PROFESSIONAL MISCONDUCT: THE CASE OF THE MEDICAL BOARD OF AUSTRALIA v TAUSIF (OCCUPATIONAL DISCIPLINE)

In 2014, the Australian Capital Territory Civil and Administrative Appeals Tribunal (ACAT) made a finding of professional misconduct against a Canberra general practitioner working in two bulk-billing medical practices established by a corporate medical practice service company, Primary Health Care Limited (Medical Board of Australia v Tausif (Occupational Discipline) [2015] ACAT 4). This column analyses that case, particularly in relation to the ACAT finding that the practitioner’s professional misconduct was substantially contributed to by an unsafe system of care, specifically, the failure of Primary Health Care to provide supervision and mentoring for clinicians working at its medical centres. The case highlights the professional pressures carried by general practitioners who practise medicine within the framework of corporate bulk-billing business models. The column also examines the related issue of general practitioner co-payments in Australia and their impact on business models built around doctors purportedly characterised as independent contractors, bulk-billing large numbers of patients each day for short consultations.

INTRODUCTION: TENSION BETWEEN PROFESSIONAL STANDARDS AND CORPORATE FOR-PROFIT MEDICAL PRACTICE MODELS

In Medical Board of Australia v Tausif (Occupational Discipline), the ACT Civil and Administrative Appeals Tribunal made a finding of professional misconduct against a Canberra general practitioner who had inappropriately prescribed Sch 8 medications, particularly opioids, and kept inadequate patient records. Yet the Tribunal rejected the Medical Board’s recommendation for cancellation of registration.1 A major reason for this was the exacerbation of the practitioner’s problems because of inadequate mentoring and supervision for the practitioner while she worked with drug-dependent patients in two bulk-billing medical centres. The Tribunal found this lack of institutional quality control arose from the contractual organisation of doctors’ relationships with practice management where that management failed to engage with governance arrangements supporting the requisite standard of care.2 The Tribunal also found that the “first available doctor” (no appointments) business model subverted the autonomy of the practitioner to develop high-quality relationships in the monitoring and care of patients.3

The Tausif case puts the spotlight on the ambiguities arising from corporate practice control models, which determine that medicine as practised on a day-to-day basis should first and foremost be profitable for corporate owners of the practice, while attempting to distance owners from professional responsibilities for ensuring a safe system of care, through the adoption of “independent contractor” legal-financial arrangements with contracted doctors.

Employment law regarding contractors has been a growing area of law as increasingly contractual workforce arrangements replace employee arrangements across many industries. This column

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1 Medical Board of Australia v Tausif (Occupational Discipline) [2015] ACAT 4 at [6].
2 Tausif [2015] ACAT 4 at [53].
3 Tausif [2015] ACAT 4 at [46].
examines a number of key issues that have been exposed by cases in Australia and overseas regarding the apportionment of responsibility vis-à-vis independent contractors and principals in the workplace.

Relevant to the practice context within which this column analyses the Tausif case is the corporatisation of general practice in Australia which began to gather momentum during the mid-1990s when a number of companies began to offer practitioners “practice management” services. These services handle all the administrative aspects of a practice, including finance, staffing, and information technology as well as the provision of treatment facilities and equipment. Doctors are offered lucrative terms to sell their practices to these companies.

The management structure of corporate medical centres is typically based on business models developed to maximise profitability through administrative system efficiencies, risk management and trading on financial markets.

These business models effectively impose a corporate superstructure (a new tier) on medical practice, which impacts upon the practice of medicine, the doctor-patient relationship and collegial relationships between doctors.

This column examines these impacts, as revealed by the Tausif case, and highlights the need for greater consideration by professional oversight bodies in Australia of the challenges such corporate business models are likely to pose for medical quality and public safety.

**PRACTITIONER’S PROBLEMS WITH PRESCRIBING OPIOIDS TO DRUG-ADDICTED PATIENTS**

On 6 December 2013, the Medical Board of Australia brought a disciplinary action to ACAT against Dr Syeda Tausif for alleged professional misconduct in regards to her prescribing practices for controlled medicines and her inadequate and incomplete patient health records.

