Ellis v Medical Board of Australia - [2020] VCAT 862

VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

ADMINISTRATIVE DIVISION

VCAT REFERENCE NO. Z422/2020

REVIEW AND REGULATION LIST

CATCHWORDS

Review and Regulation List - *Health Practitioner Regulation National Law (Victoria) Act 2009* – – immediate action to suspend registration of registered medical practitioner – social media commentary – whether opinions had no proper clinical basis, were contrary to accepted medical practice, or were otherwise untrue or misleading – whether commentary denigrating or demeaning of groups within society - whether reasonable belief that because of conduct practitioner poses serious risk to persons – whether reasonable belief that immediate action necessary – whether reasonable belief that immediate action otherwise in the public interest - appropriate form of immediate action - decision of Board confirmed.

APPLICANT	Dr Michael Ellis
RESPONDENT	Medical Board of Australia
WHERE HELD	55 King Street, Melbourne
BEFORE	J Billings, Senior member
	Dr P Molloy, Member

Dr L Warfe OAM, Member

HEARING TYPE	Hearing via video conference
DATE OF HEARING	1 July 2020
DATE OF ORDER	10 August 2020
CITATION	Ellis v Medical Board of Australia (Review and Regulation) [2020] VCAT 862

ORDER

Under section 202(1)(a) of the *Health Practitioner Regulation National Law (Victoria) Act 2009* the Tribunal confirms the decision of the respondent dated 2020.

J Billings **Senior Member**	**Dr P Molloy** **Member**	**Dr L Warfe OAM** **Member**

APPEARANCES:

For Applicant	Dr P Halley of counsel
For Respondent	Mr B Jellis of counsel.

NOTE: Orders under the *Open Courts Act 2013* are in force.

On 27 July 2020 the Tribunal made the following order under the *Open Courts Act 2013* :

1. Any report of the whole or part of these proceedings or information derived from this proceeding that might enable the notifier or the respondent's witnesses or their family members to be identified must not be published or otherwise disclosed.

2. This order applies throughout Australia on the basis that the Tribunal's reasons for decision for final orders are published on AustLII and that website may be accessed throughout Australia. The privacy of the notifier and witnesses would be breached if persons living outside Victoria know or come to know their identity or that of members of their families.

3. This order operates until the later of the death of all of the relevant notifier and the witnesses.

REASONS

1. This case concerns immediate action taken by the Medical Board of Australia (**the Board**) to suspend the registration of the applicant, Dr Michael Ellis.

2. The decision to suspend Dr Ellis' registration was made on 29 May 2020.

3. Section 156(1)(a) of the *Health Practitioner Regulation National Law (Victoria) Act 2009* (**the National Law**), set out below, relevantly provides that a National Board may take immediate action in relation to a registered health practitioner if it reasonably believes that because of his or her conduct the practitioner poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety. Section 156(1)(e) relevantly provides that a National Board may take immediate action if it reasonably believes the action is otherwise in the public interest. Section 155 defines "immediate action" as the suspension, or imposition of a condition on, the health practitioner's registration, or accepting an undertaking from the health practitioner, among other things.

4. Dr Ellis has appealed to VCAT under section 199 of the National Law .

5. Dr Ellis is aged 76 years. He obtained a Bachelor of Medicine and Bachelor of Surgery from the University of London in 1967. He later became a member of the Royal College of Physicians and a member of the Royal College of Surgeons. He holds further medical and non-medical qualifications. Dr Ellis practised medicine in Australia and the United Kingdom during the 1980s. Since 1990 he has practised full time in Australia. Information that Dr Ellis provided to the Board indicates that he has specialised in Balint Psychology, which he describes as being based on the psychological dynamic between the doctor, the patient and the illness. According to his online biography, Dr Ellis is an Integrative Physician, Futurist, and Peace Worker. He has founded or otherwise been involved in several organisations dedicated to world peace and other causes.

6. The Board received a notification concerning Dr Ellis in November 2019. The notification, made by the practice manager of the clinic in Melbourne where Dr Ellis was working at the time, concerned various matters. The notification prompted an investigation into Dr Ellis' use of social media. The investigation revealed material that Dr Ellis posted to Facebook pages that he set up, being his personal Facebook page and four Facebook pages of entities that he established or represented. (For convenience, we generally refer to Dr Ellis' "posts" though note that many posts were actually "re-posts" of material created by other persons).

7. On 20 May 2020 AHPRA issued a notice of proposed immediate action. The notice included extracts of Dr Ellis' social media commentary dating from August 2017 to April 2020 (**the 56 posts**). The 56 posts contain information and opinions about vaccines, chemotherapy, COVID-19 and other medical topics, and opinions about certain religious and other groups.

8. In response to the notice, Dr Ellis offered an undertaking essentially that he would close his social media accounts; that he would not reopen any of the accounts or post on any social media forum until finalisation of AHPRA's investigation or determination by the Board; and that he would make all efforts to delete his social media commentary. Dr Ellis now declares that he has done those things.

9. Written and oral submissions were made by or on behalf of Dr Ellis to the Board.

10. Dr Ellis gave oral evidence to the Tribunal. The parties made oral and written submissions.

Medical practitioners and social media

11. Before we consider Dr Ellis' social media commentary, we make these important points.

12. We are not required to consider the right to freedom of expression that all citizens enjoy. The right to freedom of expression is in any event not unlimited [1] . Similarly, this case does not concern academic freedom. Rather, the case concerns a registered health practitioner's particular use of social media.

---

[1] For instance, see s. 15 of the Victorian *Charter of Human Rights and Responsibilities Act 2006* which provides that special duties and responsibilities are attached to the right to freedom of expression and the right may be subject to lawful restrictions reasonably necessary to respect the rights and reputation of other persons or for the protection of public health, among other matters.

---

13. Registered medical practitioners have special obligations. *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014) (**the Code**) includes the following statement at 1.4 - Professional values and qualities of doctors:

> While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice. Doctors have a

duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy. *Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion.* Patients also rely on their doctors to protect their confidentiality. *Doctors have a responsibility to protect and promote the health of individuals and the community.* Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. *This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.* Good communication underpins every aspect of good medical practice. Professionalism embodies all the qualities described here, and includes self-awareness and self-reflection. Doctors are expected to reflect regularly on whether they are practising effectively, on what is happening in their relationships with patients and colleagues, and on their own health and wellbeing. They have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgement as they gain experience, and contribute to their profession. (Emphasis added)

14. Guidelines issued in November 2019 entitled *Social media: How to meet your obligations under the National Law* (**the Social Media Guidelines**) note that the inappropriate use of social media can result in harm to patients and to the profession. The Social Media Guidelines further note that information stays on social media indefinitely – that it is often impossible to remove or change and it can be circulated widely, easily and rapidly. In a section about "common pitfalls" the Social Media Guidelines advise that National Boards may consider social media use in a practitioner's private life (even where there is no identifiable link to the person as a registered health practitioner) if it raises concern about the practitioner's fitness to hold registration. There is this warning: "While you may think you are engaging in social media in a private capacity because you do not state you are a registered practitioner, it is relatively easy and simply for anyone to check your status through the register, or make connections using available pieces of information".

15. The Social Media Guidelines give examples of when social media activity could trigger someone making a notification about a registered practitioner:

Public health messages

While you may hold personal beliefs about the efficacy or safety of some public health initiatives, you must make sure that any comments you make on social media are consistent with the codes, standards and guidelines of your profession and do not contradict or counter public health campaigns or messaging. A registered health practitioner who makes comments, endorses or shares information which contradicts the best available scientific evidence may give legitimacy to false health-related information and breach their professional responsibilities. Practitioners need to take care when commenting, sharing or 'liking' such content if not supported by best available scientific evidence.

- and -

Cultural awareness, safety and practitioner and patient beliefs – social and clinical

As a registered health practitioner, your views on clinical issues are influential. Comments in social media that reflect or promote personal views about social and clinical issues might impact on someone's sense of cultural safety or could lead to a patient/client feeling judged, intimidated or embarrassed.

Evidence regarding Dr Ellis' conduct

16. There is no controversy that years ago Dr Ellis set up and began to administer various Facebook pages. One was his personal Facebook page. Other pages were in the names of entities that he established or otherwise represented. The Tribunal Book includes over 200 pages containing screen shots of more than 140 posts to the Facebook pages. The 56 posts do not represent the whole of Dr Ellis' relevant social media commentary: they were described by counsel for the Board as the "most critical" ones. Some of the 56 posts were made to more than one of the Facebook pages.

17. Dr Ellis told AHPRA in February 2020 that 75 of his friends had access to his personal Facebook page. A screen shot of an October 2019 post to one of the other Facebook pages, that was focussed on at the hearing, includes the information that "11,500 people like this" and "11,521 people follow this". (We record later on what Dr Ellis has said about that information).

18. Counsel for the Board placed the posts into two broad categories – "Medical Statements" and "Vilification Statements".

19. Within the category of Medical Statements there were expressions of essentially moral views (about abortion, for instance[2]) as opposed to expressions of strictly medical opinion (for instance, about the safety and efficacy of vaccines). We clarified that counsel intended "vilification" to have its ordinary meaning as opposed to the meaning given in the *Racial and Religious Tolerance Act 2001* [3] . Dr Ellis' position, plainly, is that he would never vilify anyone. We consider later whether his commentary was, on the other hand, denigrating or demeaning.

---

[2] For example, on this subject, Dr Ellis said in response to a question by his counsel that his use of the expression "murder" was inappropriate and that was used "in a moment of time" in response to media reports about late term abortion in New Zealand.

[3] Section 8 of the *Racial and Religious Tolerance Act 2001* (headed **Religious vilification unlawful**) prohibits a person, on the grounds of the religious belief or activity of another person or class of persons, from engaging in conduct that incites hatred against, serious contempt for, or revulsion or severe ridicule of, that other person or class of persons.

---

20. It is convenient for us to put the commentary into two categories, but we will instead refer to "Medical Statements" and "Social Statements".

21. In the notice of proposed immediate action, AHPRA described the 56 posts. It described posts 1-38 as commentary expressing and encouraging views regarding vaccination, chemotherapy, and treatment for COVID-19 and other health topics that have no proper clinical basis and/or are contrary to accepted medical practice and/or are otherwise untrue or misleading[4]. It described posts 39-45 as statements that are denigrating and demeaning to the LGBTQI community. It described posts 46-48 as "anti-abortion sentiments". It described posts 49-56 as denigrating and/or demeaning and/or broadly critical of the religion of Islam and that specifically call for the end to migration to Australia by Muslims.

---

[4] Given, especially, the concessions that Dr Ellis made in his oral evidence, we do not refer in detail to the literature relating to "accepted medical practice". We note that the Board's immediate action decision referred especially to information published by the World Health Organisation, the US Center for Disease Control, and the Australian Department of Health.

---

22. For the purpose of our decision it will be sufficient to refer specifically to a sample of the Medical Statements and the Social Statements.

Dr Ellis' response and evidence in support

23. Dr Ellis' lawyers submitted a response to AHPRA's notice of proposed immediate action. The response, dated 26 May 2020, included the offer of undertaking we have mentioned. There was also an undated statement by Dr Ellis. Dr Ellis' statement included the following:

> I was horrified and shocked to see the information provided by AHPRA. When presented in this way I realise I should never have posted the information on Facebook. At the time the posts were made they were topical and provided current views that were being brought forward at the time for debate. Mainly I was re-posting information sent to me and (sic) was commonly posted by others. I never saw myself as an influential person, influencing potential patients/the public at large. The posts did not reflect my personal views; just what was topical at the time and in no way whatsoever influenced my medical practice …
>
> As soon as I read the AHPRA report I immediately closed down all of my Facebook pages and my own personal Facebook page …
>
> I am extremely sorry and deeply ashamed to have unwittingly been a threat to the public. I deeply regret this. If necessary, I am willing to make a public apology.

24. Dr Ellis went on to say that he had never refused to give vaccinations or gone against a patient's wish for termination of pregnancy. He said that he never influenced a cancer patient's treatment but always referred the patient to an oncologist. He said that he prescribed pharmaceuticals as appropriate. He said that he was not against the LGBTQI or Muslim communities and that, among other things, he had friends within those groups. Regarding

COVID-19, Dr Ellis said that he had never treated a patient with the disease. He made special mention of correspondence he initiated with the Royal Australian College of General Practitioners (**RACGP**) on the topic: see below. Dr Ellis said he now realised he should never "have been party to" the use of social media. He said that he had never meant to do any harm. He said that, having read the Code, he viewed his actions differently. He reiterated that in no way had his practice of medicine been influenced by any material that he posted and that his personal opinions were "always open to the latest scientific evidence". He said he always followed the Board's Guidelines and health information provided by the Australian Government and the RACGP.

25. The immediate action decision records submissions made orally by or on behalf of Dr Ellis on 28 May 2020. The main further points that Dr Ellis made were these. He was brought up before the time that social media came into existence and was somewhat naïve about it: he did not know the material he posted was so accessible. He did not want to be part of the controversy. Social media was no longer what it should be. Dr Ellis proposed completing education modules to update himself on vaccination and disease prevention. He said he was contrite. The decision also records that, in response to a question from the Board about "why he felt compelled to post such views if he did not hold those views", Dr Ellis said that he was posting information without realising the effect it would have.

Dr Ellis' oral evidence to the Tribunal

26. In cross-examination, Dr Ellis acknowledged that he intended the material he posted to be read, and that the people who read it (who could be doctors or general members of the public) might be influenced by it.

