QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

CITATION:	*Ting v Chief Executive, Queensland Health* [2020] QCAT 265
PARTIES:	**DR JOHN YUK CHING TING** (applicant) **v** **CHIEF EXECUTIVE, QUEENSLAND HEALTH** (respondent)
APPLICATION NO/S:	GAR084-19
MATTER TYPE:	General administrative review matters
DELIVERED ON:	28 July 2020
HEARING DATE:	8 – 9 October 2019
HEARD AT:	Brisbane
DECISION OF:	Allen QC DCJ, Deputy President
ORDERS:	**The decision of the respondent is confirmed.**
CATCHWORDS:	PROFESSIONS AND TRADES – HEALTH CARE PROFESSIONALS – MEDICAL PRACTITIONERS – LICENCES AND REGISTRATION – where the applicant medical practitioner has applied for a review of the decision of the respondent pursuant to section 24 of the *Health (Drugs and Poisons) Regulation* 1996 to cancel the endorsements of the applicant in relation to Schedule 8 controlled drugs and Schedule 4 restricted drugs of dependency. *Criminal Law (Rehabilitation of Offenders) Act* 1986 (Qld), s 9 *Health Act* 1937 (Qld), s 5 *Health (Drugs and Poisons) Regulation* 1996 (Qld), s 15, s 21, s 23, s 24, s 25A, s 33, s 58, s 78, s 81, s 120, s 122, s 161, s 213 *Queensland Civil and Administrative Tribunal Act* 2009 (Qld), s 19, s 20
APPEARANCES & REPRESENTATION:	
Applicant:	The applicant appeared on his own behalf
Respondent:	S Munasinghe instructed by Crown Law

REASONS FOR DECISION

Introduction

[1] On 8 February 2019, Dr Susan Ballantyne, a delegate of the Chief Executive, Queensland Health ("the respondent") decided, pursuant to section 24 of the *Health (Drugs and Poisons) Regulation* 1996 ("the *Regulation*"), to cancel the endorsements of Dr John Yuk Ching Ting ("the applicant") under section 58 of the *Regulation* in relation to Schedule 8 controlled drugs and under section 161 of the *Regulation* in relation to Schedule 4 restricted drugs of dependency. The applicant has applied for a review of the decision of the respondent.[1]

[2] At all material times the applicant was registered under the *Health Practitioner Regulation National Law (Queensland)* to practise in the medical profession and thus[2], prior to the decision under review, held endorsements[3] under section 58 of the *Regulation* with respect to controlled drugs[4] and pursuant to section 161 of the *Regulation* with respect to restricted drugs.[5] The effect of the decision of the respondent was to cancel the applicant's endorsement under section 58 of the *Regulation* in relation to Schedule 8 controlled drugs entirely and the applicant's endorsement under section 161 of the *Regulation* in relation to Schedule 4 restricted drugs in part. The decision cancelled the endorsement of the applicant under section 161 of the *Regulation* in relation to Schedule 4 restricted drugs of dependency.[6] The applicant has retained his endorsement under section 161 of the *Regulation* in relation to Schedule 4 restricted drugs which are not restricted drugs of dependency.

Health (Drugs and Poisons) Regulation 1996

[3] The provisions of Chapter 1, Part 5 of the *Regulation* deal with endorsements and include the following relevant provisions:

> **15 Suitability of person to hold endorsement**
>
> (1) In deciding whether a person is a suitable person to hold, or to continue to hold, an endorsement the chief executive may have regard to, and may make inquiries about, the following—

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1 The application to review a decision filed 5 March 2019 states that the decision to be reviewed is "Notice of Urgent Cancellation of Approvals dated 19/2/2019" and annexes a copy of a notice of urgent cancellation of approvals pursuant to s 25A of the *Regulation* by which the delegate of the Chief Executive gave the applicant notice of cancellations of approvals previously granted under sections 78, 122 and 213 of the Regulation to treat specified patients with schedule 4 and schedule 8 drugs. Such notice stated that the ground for such cancellation was the cancellation, pursuant to section 24 of the *Regulation*, of the applicant's endorsements under section 58 of the *Regulation* in relation to Schedule 8 controlled drugs and under section 161 of the *Regulation* in relation to Schedule 4 restricted drugs of dependency. Notwithstanding the terms of the application to review a decision, the parties' conduct of the litigation, including the material filed by the parties and the parties' submissions, written and oral, make it clear that it is the decision of 8 February 2019 that is in fact the subject of application to review: see T1-9:15-25.

2 See section 36 and definitions of "medical practitioner" and "doctor" in Schedule 1 of the *Acts Interpretation Act* 1954 and sections 14(1) and 17 of the *Statutory Instruments Act* 1992.

3 See definitions of "endorsement" and "authority" in appendix 9 of the *Regulation*.

4 See definition of "controlled drug" in appendix 9 of the *Regulation* and Schedule 8 of the Poisons Standard (Cth).

5 See definition of "restricted drug" in appendix 9 of the *Regulation* and Schedule 4 of the Poisons Standard (Cth).

6 See definition of "restricted drug of dependency" in appendix 9 of the *Regulation* and Appendix 8 of the *Regulation*.

(a) the person's knowledge and understanding of the person's obligations under this regulation;
(b) the person's qualifications and experience;
(c) the person's character and standing;
(d) any previous convictions the person has under the Act or this regulation;
(e) whether the person engages, or has engaged, in conduct that risks, or is likely to risk, a controlled drug, a restricted drug or a poison being used for a purpose that is unlawful under a law of a State or the Commonwealth.

(2) Subsection (1) does not limit the matter to which the chief executive may have regard in considering the suitability of the person to hold an endorsement.

(3) In this section—
this regulation includes the *Poisons Regulation 1973*.

21 Holder of endorsement must comply with conditions

The holder of an endorsement must not contravene a condition of the endorsement. Maximum penalty—80 penalty units.

23 Grounds for suspension or cancellation of endorsement

Each of the following is a ground for the suspension or cancellation of an endorsement—

…
(b) the holder of the endorsement is not a suitable person to hold the endorsement;
…
(d) the holder of the endorsement has breached a condition stated in the endorsement;
(e) the holder of the endorsement has contravened a provision of this regulation;
…

24 Procedure for suspension or cancellation of endorsement

(1) If the chief executive considers there is a ground to suspend or cancel an endorsement (the ***proposed action***), the chief executive may give the holder of the endorsement (the ***endorsement holder***) a written notice that—
(a) states the proposed action; and
(b) states the grounds for the proposed action; and
(c) outlines the facts and circumstances forming the basis for the grounds; and
(d) if the proposed action is suspension of the endorsement—states the proposed suspension period; and
(e) invites the endorsement holder to show, in writing and within a stated time of at least 28 days, why the proposed action should not be taken.

(2) The notice must state whether the proposed action relates to—
(a) all controlled drugs, restricted drugs, poisons or activities permitted under the endorsement; or
(b) a stated controlled drug, restricted drug or poison or a stated activity permitted under the endorsement.

(3) If, after considering all written representations made within the stated time, the chief executive still considers there is a ground to take the proposed action, the chief executive may—
(a) if the proposed action was to suspend the endorsement for all controlled drugs, restricted drugs, poisons or activities permitted under the endorsement for a stated period—suspend the endorsement, for not longer than the proposed suspension period, for—
(i) all controlled drugs, restricted drugs, poisons or activities permitted under the endorsement; or

(ii) a stated controlled drug, restricted drug or poison or a stated activity; or

(b) if the proposed action was to suspend the endorsement for a stated controlled drug, restricted drug or poison or a stated activity for a stated period—suspend the endorsement for the controlled drug, restricted drug, poison or activity for not longer than the proposed suspension period; or

(c) if the proposed action was to cancel the endorsement—

(i) for a stated controlled drug, restricted drug or poison or a stated activity—either cancel the endorsement, or suspend it for a stated period, for the controlled drug, restricted drug, poison or activity; or

(ii) if subparagraph (i) does not apply—either cancel the endorsement or suspend it for a stated period.

(4) Within 10 days after the chief executive makes the decision, the chief executive must give written notice of the decision to the endorsement holder.

(5) If the chief executive decides to suspend or cancel the endorsement, the notice must—

(a) be a QCAT information notice for the decision; and

(b) state the day before which the endorsement holder is not permitted to apply to the chief executive under section 26A.

