SUPREME COURT OF QUEENSLAND

CITATION:	*Jones v Medical Board of Australia and Anor* [2017] QSC 238
PARTIES:	**ANDREW JONES** (applicant) **v** **MEDICAL BOARD OF AUSTRALIA** (first respondent) **THE QUEENSLAND NOTIFICATIONS COMMITTEE OF THE MEDICAL BOARD OF AUSTRALIA** (second respondent)
FILE NO/S:	BS No 7832 of 2016
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	27 October 2017
DELIVERED AT:	Brisbane
HEARING DATE:	12 July 2017
JUDGE:	Martin J
ORDER:	**1. The application is dismissed.**
CATCHWORDS:	ADMINISTRATIVE LAW – JUDICIAL REVIEW – POWERS OF COURTS UNDER JUDICIAL REVIEW LEGISLATION – DECLARATIONS – where the applicant is a medical doctor – where the applicant decided not to recommence a Warfarin prescription for a patient – where that patient later died – where a complaint was then made against the applicant – where the respondent issued a caution to the applicant – where the applicant seeks a declaration that a declaration the respondent's decision is void – where the parties agree that relief under Part 3 of the *Judicial Review Act* 2003 and certiorari are unavailable – where the respondent submits that, consequently, a declaration is not an available remedy – whether a declaration may be granted ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – where the applicant alleges the respondent acted without jurisdiction – whether a jurisdictional error is shown – where the applicant alleges that the respondent acted unreasonably – whether the respondent's action was

unreasonable – where the applicant alleges that the respondent took into account irrelevant considerations and did not take into account relevant considerations – whether the respondent took into account only and all relevant considerations – where the applicant alleges that the respondent failed to afford natural justice – whether the applicant was afforded natural justice

Health Practitioner Regulation National Law Act 2009, s 178
Judicial Review Act, s 20(2)(c), s 43

Ainsworth v Criminal Justice Commission (1991-1992) 175 CLR 564, cited
Amos v Western New South Wales Local Health District [2016] NSWSC 1162, cited
Bass v Permanent Trustee Co Ltd (1999) 198 CLR 334, cited
Forster v Jododex Australia Pty Ltd (1972) 127 CLR 421, cited
Gardner v Dairy Industry Authority (NSW) (1977) 52 ALJR 180, cited
Kronen v Federal Commissioner of Taxation (2012) 213 FCR 495, distinguished
Minister for Immigration and Ethnic Affairs v Wu (1996) 185 CLR 259, applied

Plaintiff M61/2010E v Commonwealth (2010) 243 CLR 319, cited
Taylor v O'Beirne and Ors [2009] QSC 395, cited
Woollard v Medical Board of Australia [2016] WASCA 151, cited

COUNSEL: A D Scott for the applicant
T J Bradley QC and D J Fuller for the respondents

SOLICITORS: Moray & Agnew for the applicants
Minter Ellison for the respondents

[1] Andrew Jones has been in practice as a medical practitioner for over 30 years. In June 2016, the Medical Board of Australia administered a "caution" to him. He now seeks to have the decision to administer that caution judicially reviewed and to have a declaration made that it was void and of no force or effect.

[2] The Medical Board has the power to caution a practitioner under s 178 of the Schedule to the *Health Practitioner Regulation National Law Act* 2009 (National Law). Pursuant to the National Law the Medical Board of Australia is a "National Board" and may, under s 178(2):

> "… decide to take one or more of the following actions … in relation to [a] registered health practitioner …-
>
> (a) caution the registered health practitioner …"

[3] In a letter from the Australian Health Practitioner Regulation Agency (AAHPRA)[1] to Dr Jones, it was asserted that it was the second respondent which had decided to, and did, caution the applicant. The second respondent is a committee with no separate legal existence and, more importantly, no direct statutory power to caution. It was agreed that the Medical Board had delegated its function under s 178 to the second respondent. While the material shows that the second respondent did make the decision to caution Dr Jones, cl 29(7) of Schedule 7 of the National Law provides that a delegated function that has been properly exercised by the delegate is taken to have been exercised by the delegator. In the light of that provision, I have proceeded on the agreed basis that the Medical Board was the relevant decision maker.

Grounds of review

[4] Dr Jones asserts that he is aggrieved by the decision because it is prejudicial to his reputation.

[5] He relies on the following grounds:

(a) there was no jurisdiction to make the decision within the meaning of s 20(2)(c) of the *Judicial Review Act* 1991 (JR Act);

(b) the decision was an exercise of power so unreasonable that no reasonable person could so exercise that power within the meaning of s 23(g) of the JR Act;

(c) there was a failure to take into account a relevant consideration within the meaning of s 23(b) of the JR Act;

(d) there was a taking into account of an irrelevant consideration within the meaning of s 23(a) of the JR Act; and

(e) there was a breach of the rules of natural justice in the making of the decision within the meaning of s 20(2)(a) of the JR Act.

