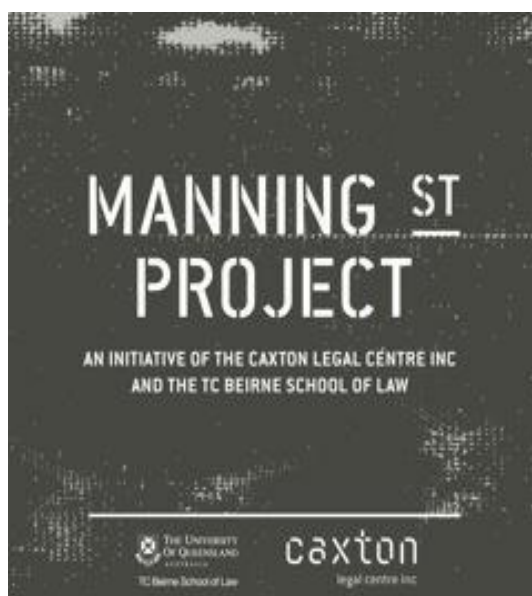


UQ PRO BONO CENTRE - MANNING ST PROJECT

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DRUGS AND DOCTORS: how the law responds to doctor-shopping in Australia

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DRUGS AND DOCTORS

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1. FOREWORD

In recent years, there has been a significant increase in the diversion and non-medical use of prescription pharmaceuticals. In Australia, benzodiazepines and opioids are the medications most commonly diverted for illicit use.¹ ‘Doctor-shopping’ is the most common method of diversion for prescription drugs.

The term ‘doctor-shopping’ describes the simultaneous attendance upon numerous doctors by one patient, in order to obtain excess prescriptions beyond medical need. The prevalence of this illegal practice is rapidly increasing, but evidence quantifying such a proposition remains largely anecdotal. Hence, this paper seeks to critically examine the prevalence of doctor-shopping, focusing on the medico-legal and regulatory frameworks which attempt to address this issue. In doing so, the way in which relevant stakeholders are contributing to the ongoing occurrence of doctor-shopping is identified. The paper provides policy reform recommendations which aim to reduce the incidence of ‘doctor-shopping’ and ameliorate its associated social cost.

The research into the issue of doctor-shopping was conducted by students of the Manning St Project, in partnership with Sisters Inside. Sisters Inside is an independent community organisation that advocates for the human rights of women in the criminal justice system. Sisters Inside provides assistance to women who have been processed by the criminal justice system, many of whom (and for a variety of reasons), abuse prescription medication.

The students who authored this paper are Elly Brand, Isobel Farquharson, Karrie Hartwig and Kah Hey Loh. Margaret Fitzpatrick from Sisters Inside and Monica Taylor from the UQ Pro Bono Centre provided overall project supervision and guidance. Professor John Devereux from the TC Beirne School of Law also provided guidance with the medical law aspects of the paper.

¹McGregor C, Gately N, and Fleming J, ‘Prescription drug use among detainees: Prevalence, sources and links to crime’ (Trends & Issues in Crime and Criminal Justice, 423, Australian Institution of Criminology August 2011) 1 <http://www.aic.gov.au/publications/current%20series/tandi/421-440/tandi423.html>

2. EXECUTIVE SUMMARY

This paper aims to critically examine the prevalence of doctor-shopping in an Australian context. It does so by undertaking a comprehensive analysis of current statutory, medico-legal and organisational frameworks that seek to respond to the practice of doctor-shopping in Australia.

Medical practitioners are in a unique position to identify patients presenting symptoms associated with prescription medication addiction, through consistent consultation and treatment. As such, practitioners have been identified as critical to the recognition of such symptomology and the implementation of effective prevention strategies. This research paper therefore focuses on the conduct of medical practitioners in the context of doctor-shopping. The paper does not focus on patient liability or criminal misconduct regarding the diversion and misuse of prescription medication.

Section I of this paper will define doctor-shopping and provide a statistical overview of the extent of the problem in Australia. It will identify the reasons for doctor-shopping and the difficulties associated with identifying this practice through current data sets.

Section II of the paper will detail the strengths and weakness of the current regulatory regime in identifying doctor-shoppers and prosecuting medical practitioners who enable patients to misuse medications. Regulatory bodies and statutory schemes that are examined include the:

- Australian Medical Association;
- Australian Health Practitioner Regulation Agency;
- Health Quality Complaints Commission;
- Medicare and Professional Services Review;
- Prescription Shopping Program; and
- *Health (Drugs & Poison) Regulation 1996* (Qld).

The common law standard of care owed by medical practitioners to patients is examined in section III, with a specific focus on the relevant merits of contractual, fiduciary and tortious duties.

Throughout the paper a number of recommendations are made with a view to improving the current regulatory frameworks as they relate to the reduction of the incidence of doctor-shopping practices.

3. SUMMARY OF RECOMMENDATIONS

(A) AUSTRALIAN MEDICAL ASSOCIATION (AMA)

1. That the AMA improves its partnership with the Royal Australian College of General Practitioners and the Royal Australasian College of Physicians to increase the promotion of its practical guidelines regarding opioid prescription.
2. That the AMA Ethics and Medico-Legal Committee continue to raise the issue of doctor-shopping in relevant member contexts (publications, forums etc.)

(B) AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (AHPRA)

3. That the definition of who may make a voluntary notification under s145 of the *Health Practitioners Regulation National Law Act 2009 (Qld)* be expanded to expressly include members of the public and/or interested organisations making complaints in relation to the actions of a practitioner advising a third party.
4. That duplicate administrative processes between AHPRA and state regulatory bodies regarding investigation of 'notification' complaints be removed.

(C) HEALTH QUALITY COMPLAINTS COMMISSION (HQCC)

5. That section 41 of the *Health Quality and Complaints Commission Act 2006 (Qld)* be amended to widen the scope of persons eligible to bring a complaint to include members of the public and interested organisations.
6. That anonymity is granted to all persons who make a complaint to the HQCC unless it is in the public interest for the person to provide their name.

(D) MEDICARE: PROFESSIONAL SERVICES REVIEW (PSR)

7. That a comprehensive national review of the PSR be undertaken. That review should consider, inter alia, the limited impact of the 80/20 rule and possibility of widening the scope of complainants to include members of the general public and interested organisations.

(E) MEDICARE: PRESCRIPTION SHOPPING PROGRAM (PSP)

8. That technological procedures be improved to ensure that the 'doctor-shoppers' list:
 - a. automatically populates for medical practitioners without the need for the medical practitioners to register to have access to the system; and
 - b. is made available to all registered pharmacists.

(F) HEALTH (DRUGS & POISON) REGULATION 1966 (QLD)

9. That the penalty units prescribed for medical practitioners who contravene the Act be increased, and correspondingly, that the penalty units prescribed for patients who attempt to obtain the drugs be reduced.