Dr Tausif (the respondent) was contracted, at the time, through her company Syeda & Shaikh Pty Ltd to provide GP medical services at Ginninderra and Phillip Medical Centres, which are part of a nationwide network of medical practices owned and operated by Primary Health Care Limited.

The possibility of misconduct regarding Dr Tausif had first been brought to the attention of the ACT Chief Health Officer who then notified the Australian Health Practitioner Regulation Agency (AHPRA) on 29 August 2012.

An investigation made by the Medical Board, under s 160 of the National Law, revealed that Dr Tausif had over the period 2011-2012 prescribed controlled medicines (opioids) without the approval of the Chief Medical Officer as required by the *Medicines, Poisons and Therapeutics Goods Act 2008* (ACT). It was also found that she had prescribed these drugs in doses and/or at frequencies that the safety of drug-dependent patients, many of whom were taking other medications, was put at risk.

It was further alleged that her medical records were in breach of the Medical Board’s Code of Conduct for Doctors, specifically in relation to failure to take and record adequate notes; record patients’ requests for controlled medicines; make or record a diagnosis; consider and record a patient’s medical history; or provide a treatment plan.

On 13 September 2012, the Board placed conditions on Dr Tausif’s registration citing her “lack of awareness of the seriousness of her practise patterns and lack of awareness of her professional responsibilities.”

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6 The Board’s preliminary assessment was in accordance with s 149(1)(a) of the National Law.

obligations under the legislation", in responding to a show cause notice issued under s 157 of the National Law. In the interests of protecting public health and safety (s 156(1)(a)), the Board placed a condition on her registration under s 178(2)(c):

Not to prescribe any S4 or S8 medications, including controlled medicines requiring Chief Health Officer Approval under the Medicines, Poisons and Therapeutic Goods Act 2008, pending further investigation into the matter.8

Following an investigation, the Board filed an application for disciplinary action in December 2014 against Dr Tausif with the Tribunal.

Two months later, the Board procured the respondent’s prescribing history from the Department of Human Services (Medicare) in order to investigate concerns that the respondent may have been prescribing Sch 4 and Sch 8 medications in breach of the conditions placed on her practice.9 On 20 February 2014, the Board proposed to suspend her registration. Dr Tausif responded with written and oral submissions (26 and 27 February) which satisfied the Board that “immediate action was not warranted”.10 Then on 5 March 2014 she made another written submission requesting that the restrictions on prescribing Sch 4 medicines (which include antibiotics and other commonly prescribed medications) be lifted. She argued that restrictions on prescribing routine medications amounted to a “suspension of practice” which in the circumstances was not warranted.11 On 27 March 2014, the Board refused Dr Tausif’s request, maintaining imposition of all conditions on her practice. Following another alleged breach of her conditions, regarding the prescribing of a clinically appropriate antibiotic from a prescription pad signed by another doctor, the Board decided to suspend her registration as of 6 May 2014.12

LACK OF SUPERVISION AND MENTORING A FACTOR IN TRIBUNAL’S FINDING OF PROFESSIONAL MISCONDUCT

An amended application for disciplinary action (the amended application) was filed and the Tribunal was informed on 2 June 2014 that the respondent:

intended to concede that the conduct alleged represented “professional misconduct” within the meaning of s 5 of the National Law.13

At the Tribunal hearing in June 2014, Dr Tausif did not challenge any of the expert opinion or other evidence presented in relation to the occasions it was alleged her practices were unsafe for patients. After weighing the evidence, the Tribunal made a finding of professional misconduct within the meaning of s 5 of the National Law.14

The Tribunal found that the impugned conduct represented significant global problems with the respondent’s clinical competence and judgment. Of particular concern were the respondent’s unsafe prescribing (particularly on occasion unusually large amounts and to patients who appeared to be abusing the system due to addictions) of Schedule 8 medications and her failure to accept and utilise advice from colleagues about such patients, even when it was expressly written in clinical notes.15

Yet the Tribunal also found that Dr Tausif’s professional problems appeared “to have gone undetected, uncorrected and unreported in the two practices in which she worked for approximately three years, the Ginninderra and Phillip practices of Primary Health Care”.16