27. Dr Ellis acknowledged several times during the hearing that he had used language on the Facebook pages that was "inappropriate". He apologised for that. He described his language as sometimes being "too passionate", "too emotional", "excessive", "extreme", "momentary", "exclamatory" or "explosive". Under cross-examination, Dr Ellis conceded that there were posts that were themselves "inappropriate". He apologised for that too, although not unqualifiedly.

28. We give some examples, relating to Medical Statements, that emerged during cross-examination. These examples refer to posts not on Dr Ellis' personal Facebook page but on one or more of the other pages.

29. One post begins with the heading or introduction "Something is rotten in the state of Denmark. A line from the play Hamlet". There follow photographs and information about an infant who was said to have died within hours of being vaccinated. The material indicates that doctors considered it to be a case of SIDS, but the mother said the death was caused by the vaccine. Dr Ellis did not agree with counsel for the Board that by posting the material he promoted the view that the child was killed by the vaccine. He said we had to find out the cause of death. It was put to him that the post suggests that the vaccine was the cause. He responded by saying "maybe, but there might be other causes as well". When it was then put to him that his post did not refer to any other (possible) cause, Dr Ellis said his purpose was to have a discussion, though he remarked in effect that Facebook does not really enable discussion.

30. Dr Ellis was asked by counsel about an article he re-posted below a heading or introduction that he added - "PROOF OF THE TOXICITY OF VACCINES!!!!". The article claimed that aluminium in vaccines was having "crippling neurological consequences". Dr Ellis agreed that it was "wholly inappropriate" for a medical practitioner (whether identified as a medical practitioner or not) to publish a public health message that could leave a member of the general public "terrified" by the thought of vaccination for them or their child. But he said he would not have done that if he knew the message would be linked to him as a medical practitioner. He said it was not the kind of thing a doctor should say, and he regretted it.

31. Dr Ellis was also asked about his re-post of an article that referred, with implied approval, to the British physician, Dr Andrew Wakefield, who linked the MMR vaccine to autism but who, among other things, was sanctioned by the General Medical Council for dishonesty in his research. Dr Ellis acknowledged that he did not refer to that context when he re-posted the article, even though he was aware of Dr Wakefield's history. Dr Ellis said he was quoting someone else's article. He said the article was not his "viewpoint". He said that he could not censor or "black out" everything people said. Dr Ellis also said, however, that he realised it was inappropriate and he apologised.

32. There was a re-posted article that asserted that the concept of compulsory vaccination had "national socialist roots … that spring from the same 'master race' that led the Nazis to embrace eugenics … and dysgenics …" Dr Ellis said that it was not his comment and he didn' t agree with it. He acknowledged that he did not say on the Facebook page that he disagreed with the comment; he said his purpose of re-posting it was for there to be a discussion. In relation to the re-post of a "Leaked Pentagon Video" suggesting there existed a vaccine designed to modify people's behaviour, Dr Ellis accepted that the view expressed there was a "fringe view", but he then asked: "Can't we let people decide?" Concerning the posting of a YouTube video by the so-called "conspiracy theorist" David Icke (a commentator who, according to media reports, has been banned from entering Australia), Dr Ellis stated that he posted the material only because of "freedom of information". He said he was not trying to convince anyone. He added that he did not suppose that many people would actually view the video. Counsel put to Dr Ellis that a registered medical practitioner encouraging people to learn about vaccines should not be referring the general public to David Icke. Dr Ellis agreed with that proposition, but he said in effect that this was not his personal page and that, if he had known that the page was seen as being connected to him as a doctor, he would never have posted the material. Counsel put to Dr Ellis that a responsible physician should have grave concerns about referring the public to David Icke. Dr Ellis' response was to say that the public has the right to decide - that is "freedom of information".

33. There was a post, dated 30 January 2020, that was evidently about vitamin C and COVID-19. It spoke of "universal agreement amongst [d]octors practising functional or integrative medicine that [v]itamin C is of tremendous value in preventing and curing [viral] illnesses". The post included a suggested protocol for taking vitamins and minerals "to prevent or [minimise] symptoms for future viral infection". Dr Ellis agreed with counsel that it was possible that a reader who was not medically qualified might come across the post and decide they should follow the protocol.

34. There were further posts concerning vitamin C and COVID-19. A post made on 2 March 2020 to another Facebook page contained what Dr Ellis said was another person's statement that vitamin C is "very effective at killing the [corona]virus – and boosting the immune system". Dr Ellis acknowledged that the statement appeared without any qualification: he said that the statement did not really express what was contained in the literature attached to the posts. He acknowledged that there was not enough evidence to show that vitamin C kills coronavirus if taken orally, but he maintained there was evidence of its success in treating coronavirus in Shanghai and Wuhan when given intravenously. The March 2020 post includes this statement:

> News media attacks on vitamin C are centered (sic) on false allegations of dangers with megadoses. This tactic lets the media ignore the truth that even LOW doses of vitamin C reduce symptoms and death rates. Do not let the media spin this issue. Advocates of vitamin C are medical doctors, not spin doctors. They are experienced, credentialed clinicians who have read the science …

35. Dr Ellis agreed that the reference to "LOW dose" was not a reference to intravenous infusions of vitamin C. When it was put to him that there was "absolutely no evidence base" for the suggestion that vitamin C is very effective in killing coronavirus, Dr Ellis said he did not all have all the information available. He pointed to the large number of references included in the post about vitamin C. He said vitamin C had been used for 50-60 years. While saying he wasn't sure about the matter, he said he believed that vitamin C had been imported to China, particularly to Wuhan, in huge numbers of oral doses, but he also said that he didn't have information as to whether it was used in Wuhan at the time.

36. Counsel for the Board put to Dr Ellis that it was "grossly inappropriate" for a registered medical practitioner to be publishing the unqualified statement that vitamin C is very effective at killing the virus. Dr Ellis' response was to say it was not his post and that, if he had read it more carefully, he would not have used the statement. When counsel immediately noted that the statement appeared in the first sentence, Dr Ellis said he apologised and that there was not sufficient evidence to make the statement, but he maintained that there was a lot of evidence to suggest that vitamin C had been very effective for 50-60 years for use with viral illnesses. He remarked that COVID-19 was a new disease, so one couldn't say the same thing about COVID-19. He referred to the recent public discussion about the effect of certain antimalarial drugs on COVID-19. Dr Ellis said that "presumably" vitamin C "could be an effective use" or at least it would boost the immune system, which everyone needs. He said that the statement was an interesting comment that called for discussion and dialogue.

37. Dr Ellis agreed with counsel that what he said in response to these last questions was more qualified and nuanced than what appeared in the post. He agreed too that the protocol for the use of vitamins and minerals was not tailored to the needs of any individual patient. And he agreed that a risk of publishing suggested protocols to the world at large was that a member of the public might think it was a good idea to follow the protocols without seeking medical advice. Here Dr Ellis said that he believed such things should be done on medical advice. He said that was the reason he took the pages down - because he realised the information could be misunderstood. Dr Ellis said he was regretful and sorry. He did not agree that in posting the material he had suggested that people should follow the protocol. He said he thought that discussion with a doctor was required before a person followed the protocol. He added that he

was not the only person publishing the information and that other people were doing that too, though he immediately acknowledged that this did not justify him as a doctor publishing the information. In this context Dr Ellis remarked that a lot of people were taking vitamin C without obtaining medical advice.

38. Dr Ellis acknowledged that nowhere in the post did he suggest that someone consult a registered medical practitioner about these topics. Counsel then put to Dr Ellis that if a patient had attended him around this time and asked about COVID-19 he would have said that vitamin C is very effective at killing the virus. Dr Ellis said that "not in a million years" would he say that. Asked, then, why he would he would publish the view to the public at large but not share the "insight" with patients who consulted him, Dr Ellis said in effect that it was a mistake: the statement should have not been expressed the way it was as vitamin C was effective only when given intravenously.

39. We have mentioned correspondence about COVID-19 that Dr Ellis initiated with the RACGP. The correspondence took place in April 2020. On 22 April 2020 Dr Ellis sent the RACGP an email in which he sought its advice about him recommending the use of vitamin C in his General Practice as a supplement that may "cure, prevent or ameliorate influenza or covid 19 (sic)". (In the course of the email Dr Ellis made a similar inquiry about vitamin D). The email stated that patients had been asking him for his opinion. Dr Ellis noted that vitamin C had been given intravenously to treat Covid-19 patients in Wuhan, Shanghai and New York. He enclosed information that he said a patient had given him. (The information was substantially the same as the information referred to in the January and March 2020 posts, including the protocol for the use of vitamins and minerals). The email included this statement: "We all know that there is no evidence that vitamin C will work on SARS-Cov-2 because it's a new virus". But that statement was soon followed with a statement that reports from Chinese and American hospitals were confirming that intravenous vitamin C was effective in treating Covid-19 induced Acute Respiratory Distress Syndrome.

40. On 24 April 2020 there was an email in reply on behalf of RACGP. The material parts read:

> Unfortunately, we are not in a position to recommend specific protocols and processes of this nature. Clinicians retain autonomy in their treatment of patients, and you are encouraged to continue in your usual practice.
>
> The RACGP supports the use of interventions with a strong evidence base, and in the case of COVID-19 this is an evolving science. We will continue to discuss viable, evidence-based options for the assessment and treatment of COVID-19 with the Federal Government and Chief Medical Officer as appropriate.

41. Counsel for the Board questioned Dr Ellis about this correspondence. Dr Ellis did not agree that the RACGP position was that there was no evidence to support the use of vitamin C for COVID-19. He said the RACGP did not "negate it". He said that the RACGP did not point to any evidence whatsoever. Dr Ellis acknowledged that he did not remove his posts between the time he received the RACGP's response in April and the time he received the Board's notice of proposed immediate action in May.

42. Further on the point as to whether people who visited the Facebook pages (other than Dr Ellis' personal Facebook page) would realise that the posts were made by a medical practitioner, Dr Ellis agreed that some of them would be people who came to know him through his global

peace movement, so some would know that he is a medical practitioner. At the same time, he said that not all of the people visiting the sites - "very few", he said - would have known that he was associated with the sites. He said he wanted to keep his identity secret. He said that was why he was shocked when AHPRA referred the posts to him for his response. Dr Ellis remarked that he received scant responses to the posts, and he said that the people who followed the pages had their own ideas. On the other hand, earlier during cross-examination Dr Ellis acknowledged that in a screen shot of a post made in January 2020 he "signed off" as Dr Michael Ellis and so (from that and from the context) he identified himself as a medical practitioner.

43. Regarding the information that one of the pages had 11,500 "likes", Dr Ellis said that it did not mean that those people had subscribed or that they were viewing the page at the time. As to the 11,521 followers, he said that it indicated that people said they were followers, but it did not necessarily mean that they followed the page: one would have to look at the statistics to see who was viewing the page on the day, and one would find there were very few people actually looking at the page. Dr Ellis stated, further, that he was not sure whether it was likely that Facebook would make the page appear in the "news feed" of a person who opted to be a follower.

44. Dr Ellis was questioned about the statement he made to the Board that the posts did not reflect his personal views. He acknowledged that what he said to the Board was inaccurate. Dr Ellis added, though, that he thought he was in a "complete and utter state of shock" at the time he received the notice of proposed immediate action and the screen shots. He also said that he had only a few days to respond. He said he was not thinking "correctly" at the time. Since then he had had time to reflect.

45. Dr Ellis told the Tribunal that the posts were his "viewpoints at the time" but they were not his "beliefs". He made the comment that evidence about vaccines was moving "back and forth all the time" and that there were pros and cons about them. (At the conclusion of his oral evidence we invited Dr Ellis to say more about whether his views had changed, and how: see further below). Dr Ellis stressed that he gave vaccinations in his clinical practice. Earlier in giving oral evidence, Dr Ellis said that when he posted material, he was not trying to influence people so much as to get them to think. He also said that a lot of people who access Facebook already have their own ideas and that Facebook is not a good forum for discussion.

46. Dr Ellis was questioned further by counsel for the Board about the Medical Statements and the Social Statements. We will refer to the most important points when we evaluate Dr Ellis' evidence. We mention here that Dr Ellis made general assertions about his social media commentary. One was that the statements relied on were a concentration of particular statements that did not present the whole picture of his social media commentary. Another point was to the effect that when he used social media, he just got caught up in the intemperate language that many people use there.

47. We also mention that in a post made in December 2019 Dr Ellis stated that Facebook had prohibited him from "printing" his Facebook page as it had "repeatedly posted content that has been disputed by third party fact checkers". As already noted, Dr Ellis continued to post material after that time. Elsewhere there appeared a post to similar effect - that YouTube had

removed a video on the grounds that it "violated their community standards". Dr Ellis however told the Tribunal in effect that he did not have his own YouTube videos and that the statement was made by the person to whose video it was that he had given a link to.

The Law

48. Section 156(1) of the National Law relevantly provides:

> **156 Power to take immediate action**
>
> (1) A National Board may take immediate action in relation to a registered health practitioner or student registered in a health profession for which the Board is established if—
>
> (a) the National Board reasonably believes that—
>
> (i) because of the registered health practitioner's conduct, performance or health, the practitioner poses a serious risk to persons; and
>
> (ii) it is necessary to take immediate action to protect public health or safety …
>
> (e) the National Board reasonably believes the action is otherwise in the public interest.
>
> *Example of when action may be taken in the public interest –*
>
> A registered health practitioner is charged with a serious criminal offence, unrelated to the practitioner's practice, for which immediate action is required to be taken to maintain public confidence in the provision of services by health practitioners.