SECTION I

4. DOCTOR-SHOPPING IN CONTEXT

(A) BACKGROUND

‘Doctor-shopping’ refers to a pattern of behaviour whereby a patient fraudulently presents symptoms to multiple doctors in order to obtain prescription medication beyond his or her actual medical need. Medicare Australia terms such patients as ‘prescription shoppers’, identified on the basis that they have attended on six or more registered prescribers in a three month period, or obtained a total of 25 or more target PBS items and/or 50 or more PBS items.²

Doctor-shopping is one of the most common and easiest methods for the diversion of prescription medication for non-medical use. The misuse of prescription medication arises ‘when an individual administers medications in a manner or in dosages unintended by their prescriber, for instance to achieve an intoxicated state’.³

The *2010 National Drug Strategy Household Survey* reports that from 2007-2010 there was a significant increase in the diversion of pharmaceuticals for non-medical purposes, rising from 3.7% to 4.2%.⁴ This is higher than the comparative rise in consumption of illicit drugs such as cocaine, which only increased 1.6% to 2.1% for the same period.⁵ Prescription medications identified by the survey as being used for non-medical purposes included benzodiazepine, opioid analgesics, stimulants and over-the-counter medications, such as those containing pseudoephedrine. Similarly, the United Nations has recognised that the non-medical use of prescription drugs is ‘a unique category of substance use and is a global health concern’.⁶

The harms associated with non-medical prescription drug use, notably dependence and overdose, are well-documented,⁷ however, prevention strategies seeking to reduce diversion practices such as doctor-shopping, remain light on the ground.

² Department of Human Services, Government of Australia, *Prescription Shopping Program* <<http://www.medicareaustralia.gov.au/prescriber/pbs/prescription-shopping/index.jsp#N1002A>>.

³ Roger Nicholas, Nicole Lee and Ann Roche, ‘Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses’ (Report, National Centre for Education and Training on Addiction, Flinders University, 2011) 114. <nceta.flinders.edu.au/files/6112/2823/3742/EN448_Nicholas_2001_pdf>.

⁴ Australian Institute of Health and Welfare, ‘2010 National Drug Strategy Household Survey Report’ (Drug statistics series no. 25. Cat. no. PHE 145, Australian Institute of Health and Welfare, July 2011) 145.

⁵ *Ibid.*, 8.

⁶ United Nations Office on Drugs and Crime ‘The Non-Medical Use of Prescription Drugs’ (Policy Directions Issues, United Nations Office on Drugs and Crime, 2011) 1. <http://www.undoc.org/docs/younet/Final_Prescription_Drugs_Paper.pdf>.

⁷ Wendy Loxley, ‘Benzodiazepine Use and Harms Among Police Detainees in Australia’ (*Trends & Issues in Crime and Criminal Justice* no. 336, Australian Institute of Criminology, 2007) <<http://aic.gov.au/publications/currentseries/tandi/321-340/tandi336.aspx>>; See generally Cathrine McGregor, Robert Ali, Robert Lokan, Paul Christie and Shane Darke, ‘Accidental Fatalities Among

(B) TECHNIQUES OF ‘DOCTOR-SHOPPERS’

A number of methods may be employed by doctor-shoppers to access prescription medications. In a 2011 study conducted by the Australian Institute of Criminology, relevant data was collected from 986 participating pharmaceutical users relating to the methods used to obtain prescription medications beyond medical need.⁸ Of the 189 pharmaceutical users who provided data, 21% had used a script in their own name written by a doctor. Of this 21%, more than half admitted to attending a different doctor each time they required a prescription and a further third stated that they had had deliberately provided inaccurate information to obtain a prescription.⁹

It was further noted in the study that another method by which doctor-shoppers obtained their various prescriptions was through forgery of scripts or by using scripts that were written for friends or family members.

Hence, the most common methods employed by doctor-shoppers rely upon individuals taking advantage of the vulnerabilities of inexperienced doctors and the complacency of careless ones.¹⁰

(C) DATA ON DOCTOR-SHOPPING

The lack of updated data causes difficulties in measuring the true extent of the problem of doctor-shopping. For example, the National Drug Strategy Household Survey in 2010 revealed that 27.6% of individuals aged over 14 years used misused prescription medications on a daily basis.¹¹ However, these findings are to be treated cautiously as they do not necessarily reflect the true extent of doctor-shopping. This is because the survey excludes a number of groups from participating in the data collection process, such as patients in prison or in public hospitals.¹² Therefore the data available in Australia with respect to doctor-shopping is limited, especially in comparison to the United States and European nations.¹³

A key difficulty to properly detecting the incidence of doctor-shopping remains the status of pharmaceuticals as controlled substances, which are legitimate treatments for recognised medical conditions.¹⁴ It therefore becomes challenging to differentiate data sets in order to determine what prescriptions were obtained through doctor-shopping practices. Raw pharmaceutical data is available through publications such as the Australian Statistics on Medicines, which draws on data collected through the Pharmaceutical Benefits Scheme

Heroin Users in South Australia 1994–1997: Toxicological Findings and Circumstances of Death’ (2002) *Addiction Research and Theory* 10(4) 335.

⁸Catherine McGregor, Natalie Gately and Jennifer Fleming, above n1, 3.

⁹Ibid., 4.

¹⁰Benny Monheit, ‘Prescription Drug Misuse’ (2010) *39 Australian Family Physician* 540, 542.

¹¹Australian Institute of Health and Welfare, ‘2010 National Drug Strategy Household Survey Report’ (Drug statistics series no. 25. Cat. wno. PHE 145, Australian Institute of Health and Welfare, July 2011), 161.

¹²Drugs and Crime Prevention Committee, ‘Inquiry into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs in Victoria’ (Final Report, Parliament of Victoria, 2007) 40.

¹³Ibid., 1.

¹⁴United Nations Office on Drugs and Crime, above n4, 5.

(‘PBS’). If it is accepted that a fraction of that 8.5% relates to medication obtained through doctor-shopping, then the economic impact of doctor-shopping becomes more apparent.¹⁵

(D) ROLE OF MEDICAL PRACTITIONERS

A primary medical practitioner (or GP, general practitioner) is ideally positioned to identify patients who may be doctor-shopping or misusing prescription medications. Regular patient consultations provide GPs with the ability to identify symptoms associated with pharmaceutical dependence, to assess the severity of substance use and to seek to address dependence within the context of the client/doctor relationship.

Currently, practice guidelines produced by the Royal Australasian College of Physicians are used in the prescription of opioids.¹⁶ These provide strategies that medical practitioners may employ when dealing with patients who are dependent upon prescription medications (for example, recommending lifestyle change strategies). The proper use of these practice guidelines should mitigate the quantity and frequency of medications being prescribed to doctor-shoppers. There are also strategies within the practice guidelines for prescribers to implement when faced with a patient who is demanding highly addictive prescription medications. Of course, for these practice guidelines to be effective requires the medical practitioner to correctly identify signs of prescription drug abuse.

¹⁵ Drug Utilisation Sub-Committee, ‘Australian Statistics on Medicines 2009’ (Commonwealth Department of Health and Ageing, Australian Government, 2011) 23.

¹⁶ The Royal Australasian College of Physicians, ‘Prescription Opioid Policy: Improving Management of Chronic Non-Malignant Pain and Prevention of Problems Associated with Prescription Opioid Use’ (The Royal Australasian College of Physicians, 2009) <<http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/CNMP-pdf.aspx>>.