8 Tausif [2015] ACAT 4 at [6].
9 Tausif [2015] ACAT 4 at [7].
10 Tausif [2015] ACAT 4 at [7].
11 Tausif [2015] ACAT 4 at [7].
12 Tausif [2015] ACAT 4 at [7].
13 Tausif [2015] ACAT 4 at [9(b)].
16 Tausif [2015] ACAT 4 at [16].
Evidence was sought by the Tribunal at hearings in July and November 2014, to determine the “nature of mentoring and supervision” at both practices. Evidence from the lead doctors, Dr Ajulo and Dr Johar, indicated that training for commencement at the practices was in the use of the billing system, that supervision and mentoring were not a specified responsibility of the lead doctors, and that “occasional in-house clinical meetings” were organised, but that the respondent was unable to attend because she was rostered out-of-hours. Dr Ajulo and Dr Johar asserted that the:

AHPRA-certified “independent contractor” nature of the contractual arrangements between doctors and Primary Health Care precluded much supervision and mentoring.\(^{18}\)

In further evidence pertaining to their knowledge of Dr Tausif’s prescribing restrictions they stated that Primary Health Care had not sent them a letter advising them of the situation or how to deal with it.\(^{19}\) They did, however, become aware that she was unable to prescribe Sch 8 medications. Dr Johar said he responded by having “a few chats” with her.\(^{20}\) Dr Ajulo declined to offer her any supervision or mentoring as he considered it was not his “contracted role” to do so.\(^{21}\) Ironically, in regards to her Sch 4 and Sch 8 prescribing restrictions, he said “it would be difficult” to work with such restrictions in such a practice.\(^{22}\) The Tribunal took this to imply that:

there was no general acknowledgement of responsibility to assist the respondent to comply with those restrictions whilst she was still working in those practices. An argument can be made that these aspects of professional practise at the Ginninderra and Phillips practices of Primary Health Care contravene the requirement for public protection and safety in section 18 of the HP Act [Health Professionals Act 2004 (ACT)].\(^{23}\)

That Dr Tausif chose to continue working at the practices, even though it was difficult under the Sch 4 and Sch 8 prescribing restrictions, arose in evidence at the Tribunal, emanating from her concerns that there would be “severe financial consequences as a result of her contract with the company” if she stopped working.\(^{24}\) The Tribunal went on to conclude that:

a large part of the respondent’s problems arose in the case of each suspension, from the low levels of supervision and mentoring available in the Phillip and Ginninderra practices of Primary Health Care.\(^{25}\)

Dr Johar admitted in evidence that the Phillip Centre practice “has responsibilities to patients beyond those of specific doctors to specific patients in individual clinical encounters.”\(^{26}\) However, the Tribunal was not privy to any documentation setting out what the responsibilities of lead doctors were or whether they met with AHPRA compliance standards.\(^{27}\)

The Tribunal did not find fault with Dr Johar or Dr Ajulo, but rather considered the lack of supervision and mentoring to be systemic in that it related to the contractual arrangements between practitioners and Primary Health Care. The Tribunal went on to find that it was a:

failure of the leadership of Primary Health Care to engage properly in its governance arrangements with the requisite professional standards required for public protection and safety [under s 8 of the Health Professionals Act 2004 (ACT)].\(^{28}\)

\(^{17}\) Tausif [2015] ACAT 4 at [17].
\(^{18}\) Tausif [2015] ACAT 4 at [43].
\(^{19}\) Tausif [2015] ACAT 4 at [45].
\(^{20}\) Tausif [2015] ACAT 4 at [45].
\(^{21}\) Tausif [2015] ACAT 4 at [45].
\(^{22}\) Tausif [2015] ACAT 4 at [45].
\(^{23}\) Tausif [2015] ACAT 4 at [45].
\(^{24}\) Tausif [2015] ACAT 4 at [49].
\(^{25}\) Tausif [2015] ACAT 4 at [42].
\(^{26}\) Tausif [2015] ACAT 4 at [43].
\(^{27}\) Tausif [2015] ACAT 4 at [48].
\(^{28}\) Tausif [2015] ACAT 4 at [53].
The Medical Board sought cancellation of registration of Dr Tausif on the grounds of the: unsafe way the respondent had administered and documented her Schedule 8 prescriptions … and the way in which she attempted to circumvent the admittedly harsh Schedule 4 prescription restriction the Medical Board imposed.²⁹