49. In *Kozanoglu v Pharmacy Board of Australia* [2012] VSCA 295 at [95] ff the Victorian Court of Appeal made important observations about appeals against decisions to take immediate action:

> 119 … The appeal to a responsible tribunal under the National Law is neither an appeal in the strict sense, nor a rehearing de novo. It is rather a hybrid, whereby the material to be considered is confined to that placed before the initial decision-maker, but with the opportunity available to both parties to present additional evidence which bears directly upon that decision as originally taken. It is not 'open slather', but nor is it an appeal confined to error …
>
> 126 The IAC [Immediate Action Committee of the Board] will generally be required to make quick decisions on the basis of limited information. When full information is later obtained, a belief which, on the limited information was reasonably based, may be shown to have been in error. Accordingly, the IAC and the Board must always be conscious of the possibility of error. The consequences of that error may be serious. Two safeguards against such consequences should therefore be kept to the forefront. The first is the importance of a timely referral to a panel, or to VCAT. The second is that, while the safety of the public

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

50. **Following paragraph cited by:**

Medical Board of Australia v Sami (25 February 2022) (Cavanough J)

54. Thereafter, under the heading 'The legal context', VCAT sets out lengthy passages from the written submissions of the Board. [87] VCAT does not, at this point, express or foreshadow any intention not to accept any part or parts of the passages about to be set out.[88] The passages quoted by VCAT include, first, the salient provisions of s 155 and 156 of the National Law . They include, next, the following parts of s 3 of the National Law , being the only parts thereof that the Board had cited:

> (2) The objectives of the national registration and accreditation scheme are—
>
> > (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; …
>
> (3) The guiding principles of the national registration and accreditation scheme are as follows—
>
> > …
> >
> > (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The next part of VCAT's quotation from the Board's written submissions reproduces the next heading contained in those submissions, namely 'The applicable principles', and it reproduces all of the paragraphs that had appeared under that heading. Those paragraphs had commenced as follows:

> Section 156 of the National Law empowers the Board to take immediate action against a medical practitioner. Immediate action is 'designed to operate for an interim period, until an investigation or disciplinary proceeding with respect to the medical practitioner is able to be concluded'. [89] The purpose of that action is 'to put measures in place to protect against, or ameliorate, harm pending the determination' of that process. [90]

The succeeding paragraphs of the Board's written submissions to VCAT, as quoted by VCAT, were headed 'Section 156(1)(a)'. Omitting paragraph and subparagraph numbers, they read as follows:

> The power to take immediate action under section 156(1)(a) is only enlivened if the Board (or the Tribunal on review) has formed a reasonable belief that:

- because of the practitioner's conduct, performance or health;
- the practitioner poses a serious risk to persons; and
- immediate action is necessary to protect public health or safety.

The first of these matters is a factual one; the remaining two are evaluative. [91] All three matters, however, require the formation of a 'reasonable belief'. [92]

- A reasonable belief 'does not require proof of conduct' but rather 'an inclination of the mind toward assenting to, rather than rejecting, a proposition'. [93]
- 'The underlying facts giving rise to the reasonable belief… do not have to be established on the balance of probabilities, however there must be proven objective circumstances sufficient to justify the belief.' [94] In this regard, the VCAT has said this about decisions made under s 156(1)(a): [95]

> In *WD v Medical Board of Australia* [2013] QCAT 614 Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:
>
> 1. an immediate action order does not entail a detailed enquiry;
> 2. it requires action on an urgent basis because of the need to protect public health and safety;
> 3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;
> 4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
> 5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;
> 6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;
> 7. a complaint that is trivial or misconceived on its face will clearly not be given weight;
> 8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

- The Tribunal has regarded the following description—as to when it might hold the requisite reasonable belief—as 'uncontroversial': [96]

> I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons.

Three more points may be made about section 156(1)(a).

First, in determining whether it holds a reasonable belief that—because of the practitioner's conduct, performance or health—the practitioner poses a serious risk to persons, the Board (and the Tribunal on review) should consider these questions:

- what serious risk does the practitioner pose (in short: 'serious risk of what')?; and
- to whom does the practitioner pose that serious risk (in short: 'serious risk to whom')? [97]

Approaching the matter in this way greatly assists the Board (and the Tribunal on review) to determine whether it holds a reasonable belief that it is necessary to take immediate action, and what form that immediate action should take.

Secondly, whilst the safety of the public must be the 'prime concern' under section 156(1)(a), that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. [98]

And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [99]

via

[91] Citing *Bernadt* [66]; *Ahmad v Medical Board of Australia* [2017] VCAT 1646, [71] and *Ellis v Medical Board of Australia* [2020] VCAT 862, [50] ('*Ellis*').

Sami v Medical Board of Australia (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

28. The first of these matters is a factual one; the remaining two are evaluative. [6] All three matters, however, require the formation of a "reasonable belief".

via

[6] *Bernadt v Medical Board of Australia* [2013] WASCA 259 at [66] , *Ahmad v Medical Board of Australia* [2017] VCAT 1646 at [71] , *Ellis v Medical Board of Australia* [2020] VCAT 862 (" ***Ellis*** ") at [50] .

Sami v Medical Board of Australia (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

50. As noted in *Bernadt*, the first step in the s 156(1)(a) analysis involves the consideration of a factual question. [24] In that case, the president of the Western Australian Supreme Court of Appeal said:

> 66 The 'reasonable belief' requirement applies, in my view, to the three components, including the factual substratum ((i)(1)) on which the evaluative assessments (in (i)(2) and (ii)) are to be made. That being so, the fact or facts directly in issue concerning a practitioner's conduct, performance or health do not have to be proven on the balance of probabilities … However, there must be proven objective circumstances sufficient to justify the belief.

via

[24] *Bernadt v Medical Board of Australia* [2013] WASCA 259 at [66] , *Ahmad v Medical Board of Australia* [2017] VCAT 1646 at [71] , *Ellis v Medical Board of Australia* [2020] VCAT 862 (" ***Ellis*** ") at [50] .

Concerning the notion of reasonable belief in s. 156(1)(a) , in *Bernadt v Medical Board of Australia* [2013] WASCA 259 McClure P stated:

> 65 It is necessary to identify with precision what it is that must be the subject of the reasonable belief. There are three components in subpars (i) and (ii) of s 156(1)(a) , one factual and two evaluative. They are:
>
> (i) (1) because of (that is, by reason of) the practitioner's conduct, performance or health
>
> (2) the practitioner poses a serious risk to persons; and
>
> (ii) it is necessary to take immediate action to protect public health or safety.
>
> 66 The 'reasonable belief' requirement applies, in my view, to the three components, including the factual substratum ((i)(1)) on which the evaluative assessments (in (i)(2) and (ii)) are to be made. That being so, the fact or facts directly in issue concerning a practitioner's conduct, performance or health do not have to be proven on the balance of probabilities … However, there must be proven objective circumstances sufficient to justify the belief.

51. His Honour cited *George v Rockett* [1990] HCA 26. *George v Rockett* concerned the power to issue a search warrant. The High Court of Australia observed that when a statute prescribes that there must be "reasonable grounds" for a state of mind - including suspicion and belief - it requires the existence of facts which are sufficient to induce that state of mind in a reasonable person: at [8] . The High Court went on to say, at [14]:

> The objective circumstances sufficient to show a reason to believe something need to point more clearly to the subject matter of the belief, but that is not to say that the objective circumstances must establish on the balance of probabilities that the subject matter in fact occurred or exists: the assent of belief is given on more slender evidence than proof. Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture.

52. In a more recent case that concerned immediate action taken under the National Law , *Syme v Medical Board of Australia* [2016] VCAT 2150, at [34]-[36] , VCAT summarised the relevant principles in this way:

> 34. The facts do not need to be proved on the balance of probabilities but there must be proven objective circumstances sufficient to justify the belief.
>
> 35. In *WD v Medical Board of Australia* [[2013] QCAT 614 at [8]] Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:
>
> 1. an immediate action order does not entail a detailed enquiry;
>
> 2. it requires action on an urgent basis because of the need to protect public health and safety;
>
> 3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;
>
> 4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
>
> 5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;
>
> 6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;
>
> 7. a complaint that is trivial or misconceived on its face will clearly not be given weight;

8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

36. In *Oglesby v Nursing & Midwifery Board of Australia* [[2014] QCAT 701 at [20]] Horneman-Wren J elaborated as follows:

> [20] ... I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. **In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons**. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons. [Emphasis added]

53. The cases mentioned so far were decided before s. 156(1)(e) of the National Law came into effect in early 2018: see generally *Farshchi v Medical Board of Australia* [2018] VCAT 1619. In *Farshchi* the health practitioner had been charged with serious criminal offences and VCAT considered s. 156(1)(e) .

54. Niall JA noted in *Medical Board of Australia v Liang Joo Leow* [2019] VSC 532 at [74] that the Board "may take immediate action under s 156(1)(e) where it reasonably believes the action is 'otherwise in the public interest'". His Honour continued:

> The word 'otherwise' indicates that this sub-section provides an additional and alternative source of power that is available where none of the other specific circumstances has been established. The subject matter of the relevant belief is whether the taking of immediate action is in the public interest …

55. The "public interest" has been described by the Victorian Court of Appeal as "a protean concept": *Medical Practitioners Board of Victoria v Lal* [2009] VSCA 109 at [56] . The Court went on to say that "[w]hat is relevant to the public interest depends on the statutory context in which the concept is used. Its content cannot be confined by reference to any predetermined generic criteria …" In the preceding year, in *East Melbourne Group Inc v Minister for Planning* [2008] VSCA 217 at [126] , citing *Sullivan v Farrer* (1989) 168 CLR 210, 216, Warren CJ said this:

> … The expression 'in the public interest' in a statute has been interpreted as importing a discretionary value judgment to be made by reference to undefined factual matters, confined only 'in so far as the subject matter and the scope and purpose of the statutory enactments may enable ... given reasons to be [pronounced] definitely extraneous to any objects the legislature could have had in view'

56. In *Farshchi* VCAT referred to the legislative history of s. 156(1)(e) , noted relevant provisions of the National Law relating to interpretation, and quoted the Explanatory Memorandum and Second Reading speech [5] .

[5] Clauses 8 and 10 of Schedule 7. As the decision in *Farshchi* records, the Explanatory Memorandum states at page 13 :

57. Section 156(1)(e) contains the *Example of when action may be taken in the public interest* set out above. The National Law provides that an example is not exhaustive; it does not limit, but may extend, the meaning of the provision; and the example and the provision are to be read in the context of each other and the other provisions of the National Law , but, if the example and the provision so read are inconsistent, the provision prevails. The National Law permits reference being made to the Explanatory Memorandum and Second Reading Speech, for instance to confirm the interpretation conveyed by the ordinary meaning of the provision: see also *CJE v Medical Board of Australia* [2019] VCAT 178.

58. **Following paragraph cited by:**

du Toit v Health Ombudsman (15 November 2023) (Judicial Member J Dick SC, Assisted by:, Professor D Ellwood AO, Medical Practitioner Panel Member, Dr W Grigg, Public Panel Member, Professor D Morgan OAM, Medical Practitioner Panel Member)

32. The respondent directs the Tribunal to observations made in *Medical Board of Australia v Liang Joo Leow* [2019] VSC 532, at [85] and [94] an d quoted in *Ellis v Medical Board of Australia* [2020] VCAT 862 at [58] .:

…

The meaning of public interest is informed by the example. It is necessary for the Tribunal to proceed on the basis that public confidence in the provision of services by health practitioners is an aspect of the public interest. However, the Tribunal does not need to apply the example as if it were a statutory test. Specifically, the Tribunal was not required to analyse the issue of whether public confidence would be maintained, as opposed to whether, and to what extent, public confidence would be impacted and whether the extent of any such impact would require, in the public interest, that immediate action be taken.

…

The concept of public confidence has no fixed meaning or content. It is a difficult concept to measure. In assessing how the public might view the facts, it is important that visceral responses, as prevalent or legitimate as they might be, do not dominate at the expense of a considered response, having regard to all of the competing factors.

…

CJE was another case in which the health practitioner had been charged with serious criminal offences. The case, decided by majority with one health practitioner member dissenting, went on appeal to the Supreme Court of Victoria: *Liang Joo Leow*, cited earlier. Niall JA made further important observations about s. 156(1)(e) especially at [75] ff. His Honour referred to the context in which the expression "public interest" is used – not only the example but also the nature and purpose of the power to take immediate action. He noted that the purpose of the power to take immediate action is "to put measures in place to protect against, or ameliorate, harm pending the determination". His Honour then said this:

> 81 In circumstances where the allegations, if substantiated, may reflect on the practitioner's fitness to hold registration and may ultimately justify suspension or cancellation, it may be necessary, in the public interest, to take immediate action rather than await the outcome of the charges. In some cases, immediate action will be required because of a risk to patient safety or well-being. It may be possible for the Board to conclude that there is a serious risk to persons based on the material it has, even though criminal charges remain outstanding. In other cases, it may be necessary to take action to reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession as a whole.
>
> 82 As a consequence, the Board may conclude, in those circumstances, that it is in the public interest to take immediate action in order to address the question of public confidence. The relevant public confidence to which the example is directed is confidence in the provision of services by health practitioners …
>
> 85 Ultimately, the question is whether or not the Board reasonably believes, in circumstances where none of the other sub-paragraphs of s 156(1) apply, that it is necessary in the public interest to take immediate action. The meaning of public interest is informed by the example. It is necessary for the Tribunal to proceed on the basis that public confidence in the provision of services by health practitioners is an aspect of the public interest. However, the Tribunal does not need to apply the example as if it were a statutory test. Specifically, the Tribunal was not required to analyse the issue of whether public confidence would be maintained, as opposed to whether, and to what extent, public confidence would be impacted and whether the extent of any such impact would require, in the public interest, that immediate action be taken …
>
> 94 In my view, there was no error in regarding public confidence as being reflected in the reputation of the profession and the willingness of members of the public to access medical treatment. The concept of public confidence has no fixed meaning or content. It is a difficult concept to measure. In assessing how the public might view the facts, it is important that visceral responses, as prevalent or legitimate as they might be, do not dominate at the expense of a considered response, having regard to all of the competing factors. The Board did not submit to the contrary.