[6] A further ground in the application was not pursued at the hearing.

Relief sought

[7] At the hearing, the applicant accepted that the decision complained of was neither susceptible to relief under Part 3 of the JR Act nor to certiorari. Thus, the question raised by the material was whether or not declaratory relief is available. In that case, the applicant has to show that the question about which declaratory relief is sought is not hypothetical and that a declaration will produce foreseeable consequences for the parties.

[8] The respondent argues:

(a) that a declaration will not be made when substantial relief such as certiorari is not available; and

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[1] A body established under the National Law to provide administrative assistance to among others, the Medical Board of Australia.

(b) the applicant has, in any event, not established a ground of review.

The history of this matter

[9] The events which led up to the administration of the caution may be summarised in the following way:

8 April 2015

- Margaret McGurk was admitted to Pindara Private Hospital. She was 87 years old and had been admitted on a number of other occasions. She had been using the drug Warfarin since 2009.
- She was examined by Dr Michael Heaney.

9 April 2015

- The applicant examined her. He had seen Mrs McGurk before. She had been under his care on two earlier admissions.
- The applicant formed the view that there was evidence of a chest infection and deterioration in cardiac function.
- He also noted that Mrs McGurk's Warfarin had not been charted in the emergency care centre and agreed that this was the safest option. He did not decide to cease Warfarin. So far as it is necessary to determine, it is likely that Dr Heaney decided to temporarily withhold Warfarin. The applicant did not recommence the Warfarin.

10 April 2015

- The applicant went on leave.
- Dr Negas assumed her care until 17 April 2015.

16 April 2015

- Mrs McGurk suffered a stroke. She passed away on 25 April.

7 May 2015

- Mrs McGurk's son lodged a complaint in which he alleged that the applicant had "removed [Mrs McGurk] off her Warfarin without any consultation with Dr Greenwood".

10 June 2015

- The Health Ombudsman wrote to the applicant notifying him that the complaint had been accepted and invited him to make a submission.
- On the same day, the applicant forwarded his submission in which he made the following points:

(a) The reasons for admission of Mrs McGurk were uncertain.

(b) Mrs McGurk's Warfarin had not been "charted" in the emergency care centre and "in the clinical setting I agreed this was the safest option".

(c) He had a lengthy meeting with Mrs McGurk's son in which he "made efforts to explain all of the clinical decision-making processes I have followed".

30 October 2015

- The Health Ombudsman's decision was given. It identified the complaints as:

  Issue 1 Wrong/inappropriate treatment - Mrs McGurk's son stated the decision to remove Warfarin by Dr Jones was incorrect, inadequately assessed and made without referral to her other relevant treating specialists.

  Issue 2 Unexpected treatment outcome/complication - Mrs McGurk's son stated that the stroke suffered by Mrs McGurk was caused, and/or contributed to, by Dr Jones's decision to discontinue Warfarin.

- The Ombudsman advised that he had decided to refer the matter to AAHPRA and the National Boards.

- The Ombudsman sought and obtained clinical advice from a specialist in the field - Dr Mark Dooris. In his report he said, among other things:

  > "I can find no formal documentation of an active decision to discontinue Warfarin therapy (either temporarily or permanently) in the notes provided to me. There is a possible reference to Warfarin on an admission note within the interpretation of handwriting …"

- Dr Dooris canvassed a number of possible reasons to discontinue Warfarin. He concluded that the "removal of Warfarin at ED" was not clinically indicated and emphasised that he could not find any documentation citing or formally evaluating the removal to inform the risk benefit for cessation of Warfarin.

- He concluded:

  > "Risk benefit of anticoagulation for her would have, therefore, been a complex judgment and would necessarily have involved complex discussions with her (and her family). The problem is, though such a discontinuation could be justifiable, I can find no direct or indirect contemporaneously recorded information show [sic] why or how this was justified, decided or communicated."

8 December 2015

- AAHPRA wrote to the applicant inviting him to make a further submission.

22 December 2015

- The applicant's solicitors wrote in response to the invitation from AAHPRA and submitted that no further action should be taken against the applicant. An opinion from another expert was attached to the submission which, in summary, concluded that the removal of Warfarin did not contribute to Mrs McGurk's stroke and subsequent death.
- The submission also referred to the recollection of the applicant of a discussion with Dr Greenwood and Mrs McGurk's son on 20 April.

22 April 2016

- The applicant was sent a "show cause" letter by AAHPRA in which it was stated that it had formed the belief that the way he practised the health profession, is or may be unsatisfactory, and proposed under s 178 of the National Law to caution him.

16 May 2016

- The applicant's solicitors responded to the show cause letter.

