression.[77]

[82] As the Board pointed out, in most other immediate action cases, the issue before the Board or Tribunal has been whether or not the alleged conduct actually occurred, the practitioner conceding that if it did occur the conduct was such that immediate action was appropriate.[78] In those cases the conduct alleged was clearly stated. In the present case there was no dispute about what the appellant has and has not said and done. Rather, the questions were and are:

(a) whether the conduct relied upon by the Board could amount to conduct of the kind proscribed under the National Law; and

(b) whether the Board or Tribunal could reasonably believe that because of that conduct, the appellant posed a serious risk to persons and that immediate action was necessary to protect public health or safety.

[83] As I have said, the conduct alleged by the Board, and thus to be considered by the Tribunal in the present matter, was the conduct set

[77] See for example Reasons [17] – [22], [27], [46] – [50], [60] – [86], [95], [97] – [99] and [100] – [104].
[78] Reasons [25] – [28].

out in [13] of the Reasons and quoted in [74] above, namely the appellant's conduct after he received Mr Brayley's emails in mid-April. The conduct was failures by the appellant, "as a registered medical practitioner", to take positive action by responding "in an appropriate manner" to Mr Brayley's stated intent to take his own life within two weeks and to take positive steps to "obtain any information from Mr Brayley to assess any medical condition (including depression), provide any treatment of that condition (if he considered one existed) or refer him to assessment, specialist care or treatment."[79]

[84] However at [88] the Tribunal treated Mr Brayley's conduct as "supporting persons such as Mr Brayley (who are not terminally ill) to take their own lives" and therefore "appear[ing] inconsistent with the responsibility to protect and promote their health and prolong their life." At [97] and [98] the Tribunal implied that the appellant should have enquired as to Mr Brayley's motives, assessed his suffering and reasons for it, encouraged him to pursue alternatives and entered into some dialogue with a view to further referral or assessment.

[85] The Tribunal proceeded to decide that it was this and other positive conduct on the part of the appellant, not just the conduct comprising the failures set out in [13], that posed a serious risk to other persons by

[79] See Reasons [13] – [15]. See too [65] – [83], [97] – [98]. See too the passage quoted above at [62] from the record of the IAC's Reasons of 23 July reproduced in the Notice of Immediate Action dated 23 July 2014.

providing “an alternate pathway to ending life”[80] and that “people may elect to follow the pathway to suicide believing it to be a pathway sanctioned by a medical practitioner and perhaps the medical profession generally.”[81]

Grounds 1 & 4

[86] In relation to ground 1 counsel for the appellant advanced four propositions:

(a) In order for s 156 to apply the conduct needs to have a sufficient nexus or connection with professional practice. In the absence of that connection there would be no occasion to take “immediate action”. Nor would taking immediate action achieve any protective purpose of the provision.

(b) The conduct complained of needs to be clearly identified.

(c) The conduct alleged against the appellant took the form of a failure to act, namely an omission.

(d) An omission would only be relevant conduct if the appellant had a professional obligation to act or respond. There had to be a legal obligation or a binding obligation to act. Because there was no legal obligation to act and no expert evidence adduced to show

[80] Reasons [93].
[81] Reasons [99].

that there was a professional obligation to act in such circumstances, such an obligation had to be found in the Code. The Code, properly construed, did not impose such an obligation.

Connection or nexus with medical practice

[87] The appellant submitted that s 156(1) can only apply to conduct which has a connection or nexus with professional practice. Because the purpose of s 156 is to take immediate action in relation to the practitioner's registration in order to protect public health or safety where a practitioner poses a serious risk to persons because of his or her conduct, the provision can only apply to conduct which has such a nexus with professional practice.

[88] Counsel contended that the point of the power conferred under s 156 is to protect against the conduct because it is the conduct that causes the risk to health and safety. I disagree. It is the practitioner who must pose the serious risk to persons, not the conduct. Of course the conduct will be of important relevance in determining that question.

[89] In many cases, unless the conduct does have some connection with the medical practice, it will be unlikely to be such as to cause the practitioner to pose a serious risk to persons warranting immediate action. Examples might include numerous driving convictions or persistent failure to pay bills. On the other hand it is not difficult to

envisage conduct which, although unconnected with medical practice, may lead to a conclusion that the medical practitioner poses a serious risk and that immediate action is necessary. An example might be allegations of sexual misconduct totally unrelated to the practice, but raising serious concerns about the practitioner posing a serious risk to the health or safety of patients.