59. There is a further case to mention: *Kok v Medical Board of Australia* [2020] VCAT 405. We say more about that case later in these reasons. In contrast to the circumstances in *Farshchi* and *CJE*, the practitioner was not charged with serious criminal offences, so the case did not fall within the example in s. 156(1)(e). Like the present case, immediate action was taken in response to the practitioner's use of social media.

The questions for the Tribunal

60. In making the correct or preferable decision, the questions we must answer are whether we reasonably believe that, because of his conduct, Dr Ellis poses a serious risk to persons; and whether we reasonably believe that it is necessary to take immediate action to protect public health or safety. Alternatively, we must consider whether we reasonably believe that immediate action is otherwise in the public interest. The next question would be what the immediate action should be.

Consideration of the evidence

61. Dr Ellis has admitted posting to the Facebook pages material that includes the 56 posts dating from August 2017 to April 2020. Dr Ellis has apologised, taken steps to remove the material, and promised not to repeat the conduct. He proposed to the Board that he undertake relevant education. Now he proposes also that he receive mentoring.

62. We have recorded a selection of the responses that Dr Ellis gave during cross-examination. Many of the responses demonstrate that, in one way or another, despite the apology he offered and some important concessions he made, Dr Ellis has not taken full responsibility for his conduct. On the contrary, to a significant degree he obfuscated, minimised the seriousness of his conduct, or tried to distance himself from the commentary. We consider that the many unsatisfactory statements Dr Ellis made to the Board and to the Tribunal indicate that he lacks insight and genuine remorse. Dr Ellis' statements contribute to the reasonable belief we have formed.

63. In particular, we do not accept that Dr Ellis was naïve about the accessibility of what he posted on social media; that he did not realise the effect posting the material would have; or that he did not see himself as an influencer of public opinion. Dr Ellis was not an occasional user of one personal Facebook page: he set up his own page plus four other pages. He regularly posted to those sites over the years. Although he sought to minimise the significance of the fact, one of the pages had over 11,000 "likes" and over 11,000 followers. (We notice that some posts included an exhortation by the original author for viewers to share the material. No evidence of further re-posting by readers was given to us. It is of course impossible to say to what extent the material has been shared or whether it continues to be shared even now after the pages have been taken down).

64. Dr Ellis said to the Board that he was horrified and shocked to see the information AHPRA gave him, yet it was he who posted the material.

65. Dr Ellis made the further statement to the Board that the posts did not reflect his personal views. We consider that the Board correctly described the situation when it said in its decision that Dr Ellis' "social media presence, as represented by the identified posts, did not amount to that of a neutral moderator of debates about topics in contemporary medicine". Dr Ellis acknowledged to us that the statement he made to the Board was inaccurate.

66. Dr Ellis claimed that he was in shock when he was notified about the proposed immediate action, and that he had little time to respond. We do not accept that to be a reasonable explanation for the misleading statement he made to the Board. What he said to the Board indicated an unwillingness to take responsibility. Neither do we accept the statement he made to us that the posts reflected his personal views "at the time" he posted them but that they

were not his beliefs; or that he was simply posting what was topical in the interests of promoting discussion. As noted earlier, we invited Dr Ellis to say more about whether and how his views had changed. He more or less restated that the views published never represented his beliefs. We found this response by Dr Ellis to be unconvincing and generally satisfactory. It may be that Dr Ellis has reconsidered the topic of chemotherapy, for instance. (He acknowledged that the proponent of the view he published had been discredited: see further below). But, in other instances, we were not persuaded that he had changed his views at all. Taking the example of vaccination, whether Dr Ellis posted his own statements, other persons' statements, or other persons' statements with his comments added, he posted material over a substantial period of time. And while the material was not universally against vaccination, it was overwhelmingly against vaccination. For the most part the opinions were expressed in emphatic and alarmist terms, without any qualification.

67. Because he is a medical practitioner, Dr Ellis' conduct would have been serious even if his identity as doctor was unknown to his readers. The evidence however indicates that his identity was known to a proportion of those who visited the sites or that it was otherwise ascertainable. In this regard, we found Dr Ellis' statements to the effect that he tried to keep his identity as a registered medical practitioner secret to be unconvincing.

68. We will soon turn to the question of risk. Before we conclude this section of our reasons, we refer to further evidence about the Medical Statements; evidence about the Social Statements; and character evidence.

Further Medical Statements

69. Dr Ellis was cross-examined about the following post in September 2017. (In this instance the Facebook page states "Michael Ellis shared a post"):

> DRS ARE COERCED AND CAJOLED AND THREATENED TO FLLW
> THE GUIDELINES OF BIG PHARMA!!
> BIG PHARMA DOES NOT CARE ABOUT PATIENTS
> BIG PHARMA CARES ABOUT PROFITS!!!
> DOCTORS ARE EDUCATED ABD BRAIN WASHED UNDER THE GUIDE LINES OF BIG PHARMA
> DOCTORS TREAT DESEASES NOT PEOPLE
> HOSPITALS ARE GIANT ABATTOIR CONVEYER BELT SYSTEMS TO DEAL WITH DISEASES
> 30% OF PEOPLE WHO GO TO HOSPITALS COME OUT WITH FURTHER MORBIDITY OR DO NOT COME OUT AT ALL AS THEY ARE DEAD KILLED BY IATROGENSIS !!! (sic)

70. Dr Ellis said that he was not trying to be disparaging of doctors when he made the remark about brainwashing. Rather, he said, he was commenting on the system. He apologised for what he said. Similarly, the comment he made comparing hospitals to abattoirs was, he said, a comment on the hospital system, although he conceded that a member of the public reading the post may dissuaded from seeking treatment, so he was glad that the post had been taken down.

71. Concerning a statement posted made in August 2017 - that chemotherapy does not help breast and organ cancers - Dr Ellis agreed that the statement was unqualified. Asked whether he agreed that the view "is completely outside acceptable medical practice in Victoria", Dr Ellis acknowledged that the claim had since been discredited. He was sorry he had put that up. He agreed that someone reading the comment may be put off chemotherapy, but he said that there was no way he would give such view to a patient. He said he always referred patients to an oncologist.

72. There was a post in April 2018 in which Dr Ellis wrote "IF YOU SEE A PSYCHIATRIST YOU MAY AS WELL SEE AN UNDERTAKER!!!". Dr Ellis acknowledged that the post gave the impression that he was referring to all psychiatrists, but he said that the post was his momentary reaction to a specific report about one psychiatrist. He did not agree that someone reading it would be dissuaded from seeing a psychiatrist. He said people already had their opinions and may already have a psychiatrist.

The Social Statements

73. The posts concerning the LGBTQI community included ones with comments on media reports. For instance, in May 2018 Dr Ellis commented on a report to the effect that child care centres were required to ensure toys and books were "gender equitable". He wrote that "Gaydom comes first at the expense of normal family values - this is an atrocity against the heterosexual community in Australia". He did not agree that this suggested that homosexuality is inconsistent with "normal family values". Dr Ellis said in effect that he meant "heterosexual family values" and that he was just trying to point out the biological and psychological difference between male and female and the understanding of families on that basis, but he said that his comments were excessive, and he apologised.

74. There was a post in November 2019 with a comment on a report - that HIV-positive men in New Zealand would be allowed to donate to a sperm bank -to the effect that this would give rise to "a likelihood of [a] child having a tendency to gaydom threatening germ line of humanity". Dr Ellis said he thought "germ line of humanity" was the wrong term to use, but he did not think he was there suggesting that a tendency to being gay was a bad thing. He said he thought there would have been more to the post that was not in the material. He said he did not consider homosexuality to be abnormal or a bad thing. Counsel for the Board asked Dr Ellis if he thought a homosexual person reading the post, knowing he was a medical practitioner, would be legitimately concerned about the treatment Dr Ellis would give that person. Dr Ellis said "maybe" but added that he had looked after homosexual patients really well.

75. Generally regarding these posts, Dr Ellis said that he was expressing his views at the time but not his beliefs. He said that he was posting topical material for discussion.

76. Similarly, the posts regarding Islam included ones with comments on media reports. According to one report, a law passed in Iran permitted a man to marry an adopted daughter as young as 13 years old. Dr Ellis' comment on the post read: "This is ISLAM". Dr Ellis told the Tribunal that he was not saying in the post that the report reflected Islam in Australia: it was just something that was topical at the time. Another report concerned a Saudi woman detained in Bangkok who said she was afraid her family would kill her. Dr Ellis wrote: "This is what moslems (sic) do to moslems (sic) Should they be allowed to

immigrate en masse to Australia?" Dr Ellis said that unfortunately his comment was not clear. He mentioned that he had worked with Muslims in a clinic in Melbourne. He said that in the post he was commenting only about fundamentalist Islam in certain other countries - not Australia. He did agree "to some extent", however, that a Muslim patient reading that would have concern about whether he would treat the patient with dignity and respect. There was another post where Dr Ellis commented on a report alleging sex-trafficking of British citizens by Muslim gangs. Dr Ellis wrote: "Australia cannot continue to import people from cultures and countries who will not adopt our culture and live by our laws". Dr Ellis did not concede that the comment was unqualified. He said that those who came to Australia did follow Australian laws, so that the statement was "a non sequitur".

Character references

77. Dr Ellis submitted over a dozen character references. None of the persons who provided a reference gave oral evidence to the Tribunal.

78. The references do not substantially assist Dr Ellis' case, although they do give some support for his evidence that, in practice, he gave vaccinations and otherwise acted in accordance with accepted medical practice.

79. Two patients (evidently a married couple) wrote letters in 2019 that paid tribute to Dr Ellis' qualities as a doctor though the letters did not refer to his activities on social media. There was also an undated letter addressed to Dr Ellis by an outgoing policy adviser to the AMA that thanked him for his engagement with her and her section of the organisation. The other, more recent, references were by medical colleagues, including specialists (two ophthalmologists, a dermatologist and an ENT surgeon) to whom Dr Ellis had referred patients; practice managers (not the notifier) of practices where he had worked; and a nurse manager. In one case, the practice manager wrote that Dr Ellis had "always followed correct medical protocols" (including giving vaccinations), though he did not say what the duration of his professional experience of Dr Ellis was. There were others who, similarly, did not say for how long they had worked with Dr Ellis. Another practice manager wrote that Dr Ellis worked in her clinic "from 2017 to 2018" where, among other things, he gave vaccinations, referred patients to specialists, and sent patients to hospital when required. Yet another practice manager wrote that Dr Ellis worked at her clinic from 2014-2019. She too said, among other things, that Dr Ellis gave vaccinations and referred patients to specialists and hospitals. A GP wrote a similar letter, saying that Dr Ellis worked in her clinic from 2015-2016. A common theme in the refences was that there had been no complaints by patients. With one possible exception that we mention below, none of these persons stated that they had actually read or were otherwise aware of the content of Dr Ellis' social media commentary. One practice manager said he was aware "of the allegations that were brought up against Dr Ellis with AHPRA", without indicating whether that related to social media or the matters in the notification. If the other referees mentioned social media at all, they said merely, for instance, that they were aware that the regulator was taking action against Dr Ellis concerning social media posts.

80. There were also two references regarding what the authors described as Dr Ellis' work on "global peace, sustainability and ethical issues". Professor Russell D'Souza, UNESCO Chair in Bioethics (Haifa), wrote that he was aware of the action taken by the regulator against Dr Ellis regarding social media posts. He said he had known Dr Ellis for 15 years. Professor D'

Souza did not expressly state that he had read or was otherwise aware of the content of Dr Ellis' social media commentary, though he did say that he was familiar with Dr Ellis' work in global peace and other areas. He said that he considered Dr Ellis to be a person who had shown great interest and leadership in these areas. The final reference to consider was by Hungarian philosopher of science, Professor Ervin László. Professor László stated that he had known Dr Ellis for four years. He said that he was aware of the action taken by the regulator against Dr Ellis regarding social media posts. He said that Dr Ellis had shown himself to be "sincerely devoted to human rights, social justice, and spiritual freedom, contributing to a common ground for humanity".

Consideration of risk

81. In considering whether we reasonably believe that because of his conduct Dr Ellis poses a serious risk to persons, we focus on the Medical Statements. On the basis of the evidence we have referred to, we have a reasonable belief as to the following matters in particular. Dr Ellis has published material – about vaccines, chemotherapy, and vitamin C and COVID-19 - that has no proper clinical basis or that is contrary to accepted medical practice or that is otherwise untrue or misleading. He has publicly disparaged medical practitioners, including psychiatrists, the hospital system and pharmaceuticals. Dr Ellis' commentary has had at least the potential to deter members of the public from obtaining vaccination for themselves or their children, or from having chemotherapy; to encourage them to rely on unproven protocols for the prevention or treatment of COVID-19; and to undermine their confidence in doctors, hospitals and pharmaceuticals. There were evidently thousands of persons who (wherever they were located) accessed the social media commentary. A proportion of them knew that the commentary was by a registered medical practitioner. Members of the public include vulnerable persons or persons who at least lack the qualifications necessary to evaluate the Medical Statements properly and make safe decisions about their health care.