8 July 2016

- The respondent's decision is communicated to the applicant.
- The Board identified four issues:

  (a) clinical care - inadequate or inappropriate treatment: whether Dr Jones inappropriately ceased the medical Warfarin;

  (b) clinical care - inadequate or inappropriate treatment: whether Dr Jones should have consulted with the patient and her cardiologist to discuss her Warfarin therapy during her admission to hospital;

  (c) clinical care - inadequate or inappropriate treatment: whether Dr Jones conducted a risk assessment relating to the cessation of the Warfarin medication during her admission to hospital; and

  (d) communication - failure to communicate openly, honestly and effectively: whether Dr Jones communicated sufficiently the risks and benefits in relation to the cessation of Warfarin therapy to Mrs McGurk and/or her legal guardian during her admission.

- The conclusions of the respondent were set out in the letter of 8 July 2016 and, in summary, they were as follows:

  (a) With respect to issue (a), the committee was unable to form an opinion in relation to whether removal of the patient from the medical Warfarin was inappropriate and/or unreasonable in the circumstances and decided to take no action in relation to issue (a).

  (b) With respect to issues (b), (c) and (d), the committee decided in relation to these issues that the conduct of the practitioner is, or may be, unsatisfactory because the committee considers the practitioner's performance regarding the assessment and treatment of the patient related to the abovementioned issues,

constitutes unsatisfactory professional performance, that is performance of a lesser standard than reasonably expected of a practitioner with an equivalent level of qualifications or experience.

[10] The committee noted Dr Dooris's independent clinical opinion that "in the patient's case, a review of [her] clinical situation assessing the risk-benefit of ongoing Warfarin … and [then] communicat[ing] this judgement to the patient or the legal guardian and family may have been a reasonable consideration in the patient's case".

[11] The Committee went on to conclude:

> "x. The committee notes whilst the practitioner relies on the clinical opinion of Dr Ringrose and the practitioner submits the decision to cease the patient's Warfarin therapy was reasonable, the following issues remain as professional performance considerations that may be considered unsatisfactory, namely:
>
> i. the clinical records suggests there was no specific risk of assessment conducted by the practitioner, specifically related to the suspension or cessation of the patient's Warfarin therapy;
>
> ii. upon the records there is no sufficient evidence the practitioner effectively communicated and discussed with the patient and/or their legal guardian/family, the risks and benefits associated with the cessation/suspension of the patient's Warfarin therapy to enable the patient and/or legal guardian/family to contribute to an informed decision about the patient's Warfarin treatment; and
>
> iii. the practitioner submitted he did not discuss with the patient's treating cardiologist, Dr Greenwood, the Warfarin therapy and/or its cessation/suspension in relation to her admission to the hospital on 8 April 2015."

Can the decision to caution the applicant be the subject of an order under the JR Act?

[12] The Board contends that no relief under the JR Act is available because, putting to one side the argument about whether the Board committed any reviewable error, the decision to caution does not confer, alter or otherwise affect legal rights or obligations. The applicant accepts that the decision is not able to be reviewed (in that sense) and that certiorari is not available.

[13] Dr Jones, though, seeks a declaration on the basis that, while the decision does not affect his rights, it does affect his interests, namely, his reputation and his continued registration under the National Law.

[14] The Board answers that by submitting that a declaration that the Board's decision is void cannot be made because:

(a) the ordinary rule is that declarations are not made when substantive relief such as certiorari is unavailable; and

(b) no reason has been given to displace that ordinary rule.

[15] The first step in considering this argument is to find the proper characterisation of the decision to caution. The power to caution is conferred by the National Law. Section 178 relevantly provides:

> "**178 National Board may take action**
>
> (1) This section applies if—
>
> (a) a National Board reasonably believes, because of a notification or for any other reason—
>
> (i) the way a registered health practitioner registered by the Board practises the health profession, or the practitioner's professional conduct, is or may be unsatisfactory; or
>
> (ii) a registered health practitioner or student registered by the Board has or may have an impairment; or
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> (iii) a student has been charged with an offence, or has been convicted or found guilty of an offence, that is punishable by 12 months imprisonment or more; or
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> (iv) a student has or may have contravened a condition of the student's registration or an undertaking given by the student to a National Board; and
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> (b) the matter is not required to be referred to a responsible tribunal under section 193; and
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> (c) the Board decides it is not necessary or appropriate to refer the matter to a panel.
>
> (2) The National Board may decide to take one or more of the following actions (relevant action) in relation to the registered health practitioner or student—
>
> (a) caution the registered health practitioner or student;
>
> (b) accept an undertaking from the registered health practitioner or student;
>
> (c) impose conditions on the practitioner's or student's registration, including, for example, in relation to a practitioner—
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> (i) a condition requiring the practitioner to complete specified further education or training within a specified period; or
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> (ii) a condition requiring the practitioner to undertake a specified period of supervised practice; or

(iii) a condition requiring the practitioner to do, or refrain from doing, something in connection with the practitioner's practice; or

(iv) a condition requiring the practitioner to manage the practitioner's practice in a specified way; or

(v) a condition requiring the practitioner to report to a specified person at specified times about the practitioner's practice; or

(vi) a condition requiring the practitioner not to employ, engage or recommend a specified person, or class of persons;

(d) refer the matter to another entity, including, for example, a health complaints entity, for investigation or other action.

