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FOCUS

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MEDICAL PRACTITIONERS AND ANTI-COMPETITIVE CONDUCT

Partner Carolyn Oddie and Law Graduate Jenny Kaldor report on the recent decision of the Federal Court in ACCC v Knight in relation to a claim by the ACCC that two doctors had engaged in anti-competitive conduct in relation to the running of their practices.

We look at a range of issues in health, including the first set of standards issued by the Queensland Health Quality and Complaints Commission

HOW DOES IT AFFECT YOU?

Doctors must be aware that individuals in private practice – and not just corporations – are subject to laws regulating anti-competitive conduct. This decision is a reminder that entering into a market-sharing agreement with another doctor, or making an arrangement which places restrictions on another doctor's practice, will attract the eye of the competition watchdog.

BACKGROUND

This claim was brought by the Australian Competition and Consumer Commission (the ***ACCC***) against Dr John Knight and Dr Iain Ross, both cardiothoracic surgeons practising in the Adelaide metropolitan area.[1] The doctors were two of only seven or eight such surgeons in the region who supplied cardiothoracic surgical services to private patients in South Australia.

In 2001, the doctors made an arrangement between themselves relating to a third cardiothoracic surgeon, Dr Craig Jurisevic. They agreed that until Dr Jurisevic obtained further training and experience, they would hinder him from providing services in the market by preventing his accreditation and appointments at various hospitals. The doctors believed that Dr Jurisevic's relative inexperience presented an unacceptable risk to patients.

In 2003 and 2004, Dr Knight and Dr Ross attempted to make further arrangements, this time in the form of 'non-compete' or market-sharing agreements, with a fourth cardiothoracic surgeon, Dr James Edwards. They suggested that Dr Edwards should agree not to supply cardiothoracic surgical services to patients at one cardiac unit in competition with Dr Knight and Dr Ross. In exchange, Dr Knight and Dr Ross would agree not to supply cardiothoracic surgical services to patients at another cardiac

1. [2007] FCA 1011.

unit in competition with Dr Edwards. Dr Knight and Dr Ross believed these arrangements were necessary to maintain the viability of the two separate units. Dr Edwards refused to enter into the arrangement.

The ACCC alleged that these arrangements had the purpose or effect of substantially lessening competition in the market, in breach of section 45 of the South Australian Competition Code.

RELEVANT LEGISLATION

The *Trade Practices Act 1974 (*Cth) (the ***TPA***) is the Commonwealth instrument under which the ACCC promotes, monitors and enforces fair trading. Until 1995, the TPA's restrictive trade practices, or competition, provisions applied only to corporations.

However, in 1995, following a decision to apply the TPA to all 'persons' carrying on a business, the Competition Code (the ***Code***) was enacted by each state and territory. The Code applies to individuals such as professionals. So, even though this case relates to doctors in South Australia, similar provisions apply all over the country as part of a single National Competition Policy.

THE DECISION

Dr Knight and Dr Ross admitted that the arrangements they made and attempted to make were likely to have the impact of 'substantially lessening competition in the market' (the relevant test under the TPA and the Code).

The 2001 arrangements signalled to newly admitted cardiothoracic surgeons that they would need further clinical training before entering the market, thereby raising barriers to entry. Had Dr Edwards agreed, the 2003-04 arrangements would also have had the effect of substantially lessening competition in the market, as they would have prevented the doctors from offering cardiothoracic surgical services in competition with each other.

Because Dr Knight and Dr Ross admitted the ACCC's allegations, the Federal Court decision by Justice Mansfield was primarily concerned with the penalty to be imposed on them. The judge considered the circumstances of the conduct, the amount of loss and damage caused, the deliberateness of the contravention and any prior contravention by the doctors.

Justice Mansfield accepted that, while their conduct was certainly deliberate, the doctors honestly believed it was necessary and in the best interests of their patients and the profession. Nevertheless, the judge also noted that because the two doctors were respected senior members of their profession, their opinion and arrangements were likely to be highly influential with their peers, thus creating a stronger impact in the market.

The judge found that the 2001 conduct was likely to have ongoing effects on competition in the market, and that the 2003-04 conduct, while only attempted contraventions, was 'nevertheless serious'.