(5A) The day mentioned in subsection (5)(b) must be a day the chief executive believes is reasonable having regard to the grounds for the suspension or cancellation.

(6) The decision takes effect on the later of—

(a) the day the notice is given to the endorsement holder; or

(b) the day of effect stated in the notice.

…

[4] Section 21 of the *Regulation* was contravened by the applicant, as well as the following provisions of the *Regulation*:

78 Specified condition drugs—amphetamine, dexamphetamine, lisdexamfetamine, methylamphetamine, methylphenidate

(1) Subject to section 74(3), a person must not dispense, obtain, prescribe, sell or use a specified condition drug unless the person—

(a) dispenses, obtains, prescribes, sells or uses the specified condition drug under an approval; or

(b) is a doctor and dispenses, obtains or prescribes the specified condition drug for the treatment of—

(i) narcolepsy; or

(ii) brain damage in a child at least 4 years; or

(iii) attention deficit disorder in a child at least 4 years; or

…

Maximum penalty—80 penalty units.

(2) The chief executive may give an approval mentioned in subsection (1)(a) only to—

(a) a doctor; or

(b) a person who satisfies the chief executive that the specified condition drug is to be used for a genuine analytical or research purpose.

(3) In this section—

specified condition drug means the following controlled drugs—

(a) amphetamine;

(b) dexamphetamine;

(c) lisdexamfetamine;

(d) methylamphetamine;

(e) methylphenidate.

81 Oral prescription

(1) A prescriber may give a dispenser an oral prescription for a controlled drug the prescriber is endorsed to prescribe.

(2) Within 24 hours after giving the oral prescription, the prescriber must ensure a paper prescription for the drug is sent by facsimile transmission to the dispenser.
Maximum penalty—20 penalty units.

(3) Within 7 days after giving the oral prescription, the prescriber must send a paper prescription by post or by hand or send an electronic prescription for the drug to the dispenser.
Maximum penalty—40 penalty units.

(4) If the dispenser does not receive a paper prescription or electronic prescription for the drug from the prescriber within 14 days after being given the oral prescription, the dispenser must immediately give a written report about the circumstances to the chief executive.
Maximum penalty—20 penalty units.

120 Notice required if lengthy treatment with controlled drug

(1) This section applies if a doctor or nurse practitioner—

(a) administers, dispenses, prescribes or supplies, or intends to administer, dispense, prescribe or supply, a controlled drug in the treatment of a patient for more than 2 months; or

(b) reasonably suspects a patient has been treated with a controlled drug by another doctor or nurse practitioner for more than 2 months and the doctor or nurse practitioner intends to administer, dispense, prescribe or supply a controlled drug in the treatment of the patient.

(2) The doctor or nurse practitioner must immediately give the chief executive a written report in the approved form about the circumstances of the patient's treatment.
Maximum penalty—40 penalty units.

(3) The chief executive may ask the doctor or nurse practitioner to give the chief executive additional information about the treatment of the patient within a stated reasonable time.

(4) The doctor or nurse practitioner must comply with the request, unless the doctor or nurse practitioner has a reasonable excuse for not complying with it.
Maximum penalty—40 penalty units.

122 Approval needed for treating certain drug dependent persons with controlled drugs

(1) If a relevant practitioner reasonably believes a person is a drug dependent person, the relevant practitioner must not, without an approval—

(a) dispense or prescribe a controlled drug for the person; or

(b) administer or supply a controlled drug to or for the person; or

(c) give an oral or written instruction to supply a controlled drug to or for the person.

Maximum penalty—60 penalty units.

(2) If a relevant practitioner reasonably believes that it is necessary for the relevant practitioner to treat a drug dependent person, or the relevant practitioner proposes to treat a class of drug dependent persons, the relevant practitioner must give the chief executive a report in the approved form about—

(a) if the relevant practitioner reasonably believes that it is necessary to treat a drug dependent person—the circumstances of the person's treatment; or

(b) if the relevant practitioner proposes to treat a class of drug dependent persons—the class of drug dependent persons the relevant practitioner proposes to treat and the proposed treatment of the persons.

Maximum penalty—40 penalty units.

(3) The chief executive may ask the relevant practitioner to give the chief executive stated additional information about the treatment of the drug dependent person or class of persons within a stated reasonable time.

(4) The relevant practitioner must comply with the request, unless the relevant practitioner has a reasonable excuse for not complying with it.
Maximum penalty—40 penalty units.

(5) If the chief executive is reasonably satisfied that, for the welfare of the drug dependent person or class of drug dependent person, it is necessary for the relevant practitioner to treat the person or persons with a controlled drug, the chief executive may give the relevant practitioner written approval to administer, dispense, prescribe, supply or give an oral or written instruction to supply a stated quantity or volume of the controlled drug.

(6) Also, if the chief executive is reasonably satisfied that, for the welfare of the drug dependent person or class of drug dependent persons, it is necessary for the chief executive to give the relevant practitioner an oral approval to administer, dispense, prescribe, supply or give an oral or written instruction to supply a stated quantity or volume of the controlled drug to or for the person or persons, the chief executive may give the oral approval.

(7) However, if the chief executive gives the relevant practitioner an oral approval, the chief executive must give the relevant practitioner written confirmation of the approval as soon as possible after giving the oral approval.

(8) A relevant practitioner to whom a written or oral approval has been given under subsection (5) or (6) must not administer, dispense, prescribe, supply, or give an oral or written instruction to supply a controlled drug to the person or persons other than under the approval.
Maximum penalty—60 penalty units.

(9) An approval given under this section has effect for the period stated in the approval.

(10) This section does not apply to a relevant practitioner treating a drug dependent person as an inpatient in a hospital.

(11) In this section—
relevant practitioner means a doctor, nurse practitioner or surgical podiatrist.

213 Approval needed for treating certain drug dependent persons with restricted drugs of dependency

(1) A relevant practitioner must not, without an approval—
(a) dispense or prescribe a restricted drug of dependency for a person the relevant practitioner reasonably believes is a drug dependent person; or
(b) administer or supply a restricted drug of dependency to or for a drug dependent person.
Maximum penalty—60 penalty units.

(2) If a relevant practitioner reasonably believes it is necessary for the relevant practitioner to treat a drug dependent person, or the relevant practitioner proposes to treat a class of drug dependent persons, with a restricted drug of dependency, the relevant practitioner must give the chief executive a report in the approved form about—
(a) if the relevant practitioner reasonably believes it is necessary to treat a drug dependent person—the circumstances of the person's treatment; or
(b) if the relevant practitioner proposes to treat a class of drug dependent persons—the class of drug dependent persons the relevant practitioner proposes to treat and the proposed treatment of the persons.

(3) The chief executive may ask the relevant practitioner to give the chief executive stated additional information about the treatment of the drug

dependent person, or class of drug dependent persons, within a stated reasonable time.

(4) The relevant practitioner must comply with the request, unless the relevant practitioner has a reasonable excuse for not complying with it.
Maximum penalty—20 penalty units.

(5) If the chief executive is reasonably satisfied that, for the welfare of the drug dependent person, or class of drug dependent persons, it is necessary for the relevant practitioner to treat the person, or class of persons, with a restricted drug of dependency, the chief executive may give the relevant practitioner a written approval to administer, dispense, prescribe, supply or use a stated quantity or volume of the restricted drug.

(6) Also, if the chief executive is reasonably satisfied that, for the welfare of the drug dependent person, or class of drug dependent persons, it is necessary for the chief executive to give the relevant practitioner an oral approval to administer, dispense, prescribe, supply or use a stated quantity or volume of the restricted drug of dependency to or for the person or persons, the chief executive may give the oral approval.

(7) However, if the chief executive gives the relevant practitioner an oral approval, the chief executive must give the relevant practitioner written confirmation of the approval as soon as possible after giving the oral approval.

(8) A relevant practitioner to whom an approval has been given about a restricted drug of dependency for a drug dependent person, or class of drug dependent persons, must not administer, dispense, prescribe or supply a restricted drug of dependency to, or use a restricted drug of dependency on, the person or persons other than under the approval.
Maximum penalty—60 penalty units.

(9) This section does not apply to a relevant practitioner treating a drug dependent person as an inpatient in a hospital.

(10) In this section—
relevant practitioner means a doctor, nurse practitioner or surgical podiatrist.

