Margaret Faux
PhD Candidate | Solicitor | RN | Founder and CEO

26 July 2021

Competition Exemptions Branch
Australian Competition & Consumer Commission
exemptions@accc.gov.au

Dear Exemptions

RE: HONEYSUCKLE HEALTH (HH) AND NIB, AUTHORISATION AA1000542

I refer to my previous correspondence in relation to the above application, your draft determination dated 21 May 2021 and the pre-determination conference held on 8 July 2021. Thank you for permitting me a short extension of time to make the following further submissions.

The following submissions include some general information around the operation of Australia's very complex health financing arrangements. I have included this information as I believe it may assist the ACCC to achieve clarity around certain key issues when it weighs up consumer benefits/detriments that may result from this application.

The focus of my submissions remains on Gapcover schemes and MPPA's, which are the key areas likely to impact consumers. As previously stated, medical billing and compliance is the topic of my recently completed doctoral research. My PhD also discusses hospital billing (because medical and hospital billing are inextricably linked), however, consumers do not now and have never been privy to the details of hospital claims which are paid on their behalf by private health insurers (PHI), and therefore the nexus between hospital claims and patient out-of-pocket costs (OOPs) is more distant.

The consumer perspective and Value Based Care (VBC)

I have worked for decades at the interface of patients, payers, and providers, where health payments are transacted. It is a dark and disturbingly secret part of our health system that few understand.

As I alluded to in the conference, I believe it is very important for the ACCC to understand that there will be no consumer buy-in around this application, because consumers have no knowledge of what happens beneath the surface of health financing transactions. Patients do not know that their doctor or hospital has not been paid after they have been discharged from hospital. Claims for reimbursement are submitted to the PHI's for payment anywhere between three days and two years after the patient has been discharged from hospital, and the battles for payment that often ensue are fought behind the scenes by organisations like mine.

We do not burden patients with the battles we fight around payment, and in my experience, others who do the same work, adopt the same approach, which is protective of patients. For example, in a recent case, we did not call the patient to say something like:

> *'Thought we would just let you know that your health fund has refused to pay the cardiologist who resuscitated you after your post-operative cardiac event, because your policy doesn't cover cardiac care.'*

The cardiologist in that case instructed us to write the claim off, which is common. The patient will never know.

In time, as research into the alleged benefits of VBC matures, it will be interesting to see if the VBC datasets are examined with sufficient granularity to capture scenarios where patients were recorded as having achieved good health outcomes at a lower cost (which ticks both VBC boxes), the lower costs having been achieved because the PHI refused to pay for all or part of the treatment. It is a phenomenon I see daily, and I often ponder the extent to which it may be incorrectly reported in VBC success data around the world. It is my impression that the incidence of misreporting of VBC in this manner may be significant, and is an area ripe for focussed academic attention.

A poorly understood Medicare principal which will cause this initiative to fail consumers

In *Health Insurance Commission v Peveril [1994] HCA 8* the Australian High Court settled certain key issues concerning the legal nature of the Medicare benefit including who has contracts with whom in the context of a Medicare billing transaction. *Peverill* confirmed the existence of a contract between a medical practitioner and a patient.

The High Court has further deliberated upon this issue in various cases including *Wong v Commonwealth of Australia [2009] HCA 3*, when Kirby J characterised section 51(xxiiiA) of the Australian Constitution (which underpins Medicare's fee-for-service arrangements) as a rare constitutional guarantee because it protects both doctors and patients equally, by cocooning their relationship inside general principles of contract law. He stated:

> *"However, the prohibition on "any form of civil conscription" is designed to protect patients from having the supply of "medical and dental services", otherwise than by private contract, forced upon them without their consent."*

Even the simplest Medicare claims (to which PHI medical claims are pegged) are surprisingly complex legal transactions. In essence, Medicare benefits are payable for clinically relevant services only, but the fact that a service is not clinically relevant does not mean it cannot be provided, it just means there is currently no Medicare rebate for it. Common examples of non-clinically relevant services are booking or administration fees, some family meetings, and the burgeoning cosmetic botox and filler market.

Therefore, while possibly unethical, there is usually no legal barrier to doctors charging for non-clinically relevant services such as booking fees (there is one exception discussed in my thesis). In addition, the Services Australia Department, which administers the Medicare scheme, has no legal authority to collect and process information concerning income tax. This includes anything that does not attract a Medicare benefit, such as booking fees and things like common cosmetic Botox injections. If Medicare were to collect this type of information, it would be acting outside its permitted legal functions. Medicare therefore advises doctors as follows:

> *"Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. … When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient." (MBS Book)*

Additional examples confirming the legality of medical practitioners charging private fees for private contracted, non-clinical services are the GP co-ops in the Australian Capital Territory, who were expressly given government grant funding to operate as bulk bill clinics charging annual membership fees; many GP clinics now charge annual membership fees, and as recently as last week, the

Department of Health confirmed that doctors are free to charge private fees for non-clinically relevant services (**See Annexure A**) as long as the service is not billed to Medicare. These common transactions are never seen by the government or the PHIs because they are recorded on separate software systems.

So, booking fees are, prima facie, legal (with one exception) because they are non-clinically relevant services, always provided in the outpatient setting where the PHI's have no jurisdiction, negotiated as a private contract between the doctor and patient, just like cosmetic botox injections. Further, as I explained in my first submission, even if all such fees were declared illegal by a Court, doctors could simply shift the cost legally to the clinically relevant services they provide, and maintain their incomes.

Given the above, it is worth the ACCC considering why it is that despite the PHIs having alleged that booking fees are illegal for years, not one PHI has ever initiated legal proceedings to stop this alleged illegality, despite ample evidence of such practices being available to them. And further, what law has changed such that the ACCC can have confidence the HHBG application can solve this problem?

NIB's current Gapcover Terms and Conditions (T&C's) state:

> *"If you elect to charge for a service through MediGap, you acknowledge and agree that the Member will not be charged any additional booking, administration, technology or facility fees, or any other such fees related to that Treatment."*

Quite apart from being inconsistent with Medicare's advice and the provisions of the broader statutory scheme, there is an infinite array of ways in which doctors can easily and legally circumvent this requirement by arguing the fees *were not 'related to that Treatment'*.

For example, a failure of conservative treatment is an indication for surgery. Evidence of this is shown below in a decision of the Director of the Professional Services Review Agency, where a surgeon was severely punished and required to pay back $500K to Medicare for proceeding too quickly to a surgical intervention (among other things). The report is available at this link: **https://www.psr.gov.au/case-outcome/psr-directors-update-june-2019**

> "*An agreement with a general surgeon.*
> *The practitioner billed more than 17,000 services in the year under review, including more than 90 services on 59 days. The Director reviewed this practitioner's rendering of Medicare Benefit Schedule (MBS) items 104, 105, 18264, 32000, 32006, 32025, 32072, 32093, 32111, 32129, 32131, 32135, 32139, 32145, 32165, 35595 and 45200 and had no concerns in relation to MBS item 104. The Director had persisting concerns that:*
>
> - *records of consultations and procedures were either non-existent or inadequate;*
> - *MBS item 105 was often billed for consultations that were post-operative in nature or for the rendering of a therapeutic item;*
> - *consent to procedures for all therapeutic procedures was either not adequately obtained or not adequately recorded;*
> - *MBS requirements were not met for many services (in that multiple items were often billed for what peers might consider a single service or the service was not otherwise performed in accordance with the descriptor (or at all));*

- *not all services were clinically indicated, with the practitioner often appearing to proceed straight to a surgical option ahead of more conservative forms of treatment where only mild symptoms were identified; and*
- *clinical input was inadequate or inadequately recorded.*

The practitioner acknowledged they engaged in inappropriate practice in connection with providing these items of concern. The practitioner agreed to repay $500,000, to be disqualified from providing MBS items 32131 and 32111 for 12 months, and will be reprimanded by the Director."

The problem around this issue in the context of the HHBG application, is that, while Gapcover schemes provide a level of transparency (because Gapcover T&Cs and fee schedules are in the public domain) MPPA's will provide no such transparency. Being confidential contracts, MPPA's will introduce cavernous interpretive spaces around contract terms, which may or may not be consistent with the provisions of the vast statutory scheme regulating Medicare and the PHI's. In addition to this leading to potential backdoor boycotts of providers (described further below), medical practitioners who sign MPPA's will still have ample space and opportunities to charge patients OOPs. Consider this common example of a patient journey through conservative treatment:

1. A patient sees the GP with a painful knee. The GP refers the patient to an orthopaedic surgeon.
2. The GP referral has a 12-month duration commencing from the date of the first consultation with the surgeon, *not* the date on the referral. This is important because delays obtaining an appointment with the surgeon are irrelevant. The 12-month period starts on the date of the first surgical consultation and the referral remains open for 12-months from that date.
3. At the first consultation, the surgeon may initiate conservative treatment such as physiotherapy, and follow up in say 3-months. The patient pays say $500 for item 104 and receives an 85% rebate of $76.80, leaving the patient $423.20 out of pocket. There are no immediate plans for surgery and therefore it has nothing to do with the PHI at this stage.
4. Three months later the surgeon chooses to continue conservative treatment and suggests a steroid injection into the knee. Assume another $500 fee for the consultation.
5. A week later the surgeon does the steroid injection, in her/his rooms. Assume another $500 for the consultation and say $1000 for the injection. Still nothing to do with the PHI at this stage because surgery is not planned, and the PHI is not contributing financially to any of these treatments.
6. This process can continue for as long as the surgeon deems it necessary and during this journey the patient may also require repeat x-rays, pathology, and MRI's all of which incur additional OOPs. The HHBG cannot control this process and we already know that it is often these types of cumulative OOPs that patients incur out-of-hospital that impact them the most, rather than a single inpatient episode. The article at this link explains this well, and a table from the article is copied below
   https://thenewdaily.com.au/life/wellbeing/2019/12/01/breast-cancer-costs-health/

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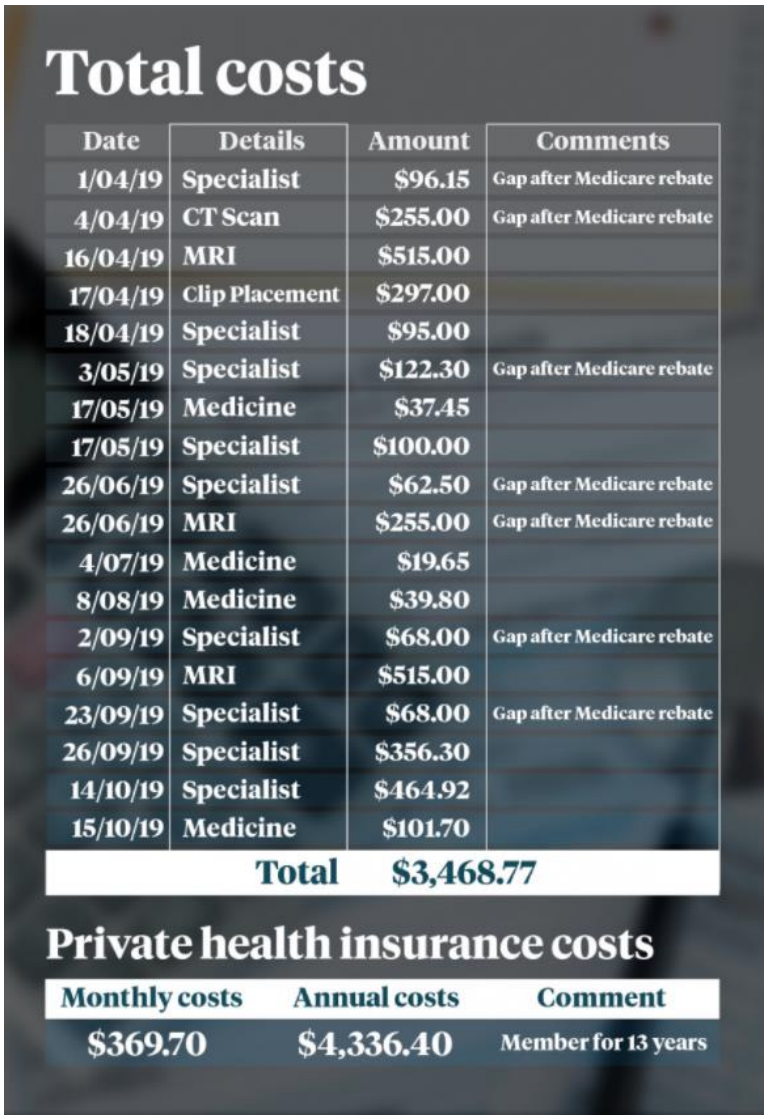

Total costs

Date	Details	Amount	Comments
1/04/19	Specialist	$96.15	Gap after Medicare rebate
4/04/19	CT Scan	$255.00	Gap after Medicare rebate
16/04/19	MRI	$515.00	
17/04/19	Clip Placement	$297.00	
18/04/19	Specialist	$95.00	
3/05/19	Specialist	$122.30	Gap after Medicare rebate
17/05/19	Medicine	$37.45	
17/05/19	Specialist	$100.00	
26/06/19	Specialist	$62.50	Gap after Medicare rebate
26/06/19	MRI	$255.00	Gap after Medicare rebate
4/07/19	Medicine	$19.65	
8/08/19	Medicine	$39.80	
2/09/19	Specialist	$68.00	Gap after Medicare rebate
6/09/19	MRI	$515.00	
23/09/19	Specialist	$68.00	Gap after Medicare rebate
26/09/19	Specialist	$356.30	
14/10/19	Specialist	$464.92	
15/10/19	Medicine	$101.70	
	Total	$3,468.77	

Private health insurance costs

Monthly costs	Annual costs	Comment
$369.70	$4,336.40	Member for 13 years

The fact is that every surgeon has a full 12-month referral period in which to provide whatever services at whatever prices she/he likes. Further, even during a hospital admission, where the PHIs do have jurisdiction, their ability to ensure a no-gap experience will be limited to the simplest patients, who they may therefore cherry pick. Consider the following three recent real cases conveyed to me by a client:

<u>Patient 1:</u>

Patient was admitted for back surgery but did not recover well post-operatively and was referred to a pain specialist. The patient then required drug and alcohol treatment, then rehabilitation, then overdosed, then spent two nights in ICU, then had to be assessed in the emergency department for scheduling due to psychosis, then was discharged.

The only part of this case, where an application such as the HHBG may be able to ensure a no-gap experience for the patient is possibly the initial back surgery.

Patient 2:

The patient was admitted for hip replacement surgery, then required inpatient rehabilitation, then acquired a blood clot in the lung requiring referral to a respiratory physician, then a pre-existing neurological condition worsened, was then seen by a neurologist, then returned to inpatient rehabilitation.

The only part of this case, where an application such as the HHBG may be able to ensure a no-gap experience is possibly the initial hip surgery.

Patient 3:

A country patient was admitted with a deteriorating neurological condition and had emergency neurosurgery. The patient became paraplegic and required inpatient rehabilitation. The patient then acquired a chest infection requiring review by a respiratory physician. The patient deteriorated and was moved to ICU for ventilation. The patient's left shoulder then became septic requiring orthopaedic surgery for a washout of the infected joint. The patient returned to ICU but deteriorated further and subsequently required cardio-thoracic surgery for the removal of pus from the chest cavity. The patient is now receiving palliative care.

While the above cases represent complications of surgery, they are not uncommon. The HHBG application may discriminate against these types of patients or those with complex health needs, who may experience higher OOPs than patients who are more fit, less affected by chronic disease and luckier. The applicant may argue that community rating prevents this type of discrimination, but the phenomenon of what I have described as 'managed care creep' in my thesis happens behind the scenes where claims are inappropriately questioned, delayed, rejected, lost and so on.

I suggest that the applicant should be required to comprehensively answer the question of how it intends to provide a complete no-gap experience across the entire continuum of care, both inpatient and outpatient (without causing medical practitioners to shift costs to consumers as OOPs), and if it cannot, I submit that the public benefit argument of this application must fail.

Applicant's lack of transparency

In both of my previous submissions I have expressly urged the ACCC to request details of proposed changes to NIB's gapcover terms and conditions, because that is where indirect pressure will likely be hidden, with flow on effects to consumers as OOPs. The fact that the applicant has continually failed to respond to this specific issue is worrying.

Given the applicant's apparent unwillingness to be transparent about changes to its gapcover terms (which should be uncontroversial), if the ACCC decides to authorise the application, I would suggest restricting the authority to three years and 20% of the market. Absent any concerning conduct, it will then be a relatively simple process for the applicant to apply for an extension of the authority beyond the initial three-year period.

Potential negative impact on consumers if forced into gold policies

The Clinical Partners Program of the applicant (CPP) is currently only available for hip and knee replacements, which are covered under gold policies only. As I stated in the conference, I suggest the ACCC seeks written assurance from the applicant that it will not engage in any conduct, including

through 3rd parties intermediaries such as *iSelect* and *Compare-the-Market* that will push consumers to take up more expensive gold policies that they cannot afford and do not need. This would effectively do nothing more than shift consumer OOPs from doctors to the PHIs. The ACCC has already seen this type of conduct with Medibank Private https://www.accc.gov.au/media-release/medibank-in-court-for-alleged-misrepresentations-to-members-about-benefits

Granting of this authority should require written confirmation that the CPP will be made equally available to all policy holders not just gold policy holders.

The potential for backdoor boycotts

The HHBG application specifically states there will be no boycotting of any provider. However, the application also provides that the HHBG will assess medical practitioner compliance including 'accuracy of claims' and 'excessive use of MBS items', and may make findings of 'fraudulent claims' and would share such findings with other payers participating in the HHBG. Of concern is the fact that despite its assertions to the contrary, the HHBG application seems likely to lead to collective boycotts of providers if for example the HHBG makes a unilateral finding of criminal fraud by a provider, and circulates that decision among group participants.

It is unclear how the HHBG purports to have legal authority to make findings of fraud outside of the criminal justice system, and nor does the HHBG have any demonstrated expertise in medical billing compliance. In fact, the HHBG application expressly demonstrates gaps in the medical billing literacy of the applicant such as by incorrectly stating that the Department of Veterans Affairs (DVA) maintains its own no-gap scheme, enabled by a process of individually contracting with medical practitioners, who then do not charge co-payments to DVA policyholders. This is wholly incorrect.

Evidence of the very serious consequences that can result when unqualified individuals think they understand medical billing compliance were seen in the Federal Court case of *Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd [2018] FCA 2033*, which is available at this link: https://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2018/2018fca2033

The case concerned MBS item number interpretation, which my thesis demonstrates, is profoundly complex. The facts of the case were essentially that Bupa asserted one interpretation of an MBS item, and Dr Chang another. The court preferred Dr Chang's interpretation, declaring that Bupa had:

> *"…breached the contract between it and Dr Chang being the "BUPA Medical Gap Scheme Terms and Conditions dated March 2016" (**Contract**) by purporting to deregister Dr Chang from the "Bupa Medical Gap Scheme" with effect from 15 August 2016 when it failed to comply with the express term of the Contract being the term providing for the "Bupa's Medical Gap Scheme deregistration procedure"."*

This case demonstrates the point I made during the conference that if the HHBG unilaterally deregisters a provider from the CPP, the only option for the provider will be to engage in expensive legal proceedings.

Accordingly, if this authorisation proceeds, I suggest that a clear communication channel, via a direct point of contact at the ACCC, is made available to all stakeholders, to report this type of backdoor boycotting, should it occur.

91C Revocation of an authorization and substitution of a replacement

In anticipation that this application, if granted, may require review and revocation, I have copied the revocation provisions of the consumer law below, which are obviously well known to the ACCC.

> *(3) If, at any time after granting an authorization, it appears to the Commission that:*
> *(a) the authorization was granted on the basis of evidence or information that was false or misleading in a material particular; or*
> *(b) a condition to which the authorization was expressed to be subject has not been complied with; or*
> *(c) there has been a material change of circumstances since the authorization was granted;*

I suggest the following should be flagged as potential future triggers for a revocation process:

- Evidence of the HHBG purporting to exercise authority over Medicare billing compliance.
- Evidence of the HHBG boycotting a provider based on a unilateral interpretation of a disputed contract term in a HPPA or MPPA.
- Evidence of the HHBG removing practitioner provider numbers from the ECLIPSE billing interface, to effectively block access to baseline statutory benefits. This is a phenomenon I have witnessed and alluded to in my previous submission document.

The administrative burden will increase not decrease

The suggestion made by the applicant that this application will reduce costly administrative burdens across the health payments landscape is just nonsense. While administrative work may reduce for HHBG payers, the burden will just be shifted to the other side of the transaction where I work, and where costs are quickly passed to patients.

For example, a private surgical operating list of 15 patients, would usually include a mix of patients insured with BUPA, Medibank Private, HCF, at least four other PHI, one or two workers compensation patients, a few DVA patients, a self-insured patient, and sometimes overseas visitors with international insurance. If the HHBG application goes ahead, more complexity will be added, not less. The billing rules and rates are already different for every patient on the list, and with the HHBG, we will also be required to engage in debates about the interpretation of confidential contract terms.

Conclusion

Evidence suggests that medical practitioners do not understand the operation of their health systems, and how to bill correctly. The published academic article attached as **Annexure B** describes this global phenomenon. It forms part of the literature review chapter of my thesis.

That said, the Australian medical profession must take some responsibility for the aggressive approach of payers like HHBG, having done nothing to address problems around medical billing compliance and OOPs.

Standing in the shoes of payers like the HHBG momentarily, I understand how worrying it would be to know for example, that unqualified individuals among the medical profession openly teach doctors how to ‘pack and stack’ MBS item numbers to extract as much as possible from the public

purse every time they see a patient. The profession continues to not only turn a blind eye to this outrageous conduct, but actively encourages it by accrediting this type of training so that doctors can earn continuing professional development (CPD) points for participating. The optics are unflattering – doctors earn CPD points for learning borderline medical billing practices that commodify patients. It is nothing short of a disgrace. To understand this, please see the case of *Anand & Anor v Armstrong & Anor [2020] SADC 34 (31 March 2021)* attached as **Annexure C**, and a commentary article about the case attached as **Annexure D**. The *Armstrong* case is also discussed in my thesis.

I wish to reiterate a statement I have previously made which is that I want solutions to OOPs too, and have worked tirelessly over the past decade quietly chipping away educating doctors on how Medicare and the PHIs work and how to bill correctly, and completing a PhD on the topic of Medicare claiming and compliance. To the best of my knowledge, I am the only experienced lawyer in Australia who teaches Medicare and medical billing law to doctors, including the ethical dimensions of billing decisions, responsible approaches to price setting, and the practical impacts egregious OOPs have on the proper functioning and sustainability of the entire health system.

The HHBG will not solve these problems because they are deeply structural and more complex and nuanced that the applicant understands. Solutions to problems like consumer OOPs will require multi-pronged approaches across regulation, education, and digital reform, not a buying group like the HHBG. At best, the HHBG will have no impact on OOPs, but at worse, it may increase consumer OOPs quickly and significantly, as doctors shift the cost burden to their patients.

I remain opposed to this application, but if it proceeds to authorisation, I urge the ACCC to consider imposing the recommendations I have made herein.

I would be happy to discuss further if required.

Yours sincerely

Margaret Faux

AUSTRALIAN DOCTOR **NEWS**

GPs can charge anti-vaxxers private fees for fake consults, says health dept

Officials say the mandatory bulk-billing requirement can be waived by doctors if there is no 'personal health purpose' for the consult

2 minutes to read

21st July 2021

By Geir O'Rourke |

15

Anti-vax activists who book fake consults so they can 'educate' GPs about the dangers of COVID-19 vaccines can be charged private fees, although they probably could not claim on Medicare, the Department of Health says.

Reignite Democracy Australia is currently urging its 50,000 followers on Facebook to book appointments with GPs and then, during the consult, read out a prepared questionnaire and record the GP's answers, along with their name and their practice.

The group's founder, Monica Smit, claimed it would sow a "seed of doubt" in the mind of the GP.