SECTION II

5. REGULATORY BODIES

(A) THE AUSTRALIAN MEDICAL ASSOCIATION (AMA)

The Australian Medical Association (AMA) is the largest independent membership organisation for medical practitioners in Australia. It represents all registered medical practitioners and medical students in the country. The main objective of the AMA is to ensure a dialogue exists between the medical profession, and political and activist groups.

Providing ethical and moral guidelines to its members is a core function of the organisation. The purpose of these guidelines is to provide helpful advice and guidance to medical practitioners for managing their professional conduct. In order to provide this information, the AMA's structure includes a number of independent committees that deal singularly with specific issues. For example, there is an Ethics and Medico-Legal Committee that is responsible for developing such ethical codes and moral guidelines.

The Committee's emphasis is on policy development rather than preventative or disciplinary enforcement. It is certainly important that doctors are aware of their ethical obligations; indeed, it is suggested through anecdotal evidence that part of the problem with regard to doctor-shopping is that doctors are simply not aware of the variety or depth of problems regarding addiction and prescription drug use. Therefore the information the AMA provides to its members can serve to help reduce environments in which doctor-shopping succeeds. As the AMA provides no disciplinary function, it has no ability to enforce best practice by its members. Its contribution to stemming the practice of doctor-shopping is therefore limited to its educative function, through policy development and education of its members. As the largest membership body of medical practitioners in the country, the AMA is in a unique position to model preferred practices and to develop a positive professional culture regarding doctor-shopping. The ongoing importance of education of AMA members cannot be underestimated.

Recommendation 1

That the AMA improves its partnership with the Royal Australian College of General Practitioners and the Royal Australasian College of Physicians to increase the promotion of its practical guidelines regarding opioid prescription.

Recommendation 2

That the AMA Ethics and Medico-Legal Committee continue to raise the issue of doctor-shopping in relevant member contexts (publications, forums etc.)

(B) AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) is a national statutory body responsible for overseeing the registration of health care professionals.¹⁷ AHPRA was established in order to implement a national registration and accreditation scheme encompassing 14 national health practitioner boards, which includes the Medical Board of Australia.¹⁸ Constitutionally, the Federal Government was unable to create a singular scheme, so each State and Territory enacted legislation in order to give effect to a national scheme.

An important function of AHPRA is to regulate the professional conduct, performance and health of registered practitioners. The handling of complaints is done through an investigative process using ‘notifications’. Notifications can be either mandatory (made by other practitioners, employers or education providers)¹⁹ or voluntary (made by an entity that believes that a ground on which a voluntary notification may be made exists in relation to a health practitioner).²⁰ The legislative requirements for mandatory and voluntary notification differ. There are currently seven grounds for voluntary notification, the first of which is that the practitioner’s professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner’s professional peers.²¹ Practitioner conduct such as failing to recognise signs of a patient’s abuse or addiction to prescription medication, or incorrectly prescribing medication that is inappropriate for the patient’s complaints, could arguably fall within this ground.

It is unclear from the legislation whether a member of the general public concerned about a practitioner’s professional conduct could make a voluntary notification. Anecdotal evidence from Sisters Inside suggests that previous notification attempts from workers of that organisation – in relation to concerns about the professional conduct of a number of medical practitioners who frequently prescribe medication to clients with serious and persistent drug dependency - have failed to be accepted. An expanded and improved legislative definition about who can make a voluntary notification would arguably lead to better use of this complaints tool in relation to curbing doctor-shopping practices.

Recommendation 3

That the definition of who may make a voluntary notification under s145 of the *Health Practitioners Regulation National Law Act 2009 (Qld)* be expanded to expressly include members of the public and/or interested organisations making complaints in relation to the actions of a practitioner advising a third party.

AHPRA merely provides a referral service for notifications, rather than resolving complaints.²² Where a notification is determined to have merit, AHPRA will pass this

¹⁷ *Health Practitioners Regulation National Law Act 2009 (Qld)* s25

¹⁸ *Health Practitioners Regulation National Law Act 2009 (Qld)* s 31

¹⁹ *Health Practitioners Regulation National Law Act 2009 (Qld)* ss141-143

²⁰ *Health Practitioners Regulation National Law Act 2009 (Qld)* s145

²¹ *Health Practitioners Regulation National Law Act 2009 (Qld)* s144(1)(a)

²² Australian Health Practitioner Regulation Agency, ‘Annual Report 2011– 2012’ (Report, Australian Health Practitioner Regulation Agency, 1 November 2012) 81 <<http://www/ahpra.gov.au/legislation-andPublications/AHPRA-Publications.aspx>>.

information on to the appropriate national health practitioner board. If required, the national board may then refer the issue to a State or Territory health complaints entity. This two-stage referral process results in unnecessary duplication and a lack of clear timeframes in which a complaint made to AHPRA may be resolved. To make the AHPRA notification process more effective, it would be desirable to remove duplication during the notifications stage.

Recommendation 4

That duplicate administrative processes between AHPRA and state regulatory bodies regarding investigation of ‘notification’ complaints be removed.

(C) HEALTH QUALITY COMPLAINTS COMMISSION (HQCC)

The Health Quality Complaints Commission (HQCC) is a statutory body constituted under the *Health Quality and Complaints Commission Act 2006 (Qld)*. The HQCC has jurisdiction only within Queensland. The objectives of the HQCC are to monitor, review and report on the quality of health services and manage complaints brought against health services.

A prominent issue that allows the practice of doctor-shopping to continue is the failure by doctors to prescribe medication with propriety, or to adequately consult with their patients in order to assess whether they are drug dependent. Ideally these doctors should be made accountable for their poor patient consultation. On its face, the purpose for which the HQCC was established would enable it to fulfil this role. However, inherent problems in the organisational structure of the HQCC mean that diligent corrective action against such doctors is difficult to achieve.

The problems with the HCQQ derive primarily from its statutory basis. As is stated in the *Health Quality and Complaints Commission Act 2006*, a complaint may be raised to the HQCC on the basis of either (a) quality of health services provided; or (b) the health service generally.²³ The scope under which complaints can be brought is considered to be wide enough to target the doctors allowing the practice of doctor-shopping, however the persons who are able to lodge such complaints is too limited.

Section 40 of the Act states that only the user of a health service, the Minister or a user’s representative as defined under section 41 may lodge a complaint. Closer inspection of the definition of a user’s representative under section 41 shows that in order for any third party (for example a social worker, or unofficial guardian of a user) to be able to make a complaint about a health service or quality of health service, the “commission needs to be satisfied that it would be difficult or impossible for the user to make the complaint personally.”²⁴

Furthermore, even if the HCQQ is satisfied that the user would not be able to make a complaint on their own behalf, then the third party must be either an attorney for the user under an enduring power of attorney under the *Powers of Attorney Act 1998*, a statutory health attorney under the *Powers of Attorney Act 1998*, or an adult guardian for the user under the *Guardianship and Administration Act 2000*.²⁵ This entirely excludes the possibility of

²³ *Health Quality and Complaints Commission Act 2006*, s35

²⁴ *Health Quality and Complaints Commission Act 2006*, s41(1)

²⁵ *Health Quality and Complaints Commission Act 2006*,

complaints being brought by social workers, partners or unofficial guardians. It is implausible that persons who are drug dependent and reliant upon the practice of doctor-shopping would bring a complaint about the doctors from whom they have obtained fraudulent prescriptions. Hence, complaints of this nature would need to be brought to the attention of the HQCC entirely by user representatives. The scope of the definition is arguably too narrow to include third parties who may have a genuine interest in the provision of health services which drug dependent users are receiving; under the current definition such parties have no legal standing.