82. The coronavirus pandemic has increased the risk that vulnerable or unqualified persons would, out of fear or desperation, turn to "advice" from unreliable sources.

83. Further in relation to COVID-19 and the correspondence Dr Ellis had with the RACGP, we say this. There could perhaps have been a more definite statement by the RACGP to Dr Ellis to the effect that the use of vitamin C has no proper clinical basis or that it is contrary to accepted medical practice. However, we do not consider that Dr Ellis characterised the RACGP's position reasonably when he said that the RACGP did not negate the use of vitamin C, or that the RACGP did not point to any evidence whatsoever. The RACGP said plainly enough that it was "not in a position to recommend specific protocols and processes of [the] nature" he was inquiring about, and that it supported "the use of interventions with a strong evidence base". The RACGP did not say expressly or impliedly, in our view, that there was a "strong evidence base" for vitamin C. It is very concerning that by the time Dr Ellis wrote to RACGP in April 2020 he had posted about vitamin C and COVID-19 in January and March and that, although he received the RACGP's response in April, he did not take any steps to remove the posts until after he received the notice of proposed immediate action in May. We consider that his behaviour was reckless.

84. The discussion so far shows that a distinction may be drawn between any risk Dr Ellis may pose to persons by his social media commentary and any risk he may pose to persons by the way he practises medicine. There was a submission made on Dr Ellis' behalf that pointed to

the use of the present tense in s. 156(1)(a) where it requires consideration whether the practitioner *poses* a serious risk to persons. Counsel submitted in effect that, because Dr Ellis closed the Facebook pages and stopped posting material on social media, "it cannot be said that there is an extant serious risk".

85. That submission needs to be examined closely. A more straightforward case to consider might be one where, say, there is evidence that a registered health practitioner struck a patient. The conduct is past conduct, but the decision-maker may reasonably believe that because of the conduct the practitioner poses a serious risk to persons, being the risk that he or she will physically harm patients. In this example the past conduct (which, of course, may ultimately not be proved) and the future conduct to which the risk relates are essentially the same.

86. The submission appears to be that as Dr Ellis has given up using social media, we cannot reasonably believe that because of his (past) conduct in using social media he now poses a serious risk to persons, being the risk that he will use social media in a way that involves harm or potential harm.

87. We address the submission this way. We have a reasonable belief that because of his conduct Dr Ellis poses a serious risk to persons. We see there as being more than one way in which he poses a serious risk to persons. The risk that he would now use social media inappropriately may be a relatively low risk. The misleading or otherwise unsatisfactory statements that Dr Ellis has made, however, contribute to the reasonable belief we have formed that he poses a serious risk to persons through the publication of information or opinion (that has no proper clinical basis or is contrary to accepted medical practice or is otherwise untrue or misleading), whether that is now via social media or by some alternative means. But, over and above that, while Dr Ellis has asserted that the material he posted has "in no way whatsoever influenced [his] medical practice", we have a reasonable belief that because of his conduct he poses a serious risk to persons in the way he practises medicine. The misleading or otherwise unsatisfactory statements Dr Ellis has made are relevant in this regard too.

88. **Following paragraph cited by:**

Medical Board of Australia v Sami (25 February 2022) (Cavanough J)

54. Thereafter, under the heading 'The legal context', VCAT sets out lengthy passages from the written submissions of the Board. [87] VCAT does not, at this point, express or foreshadow any intention not to accept any part or parts of the passages about to be set out.[88] The passages quoted by VCAT include, first, the salient provisions of s 155 and 156 of the National Law . They include, next, the following parts of s 3 of the National Law , being the only parts thereof that the Board had cited:

(2) The objectives of the national registration and accreditation scheme are—

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; …

(3) The guiding principles of the national registration and accreditation scheme are as follows—

…

(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The next part of VCAT's quotation from the Board's written submissions reproduces the next heading contained in those submissions, namely 'The applicable principles', and it reproduces all of the paragraphs that had appeared under that heading. Those paragraphs had commenced as follows:

Section 156 of the National Law empowers the Board to take immediate action against a medical practitioner. Immediate action is 'designed to operate for an interim period, until an investigation or disciplinary proceeding with respect to the medical practitioner is able to be concluded'. [89] The purpose of that action is 'to put measures in place to protect against, or ameliorate, harm pending the determination' of that process. [90]

The succeeding paragraphs of the Board's written submissions to VCAT, as quoted by VCAT, were headed 'Section 156(1)(a)'. Omitting paragraph and subparagraph numbers, they read as follows:

The power to take immediate action under section 156(1)(a) is only enlivened if the Board (or the Tribunal on review) has formed a reasonable belief that:

- because of the practitioner's conduct, performance or health;
- the practitioner poses a serious risk to persons; and
- immediate action is necessary to protect public health or safety.

The first of these matters is a factual one; the remaining two are evaluative. [91] All three matters, however, require the formation of a 'reasonable belief'. [92]

- A reasonable belief 'does not require proof of conduct' but rather 'an inclination of the mind toward assenting to, rather than rejecting, a proposition'. [93]
- 'The underlying facts giving rise to the reasonable belief… do not have to be established on the balance of probabilities, however there must be proven objective circumstances sufficient to justify the belief.' [94] In this regard, the VCAT has said this about decisions made under s 156(1)(a): [95]

In *WD v Medical Board of Australia* [2013] QCAT 614 Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:

1. an immediate action order does not entail a detailed enquiry;

2. it requires action on an urgent basis because of the need to protect public health and safety;

3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;

4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;

5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;

6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;

7. a complaint that is trivial or misconceived on its face will clearly not be given weight;

8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

· The Tribunal has regarded the following description—as to when it might hold the requisite reasonable belief—as 'uncontroversial': [96]

> I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons.

Three more points may be made about section 156(1)(a).

First, in determining whether it holds a reasonable belief that—because of the practitioner's conduct, performance or health—the practitioner poses a serious risk to persons, the Board (and the Tribunal on review) should consider these questions:

· what serious risk does the practitioner pose (in short: 'serious risk of what')?; and

· to whom does the practitioner pose that serious risk (in short: 'serious risk to whom')? [97]

Approaching the matter in this way greatly assists the Board (and the Tribunal on review) to determine whether it holds a reasonable belief that it is necessary to take immediate action, and what form that immediate action should take.

Secondly, whilst the safety of the public must be the 'prime concern' under section 156(1)(a), that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. [98]

And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [99]

via
[99] Citing *Ellis* [88] .

Sami v Medical Board of Australia (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

32. And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [13]

via
[13] *Ellis* at [88] .

The language of s. 156(1)(a) naturally accommodates the situation where the alleged conduct and the conduct to which the risk relates are essentially the same, as in the above example: decision-maker can reasonably believe that because of the practitioner's conduct in striking a patient he or she poses a serious risk to persons, being the risk that he or she will physically harm patients. The language of the provision may not so easily accommodate every element of the present case. Can it be said that we reasonably believe that *because* of Dr Ellis' past use of social media he currently poses a serious risk to persons, being the risk that he would practise medicine in a way that has no proper clinical basis or is contrary to accepted medical practice? The difficulty lies in the word "because". But, although the nature of the past conduct and the nature of the conduct to which the risk relates will usually be essentially the same, we do not see that s. 156(1)(a) requires them to be the same. Therefore, we can and we do have a reasonable belief that because of Dr Ellis' conduct in expressing the particular

views on social media (in the manner he has, and for the period of time that he has) he poses a risk to patients in his practice. The reasonable belief involves the straightforward proposition that people are more likely to act according to their views and opinions than contrary to them. In saying that, we acknowledge that health practitioners should generally be able to give priority to accepted medical practice over any conflicting personal views they may hold. But in Dr Ellis' case, we are considering a practitioner who has repeatedly published emphatic, and often extreme, views. We are conscious that Dr Ellis strongly maintains that when he sees patients, he gives priority to accepted medical practice. The character references provide some support for that. We emphasise, however, that we are not weighing probabilities. We are considering our reasonable belief.

89. We will return to the point about the connection between a medical practitioner's social media commentary and his or her practice of medicine when we discuss the case of *Kok* in the context of s. 156(1)(e) . Before turning to consider the need for immediate action, there are further matters to mention.

90. First, on the point of interpretation, we draw support for our analysis from the statement by Horneman-Wren J in *Oglesby* that we highlighted earlier. His Honour was of course not proposing a different test to the statutory test, but he expressed the matter in a way that indicates that the nature of the conduct and the nature of the risk need not be the same. He said:

> [A] reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons.

91. Secondly, there is the obvious point to make that the practice of medicine is not limited to the physical acts involved in treating patients. The practice of medicine includes the discussions that a doctor has with patients. Dr Ellis has said that he has never refused to give patients vaccinations. He has said that he has given hundreds of vaccinations. The reasonable belief we have – that he poses a serious risk to persons – includes the risk that he would not encourage a patient to receive vaccination where it was indicated, or that he would discourage a patient from receiving vaccination. It is so that some of the persons who provided character references said that Dr Ellis gives vaccinations, but it is not apparent that they had or could have relevant knowledge about Dr Ellis' discussions with patients on the topic.

92. In summary, expressing the matter in terms similar to those used by Horneman-Wren J in *Ogle sby*, we have a reasonable belief that, because of his conduct, Dr Ellis poses a serious risk to persons. We consider that there is a real possibility that he will engage in conduct that could be harmful to persons - whether by publishing (in one form or another) statements that are the same as or similar to the Medical Statements we have been considering; or by practising medicine in accordance with the views he has expressed in those statements rather than in ways that have a proper clinical basis and are in accordance with accepted medical practice. The possibility of Dr Ellis acting in that way is not remote or fanciful, and the possible harm is not trivial.

93. We recognise that immediate action, if taken in the form of suspension, would operate differently in addressing these risks. If suspended, Dr Ellis could not practise medicine, but he could continue in one way or another to promote the views he has promoted in the

past. The point is that he could do that only as a medical practitioner whose registration was suspended.

Whether it is necessary to take any and what immediate action

94. We now consider whether we reasonably believe that it is necessary to take immediate action and what form the immediate action should take.

95. We have noted that Dr Ellis offered the undertaking set out earlier. The Board accepts that he has taken the steps that he can to bring about the end of his social media presence. Further to that, Dr Ellis has said he is prepared to pursue relevant education and receive mentoring.

96. The serious risks about which we have formed a reasonable belief are not only that Dr Ellis would resume publishing harmful or potentially harmful views, whether via social media or otherwise, but also that he would practise in ways contrary to accepted medical practice.

97. We have a reasonable belief that Dr Ellis poses a serious risk to persons and that it is necessary to take immediate action to protect public health or safety. In evaluating the risk, we have regard to the nature and extent of Dr Ellis' social media commentary and to his persistence in that conduct. But, further, we have regard to Dr Ellis' misleading or otherwise unsatisfactory responses to the concerns raised about his social media commentary from the time the Board gave him notice of proposed immediate action up until the time he gave oral evidence to the Tribunal.

98. It was submitted that, instead of suspending Dr Ellis' registration, we could impose conditions on his registration having the same effect as the undertaking. There could also be conditions as to education and mentoring. We consider that such measures would not adequately address the identified risks, given Dr Ellis' serious and repeated conduct and the view we have taken about the statements he has made to the Board and to the Tribunal.

99. We are mindful that, if his registration is suspended, there will likely be hardship for Dr Ellis that will intensify the longer it is before the matter reaches its conclusion. However, we do not consider that any measures short of suspension would adequately protect the public while investigations are in progress.

100. We are also mindful that especially at present, during the pandemic, there is a public interest in health practitioners being able to practise. We have taken that into account, but we still consider suspension to be necessary to protect the public from the particular risks we have identified.

Consideration of the public interest

101. In *Liang Joo Leow* Niall JA observed that s. 156(1)(e) provides an additional and alternative source of power that is available where none of the other specific circumstances has been established. We do not understand his Honour to have been suggesting that a decision-maker is precluded from considering s. 156(1)(e) if the circumstances under s. 156(1)(a) have been established[6]. The present case illustrates that it can be important to consider both.

[6] Paragraph (e) is separated from the rest of s. 156(1) through what appears to be a drafting anomaly likely to have come into being when paragraph (e) was added: whereas there is a semi-colon followed by the word "or" at the end of paragraphs (a), (b) and (c), at the end of paragraph (d) there is a full stop.

---

102. The Medical Statements are relevant both to s. 156(1)(a) and s. 156(1)(e) whereas the Social Statements are relevant only to s. 156(1)(e) . The question under s. 156(1)(e) is whether we reasonably believe that immediate action is otherwise in the public interest. As Niall JA further observed, it is necessary for us to proceed on the basis that public confidence in the provision of services by health practitioners is an aspect of the public interest.

103. We do not repeat everything that we have said about the Medical Statements. We simply reiterate that Dr Ellis' social media commentary has at least had the potential to cause serious harm to members of the public, especially the vulnerable and the unqualified.

104. So far as the Social Statements are concerned, we have deliberately avoided using the term "vilification". We are not required to determine whether any of the Social Statements would amount to vilification. In our view, the notice of proposed immediate action more accurately described social commentary that was denigrating or demeaning of particular groups. (Towards the end of these reasons we say something about Dr Ellis' statements in comparison to the ones made by the practitioner in *Kok*).

105. To denigrate a person is to defame or disparage the reputation of the person. To demean a person is to lower their dignity. We consider that the Social Statements we have referred to that relate to members of the LGBTQI community were denigrating and demeaning to that social group. We further consider that the Social Statements we have referred to that relate to Muslims were denigrating and demeaning to adherents of their religion.