"If doctors stop getting the jab, we're going to have a chance of saving some lives," she declared on her Facebook page last week.

The RACGP has already said GPs should tell any fake patients to leave immediately and, if they refuse, consider calling the police.

The health department said Medicare funding could also be an issue.

In a statement to *Australian Doctor,* it stressed it was open if the GP wanted to "privately bill a person (ie, not submit a claim to Medicare) when the attendance does not meet the Medicare requirements or is not for a personal health purpose".

It stressed that there would be cases when GPs could bill one of the MBS vaccination items; however, the consult would have to fulfil the requirements of their descriptors.

Read more: *The GP vs Clive Palmer: The information war on COVID-19 vaccines*

The items are defined as 'suitability assessments' for vaccination and are not contingent on whether the patient wanted to go ahead with a dose.

However, under the descriptor, a GP — or another health practitioner working under the GP's supervision — must take either a short patient history or a limited clinical examination which the activists may not consent to.

Medical billing expert Margaret Faux said GPs were prohibited from billing the MBS for services if they were not clinically relevant.

GPs were therefore entitled to charge a private fee to listen to a member of the group, provided they obtained the individual's financial consent.

However, she said it could be "legally vexed" in situations where it was not immediately clear that the patient was there for purely activist purposes.

"If the service is clinically relevant, then a Medicare rebate is available and the patient is entitled to receive that benefit," she said.

> **"The issue for the GP is going to be at what point do they know whether it is a genuine consultation or simply activism from the patient?"**

“My best advice would probably be to simply remove the patient from your surgery as best as you can.”

Reignite Democracy Australia has yet to reveal the list of questions that it will use during the planned blitz, but Ms Smit told her supporters the consults should be “very polite” and not about “going in there roaring and screaming”.

Ms Smit, who has described herself as a hobby journalist, said the protest was inspired by Prime Minister Scott Morrison urging people to “speak to their GP”.

Have you got an experience, patient case or insight you want to share about COVID-19 or just want to vent about the latest government announcement? Join other doctors in *AusDoc*'s Coronavirus Group.

Human Resources for Health

REVIEW

Open Access

Educational needs of medical practitioners about medical billing: a scoping review of the literature

Margaret Faux[1*], Jon Adams[2] and Jonathan Wardle[3]

Abstract

Introduction: The World Health Organization has suggested the solution to health system waste caused by incorrect billing and fraud is policing and prosecution. However, a growing body of evidence suggests leakage may not always be fraudulent or corrupt, with researchers suggesting medical practitioners may sometimes struggle to understand increasingly complex legal requirements around health financing and billing transactions, which may be improved through education. To explore this phenomenon further, we undertook a scoping review of the literature to identify the medical billing education needs of medical practitioners and whether those needs are being met.

Methods: Eligible records included English language materials published between 1 January 2000 and 4 May 2020. Searches were conducted on MEDLINE, PubMed, Google Scholar, CINAHL, LexisNexis and Heinonline.

Results: We identified 74 records as directly relevant to the search criteria. Despite undertaking a comprehensive, English language search, with no country restrictions, studies meeting the inclusion criteria were limited to three countries (Australia, Canada, US), indicating a need for further work internationally. The literature suggests the education needs of medical practitioners in relation to medical billing compliance are not being met and medical practitioners desire more education on this topic. Evidence suggests education may be effective in improving medical billing compliance and reducing waste in health systems. There is broad agreement amongst medical education stakeholders in multiple jurisdictions that medical billing should be viewed as a core competency of medical education, though there is an apparent inertia to include this competency in medical education curricula. Penalties for non-compliant medical billing are serious and medical practitioners are at risk of random audits and investigations for breaches of sometimes incomprehensible, and highly interpretive regulations they may never have been taught.

Conclusion: Despite acknowledged significance of waste in health systems due to poor practitioner knowledge of billing practices, there has been very little research to date on education interventions to improve health system efficiency at a practitioner level.

Keywords: Medical billing education, Health care fraud and non-compliance, Health system literacy, Legal liability of medical practitioners, Health insurance

Introduction

The World Health Organization (WHO) has stated that "health-care systems haemorrhage money", citing ten causes of inefficiencies and remedies [1]. In the cited domain of waste attributable to fraud and corruption, the solutions proffered focus on measures to police and sanction wrong doers, such as medical practitioners who

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over-service in fee-for-service payment environments [1]. Notably absent is any suggestion that teaching medical practitioners how their health systems work and how to allocate health dollars correctly may improve their compliance and reduce waste. This is despite evidence from the US, Canada and Australia suggesting medical practitioners may have at best, only a cursory understanding of the complex financial and billing infrastructure in their health systems, which may be contributing to unintentional misuse and exposure to serious legal sanctions [2].

In Australia, despite an overarching assumption that doctors have high legal literacy in relation to correct billing using Australia's national universal health system, Medicare [2], a recent study seeking to measure that experience, challenged that assumption, suggesting medical practitioners may instead be experiencing difficulties accessing reliable medical billing advice [3]. In 2016, the Government of the Netherlands acknowledged this educational gap by introducing a requirement that universities and medical specialist training colleges provide education to medical practitioners in relation to medical billing and the costs of providing care, the stated aim being to tackle billing mistakes and fraud through prevention, rather than solely through punitive post-payment policing [4]. While this intervention has been implemented, it does not appear to have been evaluated. However, the Dutch Healthcare Authority now details how consumers can report suspected healthcare fraud [5]. This may suggest that successful implementation of medical billing education has placed the Netherlands Government in a better position to prosecute deliberate misconduct when it is reported.

However, while medical billing education has been recognised as an effective measure to improve compliance, reduce incorrect billing and improve integrity of health financing systems [6], formal education initiatives remain rare and many medical practitioners may have received no training whatsoever [7]. To explore this phenomenon further, a scoping review of the literature was undertaken [8] to determine the extent to which focused examination has been undertaken of the educational needs of medical practitioners in relation to medical billing compliance and whether those needs are being met.

Methods

Search strategy and selection criteria

Inclusion criteria targeted literature that specifically cited teaching and education of medical practitioners in relation to medical billing, using combinations of keywords such as "medical billing and education", "medical billing and curricul*", "billing and coding education", "physician medical billing", "Medicare billing education". The word "coding" was included in the keywords, because medical billing is referred to as medical coding in some jurisdictions. Materials dealing with individual health care system specifics and medical billing in the broad contexts of health economics, politics and health policy were deemed not relevant and excluded.

Grey, commentary materials and legal literature were included in the search strategy and manual searching was undertaken to review bibliographies and reference lists in the material originally sourced. No country restrictions were put in place.

As this is a novel topic and of interest to the general health, social sciences and legal communities, relevant databases in these areas were initially searched including MEDLINE, PubMed, Google Scholar, CINAHL, LexisNexis and Heinonline. We initially included the CINAHL nursing and allied health database, to capture possible results from multi-disciplinary billing settings such as Rehabilitation Medicine and Palliative Care. However, no relevant results were returned so CINAHL was later excluded. LexisNexis and Heinonline are important legal databases, which were included as they are likely repositories of law reports and articles dealing with medical practitioners who had been prosecuted for incorrect billing through law enforcement, as the WHO recommends. In countries where the rule of law is upheld, education about laws is usually made available prior to individuals being required to engage with those laws. We therefore searched these databases to determine whether medical practitioners had discussed educational needs in the context of policing and prosecution for incorrect billing. LexisNexis returned numerous irrelevant results which were unable to be reduced by refining search terms. All results found on LexisNexis were duplicates of those found on Heinonline and due to Heinonline enabling more granular refinement of search criteria, we excluded the LexisNexis database in final searches.

Due to the large number of initial search hits, numerous filtering strategies were applied and criteria refined until sensitivity and specificity appeared to be optimised. This process identified 3022 records of materials published in the last 20 years. We undertook further manual searching on Google Scholar to ensure any grey literature were found as well as again manually reviewing bibliographies and reference lists in the material originally sourced.

As this topic tends to divide opinion along partisan lines (i.e. "medical practitioners are deliberately committing fraud", or, "are unintentionally making errors"), opinion pieces and grey literature had the potential to be very relevant in the evolving discussion on the causes of non-compliant medical billing. To ensure we did not reject key insights numerous government reports were

included. Only two empirical Australian studies directly related to the research topic were found.

Results

After removing duplicates and unrelated records, we screened the abstracts of the remaining 241 records, and excluded a further 155 records which did not meet inclusion criteria, because they did not specifically target educational needs of medical practitioners around medical billing. We also excluded a further 12 records which were legal cases concerning non-compliant medical billing and fraud, because they did not specifically address teaching and education of the medical practitioners who were the subject of those proceedings. An additional 44 records met the inclusion criteria as a result of manual processes. The majority of relevant results on medical billing in Australia were found in grey literature and commentary, which may therefore have an inherent bias, while in the US the topic appears to be more mature, with substantial numbers of empirical studies found. In Canada, only one empirical study and one commentary article met the inclusion criteria. Summary results of the search are presented in Fig. 1. Although a comprehensive international, English language search with no country restrictions was conducted, results were limited to three countries

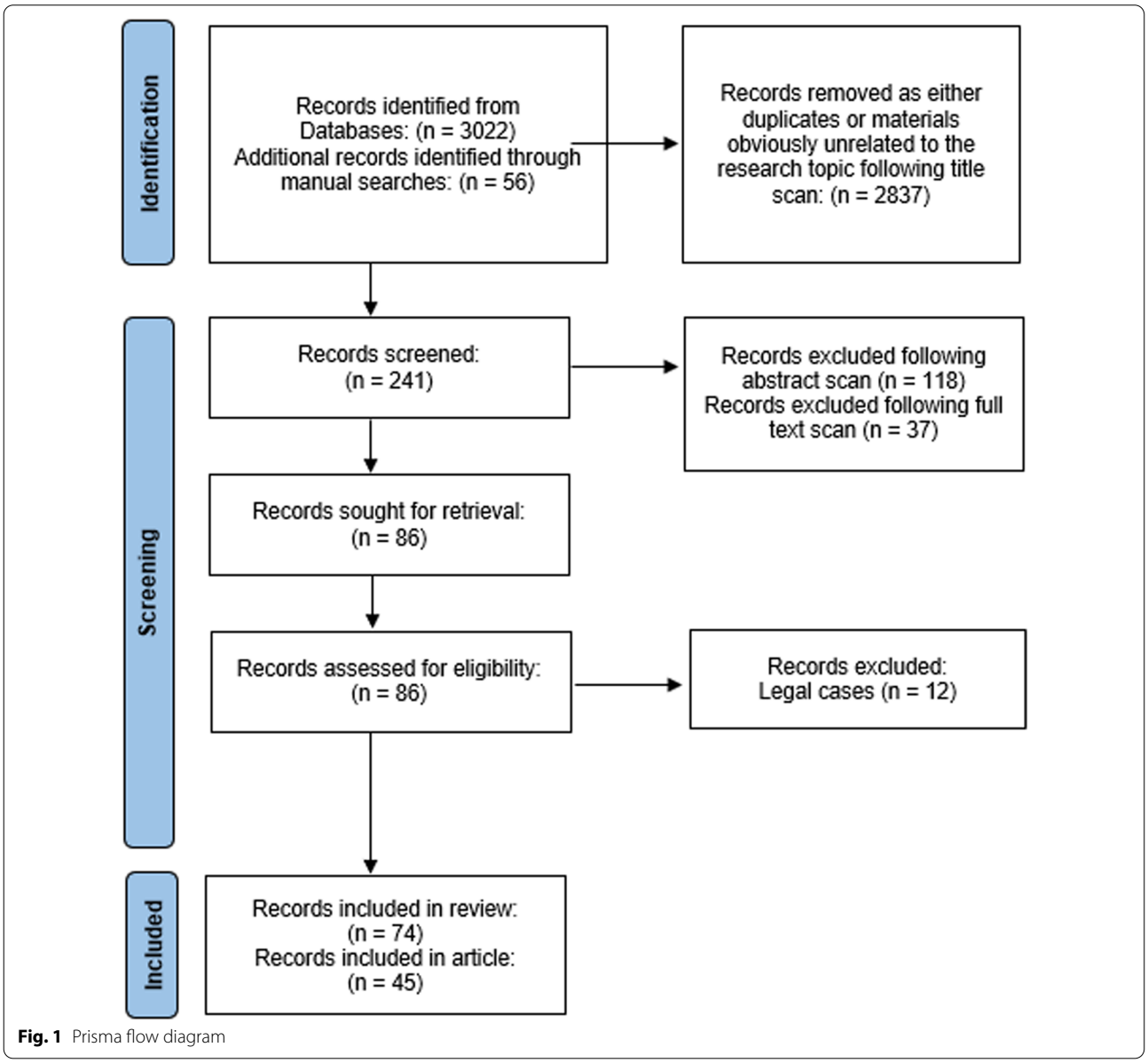

Fig. 1 Prisma flow diagram

(Australia, Canada, US). The final results were sorted into four categories, presented in Table 1.

For ease of reference, what follows is a stepwise presentation of the results in Table 1, commencing with empirical literature and ending with commentary and opinion pieces.

Empirical literature—Australia

A 2004 doctoral thesis on the topic of Medicare fraud and inappropriate practice provided a detailed analysis of how fraud and overserving allegedly became entrenched in Australia's health system between 1975 and 1996 [9]. The study was "primarily an empirical study" which included over 59 qualitative interviews with politicians, leading stakeholder representatives, senior public servants, fraud investigators, journalists, and others who spoke on condition of anonymity. The study suggested the extent of non-compliant medical billing in Australia at the time may have been over 25% of the schemes' total cost, and definitely not under 10%. Precise quantification was not possible. Solutions to non-compliance were positioned through a criminal justice lens, with education only briefly mentioned as a weaker, less effective solution than regulation and policing. The thesis argued lax regulation and inadequate resourcing had led to a failure of necessary oversight and prosecution of errant medical practitioners. The study did not offer any explanation for non-compliant medical billing beyond deliberate abuse, and most interview participants appeared to share the view that medical practitioners "know how to bill correctly…" though subsequent research suggests this may not be the case [3]. In a study of medical practitioner education stakeholders [3] the authors conducted a national cross-sectional survey which reported the first attempt to systematically map the ways Australian medical practitioners obtain education and understanding of medical billing, and explored the perceptions of medical education stakeholders on the topic. The results revealed little medical billing education was occurring with the majority of participants (70%, $n=40$) reporting they did not offer and had never offered medical billing education. However, 89% of participants thought medical billing education should be provided but there was no consensus on who should provide it or when it should occur.

Table 1 Final search results

Category	Australia	US	Canada	Total
Empirical	2	28	1	31
Grey	37			37
Commentary/opinion	3	2	1	6
Total				74

The study also found that most education in this area occurs on an ad hoc basis and is taught by medical practitioners who themselves have never been formally taught correct use of the Medicare scheme because no national, government approved curriculum has ever existed. The knowledge of those teaching the topic was therefore reported as variable, and the researchers reported this as being **c**onsistent with US findings, which suggest that rather than reliance on ad hoc training, development of a national medical billing curriculum should be encouraged to improve compliance, expedite judicial processes and reduce waste.

Empirical literature—US and Canada

Our review found studies specifically seeking to measure an equivalent experience have been primarily undertaken in the US, where a different medical billing system to Australia's operates, and where the heterogeneity of service providers and payers may warrant additional focus on billing education. The Australian medical billing system is based on a unique schedule of service codes known as the Medicare Benefits Schedule (MBS), whereas the US uses the International Classification of Disease (ICD) and Current Procedural Terminology (CPT) codes. Canada uses different billing codes again, known as the Ontario Health Insurance Plan (OHIP) Schedule of Benefits and Fees.

However, an assessment of the differences between these code sets and the practical application of each suggests the challenges faced while undertaking medical billing in all three countries is similar because the cognitive process of matching clinical encounters to an administrative dataset is the same.

US research on the subject of medical billing and reimbursement is more advanced than in Australia due to increased recognition in that jurisdiction that medical billing is a component of every interaction between a patient and a medical practitioner [7, 10–16]. The US literature suggests that training in the area of medical billing should be viewed as a core competency and a national curriculum on the topic should be developed [7]. However, despite the Accreditation Council for Graduate Medical Education in the US agreeing that education about practice management and economics forms part of the required core competencies for medical practitioners, teaching of those subjects is variable and no formal national curriculum exists. One of the recognised challenges identified in the US material is that of 'teaching the teachers' [7]. With no written curriculum on the topic of medical billing, researchers pointed out that teaching of the subject will be variable and will depend on the expertise, experience and the confidence of senior mentors who may themselves have had little training in the area.

In one study involving a cross-sectional, needs assessment survey of second year community and university-based internal medicine residents from four US geographic regions [10], participants ($n=133$) completed a questionnaire which included 27 questions, and the findings indicated that medical practitioners rated their own knowledge of Medicare billing as low. Participants also strongly agreed that their training in medical billing was inadequate and that it was important and should be a requirement of residency training programmes.

In a 2009 study examining the adequacy of training in the area of medical billing and coding as perceived by 2300 recently graduated paediatricians recruited from the American Board of Pediatrics database of recent graduates [7], less than 20% of respondents reported their training in medical billing and coding as adequate. The key points emanating were that medical billing and coding is not uniformly taught and should be included in the core competency requirements for medical residents. Further, that work needs to be done to develop and test a curriculum in medical billing and coding and that residency programmes need to ensure they are equipped to practise.

In another descriptive study of 104 medical students examining attitudes to professionalism [11], preferences in the importance of professional competencies, teaching preferences in professionalism and the egregiousness of 30 vignettes of professional misconduct, participants rated illegal billing as the second most egregious of 30 vignettes of misconduct. Substance abuse was reported as being the most serious misconduct (86.8%), followed by illegal billing (69.1%) which was rated higher than sexual misconduct (50%).

Since 2016, we found an increase in the number of US studies on this topic, where results have echoed earlier findings that the level of medical billing literacy amongst medical practitioners remains demonstrably low and may be improved by targeted education [11–15]. In one recent US study, more than 70% of medical practitioner participants felt there was a need for medical billing and coding to be included in the medical curriculum [16] and a 2019 study of senior residents and staff physicians in Ontario, Canada ($n=33$) [17] described the billing accuracy of the medical practitioner participants as poor overall, with billing errors and omissions causing substantial revenue losses. Participants in that study felt that current medical billing education was both insufficient and ineffective and desired more.

Grey literature and commentary

A review of policy and parliamentary papers uncovered numerous Australian government reports dealing with medical billing compliance, and a 2018 analysis and critique of the US government's approach to managing Medicare compliance mirrored many of the challenges being experienced in relation to medical billing compliance in contemporary Australia.

Government reports—Australia

The principal government reports uncovered were the Annual Reports of the Professional Services Review Scheme (PSR) in Australia. [18] The PSR was established in 1994 as a peer review scheme to investigate Medicare services billed by medical practitioners, with the objective of protecting the integrity of the scheme.

A review of 25 years of the annual reports reveals the PSR has been plagued by costly legal challenges by medical practitioners who have felt aggrieved by a lack of due process, flawed extrapolation methodologies and inadequate legal reasoning to support adverse findings against them. The annual reports also consistently cited medical practitioner confusion about correct billing practices. Unfortunately, full decisions of the PSR, which may assist practitioners to understand how to bill correctly have never been published due to codified secrecy provisions which protect the agency from public scrutiny.

The operation of the PSR was the subject of a Senate Enquiry in 2011 [19]. During the enquiry, submissions from medical practitioners highlighted both the complexity of Medicare billing and the inadequacies in the resources available to them concerning its proper use. This directly contradicted institutional submissions from Medicare suggesting that ample resources and reliable support were available. One submission by a medical defence union representative indicated that processes should be in place to enable medical practitioners to obtain clarity about the use of the MBS and another drew a comparison between the advice and written rulings available from the Australian Taxation Office and the lack of such information and advice from Medicare, suggesting that this meant medical practitioners could unknowingly fall into error. The Senate Committee concluded that, although it was the responsibility of medical practitioners to make clinical judgments, as much advice and information as possible should be available to them in relation to MBS itemisation. However, the committee was silent as to who should provide this advice and information.

In addition to the PSR reports and Senate Enquiry, manual searches revealed a departmental newsletter to the profession in February 2007 titled 'Education the Key to Compliance' in which the government announced that by changing medical practitioner claiming and prescribing behaviour through an education and compliance programme, $250 million in Medicare programme savings had been achieved in the previous year [6].

Commentary on the Medicare appeals process—US

The challenges plaguing the Australian PSR appear similar to those reported in the US, where one commentator described the US Medicare appeals system as broken [20], and a US court has pondered whether Medicare laws have become so Byzantine that the government had lost control of them [20]. The combined effects of complex, constantly changing, opaque medical billing rules and the use of extrapolation techniques appear to be at the heart of the problem which may have rendered the US government unable to manage medical billing compliance under its fee-for-service Medicare scheme, to the point where it "seems unable to keep up with it's own frenetic lawmaking" [20]. Further, that the US Department of Health and Human Services conceded it would take more than 10 years to clear the backlog of Medicare appeals awaiting review by an Administrative Law Judge (ALJ) noting ALJs overturn decisions against medical practitioners over half of the time [20]. This may suggest that like their Australian counterparts, US medical practitioners may be struggling to understand complex medical billing rules they have never been taught and appearing before an ALJ is the first time they are afforded a merit-based, evidentiary hearing and benefit from due process before a truly independent arbiter.

Canadian commentary

A recent publication in the *Journal of Medicine and Philosophy* initiated an important discussion concerning the moral dimensions around compliant medical billing, suggesting creative billing practices should be stigmatised rather than celebrated from within the profession itself [21]. The author described as a 'rather surprising oversight' that while medical ethics is a recognised component of medical education, the financial aspects of medical practice are almost never discussed and medical practitioners therefore receive little or no guidance in this important area. Further, that in fee-for-service payment environments, medical practitioners have enormous latitude in regards how they describe their services, with often very little effective oversight by payers. Therefore, the human temptation to misrepresent the services they provide can sometimes be significant, particularly where a seemingly small 'fiddle' to a service description can lead to higher reimbursement. The related ethical challenges are never taught nor mentioned throughout medical undergraduate or postgraduate training, yet the legal consequences when medical practitioners are found in breach of payment rules are usually very serious. The author argued that both medical schools and specialist colleges have failed in their duty to address this critical gap in learning and suggested some colleges may actually be cultivating the practice of questionable or borderline billing to 'maximise' or 'optimize' financial return. Moreover, that medical practitioners often fail to see the connection between their own poor billing conduct and the failure of the health system overall and that to address these challenges, both education and regulation are required.

Australian government educational materials

We found a number of resources produced by Medicare described as 'Compliance Education for Health Professionals' [22]. These include a "Medicare Billing Assurance Toolkit" and various e-learning modules. A review of these resources found a heavy focus on penalties for non-compliance without providing comprehensive information on how to be compliant. The resources suggested an overarching departmental view that medical practitioners possess a high level of legal literacy regarding correct use of Medicare, though available evidence challenges this position [3]. The resources were found to be rudimentary, offering little more than directing medical practitioners to the MBS if they are unsure of billing requirements, which is unhelpful considering findings of a recent study suggested the MBS has become complex and incomprehensible [2].

Where education does exist, it may not be directed to the relevant parties. During manual searching from the bibliographies and references lists in the preliminary searches, a training course was found that appears to be the only government accredited course in Australia dealing with the processing of medical accounts [23]. On review of the course materials, performance criteria and outcome measures, it was found that this was a basic certificate level course designed for medical receptionists who are not responsible for MBS billing, rather than being targeted at medical practitioners who are.

US government educational materials

We also reviewed educational materials available to US medical practitioners who we found are similarly required to self-learn the complexities of medical billing by reading a number of resources such as Explanation of Benefits Remittance Statements they receive when the claims they submit are denied, publications produced by intermediaries in the medical billing process who are contracted by the federal government (known as Medicare Administrative Contractors), and materials on the Centres for Medicare and Medicaid Services website [23]. However, evidence suggests medical billing literacy among US medical practitioners remains low [7, 10–16] and the above resources are inadequate to prepare them to bill correctly and protect them from post-payment investigation.