Furthermore, as a side issue, users are only able to make complaints anonymously if the HQCC deems that such a complaint is in the public interest²⁶ and it is required of complainants that a statutory declaration be signed.²⁷ While statutory provisions of this nature do serve a procedural purpose, it is suggested that they discourage drug users from bringing complaints due to fear that their personal circumstances will be called into question.

Recommendation 5

That section 41 of the *Health Quality and Complaints Commission Act 2006 (Qld)* be amended to widen the scope of persons eligible to bring a complaint to include members of the public and interested organisations.

Recommendation 6

That anonymity is granted to all persons who make a complaint to the HQCC unless it is in the public interest for the person to provide their name.

(D) MEDICARE

Medicare is the principal public health care provider for the country. Medicare has implemented a prevention and disciplinary regime which targets the practice of over-prescription by doctors; the flow-on effect of which places an embargo on persons attempting to procure medications on the Pharmaceutical Benefits Scheme ('PBS') through doctor-shopping practices. The overall objective of this strategy is to 'protect the integrity of the Pharmaceutical Benefits Scheme'²⁸ which Medicare operates, as well as to protect the provision of Medicare benefits to service providers. It is useful to note that schemes collated under or by Medicare only relate to public health provisions; the subsequent discussion and recommendations do not relate to private health practitioners or providers.

The Medicare scheme that focuses on prescribers does not focus on doctor-shopping *per se*. Rather, it focuses on the identification of medical malpractice, which includes a tendency to over-prescribe. It appears that the general public can easily identify which doctors have a tendency to over-prescribe, and it is these doctors who are then targeted by doctor-shoppers.

²⁶ *Health Quality and Complaints Commission Act 2006*, s47

²⁷ *Health Quality and Complaints Commission Act 2006*, s49

²⁸ Department of Human Services, Government of Australia, *Practitioner Review Program*, 4 September 2012 < <http://www.medicareaustralia.gov.au/provider/business/audits/prp.jsp>>.

By reading between the lines it is possible to see that the scheme may help prevent doctor-shopping, yet that is not the stated aim of the scheme.

In contrast Medicare has set up a system which focuses on ‘identifying and reducing’ the number of doctor-shoppers in the community. Specifically the system attempts to limit the capability of individuals to obtain ‘PBS subsidised medicines in excess of their medical need’.²⁹

It is suggested that both levels of intervention could be effective in the prevention of doctor-shopping; however presently neither level currently provides an effective way to prevent the practice.

MEDICARE: FOCUSING ON PRACTITIONERS THROUGH THE PSR

The Professional Services Review (‘PSR’) was established in 1994 through the *Health Insurance Act 1973* (‘the Act’) in order to protect the integrity of the PBS, and to protect patients and the community in general from the risk associated with inappropriate medical practice.³⁰ It attempts to meet these objectives through reviewing and examining potentially inappropriate practice by doctors when they provide Medicare services, or prescribe Government subsidised medications under the PBS. Although the PSR is not run by Medicare itself, cases come before it through a system of review designed by Medicare, and the two are closely linked.

“Inappropriate practice” is a term widely defined by the Act in section 82. It provides that:

1. *A practitioner engages in inappropriate practice if the practitioner’s conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that:*
 - a) *If the practitioner rendered or initiated the services as a general practitioner – the conduct would be unacceptable to the general body of general practitioners; or*
 - b) *If the practitioner rendered or initiated the services as a specialist (other than a consultant physician) in a particular specialty – the conduct would be unacceptable to the general body of specialists in that specialty*
 - c) *If the practitioner rendered or initiated the services as a consultant physician in a particular specialty – the conduct would be unacceptable to the general body of consultant physicians in that specialty; or*
 - d) *If the practitioner rendered or initiated the services as neither a general practitioner nor a specialist but as a member of a particular profession – the conduct would be unacceptable to the general body of the members of that profession*
2. *A person (including a practitioner) engages in inappropriate practice if the person:*
 - a) *Knowingly, recklessly or negligently causes, or knowingly, recklessly or negligently permits, a practitioner employed by the person to engage in conduct that constitutes inappropriate practice by the practitioner within the meaning of subsection (1); or*
 - b) *Is an officer of a body corporate and knowingly, recklessly or negligently causes, or knowingly, recklessly or negligently permits, a practitioner employed by the body corporate to*

²⁹ Department of Human Services, Government of Australia, *Prescription Shopping Program*, 11 September 2012 < <http://www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.jsp>>.

³⁰ Department of Human Services, Government of Australia, above n 28.

engage in conduct that constitutes inappropriate practice by the practitioner within the meaning of subsection (1)

3. A Committee must, in determining whether a practitioner's conduct in connection with rendering or initiating services was inappropriate practice, have regard to (as well as to other relevant matters) whether or not the practitioner kept adequate and contemporaneous records of the rendering or initiation of the services.³¹

Section 82 demonstrates that the focus of the PSR is on medical practitioners who engage in practices considered inappropriate by a contemporaneous group of practitioners. Thus inappropriate practice has been widely defined. A doctor who is prescribing in such a manner that is found attractive by doctor-shoppers is probably engaging in 'inappropriate practice' for the purposes of the Act. This may be because they are not taking enough time, through patient consultation, to address the issues which the patient is presenting with; or they may be in the habit of over-prescribing.

Sections 83-85 of the Act provide for the PSR to be constituted by a Director, Panel and Deputy Directors. Each of these positions is filled by appointment from the Minister for Health and Aging in consultation with the Australian Medical Association.³² Therefore there is a clear link between the PSR and government, which is unsurprising given the objective of the PSR is to protect Medicare and the PBS.

The scheme through which the PSR reviews individuals works in combination with the Medicare-run Practitioner Review Program ('PRP'). The PRP operates to deal with practitioners whose provision of services under Medicare, or prescription of medication under the PBS, may be indicative of inappropriate practice. This is determined by data collected by each service respectively.³³ For example, inappropriate practice may be suspected where a doctor has infringed the 80/20 rule. The rule is that a doctor will be 'deemed' to have engaged in inappropriate practice if 'he or she has rendered 80 or more professional attendances on each of 20 or more days in a 12 month period'.³⁴ The relevance here to doctor-shopping is that if a doctor is seeing a high volume of patients, they may be failing to properly engage with the patient in consultations. This may make doctors a target for doctor-shoppers.

Having determined the doctor may be engaging in inappropriate practice, the individual in question will then be subject to the five-stage PRP, which involves various pre- and post-interview stages, as well as a review period and the possibility of delegation of the review to the PSR.³⁵ The process is a lengthy one, which may be frustrating for individuals concerned about medical malpractice. However, the various checks and reviews built into the process that contribute to its length also go some way to ensuring that only those professionals who have demonstrated truly questionable conduct come before the review body.