(3) If the National Board decides to impose a condition on the registered health practitioner's or student's registration, the Board must also decide a review period for the condition."

[16] Before the Board can take any relevant action, it is required under s 179 to give the practitioner notice and to invite a submission. That process took place.

[17] Section 225 sets out the information which must be recorded on the national register or specialists register. There is no reference to the inclusion of cautions, but it is not prohibited. It would be open to the Board, if it otherwise thought it appropriate, to have the caution included on the register.[2] These registers are available for inspection by the public.[3]

[18] The nature of a caution was the subject of incidental consideration by the Western Australia Court of Appeal in *Woollard v Medical Board of Australia*.[4] In that case, a complaint had been made against a doctor alleging a failure to explain the risks and possible complications of a coronary angioplasty, and to discuss alternative, non-invasive, treatment options. It was also alleged that the doctor failed to maintain clear, appropriate, accurate and detailed clinical records of his discussions with the patient concerning the coronary angioplasty. The sole ground of appeal before the Court of Appeal was that the primary judge erred in law by failing to grant certiorari on the basis of the alleged inadequacy of the Performance and Professional Standards Panel's reasons for decision. The Court of Appeal accepted that the reasons which had been given were sufficient. The court went on to make some obiter remarks which are pertinent in this case. The court said:

"[69] Although the National Law provides for appeals to the State Administrative Tribunal from a number of disciplinary decisions, it does not provide for an appeal from a decision to caution a practitioner. It was

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2 See s 225(p).

3 Section 228.

4 [2016] WASCA 151.

presumably the absence of any right of appeal which led the appellant to seek judicial review of the Panel's decision. If such an avenue of appeal were available, its existence would ordinarily be a powerful discretionary consideration against the issue of certiorari.

[70] Parliament's omission to provide for any right of appeal in this case might be explained by the absence of any impact which a 'caution' has on the legal rights and obligations of the health practitioner. That lack of legal effect on legal rights and duties also raises a question as to whether certiorari lies to quash the Panel's decision to caution the appellant. In the present case, that question would arise where the error alleged - a failure to give reasons - would be an error of law on the face of the record, rather than a jurisdictional error going to the validity of the decision to caution.

[71] The failure of the appellant's ground of appeal makes it unnecessary to determine whether certiorari, or declaratory relief as an alternative to certiorari, would have been available if the alleged error had been established." (emphasis added)

[19] The respondent argues that because of the nature of the warning which has been given, the applicant is not entitled to declaratory relief. In support of that contention the respondent refers to the decision of Ann Lyons J in *Taylor v O'Beirne and Ors*.[5] That was a case which concerned a released prisoner within the meaning of the *Dangerous Prisoners (Sexual Offenders) Act* 2003. The prisoner had been sent a number of letters by the district manager of the Inala Probation and Parole Service giving him notice that he had not complied with a particular direction on a specified occasion, that formal contravention action would not be taken, but that further failure might result in the supervision order being returned to the Supreme Court for contravention action. Her Honour rejected the application for review and, in relation to an argument raised late in the proceedings seeking declaratory relief, said that as the decisions were not final and determinative and because they did not impose a penalty or affect legal rights, she did not consider that there was a basis for the granting of declaratory relief.

[20] The respondent also referred to a decision of Beech-Jones J in *Amos v Western New South Wales Local Health District*.[6] In that case, Dr Amos sought relief in a number of forms. So far as is relevant, he sought an order quashing a decision to issue a letter that referred to him misconducting himself and which warned of possible disciplinary action. These were referred to as the "warning decision" and "warning letter" respectively. The warning letter was different in substance and approach to that of the warning letter sent to Dr Jones. The warning letter in *Amos* contained the following:

> "You have made previous commitments to ensure that this type of unprofessional behaviour does not reoccur, however the pattern of unacceptable conduct has continued. Therefore, please consider this letter a formal warning that further

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5 [2009] QSC 395.

6 [2016] NSWSC 1162.

> sustained incidence of this type of behaviour may result in further disciplinary action.
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> These actions are clearly in breach of the NSW Health Code of Conduct … which defines standards of ethical and professional conduct required of everyone working in NSW Health in any capacity, the outcomes we are committed to, and the behaviours which are unacceptable and will not be tolerated."[7]

[21] That letter was to be retained within the "record" of Dr Amos's appointment. It records a conclusion that he had contravened the NSW Health Code of Conduct. It was contended that by issuing the warning letter and placing it on Dr Amos's file his reputation was damaged. It was also submitted that it "prejudiced his rights and interests as a VMO, and his interests with respect to renewal of future appointment as a VMO and his future employment as a health professional, and hence affected his [livelihood]". Beech-Jones J held that the issuing of the letter and placing it on the file did not have that effect. In relation to his reputation, the letter was a private communication which was only to be kept on the file. His Honour distinguished the circumstances in *Ainsworth v Criminal Justice Commission*,[8] where declaratory relief was granted in respect of the final report of an investigative body that was published to the public and the legislature at the completion of an inquiry.