On the other hand, neither Dr Knight nor Dr Ross had previously been involved in any contravention of the TPA or the Code. Neither, it was clear, did they have any knowledge of the TPA or the Code, or how these applied to them. They were not acting in knowing contravention of the law. Further, because the doctors cooperated with the ACCC, saving the court's time and resources, Justice Mansfield allowed a significant discount to their proposed penalties.

The doctors were each ordered to pay a penalty of $55,000 and to attend an ACCC trade practices compliance program. The judge noted that deterrence was the principal object here:

> *the penalty must be substantial enough that the party realises the seriousness of its conduct and is not inclined to repeat such conduct. ... [There is also] the need to impose a sum which members of the public will recognise as significant and proportionate to the seriousness of the contravention.*

CONCLUSION

Individuals in private practice – and not just corporations – are subject to laws regulating anticompetitive conduct. All professionals should be mindful of the provisions of the TPA and the Code when making decisions with others about the running of their practice.

THE HEALTH QUALITY AND COMPLAINTS COMMISSION'S SEVEN STANDARDS

The Health Quality and Complaints Commission was established in 2006 by the *Queensland Parliament under the Health Quality and Complaints Commission Act 2006* as an oversight body to guide health service providers in relation to monitoring and improvement in the quality of their health services. Lawyer Emily Barnes reviews the first set of standards issued by the Health Quality and Complaints Commission, designed to assist both the Commission and health service providers in determining what will be a 'reasonable' quality improvement process.

HOW DOES IT AFFECT YOU?

In Queensland, health service providers are under a statutory obligation to improve the quality of their health services. As of 1 July 2007, health service providers must demonstrate that they have discharged this obligation by either complying with the seven standards set by the Health Quality and Complaints Commission or by applying and complying with protocols or guidelines that the Health Quality and Complaints Commission deems reasonable.

BACKGROUND: THE COMMISSION

Section 20 of the *Health Quality and Complaints Commission Act 2006* (the ***Act***) provides that a health service provider (***HSP***) must establish, maintain and implement reasonable processes to improve the quality of health services provided by or for the provider, including processes to monitor the quality of health services and to protect the health and wellbeing of users of health services. Under s22 of the Act, the Health Quality and Complaints Commission (the ***HQCC***) has the power to make standards about the processes a HSP may adopt in order to comply with s20.

On 1 July 2007, the HQCC released its first seven standards.

THE STANDARDS

After considering the burden of disease, severity of impact on consumers, frequency of occurrence, major process/system failings in patient safeguards, and the recent reviews and inquiry into health services in Queensland, the HQCC (through a consultation process with key stakeholders) selected the following standards:

- review of hospital related deaths;
- management of acute myocardial infarction (***AMI***) on, and following, discharge;
- surgical safety;
- hand hygiene;
- credentialling and scope of clinical practice;
- complaints management; and
- provider's duty to improve the quality of health services.

These standards apply to all HSPs as defined by the Act, effective from 1 July 2007. The educative rollout of the standards by the HQCC across the state will occur up until December 2007 and accordingly the monitoring and reporting requirements relevant to the standards will also be implemented on a staged basis.

Pursuant to their obligations under the Act, HSPs will need to demonstrate that they are acting in accordance with the standards. They can do this through:

- self assessment;
- reporting quality improvement initiatives;
- self measurement (including data from third parties); and
- reporting mandatory data items to the HQCC,

in relation to each of the goals listed for the standard(s) relating to their specific activities (with the exception of the seventh standard, which is superfluous and merely states what is already provided for in s 20 of the Act, and by the actual implementation of the standards).

The HQCC will, in turn, confirm compliance of the HSP through verification of:

- self assessment responses;
- self measurement methods; and
- the accuracy of mandatory data items (along with appropriateness of methods).

To do this, the HQCC will engage in audits, on-site inspections, documentary reviews, interviews with staff, observational assessments and other methodologies.

The following overview of each of the seven standards is only that, and all HSPs and other interested persons are directed to the endorsed standards manual.

STANDARD 1: REVIEW OF HOSPITAL-RELATED DEATHS

The standard: All deaths that occur within Queensland hospitals (and within the community if a hospitalisation has occurred within a preceding 30 days of the death), are to be reviewed and three set checks undertaken.

The goal: That all hospital-related deaths are reviewed, quality improvement opportunities are identified and recommendations arising from the reviews are implemented.