³¹ *Health Insurance Act 1973* (Cth) s 82.

³² *Ibid* ss 83(2), 84(3), 85(3).

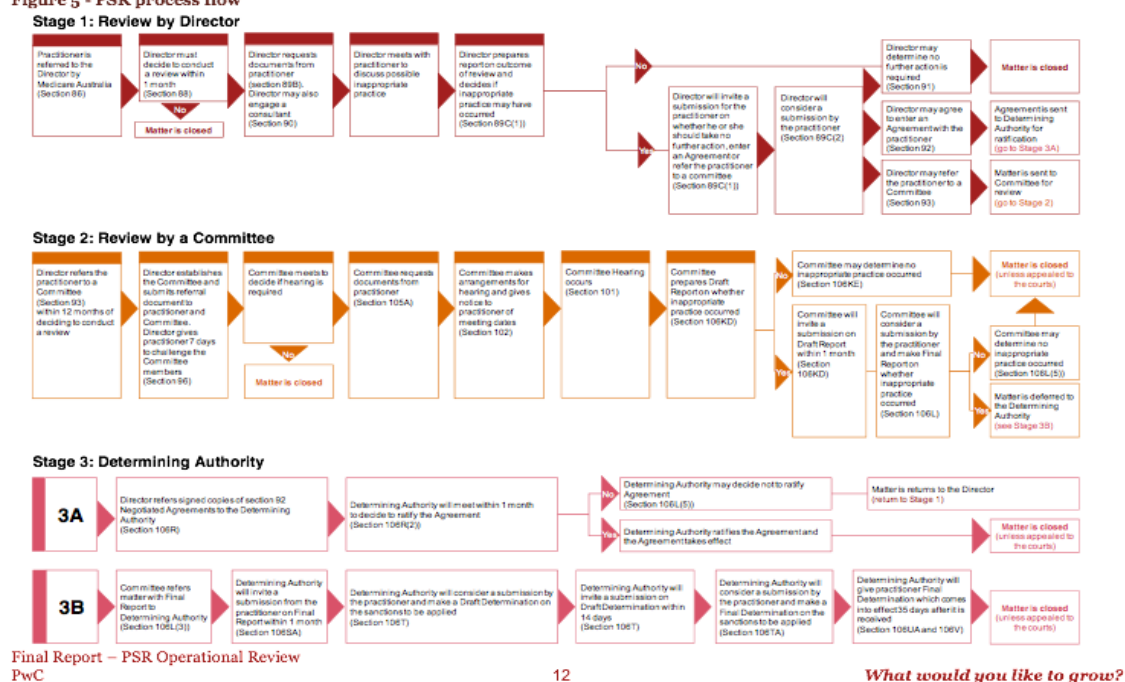
³³ Department of Human Services, Government of Australia, above n 28.

³⁴ Medicare Australia, Government of Australia, *Practitioner Review Program: The 80/20 Rule*, 4 September 2012, <<http://www.medicareaustralia.gov.au/provider/business/audits/files/4426-practitioner-review-program-80-20-rule.pdf>>.

³⁵ Department of Human Services, Government of Australia, above n 28.

The process of the PSR itself is summarised by the following diagram.³⁶

Figure 5 - PSR process flow



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What would you like to grow?

As shown in the diagram, there are various outcomes from a review by the PSR. Either the Director believes the matter should be closed, or they will refer the matter to the Committee or determining authority for consideration. Should the matter go to the Committee, they will then either close the matter, determining there was no inappropriate practice, or defer the matter to the determining authority. Should the matter go to a determining authority, they can choose to close the matter, design an agreement, or make a final determination as to whether or not inappropriate practice has occurred, and determine the appropriate penalty associated with that finding.

The PSR has recently experienced problems relating to the manner in which the Minister has made appointments to the positions of Deputy Directors and panel members. As outlined, the Minister – must discuss all appointments with the AMA. However, it appears that on a number of occasions the Minister did not comply with this condition. As a result, a number of medical practitioners who had come before the PSR sought to have their determinations made redundant, claiming the review body had been invalidly constituted.

The matter came before the Federal Court in the case of *Kutlu v Direction of Professional Services Review*.³⁷ It was successfully argued by a number of practitioners that the purported appointments were invalid and of no effect, and that the PSR committees to which those individuals were appointed were invalidly constituted. As a result of this finding, the Court

³⁶ Department of Health and Aging, *Professional Services Review: Operational Review*, 1 October 2012, <<http://resources.news.com.au/files/2011/12/27/1226231/306715-professional-services-review.pdf>>.

³⁷ [2011] FCAFC 94.

went on to find that any draft or final reports made by those committees were also invalid and of no effect.

The Court found consultation with the AMA to be a key component of the appointment process, especially in light of the important function that those appointed would be performing as officers of the Commonwealth under section 75v of the *Constitution*.³⁸ To that end it was found that the design of the appointment process outlined in the *Health Insurance Act* 'ensure[d] public confidence in the decisions reached',³⁹ and failure to comply with that design was completely unacceptable. The inconvenience caused by the finding of inappropriate appointments did not sway the Court from its decision.

As a result of the Minister's failure to comply with those conditions, decisions of the PSR have been called into question. Those professionals that had been disciplined by the body have, in some cases, had their disciplinary actions declared void or rescinded. Additionally the PSR voluntarily discontinued 39 investigations 'as a result of concerns about the appointment process'.⁴⁰ This has led to subsequent delays in the ability of the PSR to work on draft and final reports.⁴¹

Plans have been laid for retrospective legislation to safeguard other decisions made by the review body, but the whole process does call into question the ability of the PSR to operate effectively. It also goes some way to damaging the reputation of those running the body. This is unfortunate, as a peer review body depends to some extent on its reputation in order for its judgments to be respected and accepted by both the medical community and the wider public.

In addition to problems with the appointment process, the PSR has been subject to other criticisms. One common criticism levelled at the PSR originates from practitioners who claim that the Review is not a true peer review. This is because some practitioners believe that their professions are not adequately represented on the Panels.⁴² While this may have an impact on the validity of decisions reached by the PSR, it does not, in a general way, affect the ability of the body to deal with doctors who have been engaging in practices of the type likely to attract doctor-shoppers. This is because in a general sense, it is general practitioners that are targeted by doctor-shoppers, and they are adequately represented.

As this paper has already identified, a major concern for individuals and organisations trying to combat doctor-shopping is their inability to communicate with bodies that regulate the activities of medical service providers. This is a consistent problem for Sisters Inside. The PSR does little to address this problem, with its focus on inappropriate practice largely drawn from statistical analysis rather than community referrals. The practice of using statistics is

³⁸ *Kutlu v DPSR*, above n37 at [16].

³⁹ *Ibid* [20].

⁴⁰ Andrew Davey for Unsworth Legal, *The Professional Services Review Scheme – Failure of the Ministers' to consult the AMA*, 12 October 2012, <<http://www.unsworthlegal.com.au/media-publications/the-professional-services-review-scheme-failure-of-the-ministers-to-consult-the-ama-kutlu-v-director-of-professional-services-review-2011-fcafc-94/>>.