[22] The applicant recognises that the remarks in these three cases do give rise to a question about what effect, if any, the decision to caution has. This issue was resolved by the concession made by Mr Scott that "the decision doesn't affect rights, but it does affect interests, in particular, my client's interest in his reputation and also his interest in his continued registration under the national law".[9]

[23] There were two areas in which the applicant contended that, although the caution would not be made public by the Board, it would nevertheless, be disclosed. First, the existence of caution had to be made known to the Health Ombudsman. Secondly, the applicant would be obliged to disclose it to his current employer and any future employers.

The availability of a declaration

[24] A declaration is able to be made in cases where the decision does not affect rights but does have an adverse effect on a person's reputation. In *Ainsworth v Criminal Justice Commission*,[10] the High Court considered a report by the Criminal Justice Commission[11] which contained adverse recommendations about certain persons involved in the poker machine industry. The report was tabled without any notice having been given to the persons adversely mentioned. It was accepted that the report had practical consequences for the appellants' reputations. It

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7 At [23].

8 (1991-1992) 175 CLR 564.

9 At T1-34.

10 (1991-1992) 175 CLR 564.

11 Now the Crime and Corruption Commission.

followed that a declaration would be made in terms indicating that the appellants had been denied natural justice.

[25] But, the Board argues that there is a rule, summarised by Besanko J in *Kronen v Federal Commissioner of Taxation*,[12] that "no declaration of right will be made where certiorari and mandamus do not lie". That is not, with respect, a completely accurate summary of what his Honour said.

[26] In *Kronen*, Besanko J said:

> "[42] The starting point is that, although the applicant claims declarations, the ordinary rule **in the circumstances of this case** is that no declaration of right will be made where certiorari and mandamus do not lie: *Plaintiff M61/2010E v Commonwealth* (2010) 243 CLR 319 at [101]. There is nothing to suggest that the ordinary rule does not apply in this case.
>
> [43] For the jurisdiction in s 39B(1A)(c) of the *Judiciary Act* to be engaged, the right owing its existence to federal law must be a right capable of enforcement by an order in the nature of certiorari or mandamus. That is so even if the relief granted is a declaration.
>
> [44] The question is whether there is a decision of the respondent capable of attracting certiorari and a public duty capable of attracting mandamus." (emphasis added)

[27] Besanko J was making the point that the prerequisites for the operation of s 39B(1A)(c) of the *Judiciary Act* 1903 had to be met before a declaration might be made. Thus, his Honour's reference to "the circumstances of this case" included those statutory requirements – requirements which do not exist in this case.

[28] His Honour also referred to *Plaintiff M61/2010E v Commonwealth*[13] (the "*Offshore Processing Case*") as authority for the proposition. In that case, the circumstances in which the "ordinary" rule will not apply were considered. A unanimous High Court decided that the plaintiffs' claims for certiorari and mandamus should be rejected. Because of the provisions of the relevant legislation, mandamus would not issue to compel the Minister to consider or reconsider exercising a particular power. The unavailability of mandamus entailed that there was no utility in granting certiorari to quash the relevant recommendation.

[29] The court said:

> "[101] Although the plaintiffs' claims for certiorari and mandamus should be rejected, a declaration should be made in each case that the processes undertaken to arrive at the reviewer's recommendation were flawed in the respects that have been identified. In many cases, the conclusion that certiorari and mandamus do not lie would require the further

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[12] (2012) 213 FCR 495.

[13] (2010) 243 CLR 319.

conclusion that no declaration of right should be made. Why should a declaration be made in these matters?

[102] The power to grant declaratory relief is a power which '[i]t is neither possible nor desirable to fetter … by laying down rules as to the manner of its exercise'. As pointed out in *Ainsworth v Criminal Justice Commission*, it is a form of relief that is confined by considerations which mark out the boundaries of judicial power." (citations omitted)

[30] In that case, there were three matters which told in favour of a declaration:

(a) It could not be said that a declaratory order would produce no foreseeable consequences for the parties.[14]

(b) The declaratory relief was directed to determining a legal controversy – it was not directed to answering some abstract or hypothetical question.[15]

(c) Each plaintiff had a "real interest" in raising the questions to which the declaration would go.[16]

[31] It is unnecessary to delve any further into the application or existence of any "ordinary rule". *Ainsworth* and the *Offshore Processing Case* make it clear that declaratory relief can be afforded in the absence of other prerogative relief. As was said in *Ainsworth*:

> "It does not follow that, because mandamus and certiorari are inapplicable, the appellants must leave this Court without remedy. The law with respect to procedural fairness has developed in spite of the technical aspects of the prerogative writs."[17]

[32] Finally, the JR Act has dislocated any connection there might have been between orders for prerogative relief and a declaration. Section 43 of the JR Act provides that a declaration may be sought whether or not prerogative orders are sought and whether or not prerogative orders could have been sought:

> "**43 Application for review**
>
> (1) An application for—
>
> (a) a prerogative order; or
>
> (b) a prerogative injunction;
>
> must be made by way of an application for review.