STANDARD 2: MANAGEMENT OF AMI ON AND FOLLOWING DISCHARGE

The standard: That AMI is managed on and following discharge in accordance with the *Guidelines for the Management of Acute Coronary Syndromes (Long-term management after control of myocardial ischaemia)*[2] to ensure, among other things, coordinated ongoing patient care, the monitoring of patient response to medication and accountability for patient care post-discharge.

The goal: That all patients receive long-term care in compliance with evidence-based best practice guidelines and that the incidence of secondary disease is reduced.

STANDARD 3: SURGICAL SAFETY

The standard: That best practice guidelines are implemented by HSPs to reduce the risk associated with procedures, including of surgical infections, incorrect surgery and venous thromboembolism.

The goal: Improvement of surgical safety demonstrated by reduced rates of surgical site infection, patient safety incidents and thromboembolism.

STANDARD 4: HAND HYGIENE

The standard: That hand hygiene is kept in accordance with the *Guidelines on Hand Hygiene in Health Care*.[3]

The goal: A sustained reduction in healthcare-associated infections that are associated with poor hand hygiene practices.

STANDARD 5: CREDENTIALLING AND SCOPE OF CLINICAL PRACTICE

The standard: That all medical practitioners in hospitals be credentialled in accordance with the *Standard for Credentialling and Defining the Scope of Clinical Practice*, and that they provide medical intervention that is both within their defined scope of practice and within the service capability of the hospital.

The goal: All care provided to patients is undertaken by (or supervised by) a credentialled medical practitioner and is within the approved scope of her/his clinical practice.

STANDARD 6: COMPLAINTS MANAGEMENT

The standard: The implementation of *Better Practice Guidelines on Complaints Management for Health Care Services*[4] by HSPs.

The goal: To provide a consistent complaints management system across HSPs in Queensland that is accountable, transparent, efficient and accessible.

2. Produced by the National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand.

3. World Alliance for Patient Safety, *WHO guidelines on hand hygiene in health care (advanced draft): clean hands are safer hand*s, Geneva: World Health Organisation 2005.

4. These guidelines were developed by the Australian Council for Safety and Quality in Health Care.

STANDARD 7: PROVIDER'S DUTY TO IMPROVE THE QUALITY OF HEALTH SERVICES

The standard: To establish, maintain and implement reasonable processes to improve the quality of health services under s 20 of the Act.

The goal: Risks to patient safety are assessed and processes (which can be demonstrated) are put in place that improve both the safety and quality of the care provided to patients.

CONCLUSION

The standards set by the HQCC offer a multi-pronged approach to guiding HSPs towards better health care for Queensland patients. With the main focus of the standards and their compliance being on HSPs and self-regulation (granted, to a point), it will be interesting to see how this system develops in terms of how proactive the HQCC becomes in overseeing HSP compliance and the demonstrated consequences for breaches of the standards.

DISCRIMINATION IN RELATION TO AN ASSISTANCE ANIMAL

It is potentially unlawful for a medical practitioner to refuse to provide medical services to a person with a disability (which is very widely defined) on the grounds that the person is accompanied by an 'assistance animal'. Lawyer Elena Tsangari reviews the recent decision in *Forest v Queensland Health*[5] where the Federal Court had to consider what was required for an animal to be classed as an 'assistance animal'.

HOW DOES IT AFFECT YOU?

This case serves as a reminder to medical practitioners that care must be taken if a patient presents for treatment with an 'assistance' animal. Under the discrimination legislation, any animal trained to assist a disabled person to alleviate the effect of his or her disability is potentially an assistance animal and any refusal to provide treatment to a patient accompanied by an assistance animal could amount to unlawful discrimination. Reliance on policies prohibiting animals on the premises will not be sufficient justification.

BACKGROUND

The applicant, Mr Forest, suffered from a personality disorder and claimed that he had trained two dogs as assistance dogs to mitigate the anxiety and distress he experienced as a result of his disorder.

On numerous occasions, Mr Forest attended at the Cairns Base Hospital and the Smithfield Community Health Centre accompanied by one of his assistance dogs. Notwithstanding Mr Forest's assertions that each dog was an assistance animal within the meaning of the

5. [2007] FCA 936.

Disability Discrimination Act 1992 (Cth) (the ***Act***), representatives of Queensland Health advised Mr Forest that he would not be treated while accompanied by a dog.