⁴¹ Department of Human Services, Government of Australia, *Annual Report 2010-11*, 12 October 2012, <http://www.psr.gov.au/images/annualreports/psr_annual_report_2010-11.pdf> at page 17.

⁴² Dr Rhonda Jolly, *Health Insurance Amendment (Professional Services Bill) 2012*, No. 152 of 2011-12, 24 October 2012, <http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1112a/12bd152>.

also a common criticism of the PSR levelled by medical practitioners, who claim that the emphasis on statistics displaces the focus from the practices and practitioners themselves.⁴³ Thus the emphasis on statistics does not appear to meet the needs of either the community or the medical practitioners. With criticism such as this levelled at the PSR, it is suggested that the system requires a comprehensive review with a view to increasing its overall relevance and effect.

The major focus on statistics as a means of identifying doctors engaging in inappropriate practice means that to some extent the scope of the PSR is too narrow. For example, in order to breach the 80/20 rule and be regarded as a concern, a doctor must be seeing a large number of patients on a regular basis. Yet the doctor who sees fewer patients but engages in inappropriate and possibly negligent prescribing practices will not be picked up through this system. Again, this is another area which could be modified through review to more effectively address the issue of doctor-shopping in Australia.

It is also important to restore public faith in the PSR process by ensuring that all procedures for election of Panel members are followed. Despite recent negative publicity, the PSR is a potentially effective vehicle that could be used to prevent doctor-shopping. Its goal is, after all, to ensure that medical professionals are not engaging in inappropriate practice; and doctors who leave themselves open to facilitate doctor-shopping are surely acting in some way inappropriately.

One specific improvement that could be made would be to allow the public to make submissions about doctors they believe are acting inappropriately. These would not necessarily need to go straight to the PSR; rather, if the allegations were found to have merit, the doctors could be reviewed through the five-stage PRP, with Medicare making the final decision about the appropriateness of a referral to the PSR. Such action would open new ways for the review process to commence, which would also assist in tackling some of the other issues that have been identified with the PSR.

Recommendation 7

That a comprehensive national review of the PSR be undertaken. That review should consider, inter alia, the limited impact of the 80/20 rule and possibility of widening the scope of complainants to include members of the general public and interested organisations.

MEDICARE: FOCUS ON IDENTIFYING INDIVIDUALS AS DOCTOR-SHOPPERS

An alternative way in which Medicare seeks to protect the integrity of the PBS is through the administration of the Prescription Shopping Program ('PSP'). Medicare states that the objective of this Program is to 'identify and reduce the number of patients obtaining PBS subsidised medicines in excess of their medical needs'.⁴⁴ As a corollary to this objective, if individuals cannot access excessive prescription drugs it will decrease their health risk, as

⁴³ Ibid.

⁴⁴ Department of Human Services, Government of Australia, above n 29.

well as decreasing the burden on taxpayers, who are subsidising both consultations and drugs.⁴⁵

The service works both as an information service and an alert service. Practitioners who suspect an individual of ‘getting more medicine than they need’ can contact the Prescription Shopping Information Service (‘PSIS’), in order to find out which drugs have been prescribed, in what quantities and in what timeframe.⁴⁶ Additionally, the alert service works to inform doctors if they have ‘prescribed to a patient of concern’.⁴⁷ In the former situation the onus is on the doctor to take the initiative and contact the PSIS, whereas in the latter situation the doctor is informed after the fact by a third party.

In theory, the PSIP is a useful resource that could assist doctors in determining whether or not their patient has a possible history of doctor-shopping, or is attempting to doctor shop in their present consultation. The Department of Human Services suggests that 1119 new prescribers registered for access to the PSP in 2010/11, bringing the total number of registered prescribers up to 26 586.⁴⁸ The number of PSIS calls was said to increase by 9.5% from 2009/10, an increase stated as attributable to ‘an awareness of the program by health professionals as a result of communication and promotional activities’.⁴⁹ The increase in number is encouraging, but the continued prevalence of the problem suggests that it is not enough.

Perhaps a useful vehicle for the increased effectiveness of the PSP and PSIS would be to make the resource results automatically populate for practitioners, or alternatively to make the information available to registered pharmacists. Should the information automatically populate, it would mean that practitioners could not participate in the over-prescription of medication without knowledge of the situation. Should the information be available to pharmacists, it may provide another level of protection whereby doctor shoppers would not be able to access excessive amounts of prescription drugs. It would be another hurdle to pass before being able to take the drugs home.

While the PSP could be a useful system, there is also the possibility that doctor-shoppers could ask partners or friends to attend consultations and collect prescriptions fraudulently on their behalf. That these kinds of consultations could take place demonstrates the need for a cohesive response on the part of Medicare that focuses on expanding the knowledge and awareness of doctors to these issues, identifying doctors engaging in inappropriate practice, combined with finding and dealing with those engaging in doctor-shopping themselves.

Recommendation 8

That technological procedures be improved to ensure that the ‘doctor-shoppers’ list:

- a. automatically populates for medical practitioners without the need for the medical practitioners to register to have access to the system; and
- b. is made available to all registered pharmacists.

⁴⁵ Ibid.

⁴⁶ Department of Human Services, Government of Australia, above n 29.

⁴⁷ Ibid.

⁴⁸ Department of Human Services, Government of Australia, *Medicare Australia Annual Report 2010-11*, 1 October 2012 < <http://www.humanservices.gov.au/spw/corporate/publications-and-resources/annual-report/resources/1011/medicare-australia-annual-report-2010-11-full-report.pdf>>.

⁴⁹ Department of Human Services, Government of Australia, above n 41 at page 127.

(E) HEALTH (DRUGS & POISON) REGULATION 1996 (QLD)

All states and territories have enacted legislation to regulate the prescribing of drugs of dependence and/or addition which are known as Schedule 8 drugs. Schedule 8 drugs are “poisons to which the restrictions recommended for drugs of dependence by the 1980 Australian Royal Commission of Inquiry into Drugs should apply” and are stated to include, amongst others, benzodiazepines and opioids.

The adoption of the initiative by Queensland Health resulted in *The Health (Drugs and Poison) Regulation 1996 (Qld)*. The regulation prohibits the prescribing of medication to a patient who is drug dependent unless the medical practitioner holds a permit or authority in relation to the patient. The aim of the legislation is to enable the coordination of treatment of drug dependent patients by one medical practitioner and minimise the practice of doctor-shopping.

Chapter 2, Part 9 of the regulation contains provisions relating to ‘treatment with and dependence on controlled drugs’. For present purposes the terms controlled drugs and Schedule 8 drugs will be used interchangeably. Sections in this part deal specifically with the prescription of Schedule 8 drugs:

- *S 120 - Notice required if lengthy treatment with controlled drug*
- *S 121 - Controlled drugs not to be obtained unless information disclosed*
- *S 122 - Approval needed for treating certain drug dependent persons with controlled drugs*
- *S 127 - Improper use of prescriptions for controlled drugs*
- *S 128 - False statements—controlled drugs*
- *S 130 - Unsafe disposal or use of controlled drugs*

The Regulation contains provisions relating to doctor-shopping which target three main groups. These include the practitioners, the dispensers (likely for present purposes to be pharmacists) and the doctor-shoppers themselves. Largely the Regulation focuses on the imposition of penalty units upon individuals breaching the provisions. It is challenging to find data which accurately discusses the number of penalties enforced in accordance with the Regulation on a yearly basis. As a result, while the *Health Act 1937(QLD)* makes provision for the Chief Executive to enforce penalties against practitioners outlined in the Regulation, it is difficult to make a conclusion about the effectiveness of the Regulation.