Discussion

The legal machinery underpinning fiscal transactions in health systems is typically profoundly complex. We found that the paucity of available data on this important topic does not correlate well with the impact non-compliant billing has on global health systems. Irrespective of whether the cause of non-compliance is deliberate or accidental, the size of the problem, which has been reported as averaging 7% of total health expenditure [25], is of sufficient magnitude to warrant focussed academic attention, particularly given the likely global economic slowdown caused by COVID-19. Waste caused by non-compliant medical billing in health systems can no longer be ignored. The fact that the scope and extent of this issue as a problem has been consistently identified as a major barrier to the efficiency of health systems, yet few studies have been conducted on initiatives that may help to address the issue, suggests that further research is warranted to ensure that stakeholders are able to make evidence-informed decisions when developing initiatives to combat medical billing non-compliance.

Although limited to three countries, the literature revealed a pervasive unified global view across those countries that medical practitioners obtain high levels of medical billing literacy through an osmotic process unsupported by the evidence. Unmet education needs were also evident throughout the literature across jurisdictions. Early reports [9] uncovered by our review mention short-term success with education initiatives for medical practitioners in Australia, and the PSR consistently cited practitioner confusion as being an ongoing problem. However, from the outset, very little was published in the PSR annual reports concerning available assistance to medical practitioners concerning how to use the (Australian) Medicare system correctly. The first PSR Director repeatedly advised medical practitioners via these reports to 'read the MBS book each year' and suggested speaking with Medicare when unsure of correct itemisation. However, this is and was always an unrealistic and onerous requirement on medical practitioners given the current printed version of the MBS comprises over 900 A4 pages of item numbers, explanatory notes, rules and cross references, many of which are difficult to comprehend, and a single medical service can be the subject of over 30 different payment rates and rules [26]. We also found no evidence of medical billing educational resources such as a 25-year body of precedent that might assist medical practitioners to understand how to bill correctly.

In the US, government maladministration was described as having far reaching consequences impacting the broader health system and ultimately consumers [20], and we suggest the impacts identified would be applicable in any health system.

The first such impact is that medical practitioners, as small business owners, may not have the financial means to support lengthy investigations and repay large amounts, so may become insolvent or choose to stop practising. This causes the health market to contract to the detriment of smaller providers and their patients, becoming consolidated by larger corporations with the liquidity to withstand long legal battles. Further, if small providers servicing remote communities are impacted, their absence may not be filled by larger corporates, potentially leaving such communities without medical services.

A second impact was cited as regulatory and administrative burdens causing some medical practitioners to stop treating Medicare patients completely. In Australia, where all citizens and many eligible residents are covered by Medicare, the practical expression of this type of pressure is seen when medical practitioners simply stop engaging with Medicare directly, requiring patients to instead pay full fees upfront and claim available rebates themselves. This practice is evident in the current out-of-pocket medical fees crisis in Australia [26].

Another serious and potentially dangerous impact is that working under the constant threat of audits and investigation may cause some medical practitioners to under-service their patients. Others may continue to provide services but not bill and be reimbursed for them, reducing government visibility over actual service delivery. A recent study in Australia described evidence of such practices among medical practitioners [28].

Medical practitioners act as stewards for the integrity of their health systems through the bills they submit for each clinical encounter [2]. Further, medical billing is a component of every clinical encounter (whether directly or indirectly) and the penalties for non-compliance across jurisdictions are severe. Yet medical practitioners appear to receive little formal preparation in the proper use of the billing and payments systems they are required to engage with. Moreover, opaque and interpretive medical billing codes cause difficulties for medical practitioners in multiple jurisdictions, yet no research has ever sought to examine how, when and where medical practitioners obtain the high levels of medical billing literacy expected of them.

Successful health financing systems depend on the fast flow of payments between patients, payers and providers in a context of high volumes of small transactions, often sourced from public money. For this reason, a high level of scrutiny is required to ensure the integrity and sustainability of such schemes. However, in achieving this, a proportionately high level of precision must be

maintained in the area of service descriptions and billing rules, to protect the providers who often have no option but to engage and claim reimbursements.

Limitations

A limitation of this review is the fact that results were drawn only from three countries, which may limit the generalisability of results. However, we view this as in important finding in-and-of itself, suggesting an urgent need for further work on this topic in other settings. The relatively large body of work from Australia may be reflective of the significant government role in Medicare, which unlike many universal health care systems is still reliant on fee-for-service provision by private providers, resulting in increased public accountability and interest in the topic in that country. Further work is required to examine the topic in other countries. Extensive investigation of informal, ad hoc, and spontaneous educational initiatives that may exist in some jurisdictions were not captured by this review and may be deserving of focussed research attention.

Conclusion

Despite the increased research outputs on this topic in recent years there appears to remain a mistaken global view, unsupported by scientific evidence, that medical practitioners naturally know how their health systems work and how to bill correctly, and that punitive measures are therefore the sole solution to waste caused by non-compliant billing practices. This is despite a growing body of evidence suggesting education may be effective in addressing this problem.

Emerging health systems can learn from the experiences of the health systems reported in this study by prioritising curriculum development in health financing law and practice. Educating medical practitioners about the operation of their health financing systems and how to allocate scarce health dollars correctly protects them from exposure to potentially serious legal consequences for non-compliance, and may improve the efficient and equitable distribution of national health budgets.

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Authors' contributions
MF made substantial contributions to the conception and design of the research, conducted the searches and collected the data, analysed and interpreted the findings, wrote the initial draft of the manuscript and made substantial contributions to all subsequent drafts, and critically appraised the content. JA made substantial contributions to the conception and design of the research, made substantial contributions to later versions of the manuscript and critically appraised the content. JW made substantial contributions to the conception and design of the research, made substantial contributions to the analysis and interpretation of the findings, made substantial contributions to all versions of the manuscript and critically appraised the content. All authors read and approved the final manuscript.

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Availability of data and materials
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
Margaret Faux is the CEO of a medical billing company, which also provides online education on medical billing. Margaret Faux's law firm provides free legal information on Australian medical billing.

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References

1. World Health Organization. Health systems financing: the path to universal coverage, World health report 2010.
2. Medicare billing, law and practice: complex, incomprehensible and beginning to unravel: Margaret Faux, Jonathan Wardle and Jon Adams (2019) 27 JLM 66.
3. Faux M, et al. Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders. BMJ Open. 2018. https://doi.org/10.1136/bmjopen-2017-020712.
4. Government of the Netherlands. Billing mistakes and fraud in the care sector. https://www.government.nl/topics/billing-mistakes-andfraud-in-the-care-sector/contents/preventing-billing-mistakes-andfraud-in-the-care-sector. Accessed 17 Sept 2016.
5. Dutch Healthcare Authority. Hotline. https://www.nza.nl/contact/meldpunt. Accessed 20 June 2021.
6. Medicare Australia Forum, Spring 2007: Education key to compliance. Medicare Australia Annual Report 2007–2008 available at this link https://www.servicesaustralia.gov.au/organisations/about-us/annual-reports/archive/annual-reports-2007-2008. Accessed 4 Oct 2020.
7. Andreae MC, DunhamFreed KGL. Inadequate training in billing and coding as perceived by recent pediatric graduates. Clin Pediatr (Phila). 2009;48:939–44.
8. Grant MJ, Booth A. A typology of reviews: an analysis of 14 review types and associated methodologies. Health Inf Libr J. 2009. https://doi.org/10.1111/j.1471-1842.2009.00848.x.
9. Flynn K. Medical fraud and inappropriate practice in Medibank and Medicare, Australia 1975–1995, Doctor of Philosophy thesis, School of Social Sciences, Media and Communication, University of Wollongong, 2004. https://ro.uow.edu.au/theses/2071.
10. Adiga K, Buss M, Beasley BW. Perceived, actual, and desired knowledge regarding medicare billing and reimbursement. J Gen Intern Med. 2006;21:466–70.
11. Hultman CS, Connolly A, Halvorson EG, Rowland P, Meyers MO, Mayer DC, Drake AF, Sheldon GF, Meyer AA. Get on your boots: preparing fourth-year medical students for a career in surgery, using a focused curriculum to teach the competency of professionalism. J Surg Res. 2012;177:217–23.
12. Nguyen D, O'Mara H, Powell R. Improving orthopedic resident knowledge of documentation, coding, and medicare fraud. US Army Med Dep J. 2017;Jul–Sep(2–17):95–8.

13. Paz KB, Halverstam C, Rzepecki AK, McLellan BN. A national survey of medical coding and billing training in United States dermatology residency programs. J Drugs Dermatol JDD. 2018;17(6):678–82.
14. Patel A, Ali A, Lutfi F, Nwosulheme A, Markham MJ. An interactive multimodality curriculum teaching medicine residents about oncologic documentation and billing. MedEd Portal-AAMC J Teach Learn. 2018;10:15.
15. Kelley KA, Hoops HE, Palmer L, Cohen NA, Brasel KJ. Implementation of a medical coding curriculum for surgery residents. Am J Surg. 2019;217(5):834–8.
16. Arora A, Garg A, Arora V, Rizvi M, Desai N. National survey of pediatric care providers: assessing time and impact of coding and documentation in physician practice. Clin Pediatr. 2018; 57(11). published online: May 14, 2018; Issue published: October 1, 2018 (141 (1 MeetingAbstract) 421).
17. Austin RE, von Schroeder HP. How accurate are we? A comparison of resident and staff physician billing knowledge and exposure to billing education during residency training. Can J Surg. 2019. https://doi.org/10.1503/cjs.008718.
18. Professional Services Review Annual Reports, commencing 1995 to the present. https://www.psr.gov.au/publications-and-resources/annual-reports.
19. Commonwealth of Australia. Community Affairs References Committee, Review of the Professional Services Review (PSR) Scheme; 2011.
20. Donley G. The broken medicare appeals system, failed regulatory solutions and the promise of federal litigation. 28 Health Matrix. 269 2018.
21. Heath J. Ethical issues in physician billing under fee-for-service plans. J Med Philos. 2020;45(1):86–104. https://doi.org/10.1093/jmp/jhz029.
22. Australian Government. Department of Health, Health Professional Compliance. https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-compliance#Changes. Accessed 8 March 2020.
23. Australian Government. BSBMED302B Prepare and process medical accounts. https://training.gov.au/Training/Details/BSBMED302. Accessed 19 May 2020.
24. Centres for Medicare & Medicaid Services. Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index. Accessed 19 May 2020.
25. Gee J, Button M, Brooks G. The financial cost of healthcare fraud: what data from around the world shows. University of Portsmouth Centre for Counter Fraud Studies and MacIntyre Hudson. http://www.port.ac.uk/media/contacts-and-departments/icjs/ccfs/The-financial-cost-of-healthcare-fraud.pdf.
26. Faux MS, Wardle JL, Adams J. No payments, copayments and faux payments: are medical practitioners adequately equipped to manage medicare claiming and compliance? Intern Med J. 2015;45(2):221–7.
27. Doggett J. Healthcare's out-of-pocket crisis. Inside Story, 24 October 2018. https://insidestory.org.au/healthcares-out-of-pocket-crisis/.
28. Faux M, Adams J, Dahiya S, Wardle J. Wading through molasses. A qualitative examination of the experiences of medical practitioners regarding medical billing. MedRxiv. 2020. https://doi.org/10.1101/2020.05.26.20113324.

Publisher's Note

District Court of South Australia

ANAND & ANOR v ARMSTRONG & ANOR [2020] SADC 34 (31 March 2020)

Last Updated: 3 April 2020

DISTRICT COURT OF SOUTH AUSTRALIA

(Civil)

ANAND & ANOR v ARMSTRONG & ANOR

[2020] SADC 34

Judgment of Her Honour Judge Schammer

31 March 2020

DEFAMATION - ACTIONS FOR DEFAMATION - TRIAL - EVIDENCE - PLAINTIFF'S REPUTATION AND CREDIT

DEFAMATION - JUSTIFICATION - TRUTH

DEFAMATION - PRIVILEGE - QUALIFIED PRIVILEGE - REBUTTAL OF PRIVILEGE BY MALICE

DEFAMATION - FAIR COMMENT

DEFAMATION - DAMAGES - GENERAL DAMAGES - ASSESSMENT - IN GENERAL

DEFAMATION - DAMAGES - SPECIAL DAMAGES

TORTS - MISCELLANEOUS TORTS - INTERFERENCE WITH CONTRACTUAL AND OTHER RELATIONS - RELEVANT PRINCIPLES

At all material times, both the first plaintiff and the first defendant were medical practitioners who delivered educational workshops through their respective company structures directed at providing advice to medical practitioners with respect to Medicare billings and the use of the Medicare Benefits Schedule (MBS).

The first plaintiff conducted such workshops through IqMed Pty Ltd (the second plaintiff), in collaboration with Adelaide to Outback GP Training Program Limited (ACN 601 797 371) (AOGP). The seminars were presented under the banner 'ProMBS'.

The first defendant is the sole director of Business for Doctors Pty Ltd (the second defendant) (BFD) and together the defendants operate a Facebook group, open only to medical practitioners, named 'Business for Doctors'.

The plaintiffs claim damages, including aggravated damages, from the defendants for alleged defamation and interference in contractual relations arising from the publication by the first defendant of three Facebook posts (and comments made in response thereto), two emails and one phone call between 9 and 22 September 2017 (the Publications). By way of summary, in the Facebook posts and the emails, the first defendant stated, inter alia, that the first plaintiff had used and sold the second defendant's intellectual property when he delivered a workshop on the MBS, in collaboration with AOGP, on 3 September 2017 (the initial ProMBS workshop). In the Second Email, the first defendant stated, inter alia, that the first plaintiff had misrepresented himself as an expert, was lacking in knowledge and insight and may have been defrauding Medicare.

The plaintiffs allege that the natural and ordinary meaning of the Publications is defamatory and that as a result, the first plaintiff has suffered serious injury to his personal and professional reputation, considerable embarrassment and distress. The first plaintiff claims to have suffered economic loss 'through the second plaintiff'.

In addition, it is alleged that by the publication of the emails and the phone call, the first defendant deliberately interfered with the contractual relationship between the plaintiffs and AOGP, as a result of which the second plaintiff suffered loss.

The defendants do not dispute that the first defendant published the three Facebook posts or sent the emails as pleaded. The defendants deny the first defendant said the words as claimed in the phone call, but admit the phone call was made and some of the content as alleged. The

defendants plead by way of defence that insofar as the Publications conveyed the imputation that the first plaintiff 'has knowingly passed off the work of BFD as his own', the imputation is true or substantially true and/or that the imputations conveyed by the Facebook posts and emails are subject to qualified privilege, either at common law or pursuant to s 28 of the Defamation Act 2005 (the Act). The defendants also plead that insofar as any defamatory imputations arise from the Publications, those imputations were expressions of opinion or were in the nature of fair comment rather than statements of fact and that such opinions related to matters of public interest and were based on proper material. Further, the defendants plead that the first plaintiff was not and is not well known in the Australian medical community and did not have an established reputation that could be damaged by the Publications, insofar as they conveyed the alleged imputations.

The defendants deny any alleged interference in the plaintiffs' contractual relationship with AOGP.

HELD:

1. Each of the Publications is defamatory of the first plaintiff.

2. The defendants have failed to establish any of the defences as pleaded.

3. The defendants' interference in the contractual relationship between the second plaintiff and AOGP did not cause a breach of any contract, nor was it productive of any loss to either plaintiff.

4. At the time of the Publications the first plaintiff did not have the depth of knowledge and understanding of the MBS and/or the National Health Act 1953, or experience associated with their use in practice, to be considered an expert in those areas.

5. At the time of the Publications, the first plaintiff did not have an established reputation in Australia as a provider of education to general practitioners on the MBS.

6. At the time of the Publications, the first plaintiff had been a resident in Australia for approximately ten years and had worked as a general practitioner for just over three years, such that he had some, but only a limited reputation and standing within the medical community.

7. General Damages assessed in the sum of $40,000.00.

8. Aggravated Damages awarded and assessed in the sum of $10,000.00.

9. The plaintiffs have not established any claim for damages for economic loss as specified.

10. The parties are to be heard on interest and costs.

Defamation Act 2005 ss 4, 9, 22, 23, 28, 29, 32, 36; *National Health Act 1953* ; *Evidence Act 1929* s 53, referred to.

Dow Jones & Company Inc v Gutnick (2002) 210 CLR 575; *Al-Amoudi v Brisard* [2006] EWHC 1062; [2007] 1 WLR 113; *Sands v Channel Seven Adelaide* [2009] SASC 215; (2009) 104 SASR 452; *OBG Ltd v Allen* [2007] UKHL 21; [2008] 1 AC 1; *Lumley v Gye* [1853] EngR 15; (1853) 2 E & B 216; *Hockey v Fairfax Media Publications Pty Ltd* [2015] FCA 652; *Spiller v Joseph* [2010] UKSC 53; *Channel Seven Adelaide Pty Ltd v Manock* [2007] HCA 60; (2007) 232 CLR 245; *O'Shaughnessy v Mirror Newspapers Ltd* (1970) 72 SR (NSW) 347; *Goldsborough v John Fairfax & Sons Ltd* [1934] NSWStRp 43; (1934) 34 SR (NSW) 524; *Bellino v Australian Broadcasting Corporation* [1996] HCA 47; (1996) 185 CLR 183; *Duffy v Google Inc (No 2)* [2015] SASC 206; *Bristow v Adams* [2012] NSWCA 166; *Crampton v Nugawela* [1996] NSWSC 651; (1996) 41 NSWLR 176; *Chakravati v Advertiser Newspapers Limited* (1998) 193 CLR 519; *Selecta Homes and Building Co Pty Ltd v Advertiser-Weekend Publishing Co Pty Ltd* [2001] SASC 140; (2001) 79 SASR 451; *Feo v Pioneer Concrete (Vic) Pty Ltd* [1999] VSCA 180; [1999] 3 VR 417; *Andrews & Anor v John Fairfax & Sons Ltd & Ors* [1980] 2 NSWLR 225; *Roberts v Rossiter* (1984) Aust Torts Reports 80-678; *Duffy v Google* [2015] SASC 170; (2015) 125 SASR 437; *Bruce v Odhams Press Ltd* [1936] 1 KB 697; *Radio 2UE Sydney Pty Ltd v Chesterton* [2009] HCA 16; (2009) 238 CLR 460; *Jones v Skelton* (1963) 1 WLR 1362; *Favell v Queensland Newspapers Pty Ltd* [2005] HCA 52; *Trkulja v Google LLC* [2018] HCA 25; *Fleming v Advertiser-News Weekend Publishing Company & Anor* [2016] SASCFC 109; *Eustice v Channel Seven Adelaide Pty Ltd & Ors* [2020] SASC 4; *Chase v Newsgroup Newspapers Ltd* [2002] EWCA Civ 1772; *Google Inc v Duffy* [2017] SASCFC 130; *Webb v Times Publishing Ltd* [1960] 2 QB 535; *Stephens v West Australian Newspapers Ltd* [1994] HCA 45; (1994) 182 CLR 211; *Bashford v Information Australia (Newsletters) Pty Ltd* [2004] HCA 5; (2004) 218 CLR 366; *Horrocks v Lowe* [1975] AC 135; *Roberts v Bass* [2002] HCA 57; (2002) 212 CLR 1; *Clarke v Molyneux* (1877) 3 QBD 237; *Herald & Weekly Times Ltd v McGregor* [1928] HCA 36; (1928) 41 CLR 254, considered.

ANAND & ANOR v ARMSTRONG & ANOR

[2020] SADC 34

Introduction

1. Rajan Anand (the first plaintiff) and April Lynette Armstrong (the first defendant) are both medical practitioners.

2. At all material times, both the first plaintiff and the first defendant delivered educational workshops through their respective company structures directed at providing advice to medical practitioners with respect to Medicare billings and the use of the Medicare Benefits Schedule (MBS).

3. The first plaintiff conducted such workshops through IqMed Pty Ltd (the second plaintiff), a company of which he is the sole director[1] and sole beneficial shareowner, in collaboration with Adelaide to Outback GP Training Program Limited (ACN 601 797 371) (AOGP). The seminars were presented under the banner 'ProMBS'.

4. The first defendant is the sole director of Business for Doctors Pty Ltd (the second defendant) (BFD) and together the defendants operate a Facebook group, open only to medical practitioners, named 'Business for Doctors' (the BFD Facebook group).

5. By Second Summons and Second Statement of Claim dated 5 July 2019, the plaintiffs claim damages, including aggravated damages, from the defendants for alleged defamation and interference in contractual relations arising from the publication by the first defendant of three Facebook posts (and comments made in response thereto), two emails and one phone call between 9 and 22 September 2017 (the Publications).

6. By way of summary only, in the Facebook posts and the emails, the first defendant stated, inter alia, that the first plaintiff had used and sold the second defendant's intellectual property when he delivered a workshop on the MBS, in collaboration with AOGP, on 3 September 2017 (the initial ProMBS workshop).

7. The plaintiffs allege that the natural and ordinary meaning of the Publications is defamatory and that as a result, the first plaintiff has suffered serious injury to his personal and professional reputation, considerable embarrassment and distress. He claims to have suffered economic loss 'through the second plaintiff'.

8. In addition, it is alleged that by the publication of the emails and the phone call, the first defendant deliberately interfered with the contractual relationship between the plaintiffs and AOGP, as a result of which the second plaintiff suffered loss.

9. The defendants do not dispute that the first defendant published the three Facebook posts or sent the emails as pleaded. The defendants deny the first defendant said the words as claimed in the phone call, but admit the phone call was made and some of the content as alleged.

10. The defendants plead by way of defence that insofar as the Publications conveyed the imputation that the first plaintiff 'has knowingly passed off the work of BFD as his own', the imputation is true or substantially true and/or that the imputations conveyed by the Facebook posts and emails are subject to qualified privilege, either at common law or pursuant to s 28 of the *Defamation Act 2005* (the Act).[2]

11. The defendants also plead that insofar as any defamatory imputations arise from the Publications, those imputations were expressions of opinion or were in the nature of fair comment rather than statements of fact and that such opinions related to matters of public interest and were based on proper material. The defendants deny any alleged interference in the plaintiffs' contractual relationship with AOGP.

12. Further, the defendants plead that the first plaintiff was not and is not well known in the Australian medical community and did not have an established reputation that could be damaged by the Publications, insofar as they conveyed the alleged imputations.

Trial

13. The trial proceeded to hearing over three days commencing 23 September 2019.
14. The plaintiffs were represented by counsel, Mr Lincoln Smith.
15. The first defendant was self-represented and, by permission of the court granted on 6 March 2019, also represented the second defendant.
16. Shortly prior to the commencement of the trial, the first defendant advised the plaintiffs' solicitors and the court that the defendants did not intend to call any evidence in the defence of the claim. The first defendant made it clear that she had received legal advice and therefore understood the impact such decision may have on the defendants' ability to establish the defences as pleaded.
17. The plaintiffs called evidence from the following witnesses:

1. The first plaintiff;
2. Dr Nirej Rewal, a dentist who is married to the first plaintiff's sister-in-law;
3. Dr Timothy Kelly, the Chief Executive Officer of AOGP;
4. Ms Carolyn Cheah, the Business Manager of AOGP; and
5. Ms Ridha Anand, the first plaintiff's wife.

18. The plaintiffs tendered documents, namely:
19. Exhibit P1 Various documents contained in Tender Books marked Volumes 1 and 2.[3]
20. Exhibit P2 A USB containing a video recording of a presentation delivered by the first plaintiff on 25 October 2016 as part of a Flinders University course he was completing.
21. Exhibit P3 Emails between the first plaintiff and 'askMBS' dated 2 and 12 April 2017.
22. Exhibit P4 Bundle of contractual documents evidencing the relationship between the first plaintiff and Idameneo Pty Ltd (No.123) Pty Ltd (Primary Health).
23. Exhibit P5 Extract from 'Business for Dentists' Facebook group.