[90] One of the main reasons for conferring the immediate action power upon the National Board is to enable immediate action to be taken where there has been a complaint about conduct which may amount to unprofessional conduct or professional misconduct. As I have already noted, this is not confined to conduct occurring in connection with the practice of the health practitioner's profession. There is no reason for reading down the meaning of the word 'conduct' as the appellant contends, namely by requiring it to have some nexus or connection with medical practice.[82]

[91] However I do consider that the conduct must be such as to be capable of being professional misconduct or unprofessional conduct. This is because a practitioner's conduct can only result in action in relation to his or her registration where there has been conduct of the kind regulated by the National Law, namely conduct that can be found to be

[82] See [41] to [46] above.

professional misconduct or unprofessional conduct upon the ultimate determination of the complaint.[83]

[92] The appellant also contended that s 156 only applies to conduct that is undertaken in the capacity of a medical practitioner or that occurs in the context of a doctor/patient relationship. For reasons similar to those stated above, I disagree with this contention. As with the other provisions in the National Law, s 156 is capable of applying to any registered medical practitioner irrespective of his or her particular relationship or capacity at the time of engaging in the conduct which is said to be professional misconduct or unprofessional conduct.

[93] That is not to say that there does not need to be some connection between the practitioner and the medical profession in order for immediate action to be taken. Although the conduct itself may have nothing to do with the practice of medicine, in order to take immediate action the relevant body would have to hold a reasonable belief that because of that conduct there would be a serious risk to public health or safety unless immediate action was taken in relation to that person's registration as a medical practitioner. In this regard there does need to be a connection between the practitioner and the practice of medicine in which he or she was registered to engage.

[83] By a panel under Division 11 or the responsible tribunal under Division 12. See too discussion about conduct at [41] to [46] above.

[94] From [45] of its Reasons onwards, the Tribunal considered the connection between the appellant's broader conduct and the medical profession, including "the interactions between Dr Nitschke (and his corporate entity) and Mr Brayley" since 2 February 2014, and concluded at [54] that "the interactions Dr Nitschke had with Mr Brayley had a sufficient connection with his profession."

Identification of the conduct relied upon by the Board

[95] The appellant contended that conduct alleged must be clearly identified for at least two reasons:

(a) to ensure that it falls within the jurisdiction of the Board or Tribunal; and

(b) to ensure that the practitioner is accorded procedural fairness by knowing exactly what he or she is accused of, and what case he or she has to meet.

[96] Counsel pointed out that AHPRA's letter of 14 July 2014, the "Notice of proposed immediate action and invitation to make submission",[84] identified two areas of conduct which was said to pose serious risk necessitating immediate action, namely the appellant's "General Advocacy" and his email interaction with Mr Brayley. In that context the letter said that "the Board believes that you did not exercise the

[84] AB 928-934 summarised in [54] - [57] above.

care and skill expected of a medical practitioner" and referred to cl 1.4 of the Code as imposing a "responsibility to protect and promote the health of individuals and the community."

[97] Counsel submitted that the Board rightly abandoned its reliance upon the General Advocacy allegations, because they included references to events that had occurred some considerable time earlier and were apparently not considered sufficiently serious as to necessitate immediate action at such earlier time. Counsel submitted that the Board's case before the Tribunal was confined to the appellant's interaction with Mr Brayley and in particular to the appellant's failures or omissions to obtain further information from Mr Brayley during and following the email exchanges in mid-April, including assessing his medical condition and providing treatment or referring him for specialist care.

[98] Whilst agreeing that most of the conduct relied upon by the Board concerned omissions on the part of the appellant, counsel for the respondent contended that the appellant's conduct when he emailed "I will be interested in your final statement" after being told of Mr Brayley's intention to suicide in two weeks was positive conduct in that it amounted to a tacit approval of that intention, in light of their previous interactions. Counsel also referred to other conduct to which the Board referred in [36] of its Outline of Submissions provided to the

Tribunal on 17 October 2014[85] all of which predated the email communications. Counsel also referred to that part of the IAC's decision that referred to his alleged failure to appropriately discharge professional obligations as a registered medical practitioner in his "interactions" with Mr Brayley.[86]

[99] As I have already concluded (in [76] - [78] above), following my consideration of [12] to [16] of the Reasons and of submissions by counsel for the Board to the Tribunal, the only conduct which was the clear focus of the Board's case before the Tribunal, and of the Tribunal's decision, was the failures to take the actions referred to in [83] above. Even if the "positive" conduct asserted by counsel for the respondent was part of the impugned conduct, I do not consider that would make any difference to my later conclusions about the meaning and relevance of the clause 1.4 paragraph.