[5] The definition of "drug dependent person" is found in section 5 of the *Health Act* 1937 (Qld):

drug dependent person means a person—

(a) who, as a result of repeated administration to the person of controlled or restricted drugs or poisons—
(i) demonstrates impaired control; or
(ii) exhibits drug-seeking behaviour that suggests impaired control;
over the person's continued use of controlled or restricted drugs or poisons; and

(b) who, when the administration to the person of controlled or restricted drugs or poisons ceases, suffers or is likely to suffer mental or physical distress or disorder.

Background

[6] The applicant was registered as a medical practitioner on 21 December 1990. He became a fellow of the Royal Australian College of General Practitioners in 1994.

[7] The respondent filed material and made submissions relating to the conviction of the applicant of a criminal offence in 1996. I am of the view that I am bound to

disregard such matter.[7] The respondent did not rely upon such matter in reaching her decision. I place no reliance upon such matter in my review of the decision. The matters in the following three paragraphs are referred to only as contextual matters relevant to the applicant's clinical experience.

[8] On 3 March 1997, the Medicare Participation Review Committee decided to disqualify the applicant from participation in the Medicare scheme for a period of 5 years.

[9] On 2 June 1997 the Medical Assessment Tribunal found the applicant guilty of misconduct in a professional respect. The Tribunal ordered that the applicant's name be erased from the register of medical practitioners.

[10] On 18 May 1999 the Medical Assessment Tribunal ordered that the applicant be re-registered subject to conditions including that he work in the public health system and not engage in private practice until 30 June 2002.

[11] The applicant continued to work in the public health system after 30 June 2002. From 2009 to 2013 the applicant worked in public hospitals in New South Wales as a trainee anaesthetist. Personal circumstances led to the cessation of that training before completion.

[12] The applicant was awarded a fellowship in advanced rural general practice in 2015.

[13] The applicant was involved in some rural anaesthesia until 2016. In 2017 the applicant was subject to regulatory action by the Medical Board of Australia by way of a caution and conditions placed on his registration after a finding of unsatisfactory professional performance whilst working as a general practice anaesthetist. The conditions were removed on 11 July 2018.

[14] On 10 May 2017 the applicant successfully completed Queensland Opioid Treatment Program ("QOTP") Prescriber Training.

[15] A letter dated 3 May 2017 from the respondent to the applicant enclosed a notice of approval, pursuant to section 122(5) of the *Regulation,* for the applicant to treat a maximum of five patients on the QOTP for drug dependence with the controlled drugs, methadone syrup/liquid or buprenorphine tablets/film.[8] The approval referred to places of practice as Redcliffe Medical Centre at Redcliffe and Marendy Medical Services at Margate. I understand the applicant by then to have returned to private practice as a general practitioner and working at both practices. Material filed by the parties refers to the "Marendy dosing clinic" and I infer that this general practice carried the bulk of the QOTP patient load.

[16] A letter from the respondent to the applicant dated 19 October 2017 includes as follows:

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7 *Criminal Law (Rehabilitation of Offenders) Act* 1986, s 9, and see definition of "criminal history" in appendix 9 of the *Regulation.*

8 The apparent discrepancy in the dates of his approval to do so (3 May 2017) with his qualification to do so (10 May 2017 as per paragraph [12]) was the subject of submissions by the applicant: Hearing Document 2, index details re Document No 3; T1-26:37-42.

> **Patient Treatment Class Approval for the treatment of persons on the Opioid Treatment Program for drug dependence with controlled drug methadone syrup/liquid or buprenorphine tablets/film**
>
> Please find attached your amended Patient Class Approval to treat persons on the Opioid Treatment Program for drug dependence with controlled drugs methadone syrup/liquid or buprenorphine tablets/film to **100 in total**. In accordance with section 18 of the *Health (Drugs and Poisons) Regulation* 1996, please find attached your Patient Treatment Class Approval.
>
> Your Patient Treatment Class Approval has been granted for two years and is due to expire on **30 June 2018**. As MRQ[9] does not send out reminders, you will need to seek further approval to continue prescribing after this date.

[17] The enclosed notice of approval, dated 19 October 2017, referred to places of practice as Marendy Medical Services at Margate and Dental and Medical Surgery at Albany Creek. It confirmed the terms of approval as stated in the covering letter, and also stated:

> Date of Effect: This approval takes effect as of **1st July 2017**[10]
>
> Approval expiry: **30 June 2018**.

[18] The applicant contends, and the respondent does not dispute, that the 19 October 2017 approval was given in circumstances where the applicant had taken on a retiring practitioner's large patient load at the "Marendy dosing clinic". The applicant contends that he did this as a "favour" for the MRQ, helping Queensland Health ("QH") address an undesirable situation arising from the retiring doctor's over-prescription of benzodiazepines.[11]

[19] The applicant took this large patient load, including 81 QOTP patients,[12] with him when he moved his place of practice to the Woody Point Medical Centre from 4 December 2017. The applicant contends that, as a result of the move, he lost access to important QOTP patient records.[13]

[20] The applicant's conduct leading to the decision under review occurred during 2018 in the course of his general practice at the Woody Point Medical Centre. It will be examined when considering the grounds for the decision.

[21] By letter from Dr Loveday, Director MRQ, to the applicant dated 29 June 2018,[14] the applicant was forwarded an approval under sections 18(1) and 122(5) of the *Regulation*. The covering letter included:

> Please find attached your treatment approval for prescribing to drug dependent patients on the …QOTP.

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9 Medicines Regulation & Quality – an Office within Queensland Health.

10 The applicant made submissions as to the apparent back-dating of the approval from 19 October 2017 to 1 July 2017: HD 2, index details re Document No 5; HD 4 Chronology, 1 July 2017 entry; T1-28-35.

11 See HD 6b, page 1267; HD 4 Chronology, 1 July 2017 entry; T1-22 and T1-28:20-40.

12 See HD 2, index details re Document No 10.

13 See HD 2, index details re Document No 10; HD 4 Chronology, 4 December 2017 entry; HD 6b, page 607.

14 HD 3, page 387.

> This approval is valid for four (4) weeks only and has stated conditions which you are legally required to adhere to. Over the next four weeks Medicines Regulation and Quality will be reviewing your prescribing for the QOTP with a view to determining if an extension to the approval will be provided.
>
> …
>
> In addition, please note that you are **not** able to register any further patients on the QOTP at this time.

[22] The attached approval[15] granted treatment approval to prescribe to QOTP patients the schedule 8 controlled drugs methadone syrup/liquid or buprenorphine tablets/film. It included conditions including:

> 4. No further admissions onto the Queensland Opioid Treatment Program are permitted under this approval.

and further provided:

> **Date of Effect**: This approval takes effect on **30 June 2018**
>
> **Date of Expiry**: This approval expires on **31 July 2018** unless it otherwise expires immediately upon your notification to Medicines Regulation and Quality that you have ceased prescribing for persons on the Queensland Opioid Treatment Program.

[23] In an email to the respondent and Dr Loveday on 18 July 2018,[16] the applicant provided details of a QOTP patient previously admitted to the program by another doctor and "seeking QOTP admission under Dr Ting" and asked:

> Am I able to take this patient on in the month of July 2018?

[24] By reply email on 18 July 2018,[17] a MRQ Senior Advisor thanked the applicant for his "time on the phone just now" and stated, amongst other things:

> As explained, your current approval does not allow you to take on any new patients onto the QOTP.

[25] The applicant was subsequently granted an approval[18] under sections 18(1) and 122(5) of the *Regulation* to prescribe to QOTP patients the schedule 8 controlled drugs methadone syrup/liquid or buprenorphine tablets/film. It included conditions including:

> 4. No further admissions onto the Queensland Opioid Treatment Program are permitted under this approval.

and further provided:

> **Date of Effect**: This approval takes effect on **01 August 2018**
>
> **Date of Expiry**: This approval expires on **31 October 2018** unless it otherwise expires immediately upon your notification to Medicines Regulation and Quality that you have ceased prescribing for persons on the Queensland Opioid Treatment Program.

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15 HD 3, page 388.
16 HD 3, page 390.
17 HD 3, page 390.
18 Exhibit 1.

[26] The respondent gave the applicant notice, pursuant to section 24(1) of the *Regulation*, by a show cause notice dated 29 October 2018.[19] It is unnecessary to refer to the contents of the show cause notice given that consideration will be given to the contents of the subsequent notice of cancellation of endorsements.