What can be said is that the penalty sections in the legislation usually range from 40 to 80 units. If these penalties were enforced in line with section 5 of the *Penalties and Sentences Act 1992 (QLD)*, this could equate to a maximum penalty of \$8,000 for inappropriate prescriptions, or failing to conform to the provisions for treating a patient with controlled drugs. Certainly money can be a motivator with respect to altering behaviour. However it would be hoped that in conjunction with the monetary penalty, educational reforms take place such that appropriate and prudent prescribing habits become the norm.

Additionally, it may not be helpful that the penalty provisions also target the doctor shoppers themselves. As has been discussed, often these individuals have become addicted to these prescription medications, due in part to their addictive nature. Enforcing a penalty on vulnerable individuals does little to improve this situation.

Recommendation 10

That the penalty units prescribed for medical practitioners who contravene the Act be increased, and correspondingly, that the penalty units prescribed for patients who attempt to obtain the drugs be reduced.

SECTION III

6. COMMON LAW PERSPECTIVE

It is well established by the law of negligence⁵⁰ and contracts⁵¹ that medical practitioners owe a duty to exercise reasonable skill and care to their patients in the provision of medical services. In the context of doctor-shopping and prescription of drugs by the medical practitioner to the doctor-shopper, these areas of law continue to apply.

*Rogers v Whittaker*⁵² and *Breen v Williams*⁵³ establish that in negligence and contract (through implied terms), medical practitioners owe a duty of care to exercise reasonable skill and care towards their patients in the provision of diagnosis, advice and treatment.

These duties continue to apply in the context of doctor-shopping and prescription of drugs by doctors to their patients. The applicable standard in the context of diagnosis and treatment is the standard of a reasonable, competent medical practitioner.⁵⁴ Therefore a medical practitioner could be liable in negligence and/or contract if prescriptions were incorrectly provided. However in order to be liable, it is likely that it would need to be shown that a reasonable, competent medical practitioner would not have written the script because firstly they identified the patient as a doctor-shopper, and secondly they appreciated that it would likely constitute 'inappropriate practice' to so prescribe. Failure by doctors to adhere to this predetermined standard would then be a breach of the duty of care on the part of the medical practitioners.⁵⁵

In the context of provision of medical advice with respect to prescription of pharmaceutical medications, the medical practitioners owe a duty to advise the patients about the 'material' risk inherent in the drugs.⁵⁶ Failure to adhere to the standard would amount to a breach of duty of care by the medical practitioners. It would be interesting to explore the concept of 'material risks' as a source of liability. For example, if it was not mentioned during the consultation that benzodiazepines and opioids are highly addictive substances, and patients went on to become addicted to them, a possible source of liability may arise.

The issue is not necessarily that the standard of care is not strict enough. Rather, it is that it would likely be relatively easily for a doctor who has prescribed to a doctor-shopper to demonstrate that a group of reasonable, competent medical practitioners would not have identified the patient as a doctor-shopper either. Thus the doctor has not acted in breach of the standard of care, and therefore liability would not attach. As a result this avenue of law does not provide a satisfactory result, as the doctor-shopper has been able to obtain the prescription and the doctor has not been held accountable.

⁵⁰ See *Rogers v Whitaker* (1992) 175 CLR 479.

⁵¹ See *Breen v Williams* (1996) 186 CLR 71, 78 (Brennan CJ).

⁵² (1992) 175 CLR 479.

⁵³ (1996) 186 CLR 71, 78 (Brennan CJ).

⁵⁴ See Loane Skene, *Law & Medical Practice* (Lexis Nexis Butterworths, 2nd ed, 2004) 41.

⁵⁵ *Sidaway v Bethlem Royal Hospital and Maudsley Hospital Board* [1985] AC 871, 881 (Lord Scarman); see also *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582.

⁵⁶ *Rogers v Whitaker* (1992) 175 CLR 479, 490; see also *Rosernberg v Percival* (2001) 205 CLR 434.

It could be argued that a stricter obligation may be imposed upon medical practitioners when dealing with their patients by the law of contracts and fiduciary obligations, where the obligation is framed as a duty to act in the best interest of the patient. However the imposition of such a duty is argued to be impracticable at least in the context of doctor-shopping and prescription of drugs. Due to the prescriptive nature of the law of contract and the proscriptive nature of fiduciary obligations,⁵⁷ these two areas of law are dealt with separately against the incorporation of such a duty.

(A) THE LAW OF CONTRACTS

In *Breen v Williams*,⁵⁸ the argument that the medical practitioners owe a duty of care to act in the patient's best interest (as an implied contractual term) was rejected by the High Court.⁵⁹ Therefore, it is submitted that incorporation of such a term in the context of doctor-shopping and prescription of medical drugs by the doctors is not viable. The reasons are as follows.

Firstly, incorporation of such a duty upon medical practitioners is inconsistent with the existing contractual and tortious duty upon doctors to exercise 'reasonable skill and care,' in the treatment and provision of drugs prescriptions.⁶⁰ To do so would make the medical practitioners liable for the negative effects suffered by the patients who use the prescription drugs, despite the fact that the doctors have fulfilled their duties to exercise duty to exercise reasonable skill and care in prescribing the drugs.⁶¹

Secondly, the notion of 'best interest' has been criticised as inherently uncertain in terms of content.⁶² In the context of doctor-shopping the content of the notion of 'best interest' is made difficult by the tensions inherent in the bioethical principles that govern the conduct of the medical practitioners.⁶³ Relevantly, the most obvious tension is found between the principles of beneficence, respecting a patient's autonomy and non-maleficence. The concept of beneficence requires the doctors to act in the patients' best interest.⁶⁴ Respecting patient's autonomy in this context would mean the patient's autonomy whether to undertake or to refuse treatment.⁶⁵ The concept of non-maleficence requires the doctors not to harm their patients.⁶⁶ In the context of prescription of pharmaceutical medications, differing understandings of best interests would require imposition of different standards at the same time. Evidently this is an impractical proposition.

⁵⁷ See Darryn Jensen, 'Prescription and Proscription in Fiduciary Obligations' (2010) 21 KLJ 333, 334; see also Rebecca Lee, 'Rethinking the Content of the Fiduciary Obligation' [2009] *Conveyancer and Property Lawyer* 236, 245.

⁵⁸ *Breen v Williams* (1996) 186 CLR 71.

⁵⁹ JA Devereux, *Australian Medical Law* (Routledge Cavendish, 3rd ed, 2007) 974; *Breen v Williams* (1996) 186 CLR 71, 104 (Gaudron and McHugh JJ).