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[14] *Gardner v Dairy Industry Authority (NSW)* (1977) 52 ALJR 180 at 188 and 189.

[15] *Bass v Permanent Trustee Co Ltd* (1999) 198 CLR 334 at 355-356.

[16] *Forster v Jododex Australia Pty Ltd* (1972) 127 CLR 421 at 437-438.

[17] *Ainsworth v Criminal Justice Commission* (1991-1992) 175 CLR 564 at 581.

(2) **An application for a declaration** or injunction (other than a prerogative injunction)—

(a) may be made by way of an application for review if it would be appropriate to do so having regard to—

(i) the nature of the matters in relation to which relief may be sought; or

(ii) the nature of the persons against whom relief may be sought;

in an application for a prerogative order or prerogative injunction; and

(b) may be made by way of an application for review, whether or not a prerogative order or prerogative injunction is sought in the application.

(3) If—

(a) an application for a declaration or injunction (other than a prerogative injunction) is made under subsection (2); and

(b) the court considers—

(i) that the relief sought should not be granted on an application for review; and

(ii) that the relief may have been granted if it had been sought in an action begun by writ of summons or originating summons by the applicant at the time of starting the application for review;

the court may, instead of refusing the application, order the proceeding to continue as if it had been begun in the way mentioned in paragraph (b)(ii)."

Jurisdictional error

[33] An essential prerequisite to the making of the decision under s 178 was that the Board reasonably believed that the way Dr Jones practised the health profession, or his professional conduct, is or may be unsatisfactory.

[34] There are two elements in that condition:

(a) that the belief was held - the applicant accepts that it was; and

(b) that the belief was reasonably held - the applicant says that it was not reasonably held.

[35] It was contended by the applicant that the Board proceeded upon the assumption that he had made a decision to suspend or discontinue Warfarin. A closer examination of the Board's decision of 8 July 2016 is required.

[36] The Board identified "issue (a)" in this way:

> "Whether the practitioner, Dr Andrew Jones inappropriately ceased the medication Warfarin, for the patient Mrs Margaret McGurk, during her admission to hospital with a chest infection where she subsequently suffered a stroke, at the Pindarra Private Hospital (the hospital) between 7 April 2015 and 25 April 2015."

[37] The Board then recited summaries of the material which it had before it including the clinical records of Mrs McGurk, an independent clinical opinion from Dr Dooris, the records of Dr Greenwood, and the submissions of Dr Jones. In Dr Jones' submissions,[18] the following appears:

> "11 (c) Dr Jones reviewed the patient on 9 April 2015 and considered the safest course of action to not recommence Warfarin, based on the following factors:
>
> …
>
> 20. The clinician [Dr Dooris] also fails to appreciate the decision making process of Dr Jones to not recommence Warfarin which involved a range of considerations (as mentioned above), not necessarily recorded in the patient chart. Respectfully, this is a deficiency in documentation only not evidence that due consideration was not given to risks and benefits of suspending Warfarin.
>
> …
>
> 24. (p5) Dr Jones did not recommence Warfarin on 9 April 2015 as Dr Jones determined this to be the safest approach for the patient. … "

[38] In its reasons, the Board sets out a summary of the evidence it had and specifically notes:

> "(g,ii.C) The practitioner reviewed the patient on the 9 April 2015 and considered the safest course of action was **not to recommence** Wafarin [sic] based on the factors of the ECG upon admission did not demonstrate a definitive AF indicating the need for an anti-coagulant, the infection symptoms were likely to require antibiotic therapy which would alter the Warfarin requirement …"
>
> "(g.vii) The practitioner submits the independent clinical opinion of Dr Dooris failed to appreciate the decision-making process of the practitioner relating to the decision to **not recommence** the patient on Warfarin involved a large range of considerations that were not necessarily

[18] Letter Moray & Agnew to AHPRA, 22 December 2015.

recorded on the patient's records. The practitioner submits this relates to a deficiency in documentation only and is 'not evidence that due consideration was not given to risks and benefits of suspending Warfarin'."

"(h) The Committee notes the practitioner's submission that in his decision making process **not to recommence** Warfarin for the patient; the decision involved a range of considerations that were not necessarily recorded in the patient's chart. The Committee is critical of the record-keeping practices of the practitioner and notes the importance of keeping contemporaneous and accurate records leading to clinical decisions for patients."