[100] Counsel for the appellant submitted that the Tribunal wrongly expanded the conduct that it had earlier correctly identified as being the relevant conduct, namely the conduct subject of the email interactions.

[101] Counsel referred to [49] of the Tribunal's reasons which contained a long list of "interactions between Dr Nitschke (and his corporate

[85] AB 219-235.
[86] AB 1162.

entity) and Mr Brayley" extending back as far as 2 February 2014. The following paragraphs of the Reasons, [50] – [52], also referred to the broader conduct of the appellant.

[102] This was immediately followed by a reference to *Beaumont v Beesley*[87] regarding the binding effect of "standards appropriate to the medical profession" and then the conclusion at [54]:

> The Tribunal is satisfied that the interactions Dr Nitschke had with Mr Brayley had a sufficient connection with his profession and that in the course of that conduct Dr Nitschke was bound by the Code of Conduct.

[103] Shortly after that, under the heading "Code of Conduct", the Tribunal referred to the clause 1.4 paragraph and also to clause 1.5 (which refers to the "core tasks of medicine") and said, at [58]:

> It is not difficult to see that what Dr Nitschke was doing in his interactions with Mr Brayley was not consistent with protecting and promoting his health including prolonging his life.

[104] Counsel for the appellant then referred to the detailed discussion in the Reasons from [59], much of which concerned matters other than the email interactions. This included references to the appellant assisting "with the provision of information sufficient to acquire, smuggle into Australia, test, hide and then consume the substance to take their own life" (in [79]) and supporting a person to take his own life where the

[87] [1973] 2 NSWLR 341.

person is “45 years of age, possibly suffering depression for a period of nine months and has no terminal illness” (in [80]). This was all still under the heading “Code of Conduct” and before the discussion about serious risk to persons.

[105] At [88] the Tribunal stated:

> In essence, supporting persons such as Mr Brayley (who are not terminally ill) to take their own lives appears inconsistent with the responsibility to protect and promote their health and prolong their life.

[106] This was immediately followed at [89] where the Tribunal stated that “the question is whether Dr Nitschke’s conduct leads to the Tribunal reasonably believing that” each of the elements in s 156(1)(a)(i) & (ii) were met.

[107] Counsel for the appellant contended that by referring to these other and earlier interactions the Tribunal wrongly had regard to a much broader range of conduct than that which was the focus of the appeal, namely the omissions referred to in [13] of the Reasons. I agree with that contention.

[108] As I have already concluded, it was only the conduct that was clearly identified in [13] of the Reasons that the Tribunal should have considered for the purposes of the first part of s 156(1)(a)(i) of the National Law. The Tribunal had to consider whether that conduct could

have been professional misconduct or unprofessional conduct and therefore within the relevant jurisdiction of the National Law and immediate action under Division 7.

[109] By taking into account conduct other than that identified in [13] of the Reasons in the course of considering whether the appellant's conduct could have been conduct of the kind proscribed by the National Law, the Tribunal erred in law because it took into account irrelevant considerations.

[110] Alternatively, if I am wrong about that and the Tribunal was entitled to take into account such other conduct, the appellant would have a sound basis for his complaint that he was denied procedural fairness in not having that broader conduct clearly identified and a proper opportunity to then respond.

The Code

[111] It was common ground that the Tribunal considered that the Code applied to the appellant and to the conduct relied upon notwithstanding that Mr Brayley was not a patient of the appellant. The Board did not rely on some other professional or ethical obligation such as has been the focus of many other cases.[88] Nor did it assert and rely upon some

[88] See, e.g.: *Hoile v Medical Board (SA)* (1960) 104 CLR 157; *Marten v Royal College of Veterinary Surgeons Disciplinary Committee* [1966] 1 QB 1; *Beaumont v Beesley* [1973] 2 NSWLR 341; *Roylance v General Medical Council No. 2* [2000] 1 A.C. 311; *Reyes v Dental Board of South Australia* (2002) 83 SASR 551.

common law duty or a breach of the criminal law. Counsel for the appellant referred to authority to the effect that there is no common law duty to prevent a person from attempting self-harm or even suicide.[89]

[112] The Board relied primarily upon the clause 1.4 paragraph:

> Doctors have a responsibility to protect and promote the health of individuals and the community.

[113] The appellant contended that:

(a) the Code only applies to doctors in the course of their doctor patient relationship, and therefore did not apply to the appellant in respect of the conduct alleged;

(b) alternatively, if the Code did apply to the appellant, the clause 1.4 paragraph does not impose any particular obligation upon a medical practitioner.