Key Issues

24. The initial ProMBS workshop delivered by the second plaintiff in partnership with AOGP on **3 September 2017** was the first time the first plaintiff had ever presented a workshop, for fee or reward, on the MBS.
25. There is no dispute that the first plaintiff joined the BFD Facebook group in **July 2016**, met personally with the first defendant in **April 2017** and attended a conference on the MBS delivered by BFD on **3 June 2017**.
26. Having regard to the content of the Publications, the key issue to be determined at trial is whether the second defendant's intellectual property, and in particular intellectual property relating to the use of combination billing techniques, was used by the plaintiffs in the content of the initial ProMBS workshop delivered on 3 September 2017.
27. Related to this issue, is a determination as to what was the first plaintiff's knowledge and understanding of the MBS and the *National Health Act 1953* (the Health Act) at the time of the

Publications, being relevant to a consideration of his expertise and reputation in that area within the medical profession, both before and after the Publications.

Background Information/Chronology

First Plaintiff's Qualifications/Employment History

28. The first plaintiff gave evidence that he studied for his primary medical degree (MBBS) in India. As to his other qualifications, he said he held a MRCS-UK (membership of the Royal College of Surgeons – Edinburgh) and a MRCGP from UK International (membership of the Royal College of General Practitioners). He received his Fellowship of the Royal Australasian College of General Practitioners, sitting his last examination in 2016. [4]

29. In cross-examination, the first plaintiff confirmed that he moved from India to the United Kingdom in 2003. He said he sat exams in the MRCS, but had not sat the exam for Membership of the Royal College of General Practice in the UK (MRCGP), rather in 2015 he had sat the exam for Membership of the Royal College of General Practitioners (MRCGP International). He was not a fellow of either of those colleges.[5]

30. The first plaintiff first practised in Australia in 2007. He initially worked at the Flinders Medical Centre as an Orthopaedic Registrar, but ceased such work following the birth of his first child in 2010 due to the inflexible and difficult hours. He then commenced working in general practice as a locum, visiting a nursing home and homes 'after hours'.

31. At the end of 2011, he commenced a salaried position working as a doctor for aged care residents.

32. He remained working in aged care until August 2014, when he commenced as an Incorporated Medical Practitioner working at the Primary Medical and Dental Centre in Royal Park. The first plaintiff remained there until the end of June 2018.

33. In the Plaintiffs' Closing Submissions, it is stated that thereafter he commenced his own private practice at the Glenelg Medical Centre and remains self-employed in this capacity.[6] However, the first plaintiff gave no specific evidence to that effect during examination-in-chief, instead confirming only, during cross-examination, that he currently works as a general practitioner,[7] in a practice that he purchased,[8] with around 100 patients.[9]

Interest in MBS/MBS Training

34. The first plaintiff said he never had proper training in the MBS but first came to learn of special item numbers that could be billed for after-hours consultations when he was working as a locum in about 2011.

35. When he was first employed as a salaried solicitor he had no need to utilise MBS item numbers as he was paid a standard salary, but later was able to charge for various items under a special exemption, being items relevant to aged care services.

36. The first plaintiff explained that when he commenced working with Primary Health in 2014 he was given a 'cheat sheet' with a list of the 'usual' item numbers charged, but that as a 'non-vocationally registered doctor' he earned less than other doctors, and needed to supplement his income by either doing after hours work or by learning how to use some special item numbers which would increase his earnings. He explained that this piqued his interest in the MBS and that he started going through the MBS to ascertain 'safe' item numbers to use for the provision of various services.[10]

37. In cross-examination, the first plaintiff was asked what if any other seminars or conferences he had attended with respect to the MBS other than the BFD conference in June 2017. The first plaintiff said he attended an MBS workshop run by Dr Zakaria Baig from Primary Health and he said there was a Power-Point presentation through the Primary Health Care Institute (PHCI). He did not clarify if these were two separate presentations, or when he attended such presentation(s).[11]

38. He also gave evidence that when he joined Primary Health in 2014, a couple of people came over from Sydney to teach him about the MBS, and that he also did online training with Primary Heath (again, he did not say when).[12]

Combination Billing

39. Although there was limited evidence as to precisely what 'combination billing' under the MBS entails, put simply, it involves the legitimate use of more than one MBS item number in combination with others with respect to a single consultation.[13]

40. Dr Kelly gave evidence that the use of combination billing in practice is common.[14]

41. The first plaintiff said that he learned of combination billing through his own practice and peers and first used combination billing in 2014/15.

42. The first plaintiff was asked to explain the difference between 'item number billing' and 'combination billing'. He explained:[15]

1. Okay, so when you read the book you'll find that all these item numbers are there and it's written - it's almost like a ... that is 1,000 page kind of book. But as I've just mentioned about that laceration case, I could have easily charged one particular item number, item - that where I could have made $37 or I could actually use that extra item number and bring it here and then charge that particular item number plus the laceration item number and make a lot more money. So this is the combination, compared with just the time I spent with the patient, I've done both together.

17. When was the first time you ever heard about combination billing.

1. It's not like a term or something. There's one term that the defendant uses for these things. She - they used to call it pack and stack or stack and - pack and stack kind of thing but, yeah, it's - like you know, this particular term, it's not coined by the defendant. It is like an - I was using these combination item number before I even joined the NVI so it was there, it has always been there.

17. Before you even did your course.

1. Yeah, before I did my course. So these item numbers we were using even before.

New Venture Institute (NVI)

43. In about early 2016, the first plaintiff's wife and sister-in-law both completed an entrepreneurial course operated by the New Venture Institute (NVI) at Flinders University. The first plaintiff said through a contact made by his wife during this course, he spoke with an educational entrepreneur, Sasha Dragovelic (Sasha). Sasha told him that if, in his field, he noticed a problem for which he could offer a solution, he could also become an entrepreneur.

44. Through Sasha, the first plaintiff met a potential mentor, an accountant, David Dahm. On 17 July 2016, the first plaintiff contacted Mr Dahm by email and advised him of his plans to join the entrepreneur start up program offered by NVI at Flinders University. He told Mr Dahm of an idea he had 'related to budding GPs and to increase their income' and enquired if he would be able to guide him during the course.[16] He said that when they met, Mr Dahm talked to the first plaintiff about the fact that many doctors were not well educated about the MBS. Neither Sasha nor Mr Dahm were called to give evidence.

45. The first plaintiff subsequently enrolled in and completed the Semester 2 program 'Venture Dorm 2016', being an entrepreneurial course offered through the NVI at Flinders University between July 2016 and November 2016. The first plaintiff described this course as effectively guiding students through the development of their individual business ideas, to a finale where each student presented their business model in a pitch to a panel, similar to a 'Shark Tank' presentation.

46. By reference to the course program, participants had the opportunity to attend 12 sessions between 28 July 2016 and 27 October 2016, covering such topics as the Business Model Canvass and Customer Development, Customer Relationships, Revenue, Partners, Resources and Costs. Session 12, on either 25 or 27 October 2016, was entitled 'Pitches and Judging', at which students, including the first plaintiff, gave a presentation as to their business idea and model, which presentation was video-recorded and judged to determine the course 'winner'.[17]

47. Shortly prior to that presentation, the first plaintiff sent a copy of a document outlining the 'Business Model Canvas' he had developed during the course to Ms Pearce at Flinders University.[18]

48. The first plaintiff's proposed business model was described as 'Coaching services for GPs to improve patient's (sic) outcome', to be offered by an entity called 'Achelios Health Solutions'. The target market was said to be general practitioners, with the product offered being a 'one day workshop and seminar'. This was to be supported with 'free care plan templates, ongoing online supports for 3 months, follow up and evaluation in 3 months'. To avoid risk, the first plaintiff proposed involving Medicare auditors. [19]

49. The 'Key Idea' of the business model was 'to provide professional coaching services to GP (sic) to deliver better patient's (sic) care, while increasing the value to their service'.[20]

50. A USB containing the video-recording of the first plaintiff's final pitch presentation, delivered on 25 October 2016, was tendered as Exhibit P2.

51. It is apparent from the presentation, and the material generated by the first plaintiff during the course, that the first plaintiff's business model/idea was to educate general practitioners, and in particular new general practitioners, as to how to make more money by 'rightly and smartly' using the MBS to properly claim for certain items, with a particular emphasis on claiming extra item numbers for 'Care plan/health assessments etc'.[21]

52. In his five-minute presentation, the first plaintiff outlined how by spending more time with each patient, a doctor may then have sufficient information to justify the development of a health care plan for that patient, thus resulting in increased income for the doctor through the use of more and/or more lucrative MBS item numbers and increased patient satisfaction, as the patient would feel their health care was getting the time and attention it demanded.

53. During the presentation, the first plaintiff stated that he had conducted a survey of general practitioners and ascertained some reluctance on their part to pay to attend such coaching. As such, he said he contacted the largest corporate medical practice in Australia, which had more than 1,000 general practitioners, and had struck a deal with them.

54. The first plaintiff stated that he had secured a deal whereby that practice would compel their low performing general practitioners to attend his course and if that resulted in an increase in income for the practice, the practice would reimburse those practitioners the cost of the course. The first plaintiff claimed the deal was worth $500,000, based on 250 general practitioner participants. Further, he claimed to have arranged a meeting with an 'RTO' (registered training organisation) to 'grab another deal' and to be producing software with a view to someone taking over his intellectual property.

55. The first plaintiff was offered and accepted praise from two of the three judges for his achievement in securing this deal.

56. In evidence, the first plaintiff acknowledged that he had not, in fact, secured any such deal. Rather, he claimed that he had 'hopes' of securing a good deal based on what he claimed he had been told by the State Manager of Primary Health, namely that if he had something like this he could easily make 'around half a million'.[22] The plaintiffs did not call evidence from the State Manager of Primary Health, or anyone from Primary Health.[23]

57. The following exchange occurred in cross-examination:[24]

17. In the presentation, you mentioned that you've secured a $500,000 agreement.

1. Yes, so basically it was more like a verbal. So, when I spoke to the state manager and discussed about my ideas, there's several ways I could get paid and in that calculation, it looked like that it would be equal to 500,000 even because they have that many number of GPs.

17. Who was the verbal agreement with.

1. It's not a verbal agreement, it is more like a discussion.

17. You just said there was a verbal agreement.

1. It's a verbal discussion. That's why I wanted to go to Primary in December which keep on getting postponed. So my initial contacts were like Dr Miller and Dr... and when I spoke to them they said that, yes, you have got potential of making that much.

17. Potential but in your workshop you actually presented as if you already had the agreement in place.

OBJECTION: MR SMITH OBJECTS

QUESTION ALLOWED

17. This is about integrity and about honesty in relation to the presentation, so you lied to the people there, saying that you had secured a $500,000.

1. Yes.

17. Sorry, yes.

1. No, I didn't lie to the people, it was verbal and not verbal agreement.

DR ARMSTRONG: Could I put the video back on?

17. Because we can go back to the video where you actually state that you have that.

1. Yes, I said that but when I spoke to my mentor, he said that it should be okay but I haven't had an agreement by that time. He said that there's a potential of 500,000.

17. So, your presentation said that you had an agreement in place, so you presented it as if you had already had the agreement.

1. Yes, I expected that they should because the state manager agreed I expected it to go.

17. So, you lied in your presentation.

1. I was expecting that everything would fall in place in the right way.

17. Could you maybe just answer yes or no, you lied in the presentation. A simple yes or no.

1. Yes, struck was the wrong word.

17. So, yes, you lied.

1. Struck with the wrong word, I should have said that yes, I'm in verbal agreement or I'm in a -

17. So just yes or no.

1. Yes.

17. Yes, you lied.

1. Yes.

17. Yes, because we're talking about integrity here, honesty, we're talking about your honour and yet you stood up in front of your peers that you have been working on a business plan with and you lied about an agreement.

1. I was under the impression that it would fall into my hand.

Post NVI – Seeking Business Partners (November 2016 to March 2017)

58. The first plaintiff said that based on advice he received from his mentors during the NVI course he realised he needed to partner with someone who was able to promote and assist in the delivery of his proposed workshops.

59. On 16 November 2016, the first plaintiff sent an email to Ms Cook, the Chief Executive Officer of GPEx, being a registered training provider for general practitioners, seeking the opportunity to meet with her to discuss his project which he described as 'coaching GPs about Medicare rebate to deliver better patient outcomes'.[25]

60. The first plaintiff said he met with Ms Cook and another senior doctor on 17 November 2016 and gave them the same presentation he had delivered to the NVI. The first plaintiff said that nothing came from this meeting as they wanted 'to be involved more with medical education rather than (the) commercial side of this'.[26]

61. The first plaintiff said he also talked with his lead supervisor at Primary Health, Dr Bruce Miller and the Primary Health Chief Executive Officer, Dr Zakaria Baig, about his business model. In cross-examination, he said that these discussions took the form of a proper doctor's presentation, whereas the presentation he gave to the NVI was couched in layman's terms.[27]

62. He said that tentative arrangements were made for him to meet others at Primary Health in Sydney to discuss his business model, but several planned meetings for late 2016 failed to come to fruition. Instead, the first plaintiff was upset when he later learned that Primary Health were running their own seminars on the MBS, with a session planned for March 2017 on understanding the changes in the MBS from the November 2016 update.

63. The first plaintiff gave evidence that he felt information he had shared with others at Primary Health had been used as the basis for these presentations and that he felt cheated he had not received any credit for this. He said Dr Baig had come to Adelaide and delivered several presentations on the MBS changes to staff at the five or six Primary Health care centres in Adelaide.[28]

Partnership with AOGP

64. The first plaintiff gave evidence that about a month later he was talking about his business idea with one of his colleagues, Dr Seshu Boda, who was working with another registered training organisation, AOGP. Dr Boda expressed interest in the idea and arranged for the first plaintiff to meet with AOGP representatives to discuss the possibility of working with them.

65. Until 2015, AOGP was a government funded 'contractor trainer provider' servicing the northern half of South Australia and metropolitan Adelaide. Its role was to provide training to doctors preparing for their fellowship exams. After that contract ended in 2015, AOGP remained committed to offering professional development for doctors in general practice and invested in developing and offering continuing professional development courses for general practitioners.

66. Dr Kelly gave evidence that AOGP had a database of all the training practices in that region, of all previous registrants and international doctors who had worked in rural locations.

He confirmed the majority of the database was still South Australian, a lot of which was becoming redundant.[29]

67. Ms Cheah, AOGP's business manager, estimated that in July 2017 about 70% of the AOGP database comprised South Australian doctors.[30]

68. On **22 March 2017**, the first plaintiff met with Dr Kelly, Ms Cheah and Dr Boda. At that meeting the first plaintiff delivered a similar presentation to that he had delivered to GPEx.

69. AOGP expressed interest in working with the first plaintiff to deliver Medicare education workshops in partnership.[31]

70. The first plaintiff explained that AOGP wanted him to show them the questions (or cases) he had prepared which would form the basis for his proposed workshop. He said they wanted him to present a free webinar to general practitioners, and to then present a proper seminar.[32]

71. Both Dr Kelly and Ms Cheah said that at the meeting the first plaintiff explained his journey through the health care system in Australia and told them that he had conducted research through a business course at Flinders University whereby he had surveyed general practitioners about their knowledge of the MBS and discovered that there was a gap in such knowledge.[33] He claimed to have identified an opportunity to improve education for general practitioners about the MBS. Dr Kelly said that after some initial deliberation, AOGP decided to proceed in partnership with the first plaintiff to deliver such education.

72. On **10 April 2017** AOGP and the second plaintiff executed a Confidentiality Agreement, wherein they agreed, inter alia, to share information, including ideas, concepts and intellectual property on certain terms and conditions for the purpose 'to develop and deliver education content in regards to optimising earnings through correct and effective use of MBS item numbers'.[34]

73. Dr Kelly said he believed the first plaintiff had shared one or two examples of the case scenarios he was working on (the intended content of the workshop) at this first meeting, and that 'he started sending them through fairly soon after they agreed to go ahead'.[35]

74. The second plaintiff and AOGP entered into a Collaborative Partner Agreement (the Agreement) in **May 2017** 'to develop and deliver the **initial** education workshop in regards to optimising earnings through correct and effective used of MBS item numbers' with the term of that agreement starting upon the agreement being signed, and ending upon 'completion of workshop evaluation'.[36]

75. The Agreement contained a timeline wherein all cases were to be peer reviewed and finalised by 30 June 2017, the workshop materials were to be finalised by 7 July 2017, the workshop was to be run by 29 July 2017 and the evaluation of the workshop was to be completed by 15 September 2017.

76. As to financial arrangements, the first plaintiff was asked by AOGP to estimate the number of hours he had invested in preparing the core content of the proposed workshop.

77. The first plaintiff estimated his initial investment in the project by reference to the two hours per week he attended the NVI course for its duration and the additional hours he had spent

devising the questions and answers for his various case scenarios. His estimate was a total of 90 hours at $150/hour ($13,600).

78. AOGP's 'initial investment' included arranging for a medical educator (Dr Boda) to peer review the cases devised by the first plaintiff, to develop the workshop and online materials and to market, promote and evaluate the workshop. They estimated this at a value of $14,600.

79. Net profit/loss sharing 'from workshop' (ie after deduction of all costs incurred) was to be distributed 60% as to the second plaintiff and 40% as to AOGP.

80. The Agreement expressly stated:[37]

> The success of the initial workshop will be evaluated to decide on how future education sessions can be delivered. If successful, AOGP and IqMed will continue to work together to deliver education in relation to optimising earnings through correct and effective use of MBS item numbers.

81. Dr Kelly gave evidence that he assisted the first plaintiff to draft a blog, entitled '10 May Work Smart, Not Hard' promoting the educational program to be delivered in partnership by the second plaintiff and AOGP. The program was called 'ProMBS'. In the blog, the mission of ProMBS is said to be: [38]

> ...to increase the efficiency and accuracy of billings, by educating GPs on the MBS. As well as ensuring best compliance with Medicare's billing requirements, ProMBS can provide a large increase in remuneration per given consult...

82. Although Dr Kelly stated this blog must have been dated 10 May 2017, [39] the blog expressly refers to the initial workshop to be a full day workshop in September. The Collaborative Agreement signed by Ms Ridha Anand in her capacity as a Director of the second plaintiff on 19 May 2017 and by Dr Kelly on behalf of AOGP on 22 May 2017 specifies the first workshop is to be run 'by 29 July 2017'. As such I am not satisfied the blog, in the form it appears in evidence, was finalised as at 10 May 2017.

83. Although the Agreement foreshadowed the initial ProMBS workshop would be held on or before 29 July 2017, that workshop was deferred until **2 September 2017** (see further discussion below).

84. The content of the initial ProMBS workshop is the focus of the Publications. In issue is whether the second defendant's intellectual property was used in that content. As such, it is pertinent to explore what interactions occurred between the first plaintiff and the defendants prior to 2 September 2017.

First Plaintiff's Interactions with the Defendants

85. The first plaintiff gave evidence that he joined the BFD Facebook group in around **July 2016,** and therefore at or about the time that he commenced the NVI course and at or about the same time that he contacted David Dahm about his idea 'related to budding GPs and to increase their income'.

86. There is no dispute that thereafter the first plaintiff became an active and contributing member of the BFD Facebook group. Some of his contributions were in evidence.[40]

87. On 8 November 2016, the first plaintiff followed a line of posts on the BFD Facebook group page discussing the use of health care plans.[41]

88. On 7 July 2017, the first plaintiff posted '747 and 739 can be done without the patient's physical presence'.[42]

89. On 22 July 2017, the first plaintiff posted:[43]

> Tax avoidance strategy but I guess lot of people do that. if you could show that your husband is working for you and if overall collectively you are able to save some money at the end of the financial year- then why not do this. By the way, Super is not a dead money. It will be a forced saving.
>
> There are several app which can create invoice or payslip in a touch of button.
>
> Your husband must be having a super account, so it's not an additional cost to set up a new one.

90. The first plaintiff said in examination-in-chief that in hindsight, the terminology he should have used in this post (the tax post) was 'minimisation', and explained that in Hindi the words 'avoidance' and 'saving' were similar in meaning.[44]

91. On 14 August 2017, the first plaintiff posted a response to the following post made by another BFD Facebook group member about the '80/20 Rule'.[45]

92. The post to which the first plaintiff responded read:

> Yes. The 80/20 rule relates to 'services' not 'number of patients'. So if you bill a 23 and a 2700 that's 2 services. So 60 patients can easily push you into the danger zone and you may be flagged for an audit.
>
> And if you see 60 patients a day you may be billing an absolute number of individual item numbers (such as 721) greater than 90th centile than your peers, and this is another reason you may flag for audit.

93. The first plaintiff's response (the 80/20 Rule post) was:

> Just a thought – why do we have to worry about audit. 60 or 70 services or 80 – as long as you can justify your consult and you are doing it rightly – why should one worry.

94. To which another BFD Facebook group member responded by posting:

> And yhis (sic) is why primary care is suffering in the public popularity polls...you can't provide a respectful/patient valued experience in this time frame surely! I would hope MC audits this type of practice.

95. Prompting this response from another member:

> You guys should try working in the UK. Easily 100+ patient contacts a day...sometimes 150+.

96. The following exchange occurred in cross-examination of the first plaintiff with respect to the 80/20 Rule post:[46]

17. Can we turn to p.389. I'm going to read this post. 'Just a thought, why do we worry about audit, 60 or 70 services or 80 as long as you can justify your consult and you are doing it rightly why should one worry?'

1. What page?

17. 389, this refers to the 80/20 rule.

1. Yeah, so I just put that just thoughts, that why should we be worried if we could justify the consult? It was not to suggest that you should do it or not do it.

17. Turn to p.295 and read the first paragraph of what we need to know. I'll read it. 'A GP or OMP which stands for other medical practitioner, engages in inappropriate practice if they have rendered or initiated 80 or more professional attendances on each of 20 or more in a day in a 12-month period known as a prescribed pattern of service and this is commonly referred to as a 80/20 rule'. So knowing that, do you think we should worry about billing 80 consultations in a day.

1. Thanks for enlightening. Again, yes, I was made aware about this one so I read about this and, as I said, it was just a thought that why should we worry.

17. So this is August 14th 2017, when you have already spent 12 months preparing cases.

1. Yeah.

17. You're not aware of one of the most important rules in general practice.

1. Yeah, I know that it used to - you will be automatically retired if you do more than 80 services for more than 20 days in a year, but it was just a thing raised, that if suppose there is some exceptional circumstances why can't you do that, and you can actually do that.

97. The first plaintiff agreed with a proposition put to him that a breach of the 80/20 Rule would result in a professional review of a practitioner's services and that this was a good reason not to breach the rule.[47] In re-examination he explained that there may be extraordinary circumstances justifying a breach of the rule.[48]

98. Dr Kelly was asked about the 80/20 Rule in cross-examination and he gave evidence that the rule was in place to pick up over-servicing, that generally doctors who breach the rule are over-servicing and that he knew people applied for exemptions because of special circumstances and that they usually fail.[49]

99. Dr Kelly was asked to comment with respect to the first plaintiff's 80/20 Rule post. The following exchange occurred in cross-examination:[50]

1. Well, I think to a point it's reasonable if you can justify what you're doing is a reasonable proposition. I think it doesn't look good if you're asking about doing 80 services, potentially. So yeah, I agree, it doesn't look great if you're asking about doing 80% services, I agree with the intent.

17. Do you believe that this exhibits a lack of insight into the understanding of the Health Insurance Act.

1. I'm not sure I would pull the bow that long.

100. On 6 September 2017, the first plaintiff responded to a question on the BFD Facebook page, namely, 'how often can you bill case conferences per patient', as follows:[51]

> Govt and Medicare Recommends 5 times a year. But ideally, there is no limit if you could justify it.