106. The making of the Medical Statements and the Social Statements bears on Dr Ellis' fitness to hold registration.

107. We have noted that, in contrast to Dr Ellis' case, *Liang Joo Leow* involved a practitioner who had been charged with serious criminal offences so that consideration of the example given in s. 156(1)(e) was appropriate. It is nonetheless relevant to note that Niall JA said in effect that there are not only cases where a reasonable belief about a serious risk to persons warrants immediate action. There are also cases where it may be necessary to take action to reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession.

108. **Following paragraph cited by:**

Sami v Medical Board of Australia (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

> 40. There will, then, be cases where immediate action is necessary to reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession. [20]

via

[20] *Ellis* at [108] *Sevdalis v Medical Board of Australia* [2020] VCAT 913 at [123] . There is, then, a public interest in maintaining a regulatory system that is "adequate" and "safe". There is also a public interest in maintaining a regulatory system that responds to allegations in a "fair and proportionate manner": *Farshchi* at [71] ; *Kearney* at [12] .

We consider that it is necessary for immediate action to be taken to reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the medical profession. By adopting what Niall JA said next we express our view in another way: "It is in the public interest to take immediate action in order to address the question of public confidence. The relevant public confidence … is confidence in the provision of services by health practitioners".

109. The Code and the Social Media Guidelines acknowledge that doctors have their own personal beliefs and values. The Code and the Social Media Guidelines nevertheless make clear what the problems associated with Dr Ellis' social media commentary are. The Code provides that doctors are required to display qualities such as integrity, truthfulness and compassion. Doctors have the responsibility to protect and promote the health of individuals *and the community*. Doctors must be culturally aware and respectful of the beliefs and cultures of others. The Social Media Guidelines require that doctors ensure that any comments they make on social media – whether by commenting, sharing or "liking" - are consistent with the codes, standards and guidelines of the profession and do not contradict or counter public health campaigns or messaging, lest they give legitimacy to false health-related information and breach their professional responsibilities. The Social Media Guidelines further advise that social media comments that reflect or promote personal views about social and clinical issues might impact on someone's sense of cultural safety or could lead to a patient feeling judged, intimidated or embarrassed.

110. By making the Medical Statements Dr Ellis has failed to display integrity and truthfulness and he has failed to protect and promote the health of individuals and the community. He has contradicted or countered public health campaigns or messaging and so given legitimacy to false health-related information. By making the Social Statements Dr Ellis has failed to display compassion. Further, by making the Social Statements Dr Ellis has not been respectful of the beliefs and cultures of others. Dr Ellis' Social Statements have had the capacity to impact on persons' sense of cultural safety or to lead to patients feeling judged, intimidated or embarrassed.

111. We re-state that this case does not involve consideration of the general right to freedom of expression, or academic freedom. Counsel for Dr Ellis made a submission to the effect that today's "heretics" are tomorrow's "pioneers" and that, while he was not describing Dr Ellis as a pioneer, he was submitting that to go so far as to suspend Dr Ellis' registration would have a "chilling effect" on doctors who had an interest in "advancing medicine". Counsel submitted that it would be dangerous to suspend a doctor for expressing "fringe" views because to do so

may deter other doctors from engaging in debate. Counsel further submitted that Dr Ellis' "sin" was to publish his views via the "wrong" medium - where debate and discussion can be intemperate - and that, on reflection, Dr Ellis readily admitted that.

112. We do not accept those submissions. Doctors are free to make contributions towards the advancement of medicine. Ordinarily, they do so through appropriate discourse within the professional community. In this context, there is an obvious difference between publication via social media and, say, publication in medical journals. But there is a broader point. Dissemination of material by a registered medical practitioner to the general public that is disparaging, denigrating and demeaning, or that otherwise has the capacity to cause harm to the community in the ways we have identified, is expression of a different kind altogether. To take lawful, appropriate measures against the kind of expression that Dr Ellis has engaged in cannot reasonably be claimed to deter doctors from making contributions towards the advancement of medicine. The Code and Social Media Guidelines make clear where the lines are drawn.

113. We need now to address a further submission made on Dr Ellis' behalf. Counsel referred to particular reasoning of Niall JA in *Liang Joo Leow* . When considering the adequacy of VCAT's reasons for the decision under appeal, his Honour said (at [62]):

> In my view, when read as a whole, the reasons of the majority reveal that they considered the particular allegations, and how they would be perceived by members of the public, and came to the conclusion that immediate action was not required. In that regard, the majority considered the impact on the reputation of the profession and whether patients would be dissuaded from seeking medical treatment. In the context of the facts as a whole, the majority considered that public confidence would be informed by the presumption of innocence; that no findings of wrongdoing had been made out; and that *the allegations related to a single practitioner*. (Emphasis added)

114. **Following paragraph cited by:**

> Cassim v Medical Board of Australia (Review and Regulation) (08 June 2021) (R. Tang AM, Presiding Member, Dr R. Mason, Health Practitioner Member, Dr P. Molloy, Health Practitioner Member)
>
> 59. In his closing submissions, Mr Jellis (counsel for the Board) pointed to the decision of *Ellis v Medical Board of Australia* (***Ellis***) [62] in support of the Board's position that the actions of a medical practitioner can impact on public confidence in the medical profession as a whole.

via [62] [2020] VCAT 862 [114] .

The submission was to the effect that this passage indicates that it is relevant to the public interest that the allegations relate to a single practitioner, so that public confidence in the medical profession would not be undermined by a decision not to take immediate

action. (Counsel submitted in effect that, consistent with dicta in *Lal* (at [59]) that was relied on in *CJE* , we could form the view that a decision not to take immediate action in relation to a particular practitioner "is unlikely … to have any material or lasting effect on the established reputation of the medical profession as a whole"). Counsel submitted that the reasoning of Niall JA is equally apt in Dr Ellis' case. We do not agree. It will usually be the case that allegations relate to a single practitioner. The impact on public confidence of a decision not to take immediate action against an individual doctor will depend on a range of circumstances. But Dr Ellis' case is a very different one. Dr Ellis' case cannot reasonably be compared to the case of a doctor who has been charged with serious criminal offences unrelated to his or her practice. We are considering the public interest where a practitioner has, in particular, publicly promoted views on medical topics that are contrary to accepted medical practice; disparaged other doctors, the hospital system, and pharmaceuticals; and denigrated and demeaned groups within society. We have a reasonable belief that the public would not have confidence in Dr Ellis as a medical practitioner and that for him to be allowed to continue to practise medicine pending complete investigation of the allegations would have a significant negative impact on public confidence in the medical profession: see *Liang Joo Leow* at [85] .

115. Further referring to *Liang Joo Leow* , counsel for Dr Ellis pointed out that in assessing how the public might view the facts "it is important that visceral responses, as prevalent or legitimate as they might be, do not dominate at the expense of a considered response, having regard to all of the competing factors": at [94]. That is indeed important. But we accept the Board's submission that public confidence in the profession cannot bear the continued registration of a medical practitioner who promotes the views that Dr Ellis has promoted. Further, we consider that the public would legitimately have grave concerns if, in response to Dr Ellis' conduct, the regulator - instead of taking immediate action to protect the public, maintain the reputation of the medical profession, and uphold the proper standards of the profession - did nothing.

116. We said that we would return to the connection between social media commentary and the practice of medicine when we discussed the case of *Kok* in the context of s. 156(1)(e) . We do that now. In *Kok* , VCAT expressed concerns about whether the community would accept that any medical practitioner could switch, as though they were a light, from airing disrespectful views online to providing respectful and appropriate treatment for those who fall within a class they denigrate online: at [88] . Counsel for Dr Ellis challenged this notion by referring to Dr Ellis' many positive character references, and by remarking that people can be chameleons. Counsel for the Board acknowledged that Dr Ellis may ultimately have an answer to the concern, but he highlighted, correctly in our view, that the question is whether we have a reasonable belief that immediate action should be taken. We emphasise that the concerns that we have are not only about the public's reaction to the Social Statements but also the public's reaction to the Medical Statements. We express our reasonable belief that the public would legitimately have grave concerns that Dr Ellis' published views on both medical and social topics would influence his practice of medicine.

Whether it is necessary to take any and what immediate action

117. We now consider under s. 156(1)(e) whether we reasonably believe that it is necessary to take immediate action and what form the immediate action should take. In this context it is

relevant to note, as VCAT's observed in *Farshchi* , that the public interest has more than one side. There is a public interest in health practitioners being able to practise. That is especially so now, when the public health system is under extra strain. VCAT also noted in *Farshchi* that the public interest "includes maintenance of a regulatory system which responds in a fair and proportionate manner when allegations are made": at [71]-[72] .

118. For similar reasons to the ones we gave when considering the need for immediate action under s. 156(1)(a) , we reasonably believe that it is necessary to take immediate action in the form of suspension. We have considered the likely impact on Dr Ellis of suspension pending the outcome of investigation. We have also considered the potential impact on the health system of Dr Ellis not being permitted to practise. However, given the nature and seriousness of Dr Ellis' conduct, including the responses he has made the Board and the Tribunal, we consider that measures short of suspension would not reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession as a whole. While conscious of its impact on Dr Ellis, we consider suspension to be a fair and proportionate outcome in all the circumstances.

General remarks

119. Counsel for the Board (who appeared for the Board in *Kok*) described Dr Ellis' social media commentary as more serious than Dr Kok's social media commentary whereas counsel for Dr Ellis (who appeared for Dr Kok) described Dr Ellis' social media commentary as less serious. In fairness to Dr Ellis, we say something about that. We agree that insofar as he made the Medical Statements in addition to the Social Statements, Dr Ellis' conduct was more serious. On the other hand, Dr Ellis' statements (the ones drawn to our attention, at least), while often extreme, did not go as far as Dr Kok's statements. (VCAT deliberately refrained from describing Dr Kok's posts in detail, but noted that there were ones that endorsed calls for capital punishment for doctors who carry out termination of pregnancy and others that appeared to endorse or call for violence or even genocide towards racial and religious groups: [62]. Dr Kok denied that he advocated violence, we note: [44]). However the two cases might be compared and contrasted, the real concern is always the reaction that the groups denigrated and demeaned would reasonably be expected to have.

120. Finally, there were two matters discussed at the end of the hearing that we mention now.

121. The first is that the Board referred us to Policy Direction 2019-1 – *Paramountcy of public protection when administering the National Scheme* – given in January 2020 by the COAG Health Council under s. 11 of the National Law to AHPRA and the National Boards. The Board submitted that the Policy Direction requires us to give priority to public protection as the paramount consideration; to take into account the potential impact of Dr Ellis' conduct on vulnerable people; and to consider the extent to which taking immediate action to suspend Dr Ellis' registration would support the protection of the public and engender confidence in the medical profession by deterring other practitioners from engaging in similar conduct.

122. Section 11 of the National Law makes clear that the permitted directions are directions about the policies to be applied by AHRPA or the National Boards in exercising their functions under the National Law . The Board submitted that the Policy Direction applies to the Tribunal "in reviewing the [Board's] decision, and making the correct or preferable decision standing in the shoes of the original decision-maker".

123. As the Board submitted, the relevant statutory framework must be considered. The National Law has objectives and guiding principles that the Tribunal must have regard to: see ss.3 and 4. There is, among other objectives, the objective to protect the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. And there is, among other things, the guiding principle that restrictions on practice are to be imposed only if they are necessary to ensure that health services are provided safely and are of an appropriate quality.

124. We may have regard to the Policy Direction, and we have had regard to it. The Board's submission is that we are *required* to apply the Policy Direction. The outcome of Dr Ellis' case is not affected by whether or not we accept that submission, so we do not need address it exhaustively, but we do make some observations.

125. The first aspect of the policy relied on by the Board, giving priority to protection of the public, is more or less in line with what the Court of Appeal said in *Kozanoglu* - that while the safety of the public must necessarily be the prime concern, that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. The second aspect is similarly in line with the general law, for the relevant words of the Policy Direction are "take into account the potential impact of the practitioner's conduct *on the public, including vulnerable people* within the community …" (our emphasis). The third aspect, concerning deterrence, is not so straightforward. That is because an immediate action case (in contrast to a referral where determinations are made after findings about the practitioner's conduct are made) may involve allegations that are never admitted and/or never proved.

126. A broader observation to make is that a responsible tribunal's decision in an appeal under s. 199 - where the tribunal is reviewing the exercise by the Board of its functions under the National Law - is not the same as the tribunal's determinations in a referral under s.193. A direction about the policies to be applied by the Board in exercising its functions may more readily be said to impose a duty on a responsible tribunal in the former case than in the latter case. (Notably, s. 11 of the National Law refers only to directions to the National Agency or a National Boards. That is, it does not specify responsible tribunals. That is to be contrasted with s. 4 of the National Law which clearly includes responsible tribunals because it provides: "An entity that has functions under this Law is to exercise its functions having regard to the objectives and guiding principles of the national registration and accreditation scheme set out in section 3"). Whatever the position about that, in any case that is not governed by s. 57 of the *Victorian Civil and Administrative Tribunal Act 1998* [7] , VCAT may have regard to policy, provided that the policy is lawful: see *Drake and Minister for Immigration and Ethnic Affairs (no. 2)* [1979] AATA 179 .

---

[7] There was no submission that s. 57 of *Victorian Civil and Administrative Tribunal Act 1998* applies.

---

127. The second matter discussed at the end of the hearing concerns the notification that was made in November 2019. We mentioned at the outset of these reasons for decision that the notification concerned various matters. The notification prompted the Board to investigate Dr

Ellis' use of social media. The particular use Dr Ellis made of social media that we have described was not among the matters specified in the notification.