(c) alternatively, if the clause 1.4 paragraph does impose obligations upon medical practitioners, it does not impose obligations upon a medical practitioner to protect and promote the health of a person and to assess and treat or refer that person in circumstances where that person was not a patient of the practitioner.

[89] *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215.

Application of the Code.

[114] In my view the Code applies to all doctors registered to practice medicine in Australia. Such a code is contemplated and permitted under ss 39 and 40 of the National Law, and is admissible in proceedings under the National Law against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the relevant health profession.[90]

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

[116] That the Code is intended to apply to all doctors registered to practice medicine in Australia is apparent from many of the statements in clause 1.

[90] s 41.

Effect of the clause 1.4 paragraph.

[117] In my opinion, the clause 1.4 paragraph does not impose an obligation, standard or duty the breach of which would constitute professional misconduct or unprofessional conduct. Such an obligation, standard or duty needs to be found elsewhere in the Code or shown to be an obligation, standard or duty generally accepted within the medical profession at the relevant time.[91]

[118] With the exception of clause 1.6 which is a definitional provision clause 1 is of a general and introductory nature. So much is apparent from the subheadings to clauses 1.1 to 1.5 and their respective content. For example clause 1.3 makes it clear the Code is not a substitute for the provisions of legislation and case law, does not address in detail the standards of practice within particular medical disciplines, and is not a charter of rights. Clause 1.5 refers to the "principles underpinning" the Code as applying to doctors who have little or no patient contact.

[119] The clause 1.4 paragraph is expressed in very general and aspirational terms. It is not couched in imperative terms and does not prescribe and identify any specific obligations. It has no clearly identifiable content.

[91] See for example *Dekker C/A* at [72] – [73], [80] – [86]. See too *Beaumont v Beesley* [1973] 2 NSWLR 341 per Jacobs P at 347.

[120] As counsel for the appellant pointed out, if the clause 1.4 paragraph was to impose professional obligations upon every doctor irrespective of his or her relationship with a particular person or community, every doctor would be liable to sanction every time he or she became aware that a person or community was not acting to the best of his, her or its health. Counsel gave the example of a doctor becoming aware that a person who was not his or her patient was proposing to smoke or do something else that may not be good for his or her health. Moreover, such a doctor would be under such broad and unspecified obligations even where the person does have, and indeed may have been treated by, his or her own doctor.

[121] In particular the clause 1.4 paragraph does not identify general or specific obligations of the kind asserted by the Board, namely obligations to promote or protect the health of any person and to assess and treat or refer any person irrespective of that person's relationship, if any, with the doctor. Other provisions of the Code, primarily those in clauses 2 and 3, do impose such obligations where the person is a patient of the doctor. There is no reason to suppose that those provisions necessarily apply where there is no doctor patient relationship.

[122] Nor does the clause 1.4 paragraph identify general or specific standards or duties of the kind stated or implied in the Tribunal's findings.[92] Any such obligations are to be found elsewhere. Indeed some of the standards and duties stated or implied in the Tribunal's findings may well be inconsistent with other express provisions including those directed to supporting the autonomy of a patient to make decisions to obtain or refuse treatment.[93] For example, in relation to doctors "caring for patients towards the end of their life", clause 3.12.4 states that good medical practice includes "understanding that you do not have a duty to try to prolong life at all costs."

[123] Counsel for the respondent contended that clause 1.4 "contains an important and unassailable ethical standard for the medical profession which goes to the core of medical practice" and that the Code should not be interpreted in the same way as one would construe a provision in a statute or a clause in a contract. Counsel stressed that proceedings of this kind are concerned with professional and ethical obligations standards and duties, not with legal obligations for example pursuant to statute, contract or tort principles.

[124] Counsel also referred to the Hippocratic Oath and pointed out that it too contains similarly broad language. However I was not referred to any authority that suggested that a medical practitioner might be guilty

[92] See for example [88] and [97] – [99] of the Reasons.
[93] See for example clauses 2.1.5, 2.1.11, 2.1.12, 2.3, 2.4.6 and 3.12.4.

of professional misconduct or unprofessional conduct based solely upon a breach of the Hippocratic Oath.