101. During examination-in-chief, the first plaintiff explained that he had chosen the wrong words, but what he intended was that in certain circumstances and with the right patient, more than five such services per year could be justified.[52]

102. In cross-examination, the first plaintiff said that he might have asked a question on the BFD Facebook page if he could put items 2713 and 23 together.

103. In April 2017, the first defendant visited Adelaide. The first plaintiff said that she extended an open invitation on the BFD Facebook page for those who wanted to meet with her, to contact her.

104. The first plaintiff took up that invitation and met with the first defendant on 7 April 2017. The first plaintiff said that during the meeting there were other doctors there, in the sense that it was not a 'one on one' meeting. He said at that time he was interested in setting up a multi-disciplinary practice and was keen to get the first defendant's opinion on that.

105. As to whether they had discussed the MBS, the first plaintiff said that was only a 'very, very brief' discussion, that he had raised with the first defendant the poor knowledge of the MBS among clinicians, and that although they had not discussed any specific item numbers, she had offered to send him a 'cheat sheet' which listed some rarely used item numbers.[53]

106. The first plaintiff said the material the first defendant subsequently sent to him comprised extracts from the MBS, in other words, material that was publicly available either in the book, or on-line.

107. By reference to Exhibit P1, it is apparent that the first plaintiff sent a message to the first defendant on 9 April 2017, reminding her of her offer to send him the 'cheat sheets'. In response, she sent him a link to three separate documents, 'Disability.docx', 'Focus Psychology Strategies.docx' and 'Cancer conference.docx', accompanied by a message 'here is some ones that people often miss/dont (sic) know about'.[54] Those documents are in evidence.[55]

108. The Cancer Conference document talks about the proper use of Items 871 and 872 and gives guidance as to when and how frequently these items can be used.

109. The Focus Psychology Strategies document refers to such strategies, which are to be provided only by credentialed medical practitioners, and explains how and when such services can be utilised.

110. The Disability document refers to the assessment of patients with an intellectual disability to determine if they require assistance with activities of daily living and the frequency with which such an item may be claimed by an eligible patient.

111. The first plaintiff said he attended a presentation delivered by the first defendant at a conference on 3 June 2017 (BFD Conference). He said he was under the impression the entire presentation was to be devoted to the MBS but in fact only a 45 minute to one hour presentation dealt with that topic. He said the presentation was video recorded but he said, 'I never bothered to see because those information (sic) were pretty basic which I was aware of those things anyway'.[56]

112. The first plaintiff gave evidence that the content of the second defendant's conference was about how to maximise billings with ten tips and explained how that content differed from that ultimately delivered by him in his workshops. He said:[57]

> So her 10 tips was like, you know, one, for example, that 'Your typing speed has to be fast'. This has got nothing to do with my MBS thing. 'The first one minute you should actually devote to the patient', and yes, there was something about the MBS as well but it was not like in - what I was talking about. It was about, like, combination billing, you can do two or three billing and can make this much of money. Mine was totally different. Mine was just 'Yes, you have got these item numbers which you can use it'.

113. He recalled the BFD Conference as addressing the use of items 721 and 723 in combination.[58]

114. In cross-examination, it was suggested to the first plaintiff that he had attended the 'pack and stack' session at that conference, which addressed combination billing and the MBS. Although the first plaintiff never expressly stated that he had attended that session, from his

responses with respect to that line of questioning and all of the evidence he gave to the effect that at that time he was very interested in learning more about the MBS, I find that he did so.[59]

115. The first plaintiff said he had a 'very vague recollection' of being provided with the second defendant's 'Conference Terms and Conditions' either at the time of registration for the conference or maybe after the course. At paragraph 8 of those Terms and Conditions is a clause entitled 'Rights' which states: [60]

> The Company reserves all rights to protect its content, intellectual properties and copyrights under Australian and international law.

116. The first plaintiff gave the following evidence-in-chief:[61]

17. And then you began preparing your seminar as I understand it.

1. Yeah.

17. How did you go about that.

1. So because everything started before I even met her.

17. Met her being.

1. Sorry, met the defendant and I find that this was too basic, this is not what I'm going to talk about at all. So like you know ours was in the pipeline anyway so we did a free webinar as we planned.

Initial ProMBS Workshop

Preparation/Content

117. The initial ProMBS workshop took the form of a presentation, with three presenters, the first plaintiff, Dr Kelly and Dr Boda. The format included the first plaintiff outlining clinical scenarios (or cases) with questions and answers relating to the correct and effective use of the MBS. In addition, Dr Kelly led a discussion about structures, systems and background information, which was followed by sessions conducted in small groups to discuss care plans, health assessments and the like.[62]

118. The first plaintiff gave evidence that there were about 76 cases (or patient scenarios) discussed in the presentation. These cases were designed to identify typical examples of consultations where special item numbers could be charged in addition to or in combination with standard item numbers for the attendance and/or the consultation could be extended in length or additional services offered. The aim was said to be both to increase the income for the doctor via appropriate and smart use of the MBS and to improve patient outcomes, by giving the patient more time and attention such that they believed their health issues had been properly understood and addressed.

119. The first plaintiff identified the case scenarios reproduced at pages 191-294 of Exhibit P1 as those he had prepared for the initial ProMBS workshop.[63] He explained that he had prepared these whenever he was sitting at home, after the hours he had worked as a full-time doctor,

and he estimated they took about 50 or more hours to prepare.[64] In response to a question from me, the first plaintiff confirmed that the material in Exhibit P1 comprised all of the content he presented, although the content presented by Dr Kelly and Dr Boda was not included in those materials.

120. The first plaintiff gave evidence that none of these 76 or so cases were part of the defendants' presentation.[65] Although he had not counted, he thought seven, eight or nine scenarios involved using a combination of item numbers.[66]

121. By reference to the materials in evidence, some 17 of 63 general case scenarios involved the use of more than one item number with respect to a single consultation. There were in total 70 case scenarios, of which seven related specifically to aged care.

122. The first plaintiff gave evidence that although his presentation included a case scenario utilising items 721 and 723, as had the defendants', his scenario did not involve 'a combination issue', whereas the defendants' presentation had used those item numbers in combination.[67] He said he had used these items in combination before he attended the BFD Conference and said that the use of these same item numbers in combination was something taught by others in the public domain.[68]

123. He denied he had used the defendants' combination billing techniques in the workshop.[69]

124. The following exchange occurred during the first plaintiff's evidence-in-chief:[70]

17. And just for clarity, when preparing those examples, from what knowledge did you prepare those.

1. Sorry.

17. When you prepared all your scenarios, your 76 scenarios

1. Yes.

17. - how many, if any, were prepared based on anything Dr Armstrong had -

1. None.

125. In cross-examination, the first plaintiff gave the following evidence as to the preparation of these cases:[71]

17. In relation to your MBS cases that you produced, when did you start writing the cases and what referencing material did you use.

1. MBS Online, the ... starting with MBS Online, then Medicare Benefit Schedule book and Department of Health website.

17. When did you start writing the cases.

1. I started writing these cases around July 2016.

17. And that was for the Flinders workshop presentation that you did.

1. So as I mentioned, this presentation is not about the doctors kind of thing so my cases were with me but this was because when I was doing a presentation, they were not a doctor, they were just - they were an expert from the businesses, they were expert from entrepreneur and

also the 20 people, they were not a doctor too so they won't be able to understand a particular case. But it was - it was devised around that time when I joined the course.

17. Okay.

1. So all these questions were prepared - not all these questions but, yeah, I started to prepare the questions around July 2016.

17. July 2016.

126. The first plaintiff was asked in cross-examination how and when he came to learn about the rules of billing and in particular, combination billing. He gave the following evidence:[72]

17. And how did you find out the rules of the billing so you could provide the information from the pro-MBS workshops.

1. I have learnt it through my practice. So when you talk to peers you hear about these things that yes, there is a combination billing. So I didn't have to wait till 3 June to attend your MBS seminar before I could do the pro - I could do the combination billing. I was doing it even before I met you and before doing a conference.

17. When you did you join the Business for Doctors page because there's lots of talk of combination billing on the page, so when did you actually join the Business for Doctors Facebook page.

1. I think I never even applied for somebody else has put my name forward and that's how I was on the BFD. However, I think it was around July-ish.

17. July 2016.

1. 2016, yes.

17. So, the same time that you started producing combination billing and MBS education information -

1. No.

17. - you joined a business page that was teaching MBS billing.

1. No, but that's what I'm saying, that even in 2014, 2015, I was doing the combination billing.

17. So, the combination billing that you were doing apart from 721, 723, 732 and 707 which was chronic disease management, 731 and 729 which is nursing home patients and your 707, can you give me some examples of some combination billing that were you using before you developed the pro-MBS workshop, so 2014 would be a good example.

1. Yes, so I mentioned about the case of someone coming to you with laceration, so can we charge just the 23 should we charge or the amount of time you spend with the patient, or shall we do 30026 or similar kind of item numbers for the laceration or can we do both. So obviously you've learned the course, that no, you can do actually both things.

17. When did you learn about mental health combinations with normal consultations, when were you first exposed to the combination billings of the higher level, where you bring in not just a procedure and a consult but where you're bringing multiple consultations into one process.

1. I think it's more like a ... I cannot remember 100% for sure but yes -

17. So, you didn't ask a question on the Facebook page asking if you can put a 2713 and a 23 together.
1. I might have, yes.

127. In cross-examination, it was put to the first plaintiff that the 'Shark Tank' presentation he gave to the NVI in October 2016 had not made any reference to the use of combination billing techniques. The following exchange occurred:[73]
17. So that was the Shark Tank presentation, that $500,000 Primary Health.
1. Yes.
17. So that was chronic disease and time with patients. That's wasn't combination billing ProMBS stuff. Different type of stuff.
1. It was ... In that you will obviously see that ... but I didn't use the whole thing in that five minutes.
17. But the workshop outline on p.4, there's nothing mentioned in here about combination billing. It's only about disease management, coaching services, doctor/patient relationship.
1. Yeah.
17. You talk about guest speakers from Medicare and medical indemnity insurance groups.
1. But I have been doing those combination billings before -
17. I just want to clarify the business model that you wrote about and that you spoke about.
1. Yeah.
17. This doesn't contain anything about combination billing.
1. I didn't put that much in detail. This is a very basic for -
17. You said to the court that the New Venture Institute is where you came up with the idea and concept of running combination billing workshops, yet there's nothing in here about combination billing at all.
1. You're coining at combination billing but these are just a part of not necessarily only chronic disease management. You can do everything.

128. Exhibit P3 includes a copy of an email sent by the first plaintiff to 'askMBS@humanservices.gov.au' on **2 April 2017** wherein he enquired:

> I am a GP and I have performed a case conference and a health assessment at the same time, on a nursing home resident. Lasting for a total of 80 min. What item numbers should I claim for this consult?

129. The first plaintiff received a reply on 12 April 2017, wherein he was advised that it was necessary for all service requirements for the item descriptor and explanatory notes to have been met before any service was claimed with Medicare and that a case conference and health assessment could not be provided as 'one service', rather they must be provided one at a time. The response outlined the necessary process for each such service.

130. The following exchange occurred in cross-examination:[74]

17. That's my next question to the Ask MBS question that you have here. You've forwarded an Ask MBS question which is the Department of Health now, it used to be Medicare to provide clarification in relation to the use of combining two item numbers. Apart from this single email, did you email them regarding any other material for combination billing, or where were you getting your verification from.

1. My information was, that's what I was saying, that mostly we hear from our seniors and superiors or your colleague or peers or you read about that. So that's how we were learning and which was not the right thing and that's what I mentioned that somebody told me that for obesity, I can do a care plan and somebody told me no, you cannot do it. So, I was not sure who is right, who is wrong.

131. Dr Rewal gave evidence that the first plaintiff had 'commandeered' his home office to prepare the slides he used in the initial ProMBS workshop. He said that he had assisted him with some of the grammar, but that the first plaintiff 'had made them on his own'.[75]

132. In cross-examination, Dr Rewal was asked when this occurred, and although he was uncertain of the precise date, he thought it was over a period of about three days 'a few days before his first course', and estimated this was around June, July or August 2017.[76]

133. Dr Kelly was asked what preparation was undertaken by the first plaintiff with respect to the initial ProMBS workshop. He gave the following evidence:[77]

1. Well, he shared with us the cases that he had basically on file that he'd been working on for some time, I understand, and then we would feed back to him how that one read and how this one read and we put together the presentations. We were sort of doing the development, as it were, because we had the experience and the back office support and IT support. So we'd get back to Dr Anand with 'Does this look okay, is that correct?' and we just worked it up together.

17. And over what period of time, can you recall, that that process took place.

1. Six or eight weeks, I suppose. Of that order. It was quite a bit of work for us.

17. And you said that he'd showed you the examples he had already worked on, at what point of time was that.

1. Early on, I think - I mean, there may have even been one or two in the first meeting, I'm not sure, but I think we asked him to share some and he started sending them through fairly soon after we agreed to go ahead.

17. Do you recall whether any of those - what sort of, can you recall what those examples were.

1. Things like aged care billing item numbers, when can you bill, you know, in different settings, what can you charge for those sort of things? Different item numbers that people - some people aren't aware of, like superficial versus subcutaneous foreign bodies, various procedures. Heap of stuff.

17. Was there anything about combination, using combinations.

1. Not specifically. I mean, a few of them - there may have been combination billing in a few of the cases but it certainly wasn't the focus. It was more about reinforcing the basic rules of Medicare, which is one of the things that we brought, and using the item numbers people weren't aware of was one of Rajan's focuses, as far as I recall.

Accuracy of Content

134. The first plaintiff described his knowledge of the MBS as 'above average'. As to his clinical expertise, he noted that he had done the fellowship, but otherwise described himself as an average GP.[78]

135. Dr Kelly said he expected the clinical scenarios used in the ProMBS workshop to use clinically correct information.[79] Similarly, Ms Cheah gave evidence that she expected the clinical scenarios used in the workshop to be correct in both clinical and MBS content.[80]

136. In cross-examination, both the first plaintiff and Dr Kelly were questioned at length as to the clinical accuracy of some of the case scenarios used in the initial ProMBS workshop.

137. Scenario 36 poses a question about the eligibility of a patient for a DMMR, being a medication review by a pharmacist at home. The patient is described, as are his presenting conditions (osteoarthritis and hypertension) and current medications including 'Atenol 50 mg BD' and 'Co-plavix'.[81]

138. The first plaintiff was asked in cross-examination if that was the correct dosing for Atenol. He answered:[82]

> This question was created as a hypothetical question. The question was aimed to give you an idea that whether this person is suitable to have the DMMR or not. This pill count shows that there was an issue with compliance. He was on several number of medication so that's why the question was – it was a created question so this is not a real example which I've brought here.

139. The first plaintiff agreed in cross-examination that the standard dosing regime for Atenol was 50 mg once daily, but maintained that it could also be used twice daily.

140. In response to a question as to whether CoPlavix should be prescribed for a patient suffering hypertension and osteoarthritis, the first plaintiff explained that 'this case is a created scenario' and his intention was to highlight a patient who was on more than five different medications, with more than 12 doses per day. He said 'this was not about the knowledge, all these questions'.[83]

141. As to this case scenario, Dr Kelly said that it was 'the learning point' that mattered, and that:[84]

> If it could be improved, we could improve it. It's not to say that there aren't patients out there on these medications.

142. Another case scenario addressing whether or not a DMMR was appropriate, included an example of a 35-year old nurse, post discectomy, who remained in pain. The case scenario listed the patient as taking Gabapentin 200 mg TDS, Lyrica 300 mg BD and Endone 5 mg qid PRN and stated 'She is requiring medication more often than expected. (There is no risk of dependence or drug seeking)'.[85]

143. The first plaintiff agreed that the three drugs listed were drugs of dependence, but said that again, this was a created scenario and that his intention with this scenario was to highlight the fact the patient was not on more than five different medications.[86] Dr Kelly said the slide was incorrect insofar as it said there was no risk of dependence.[87]

144. The first plaintiff agreed that scenario 42 may not be medically correct and that this was simply a created scenario, a hypothetical case, used to raise awareness of the difference in item numbers 30216 and 30219.[88]

145. Scenario 3[89] deals with the availability of health assessments and stipulates that a patient with Downs Syndrome is entitled to such an assessment. The first plaintiff agreed that to be eligible for a health assessment a patient must have an intellectual disability, and that not all patients with Down Syndrome have such a disability. He stated that he mentioned this verbally by way of explanation when giving the presentation.[90]

146. In cross-examination, the first plaintiff was asked if scenario 46[91] was an example of combination billing. He responded, 'In my opinion this is like you are using two different item numbers.'[92]

147. When questioned as to whether scenario 46 was inaccurate in that it purported to illustrate an ability to charge both items 23 (consult) and 14206 (procedure), in circumstances where there was no reference in the slide to a consultation having been undertaken, the first plaintiff said that again, this was an example where he had supplemented what was on the slide with what he told the workshop participants when discussing the scenario.[93] There were several other scenarios wherein the first defendant raised with the first plaintiff the fact that relevant information was omitted from the slide, without which the answer given was potentially inaccurate, and he explained that during the presentation such information was provided verbally in conjunction with what was on the slide.[94]

148. Dr Kelly was asked in cross-examination to read scenario 46 and based on what was stated on the slide only, said a consultation should not have been charged (although the slide stated otherwise).[95] He said that the slides required context of speaking, which is what happened in the workshops.[96]

149. Scenario 47 uses an example of a patient presenting for the removal and re-insertion of implanon, and states that three item numbers can be charged for that consult, including item

30062, being 'Etonogestrel subcutaneous implant, removal of, as an independent procedure'. [97]

150. The first plaintiff said that if the implant was removed from one arm and re-inserted into another, the second procedure would be an independent procedure. He agreed that if the implant was removed and then re-inserted into the same place, that was not an independent procedure, meaning that item 30062 could not be claimed.[98] He gave the following evidence: [99]

17. Right, so your scenario answer is incorrect here, is that what you say.
1. Actually, this was the very first one, we did change a few scenarios afterward as well, when we had even more clarification.

151. Scenario 22[100] addresses whether a second consultation can be claimed if a patient presents twice on the same day, with the second attendance being to enquire as to the results of a D-dimer ordered after the first such attendance. The case scenario stated that a second consult could be charged. The first plaintiff agreed with the proposition put to him that the second consultation was a continuation of the first, although he explained it would not be if during that second consultation other things were discussed.[101]
152. Dr Kelly was also asked about this case scenario. When asked whether the second consult was actually a continuation of the first he stated:[102]

> I would say yes, probably. We asked Medicare that specific question and didn't get an answer.

153. The first plaintiff's presentation at the initial ProMBS workshop included a bonus question concerning an elderly patient for whom a palliative care team were preparing a care plan. The question asked what was the minimum waiting period to undertake items 721 and 723 in combination.[103]
154. The first plaintiff was asked in cross-examination whether he thought that this would meet the 'exceptional criteria' for billing in less than three months, considering the patient may die within the three months. He initially answered:[104]

> In this case, obviously we were expecting it to make the exceptional criteria.

155. The answer on the second slide given was 'three months', rather than 'Now'. The first plaintiff explained this by saying that Medicare required him to make a forward plan for three months, that this was a hypothetical case and he could not predict whether or not this patient would still be alive in three months.[105]
156. In cross-examination, the first plaintiff agreed he did not perform any antenatal care, but that the ProMBS workshop used examples relating to item numbers pertaining to such care. He

said:[106]

1. Yes, and when I was presenting I was really clear about that: that I don't practice as these item numbers and I'm not an expert with these things at all. I've got no - not much of idea about these item numbers but, yeah, there were two item numbers which I have very briefly mentioned but at that time it always come with that thing that 'Look, I'm not - I don't do that'.

157. The slide reproduced on page 291 of Exhibit P1 refers to the 'Multiple Service Rule'. The first plaintiff was asked in cross-examination whether he could explain that rule and he was unable to do so. A question was posed of him whether someone teaching item numbers and who mentions the rule should know what the rule is. The first plaintiff responded:[107]

> I should, yes, and I was there but I've really lost the touch for last one, one year.

158. In cross-examination Dr Kelly was asked if this rule should be common knowledge for people who do procedures, and he said, 'should be'.[108]

159. Scenario 30 deals with a situation where a patient had a punch biopsy five days earlier and attends for the removal of sutures when the biopsy results are not yet available. The slide stated that this procedure should be charged as a further consult (item 23), rather than no charge being rendered, as would occur if the attendance was part of 'standard aftercare'.[109]

160. Dr Kelly agreed in cross-examination that he would not normally charge for this type of attendance, without discussing the results of the procedure.[110]

161. Dr Kelly agreed that the slide for scenario 43[111] provided an incorrect answer, and in fact a longer consult could have been charged. He explained 'Most of these things we have actually corrected in subsequent workshops'.[112]

162. Dr Kelly also agreed that the answer given in the slide for scenario 32 was incorrect.[113] He was asked whether he agreed the material generally was incorrect from both a clinical and MBS perspective and stated:[114]

> There's areas for improvement and they have been improved I can promise you that.

163. Dr Kelly reiterated that the slides by themselves ignored the context as explained in the workshops and while he accepted improvements could be made, he did not accept that the material was 'clinically incorrect'.[115] He considered the material had been written by someone with 'above average' knowledge of the MBS, despite some of its inadequacies, noting that people at every level struggled with the MBS.[116]

Outcome

164. The initial ProMBS workshop was held on **2 September 2017**.

165. In answer to a question in cross-examination as to why the date of the workshop was deferred from July, the first plaintiff said:[117]

> Maybe the marketing issues. So we were probably not ready with the marketing, so that was one of the reason.