⁶⁰ JA Devereux, *Australian Medical Law* (Routledge Cavendish, 3rd ed, 2007) 975; see also *Breen v Williams* (1996) 186 CLR 71, 104 (Gaudron and McHugh JJ).

⁶¹ See similar argument in *Breen v Williams* (1996) 186 CLR 71, 104 (Gaudron and McHugh JJ).

⁶² *Secretary, Department of Health and Community Services v JWB (Marion's Case)* (1992) 175 CLR 218, 270-274 (Brennan J); See also *Breen v Williams* (1996) 186 CLR 71, 103 (Gaudron and McHugh JJ).

⁶³ Examples of bioethical principles can be found in JA Devereux, *Australian Medical Law* (Routledge Cavendish, 3rd ed, 2007) 3.

⁶⁴ JA Devereux, *Australian Medical Law* (Routledge Cavendish, 3rd ed, 2007) 6.

⁶⁵ See Beauchamp TL and Childress JF, *Principles of Biomedical Ethics*, (New York: Oxford University Press 5th ed, 1996).

⁶⁶ Debbie Norval, Elizabeth Gwyther, 'Ethical decisions in End-of-Life Care' (2003) 21 *CME* 267, 267.

Thus overall it would be impractical to attempt to use an implied contractual term as a way of ensuring medical practitioners utilised appropriate prescribing practices, especially in the context of doctor-shopping.

(B) FIDUCIARY LAWS

The doctor-patient relationship is not an established category of fiduciary relationship.⁶⁷ The hallmarks of a fiduciary relationship is highlighted by *Hospital Products v United States Surgical Corporation*⁶⁸ where it was held that, commonly,

*One person is obliged, or undertakes, to act in relation to a particular matter in the interests of another and is entrusted with the power to affect those interests in a legal or practical sense...the special vulnerability of those whose interests are entrusted to the power of another to the abuse of that power.*⁶⁹

In *Breen v Williams*, the High Court had read down the scope of fiduciary duty owed by medical practitioners towards patients.⁷⁰ It is the combination of these factors that results in the submission that a general fiduciary obligation owed by medical practitioners to act in the best interest of their patients is not viable. The arguments are as follows.

Firstly, the incorporation of a duty to act in the patient's 'best interest' is inconsistent with the established tortious and contractual duties on the part of the medical practitioners.⁷¹ Also as discussed above the content of the notion of 'best interest' is argued to be problematic, at least in the context of doctor-shopping and prescription of medical drugs.

Secondly, as aforementioned, the nature of a fiduciary duty is proscriptive (as opposed to prescriptive).⁷² Therefore, fiduciary obligations are concerned with restraining the doctor from acting in a self-interested manner. For example, from taking up opportunities to pursue his or her own interests within the scope of matters which the patient brings to the doctors attention. It is not a quasi-tortious duty to act solely in the interest of the principal (patient).⁷³ Therefore, incorporation of the duty to act in the best interest of the patient on the doctors, as an aspect of the fiduciary duty, is inconsistent with the nature of the fiduciary duty itself.

Thirdly, the incorporation of such a duty in the context of doctor-shopping is not viable as the duty (if incorporated as an aspect of fiduciary law) is unlikely to be breached. A fiduciary duty is breached when medical practitioners place themselves in a position in which their private interests conflict with their duty to the patients, or when the medical practitioners derive unauthorised profit from the relationship.⁷⁴ Pertaining to the former, the medical practitioners owe a duty to exercise reasonable care and skill in the provision of drugs prescription towards the patients and the patient's interest is to obtain the drugs to relieve

⁶⁷ Loane Skene, *Law & Medical Practice* (Lexis Nexis Butterworths, 2nd ed, 2004) 63; cf *McInerney v Macdonald* [1992] 2 SCR 138, 152 (LaForest J) (accepted that the relationship between doctor and patient was a fiduciary one).

⁶⁸ *Hospital Products v United States Surgical Corporation* (1984) 156 CLR 41.

⁶⁹ *Hospital Products v United States Surgical Corporation* (1984) 156 CLR 41, 66 (Gibbs CJ).

⁷⁰ *Breen v Williams* (1996) 186 CLR 71, 108 (Gaudron and McHugh JJ).

⁷¹ *Breen v Williams* (1996) 186 CLR 71, 110 (Gaudron and McHugh JJ).

⁷² See Darryn Jensen, 'Prescription and Proscription in Fiduciary Obligations' (2010) 21 KLJ 333,334; see also Rebecca Lee, 'Rethinking the Content of the Fiduciary Obligation' [2009] *Conveyancer and Property Lawyer* 236, 245.

⁷³ *Breen v Williams* (1996) 186 CLR 71, 137 (Gummow J).

⁷⁴ *Hospital Products v United States Surgical Corporation* (1984) 156 CLR 41, 66 (Gibbs CJ).

themselves from their symptoms. Therefore, there is no conflict of duty and interest and the dispute arising is better dealt with under the duty of ‘reasonable care and skill’ (by the law of negligence and contracts). In relation to the latter, a doctor derives no profit from the relationship beyond payment of his authorised professional fees.⁷⁵ An interesting question would arise if a doctor knew the patient was doctor-shopping, and prescribed drugs anyway in order to obtain Medicare benefits. Then there would be a profit arising in breach of a duty owed to a patient, and liability may be able to attach. However that would be an exception rather than the general rule. Therefore, incorporation of a duty as an aspect of fiduciary law is not viable in the context of prescription of drugs by medical practitioners.

A fiduciary duty ought not be superimposed on these common law duties simply to improve the nature of the duty and extend of the remedy. Also, given the reluctance of the High Court in *Breen v Williams* to give a wide interpretation to the scope of fiduciary duty, it is submitted incorporation of a duty in statute which imposes a positive fiduciary duty upon the medical practitioners to act in the patient’s best interest, would likely be read down by courts in the future. Again this leaves a rather unsatisfactory overall outcome with respect to the usefulness of contract, negligence and fiduciary obligations in effectively providing a source of liability for doctors who engage in practices leaving themselves open to be targeted by doctor-shoppers.

⁷⁵ *Breen v Williams* (1996) 186 CLR 71, 109 (Gaudron and McHugh JJ).

7. CONCLUSION

It may be suggested that there is, to some extent, over-regulation of the provisions of medical services. This is especially true when examining the prevalence of doctor-shopping. A key issue with the regulatory bodies currently operating is that there are many distinct bodies, with slightly different aims, yet having areas of overlap between them. This leads to inefficiency within the system. Additionally, the bodies do not appear to target doctor-shopping directly – rather, the issue has been addressed indirectly through the flow-on effects of other targets the bodies have tried to meet. Overall then regulatory bodies would benefit from direct action on the doctor-shopping issue.

Over-regulation may be undesirable, but in the absence of effective common law solutions, regulation and education appear to be the only viable ways to address this issue. A stronger focus on doctor-shopping and the surrounding issues at tertiary levels would be ideal, as well as a repeated focus throughout the professional development of medical practitioners. It is believed that if medical practitioners were more aware of the problem, they would be less inclined to prescribe to start with, which would go a long way towards reducing the incidence of doctor-shopping.