The Tribunal fundamentally concurred with the Board stating that:

The respondent’s conduct does seem to have evinced a lack of assertiveness in standing up to dependent patients, a lack of due diligence in understanding and complying with the Medical Board’s restrictions and an inability to properly understand how to modify and document her professional conduct in regard to peer feedback.³⁰

However, the Tribunal ordered that conditions be imposed that aimed at rectifying the respondent’s conduct. The basis of this response was the Tribunal’s findings that there was “no fundamental failing in the respondent’s initial medical training”.³¹

Dr Tausif was born in Bangladesh in 1969. She studied medicine at the Sylhet Medical School and completed her internship at Sylhet hospital.³² She worked as a doctor for the Bangladesh Garments Manufacturers’ Association Health Centre for five years before migrating to Australia with her husband, who was also a doctor. Prior to receiving unconditional registration with the Medical Board of Australia, she was an intern at Canberra Hospital and a Resident Medical Officer at Calvary Hospital.³³ From December 2008 to March 2011, she worked as a general practitioner at the Gungahlin Medical Centre where she received supervision and mentoring from practitioners who “vetted her workload and patient distribution to suit her experience”.³⁴

The Tribunal also took into consideration that no patients were known to have brought a complaint against the respondent and that her “non-Schedule 8 prescribing appeared to have been clinically appropriate”.³⁵

The Tribunal also found that the lack of professional development in the way of clinical supervision and mentoring were a significant contributing factor to her unsafe Sch 8 prescribing practices and poor patient records management.³⁶

The Tribunal was guided in its decisions by the principles established in three key cases: *HCCC v Dr Della Bruna* [2014] NSWCA TOD 31 [which] require[d] that the paramount consideration be protection of public health and safety. Protection of the profession’s ethical and clinical standards is also an important consideration (*HCCC v Litchfield* (1997) 41 NSWLR 630 at 637); as is public confidence in the profession … and encouragement of professional compliance with appropriate standards (*Prakash v HCCC* [2006] NSWCA 153)).³⁷

The Tribunal ordered that Dr Tausif have Level 2 supervision by a Board-approved supervisor, whether she worked in general practice or in a hospital.³⁸ As a further means to improve her clinical practice through professional development, the Tribunal ordered that she undertake remedial courses specified by the Board.³⁹

²⁹ *Tausif* [2015] ACAT 4 at [52].
³⁰ *Tausif* [2015] ACAT 4 at [52].
³¹ *Tausif* [2015] ACAT 4 at [56].
³² *Tausif* [2015] ACAT 4 at [2].
³³ *Tausif* [2015] ACAT 4 at [3].
³⁴ *Tausif* [2015] ACAT 4 at [3].
³⁵ *Tausif* [2015] ACAT 4 at [53].
³⁶ *Tausif* [2015] ACAT 4 at [53].
³⁷ *Tausif* [2015] ACAT 4 at [55].
³⁸ *Tausif* [2015] ACAT 4 at [60] (Order 1(a)).
³⁹ *Tausif* [2015] ACAT 4 at [60] (Order 1(d)).
The Tribunal also ordered that the restrictions on prescribing Sch 8 medications continue and could only be withdrawn or changed by written approval from the Board. However, in relation to Sch 4 drugs, the Tribunal found that withdrawal of authority to prescribe Sch 4 drugs contributed to the respondent’s problems, as the restriction rendered her practice as a GP untenable. The Tribunal was critical of the Board’s imposition of Sch 4 drugs restriction as it amounted to a “de-facto suspension”. The Tribunal ordered the lifting of the restriction and ordered remedial education for the respondent in prescribing practices, patient management and patient mental health.

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The decision to impose professional support through education rather than cancellation of registration also recognised that Dr Tausif had little choice in patient selection and was required to treat drug-dependent patients, a known class of difficult patient, whom she was inexperienced in treating.

The Tribunal ordered the respondent’s authority to prescribe Schedule 4 drugs to be restored once the respondent was working in compliance with the conditions imposed and was certified that she was doing so by a lead doctor at her practice.