166. Dr Kelly gave evidence that he was unsure off the top of his head as to why the workshop was postponed, but that it must have been due to a lack of numbers.[118]

167. Ms Cheah said she was unsure why the initial workshop was postponed, but she thought that it was because 'we were still working through the cases'.[119]

168. The first plaintiff said that a free webinar was held about a month or a month and a half before the initial workshop, and that after the webinar he sat down with Dr Kelly and Dr Boda to try to correct some of the grammatical mistakes in his presentation. It was difficult to do in a meeting so instead he just started to forward his cases through 'to him' for review and any suggested changes. [120]

169. In cross-examination, the first plaintiff was asked how many people attended the free webinar and his response was 'I'm not sure; 20, 30, 40, I don't know'.[121]

170. The first plaintiff said there were 32 registered attendees at the initial ProMBS workshop and described it as 'extremely successful', as a result of which AOGP suggested to him that they should do a session once every month throughout all of Australia.[122]

171. Dr Kelly said there was a good turnout for the initial ProMBS workshop, and good reviews. [123]

172. Ms Cheah gave evidence that the first workshop was attended by around 30 people, that it ran really well and that the feedback was positive.[124] In cross-examination she acknowledged that possibly two or three attendees were funded by AOGP to attend the workshop and that if several doctors from one practice had attended, there may also have been a discount offered. [125]

173. Ms Cheah said that given the success of the initial ProMBS workshop, arrangements were put in place to run another workshop in Melbourne, scheduled for around October or November 2017 and then possibly one in Sydney. She explained that AOGP set up a register of interest for each of those proposed workshops.[126] In evidence are several emails, all dated 8 and 9 September 2017, wherein a number of potential attendees have expressed their interest in attending these proposed interstate workshops.[127]

174. The total revenue generated from the initial ProMBS workshop was $22,471.[128] After expenditure of $7,020, the surplus was **$15,451**. This sum was distributed to AOGP and the second plaintiff as follows:[129]

> Return on Investment by AOGP and IqMed $10,000 (50/50)
>
> Net profit $5,451 (60/40)

175. The second plaintiff was asked to invoice AOGP for **$8,270** (plus GST) being the $5,000 initial investment and 60% of $5,451 ($3,270).
176. Dr Kelly gave evidence that he did not think the first plaintiff (via the second plaintiff) was entitled to an additional speaking fee with respect to the first workshop.[130]
177. Ms Cheah referred to a speaking fee of $150 per hour, but explained that in terms of payment 'so all that's come from the share of profit that we were going to share at the end of the year'.[131]

The Publications

178. On **9 September 2017**, the first defendant published a post on the BFD Facebook group page (the First Post).
179. The First Post stated: [132]

> Raj Anand – would you like to explain why you have taken copyright BFD information and selling it in workshops in Adelaide under the business name iqMed? As A BFD conference attendee you are aware of the copyright and that you cannot profit from selling the information shared from this page, BFD or BFD conference.
>
> (Post left up for one hour for Raj to explain – no reply to he has been removed from the group – there has been a PM which will be forwarded to the BFD solicitors). Please read the copyright below – it is all recited to you before we teach BFD workshops and conferences. You will have legal action taken against you if you breach copyright

180. The forum enabled BFD Facebook group members to 'like' or 'comment' on the First Post. Numerous comments and 'likes' followed.
181. On **the same day**, the first defendant published a further post on the BFD Facebook group page (the Second Post) in response to a comment posted by another group member in response to the First Post. The Second Post read as follows: [133]

> [Member name] – I am not just gong (sic) to sue him I am going to make sure that everyone on BFD knows he stole the IP. Its (sic) of the lowest unprofessional standards – its (sic) not becoming of a health professional who has been given this to help him with his Billings and work. It is under copyright and he has charged $900 to use information

> that I have provided to him. AND if its (sic) not true he is welcome to sue me –

182. The first plaintiff posted a response/comment on the BFD Facebook group page (the first plaintiff's public response). Although it is pleaded that response (and the Third Post) was made on the same day as the First and Second Posts, in my view this is in error having regard to the content of that response, namely:[134]

> Hi April,
>
> Without knowing the actual fact about the ProMBS workshop and content and legally disputing it, you have no right to publish my name and email address on social media forum. You have defamed my image and caused me and my family lots of grief, without knowing the content of the course. To the BFD group members, pl don't get carried away by April's comment and allegations. ProMBS hasn't used the contents from BFD. This program was a part of my research project from August, 2016, when I was doing a business course at Flinders university. (Long before, I met you and attended the workshop)
>
> I have met April in the past and have exchanged messages, but it is a false accusation that I have used her material. Out of courtesy and respect to a fellow GP, I carried away by April's comment and allegations. ProMBS hasn't used the contents from BFD. This program was a part of my research project from August, 2016, when I was doing a business course at Flinders university. (Long before, I met you and attended the workshop)
>
> I have met April in the past and have exchanged messages, but it is a false accusation that I have used her material. Out of courtesy and respect to a fellow GP, I have even offered her to show the content what I have prepared. But I was accused as liar and thief. I still can't understand since when talking about MBS would have become her's own IP and how could I know what is in her mind, when I am saying and have proof that I have started my project in August 2016, before meeting her or attending the conference.
>
> Ps. April, it looks like you have removed a different raj anand. **Last night was very sad to me see people calling me scum bag, cheat etc without even knowing my story**. This message might get deleted soon by admin. But if they are fair, let this message and the

> screen shot stay in the thread to prove my innocence. I won't be able to access the BFD so won't be able to make further comment. (my emphasis)

183. The highlighted portion of the response makes it clear, and I find, that this response was posted by the first plaintiff on the BFD Facebook group page some time on **10 September 2017**.

184. That same day, namely **10** September 2017, the first defendant published a further post on the BFD Facebook group page (the Third Post) in response to the first plaintiff's public response. The Third Post read: [135]

> you had a right to reply Raj and failed until there has been significant fall–out. Stealing and quoting people from this page, stealing business ideas and ripping off doctors with your second rate stolen IP is NOT OK. Its (sic) people like that resulted in BFD being started because I was sick of people ripping off doctors. You (sic) August 2016 project which we discussed had nothing to do with MBS – it was about medical clinics for GPs and specialists working together which I told you wouldn't work – you then took my information, hassled me for items numbers and quoted from the BFD workshop, Facebook page and conference. That is IP theft.

185. Various members of the BFD Facebook group posted comments on the BFD Facebook group page in response to the Posts (the Comments). The Comments, many of which also attracted a written response from the first defendant, and other Group members, included, inter alia: [136]

> 'Naughty boy, copyright means exactly what it says. Those who breach it should think how they can made reparation.' (First Comment)

> 'Not done. This is essentially stealing and is a criminal offence. Plagiarism is also an offence as well. Hopefully this issue is escalated.' (Second Comment)

> '[Member name] ... the person did use someone else's copyrighted materials which was given to him out of altruism in good faith.' (Third Comment)

> 'Seriously people are so rude. Why take advantage of something like this? I hope you block him!' (Fourth Comment)

> April Lyn shit. I would love to sit down with you one day and pick your brain. I can't believe someone could be so disrespectful. (Fifth Comment)
>
> 'To Raj – as I know you're probably reading this, if you're nefarious enough to behave in this way then you probably have a way to get on here – you're a scumbag.' (Sixth Comment)
>
> 'Oh FFS, one person ruins it for the entire lot.' (Seventh Comment)
>
> 'Is there any sign of contrition at this stage? It would be nice to see, however unexpected.' (Eighth Comment)

186. At about 9:56pm on **9 September 2017** (and therefore before the first plaintiff's public response), the first defendant sent an email to Dr Kelly (the First Email). The First Email read: [137]

> Dear Tim
>
> Dr Rajan asked for assistance with his medicare Billings and has now taken the BFD Billings methods and examples and has lined with yourselves to run a workshop.
>
> This information is under copyright and BFD is a branded and logo protected organisation.
>
> I would ask that you disengage with his services prior to my taking action against him for IP theft.
>
> Regards
>
> Dr April Armstrong
>
> Business for Doctors
>
> Director

187. In response, Dr Kelly sent an email to the first defendant dated **11 September 2017** which read: [138]

> Dear April,
>
> Thanks for the heads up. However, we don't accept your contention there has been any IP theft by Rajan, and in fact we have independently invested many days of work to get this workshop running.
>
> We have have (sic) been delivering education on Medicare for many years, and Rajan has clearly been planning education around Medicare item numbers since his research project at Flinders.
>
> If you have any evidence to the contrary I'd be interested to see it, but in the meantime– I can't see how education on item numbers from the MBS is suddenly your intellectual property, and yours alone.
>
> Please refrain from public comments about ProMBS and any individuals involved.
>
> Regards
>
> Tim

188. At about 5:41pm on **15 September 2017** the first defendant sent a further email to Dr Kelly and Ms Cheah (the Second Email).

189. It is necessary to reproduce that email in its entirety, despite its length. The Second Email read: [139]

> Dear Tim and Carolyn
>
> Thank you for your email – you have asked for evidence and I therefore send the following information. There are also a number of other matters, but these are the most relevant to the AOGP involvement with this doctor.
>
> It is unfortunate that this matter has come to legal action but sadly Rajan is the first of potentially many future issues with doctors taking IP from the BFD group. In addition he misrepresents himself as an expert and has made many comments on our page that highlight he has never read (or at least digested) the MBS, nor does he have a base knowledge of the legalities of medicare billing – as medicare Billings is not just about item numbers.

AOGP have had a superb reputation for education and to have your organisation at risk by association is a shame – but if he does not cease to misrepresent our work then I will proceed with legal action which will include AOGP for aiding him in the delivery of the program.

I will give you some examples of his lack of insight and knowledge and hopefully this will enable you to make an educated risk management decision before I proceed any further.

Rajan posted on Facebook in January that he had received fellowship and now had no provider number as he (sic) 19AA/AB exception had run out on the 1/1/17. He was dismissive and lacked insight to the processes in the medicare system that required him to apply for an extension on his provider number in order to enable medicare 4-6 weeks to process his new application after fellowship. He lodged documents in late December and expected he would have an immediate reply and response, which as anyone who knows working with medicare, is not the case. The 19AA/AB special approved placements requires 28 days to process applications. Medicare provider numbers can take up to 6 weeks unless a fellow is already recognised and has online access. In addition he was under the 10 year moratorium and had only completed his fellowship 9.5 years after service.

“January 5

I need some advice

I was working int (sic) he (sic) city with a Special Approved Provider number with 19AA and 19AB exemption until 1/1/17. I completed my fellowship recently and received confirmation not he (sic) 20/12/16. My 10 year moratorium will be over in the next 5 weeks. As per the advice from the PM I applied for 19AB exception from DOH and also for Locum provider number from medicare in the same location. Due to the festive season my file hasn’t moved and I am currently not working.

Apart from the financial hit my patents (sic) are suffering (many of them are nursing home residents who cannot go elsewhere) I was told

that as I am now a registered specialists (sic) the (sic) can see the patient, prescribe and refer but can't claim anything from medicare benefits.

I tried contacting door to door between medicare and 19AB but the red tape has failed me. Feel compelled to think it is part of my duty of care and should help at least the nursing home patients without even charging them.

Don't know if there is anything else which I could do to ask Medicare for help"

You maybe aware that using social media for a learning tool is not new – we ask people not to type the work "follow" or "f" in comments but rather to turn on notifications for the post. Rajan used the social media page to update his knowledge on simple things that would be known by someone who had been studying and preparing to deliver expert advice on the MBS.

On November 8 a question was posted by a member:

"MBS clarification please – when reviewing a patient's gpmp (can be done every 3 months) can you also bill a TCA if you are reviewing the Team Care Arrangements but not giving a revised document to the rest of the health team?"

At 9:39am on the same day Rajan posted "F" indicating he could not answer the question and was waiting for an answer to be enlightened himself. You might feel that this is nitpicking but the question is actually a very basic question and was answered swiftly by a number of other doctors who use the MBS and had been working in the system for many years.

On May 25 2017 Dr Rajan posted about an education event – asking members of the group

"Are there any GPDU members going attending this event? Or attending similar events?

Wondering – are they useful?"

There was no reply to his post. I believe this may have been his test for the market using the Facebook page but could have indicated that he was going to attend an event to further his knowledge.

Business for Doctors has a social media page with nearly 10,000 members. Our ethos is to share our own personal experiences and knowledge but not to give “advice” – it is actually illegal to give financial planning or tax advice unless you are a licensed financial advisor.

On the 22nd July Dr Rajan posted

“Tax avoidance strategies but I guess a lot of people do that. If you could show your husband as working for you and if overall collective (sic) you are able to save some money at the end of the financial year – then why not do this. By the way super is not dead money. If (sic) will be a forced saving”

This post was mostly ignored by the group as the majority know

1. Tax evasion and income splitting is illegal
2. We quote from our accountants who would not agree with this statement.

Dr Rajan’s post indicates that he believes it is fine to break tax law and because “everyone else does it” – and questions his knowledge and ethics in regards to his own tax matters and the “advice” he is giving others.

The most significant post that stands out as NO understanding of the MBS and the Health Act is his response to a question posed on the 80/20 Rule.

On August 14 2017 at 3:11pm he posted

“Just a thought – why do we have to worry about audit. 60 or 70 or 80 – as long as you can justify your consult and you are doing it rightly – why should one worry.”

Immediately above his post I had explained the rule and how it is not an audit but an automatic warning of over-servicing. The MBS is very

clear about overservicing and even if you legitimately see patients and bill more than 80 services on 20 days in a 12 month period you will automatically receive a reprimand and it could trigger a full investigation into your Billings practices.

Another post indicates that he may be defrauding medicare by over servicing with case conferencing. A member asked on September 6

“Quick question – how often can you bill a case conference per patient? TIA”

His response:

“Govt and Medicare recommends 5 times a year. But ideally, there is no limit if you could justify it”

This is not correct – patients should only have a maximum of 5 per year if required and more only if there extenuating circumstances. This is written in the MBS. The saving part of his comment “If you could justify it” is massively incorrect. The review panel will decide if your justification is justified and fits the intent of the billing codes, and is the “normal accepted practice” – He lacks insight to (sic) posting such information and it creates an image of a doctor who is flaunting the system and perhaps breaching medicare.

Another blatant lack of knowledge and highlighting again that he has NOT read the MBS was a question relating to HMMR. On September 8 a question was posted asking if a HMMR had to be done at the patients (sic) home. He incorrectly answered that it did, which is not the case.

There is a significant evidence that he is not knowledgeable and using information that is second had (sic) and passing it off as his own. If it had not been for plagiarism of a doctors (sic) quote from our BFD page I would not have even looked further at his posts or the program that is running.

Rajans (sic) blog copies a post from our page – I raised the fractured ribs item number along with a list of fracture management item numbers and discussed the normal after care and process for billing

Medicare when a patient has been seen in a public hospital v's a patient who has been admitted privately and had an item number raised for fracture management. The item number is a a (sic) "per rib fracture" item number and there were lots of comments. One of our doctors (a rural doctor on call over the weekend in the footy season) commented that he was annoyed that he didn't know about the item number sooner as he was frequently attending to fracture ribs during the footy season.

Dr Rajan is an Adelaide based doctor who has predominantly done city general practice and nursing home patients – it is unlikely that he has EVER billed a fractured rib for a footy injury – let alone seen a football player with one. More likely that a nursing home patient – and if he had been a little more careful using an example that reflects his own practice rather than passing off a quote as his own would have been overlooked by everyone.

It has been suggested by a number of colleagues that he should be reported to AHPRA for unprofessional behaviour, plagiarism and passing off work as his own, but I am not going to report him. There are enough complaints and stress that AHPRA don't need this on their list and I believe it could be seen as myself having a lack of evidence to legally pursue the matter, which is not the case.

What I will be doing is reporting a suspected medicare fraudulent use of the case conferencing numbers and over servicing nursing home patients. I will use his quotes on the number of case conferences he suggests as evidence of his lack of knowledge. I will also consider discussing the matter regarding income splitting and tax evasion and deciding if this needs further investigation.

I am not doubting that he has produced 50-100 cases to give examples of medicare Billings and that these may be correct and legal – I suspect that many of the cases have come from our BFD page and from questions raised and answered by doctors on the page, not from his research as he has indicated.

I request that you take this matter seriously as the reputation of AOGP and its longstanding relationship with GPs and local doctors could be damaged by the above mentioned.

190. At about 12:20pm on **22 September 2017** the first defendant phoned AOGP and spoke with Ms Lauren Rauda (the Phone Call). It is apparent that the phone call was made shortly after AOGP sent an email to those persons who had expressed interest in attending a proposed ProMBS workshop in Melbourne before the Posts, but had not subsequently enrolled for that workshop.

191. A copy of that email is reproduced at page 107 of Exhibit P1, however there was no oral evidence with respect to that document (save for Dr Kelly confirming he had seen that document before). In summary, the email encouraged enrolment in the workshop. It made reference to, but strongly refuted, the allegations of IP theft made by the first defendant on the BFD Facebook group page and advised that the first plaintiff was taking legal action in response to such allegations.

192. That same day, Ms Rauda sent an email to Dr Kelly wherein she outlined the substance of the conversation she had with the first defendant (the Rauda email). The email read:[140]

> Below, I have outlined – to the best of my recollection – the details from this phone conversation.
>
> At approx 12:20pm today April Armstrong called me regarding an email I had sent out.
>
> I found April to be irate and not interested in having a conversation, rather wanting to vent her anger.
>
> I offered her the opportunity to speak to yourself, but she wanted to talk to me as it was my name on the email.
>
> I explained that the email was from me, as it was an approved response to the recipient's enquiry about the ProMBS workshop in Melbourne.
>
> I also explained that it was sent to a small group or (sic) 11 recipients who had expressed interest in the ProMBS workshop – not to anyone else.
>
> She wanted the email retracted and an apology sent.
>
> April said she felt the email was defamatory and that I shouldn't have used her Facebook name in the email.
>
> I explained that the BFD name was used because this was where the

recipients had heard about the workshop in the first place. They had then contacted me directly about attending the workshop.

I told April that AOGP had not advertised this workshop prior to the enquiries coming in from BFDs. There was no venue booked, and this had been emailed back to those inquiring about the workshop at the time.

April said she was “disgusted in AOGP continuing to do Rajan’s dirty work”. She said she had wanted to keep AOGP out of her issues with Rajan, but that there would be a “shit storm” if AOGP continued ahead with the workshop.

This phrase was used several times in the phone call.

April said that the words in the email were misleading, as they talk about Rajan’s legal proceedings rather than “him responding to my legal proceedings”. I advised that the email was referring to Rajan undertaking his own legal proceedings.

April asked if I would be happy for the email to be taken to the media. She said it would be to back up “her story, not ours”.

Several times during the phone call, April mention (sic) her 10,000+ doctors on her Facebook page. Asking “who do you think they will side with?” I felt this to be quite threatening and in the nature of blackmail.

She said that “AOGP’s reputation is going to be ruined”.

April called Rajan a “scum bag” and questioned his billing experience and history. “He’s never billed for a rib fracture in his life!”

I explained that the Board had been notified of her original allegations, and had approved the workshop to go ahead.

Again I advised that it would be more beneficial for her to speak directly to yourself. She said that “Tim doesn’t like me.” I replied that it wasn’t a personal issue that needed to be discussed.

I then suggested that she put her request regarding the email in

> writing to Tim. April said "the email will be coming from my lawyers", and hung up on me.

193. On 28 September 2017 Ms Rauda prepared a written statement as to her recollection of that Phone Call at the request of AOGP's lawyers, the contents of which effectively mirrored that of the Rauda email. A copy of that statement is reproduced on page 67 of Exhibit P1 (the Rauda statement).

194. Ms Rauda was not called to give evidence.

195. The first defendant admits the Phone Call was made but disputes the content of the Phone Call as pleaded. The defendants admit, with respect to the Phone Call, that the first defendant used words to the effect that she wanted 'to keep AOGP out of her issues with Rajan'.[141] The defendants also admit that the first defendant made the statement 'who do you think they [the members of the BFD Facebook group] will side with?' but say:[142]

> That the first defendant made that statement in response to a statement by Ms Rauda, who used words to the effect that 'just because you have a following on Facebook, how do you know they will believe you?'

196. Further the defendants admit that the first defendant used words during the Phone Call to the effect that 'AOGP's reputation is going to be ruined in her eyes'.[143]

197. An issue arises as to the admissibility of the Rauda email and the Rauda statement insofar as this is the only evidence of the contents of the Phone Call, noting that only part of its content is admitted in the Defence.[144]

198. Pursuant to s 53 of the *Evidence Act 1929*, apparently genuine documents purporting to be business records can be admitted in evidence in certain circumstances.

199. 'Business record' means:

. (a) any book of account or other document prepared or used in the ordinary course of a business for the purpose of recording any matter relating to the business; or

. (b) any reproduction of any such record by photographic, photostatic, lithographic or other like process.

200. I am satisfied that both the Rauda email and the Rauda statement (albeit the latter was obtained at the request of a solicitor), were prepared for the purpose of recording a matter relating to the business of AOGP, namely the workshops they were conducting in collaboration with the first plaintiff, through the second plaintiff.

201. However, s 53(2) of the *Evidence Act* states:

> A document must not be admitted in evidence under subsection (1) if the court is of the opinion –

(a) that the person by whom, or at whose direction, the document was prepared can and should be called by the party tendering the document to give evidence of the matters contained in the document; or

(b) that the evidentiary weight of the document is slight and is outweighed by the prejudice that might result to any of the parties from the admission of the document in evidence; or

(c) that it would be otherwise contrary to the interests of justice to admit the document in evidence.

202. Ms Rauda was unavailable to give evidence as she was overseas in Italy at the time of the trial.
203. The Rauda email appears to have been prepared shortly prior to 1:18pm on 22 September 2017, and therefore within an hour of the Phone Call and at a time when it could be expected the event was fresh in Ms Rauda's mind.
204. However, the Phone Call is relied upon by the plaintiffs as a defamatory publication, and as such, the accuracy of the content of that publication is critical. There was no request made by the plaintiffs for an adjournment of the trial or for the trial to proceed part heard to enable Ms Rauda to be called to give evidence. There was the potential for Ms Rauda to be available to give evidence, either by telephone during the trial as listed (notwithstanding the time difference) or at a later date.
205. Although the evidentiary weight of the document is significant, rather than 'slight', I consider the defendants will be prejudiced in the event these documents are admitted into evidence, absent Ms Rauda being subject to cross-examination.
206. In the circumstances, in the interests of justice I decline to admit either the Rauda email and/or the Rauda statement into evidence.

First Plaintiff's Response to the Publications

207. The first plaintiff gave evidence that on 9 September 2017, being the date of the First and Second Posts, he had been awarded his fellowship as a general practitioner (FRACP) and had then worked from around 5:00pm until 10:00pm at his surgery. He was not aware of the Posts until alerted to them by his wife after he finished work that night, although he said he had exchanged private Facebook messages with the first defendant during the evening.
208. He said he received a private Facebook message from the first defendant at around 9:20pm or 9:30pm that night, wherein she accused him of having stolen her intellectual property. He said he had replied stating that there must be a misunderstanding and explaining about the NVI course he had completed.[145] The private Facebook messages exchanged between the first plaintiff and the first defendant between 9 and 15 September 2019 are reproduced in full in Exhibit P1 item 15.

209. The first plaintiff explained that he was unable to respond to the Posts because he was driving. He said that he was very shaken, and that when he arrived home he rang Dr Boda and Dr Kelly, both of whom told him to calm down, to relax and said they could talk about it in the morning.[146]

210. The next day a few of his family and friends who were BFD Facebook group members had contacted him. The first defendant had removed another person with a similar name from the BFD Facebook group, meaning the first plaintiff (and his wife, who shared the same profile ID) remained members. His friends and family had noticed that a different Raj Anand had been removed from the group, and had asked if, in the Posts, the first defendant had been talking about him.[147]

211. He said that he 'just couldn't take it' so he decided to reply to the Posts on the BFD Facebook group page. In that reply, he had repeated what he had said in his private messages to the first defendant, namely that he had not stolen the first defendant's intellectual property (IP), that he had completed the NVI course long before he had met her and had come up with the idea for the workshops at that earlier time. She had replied, by way of the Third Post, but thereafter he was blocked from the group.[148]

212. The first plaintiff said that for the first two days following the publication of the Posts he had tried 'to hide in a cocoon' and felt depressed and sad. He was embarrassed and concerned that his wife had seen the comments calling him a scumbag, a cheat and a liar. He could not sleep well for a decent number of nights. He said he still felt cold thinking about the Posts and still suffered from early morning awakening.[149] He explained that in his culture it was particularly dishonourable to be called a cheat or a liar.[150]

213. The first plaintiff gave no evidence to the effect that he sought any medical treatment for any particular illness or symptoms he may have suffered at any time after the material was published.

214. Dr Nirej Rewal is married to the first plaintiff's sister-in-law and a practising dentist. He said he became a BFD Facebook group member about two years ago, although from his evidence it seems likely that he had in fact joined the 'Business for Dentists' Facebook Group – being another similar forum operated by the defendants.

215. He said he had seen the First, Second and Third Posts and upon seeing them he was upset, as he knew they were incorrect and that the first plaintiff had not stolen anyone's intellectual property.[151] He was not a BFD Facebook group member at the time, so I infer from Dr Rewal's evidence that he was shown the Posts by someone else.

216. He said that he spoke to the first plaintiff by telephone shortly after the Posts were published at which time the first plaintiff was very upset. When he saw him about a week later, he was 'visibly shaken'. Since then, he had noticed the first plaintiff had become more introverted and had suffered stress associated with these proceedings.[152]

217. In cross-examination, Dr Rewal said he was unaware if the first plaintiff sought any treatment for any issues such as anxiety, after the Posts were published.

218. Ms Ridha Anand is the first plaintiff's wife. She saw the Posts after receiving an alert on her Facebook account that she shared with the first plaintiff. She said she was shocked and could not believe it was happening, especially as earlier in the day the first plaintiff had been awarded his Fellowship, and it had been a day of celebration.

219. She rang the first plaintiff and told him about the Posts, as a result of which he was completely shaken and very upset. She said he was worried about what other people would think of him and said that a lot of his friends were messaging them asking 'What is all this?' as they were BFD Facebook group members.[153]

220. She said that thereafter the first plaintiff had difficulty sleeping and still could not sleep properly. He had also become more introverted.