[27] An email on 30 October 2018 from Dr Loveday[20] to the applicant included:

> Thank you for your time in discussing this matter on the phone today.
>
> Based on our discussion, I confirm the following matters that I discussed with you.
>
> Your current approval (see attached) to treat drug dependent persons with methadone and buprenorphine under the Queensland Opioid Treatment Program [QOTP] expires tomorrow, Wednesday 31 October 2018.
>
> This means that from after that date you cannot lawfully, act as a treatment provider under the QOTP and you cannot:
>
> - Give any written or oral instructions to a pharmacist to supply or administer methadone or buprenorphine;
> - Amend in writing or orally any written instructions you issued prior to 31 October 2018; or
> - Admit any persons for treatment to the QOTP.

[28] In an email in reply to Dr Loveday on 30 October 2018,[21] the applicant stated:

> I acknowledge the email content below by you. There will be a few extra QOTP patients admitted today that I have to submit shortly. This action contravenes my current approval attached by you.

[29] That provoked an email response from Dr Loveday the following day,[22] including:

> I advise that you should refer to the copy of the approval I have attached and that this is a legal instrument under the provisions of the Health (Drugs & Poisons) Regulation, 1996.
>
> You are lawfully required to comply with the conditions of this approval.
>
> Any actions you take that are potentially in breach of those conditions on this approval could result in actions by the Department against you.
>
> I have not in anyway given you authorisation to not comply with the conditions set out in this approval.

[30] The applicant made written representations with respect to the show cause notice by a series of emails on 3 and 4 November 2018.[23] I have considered the contents of all the emails and attachments and will refer to some relevant parts later in these reasons.

[31] After considering the written representations made by the applicant, the respondent decided, pursuant to section 24(3)(c) of the *Regulation*, to cancel the endorsements of the applicant in the ways stated earlier. The respondent gave notice to the

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19 HD 3, pages 1-90.
20 HD 3, page 92.
21 HD 3, pages 91-92.
22 HD 3, page 91.
23 HD 3, pages 94-242.

applicant of the decision, pursuant to s 24(4) of the *Regulation*, by a notice of cancellation of endorsements dated 8 February 2019.[24] It will be necessary to refer to the contents of the notice of cancellation of endorsements in some detail when considering the merits of the decision under review.

[32] On 19 February 2019, the respondent decided, pursuant to s 25A of the *Regulation*, to cancel approvals, previously granted under sections 78, 122 and 213 of the *Regulation*, for the applicant to treat specified patients with schedule 4 and schedule 8 drugs. The applicant does not seek to review that decision.[25]

[33] During 2018 the applicant was the subject of investigation by the Australian Health Practitioner Regulation Agency ("AHPRA") and the Medical Board of Australia ("Board") in relation to his clinical performance. On 7 March 2019 the Board suspended the applicant's registration. The decision of the Board was informed by the decision of the respondent under review but also by other matters relating to the applicant's clinical performance and conduct. The applicant remains suspended with the decision of the Board the subject of another application to review.[26] The Tribunal previously ordered that that application be heard after determination of this application to review the respondent's decision.[27] The respondent has placed material before the Tribunal relating to the decision of the Board and made submissions that the other matters considered by the Board support the decision made by the respondent. The respondent did not rely upon those matters in making her decision. I have not taken those matters into account in making my decision.

Nature of review

[34] Section 33(2)(c) of the *Regulation* confers jurisdiction on this Tribunal to review the decision of the respondent.[28]

[35] Sections 19 and 20 of the *Queensland Civil and Administrative Tribunal Act* 2009 (Qld)("*QCAT Act*") provide as follows.

> **19 Exercising review jurisdiction generally**
>
> In exercising its review jurisdiction, the tribunal—
>
> (a) must decide the review in accordance with this Act and the enabling Act under which the reviewable decision being reviewed was made; and
>
> (b) may perform the functions conferred on the tribunal by this Act or the enabling Act under which the reviewable decision being reviewed was made; and
>
> (c) has all the functions of the decision-maker for the reviewable decision being reviewed.
>
> **20 Review involves fresh hearing**
>
> (1) The purpose of the review of a reviewable decision is to produce the correct and preferable decision.
>
> (2) The tribunal must hear and decide a review of a reviewable decision by way of a fresh hearing on the merits.

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24 HD 3, pages 243-285.
25 T1-89:15-25.
26 Ting v Medical Board of Australia, OCR076-19.
27 *Ting v Medical Board of Australia; Ting v Queensland Health* [2019] QCAT 192.
28 *QCAT Act*, s 17.

[36] Given the nature of the review jurisdiction, the Tribunal is not limited to considering the material considered by the respondent. It can, and should, consider all relevant material and circumstances, including relevant events and circumstances since the decision. Further, the Tribunal is not limited to grounds relied upon by the respondent for the decision. Nevertheless, it is helpful to consider the material considered by the respondent in reaching her decision and her reasons for that decision.

The respondent's grounds for cancellation and reasons for decision

[37] The show cause notice dated 29 October 2018[29] specified 72 grounds for cancellation of the applicant's endorsements. Grounds 1 to 71 specified specific instances of contravention of the *Regulation* between 1 June 2018 and 24 October 2018 relating to named patients and constituted by the applicant:

(a) admitting patients to the QOTP contrary to the conditions of the approval dated 1 August 2018 in contravention of section 21 of the *Regulation*;

(b) prescribing specific condition drugs in contravention of section 78 of the *Regulation*;

(c) failing to provide requisite treatment reports to the Chief Executive in contravention of section 120 of the *Regulation*;

(d) failing to endorse scripts with collection conditions as required by an approval in contravention of section 122(8) of the *Regulation*;

(e) prescribing drugs to drug dependent persons without written approval of the Chief Executive, contrary to section 122(1) of the *Regulation*;

(f) prescribing restricted drugs of dependency to drug dependent persons without approval in contravention of section 213 of the *Regulation*;

(g) failing to provide paper prescriptions after giving oral prescriptions in contravention of section 81 of the *Regulation*.

[38] Ground 72 was that, because of the matters described in grounds 1 to 71, the applicant was not a suitable person to hold the endorsements.

[39] In a series of emails on 3 and 4 November 2018,[30] the applicant did not dispute any of the grounds specified in the show cause notice. He did refer to matters in mitigation of his conduct.

[40] The notice of cancellation of endorsements dated 8 February 2019,[31] which provides the reasons for the decision under review, repeated and relied on grounds 1 to 72 in the show cause notice and the following further matters:

(a) the applicant's knowledge of the telephone enquiry service provided by MRQ whereby prescribers can seek patient histories and identify issues with persons

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29 HD 3, pages 1-90.
30 HD 3, pages 94-242.
31 HD 3, pages 243-285.

seeking schedule 8 controlled drugs evidenced by the applicant's use of that service on occasions in 2016 to 2018;

(b) notifications sent to the applicant during the previous five years about prescribing schedule 8 controlled drugs in contravention of sections 78, 120, 121 and 122 of the Regulation;

(c) concerns regarding the number of drug dependent persons for whom the applicant had prescribed schedule 8 controlled drugs and/or schedule 4 restricted drugs of dependency and his apparent lack of compliance with his legislative obligations under the Regulation;

(d) some of the contents of the applicant's submissions in the emails of 3 and 4 November 2018 indicating further non-compliance with the Regulation, including as follows:

(i) further instances of admitting patients to the QOTP contrary to the conditions of the approval dated 1 August 2018, contrary to section 21 of the *Regulation*;

(ii) further instances of prescribing drugs to drug dependent persons without written approval of the Chief Executive, contrary to section 122(1) of the *Regulation;*

(iii) further instances of prescribing restricted drugs of dependency to drug dependent persons without approval in contravention of section 213 of the *Regulation*.