[125] Most if not all professional misconduct matters are based upon the breach of a relevant professional standard, clearly identified in a statute, professional conduct rules or codes, established precedent, or by expert evidence.[94] Moreover, most of the cases to which I was referred and which do not seem to have involved recourse to professional conduct rules or expert evidence are cases where the practitioner had actually engaged in positive conduct which was clearly improper.[95] Where, as here, the relevant conduct comprises failures or omissions to take certain action in respect of a person who is not the doctor's patient, one would normally require expert evidence about the relevant duty to act, if the duty was not clearly identified elsewhere.[96]

[126] For example s 27(1) of the *Medical Practitioners Act 1938* (NSW) contained a definition of professional misconduct which expressly included failure to attend upon a person for the purpose of rendering medical assistance in certain circumstances "without reasonable cause … within a reasonable time after being requested to do so". There was no such provision applicable to the situation in *Dekker C/A*[97] or here.

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[94] See for example *Dekker C/A* at [73].
[95] See for example *Hoile v Medical Board (SA)* (1960) 104 CLR 157; *Beaumont v Beesley* [1973] 2 NSWLR 341; *Reyes v Dental Board of South Australia* (2002) 83 SASR 551; cf *Roylance v General Medical Council No. 2* [2000] 1 A.C. 311.
[96] See for example *Dekker C/A* at [73], [77] – [86].
[97] See *Dekker C/A* at [29].

Indeed, the obligations assumed by the Tribunal to exist in the present case would seem to have no regard for the kind of qualifications of the kind expressed in s 27 of the *Medical Practitioners Act 1938* (NSW), namely "reasonable cause" and so on.

[127] Counsel for the respondent submitted that, unlike cases such as *Dekker C/A* where evidence might need to be provided in order to establish the relevant obligation, standard or duty, no such evidence is required here because the Code is that evidence. Whilst this is certainly correct to the extent that the Code does clearly identify relevant obligations, standards or duties, I do not consider that the clause 1.4 paragraph does that in circumstances such as the present.

[128] Indeed the fact that between them the Board and the Tribunal have asserted a wide range of obligations, standards and duties in relation to the appellant's interactions with Mr Brayley, all purportedly imposed in and under the clause 1.4 paragraph, demonstrates the difficulty in construing the clause 1.4 paragraph as imposing professional obligations, the breach of which can have serious ramifications for the practitioner.

[129] If the clause 1.4 paragraph was intended to apply to and impose a professional obligation upon all "doctors", and to all "individuals" and any "community", irrespective of the relationship between them if any,

and irrespective of the circumstances of interaction if any between the doctor and an individual or community, there would be no need for the rest of the Code. A doctor would constantly need to fear that any interaction with any other individual or community, including an individual who is not and never has been his or her patient, may be in breach of the clause 1.4 paragraph, even if the doctor did nothing in circumstances where there was no other obligation to do something.

[130] Such a construction of the clause 1.4 paragraph would completely defeat the whole purpose of having a code at all. It would also render otiose most parts of the carefully worded definitions of professional misconduct and unprofessional conduct.

[131] Alternatively, if contrary to the opinion that I have expressed in [117] above, the clause 1.4 paragraph does impose an obligation, standard or duty the breach of which could constitute professional misconduct or unprofessional conduct, it cannot do that in isolation.

[132] The particular obligation, standard or duty would need to be found to exist and given its content elsewhere, if not elsewhere in the Code then by reference to a generally accepted standard or duty.

[133] It is important to note that the relevant parts of the definition of professional misconduct refer to “conduct that is substantially below the standard reasonably expected of a registered health practitioner of

an equivalent level of training or experience" and conduct that is "inconsistent with the practitioner being a fit and proper person to hold registration in the profession". "Unprofessional conduct" is defined to mean "professional conduct that is of a lesser standard than that which might be reasonably expected of the health practitioner by the public or the practitioner's professional peers".[98]

[134] The existence and content of a generally accepted standard or duty would usually need to be established by calling expert evidence from a person of good repute and competence within the medical profession.[99] I say "usually" because some standards and duties, for example, general obligations upon a medical practitioner to a patient who is in his or her care to obtain further information from or about the patient, assess the patient's medical condition and provide treatment or refer the patient for specialist care, may be commonly accepted without the need for expert evidence. Even then a doctor's obligations to maintain or improve the health of his or her patient and to use reasonable skill and care in doing so may be qualified in particular circumstances.[100] Although the Board contended that the appellant owed those kind of obligations to Mr Brayley there was no basis for applying to the

[98] The definitions are contained in s 5 of the National Law.
[99] See *Dekker C/A* at [71], [73] and [74] quoted in [137] below and the references there and at [52] to *Qidwai v Brown* [1984] 1 NSWLR 100 pp 102 and 106-107. See too *Solomon v Australian Health Practitioner Regulation Authority* [2015] WASC 203 at [131].
[100] See for example *Breen v Williams* (1996) 186 CLR 71 at pp 78-79 and 102-105.

appellant the same general standards as may apply in a doctor patient relationship.