The Tribunal ordered Dr Tausif to be subject to audits of her clinical notes, at intervals required by the Board, to ensure her compliance with Pt 4 and Sch 2 of the Health Practitioner Regulation (ACT) 2010 (ACT) and the RACGP’s Standards for General Practices (4th ed), in particular Standard 1.7 “Content of Patient Health Records”.

MEDICAL DUTY TO PROVIDE A SAFE SYSTEM OF CARE IN THE CONTEXT OF CORPORATE BUSINESS MODELS

The Tausif case is significant because it supports as a principle of sound medical practice that the medical services provided by an individual practitioner should not be scrutinised for compliance with appropriate standards in isolation from a detailed examination of the business and practice models within which such practitioners work.

In placing Dr Tausif within the context of that system, the Tribunal recognised that:

- a Tribunal addressing public protection and safety as required by section 3(2)(a) of the Health Practitioner Regulation National Law (ACT) (the National Law) and section 18 of the Health Professionals Act 2004 (ACT) (the HP Act) should consider not just the conduct of a registered practitioner but also the nature of the system in which he or she practises, including that system’s levels of training, supervision, mentorship and quality control.

The system within which Dr Tausif worked was established by Primary Health Care, an ASX listed company, specialising in the provision of “management services” to health professionals. The company is one of the top three in the Australian corporate health market, along with Sonic Healthcare and Healthscope. Primary Health Care controls a network of medical centres, pathology and diagnostics services and health management software. The company expanded its network of medical centres by purchasing practices and then contracting doctors from those practices to work in the centres. It has also purchased large consolidated practice companies such as Symbion (formerly Mayne Nickless).

Essential to understanding the nature of the system operating at the Ginninderra and Phillip practices were the financial arrangements that Dr Tausif entered into with Primary Health Care. Primary Health Care’s business model appeared from what was found by the Tribunal to be carefully

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40 Tausif [2015] ACAT 4 at [60] (Order 1(c)).
41 Tausif [2015] ACAT 4 at [54].
42 Tausif [2015] ACAT 4 at [60] (Orders 1(c), 1(d), 1(g)).
43 Tausif [2015] ACAT 4 at [50].
44 Tausif [2015] ACAT 4 at [60] (Order 1(c)).
45 Tausif [2015] ACAT 4 at [60] (Order 1(e)).
47 Medicare Financing and Analysis Branch, n 4, p 25.
constructed to maximise revenues, reduce costs and limit liabilities. It is a natural goal of corporate risk management to attempt to minimise legal problems associated with “responsibilities” for the provision of services to the public, especially in health care where litigation risk is high. Documents submitted to the Tribunal show Primary Health Care’s corporate structure to consist of three key entities, Primary Health Care Limited, Artlu Unit Trust and its trustee company Idameneo (No 123) Pty Ltd.48

According to the Tribunal, the financial arrangements between Dr Tausif and Primary Health Care were established through a contract called a “Sale of Practice” between her company, Syeda & Shaikh Pty Ltd, and Idameneo (No 123) Pty Ltd.49 This contract stated that Dr Tausif was to provide medical services “for no less than 45 hours per week for 48 calendar weeks per financial year”.50 Another document, “Performance Guarantee Incorporated Medical Practitioner”, set out the obligations of the “independent contractor” to provide medical services under the “Provision of Services to Incorporated Medical Practitioner” “which included seeking payments from Medicare (clause 4.3), 50% of which were to be kept (plus a GST rate) by Idameneo Pty Ltd as remuneration for use of the premises (clause 6)”.51 Over a three-year period at Primary Health Care, Dr Tausif had approximately 30,000 patient consultations averaging 40-50 patients a day and was paid $8 per patient.52 She was also paid a retainer described as “substantial”.53

The Provision of Services document also stated what Primary’s agreed provision to the incorporated medical practitioner would be. The Tribunal noted that:

The services and facilities agreed to be provided by the company as “reasonably necessary for the conduct of an incorporated medical practice” (clause 3.2(b)) did not include clinical supervision or mentoring.54