[41] The respondent concluded:

> **REASONS FOR DECISION**
>
> I have made the decision to cancel your endorsements pursuant to s 24 of the Regulation based on the evidence and other material before me, and I am also satisfied:
>
> 11. In your submissions of 3 and 4 November 2018 you do not dispute any of the grounds detailed in the 29 October 2018 Notice, rather you have made full admissions to all the identified breaches and contraventions;
>
> 12. In your submission, you admit that, despite being aware of the requirement to seek approvals to treat drug dependent patients with S8 controlled drugs and S4 restricted drugs of dependency, you have failed on multiple occasions, to obtain or seek the requisite approvals;
>
> 13. As a trained QOTP prescriber I would expect you to have additional knowledge about the assessment and management of drug dependent patients, and the risks associated with treating such patients with S8 controlled drugs and S4 restricted drugs of dependency.
>
> 14. Of more concern is your failure to seek approvals for patients you had identified as drug dependent, where you continued to treat them with S8 controlled drugs, and/or S4 restricted drugs of dependency without seeking or obtaining the requisite approval.
>
> 15. Departmental records indicate that you have had considerable contact with MRQ, the Clinical Advisors and the S8INFO telephone enquiry

service, and you are clearly aware of your regulatory obligations when prescribing for, and treating drug dependent patients.

16. In addition, your failure to endorse prescriptions as required under approvals issued by MRQ increased risk to the individual patients and the community by allowing S8 controlled drugs and S4 restricted drugs of dependency to be freely available in the community. You have made decisions about what you thought was appropriate without consultation with MRQ, the Clinical Advisors and myself in my capacity as an Addiction Medicine Specialist.

17. In your submission, you admitted that you have overlooked on multiple occasions to provide the requisite s 120 written report regarding lengthy treatment of a patient with S8 controlled drugs;

18. Your failure to provide reports to the chief executive when treating patients with S8 controlled drugs for more than two (2) months evidences your general failure to comply with the Regulation, particularly when you have admitted that you are aware of your regulatory obligations when prescribing S8 controlled drugs, and to a lesser extent, S4 restricted drugs of dependency.

19. Finally, I am concerned that you have frequently explained your non-compliance based on your lack of access to Dr Marendy's patients' notes when treating patients that transferred to your care. I am of the view that this should not have impacted your ongoing care of these patients or your legislative requirements as the new prescriber.

20. Accordingly, based on the information before me, I am currently of the view that you are no longer a suitable person under s 15 of the Regulation, pursuant to s 23(b) of the Regulation to hold endorsements for S8 controlled drugs and S4 restricted drugs of dependency.

Date cancellation takes effect

The cancellation of your endorsements takes immediate effect on the day notice is given to you, or your legal representative.

In accordance with ss 24(5)(p) and 24(5A) of the Regulation, you are not permitted to apply to the Chief Executive under s 26A of the Regulation for an amendment or appeal of the decision to cancel your endorsements, until close of business on **8 February 2021**.

Further matters referred to on behalf of the respondent at hearing

[42] In addition to the matters considered by the respondent in reaching her decision, the respondent sought to rely upon further matters in support of the decision, including:

(a) the applicant's conviction of a criminal offence in 1996- I have disregarded this matter for reasons expressed earlier;

(b) consequent findings and orders of the Medicare Participation Review Committee in 1997 and of the Medical Assessment Tribunal in 1997 and 1999- I have only had regard to the orders made as part of the timeline of the applicant's practice relevant to the extent of his experience;

(c) regulatory action by the Medical Board of Australia in 2017 after a finding of unsatisfactory professional performance- I do not consider this matter to have

substantial relevance to the matters in issue in this review and have disregarded it;

(d) investigations and regulatory action by AHPRA and the Board in 2018 and 2019 in relation to the applicant's clinical performance- I do not consider the other matters regarding clinical performance to have substantial relevance to the matters in issue in this review, note that they are the subject of dispute in other proceedings before the Tribunal, and have chosen to disregard them.

[43] The respondent relied upon the applicant's prescribing conduct subsequent to the decision under review. For reasons that will be referred to later, the applicant did not receive notice of the decision under review until 12 February 2019. Over the following 2 to 3 weeks, the applicant continued to prescribe schedule 8 controlled drugs and schedule 4 restricted drugs of dependency.[32]

The applicant's arguments

[44] The applicant, consistently with his submissions in his emails of 3 and 4 November 2018, has not sought to deny the fact of the contraventions relied upon by the respondent in seeking a review of her decision. In material filed in the proceedings and in oral submissions during the hearing, the applicant has sought to place such matters in a context he contends should lead the Tribunal to conclude he nevertheless remains a suitable person to hold the cancelled endorsements.

[45] Some of the written and oral submissions were directed to details of the treatment of particular patients the subject of specified contraventions of the *Regulation*. I have considered those submissions but see no utility in detailing them in these reasons. Even accepting all those points made by the applicant in these instances, the points made by the applicant regarding particular cases did not detract substantially from the seriousness of the overall course of contraventions.

[46] The applicant filed voluminous written material of varying degrees of relevance and coherence. I have considered it all but will not attempt to summarise all of it. I should record that I do not accept that the somewhat hysterical, florid, scandalous and, in any event, irrelevant allegations made by the applicant concerning the conduct of legal practitioners involved in these and other proceedings before the Tribunal. I have also gained no assistance from the contents of contentious correspondence between the applicant and those legal practitioners which the applicant chose to place before the Tribunal. I will not further refer to those matters.

[47] The applicant contends that the contraventions occurred because he underestimated the burden of the QOTP patient load he undertook. They occurred in a situation where he had a heavy workload, time constraints and an inability to access patient records of the Marendy dosing clinic.[33] I accept that these factors may have contributed to the applicant's omissions to comply with his regulatory obligations. They do not excuse his conduct. They did not prevent him from discharging his regulatory obligations. The extent of the applicant's patient load, the time he chose to spend discharging his regulatory obligations and the efforts he made to obtain access to records, both of the prior clinic and relevant records held by QH, were

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32 HD 3, pages 288-386.

33 HD 2, index details re Document No 10; HD 4 Chronology, 4 December 2017 entry; HD 6a, page 1375; HD 6b, pages 540, 548 and 607.

ultimately all matters within the applicant's control. He chose not to prioritise regulatory compliance.

[48] The applicant contends that his non-compliance with legislative requirements did not result in harm to patients due to his clinical knowledge and skills in harm minimisation. His conduct did not pose a serious risk to persons.[34]I accept that the applicant acted in good faith as regards the interest of his patients. He did not intend to cause any of his patients harm. Indeed, I infer that he let his concern for his patient's comfort and wishes outweigh the need for proper regulatory compliance. There is no evidence of any actual harm caused to any patient. The potential for harm, however, is obvious.

[49] The applicant contends that his admission of patients to the QOTP contrary to the conditions of the approval dated 1 August 2018, in contravention of section 21 of the *Regulation*, occurred because he misunderstood the terms of the approval and took it to mean that the prohibition on admitting new patients was only for the month of August 2018.[35] I do not accept the applicant's contention. His explanation was unconvincing, illogical and inherently unlikely given the terms of the approval and the other correspondence on the subject. I find that he chose to ignore the clear notice that he was to cease admission of further patients. Such conduct is consistent with the applicant's subsequent deliberate breaches.

[50] The applicant admits admitting further patients to the QOTP even after it was made clear to him beyond a doubt by 30 October 2018 that he was prohibited from doing so. The applicant's explanation for such was not entirely clear to me but appeared to be that these would have been patients who had booked appointments with him to occur after 30 October 2018 and/or had pre-existing referrals from Biala or other doctors.[36] I do not accept that the applicant has satisfactorily explained these deliberate breaches of the *Regulation* which followed clear and repeated warnings to the applicant not to act in such a way.

[51] With respect to the contraventions constituted by prescription of drugs to a "drug dependent person" without approval, the applicant contends that it was not necessarily clear that the patients were drug dependent persons at the time of prescription, a diagnosis of drug dependence or substance abuse disorder being a temporal diagnosis involving clinical judgment and the patient's presentation at the time.[37] I do not accept that this provides a satisfactory explanation for these breaches. The applicant's submissions on this topic were entirely unconvincing. The applicant admitted that all contraventions related to patients recorded on QH records as drug dependent persons and that he could have utilised the QH hotline to ascertain that.[38]

[52] A major focus of the applicant's arguments was a misguided attack upon QH and its employees. There were two major limbs to this attack- alleged "reverse breaches" by QH and alleged dishonesty on the part of a QH employee in the process of notifying the applicant of the decision under review. The applicant appeared unable to

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34 HD 2, Document No 38, pages 5-6; HD 6b, pages 540 and 548; T1-110:15-25.
35 HD 2, index details re Documents Nos 20 and 23; HD 3, page 94; T1-10-11; T1-17-19; T2-24-29.
36 T1-78-82.
37 HD 2, index details re Document No 24; T2-35-63.
38 T2-36-37; T2-40; the S8INFO telephone enquiry service referred to in the respondent's reasons for decision, as to which see further the submissions on behalf of the respondent at T2-6.

recognise the limited relevance, if any, of such matters to his application to review the decision. His pre-occupation with such matters at the expense of matters relevant to the merits of the decision and its review caused me real concern as to the applicant's insight into his own regulatory failures and his capacity and willingness to comply with regulatory requirements. It is consistent with the applicant continuing to have a combative and antagonistic attitude to the regulatory authority.