"(i) The Committee notes there are conflicting clinical opinions regarding the **cessation** of the Warfarin medication for the patient, and there is insufficient evidence to substantiate the cessation of Warfarin for the patient was inappropriate [sic]."

[39] The Board then deals with Issue "a" and says:

"(l) That Committee has considered the medical records and is unable to form an opinion in relation to whether **removal of the patient from the medication** Warfarin was inappropriate and/or unreasonable in the circumstances and decides to take no action in relation to issue 'a'.

[40] While the Board may have decided not to take action in relation to Issue "a", it does not explain why it examined the issue when the uncontradicted evidence was that Dr Jones did not remove the patient from the medication Warfarin. There appears to be confusion in the reasoning of the Board on this point. The independent advice from Dr Dooris also appears to proceed on the basis that the decision to suspend Warfarin was made by Dr Jones. That misapprehension is continued in the in the Board's consideration of the other issues.

[41] In dealing with Issues "b", "c" and "d" the Board says:

"(s) … In the committee's view, it would have been prudent and appropriate to consult with the patient's treating cardiologist about the **decision to suspend** the Warfarin medication to ensure any decision made was in the patient's best interests. The practitioner submits on the patient's final presentation to Pindara Private Hospital that he did not consult with the Dr Greenwood regarding the suspension of the patients Warfarin therapy. The Good Medical Practice Guide states at 4.5, good patient care requires coordination between all treating doctors'."

"(t) … The Committee considers that treatment plans, which by their nature involved significant risk, ought not be ordered by a practitioner in isolation. A reasonable practitioner of equivalent level of training and experience would have consulted with the patient, their family and the patient's treating cardiologist before making a **decision to cease or suspend** Warfarin and to adequately document such action."

[42] The reasoning in the preceding paragraph demonstrates a misunderstanding or misapprehension of the facts. Dr Jones did not "cease" or "suspend" Warfarin. He did, though, make a decision not to change the medication regime which, because of the decision made when the patient was admitted, did not include Warfarin.

[43] There is an inconsistency in the approach taken in the Board's decision making process. In the paragraph of its reasons which follows "(t)", it says:

> "(u) … Taking into account the practitioner's submission in relation to issue "1b" that he did not discuss the suspension of the patients Warfarin treatment with the patient's cardiologist Dr Greenwood, it would have been necessary for him to clearly record his risk and benefit assessment for the **continued suspension** of the patients Warfarin treatment, relevant to his own clinical opinion and the reasons he has determined that the **continuation to suspend** is in the best interests of the patient."

[44] In that paragraph, the Board refers to "continued suspension" and "continuation to suspend". That is an accurate description of the decision made by Dr Jones in contrast to the earlier reference to him deciding to "cease or suspend Warfarin".

[45] Later in the reasoning of the Board, a new term – "withholding of Warfarin" – is used for the decision made by Dr Jones. It is contained in this paragraph:

> "(w) The practitioner in his further submissions states in relation to issue '1d' that he did communicate with the patient regarding her management, when he reviewed her on 9 April 2015. The practitioner submits he communicated his findings and the treatment plan for her current illness. The practitioner submits he referred to this in the notes as 'uncertain history'. The practitioner's submissions do not specifically reflect that he discussed with the patient the risks and/or benefits associated with the **withholding of Warfarin**, and whether the patient provided any input into the decision to withhold her Warfarin treatment. The reference as submitted by the practitioner to 'uncertain history', to reflect his discussions of the patient's management and treatment with the patient, appears an inadequate record of his discussion with the patient or family and is insufficient documentation to suggest that he specifically discussed the risks and benefits with the patient of **suspending Warfarin**."

[46] The Board does not appear to draw a distinction between a decision to suspend the use of a particular medication and a decision to not, in effect, change that earlier decision. It also appears to have conflated some actions: cease or suspend, continue to suspend, not recommence, and withhold.

[47] It may be that the focus of both the practitioner and of the Board was on the wisdom or otherwise of ceasing Warfarin. It is entirely understandable as that had far greater ramifications than the inadequacy of recording a decision-making process. This concentration on the preliminary decision is partly reflected in the conclusion of the Board:

"(x) The Committee notes whilst the practitioner relies on the clinical opinion of Dr Ringrose and the practitioner submits the decision to cease the patient's Warfarin therapy was reasonable, the following issues remain as professional performance considerations that may be considered unsatisfactory, namely:

(i) The clinical records suggests there was no specific risk assessment conducted by the practitioner, specifically related to the suspension or cessation of the patients Warfarin therapy;

(ii) Upon the records there is no sufficient evidence the practitioner effectively communicated and discussed with the patient and/or their legal guardians/family, the risks and benefits associated with the cessation/suspension of the patients Warfarin therapy to enable of the patient and/or legal guardians/family to contribute to an informed decision about the patient's Warfarin treatment; and

(iii) The practitioner submitted he did not discuss with the patient's treating Cardiologist, Dr Greenwood, the Warfarin therapy and/or its cessation/suspension in relation to her admission to the hospital on 8 April 2015.

