

A matter of purpose

PENGILLEY HAS NEATLY summarised the long and ongoing disputation between the Australian Medical Association (AMA) and the Australian Competition and Consumer Commission (ACCC).¹ The AMA claims that medical roster arrangements are likely to constitute a breach of the primary boycott provisions of the *Trade Practices Act 1974* (Cwlth), a proposition vehemently denied by the ACCC (and by the Wilkinson Committee, which came into being as the result of vocal representations made to the federal government by the AMA).

Pengilley claims to be on the side of the angels (ie, the AMA) with wings; I prefer to be the devil's advocate.

Central to the dispute is to ask what is the meaning of the word "purpose" in any arrangement set out in section 4D(1) of the Trade Practices Act. Is it, as claimed by the ACCC, aimed at — and limited to — an anticompetitive purpose, or, as Pengilley maintains (because the word "purpose" is unqualified), does the section render illegal any roster that has the incidental effect of limiting medical services?

The kind of literal reading of the Trade Practices Act applied by Pengilley had already fallen into disuse by the end of the 16th century. In what is now known as the "Mischief Rule", the Court, in *Heydon's Case*,² asked itself "what was the mischief for which the common law did not provide and what has Parliament done to remedy it?". Thus, regarding rosters, the mischief for which the common law did not provide was the "combinations" that resulted in public harm. The incidental effect of section 4D is to give an imprimatur to all medical roster arrangements, save those

whose "substantial purpose" is to deprive the community of competition. It follows that the roster arrangements entered into in compliance with the AMA's trade practices compliance program are immune from legal challenge.

Thus, an arrangement whereby Dr X and Dr Y agree on a roster service which may incidentally deprive a community of 24-hour medical cover (eg, because of a medical manpower shortage) is clearly legal, provided no member of the roster deliberately agrees to withhold his or her services. I am puzzled by Pengilley's statement that "Indeed, no roster could function unless Doctor Y agreed not to provide services during the hours during which Doctor X is rostered on duty". Indeed, any attempt by Dr Y to keep himself or herself "out of service" is not only illegal, but unethical, and deliberately "caught" by the Act, and so it ought to be.

In the end, the argument comes down to how many angels can dance on the head of a pin. I am satisfied that Pengilley's argument in support of an amendment to the Trade Practices Act is a counsel of perfection, if only because any attempt by the ACCC to prosecute a bona fide medical roster arrangement would face insurmountable legal and evidentiary hurdles.

Paul Gerber

Assistant General Editor
Australian Law Journal, Sydney, NSW

1. Pengilley W. Medical rosters and the Trade Practices Act. *Med J Aust* 2003; 178: 337-340.

2. *Heydon's Case* (1584) 3 Co Rep 7a at 7b; 76 ER at 638. □

Rural doctors and medical rosters

RURAL DOCTORS, like their colleagues elsewhere, are thinking individuals whose main aim is to provide timely, appropriate care to the patients living in their local communities. More often than not, they are small-business operators running a practice which is becoming more complex, both in the clinical sphere and in the myriad requirements associated with accreditation, indemnity, practice incentive payments, vocational registration, the Pharmaceutical Benefits Scheme and Medicare, credentialling at the local hospital, the *Privacy Act 1988* (Cwlth), and the *Trade Practices Act 1974* (Cwlth). Non-compliance with any of these regulations and requirements can lead to severe penalties — in the case of breaches of the Trade Practices Act, exposure to \$500 000 fines for individuals. The Productivity Commission's recent enquiry into red tape in general practice¹ and the Wilkinson Review of the impact of Part IV of the Trade Practices Act on the recruitment and retention of medical practitioners in regional Australia are two demonstrable consequences of the general concern.

In rural Australia, the medical workforce faces a special subset of challenges in providing a broad range of medical services to small communities with limited resources and

support facilities. This is in an environment where there is a relative shortage of medical practitioners and an increased workload.^{2,3} Administrative and bureaucratic requirements can make the difference between staying in and leaving rural practice.^{4,5} The size of isolated rural practices does not allow for the management processes, information technology, and support staff required to meet the bureaucratic requirements.

Pengilley's article⁶ is a timely reminder that government reviews may not solve the questions faced by doctors in their everyday work in their efforts to comply with the law. Grey areas of the law will only be resolved by changes in the law itself, not by reviews. Pengilley has given an example of rostering for 16 hours out of 24, which would almost certainly be in contravention of the law and bring the full force of the Australian Competition and Consumer Commission (ACCC) down on those doctors. There are real examples happening in Australia today of doctors struggling to provide services in a sustainable manner so that they do not become exhausted, which may lead to disruption of their family, social and professional life and ultimate cessation of practice in that community. For example, a consensus of opinion is that rural doctors require a one-in-four