[135] Further, even if there was a generally accepted standard or duty upon a medical practitioner to take some action in relation to a person who is not his or her patient in particular circumstances, it would need to be established that there was a specific professional duty on a medical practitioner to take the kind of action that the Board contended and the Tribunal considered the appellant should have taken, and not to do the kind of things that the Tribunal decided the appellant should not have done, in the particular circumstances of his various interactions with Mr Brayley.[101] This would invariably require expert evidence as to the specific professional duty generally accepted by members of the profession, by reference to the particular circumstances and roles of all relevant persons at the relevant time.[102]

[136] *Dekker C/A* also concerned a doctor who failed to take certain action in relation to a person was not her patient. The doctor had witnessed a motor vehicle accident at night time and, instead of stopping to render assistance to the driver of the motor vehicle, she drove to a nearby police station and reported the accident. The Western Australia State Administrative Tribunal found that she was guilty of "improper conduct in a professional respect" contrary to s 13 of the *Medical Act*

[101] See [83] and [84] above referring to [13], [88], [97] & [98] of the Reasons.
[102] *Dekker C/A* [77], [80] – [86].

1894 (WA). It was common ground that the test for improper conduct was conduct "which would reasonably be regarded as improper by professional colleagues of good repute and competency" – applying *Cranley v Medical Board of Western Australia.*[103] In *Cranley* Ipp J had said: "A medical practitioner facing a charge under s 13(1)(a) is to be judged in accordance with the ethical standards of his profession."[104]

[137] At [71] – [73] the Court of Appeal said:

> [71] Ordinarily, at least, it would be expected in a case of this kind that the Tribunal would first consider, and make careful findings of fact about, medical practitioner's conduct and all relevant circumstances in which it occurred. The relevant circumstances would, at least ordinarily, include any standard, or specific professional duty, generally accepted within the medical profession at the time, which had potential application to the other primary facts as found: *Qidwai* (106 – 107).
>
> [72] The question of whether there existed a generally accepted professional standard or duty, and its content, would be questions of fact.
>
> [73] The conventional ways in which such facts would be proved … would, generally speaking, involve, or include, the Medical Board calling expert evidence from a person of good repute and competence within the medical profession to attest to the existence of the generally accepted standard or duty and its content or to tender any relevant professional conduct rules (see, eg, *Psychologists Board of Queensland v Robinson* [2004] QCA 405 [24]), or to point to any applicable statutory regime governing the conduct in question. In some cases a professional duty or obligation may be such that the Medical Board would invite the Tribunal, having regard to the expertise of its members, to take notice of the fact of the obligation and its contents without the need for evidence: cf Cooke (616). A duty

[103] Unreported, Supreme Court of Western Australia, Ipp J, 21 December 1990 (BC9000957) (*Cranley*).
[104] BC9000957 at 7.

> not to have sexual relations with a patient might be an obligation of that kind.

[138] The Court of Appeal went on to consider the specific professional duty allegedly owed by the practitioner to a person who was not her patient. The Court held that for there to be a specific and prescriptive obligation of the kind asserted by the Board upon the practitioner in the particular circumstances in which she found herself, there would need to be evidence to that effect. Because there was no expert evidence of such a duty, the Tribunal erred in law.[105]

[139] In the present matter there was no evidence before the Tribunal that there were general or specific obligations accepted within the medical profession either of the kind asserted by the Board or of the kind assumed by the Tribunal.

[140] Because there was no evidence, and no evidence to support an inference, that the conduct alleged by the Board could be in breach of the Code or the National Law, the Tribunal could not have formed a reasonable belief that the conduct alleged could be conduct of a kind that could be the subject of the National Law. The Tribunal could not have formed a reasonable belief that because of that conduct the appellant posed a serious risk to persons and it was necessary to take immediate action to protect public health or safety.

[105] *Dekker* C/A [80] – [86].

[141] I conclude that the Tribunal misconstrued the Code in holding that it imposed upon the appellant the obligations standards and duties asserted by the Board. I also conclude that the Tribunal misconstrued the Code in holding that it imposed the obligations standards and duties asserted by it, to the extent that they differed from those asserted by the Board. They are errors of law.[106] I therefore allow the appeal on the basis of grounds 1 and 4.

Ground 2 - procedural fairness

[142] The relevant legal principles are not controversial. The Tribunal was obliged to accord procedural fairness to the appellant. Per the Court in *Chief Executive Officer Department for Child Protection v Hardingham*[107]:

> It is a fundamental rule of the common law doctrine of natural justice that where an administrative decision may deprive a person of some right relating to his livelihood, he is entitled to know the case sought to be made against him and to be given an opportunity to reply to it.