[53] The applicant's eccentric notion of "reverse breaches" received much attention in the written material he filed in the proceedings[39] and his oral submissions.[40] I will not attempt to summarise the complex reasoning and mathematical formulae utilised by the applicant to develop this argument. As I was able to understand the argument, QH committed "reverse breaches" of provisions of the *Regulation* when it granted the applicant backdated approvals to treat patients on the QOTP and failed to process reports submitted by the applicant in a timely fashion. The applicant then engaged in a numerical comparison of his admitted breaches and the alleged "reverse breaches". The purpose of the exercise never became quite clear to me despite my attempts at clarification. It appears most unlikely to me that the events relied upon by the applicant as constituting "reverse breaches" could constitute contraventions of the *Regulation*. The material before me does not reveal contraventions of the *Regulation* by anyone other than the applicant. In any event, I never received any satisfactory explanation from the applicant, despite my attempts, as to why such matters could assist me in determining the review proceedings. I was left with the impression that the applicant was arguing that his contraventions should be written off in some type of accounting exercise against the alleged "reverse breaches" so as to minimise or excuse his own culpability. The argument is demonstrative of the applicant's combative attitude towards steps taken to restrict his prescribing practices.

[54] Much attention was devoted by the applicant in his written material[41] and oral submissions[42] to a delay of some days in the notification to him of the decision under review. The decision was made by the respondent on 8 February 2019. There was an attempt the same day to forward the notice of cancellation of endorsements dated 8 February 2019 by email. Such attempt was unsuccessful because the recipient's email address was incorrect- one letter of the applicant's correct email address was absent in the address used. Consequently, it was not until the afternoon of 12 February 2019 that the applicant saw a copy of the notice that had been posted to his work address. The applicant would not acknowledge the possibility of an innocent mistake on the part of the QH employee who sent the email on 8 February 2019. The applicant persisted in advancing a theory that the misaddressing of the email was deliberate and designed to prejudice him. I will not detail the substance of the applicant's argument to that effect. After having considered the applicant's detailed submissions, I am not persuaded that the misaddressing was anything other than inadvertent and do not accept the applicant's submissions to the contrary. There is no sensible reason why the QH employee would choose to engage in the deliberate dishonesty alleged by the applicant.

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39 HD 2, index details re Documents Nos 7 and 10, Document No 45, and Document No 47, pages 2 and 4-5.

40 T1-22-23; T1-33-35; T1-40-48; T1-71-72; T1-75-76;

41 HD 2, index details re Document No 31, Document No 36, pages 1-3, and Document No 47, pages 3-4 and 6-10.

42 T1-60-68.

[55] The respondent specifically conceded that notice of the cancellation should not be regarded as having been given until 12 February 2019 and made it clear that the respondent was not seeking to rely upon any breaches of the Regulation by prescriptions by the applicant from 8 to 12 February 2019.[43] Notwithstanding that concession, the applicant argued he was prejudiced by the late receipt of the notice of cancellation. He submitted that, had he had notice of the cancellation on 8 February 2019, he could have changed his work arrangements so as to avoid the circumstances that led to him continuing to prescribe schedule 8 controlled drugs and schedule 4 restricted drugs of dependency after having received notice of the cancellation of his endorsements to do so on 12 February 2019.[44] The applicant's submissions were not persuasive. The applicant was unable to explain why he had not planned to put any alternative work arrangements in place between being required to show cause and receiving the notice of cancellation.[45]I do not accept that the four day delay in receipt of the notice of cancellation caused any real prejudice to the applicant or contributed to his prescribing, contrary to the notice, after 12 February 2019.

[56] The applicant otherwise sought to justify his continued prescription of schedule 8 controlled drugs and schedule 4 restricted drugs of dependency after 12 February 2019 as clinically appropriate. The Board noted the applicant's approach as follows:

> You received MCHTU's Notice of Cancellation at 3pm on 12 February 2019. You understood that it meant stop using relevant schedule 4 and schedule 8 drugs immediately. Your goal was to rapidly comply with the Notice in a clinically safe manner over the following one to two weeks. You intended to rapidly wean and stop schedule 4 restricted drugs and schedule 8 controlled drug use and replace them with alternative medication such as Tramadol. You are aware that this will breach the Notice. You also intended to ask other doctors to take over the care or consult of patients needing to continue those drugs, including medicinal cannabis.[46]

[57] In material filed in the proceedings, the applicant stated as follows:

> In regards to I carrying out unlawful activities or breaches by writing S4 and S8 scripts between 12/2/2019 to 7/3/2019, I agree that Cancellation of S4/S8 legislatively meant "effective immediately" but I advocate to view those unlawful activities or breaches more in an "EBP[47] manner" rather than purely legislative manner "wean/ stop S4 and S8 drug use in my attempt to 'safely' deal with the S4 and S8 cancellation" vs "delay and applying for S4/S8 reinstatement before I return to work had I have the knowledge of Cancellation on 8/2/2019" vs "seeing selective patients".[48]

[58] As to such explanation, I agree with the concern expressed by the Board:

> The Board were concerned that 'rapidly weaning' a patient off medication which they have previously required is a potentially unsafe method of taking steps to comply with restrictions and your submission in this regard is a further indication that you lack insight into the serious risk posed by your unsafe prescribing.[49]

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43 T1-64:45-65:5.
44 T1-66-67.
45 T2-75-76.
46 HD 6b, page 541, paragraph e.
47 "Evidence-based Practice": HD 2, page 1, paragraph 5.
48 HD 2, pages 3-4, paragraph 10.
49 HD 6b, page 541, paragraph 16.

[59] The applicant's submissions as to why he did not immediately arrange for other doctors at his place of practice to take over care of, or, at least, prescription of schedule 8 controlled drugs and schedule 4 restricted drugs of dependency to, his patients after receiving the notice of cancellation were unpersuasive.[50] There was evidence which suggested that the applicant had not informed his supervisor of the cancellation by 22 February 2019.[51]

[60] I find that the applicant has not satisfactorily explained his continuing to prescribe schedule 8 controlled drugs and schedule 4 restricted drugs of dependency after receiving notice of the cancellation of his endorsements to do so. I conclude that the applicant chose to deliberately contravene the *Regulation* by doing so, rather than make suitable arrangements for the transfer of care of the patients. The applicant should reasonably have contemplated the need to do so at the latest when required to show cause on 29 October 2018. Even had he laboured under an unrealistic belief as to his prospects of showing cause, the applicant should have immediately made such arrangements on and from 12 February 2019. His decision not to do so is further evidence of his deliberate contraventions of the *Regulation*. They add to a picture of the applicant deliberately defying restrictions on his prescribing practices where he believed such restrictions were not required.

[61] The applicant relies upon an email of 17 May 2019 from Mr Steve Flavel, pharmacist, Woody Point Pharmacy, to the applicant. Mr Flavel states:

> I have had many conversations to MRQ and Dr. Bill Loveday with regard to and in support of your situation, particularly with reference to my observation of so many people now who I have observed to now go off the programme and turn back to illicit drugs as a result of your suspension. While some patients may well have taken advantage of your busyness, I firmly believe that patients seeing you benefited enormously from your personal care and attention albeit possibly at the cost of your paperwork.
>
> I personally cannot recall any non-compliance issues with the Poisons and Drugs regulation as with every issue I observed, you provided me with the respect of immediate consultation via phone to correct any outstanding issues. I am aware however of the fact that due to the sensitivity of the nature of the comments you may need to put in a patients file during a consultation, that in doing so has been logistically challenging for you especially due to the relative busyness of your work and the seemingly urgent demands of the next patient preventing you from writing up the necessary patient notes and documentation of your previous consultation. Surely with a minor structural workplace change, these logistical and practical issues could be easily implemented without the need for an ongoing continuance of suspension.
>
> I will put these thoughts in writing as you have my utmost support as a physician and friend.[52]

I accept that Mr Flavel genuinely holds the opinions expressed in his email, based upon such knowledge he has of the applicant's prescribing practices in his role as a prescriber. I have taken his views into account, particularly insofar as they support the applicant's contention that his contraventions of the Regulation occurred in the context of a heavy workload and time constraints.