128. We invited submissions as to what regard if any we should have to the notification. Dr Ellis' counsel conveyed his understanding that there is no ongoing investigation about those allegations and that we should therefore conclude that the allegations have no substance. Counsel for the Board simply said that the Board did not rely on the matters in the notification. He foreshadowed that the Board would submit that the Tribunal should not put any weight on them.

129. We allowed time for the parties to make further submissions on the point.

130. We have now been informed that in fact there is an ongoing investigation. By email dated 2 July 2020 Dr Ellis' representatives stated that their inquiries revealed that AHPRA is investigating the allegations. The Board has not yet made a decision about them. There were no further submissions on behalf of Dr Ellis. By email dated 3 July the Board's representatives informed the Tribunal that the Board did not rely on "the factual detail of the notification itself … in this review" and it did not ask the Tribunal to.

131. There was ultimately no submission that it would be wrong for us to have regard to the allegations in the notification. We would not have expected there to be. Here we refer again to what Horneman-Wren J said in *WD v Medical Board of Australia* [2013] QCAT 614: "an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations".

132. An allegation in the notification reads: "Declines to administer childhood vaccinations". Against this allegation would need to be weighed Dr Ellis' evidence (that he has never refused to give patients vaccinations and that he has given hundreds of vaccinations) and what support the character witnesses give for Dr Ellis' evidence. Notwithstanding all that evidence, we have considered risks including the risk that Dr Ellis would not encourage the use of vaccines or that he might even seek to discourage patients from having a vaccination. In the circumstances of this case we have been able to form a reasonable belief under s. 156(1)(a) and s. 156(1)(e) without placing any weight on what appears in the notification.

Conclusion

133. For the reasons we have given, we consider that the decision of the Board should be confirmed.

J Billings	**Dr P Molloy**	**Dr L Warfe OAM**
Senior Member	**Member**	**Member**

The threshold for immediate action in its current form in section 156 [prior to the introduction of s. 156(1)(e)] may constrain the National Board from taking swift action where it is warranted to protect public health, public

safety or the public interest. For example, if a practitioner has been charged with a serious crime, and the relationship between the alleged crime on the practitioner's practice is not yet well established, the "public interest" may require a National Board to constrain the practitioner's practice until the criminal matter is resolved, both for the protection of the public and for public confidence in the health profession.

And the Second Reading Speech states at page 2716:

It is important to ensure that immediate action can be taken against health practitioners where public interest considerations require it. An example of where the public interest test may be used to take immediate action is if a serious criminal charge [is] laid but the charges may not be directly related to the person's conduct as a health practitioner. In cases like these it can be difficult to show that the threshold of "serious risk to persons" in the National Law is reached. However, it may be appropriate to impose conditions on the person's registration for public protection and confidence in the health profession.

Cited by:

Medical Board of Australia v Stephen Hindley [2023] TASCAT 223 (01 December 2023) (A Clues, Deputy President, Dr A Barratt, Professional Member, F Ederle, Community Member)

> Further, the comments made by the Tribunal in *Ellis v Medical Board of Australia (Review and Regulation)* [2020] VCAT 862 at [111]-[112] are also relevant. The Tribunal said:

du Toit v Health Ombudsman [2023] QCAT 373 (15 November 2023) (Judicial Member J Dick SC, Assisted by:, Professor D Ellwood AO, Medical Practitioner Panel Member, Dr W Grigg, Public Panel Member, Professor D Morgan OAM, Medical Practitioner Panel Member)

32. The respondent directs the Tribunal to observations made in *Medical Board of Australia v Liang Joo Leow* [2019] VSC 532, at [85] and [94] and quoted in *Ellis v Medical Board of Australia* [2020] VCAT 862 at [58] .:

> ...
>
> The meaning of public interest is informed by the example. It is necessary for the Tribunal to proceed on the basis that public confidence in the provision of services by health practitioners is an aspect of the public interest. However, the Tribunal does not need to apply the example as if it were a statutory test. Specifically, the Tribunal was not required to analyse the issue of whether public confidence would be maintained, as opposed to whether, and to what extent, public confidence would be impacted and whether the extent of any such impact would require, in the public interest, that immediate action be taken.
>
> ...
>
> The concept of public confidence has no fixed meaning or content. It is a difficult concept to measure. In assessing how the public might view the facts, it is important that visceral responses, as prevalent or legitimate as they might be, do not dominate at the expense of a considered response, having regard to all of the competing factors.

...

Groves v Medical Board of Australia [2023] TASCAT 113 (15 June 2023) (Ms L D Jack, Senior Member, Dr I Sale, Ordinary Member, Dr J Bakas, Ordinary Member)

22. Thus, although the example of immediate action in the public interest set out as part of s 156 (1)(e) of the National Law refers to a practitioner having been charged with a serious criminal offence, unrelated to the practitioner's practice, it is accepted that 'public interest' immediate action is not limited by that example, and immediate action has been taken under s 156(1)(e) in circumstances where no criminal charges have been laid against the particular practitioner (including where action has been taken on the basis of the practitioner's social media activity). [14]

via

[14] For example, *Appanna v Medical Board of Australia* [2021] VCAT 277, upheld on appeal in *Appanna v Medical Board of Australia* [2021] VSC 679; *Freeman and Medical Board of Australia [No 2]* [2023] WASAT 27 ; *Kok v Medical Board of Australia* (Ibid); *Ellis v Medical Board of Australia* [2020] VCAT 862 .

Medical Board of Australia v Sami [2022] VSC 90 (25 February 2022) (Cavanough J)

54. Thereafter, under the heading 'The legal context', VCAT sets out lengthy passages from the written submissions of the Board. [87] VCAT does not, at this point, express or foreshadow any intention not to accept any part or parts of the passages about to be set out.[88] The passages quoted by VCAT include, first, the salient provisions of s 155 and 156 of the National Law . They include, next, the following parts of s 3 of the National Law , being the only parts thereof that the Board had cited:

> (2) The objectives of the national registration and accreditation scheme are—
>
> > (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; ...
>
> (3) The guiding principles of the national registration and accreditation scheme are as follows—
>
> > ...
> >
> > (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The next part of VCAT's quotation from the Board's written submissions reproduces the next heading contained in those submissions, namely 'The applicable principles', and it reproduces all of the paragraphs that had appeared under that heading. Those paragraphs had commenced as follows:

> Section 156 of the National Law empowers the Board to take immediate action against a medical practitioner. Immediate action is 'designed to operate for an interim period, until an investigation or disciplinary proceeding with respect to the medical practitioner is able to be concluded'. [89] The purpose of that action is 'to put measures in place to protect against, or ameliorate, harm pending the determination' of that process. [90]

The succeeding paragraphs of the Board's written submissions to VCAT, as quoted by VCAT, were headed 'Section 156(1)(a)'. Omitting paragraph and subparagraph numbers, they read as follows:

> The power to take immediate action under section 156(1)(a) is only enlivened if the Board (or the Tribunal on review) has formed a reasonable belief that:
>
> · because of the practitioner's conduct, performance or health;
>
> · the practitioner poses a serious risk to persons; and
>
> · immediate action is necessary to protect public health or safety.
>
> The first of these matters is a factual one; the remaining two are evaluative. [91] All three matters, however, require the formation of a 'reasonable belief'. [92]
>
> · A reasonable belief 'does not require proof of conduct' but rather 'an inclination of the mind toward assenting to, rather than rejecting, a proposition'. [93]
>
> · 'The underlying facts giving rise to the reasonable belief… do not have to be established on the balance of probabilities, however there must be proven objective circumstances sufficient to justify the belief.' [94] In this regard, the VCAT has said this about decisions made under s 156(1)(a): [95]
>
> > In *WD v Medical Board of Australia* [2013] QCAT 614 Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:
> >
> > 1. an immediate action order does not entail a detailed enquiry;
> >
> > 2. it requires action on an urgent basis because of the need to protect public health and safety;
> >
> > 3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;
> >
> > 4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
> >
> > 5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;

6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;

7. a complaint that is trivial or misconceived on its face will clearly not be given weight;

8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

· The Tribunal has regarded the following description—as to when it might hold the requisite reasonable belief—as 'uncontroversial': [96]

> I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons.

Three more points may be made about section 156(1)(a).

First, in determining whether it holds a reasonable belief that—because of the practitioner's conduct, performance or health—the practitioner poses a serious risk to persons, the Board (and the Tribunal on review) should consider these questions:

· what serious risk does the practitioner pose (in short: 'serious risk of what')?; and

· to whom does the practitioner pose that serious risk (in short: 'serious risk to whom')? [97]

Approaching the matter in this way greatly assists the Board (and the Tribunal on review) to determine whether it holds a reasonable belief that it is necessary to take immediate action, and what form that immediate action should take.

Secondly, whilst the safety of the public must be the 'prime concern' under section 156(1)(a), that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. [98]

And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of

posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [99]

via

[91] Citing *Bernadt* [66]; *Ahmad v Medical Board of Australia* [2017] VCAT 1646, [71] and *Ellis v Medical Board of Australia* [2020] VCAT 862, [50] (' *Ellis'*).

Medical Board of Australia v Sami [2022] VSC 90 (25 February 2022) (Cavanough J)

54. Thereafter, under the heading 'The legal context', VCAT sets out lengthy passages from the written submissions of the Board. [87] VCAT does not, at this point, express or foreshadow any intention not to accept any part or parts of the passages about to be set out.[88] The passages quoted by VCAT include, first, the salient provisions of s 155 and 156 of the National Law . They include, next, the following parts of s 3 of the National Law , being the only parts thereof that the Board had cited:

> (2) The objectives of the national registration and accreditation scheme are—
>
> > (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; ...
>
> (3) The guiding principles of the national registration and accreditation scheme are as follows—
>
> > ...
> >
> > (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The next part of VCAT's quotation from the Board's written submissions reproduces the next heading contained in those submissions, namely 'The applicable principles', and it reproduces all of the paragraphs that had appeared under that heading. Those paragraphs had commenced as follows:

> Section 156 of the National Law empowers the Board to take immediate action against a medical practitioner. Immediate action is 'designed to operate for an interim period, until an investigation or disciplinary proceeding with respect to the medical practitioner is able to be concluded'. [89] The purpose of that action is 'to put measures in place to protect against, or ameliorate, harm pending the determination' of that process. [90]

The succeeding paragraphs of the Board's written submissions to VCAT, as quoted by VCAT, were headed 'Section 156(1)(a)'. Omitting paragraph and subparagraph numbers, they read as follows:

> The power to take immediate action under section 156(1)(a) is only enlivened if the Board (or the Tribunal on review) has formed a reasonable belief that:
>
> · because of the practitioner's conduct, performance or health;

- the practitioner poses a serious risk to persons; and

- immediate action is necessary to protect public health or safety.

The first of these matters is a factual one; the remaining two are evaluative. [91] All three matters, however, require the formation of a 'reasonable belief'. [92]

- A reasonable belief 'does not require proof of conduct' but rather 'an inclination of the mind toward assenting to, rather than rejecting, a proposition'. [93]

- 'The underlying facts giving rise to the reasonable belief… do not have to be established on the balance of probabilities, however there must be proven objective circumstances sufficient to justify the belief.' [94] In this regard, the VCAT has said this about decisions made under s 156(1)(a): [95]

> In *WD v Medical Board of Australia* [2013] QCAT 614 Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:
>
> 1. an immediate action order does not entail a detailed enquiry;
>
> 2. it requires action on an urgent basis because of the need to protect public health and safety;
>
> 3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;
>
> 4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
>
> 5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;
>
> 6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;
>
> 7. a complaint that is trivial or misconceived on its face will clearly not be given weight;

> 8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

- The Tribunal has regarded the following description—as to when it might hold the requisite reasonable belief—as 'uncontroversial': [96]

> I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons.

Three more points may be made about section 156(1)(a).

First, in determining whether it holds a reasonable belief that—because of the practitioner's conduct, performance or health—the practitioner poses a serious risk to persons, the Board (and the Tribunal on review) should consider these questions:

- what serious risk does the practitioner pose (in short: 'serious risk of what')?; and

- to whom does the practitioner pose that serious risk (in short: 'serious risk to whom')? [97]

Approaching the matter in this way greatly assists the Board (and the Tribunal on review) to determine whether it holds a reasonable belief that it is necessary to take immediate action, and what form that immediate action should take.

Secondly, whilst the safety of the public must be the 'prime concern' under section 156(1)(a), that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. [98]

And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [99]

via

[97] Citing *Syme* [160]–[170] , *Ellis* [91]–[92] .

Medical Board of Australia v Sami [2022] VSC 90 (25 February 2022) (Cavanough J)

54. Thereafter, under the heading 'The legal context', VCAT sets out lengthy passages from the written submissions of the Board. [87] VCAT does not, at this point, express or foreshadow any intention not to accept any part or parts of the passages about to be set out.[88] The passages quoted by VCAT include, first, the salient provisions of s 155 and 156 of the National Law . They include, next, the following parts of s 3 of the National Law , being the only parts thereof that the Board had cited:

> (2) The objectives of the national registration and accreditation scheme are—
>
> > (a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; ...
>
> (3) The guiding principles of the national registration and accreditation scheme are as follows—
>
> > ...
> >
> > (c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The next part of VCAT's quotation from the Board's written submissions reproduces the next heading contained in those submissions, namely 'The applicable principles', and it reproduces all of the paragraphs that had appeared under that heading. Those paragraphs had commenced as follows:

> Section 156 of the National Law empowers the Board to take immediate action against a medical practitioner. Immediate action is 'designed to operate for an interim period, until an investigation or disciplinary proceeding with respect to the medical practitioner is able to be concluded'. [89] The purpose of that action is 'to put measures in place to protect against, or ameliorate, harm pending the determination' of that process. [90]

The succeeding paragraphs of the Board's written submissions to VCAT, as quoted by VCAT, were headed 'Section 156(1)(a)'. Omitting paragraph and subparagraph numbers, they read as follows:

> The power to take immediate action under section 156(1)(a) is only enlivened if the Board (or the Tribunal on review) has formed a reasonable belief that:
>
> · because of the practitioner's conduct, performance or health;
>
> · the practitioner poses a serious risk to persons; and
>
> · immediate action is necessary to protect public health or safety.