[143] While the content of the obligation to accord procedural fairness will vary from case to case, as a general rule one would expect that the conduct and other facts and circumstances relied upon would be clearly identified prior to the hearing and if that conduct were to be expanded

[106] *S v Crimes Compensation Tribunal* [1998] 1 VR 83 at 88; *Genco and City of Melbourne v Salter and Building Appeals Board* [2013] VSCA 365 at [136].
[107] (2011) 214 A Crim R 259 (Martin CJ, Murphy JA and Allanson J) at [62] citing *Kioa v West* (1985) 159 CLR 550 at 587 (Mason J) and 628 (Brennan J).

upon and additional circumstances alleged, the practitioner would have the opportunity to respond before the tribunal decided the matter. A person should also be informed of the risk that an adverse finding may be made against them unless the risk necessarily inheres in the subject matter to be decided.[108]

[144] I have already referred to the way in which the Board based its decision of 23 July 2014 and its position before the Tribunal on the conduct set out in [13] of the Reasons and concluded that the Tribunal had regard to a broader range of conduct than that which was the focus of the Board's case before it when considering the first part of s 156(1)(a)(i) of the National Law.[109]

[145] Although much of the background material, including evidence concerning the appellant's involvement with workshops, online forums, Exit International and the Peaceful Pill Handbook, was before the Tribunal, partly to place the emails into some context and partly to enable the Tribunal to assess the serious risk of harm and the necessity for immediate action, there seems to have been some confusion as to whether it was also to be relied upon by the Tribunal as part of the

[108] *Re Refugee Review Tribunal & Anor; Ex parte Aala* (2000) 204 CLR 82 at [4] per Gleeson CJ, [76] per Gaudron and Gummow JJ, at 121 per McHugh J; *Re Minister for Immigration and Multicultural Affairs; Ex parte Miah* (2001) 206 CLR 57 at [99] per Gaudron J, *Commissioner for Australian Capital Territory Revenue v Alphaone Pty Ltd* (1994) 49 FCR 576 at 591.
[109] See [100] to [108] above.

conduct said to have been in breach of the Code.[110] The fact that such material and associated oral evidence, including evidence and submissions about rational suicide, was tendered during the hearing and the fact that the Board had only very recently abandoned formal reliance on Dr Nitschke's "General Advocacy", could well have put the appellant into a position of considerable uncertainty as to exactly what was being alleged against him and what further materials were or were not likely to be relevant to what parts of the s 156(1)(a) process.

[146] I do not consider that the appellant was given adequate opportunity to respond to the broader range of conduct ultimately relied upon by the Tribunal for the purposes of the first part of s 156(1)(a)(i). When he did attempt to tender additional materials, notwithstanding that he attempted to do that late in the proceedings and that some of them may have turned out to be irrelevant, his attempt was refused essentially for the reason that they were not relevant to the issues raised by the Board.

[147] I consider that Ground 2.1 is made out.

[148] In relation to Ground 2.2, it is difficult for me to assess the relevance of the additional materials which the appellant sought to tender but were rejected without reading those materials, the written submissions before the Tribunal, other relevant exhibits, and the transcripts of the

[110] See references in [100] to [108] above to conduct not related only to the serious risk and immediate action issues.

oral submissions and oral evidence presented to the Tribunal. Even if not relevant to the conduct to be considered for the purposes of the first part of s 156(1)(a)(i), the appellant contended that the rejected materials were relevant to the issues of serious risk to persons and the necessity to take immediate action to protect public health or safety.

[149] Counsel for the respondent contended that even if some of those materials were relevant most of them would have little or no weight because they were not journal articles written and reviewed by members of the medical profession.

[150] As this appeal will be allowed on other grounds there is no utility in me delaying my decision for such time as would be required for me to undertake the large and unnecessary task of perusing all that material and assessing whether the admission of some or all of the disputed materials into evidence would possibly have made a difference to the result.[111]

[151] I reject Ground 2.3. The Respondent's Outline of Submissions,[112] which the Board had provided to the appellant about three weeks before the hearing, included reference to Mr Brayley's purchase of the Peaceful Pill Handbook which had been co-authored by the appellant,

[111] *Stead v State Government Insurance Commission* 161 CLR 141 at 145; *Australian and Overseas Telecommunications Corporation Ltd v McAuslan* (1993) 47 FCR 492 at 516; *Re Refugee Review Tribunal & Anor; Ex parte Aala* (2000) 204 CLR 82 at [4], [77] – [78], [80] and [104].
[112] AB 219-235.

and Mr Brayley's attendance at the appellant's workshop in Perth on 24 February 2014. The Peaceful Pill Handbook included detailed information on acquiring Nembutal from overseas and importing it into Australia. The appellant also provided this information to attendees at his workshops, including the workshop attended by Mr Brayley. The appellant provided an aide memoire to the Tribunal referring to some of this material.