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50 See T1-91-94.
51 HD 3, page 367 and see T1-94-95.
52 HD 2, Document No 40.

[62] The applicant also relies upon a support letter dated 6 May 2019 from a case manager working for a youth support organisation which refers, amongst other things, supports young people accessing medical treatment. He states:

> In my experience, Dr Ting has been able to provide an exceptional level of care to some of the most difficult cases I work with, bringing expertise while successfully engaging them in the process. Colleagues have relied on Dr Ting over the past year to help provide intervention for transient young people, young mothers and numerous clients seeking treatment for their mental health.
>
> Although I work within a mental health outreach program, it is my personal experience as a patient of Dr Ting that has led me to appreciate his knowledge of pharmacology and desire to see people achieve their best quality of life. Having accessed Dr Ting more than 12 times in the last 18 months, I cannot emphasize enough the important role he has played in allowing me to manage my own mental health symptoms and medications. Dr Ting's background working with drugs of dependence has been invaluable in my treatment and he has been the only health practitioner in the last 17 years who would assist me in reducing my medications safely and gradually removing those of dependence from my life as we searched for appropriate replacements. This was a challenging and difficult process for me, and I have a profound appreciation for his responsiveness and support throughout this time.
>
> I believe Dr Ting provides a unique and important service to the community.

I have taken into account this genuine and eloquent accolade of the applicant. It is consistent with my own conclusion that the applicant genuinely cares for his patients. He meant no harm to his patients by his breaches. Indeed, his regulatory failures seem to stem from his prioritisation of what he believes to be in the best interests of his patients over, and sometimes to the exclusion of, regulatory requirements.

[63] In this regard, the applicant's admitted contraventions of the *Regulation* particularised as grounds 67 and 68 in the notice to show cause and the notice of cancellation provide insight into the applicant's weighing up of what he regards as clinically appropriate for a patient vis-à-vis any regulatory constraint to the contrary. Grounds 67 and 68 related to the applicant's prescription of schedule 8 medications to a drug dependent married couple. The applicant held treatment approvals for both subject to collection conditions that were to be endorsed on all prescriptions, including twice weekly pick up of the medication. Such a condition as to the frequency of collection is directed towards minimising the dose available to the patient at the time of collection for reasons of harm minimisation. The applicant contravened section 122(8) of the *Regulation* by failing to endorse the collection conditions on their prescriptions, thus permitting collection weekly rather than twice weekly as required by the treatment approval. The applicant did so deliberately because of the couple's limited transport and financial resources which would be stressed by the need to travel to the pharmacy twice weekly rather than weekly. He did so despite earlier clear written advice from the respondent to the contrary with respect to the female patient.[53]In material filed in the proceedings, the applicant described that advice as "containing impractical, incorrect, and misrepresenting information on Pain Management issue/comment for [redacted] who has virtually no money for car petrol."[54]

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53 HD 2, Document No 15.

54 HD 2, index details re Document No 15.

[64] The applicant's submissions during the hearing on this issue provided further insight as to his attitude towards regulatory compliance:

> DR TING: So, basically, my argument is, yes, that twice-weekly conditions stated on that was – is a breach. So, if you don't put that on the script, it's a breach. So there was a phone call with – MMU in regarding as to whether that should be relaxed. So, essentially, what I've done in that [indistinct] instead of making it twice weekly, I make it weekly on the clinical grounds that it's a complex patient and there was, you know, financial and transport problems. So the description is that this patient and the wife – what they are telling me is that they have only 5 like 10 or $20 petrol money to get to chemist for [indistinct]
>
> So, in that scenario, I was – my justification for – I guess you can call it "breach of the condition" – instead of twice weekly, I make it weekly is because, look, you have to cater to the patient clinical situation. So it's not a wilful – you know, instead of twice weekly, you make it weekly. It's more to cater them. And the other counter submission to the MMU is that, if the patient needs to be, you know – if you make it weekly and if the patient somehow misbehave or financially got better, then we can always go back to twice weekly. So [indistinct] I call it "evidence best practice" in the sense that, you know, you have to adjust condition. Sure, the condition are for safety of patient, but sometimes you have to cater for the specific situation. So the specific situation in this [indistinct] is financial. Patient are well-behave and so forth. So I – I just want to take that into consideration for that section that I was talking about. So section 122(8) for that counter-argument to the respondent argument.[55]
>
> DR TING: So, basically, this email – look, what Susan Ballantyne is implying, if you read through the email, I think she's – she's saying that twice weekly is safer for the patient which makes sense in the [indistinct] or clinical reasoning. But, if you read through the – the email, is that, you know, I talked to her about this patient and I got support from the pharmacist as well. If you read through the second 5 page – first page, second page, there was correspondence between the pharmacist, Steven Flavel, supporting what we're doing. So what the pharmacist and I were saying is that, you know, this patient situation is such that there is financial difficulty and a lot of complex issue and, in this specific circumstances, there is a rationale for relaxing the – the number of times he had to collect the medication.[56]
>
> DEPUTY PRESIDENT: Okay. So what has happened is you've advocated for the patient, but Dr Ballantyne has said twice weekly.
>
> DR TING: Yes, your Honour.
>
> DEPUTY PRESIDENT: That's a condition of the approval which is later given on the 24th, but you haven't, in fact, written that on the script.
>
> DR TING: Correct, your Honour. I think that's what's happening.
>
> DEPUTY PRESIDENT: And you've done that because you don't agree with Dr Ballantyne.
>
> DR TING: I'm not sure – look, like, your Honour was trying to say whether it's – whether there's an intentional sort of – I don't agree. I can't quite recollect. So, basically, the approval was – I think it's a lead up to the approval basically, I think is the best way to describe it. So there was, you know, discussion between Dr Ballantyne and myself, you know, what to do and so forth. So my advocate was for – instead of twice weekly, it was for weekly, I guess, and then it can be, you know - - -

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55 T2-30:45-T2-31:20

56 T2-32:1-10.

DEPUTY PRESIDENT: But you didn't take the decision for an answer.

DR TING: The person who give the approval – I mean, it's a complex Queensland Health system. So, even though my discussion is with Dr Ballantyne, the approval subsequently meant, if you look – if you manage to hunt it down, is not Dr Ballantyne herself that wrote that approval. I think Margo Hickman would be the person or another person who wrote that approval. So it's quite - - -

DEPUTY PRESIDENT: But the approval was consistent with the opinion that she had expressed - - -

DR TING: Yes. No. I'm not - - -

DEPUTY PRESIDENT: - - - in her email.

DR TING: Sorry?

DEPUTY PRESIDENT: The approval was consistent with the opinion she had expressed. It wasn't inconsistent with it.

DR TING: No. It was consistent with the – yes. The approval was consistent with the opinion that she said.

DEPUTY PRESIDENT: Yes. But you decided you didn't agree. So you do otherwise.

DR TING: Look, you can look at it in that matter, but, look, I – what I'm trying to make a point – you know, whether it's a wilful – what you call "wilful". Look, I do not recall whether – you know, when approval is and so forth. So my rationale of what I'm doing there essentially is that for the patient interest and based on clinical grounds, you know, just to – you know, just the best outcome because the patient can't afford to travel and so forth. So, look, the main point is I agree it's a breach. So, you know, if you don't write twice weekly, like what approval says, it's a definite breach. So I'm not arguing against that, but what I'm advocating is in the clinical manner, sometime – you know, you have to bend the rules, I guess, or, you know, change the condition to suit – suit the patient, basically.[57]

DR TING: Like, the example we give for [redacted], the case that we mentioned about. Look, it's a difficult situation. The chemist and I, we held a meeting about that patient and we decide, "Look, hang on. Sure, the regulation – the – in those conditions say it has to be twice weekly, and so forth." But if the patient doesn't have money sometime you just have to adjust that breach. I mean, the better option in that situation would be, in my opinion – I mean, it's a respectful opinion – you can give a patient some leeway. And I just say weekly collection and not get me into trouble, in the sense that you will breach. But my counter-argument with Dr Ballantyne, or part of it, is, it will not be a breach. So if the endorsement say once a week, if I change that to twice a week for a good reason you wouldn't call that a breach, even though it doesn't strictly, you know, comply exactly as it is.