The first of these matters is a factual one; the remaining two are evaluative. [91] All three matters, however, require the formation of a 'reasonable belief'. [92]

- A reasonable belief 'does not require proof of conduct' but rather 'an inclination of the mind toward assenting to, rather than rejecting, a proposition'. [93]

- 'The underlying facts giving rise to the reasonable belief… do not have to be established on the balance of probabilities, however there must be proven objective circumstances sufficient to justify the belief.' [94] In this regard, the VCAT has said this about decisions made under s 156(1)(a): [95]

> In *WD v Medical Board of Australia* [2013] QCAT 614 Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:
>
> 1. an immediate action order does not entail a detailed enquiry;
>
> 2. it requires action on an urgent basis because of the need to protect public health and safety;
>
> 3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;
>
> 4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
>
> 5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;
>
> 6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;
>
> 7. a complaint that is trivial or misconceived on its face will clearly not be given weight;
>
> 8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

- The Tribunal has regarded the following description—as to when it might hold the requisite reasonable belief—as 'uncontroversial': [96]

> I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons.

Three more points may be made about section 156(1)(a).

First, in determining whether it holds a reasonable belief that—because of the practitioner's conduct, performance or health—the practitioner poses a serious risk to persons, the Board (and the Tribunal on review) should consider these questions:

- what serious risk does the practitioner pose (in short: 'serious risk of what')?; and

- to whom does the practitioner pose that serious risk (in short: 'serious risk to whom')? [97]

Approaching the matter in this way greatly assists the Board (and the Tribunal on review) to determine whether it holds a reasonable belief that it is necessary to take immediate action, and what form that immediate action should take.

Secondly, whilst the safety of the public must be the 'prime concern' under section 156(1)(a), that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. [98]

And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [99]

via

[99] Citing *Ellis* [88].

Medical Board of Australia v Sami [2022] VSC 90 (25 February 2022) (Cavanough J)

102. It is true, of course, that the past conduct of a registered health practitioner, especially if there be little or no controversy about it, might serve to inform an assessment about likely present or future conduct on the part of that practitioner, and therefore to inform assessments about present or future serious risk to persons and about whether it is necessary to take immediate action to protect public health or safety. [173] And an omission to form a view about the probabilities or the possibilities relating to the alleged past or present conduct of the relevant health practitioner *might*, in a particular case, even render legally unreasonable or otherwise invalid on administrative law grounds a decision purportedly made under s 156(1)(a). However, such a conclusion will only be open where the particular facts of the case warrant it. And there will be cases where the past conduct of a registered health practitioner is of little or no moment. For example, circumstances may have changed such that the practitioner's past conduct has been overtaken by events.

via

[173] See, eg, *Oglesby v Nursing and Midwifery Board of Australia* [2014] QCAT 701 (Horneman-Wren J), [20] ; *Ellis* [85]–[92] .

Medical Board of Australia v Sami [2022] VSC 90 (25 February 2022) (Cavanough J)

105. Further, it is noteworthy that the power to take immediate action under s 156(1)(a) on the 'conduct' basis is not confined to cases where it is reasonably believed that the practitioner poses a serious risk to persons (and threatens public health or safety) because of past or present or continuing conduct. For example, the power may arise because the decision-maker reasonably believes that the practitioner poses a serious risk to persons only because of the practitioner's anticipated future conduct. Such a belief might have nothing to do with any suggested past or present conduct of the practitioner. Instead, it might arise because of some indication given by the practitioner (by way of a statement or otherwise) about what the practitioner intends to do in the (near) future. [182] Thus, in my opinion, the 'conduct' to which s 156(1)(a) refers is conduct in a broad sense. That sense is conveyed by saying that, for the purposes of s 156(1)(a)(i) , the perceived serious risk to persons must be 'conduct-related', 'performance-related' or 'health-related', as the case may be. Generally speaking, of course, even *actual* past conduct of a practitioner cannot, of itself, pose any present or future risk to persons or render it necessary to take 'immediate action' to protect public health or safety. What is done is done. The required analysis must look mainly to the present and the (near) future. The only steps that can be taken under s 156(1)(a) by way of 'immediate action' are the steps listed in s 155 , namely to suspend, or to impose a condition on, a practitioner's registration, or to accept an undertaking from the practitioner, or to accept the surrender of the practitioner's registration. These are all steps directed to the prevention or modification of present and future conduct, not past conduct, on the part of a registered health practitioner.

via

[182] Cf *Ellis* [86]–[92] .

Nursing and Midwifery Board of Australia v Palle (Review and Regulation) [2021] VCAT 1009 (22 July 2021) (A Dea, Senior Member, M Archibald PSM, Member, M Hally, Member)

59. We noted the Board's submissions referring to other cases concerning social media. [7]

via

[7] *Nursing and Midwifery Board of Australia v Horne* [2020] TASHPT 7; *Kok v Medical Board of Australia* [2020] VCAT 405; and *Ellis v Medical Board of Australia* [2020] VCAT 862 .

Cassim v Medical Board of Australia (Review and Regulation) [2021] VCAT 595 (08 June 2021) (R. Tang AM, Presiding Member, Dr R. Mason, Health Practitioner Member, Dr P. Molloy, Health Practitioner Member)

59. In his closing submissions, Mr Jellis (counsel for the Board) pointed to the decision of *Ellis v Medical Board of Australia* (***Ellis***) [62] in support of the Board's position that the actions of a medical practitioner can impact on public confidence in the medical profession as a whole.

via

[62] [2020] VCAT 862 [114] .

Sami v Medical Board of Australia [2021] VCAT 447 (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

48. Sometimes, the 'conduct', in the sense of the actions taken by the practitioner, is not in dispute. For example, there may have been social media posts which are plain for all to see (*Kok* and *Ellis* , for example).

Sami v Medical Board of Australia [2021] VCAT 447 (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

28. The first of these matters is a factual one; the remaining two are evaluative. [6] All three matters, however, require the formation of a "reasonable belief".

via

[6] *Bernadt v Medical Board of Australia* [2013] WASCA 259 at [66] , *Ahmad v Medical Board of Australia* [2017] VCAT 1646 at [71] , *Ellis v Medical Board of Australia* [2020] VCAT 862 (" ***Ellis*** ") at [50] .

Sami v Medical Board of Australia [2021] VCAT 447 (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

30.2 to whom does the practitioner pose that serious risk (in short: "serious risk to whom")? [11]

via

[11] *Syme* at [160]-[170] , *Ellis* at [91] –[92] .

Sami v Medical Board of Australia [2021] VCAT 447 (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

32. And **thirdly**, immediate action may be taken under section 156(1)(a) where the alleged conduct is the same as the conduct to which the serious risk relates. But it is not confined to that scenario. For example, immediate action has been taken under that section where the alleged conduct (of posting material on social media) was not the same as the conduct to which the serious risk relates (of harming patients in the practitioner's practice). [13]

via

[13] *Ellis* at [88] .

Sami v Medical Board of Australia [2021] VCAT 447 (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

> 40. There will, then, be cases where immediate action is necessary to reassure the public that the regulatory system is safe and adequate to protect the public and the reputation of the profession. [20]

via

[20] *Ellis* at [108] *Sevdalis v Medical Board of Australia* [2020] VCAT 913 at [123] . There is, then, a public interest in maintaining a regulatory system that is "adequate" and "safe". There is also a public interest in maintaining a regulatory system that responds to allegations in a "fair and proportionate manner": *Farshchi* at [71] ; *Kearney* at [12] .

Sami v Medical Board of Australia [2021] VCAT 447 (06 May 2021) (Jonathan Smithers, Senior Member, Robyn Mason, Member, Patricia Molloy, Member)

> 50. As noted in *Bernadt*, the first step in the s 156(1)(a) analysis involves the consideration of a factual question. [24] In that case, the president of the Western Australian Supreme Court of Appeal said:
>
> > 66 The 'reasonable belief' requirement applies, in my view, to the three components, including the factual substratum ((i)(1)) on which the evaluative assessments (in (i)(2) and (ii)) are to be made. That being so, the fact or facts directly in issue concerning a practitioner's conduct, performance or health do not have to be proven on the balance of probabilities ... However, there must be proven objective circumstances sufficient to justify the belief.

via

[24] *Bernadt v Medical Board of Australia* [2013] WASCA 259 at [66] , *Ahmad v Medical Board of Australia* [2017] VCAT 1646 at [71] , *Ellis v Medical Board of Australia* [2020] VCAT 862 (" ***Ellis*** ") at [50] .

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

> 54. The question of whether VCAT is bound by the Policy Direction was referred to but not decided in two recent VCAT cases: *Ellis v Medical Board of Australia* [7] (***Ellis***), and *Vo v Medical Board of Australia* (***Vo***). [8]

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

> 54. The question of whether VCAT is bound by the Policy Direction was referred to but not decided in two recent VCAT cases: *Ellis v Medical Board of Australia* [7] (***Ellis***), and *Vo v Medical Board of Australia* (***Vo***). [8]

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

> 55. In *Ellis* , at [124] , the Tribunal expressed the view that it *may* have regard to the Policy Direction and had done so. In relation to the Board's submission that the Tribunal was *requir ed* to apply the Policy Direction, which did not in the Tribunal's view affect the outcome, it made the following observations, at [125]-[126]:

125 The first aspect of the policy relied on by the Board, giving priority to protection of the public, is more or less in line with what the Court of Appeal said in *Kozanoglu* - that while the safety of the public must necessarily be the prime concern, that safety should be secured with as little damage to the practitioner as is consistent with its maintenance. The second aspect is similarly in line with the general law, for the relevant words of the Policy Direction are 'take into account the potential impact of the practitioner's conduct *on the public, including vulnerable people* within the community ...' (our emphasis). The third aspect, concerning deterrence, is not so straightforward. That is because an immediate action case (in contrast to a referral where determinations are made after findings about the practitioner's conduct are made) may involve allegations that are never admitted and/or never proved.

126 A broader observation to make is that a responsible tribunal's decision in an appeal under s.199 - where the tribunal is reviewing the exercise by the Board of its functions under the National Law - is not the same as the tribunal's determinations in a referral under s.193. A direction about the policies to be applied by the Board in exercising its functions may more readily be said to impose a duty on a responsible tribunal in the former case than in the latter case. (Notably, s.11 of the National Law refers only to directions to the National Agency or a National Boards. That is, it does not specify responsible tribunals. That is to be contrasted with s.4 of the National Law which clearly includes responsible tribunals because it provides: 'An entity that has functions under this Law is to exercise its functions having regard to the objectives and guiding principles of the national registration and accreditation scheme set out in section 3'). Whatever the position about that, in any case that is not governed by s. 57 of the *Victorian Civil and Administrative Tribunal Act 1998* [9] , VCAT may have regard to policy, provided that the policy is lawful: see *Drake and Minister for Immigration and Ethnic Affairs (no. 2)* [1979] AATA 179 .

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

62. Neither *Ellis* nor *Vo* support the Board's submission to this effect, in our view. In both, the Tribunal expressed reservations about the submission, noting the contrast between s 4 and s 11 of the National Law.

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

63. In *Ellis* , the Tribunal said only that the Tribunal *may have regard to* the Policy Direction. We agree that the Tribunal may do so. In *Vo*, the Tribunal said the question was 'not beyond doubt'. Without seeking to rephrase what the Tribunal said, we take that to mean that, contrary to the Board's submission, it was not clear that the Tribunal would be so bound.

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

68. Finally, we agree with and repeat the observations made in *Ellis* and *Vo*, that the Policy Direction does not add to the already well-established principles in the case law applied by the Tribunal, save that in the case of an immediate action decision, general deterrence is not and cannot be a relevant consideration, for the reasons stated in *Ellis* and *Vo*.

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

68. Finally, we agree with and repeat the observations made in *Ellis* and *Vo*, that the Policy Direction does not add to the already well-established principles in the case law applied by the Tribunal, save that in the case of an immediate action decision, general deterrence is not and cannot be a relevant consideration, for the reasons stated in *Ellis* and *Vo*.

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

54. The question of whether VCAT is bound by the Policy Direction was referred to but not decided in two recent VCAT cases: *Ellis v Medical Board of Australia* [7] (***Ellis***), and *Vo v Medical Board of Australia* (***Vo***). [8]

via

[7] [2020] VCAT 862 ; http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCAT/2020/862.html .

Gerstman v Medical Board of Australia [2020] VCAT 1367 (07 December 2020) (E Wentworth SM; A Reddy and Yi-Lee Phang MM)

54. The question of whether VCAT is bound by the Policy Direction was referred to but not decided in two recent VCAT cases: *Ellis v Medical Board of Australia* [7] (***Ellis***), and *Vo v Medical Board of Australia* (***Vo***). [8]

via

[7] [2020] VCAT 862 ; http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/vic/VCAT/2020/862.html .