Impact on Relationship Between the Plaintiffs and AOGP

221. Dr Kelly gave evidence that he learned about the First, Second and Third Posts after being told about them by the first plaintiff, and that he had then seen screenshots of them. He said he felt sorry for the first plaintiff, and believed he was being treated unfairly.[154]

222. Upon receiving the First Email, Dr Kelly had replied to the first defendant, asking for evidence that there was IP theft. Dr Kelly explained that 'we believed that there hadn't been any IP theft and we were keen for transparency on whether there was IP theft'.[155]

223. Dr Kelly said that he interpreted the last line of the First Email, namely, 'I would ask that you disengage with his services prior to my taking action against him for IP theft', as a threat.[156]

224. As previously stated, on 11 September 2017 Dr Kelly replied to the First Email seeking evidence that the first plaintiff had committed IP theft.[157] The first defendant sent the Second Email in response to this request.

225. Dr Kelly said that in his view, the first defendant had not provided any evidence of IP theft and the Second Email was simply an attack on the first plaintiff.

226. AOGP is a company governed by a board of directors (the Board). Dr Kelly gave evidence that the Board agreed with his suggestion that an indemnity be obtained from the plaintiffs to protect AOGP given the various threats of legal action made by the defendants.

227. On 21 September 2017, Dr Kelly sent a letter to the plaintiffs on behalf of AOGP wherein he acknowledged the plaintiffs' firm rejection of the allegations of copyright infringement made by the first defendant and outlined that AOGP was keen to continue to deliver the ProMBS education workshops. The letter requested the plaintiffs confirm there had been no infringement of any IP rights in the ProMBS workshop materials and to agree to indemnify AOGP in the event that it suffered any cost or expense in the event of any claim made against it by the defendants or any other party, alleging infringement of intellectual property rights relating to the ProMBS workshops.[158]

228. Dr Kelly gave evidence that the plaintiffs (through the first plaintiff) complied with this request.[159]

229. Dr Kelly replied to both the Second Email and the Phone Call, by email dated 22 September 2017 wherein he stated:[160]

> We asked for any evidence of IP theft that you had, and all you were able to share was the fact that an example case on the public blog involved use of an item number for rib fracture. We do not accept this is evidence for IP theft when providing education on the MBS as it is there in the public document for all to see. The rest of your response was a personal attack on Rajan, and in our view, irrelevant to the question of IP theft.
>
> The email went to 11 people who had registered interest in the Melbourne workshop and it is a statement of the truth from our perspective. I know how much work AOGP has put into developing these workshops and we are keen to continue with them. I have seen the coverage this workshop received on BFD FaceBook page, and AOGP was drawn into negative discussions with no right of reply, so I suspect damage has already been done.
>
> We are not interested in legal disputes, we are interested in continuing our work to support general practice. We note however, in your discussion with Lauren your statements regarding the ability to damage our reputation through social media, please consider your actions carefully.

230. In response, on 22 September 2017, the first defendant sent an email to Dr Kelly in the following terms:[161]

> Your previous email you asked for evidence that Raj had taken information from our page. I outlined clearly a copying of a case that is the exact case you use on your webpage where he has quoted from the BFD page of another doctor and passed this off as his own quote. He has also posted numerous time which indicates he is not only using the work of other people, but fails to actually be able to interpret the work correctly and lacks understanding of the medicare system and billings. Your response was to forward this onto a solicitor to be used in evidence that I have damaged his reputation, despite you asking for this evidence.
>
> AOGP have sent out an email – you say to 12 people who have show

> (sic) interest in the workshop. Do you think sending out this email stating that there is legal action is of benefit to AOGP, BFD or Rajs (sic) cause. Doctors do not like conflict or litigation and your email is more likely to alienate them from your services? I have forwarded the email to my solicitor and she has advised that there is no case for me to take action against AOGP for making the statement as it is in part true as Raj has sort (sic) legal advice (on my recommendation) in regards to the claim of IP theft. AOGP however are not making a good case for me not to defend the email and explain –
>
> I would strongly urge you to reconsider being involved in a legal conflict. My history with AOGP is leaning towards wanting to protect the organisation but you are pressing me to think otherwise.
>
> Your cooperation is removing the proMBS case that is a takeoff from our page and ceasing sending emails to potential participants is requested.

231. Dr Kelly responded by email to the first defendant on 25 September 2017:[162]

> I missed you (sic) previous response on Friday sorry.
>
> AOGP is willing to remove the case sample you mention from our website and to not mention BFD or yourself in any email to potential participants on the following basis:

1. This is done with a denial of liability.
2. It will be in full resolution of any claims you or Business For Doctors may have against AOGP, its officers and employees for any matter to date.
3. You and Business For Doctors agree to make no adverse statement of AOGP, its officers and employees.

> I await your response.

232. Dr Kelly's evidence was that notwithstanding the Publications, AOGP remained committed to working in partnership with the plaintiffs and to continue the delivery of the ProMBS workshops.

233. Dr Kelly said that he was quite upset for his staff member (Ms Rauda) in having to deal with the Phone Call. Having informed the Board of what was happening, AOGP determined to keep running the workshops, continuing to involve the plaintiffs, as they were confident they were providing a needed service and not infringing any copyrights.[163]

234. Dr Kelly was asked if AOGP's business arrangements with the second plaintiff changed at all after the Publications. He answered:[164]

1. They changed in the next year, in 2018 we renegotiated another arrangement but really Rajan had to pull back from being involved. He was feeling - I can't speak for him, but he told me he was feeling stressed by it all and it was better that he, he not be involved up-front. We - from our perspective, AOGP wanted to avoid association with any legal battles or things like that, so we asked to remove IQMed from branding and things like that in terms of the workshop but Rajan still, we renegotiated the 50/50 profit-sharing arrangement –

> Q. In terms of any speaker fee, did he receive -

1. I think that year - you might have to ask our business manager, but I think that year he was going to receive speaker fees and we don't currently have an arrangement because we've been waiting for things to settle down, really, **and Rajan said his attention is otherwise diverted**.
17. So when the 2018 agreement expired, nothing has been -
1. No, it hasn't flowed on.

> (my emphasis)

235. Ms Cheah gave evidence that the first plaintiff shared with her the First, Second and Third Posts, and her response to reading them was:[165]

> I felt that it was unprofessional and I felt sad and sorry that someone had to go through this experience of other people saying things about him.

236. She said she felt this way because she believed that the first plaintiff had not taken the material.[166]

237. When asked how she felt upon reading the First and Second Emails Ms Cheah said:[167]

> I didn't really feel anything because I suppose what was important to AOGP was that the cases – that we had reassurance from Rajan that the cases that was (sic) brought to us where we worked on for the workshop was not stolen intellectual property. I can't say what I thought of whether Rajan was doing the right thing or the wrong thing. Some of the item numbers I'm not aware of.

Further Proposed ProMBS Workshops

238. The first plaintiff gave evidence that because of the first defendant's bad mouthing of him and the impact on his reputation, there were 'a few seminars which got cancelled'.[168] He said

he did not present again until February 2018 in Melbourne and he could not recall what fee he had received from that workshop.[169]

239. In response to specific questioning during examination-in-chief as to what may have happened to events planned for Sydney and Melbourne he said that a workshop planned for Melbourne in October 2017 had not gone ahead, nor had an event planned for Sydney in November 2017. He gave hearsay evidence of what he had been purportedly told by Ms Cheah as to why, namely that a few calls had been made to AOGP saying 'AOGP is cheat and this is very unprofessional for AOGP to do that'.[170]

240. The first plaintiff said the Melbourne workshop eventually took place in February 2018, that was a good event and they received a good review.[171]

241. He initially said he did not know if the Sydney event was rescheduled, as he had started taking less interest in the MBS.[172] However, after being shown a document entitled 'ProMBS workshop net position as at 27 March 2018',[173] which referred to a ProMBS workshop scheduled for Sydney in March 2018, he said this workshop had to be cancelled 'because a few number of parties cancelled'.[174]

242. He said that the profit sharing agreement with AOGP was re-negotiated such that instead of receiving 60% of any net profit, the second plaintiff was only to receive 50%. The first plaintiff said that AOGP 'had to work on it a lot more compared to (what) they thought', and he referred to additional work apparently caused due to complaints made, resulting in auditors attending two ProMBS workshops.[175]

243. The first plaintiff believed that at least one of those complaints came from the first defendant.

244. As to what happened in terms of his involvement with the ProMBS workshops after February 2018, the first plaintiff gave the following evidence:[176]

17. What fee did you get for that.

1. I don't remember.

17. Okay. How many more seminars did you present at after that.

1. No, I think **after Melbourne there was so much of fall out and bad mouthing and this thing was continuing that I started to distance myself from the whole thing**. Then around - yeah, I started to distance myself.

17. And was that something which you instigated or was it instigated by AOGP or how did that come about.

1. I think **it was probably more with my mood as well,** that I was like - yeah, I - when I took this whole thing, I never thought that I will be sitting in a court and testifying or doing anything like that. I thought that it's just going to be one small thing, I'm just doing a presentation for general practitioners and that's it. I never thought it would go to this kind of level that I have to be in a court.

HER HONOUR

17. Sorry, I didn't get your answer. Was it your idea or their idea or how did it come to be you distanced yourself from this thing.

1. Okay. On 21 February I received an email from **Primary Health Care**, so if you recall from the letter of 25 October which Dr Armstrong has sent to me, in that she has mentioned that she is going to negotiate with Primary Health solicitor to be a part of - where she said that she will be seeking a financial backing and she will also be negotiating with Primary Health Care solicitor to be against me. So 21 Feb I received an email from the legal team stating that they have been made aware that I have stolen their idea and I'm presenting it as my own ... seminar. **So they ask me to stop it.** When I receive that email, then I contacted the CRO, Mr Simon Cross, for Primary Health Care and I told him and I reminded him that 'Simon, before even going to AOGP, I have actually contacted the Primary Health Care to do the same thing for you. So this idea, I brought it to you first so don't say that I have taken your idea and producing it as a pro MBS'. So he called me back, that 'Raj, let me speak to the legal - my legal team then I'll give you a call'. So I spoke to him. What he told me, that one of the GP from Western Australia has befriended Dr Shirley Fung. Shirley Fung is a director of Primary Health Care Institute which is a teaching wing. And she has solicited, the right - she has asked for my billing record and at that time Shirley Fung was made aware that I might have stolen the idea from Primary and I'm passing it out as a ...

17. Hold on, I still don't know the answer to the question though. You've said you decided to distance yourself from the whole thing. **Is it because of what happened with Primary Health Care.**

1. Okay, I haven't finished it so I'll finish it off.

17. Okay.

1. So that's how I came to know. So what Simon Cross told me that 'Raj, I would like you to be out of this whole thing altogether and we will drop any cases from PHCI against you.' So I have to withdraw from the AOGP website. I have to withdraw from presenting any case. **He said that 'Till your terms with Primary is there I would not like you to be involved with the pro MBS seminar' and that's why I have withdrawn**.

(my emphasis)

245. In cross-examination, the first plaintiff said that an example on the ProMBS website wherein the first plaintiff claimed to have missed three to four fractured ribs per weekend and anything to do with his name on that website was removed at the request of Primary Health (the fracture blog). He gave the following evidence:[177]

1. Yeah, it was removed, because Primary has told me that my name cannot be used anywhere, when I was working. So, that time they've taken it off and since then I don't think it's there. And I haven't even bothered to look into that website since.

17. Okay, thank you. So it was because Primary Health told you not to be involved.

1. Absolutely, 'Take your name off' and everything.

246. The first plaintiff gave evidence that he did not deliver any further ProMBS workshops, despite them being run in both Creswick and Brisbane in April 2018. This was during the period when he was still under contract with Primary Health, namely until 30 June 2018.

247. However, following the termination of that contract, he said 'I was free'. He then returned to present ProMBS workshops held in Adelaide on 21 July 2018 and in Melbourne on 11 August 2018. He gave evidence that he had not presented since then as he had lost interest in the MBS, associated with the ongoing dispute with the defendants. He also explained that in response to a complaint, which he believed had come from the first defendant, an auditor attended one of those workshops and that it was causing him too much stress, so he 'decided to just pull out'.[178]

248. The first plaintiff gave the following evidence:[179]

> Frankly speaking, I've been trying my best to just avoid being with MBS. I mean, the last general presentation with the ProMBS was in July 2018, and then I just said that 'Look, I just cannot take it'. I'm Just, even reading, like, you know, going through the book, or some people talking about that, 'What are the item numbers you should use?' I just said that, 'Look, just don't ask me, I don't care'. I want to be out of this - it's been just being prolonged for such a long period.

249. However, in response to a question as to what his future plans would have been in terms of continuing these types of workshops, the first plaintiff that 'once this court case gets settled' he would like 'to continue with the MBS'.[180]

250. As to any cancelled ProMBS workshops, Dr Kelly said that he was aware a planned workshop for October 2017 in Melbourne was cancelled due to lack of interest, with only one person registering despite AOGP receiving 11 or 12 expressions of interest. He said a workshop would run if there were 20 confirmed attendees. He said that they had been planning to run a workshop in Sydney in 2017 but did not go further and say what (if anything) happened with that workshop. He did not know what level of interest there may have been with respect to that workshop.[181]

251. Dr Kelly gave no further evidence on the topic of any cancelled workshops and what, if any, loss was sustained by AOGP (and therefore the plaintiffs) as a result.

252. Dr Kelly confirmed that although AOGP did not currently have a contract with the second plaintiff, AOGP had continued to run about 10 ProMBS workshops per year, with between six or eight held during 2019 up until when he gave his evidence on 24 September 2019.[182]

253. Ms Cheah gave evidence that due to the success of the initial ProMBS workshop, there were plans made to hold a workshop in Melbourne in maybe October or November of 2017, and 'possibly one in Sydney.' She said they had people email them about those proposed workshops so they set up a register of interest.[183] These emails are reproduced in Exhibit P1 and include a total of nine expressions of interest for a proposed workshop in Melbourne in

October 2017 and seven expressions of interest with respect to a proposed workshop in Sydney in November 2017, with those expressions of interest all being received on either 8 or 9 September 2017, and therefore immediately before the Publications.[184]

254. Ms Cheah gave the following evidence-in-chief:[185]

17. What happened to, firstly, the Melbourne workshop.

1. So then I suppose the incident happened, I can't remember -

17. Can you explain what you mean by 'the incident'.

1. The Facebook incident happen where lots were exchanged between, I suppose, April and - in regards to Rajan, so we thought maybe because of that that we would postpone the Melbourne and Sydney workshop and let it all settle down rather than be in the thick of it and trying to promote two other workshops.

17. As a result of that, did you incur any particular charges.

1. No, because I hadn't actually at that time signed any agreement with Crown and I hadn't found a venue at Sydney yet at that point.

255. On the issue as to what loss of profit may have been sustained by AOGP (and therefore the second plaintiff) as a result of the cancellation of any workshops, Ms Cheah gave the following evidence, while she was being shown a copy of the Second Statement of Claim:[186]

17. If you go to p.13 of that document, and you see that there's a claim for lost profits from cancelled seminars for $6,000, do you have any comment in relation to that.

1. 'Loss of profit', so you mean - so we expect to make around 4,000 per - on average per workshop, so you're saying that because we cancelled three workshops therefore it's three times 2,000?

17. Do you know what the loss of venue hire fees -

1. Yeah, that was the Sydney venue.

17. So that had already been paid, had it.

1. Yeah, yeah, yeah.

256. Ms Cheah also identified the document entitled 'ProMBS Workshop net position as at 14 August 2018'[187] as outlining 'the share of profit for 2018'.[188] There was no evidence before the court as to who created that document or from what source material.

257. That document describes net profit from ProMBS workshops conducted during the period 1 January 2018 to 14 August 2018 in the sum of $24,226.25, shared equally between AOGP and the second plaintiff. Ms Cheah's evidence was to the effect that this sum represented the entirety of income from the ProMBS workshops for 2018, although I note the schedule refers specifically to it being the financial position as at 14 August 2018.

258. As to the arrangements between AOGP and the second plaintiff, Ms Cheah said that either in late 2017 or early 2018 a further agreement was signed for 2018 wherein AOGP and the second plaintiff agreed to split the net profit received from the ProMBS workshops 50/50, with any speaker fee coming from that profit share.[189]

259. She confirmed that arrangement ended on 31 December 2018, such that there was currently no service agreement between AOGP and the second plaintiff. When asked why, she said:[190]

> I think he wanted to make sure that everything settled before and, I don't know.

260. Ms Cheah said that the first plaintiff presented at the ProMBS workshops held in Melbourne in February 2018, Adelaide in July 2018 and Melbourne in August 2018. She said that the response to the Melbourne workshop – which in effect replaced that cancelled in October 2017 – was 'a pretty good response'.[191]

261. Ms Cheah said a workshop planned for Sydney in March 2018 was cancelled, incurring charges including a venue hire fee with the Hilton of $4,497.89.[192] As to why it was cancelled, Ms Cheah said 'Sydney is just a really hard market to penetrate' and that this was not an unexpected result. She added that in an attempt to increase the AOGP database in Sydney, they had manually entered details of general practices in Sydney to their database. [193]

262. As to the ProMBS workshops held in Creswick and in Brisbane in April 2018, Ms Cheah said the first plaintiff was unavailable to present in Creswick, as he 'was busy'[194] and she could not recall if he presented in Brisbane. A conference planned for Perth in 2018 had been cancelled and she agreed in cross-examination that Perth, like Sydney, was a hard market to enter into, and said that AOGP had manually sought out generic email addresses for general practices to target in Perth.[195]

263. Ms Cheah said the ProMBS workshops continued to be held. Eight had been planned for 2019, however two had been cancelled. She did not say why.[196]

Audits

264. The ProMBS workshops have been the subject of three audits – two conducted by the Royal Australian College of General Practitioners (RACGP) and one by the Australian College of Rural and Remote Medicine.[197] These audits were undertaken in the context of the ProMBS workshops being accredited with the RACGP, such that workshop participants receive CPD points for attending.

265. Dr Kelly gave evidence that such audits may be random, or generated by a complaint. The first plaintiff, Dr Kelly and Ms Cheah all gave hearsay evidence to the effect that they understood the first audit was undertaken in response to a complaint made by the first defendant.

266. Dr Kelly gave evidence that they passed both RACGP audits, although some minor amendments to processes were recommended.[198]

267. The initial ProMBS workshop was audited by way of a 'desktop review'. The results of the audit are in evidence and entitled 'Quality Assurance Assessment (QAA) Report'.[199] That

documents lists there as having been 25 attendees at the initial workshop. The audit was aimed at ascertaining whether the workshop met certain required guidelines, rather than addressing the technical accuracy of the content presented. It was conducted 'on the papers' as prepared and submitted by AOGP, which material was not in evidence.

268. The workshop conducted in Adelaide in July 2018, at which the first plaintiff and Dr Boda presented, was also the subject of an audit. This was a 'face to face review', in that two independent assessors attended the presentation. The results of that audit are in evidence.[200] Again the audit was conducted from a 'QI and CPD' perspective, rather than involving a critical analysis of the accuracy of the content. The document lists there as having been 25 attendees at that workshop, being the same number as attended the initial workshop. The content was stated to be 'very relevant to GPs', 'professionally run, with knowledgeable presenters' and 'a quality educational activity'.

269. Neither Dr Kelly nor Ms Cheah gave any evidence to the effect that AOGP's workload had increased as a result of these audits.

Assessment of the Witnesses

270. Although there was only limited evidence focussing on the first plaintiff's primary role as a general practitioner, by all accounts he continues to have a successful career in his chosen profession. It is a difficult and demanding occupation, requiring commitment in terms of many years of study and long hours dedicated to one's patients.

271. The first plaintiff is clearly intelligent, hard-working and motivated to succeed.

272. This is a case which has as its focus, the first plaintiff's reputation, his honesty and his integrity.

273. I must make findings as to the reliability and credibility of the first plaintiff's evidence, as, in many aspects, his was the only evidence on critical issues including the issue of damages.

274. After having had the opportunity of observing the first plaintiff give his evidence, and critically examining that evidence in the context of the other evidence which I accept, I am left with significant concerns as to the first plaintiff's credibility and reliability.

275. The starting point for those concerns is the lie told by the first plaintiff in the presentation he gave at the conclusion of the NVI course, namely that he had 'struck a deal' worth $500,000 with the largest corporate medical practice in Australia. I have watched the video recording of that presentation carefully. There can be no possible misunderstanding of what he said and/or what he intended to convey to those assessing him, when he said it.

276. The first plaintiff agreed in cross-examination that he had never struck any such deal. This was a concession the first plaintiff had to make. The evidence presented by him as to the development of his business model and what, if any, commercial success he had achieved with respect to it at the time of the Publications confirmed there was no such deal.

277. The first plaintiff attempted to explain what he had said by reference to a poor use of words – in the context of English not being his first language. I note the same explanation was used by the first plaintiff, namely a poor choice of words, when explaining what he meant in the

post about 'tax avoidance' and to explain another post about the billing of case conferences. Those were other occasions where the words used by the first plaintiff potentially reflected adversely on him.

278. The first plaintiff completed his primary medical degree in India but moved to the United Kingdom in 2003, where he worked for some time in orthopaedics as a registrar. He gave evidence that he was a Member of the Royal College of Surgeons in Edinburgh and obtained membership of the Royal College of General practitioners (International) in 2015. Although the first plaintiff did not give evidence as to when he moved to Australia, from the evidence it must have been in 2007 (or earlier).

279. I am satisfied that the first plaintiff was working in roles requiring regular interaction with patients in both the United Kingdom and Australia from approximately 2003 – and therefore around 13 years before giving the NVI presentation. Given the nature of that role, not only is it necessary that the first plaintiff understand what a patient may be telling him about their condition, but he must also be able to communicate with them, accurately, as to their diagnosis, prognosis and future treatment needs.

280. I do not doubt that, at times, the first plaintiff may struggle to 'find the correct word' and may struggle with grammar. This was evident in both his oral evidence and the documents he had authored which are in evidence.

281. However, the first plaintiff's intended business model involved him being required to present to (and therefore communicate accurately with) Australian general practitioners on complex issues. I am satisfied that the first plaintiff has at least an average grasp of the English language.

282. I consider it implausible that the first plaintiff simply used the 'wrong words' when giving his NVI presentation. The presentation represented the culmination of the course and the opportunity for the first plaintiff to be assessed on what he had learnt and the business model he had created. He was being judged against the other course participants. The first plaintiff gave evidence that he knew he had to be prepared for the presentation, particularly because of his language difficulties.[201] As such, it is likely and I find that the first plaintiff would have taken care to properly prepare the presentation, so that it best showcased his business model to the judging panel.

283. I find that the words used by the first plaintiff in the presentation and in discussion with the assessors thereafter, in fact conveyed and were intended to convey an untruth so as to bolster both the first plaintiff and his business model in the eyes of the assessors. I do not accept that all he meant to convey by the words he used was that he was hoping to be able to achieve a deal with a corporate partner in the future and that if he was successful in doing so, that deal had the potential to generate income of up to $500,000. The difference in what he said, and claims to have meant, simply cannot be explained by any alleged lack of grasp of the English language.

284. In addition, during the presentation, the first plaintiff claimed to have arranged a meeting to 'grab another deal' and to be 'producing software' with a view to someone taking over his

intellectual property.

285. When asked by the judging panel to explain this software, the first plaintiff explained that what he had done was write down his questions and answers (presumably being the subject of the course) and that he was intending to get a software developer involved to assist him.

286. The first plaintiff gave evidence that on 16 November 2016 he met with Ms Cook, CEO of GPex to discuss his project, although nothing came of that meeting. This was the first such meeting attended by the first plaintiff with any potential business partner relating to his business model. While it is possible that meeting was arranged before the first plaintiff gave the NVI presentation in late October 2016, there was no evidence to that effect before the court. This was not a meeting to 'grab another deal' as no other deals had, in fact, been grabbed.