(y) In relation to issues 'b', 'c' and 'd', a caution will act as a warning for the practitioner to make changes to his practice to minimise the potential for similar circumstances to arise again. Specifically, a caution will serve to remind the practitioner of the importance of maintaining appropriate clinical records and of consulting with key stakeholders in relation to significant treatment decisions.

A caution is intended to act as a deterrent so that you do not repeat the conduct. It will not be recorded on the public national register."

[48] How then, should the inelegant and inconsistent phraseology used in the Board's decision be treated?

[49] First, one must bear in mind the warning given by the High Court in *Minister for Immigration and Ethnic Affairs v Wu*.[19] The Court considered the proper role of a reviewing court and some earlier decisions which advanced the notion that such a court should afford the reasons of a decision-maker a "beneficial" construction. In *Wu*, one of the issues was whether or not the decision-maker had applied the correct test. In the reasons of the majority the following may be drawn:

(a) A court should not be 'concerned with looseness in the language ... nor with unhappy phrasing' of the reasons of an administrative decision-maker.

(b) The reasons for the decision under review are not to be construed minutely and finely with an eye keenly attuned to the perception of error.

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[19] (1996) 185 CLR 259.

(c) The reasons of an administrative decision-maker are meant to inform and not to be scrutinised upon over-zealous judicial review by seeking to discern whether some inadequacy may be gleaned from the way in which the reasons are expressed.

(d) 'The duty and jurisdiction of the court to review administrative action do not go beyond the declaration and enforcing of the law which determines the limits and governs the exercise of the repository's power. If, in so doing, the court avoids administrative injustice or error, so be it; but the court has no jurisdiction simply to cure administrative injustice or error. The merits of administrative action, to the extent that they can be distinguished from legality, are for the repository of the relevant power and, subject to political control, for the repository alone.'"[20]

[50] In *Wu*, the delegate started and finished with the correct test; it was only some phraseology in between which provided the basis for a conclusion that she had slipped from an assessment of a real chance to an assessment of the balance of probabilities. In this case, while the Board did change the description of the actions it was considering and did not stringently compartmentalise the areas under discussion, it did, at the end, return to the issue it finally resolved upon.

[51] The applicant contends that there were not sufficient facts to induce in the mind of a reasonable person that Dr Jones had engaged in the conduct for which he was cautioned. But, the applicant accepted that he did not record a large range of considerations which related to his decision not to change the medication regime. Further, he acknowledged that this showed a deficiency in documentation.

[52] The caution was not concerned with clinical treatment or the decision not to change the treatment regime. Notwithstanding the lengthy discussion of the opinions provided to the Board about the wisdom of ceasing Warfarin, this decision is about record keeping and consultation. As the final paragraph of the Board's decision makes clear, the caution concerns "maintaining appropriate clinical records and of consulting with key stakeholders in relation to significant treatment decisions".

[53] With respect to this ground and to the others – "Wednesbury" unreasonableness, failing to take a relevant consideration into account, and taking an irrelevant consideration into account – the applicant relies upon an argument that the Board impermissibly relied upon the opinion of Dr Dooris. The Board, it is said, should not have taken his opinion into account because he wrongly assumed that Dr Jones had made the decision to cease the Warfarin.

[54] While, as is observed above, some of the language used may, if subjected to a magnifying glass, suggest that the Board relied upon Dr Dooris' views concerning the cessation of Warfarin, that is not the case. The reasons given by the Board are not based on an assumption that Dr Jones decided to cease Warfarin. In their reasons the board refers to:

(a) the decision "not to recommence" Warfarin;

(b) "a review of the patient's clinical risk by ongoing Warfarin";

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[20] At 271-272.

(c) the submission from the applicant that "he continued to suspend the patients Warfarin"; and

(d) the absence of any submission from the applicant to "specifically reflect that he discussed with the patient the risks and/or benefits associated with the withholding of Warfarin".

[55] Although Dr Dooris did advance some comments based upon a misapprehension about who originally stopped the administration of Warfarin, there were other comments which were concerned with the documentation relating to the treatment of Mrs McGurk by the applicant. Given the nature of the caution administered by the Board, it is reasonable to assume that the Board has only relied upon those sections of Dr Dooris' report concerning his findings with respect to the records.

Wednesbury unreasonableness

[56] This leg of the applicant's argument is based upon the incorrect assumption that the Board relied upon that part of Dr Dooris' report which was concerned with the decision to stop the administration of Warfarin. Apart from that misunderstanding, there has been no illogicality or irrationality demonstrated in the Board's reasons.

Failure to take into account a relevant consideration / taking into account an irrelevant consideration / failure to afford natural justice

[57] For the reasons given above, these grounds are not made out.

Conclusion

[58] The applicant has not demonstrated that any of the grounds show a reviewable error on the part of the Board.

[59] The application is dismissed.