So if you have a patient, your Honour, and if the endorsements say once a week, okay, and if I decide that you, as a patient, is misbehaving or misusing the drugs, if I change your endorsement to instead of once a week to twice a week, then if Queensland Health discover that issue I'm pretty sure they won't say, "Look, hang on. This is a breach." So sometime endorsement is there to serve that purpose, but sometimes it's also there that the doctor, it's not a given right, but it's – you have – sometime you have to form a judgment and to say, "Look, for this patient it's more beneficial, in one sense, to relax that, or change the condition until perhaps if

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57 T2-33:1-T2-34:10.

> she's got more money and so forth, if she can go to – to the chemist twice a week if she have money for the petrol", and so forth.[58]

[65] Ultimately, the applicant's primary argument was that he now recognised the need for him to comply with the provisions of the *Regulation* and he would do so in the future if his endorsements and registration as a medical practitioner were restored. He expected that any restoration of his registration would involve conditions imposed by AHPRA, including limiting the number of patients he could see in an hour, and that he would not be practising in a similar environment to the one that existed at the time of the contraventions. He would not be attempting to manage a large group of drug dependent patients including patients admitted to the QOTP and he would not be labouring under the same heavy workload and time constraints that led to his contraventions. In those circumstances, the Tribunal could be confident that he was unlikely to contravene the *Regulation* and that he was a suitable person to hold the endorsements.[59]

Consideration

[66] I adopt the following comments by the Board addressed to the applicant in the context of the decision to suspend the applicant's registration as a medical practitioner:

> Controlled drugs and drugs of dependence must be strictly managed and administered. They are dangerous and there is an inherent risk of injury, addiction or death in circumstances where they are prescribed outside of the regulatory regime, ie (the Regulations)
>
> The Regulations are designed to protect public health and safety by regulating and restricting the prescribing of certain substances. The approval system stipulated within the Regulations is intended to enable appropriate treatment with these substances to be co-ordinated and monitored. The purpose of this is to reduce the possibility of adverse events occurring from poly-pharmacy and/or drug interactions, deliberate or accidental misuse or overdose, the risk of trafficking and death. Your circumvention of the Regulations and the system that underpins it therefore puts patients at risk of these serious adverse events.[60]

[67] The number and nature of the contraventions of the *Regulation* by the applicant constitute a serious and sustained failure by the applicant to comply with the regulatory conditions governing his endorsements to prescribe schedule 8 controlled drugs and schedule 4 restricted drugs of dependency. They evidence a repeated and deliberate flouting of those requirements by the applicant.

[68] The magnitude of the contravening conduct by the applicant is such that the Tribunal must examine with care the applicant's assertions that such conduct should be viewed in the particular context in which it occurred and that it is unlikely to be repeated. The Tribunal must consider with care the applicant's assertion that he now realises the importance of regulatory compliance and will comply in the future with the terms of the *Regulation*.

[69] To the contrary, the Tribunal is satisfied that the applicant is likely to contravene the *Regulation* if his endorsements (and registration) are restored. That is because of his attitude to regulatory compliance as evidenced by his past contraventions and in his

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58 T2-67:17-38.
59 T1-113; T2-79-80.
60 HD 6b, page 549, paragraphs 20-21.

conduct of these proceedings. Whilst at times in his submissions the applicant did pay lip service to the importance of regulatory compliance, particular aspects of, and the general tenor of, the applicant's submissions left me with the strong impression that the applicant is, in fact, ambivalent as the need for strict regulatory compliance. He impressed me as a person who lacked insight as to the seriousness of his course of contravening conduct. He is likely to contravene restrictions on his prescribing of schedule 8 controlled drugs and schedule 4 restricted drugs of dependency in circumstances where his clinical assessment of a patient leads him to believe that such limitations are unnecessary.

[70] The applicant would have been better placed to demonstrate development of insight into the need for regulatory compliance had he successfully completed available training as to the management of drug dependent patients and the prescribing of schedule 4 and schedule 8 drugs.[61] The applicant has not done so.

[71] None of the preceding comments are meant to suggest any onus on the applicant in these proceedings to satisfy the Tribunal that the decision under review is wrong or that he is a suitable person to hold the endorsements. Rather, it is for The Tribunal to consider by way of a fresh hearing on the merits whether the applicant's endorsements should be cancelled or suspended pursuant to section 24 of the *Regulation* on one or more of the grounds in section 23 of the *Regulation*. Given the very significant impact upon the applicant of an adverse decision, the Tribunal can only be satisfied that such action should be taken after considering the gravity of those consequences upon the applicant and being satisfied on cogent evidence that nothing less than such action is required to meet the purposes of the legislation.

[72] In deciding whether the applicant is a suitable person to continue to hold endorsements, I have, pursuant to section 15(1) of the *Regulation*, had regard to:

(a) the applicant's knowledge and understanding of his obligations under the *Regulation*: Whilst I am satisfied that the applicant has knowledge and understanding of his obligations under the *Regulation* at such a level that he is aware of the terms of those obligations and understands that failure to observe such obligations amounts to contravention of the *Regulation*, I am not satisfied that the applicant truly understands the importance of complying strictly with the terms of the *Regulation*. The lack of true understanding by the applicant of the importance of regulatory compliance is a factor weighing against his suitability;

(b) the applicant's qualifications and experience: The applicant holds requisite qualifications and registration (albeit currently suspended) as a medical practitioner. I have not regarded the current suspension of the applicant's registration as a medical practitioner as a factor weighing against his suitability. The applicant is an experienced general practitioner. The applicant's qualifications and experience is a factor in favour of his suitability;

(c) the applicant's character and standing, which I consider to be a neutral factor;

(d) the applicant's lack of any previous convictions under the *Health Act* or the *Regulation*, a factor in favour of his suitability;

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61 T2-19:29-35.

(e) whether the applicant has engaged in conduct that risks, or is likely to risk, a controlled drug, a restricted drug or a poison being used for a purpose that is unlawful under a law of a State or the Commonwealth: I find that the number and type of the contraventions by the applicant of the *Regulation* constitutes a course of conduct engaged in by the applicant that risked, or was likely to risk, controlled and restricted drugs being obtained by persons in excess of proper therapeutic amounts and/or frequency, thus risking abuse of those drugs by the persons to whom they were prescribed and/or diversion to others to whom they were not prescribed, and thus risking such drugs being used contrary to applicable legislation, a factor weighing against his suitability.

[73] Having considered those particular matters in section 25(1) of the *Regulation* and having regard to the full picture of the applicant's contraventions of the *Regulation* as revealed by the evidence and submissions, I find that the applicant is not currently a suitable person to hold the endorsements, a ground for the suspension or cancellation of the endorsements pursuant to section 23(b) of the *Regulation*.

[74] It is not in dispute that the applicant has, whilst a holder of endorsements, breached conditions stated in endorsements and contravened provisions of the *Regulation*, thus providing further grounds for the suspension or cancellation of the endorsements pursuant to section 23(d) and (e) of the *Regulation*.

[75] Grounds for the suspension or cancellation of the endorsements have been clearly established. Given my finding that the applicant is likely to contravene the *Regulation* if his endorsements (and registration) are restored, I should exercise the power pursuant to section 24(3)(c) of the *Regulation* to cancel or suspend the endorsements. After having considered all the material before me, I find that the minimum regulatory action required, pursuant to section 24(3)(c) of the *Regulation*, is the cancellation of the applicant's endorsements to prescribe schedule 8 controlled drugs and schedule 4 restricted drugs of dependency. Suspension of the endorsements, rather than cancellation, would not be appropriate. The applicant should not have the endorsements restored unless and until he can demonstrate that he is a suitable person to hold the endorsements. Having considered the grounds for cancellation, as required by section 24(5A) of the Regulation, I consider that a period of two years preclusion from re-applying for the endorsements is appropriate.

[76] The decision of the respondent is confirmed.