[152] At the hearing before the Tribunal, the appellant addressed this topic. He agreed with a suggestion put to him that at the 24 February 2014 workshop attended by Mr Brayley, he had given an account of how to obtain the drug, including a background description of what various strategies and avenues a person might pursue if they wanted to get that drug.[113]

Ground 3 - no evidence in support of findings

[153] By ground 3.1 the appellant contends that there was no evidence that Dr Nitschke had, through his corporate entity, supplied Mr Brayley with the Peaceful Pill Handbook.[114]

[154] I consider there was evidence from which the Tribunal was entitled to draw this inference. This included evidence that: Mr Brayley purchased the Handbook via the internet on 2 February 2014 by shopping with

[113] AB 448. See too Dr Nitschke's media release on 3 July 2014 (AB 922).
[114] Reasons [49(a)].

Exit International US at a particular website; Mr Judd (an APHPRA investigator) purchased a copy of the Handbook through the same website which was described as being owned by Exit International US Ltd; the Handbook itself includes a statement that it is authored by the appellant with Dr Fiona Stewart and published by Exit International US; the appellant stated during the ABC 7:30 interview on 20 June 2014 that "we publish a book called the Peaceful Pill Handbook"; in a media release on 3 July 2014 the appellant stated that "Exit member Nigel Brayley attended a Perth Exit workshop in February 2014 and purchased the banned Peaceful Pill eHandbook"; during a press conference on 24 July 2014 the appellant said that "sales of my Peaceful Pill Handbook published in the US have reached an all-time high"; and he gave evidence before the Tribunal that the Peaceful Pill Handbook was his published handbook.

[155] I reject Ground 3.1.

[156] Ground 3.2 is based upon an assertion that the Tribunal found that the appellant had supplied or assisted Mr Brayley to acquire and smuggle Nembutal into Australia. The finding is said to flow from what the Tribunal said in [49(b)] and [79] of the Reasons.

[157] Following its finding in [49(a)] of the Reasons that the appellant supplied the Peaceful Pill Handbook to Mr Brayley and that that book

provided information as to how best acquire Nembutal, the Tribunal said, at [49(b)]: “Mr Brayley in fact obtained Nembutal (one assumes following that guidance).”

[158] There was evidence to support that assumption. This included evidence that: the Peaceful Pill Handbook contained a chapter on how to obtain Nembutal and guidance on how to purchase it from China; after he had purchased the Handbook on 2 February 2014 and attended the workshop in Perth on 24 February 2014 Mr Brayley purchased an Exit Dilution Purity Kit on 27 February 2014 to test the purity of Nembutal; and the appellant explained the process adopted by Mr Brayley including his purchase of Nembutal from China in a media release on 3 July 2014 and in the written aide memoir that he provided to the Tribunal.

[159] In [79] the Tribunal said in effect that the appellant assisted Mr Brayley with “the provision of information sufficient to acquire, smuggle into Australia, test, hide and then consume the Nembutal.

[160] There was evidence in support of such a finding. This included evidence that: the Peaceful Pill Handbook authored by the appellant provided information on how to acquire Nembutal, smuggle it into Australia, test it and consume it; part of the appellant’s email of 16 April 2014 where he referred to urging people who have purchased test

kits “to say nothing when 5 police turn up on the doorstep and ensure any product they have is well hidden”; and evidence about the appellant providing information at workshops including the workshop attended by Mr Brayley in Perth on 24 February 2014 on how to acquire Nembutal from overseas, test it and consume it.

[161] I reject Ground 3.2.

Conclusion and relief

[162] I have accepted the contentions raised by Grounds 1, 2.1 and 4, and therefore allow this appeal.

[163] In light of my conclusion that the Tribunal has misconstrued the Code and purported to apply the clause 1.4 paragraph without the existence of any expert or other evidence which could possibly give that provision any content and relevance, there was no basis for the Tribunal, or for the Board, to form a reasonable belief of the kind required by s 156(1)(a) of the National Law.

[164] Accordingly I set aside the decision of the Tribunal and substitute the decision setting aside the immediate action decision of the Board.