The contractual arrangements between the companies defines the relationship as that of independent contractor to principal. This common type of workplace arrangement, which replaces the older style employer-employee relationship, has created a great deal of uncertainty pertaining to the responsibilities of each entity for workplace practices and for when things go awry in the workplace. The courts have been at pains to define the meaning of employee and contractor.55

In Leighton Contractors Pty Ltd v Fox, the High Court established that a principal had a duty of care to ensure an independent contractor was competent, even though it deemed:

The relationship between principal and independent contractor is not one which, of itself, gives rise to a common law duty of care, much less to the special duty resting on employers to ensure that care is taken.56

Primary Health Care’s contracts were carefully crafted to exclude employee relationships and to establish their definition of what is “reasonably necessary for the conduct of an incorporated medical practice” by excluding references to supervision and mentoring.57

48 Other subsidiaries in the group are Idameneo (No 124) Pty Ltd, PHC (No 01) Pty Ltd, PHC Nominees Pty Ltd and former SDS Pty Ltd. Idameneo (No 122) Pty Ltd is also listed as a major shareholder on Primary Health Care Limited’s website: http://www.primaryhealthcare.com.au/IRM/content/investors_top20shareholders.html.

49 The Tribunal subpoenaed financial documents due to the respondent’s reluctance to reveal these arrangements: Tausif [2015] ACAT 4 at [19].

50 Tausif [2015] ACAT 4 at [20].

51 Tausif [2015] ACAT 4 at [21].

52 Tausif [2015] ACAT 4 at [19]. The Tribunal heard evidence that Dr Tausif received 50% of the Medicare bulk-billing fee (which was $36 per patient). However, she received a lower fee ($16 less) because she was designated a “non-vocational” doctor. It was because of this reduction that her final payment was $8 per patient.


54 Tausif [2015] ACAT 4 at [21].


56 Leighton Contractors Pty Ltd v Fox (2009) 240 CLR 1 at [48].

57 Tausif [2015] ACAT 4 at [21].
The decision of the New South Wales Court of Appeal in Waco Kwikform Ltd v Perigo, however, suggests that this exclusion may not hold in circumstances where the principal has become aware that supervision is needed. In Waco Kwikform, a supplier of scaffolding equipment was deemed to be liable for the injuries caused to an employee of a subcontractor, Bradley Tracey Scaffolding Services Pty Ltd (BTSS). Waco Kwikform had assessed that the subcontractor was not sufficiently competent to undertake the work without supervision. In 2006, Waco Kwikform assumed responsibility for the plan of work and supervision of scaffolding installation undertaken by the subcontractor. It was held that if the employee’s accident had occurred before it had assumed supervision of BTSS’s work, it would not have owed a duty of care to him or any other BTSS employee, except in regard to the scaffolding equipment. Waco Kwikform had inadvertently become liable by means of its attempt to manage an occupational health and safety risk. The case’s counterintuitive outcome in regards to duty of care and supervision indicates the difficulties that may arise when the law is the only guide to practice policy.

In the United States during the 1990s there were numerous decisions pertaining to “enterprise liability” under which managed care providers were found liable for selection and supervision of health care providers. In McClellan v Health Maintenance Organization, it was found that the Health Maintenance Organization “had a non-delegable duty to select and retain only competent physicians” and in Doe v Dyer-Goode, the court stated that:

We find that the allegations of the complaint are sufficient to state a cause of action for negligence in the selection, retention, and/or evaluation of the primary care physician.

In the wake of Waco Kwikform and the legal decisions in the United States, it is arguable that Primary Health Care’s medical practices model of contracting doctors without the provision of supervision and mentoring, a model aiming at reducing their costs and liabilities, may fail to diminish their liability in circumstances where they know that a practitioner’s conduct presents a risk to others.

Two lead doctors from the Ginninderra and Phillip practices, giving evidence at the Tribunal, claimed they had not been advised in a letter by Primary Health Care of the restrictions placed on Dr Tausif’s practice by the Board. Consequently, no remedial action was taken by either practice or Primary Health Care in the way of supervision or mentoring to assist the respondent. The implication was that Primary Health Care assumed it was up to the respondent’s company (with whom the contract was made) to meet the requirements of s 18 of the Health Professionals Act 2004 (ACT), even though her company was merely a contractual entity and not a means by which she could garner professional support.