Mr Forest sued, claiming that Queensland Health had unlawfully discriminated against him. While Mr Forest claimed breaches of various sections of the Act, this note will focus on section 9 of the Act, which specifically deals with discrimination in relation to assistance animals. It should be noted that Mr Forest did not argue that his assistance dog should have been permitted in sterile areas; the case was confined to non-sterile areas of the premises.

THE ACT

Section 9(1)(f) provides an example of conduct that will be discriminatory. It provides that a person discriminates against a person with a disability (the aggrieved person) if the person treats the aggrieved person less favourably because the aggrieved person is accompanied by an animal trained to assist the aggrieved person to alleviate the effect of the disability.

Section 24 provides that it is unlawful for a person to discriminate against another person on the grounds of the other person's disability by refusing to provide the other person with goods or services. The section goes on to provide that such refusal will not be unlawful if the provision of the goods or services to that person would impose unjustifiable hardship on the service provider.

THE DECISION

WAS THE CONDUCT DISCRIMINATORY?

It was accepted that Mr Forest had a disability under the Act. The issue for the court was whether the dogs were assistance animals under s9 of the Act; that is, had they been 'trained to assist...to alleviate the effect of the disability'?

The court noted that the Act was not limited to dogs, but rather extended to any assistance animals, and contained no definition of *training* or *alleviate*. Given this, the court concluded that s9 contemplated 'an animal which had been trained in the sense of having been disciplined and instructed to perform specified actions, but not by any particular person or organisation, nor to any standard of accreditation by any organisation.'[6] Further, the court considered that 'alleviate' should be given its ordinary meaning; that is, to lessen or mitigate the effect of the disability. It was not necessary for the aggrieved person to 'need' the assistance animal or for the assistance animal to improve the medical condition or provide effective treatment for the disability. In light of these findings, the court held that the training that had been provided to Mr Forest's dogs and the tasks they performed for him were sufficient for the dogs to be classed as assistance animals under the Act.

In the circumstances, Queensland Health had discriminated against Mr Forest within the meaning of s9(1)(f) as it had treated him less favourably because he was accompanied by an assistance animal.

WAS THE DISCRIMINATION UNLAWFUL?

The court found that the discrimination was unlawful within the meaning of s24 of the Act and that the defence of unjustifiable hardship did not apply.

Queensland Health had argued that it would be an unjustifiable hardship if it was required to:

(a) automatically allow every animal that was said to be an assistance animal access to its premises; or
(b) expend resources conducting an assessment of the actual legitimacy of every animal that was claimed to be an assistance animal.

While the court agreed that option (a) would result in unjustifiable hardship to Queensland Health, the argument in relation to option (b) failed because there was evidence before the court that Queensland Health already expended resources in conducting assessments in relation to animals, in particular pets, brought onto its premises for therapeutic purposes (ie for terminally ill patients). In the circumstances, the court was not convinced that the development and implementation of appropriate procedures by Queensland Health to enable it to identify an assistance animal under the Act would cause unjustifiable hardship.

6. at [100].

CONSEQUENCES

While finding in favour of Mr Forest, the court noted its concerns that the current drafting of s9(1)(f) of the Act had the following potential consequences:

- any animal trained to assist a disabled person to alleviate the effects of his or her disability appears to fall within s9(1)(f), including any breed of dog, horses, monkeys or inherently dangerous animals such as dingoes;
- assistance animals merely need to be trained to assist in alleviating the effect of a disability, not trained to be obedient, well-behaved in public, be under the control of its owner or trained by any accredited training organisation or to any set standards; and
- there were no hygiene requirements nor health standards in relation to assistance animals.

The difficulties with the drafting of s9(1)(f) identified by the court in this case have already been the subject of a discussion paper released by the Disability Discrimination Commissioner in 2003 in response to a similar court decision. The report ultimately issued by the Disability Discrimination Commissioner after receipt of submissions recommended various amendments to s9(1)(f) of the Act. The amendments are yet to be made.

CONCLUSION

This case confirms that any animal trained to assist a disabled person to alleviate the effect of his or her disability is potentially an assistance animal under the Act such that any refusal to provide treatment to a patient accompanied by an assistance animal could amount to unlawful discrimination. Notwithstanding the changes recommended to s9(1)(f) of the Act in the 2003 report of the Disability Discrimination Commissioner, it would appear that the difficulties for medical practitioners and other service providers in identifying an assistance animal under the Act will continue.

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