The responsibility of the principal for providing a safe system of care in a medical practice may also fall within legal ambit of non-delegable duty of care. In New South Wales v Lepore, the High Court established that a non-delegable duty of care existed in matters where people are deemed to be vulnerable. There are many vulnerable clients in a medical practice, and specifically in this case where the respondent’s patient load included a number of patients with drug dependencies and/or mental illness.

Dr Tausif claimed that the “first available doctor” system, which placed her established patients down the queue from walk-in patients, resulted in her losing these patients because of the lengthy waiting times. This system did not support continuity of care for her patients, a mode of care best

58 Waco Kwikform Ltd v Perigo [2014] NSWCA 140.
64 Tausif [2015] ACAT 4 at [46].

(2015) 22 JLM 534 541
able to ensure patient safety. The respondent ended up treating a number of drug-dependent patients, a group with which she was not familiar, because there was no lead doctor allocating patients to practitioners.

Instead, Primary Health Care provided a centralised, online patient record system accessible by all doctors in the medical centres and by Primary’s management. Some of these records were from practices sold to Primary Health Care, which were transferred to Primary when the doctor was contracted. This is part of the “Sale of Practice”, as patient records are generally listed as a component of the “goodwill” being sold by the incorporating practice. The patient records system is critical to the “first available doctor” practice model for, without it, treating doctors would have to take detailed patient histories repeatedly, reducing their efficiency:

It was apparent to the Tribunal that the respondent’s professional problems appear to have gone undetected, uncorrected and unreported in the two practices in which she worked for approximately three years, the Ginninderra and Phillip practices of Primary Health Care.66

However, the centralised records system did not reduce the possibility of a culture defined by levels of disclosure not in keeping with the standards of the Medical Board’s Code of Practice.67 The respondent was found to have poor patient record practice, which should have shown up on the patient records system but was not detected. Primary Health Care has sued at least 36 doctors working at their practices since 2008.68 This may have caused some contractors to be reticent about bringing problems appearing in the records system to light.

In the Leighton case, the High Court established the principle that specific circumstances of work must be considered.69 Many medical practices offer a networked collegial environment governed by strict professional standards and regulations.

Avoiding clinical supervision and mentoring in an attempt to reduce liability may actually escalate the risk of liability. The Tribunal found:

that the respondent’s professional misconduct was substantially contributed to by the lack of clinical supervision and mentorship she experienced at the Primary Health Care Ltd practices at Phillip and Ginninderra.70

Further, by allowing the misconduct to go “undetected, uncorrected and unreported” Primary Health Care was not providing a safe system of care and therefore was breaching their non-delegable duty of care to patients attending the centres.

Brooke LJ in Robertson v Nottingham Health Authority, found that there was a common law duty on a health care providing institution to ensure a safe system of care:

Although it is customary to say that a health authority is vicariously liable for breach of duty if its responsible servants or agents fail to set up a safe system of operation in relation to what are essentially management as opposed to clinical matters, this formulation may tend to cloud the fact that in any event it has a non-delegable duty to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment and safe premises.72
RELATIONSHIP WITH THE AUSTRALIAN BULK-BILLING SYSTEM

The *Tausif* case illustrates how private corporations utilising the bulk-billing model to earn profits may create an unsafe system of care for patients. The Australian bulk-billing system was recently the centre of a public policy debate over a proposed co-payment.

The GP co-payment concept was promoted initially by the Australian Centre for Health Research, a private health funds “think tank”, in its submission to the National Commission of Audit in December 2013. It recommended a $6 co-payment for patients using bulk-billing services such as those that appear to dominate the business model of health care providers such as Primary Health Care.

On 9 December 2014, the Abbott government announced it would not proceed with a $7 patient co-payment fee for bulk-billed consultations. The fee to patients would be recast as a $5 cut in the Medicare rebate to bulk-billing doctors treating non-concession patients. Doctors, at their discretion, could recoup the lost income by charging patients a $5 co-payment fee. Concessional patients, which include pensioners and children under 16 years, would be exempt. There would also be a freeze on Medicare rebate increases for doctors and rebates would be standardised for consultations between 10 and 19 minutes. The latter change was seen as a clumsy attempt to improve the quality of care by discouraging “six minute medicine”. Again this latter change did not affect concessional patients.

These announced changes initially saw Primary Health Care lose 6% off its share value, but the price began to recover after analysts reported that 70% of Primary’s business was concessional cardholders and children – patient groups which are exempt from the changes.

The Minister for Health, Sussan Ley, announced further changes on 15 January 2015 which added GP mental health plans and GP management plans to the rebate exemptions list. These products would favour practices that provide multidisciplinary services. These changes were to be effective from 1 July 2015.

 Corporations like Primary Health Care are driving bulk-billing in co-operation with the government because the system gives certainty to their income base. Their key target market appears to be low socioeconomic areas, which supply their practices with patients who are largely paid for by the government. These patients are also largely exempt from government “price signal” policy, so the patient demand for their services is high, which in turn supports the “fast churn” business model they operate, with GPs processing 40-60 patients a day.

The volatility created by the serial revision of co-payment policy is good for the traders because the money is made in the price shifts, so with every co-payment policy revision made by the government, millions of dollars worth of shares change hands on the markets and for every trade made, commissions are made by the investment banks.

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79 The corporate sector has also benefited from the largesse of government funding under the GP Super Clinics scheme established in 2007: *Medicare Financing and Analysis Branch*, n 4, p 59.
This is good news for Primary Health Care’s biggest shareholders, most of whom are investment banks, National Nominees Limited, HSBC, UBS, JP Morgan, RBC Dexia Investor Services, Citicorp and Idameneo (No 122) Pty Ltd.80

CONCLUSION

The corporate medical services sector does not dominate the Australian market, but it is growing. It is, however, a powerful sector of the GP services market due to its high revenues and profitability.81

In recent times, the corporate health care practice market has consolidated to three major publicly listed companies, Primary Health Care, Sonic Healthcare and Healthscope.82 These companies have expanded their businesses through vertical and horizontal integration across a multiple of health-related businesses, including pathology, imaging diagnostic services and IT.

This corporate health sector continues to grow through the acquisition of GP practices, dental clinics and allied health services. The Australian health care market is very attractive to global health providers. Australia’s health care system expends 9.4% of gross domestic product (GDP) and has an average life expectancy of 82 years.83 This is in comparison to the Unites States which spends 17.4% of GDP on health while only achieving an average life expectancy of 78.8 years.84 From the Australian citizen’s perspective, these figures represent comparative value for money in a system that is still largely public in the hospital sector, and in general practice is still dominated by small business models that include partnerships, sole traders and associateships. However, from an investor’s perspective these figures represent the untapped capacity of Australians to pay much more for health care. This was made clear by United States consultancy firm Bain & Company, which stated in its Global Healthcare Private Equity Report in 2013 that:

Australia also continues to be an attractive area of investment for private equity investors, given the favorable macro trends and under-penetration of many private healthcare offerings.85

The new corporate business models have introduced another tier of stakeholders called shareholders, into the health services market. The apparent link between the Ginninderra and Phillip practices and shareholder bank vaults in Sydney, New York, Chicago and London reflects that new reality – a new tier of profitability operating in the health sector, which did not exist 25 years ago. It is a reality with which professional regulatory bodies, such as those in the Tausif case, must increasingly deal.

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The views expressed in this column are the author’s own and do not necessarily reflect the views of the editor who was the Presiding Member in the case discussed.


81 Primary Health Care had an 8.3% EBITDA growth in medical centres in the second half of the 2014 financial year over the previous corresponding period. Their net profit was up 7.65% (Primary Health Care Limited, Annual Report For the Year Ended 30 June 2014, p 5); Sonic Healthcare had 12% revenue growth to $3.9 billion and net profit up 15% (Sonic Healthcare, Concise Annual Report 2014, pp 6, 26); Healthscope had 5.1% revenue growth to $2.326 billion (Healthscope, Announcement of FY14 Full Year Financial Results (27 August 2014) p 1).

82 Two smaller companies, Ochre and Tristar Medical Group Health have practices in rural areas and the Australian Capital Territory.