287. The impression left by this evidence, is that the first plaintiff is prepared to not only exaggerate and overstate his achievements, and to embellish, in order to achieve his stated goals.

288. However, this is not the only aspect of the first plaintiff's evidence that caused me to question his honesty.

289. The first plaintiff was not an impressive witness. He consistently avoided providing a direct response to even simple questions and many of his answers were vague and unresponsive.

290. In addition, by his evidence, I consider the first plaintiff did his best to downplay his interactions with the defendants which predated the initial ProMBS workshop and to be dismissive of what he may have learned about the MBS through such interactions.

291. I have carefully considered this evidence, and the evidence as a whole, in reaching that conclusion, as I am mindful that the first defendant did not give any evidence to rebut what the first plaintiff had said. However, by way of example, during questioning as to his attendance at the BFD Conference, the first plaintiff was very reluctant to admit that he had attended any presentation which had, as its focus, combination billing, although, on my interpretation of his evidence, he eventually conceded he had attended the defendants' 'pack and stack' presentation.

292. He spoke in dismissive and quite disparaging terms as to the content of a session about the MBS, explaining he had not bothered to watch the video recording of that session because its content was so basic.

293. He claimed to have had only a 'very very brief' discussion with the first defendant when they met in April 2017. While there was no other evidence as to what occurred at that meeting, the language he used was quite clearly intended to convey the impression that he learned very little, if anything, about the MBS from the first defendant, from that meeting.

294. On the first plaintiff's evidence, during April and June 2017 he was actively involved in preparing the case scenarios for the initial ProMBS seminar. From all of the evidence, I am satisfied that the first plaintiff knew the first defendant to have expertise in the MBS. It is inconceivable that the first plaintiff would not have used the opportunity of meeting with the first

defendant to attempt to increase his own knowledge of the MBS and attending the BFD Conference.

295. Further, on 9 April 2017, being only two days after that meeting, the first plaintiff messaged the first defendant reminding her to send him the 'cheat sheets' as discussed. This was the same day that the Confidentiality Agreement with AOGP was executed.

296. I am satisfied that the first plaintiff was keen to learn as much as he could from the first defendant with respect to the MBS and that he had specifically sought out her advice as to what were some item numbers that general practitioners commonly missed, being the focus of his component of the initial ProMBS workshop.[202]

297. The first plaintiff's evidence was designed to understate what he had learned about the MBS from any of his interactions with the defendants.

298. The fact that the first plaintiff was so reluctant to acknowledge that any of his interactions with the defendants added to his own understanding or expertise of the MBS, was concerning.

299. There were other aspects of the first plaintiff's evidence that should be highlighted, which in my view, shed further light on his credibility.

300. When negotiating the terms of the Agreement the first plaintiff was asked to estimate what time he had (and/or would) put into the preparation of the initial ProMBS workshop (the initial investment). He estimated this at 90 hours, including the entire time he had spent by way of attendance at the NVI course.[203] This was a course the first plaintiff undertook to formulate and create his proposed business model, rather than to increase his knowledge or understanding of the MBS. The first plaintiff acknowledged in his evidence that the judging panel at NVI were not doctors and that they were not interested in any medical content – rather their focus was on his business idea and how he would put that idea into practice to make money.

301. There was no legitimate basis for the 'initial investment' in ProMBS to be estimated by reference to the time the first plaintiff spent devoted to developing his 'business model' and/or to increase his skills as a budding entrepreneur. Further, when asked during examination-in-chief how long it had taken him to 'put together' the case scenarios, he said:[204]

> I mean because I was working as a fulltime doctor, it's difficult to say, you know, this many months but whenever I am sitting at home or when I'm working on it, then I used to spend like one hour, two hour here and there. So I must say...and fifty or more than that probably.

302. It is important to remember that the first plaintiff was a general practitioner, working full time at a clinic operated by Primary Health for the duration of his attendance at the NVI course, at the time he entered into the Agreement and at the time of the initial ProMBS workshop.

303. The first plaintiff's evidence as to why he ceased presenting workshops in February 2018 and what role his dispute with Primary Health played in that decision is also important in terms of assessing his credit.[205]

304. The first plaintiff was asked during examination-in-chief as to what happened with his involvement with ProMBS after February 2018. The first plaintiff had been asked by his counsel whether what happened was instigated by AOGP or whether it was his idea. The initial response given by the first plaintiff was to the effect that he had distanced himself from continuing with the workshops because of his poor mood in the aftermath of the fallout and bad mouthing caused by the Publications. It was only when I sought to clarify his response, and whether AOGP had been involved with the decision he made to stop presenting the ProMBS workshops at that time, that he referred to the dispute he had with Primary Health.

305. I will address my findings with respect to this dispute, and what impact this had in terms of decisions made by the first plaintiff to cease presenting the ProMBS workshops, later in this judgment.

306. Further, it is clear from Dr Kelly's evidence and the content of his email to the first defendant dated 25 September 2017, and I find, that the 'fracture blog' was removed from the AOGP website by way of agreement between AOGP and the first defendant, after the first defendant had informed AOGP that this blog copied a quote from a doctor made on the BFD Facebook group page. The first plaintiff was asked why it was removed and said this was removed as a requirement of Primary Health.[206]

307. The 'fracture blog' was important as this was something the first defendant claimed had been taken from the BFD Facebook group page (albeit there was no **evidence** in fact to support that claim)[207]. By his response to that question, I consider the first plaintiff was again deliberately distancing himself from the suggestion that he had used anything he had learned from his interactions with the defendants in the preparation of the initial ProMBS workshop.

308. Having regard to all of these matters, I have significant concerns as to the reliability and credibility of the first plaintiff's evidence. In reaching this conclusion I acknowledge that the first plaintiff did make certain concessions during his evidence (including the examples already given about the lie told in the NVI presentation and the impact his dispute with Primary Care had on his decision to pull back from presenting the ProMBS seminars.)

309. However, my overall impression of the first plaintiff's evidence was that I was being left with an incomplete and unclear account of events. It was only when pressed, or when confronted with evidence to the contrary, that the first plaintiff was prepared to make these significant concessions.

310. Dr Kelly and Ms Cheah were both honest, credible witnesses who gave their evidence in a straight forward and practical manner. On occasions Dr Kelly made it clear that he was uncertain as to the precise course of events and suggested that Ms Cheah may have had a better knowledge of such topic. On those topics, I prefer and accept the evidence of Ms Cheah.

311. Dr Rewal and Ms Ridha Anand both gave very limited evidence, much of which was directed to their observations of the first plaintiff upon learning of the Publications and whether they had noticed any changes in him since then. I accept their evidence, insofar as it relates to their observations of the first plaintiff. I have disregarded any hearsay evidence given by those witnesses.

Findings of Fact on Key Issues

Did the First Plaintiff knowingly pass off the work of BFD as his own?

312. The first defendant cross-examined the first plaintiff at length as to the source of the materials used by him in the initial ProMBS workshop. She put to the first plaintiff various propositions to the effect that he had utilised BFD material in the preparation of that workshop. However, the questions put by the first defendant to the first plaintiff are not evidence, only the first plaintiff's answers to those questions are evidence.

313. There was no evidence that the second defendant holds intellectual property rights which would prevent a competitor from presenting workshops addressing the use of the MBS and/or combination billing in a general sense. The second defendant has no legal monopoly on the delivery of such education.

314. Further, there was no evidence of the defendants' ownership of any intellectual property rights with respect to any specific material.[208]

315. The first plaintiff gave evidence that after arriving in Australia he worked as an Orthopaedics Registrar at the Flinders Medical Centre from 2007 until about 2010, during which period he would have had limited, if any, exposure to the MBS. The first plaintiff worked as a salaried doctor in aged care from 2011 to 2014, during which period he had limited exposure to the MBS, but says that he learned about the aged care numbers.

316. During 2010 and 2011, the first plaintiff worked as an on-call locum, where he learned about the 'after-hours' numbers, and since August 2014 he has worked as a general practitioner. While initially employed as a general practitioner the first plaintiff was under a special exemption, meaning he earned less than other doctors. The first plaintiff gave evidence that to find ways to increase his income he began to look more closely at the MBS during this period. I accept that evidence, noting that a consistent theme from all of the first plaintiff's evidence is to the effect that he is committed to investigating potential opportunities to increase not only his income, but the income of other general practitioners.

317. The first plaintiff claimed to have first used combination billing in 2014/2015. I accept Dr Kelly's evidence that the use of combination billing in practice is common. As such, it is likely and I find that the first plaintiff had used combination billing at times, in his day to day work as a general practitioner, for approximately three years prior to the Publications.

318. The first plaintiff joined the BFD Facebook Group in July 2016.

319. On 17 July 2016 (and therefore prior to commencing the NVI program), he sent a message to David Dahm wherein he stated:

> ...I have an idea which is related to budding GPs and to increase their income...

320. By reference to the content of the NVI presentation delivered on 25 October 2016, I am satisfied that the first plaintiff's Business Model developed during that course had, as its focus,

a plan to offer education with respect to the MBS to general practitioners in partnership with corporate entities.

321. It is possible that the first plaintiff devised the idea to teach general practitioners about the use of the MBS to increase their income from what he read of or learned after joining the BFD Facebook group in July 2016. It is also possible that he joined the BFD Facebook group because he was interested in increasing his knowledge about the MBS, given what he had decided would be the focus of his business model.[209]

322. However, simply increasing one's own knowledge or expertise on a topic through learning from another does not, without more, constitute the use of another's copyright material or the passing off of another's work as one's own.

323. The 'sting' of the defendants' Publications was that the first plaintiff had taken BFD material and used it in the presentation of the initial ProMBS workshop, such that he had 'knowingly passed off the work of BFD as his own'. The sources of such material were said to be the content of the BFD Conference, the BFD Facebook group page and the first plaintiff's personal interactions with the first defendant.

BFD Conference Materials

324. There was no evidence as to the precise content of the materials presented by the first defendant at the BFD Conference in 2017, or indeed, at any other BFD conference, such that a comparison can be made of their content and that of the ProMBS case scenarios.

325. The first plaintiff denied he had used any examples or scenarios in the initial ProMBS workshop which replicated those used by BFD in its conference materials. Despite my reservations as to the first plaintiff's credibility, in the absence of any evidence to rebut that evidence, and in particular, any evidence as to the actual content of the BFD conference materials, it is impossible to make a finding on the balance of probabilities that he did so.

326. The focus of much of the cross-examination of the first plaintiff related to the numerous case scenarios which involved combination billing. However, there was no evidence to support a finding that the first plaintiff used the terminology, 'pack and stack', in the delivery of the ProMBS workshop, being terminology which I accept was utilised by BFD in its 2017 Conference.

327. While the breadth of the first plaintiff's knowledge of the use of combination billing (and the MBS in general) was likely enhanced by his attendance at the BFD Conference, simply learning from another does not, **of itself**, amount to passing off the work of the teacher as that of your own.

Meeting and Personal Interactions with the First Defendant

328. The first plaintiff's evidence is the only evidence before the court as to what occurred at his meeting with the first defendant on 7 April 2017. As previously stated, I find that it is likely

that there was some discussion with respect to the MBS during that meeting, given the first plaintiff's particular interest in that topic at that time.

329. After that meeting, the first defendant sent the first plaintiff three 'cheat sheets', again indicative of the fact that the MBS was a topic discussed during that meeting. Despite my reservations as to both the first plaintiff's reliability and credibility, I accept his evidence, in the absence of any evidence to the contrary, that two of those 'cheat sheets', namely those with respect to Cancer Care Case Conferences (Items 871 and 872) and Focus Psychological Strategies (Items 2721, 2723, 2725 and 2727)[210] were downloads of extracts from the MBS, being publicly available documents.

330. Insofar as any of the scenarios utilised by the first plaintiff in the initial ProMBS workshop referenced these materials and/or item numbers, the evidence fell significantly short of establishing that this amounted to the use of 'BFD's work'. For example, there was no evidence that any such scenario used by the first plaintiff referencing these item numbers was the same as (or even contained similarities with) any material contained in any BFD conference, or on the BFD Facebook group page.

331. While the first defendant may have alerted the first plaintiff to the existence of these publicly available materials, and thus the potential for these item numbers to be better utilised by practitioners, there was no evidence, for example, that when the first defendant met with the first plaintiff she explained to him how best to use these item numbers in practice, and that he then used what she told him to create any such scenarios. I simply do not have any evidence of precisely what the first defendant told the first plaintiff at that meeting. Her email to the first plaintiff accompanying these documents simply stated 'here are some ones that people often miss/don't know about'.

332. Even if the first plaintiff did not know about the possible use of these item numbers absent the first defendant informing him of their existence, in my view the first plaintiff's subsequent creation of any scenarios or examples using these item numbers for use in the ProMBS workshop does not amount to 'knowingly passing off the work of BFD as his own'.

333. The third 'cheat sheet' sent to the first plaintiff by the first defendant after their meeting is entitled 'Disability notes' and is in a different form to the other two 'cheat sheets'. For example, there is no specific reference to any particular item number(s) and the font used in the document is slightly different, such that it does not, on its face, present as if it is an extract from the same source as the other two 'cheat sheets'.[211]

334. In the absence of the first defendant giving evidence as to the origin of this document, or how it was created, I cannot be satisfied on the balance of probabilities that she was the author of that document, or indeed, how that document came to be in the first defendant's possession. Insofar as it is, in fact, simply a copy of a publicly available document, the same considerations arise as with the other two cheat sheets.

335. Further, there is simply not enough evidence for me to be satisfied that any case scenario used by the first plaintiff referencing health assessments[212] was the same as (or even contained similarities with) any material contained in any BFD conference, or on the BFD

Facebook group page, or was an example utilised by the first defendant when she spoke to the first plaintiff during their meeting.

BFD Facebook Group Page

336. There was only limited evidence as to the content of the BFD Facebook group page.
337. In cross-examination, the first plaintiff was asked to outline what type of combination billing he had used in practice. He gave examples of combining a procedure with a consultation. He was asked when it was that he had first learned about combination billing at a higher level, namely bringing multiple consultations into the one process, such as mental health combinations with normal consultations. His response was:[213]

> I think it's more like a...I cannot remember 100% for sure but yes-

338. When questioned thereafter as to whether he had asked a question on the BFD Facebook group page about combining items 2713 and 23 together, he answered 'I might have, yes'.[214]
339. Case scenario 13 of the initial ProMBS workshop involves the use of items 23 and 2713 in combination.[215]
340. If the first plaintiff did ask such a question, that of itself does not mean his subsequent use of a case scenario in the ProMBS workshop using that combination of item numbers necessarily amounts to 'passing off the work of BFD as his own'. Further, there is no evidence as to the precise terms of the question asked by the first plaintiff, or of the responses provided via the forum of the BFD Facebook group page. If the response contained, by way of an example, the same example used by the first plaintiff in Scenario 13, then that would amount to 'passing off the work of BFD as his own'. However, there was simply no such evidence.
341. There was evidence that the first plaintiff 'followed' a line of posts on the BFD Facebook group page discussing the use of health care plans. However, that evidence falls short of establishing that insofar as any of the case scenarios in the initial ProMBS workshop referenced the use of health assessments, he has 'passed off the work of BFD as his own'.
342. I find it is likely that the first plaintiff gained a better understanding of the use of health care plans from his involvement with the BFD Facebook group. He may have also learned, for the first time, about combining various consultations to use together in combination, being the 'higher level' combination billing which formed the basis for some of the first defendant' cross-examination of the first plaintiff. However, I am not satisfied that the first plaintiff's use of such knowledge to create his own case scenarios amounts to 'passing off the work of BFD as his own', particularly when understood in the context of the defendants' claim that what the first plaintiff had done was to use material held under copyright by BFD by way of content in the initial ProMBS workshop.

Fracture Blog

343. At trial, the defendants submitted that the plaintiffs had used information from the BFD Facebook group page and reproduced it in a blog promoting the ProMBS seminars.

344. The first plaintiff was cross-examined as to the use of an example on his blog about seeing multiple patients over a weekend with fractured ribs from football injuries:[216]

17. So on the ProMBS website the initial introduction to ProMBS stated that you had missed 3-4 fractured ribs per weekend, is that correct.

1. Probably couple. I've seen up to five in a week.

17. In a week.

1. A week as well. But if they are like in some kind of a sporting event I've seen fractures.

17. There was accusations that that content for the website had come from the Business for Doctors page and the content was removed.

OBJECTION: MR SMITH OBJECTS

17. Can you explain why it was removed.

MR SMITH: Again, objecting that where are these accusations coming from, and who is making these accusations?

17. I'm asking why it was removed off the page. So, the content has now gone off the page.

1. It was removed because of -

HER HONOUR: She can ask that question.

1. Yeah, it was removed, because Primary has told me that my name cannot be used anywhere, when I was working. So, that time they've taken it off and since then I don't think it's there. And I haven't even bothered to look into that website since.

345. The manner in which the first plaintiff answered these questions was non-responsive and evasive. Given the first plaintiff's employment history as at 2017, I doubt that he had, in fact 'missed 3-4 fractured ribs per weekend'.

346. However, the relevant blog was not in evidence. The BFD material which the defendants argued was in fact the source of that example was not in evidence.

347. The assertion made by the first defendant in the Second Email that the blog plagiarised a doctor's quote from the BFD Facebook Group page is not evidence of the truth of that assertion, it is only evidence that such an assertion was made by the first defendant.

Summary

348. I find that some of the first plaintiff's knowledge about the MBS and combination billing came from what he learned from the defendants.

349. However, absent evidence that the **case scenarios** utilised in the initial ProMBS workshop replicated and/or quoted from those used in the BFD Conference, or the BFD Facebook group page, or were obtained by the first plaintiff from his interactions with the first defendant, there is insufficient evidence to support a finding that the first plaintiff knowingly passed off the work of BFD as his own.
350. Further, there is insufficient evidence to support a finding that the first plaintiff took any materials held by BFD 'under copyright' and used them in the initial ProMBS workshop.

Plaintiff's Expertise in the MBS at the time of the Publications

Plaintiff's use of the MBS before July 2016

351. As previously stated, I accept that the first plaintiff had used the MBS and combination billing in his role as a general practitioner before he joined the BFD Facebook group in July 2016.
352. I also accept his evidence and find that from time to time, while working as a general practitioner from August 2014, the first plaintiff liaised with colleagues as to the appropriate use of certain item numbers, either alone, or in combination and that from time to time he had recourse to the MBS resources which were and are publicly available either online or in book form. I also accept the first plaintiff's evidence and find that he had undertaken training on the MBS offered through Primary Care and the PHCI.
353. However, when this experience is considered in perspective, as at **July 2016**, the first plaintiff's exposure and experience in using the MBS was limited.

Preparation of Case Scenarios

354. The first plaintiff gave evidence that he started writing the case scenarios in July 2016. I do not accept that evidence. There was simply no need for the first plaintiff to start writing the case scenarios then, having regard to his evidence that the NVI course assessors were not doctors, or interested in medical content.
355. At that stage, he was still in the very early stages of devising his business model. He was working full time in a demanding role at Primary Health, while also attending the NVI course, being a course designed to improve his entrepreneurial skills. The fact there were no such case scenarios utilised in the NVI presentation is also telling – even allowing for the fact the focus of the assessment was on the business model, not its clinical accuracy or content.
356. However, the documentary evidence supports the first plaintiff's evidence that by November 2016, he was actively seeking business partners to deliver his business model. Further, Dr Kelly gave evidence, which I accept, that when he first met with the first plaintiff on 22 March 2017, he believed the first plaintiff shared one or two examples of the case scenarios he was working on, and that he started sending further examples through to AOGP fairly soon after they agreed to work together. In this respect, I note the Confidentiality Agreement was executed on 9 April 2017 and the Agreement executed in May 2017.

357. While it is possible the first plaintiff devised a small number of case scenarios while completing the NVI course, I find it is likely that having successfully completed the course in late October 2016, the first plaintiff then began working much more diligently on the specific content of his intended workshops, so that he had something to show the various corporate partners who he hoped would agree to partner with him in the delivery of such workshops.

358. In accordance with Dr Kelly's evidence, I find that from a period commencing around mid-April 2017, the first plaintiff was actively involved in the preparation of the case scenarios, and that he continued to work on those scenarios, including in the presence of his brother-in-law, Dr Rewal in around June, July and August 2017, until shortly prior to the delivery of the initial ProMBS workshop on 2 September 2017.

359. The Agreement foreshadowed a free webinar being held prior to the initial ProMBS workshop. I accept the first plaintiff's evidence that this webinar was held about a month or a month and a half before the initial workshop, and that as a result there were changes or corrections made to some of the case scenarios. As such, I find that a large percentage of the case scenarios must have been completed by approximately mid-July 2017.

360. I am satisfied that having made the decision to develop his business model, the first plaintiff did work hard at increasing his knowledge of and familiarity with the MBS from mid to late 2016, including actively reading the publicly available MBS materials, making enquiries of askMBS, and his interactions with BFD.

361. I find that in doing so, the first plaintiff gathered sufficient knowledge about the MBS to devise the case scenarios he then used in the initial ProMBS workshop.

362. I consider it likely that a large majority of the case scenarios were prepared in the period immediately after the first plaintiff signed the Confidentiality Agreement with AOGP, and therefore from around April to July 2017.

Level of Expertise

363. In cross-examination, the first defendant suggested to the first plaintiff that he was teaching the MBS item numbers 'as an expert'. The first plaintiff's response was 'I never said I'm an expert'.[217]

364. The following exchange occurred in cross examination of the first plaintiff:[218]

17. Do you believe that you have a better knowledge than most GPs because of your extensive studies since 2014.

1. I never said I'm an expert.

17. Do you believe that you have more knowledge than the average GP and that's why you're providing this information in a workshop forum.

1. I have a feeling that a lot of people are not well educated and they're not correctly - they're not aware of what are the restrictions around it so that's why I developed this program.

17. Would you say that your knowledge is below average, average or above average.

1. My knowledge is above average.

365. Dr Kelly was asked if he considered whether the case scenarios were written by a person with above average knowledge of the MBS and his response was 'I would say so, yes'. However, Dr Kelly was not called as an expert witness and there was no evidence that he had any particular expertise in the MBS.

366. In the Second Email, the first defendant outlined several examples that she claimed supported her submission that the first plaintiff was lacking in expertise and knowledge with respect to both the MBS and the Health Act at the time of the Publications.

367. The first example related to alleged difficulties the first plaintiff encountered in obtaining a Medicare provider number. There was no evidence on this issue at trial.

368. The second example was that the first plaintiff had allegedly followed posts on the BFD Facebook group page wherein other members had enquired if MBS item numbers could be used in certain circumstances.

369. There a screenshot of a post from the BFD Facebook group page wherein the first plaintiff's name appears adjacent the letter 'F' after a post made enquiring about the use of health care plans.[219] The first plaintiff agreed with a proposition put to him in cross-examination that by marking 'F' next to that post, he was following it, and waiting to be notified when others responded to it. However, he also explained that he intended to reply to the post later but subsequently saw that others had replied, and said that he was aware of the billing requirements of a team care arrangement at that time.[220]

370. The fact the first plaintiff had time to read the post and 'follow it' suggests that he may have also had time to post a response with the appropriate answer, if he knew it, as he claims he did. However, this is a very tenuous basis upon which the first plaintiff's expertise in the MBS can be gauged. I mention this example only for the sake of completeness and do not consider it relevant to my analysis of his expertise.

371. A further example was the first plaintiff's response made to another post on the BFD Facebook group page on 6 September 2017 about the frequency of billing of case conferences.[221] It was submitted that the first plaintiff's response was inaccurate, thus demonstrating his lack of expertise. However, in the absence of there being any admissible evidence as to how many case conferences can be billed per patient per year, and what are the ramifications if a medical practitioner exceeds that number, this evidence does not assist me in making findings as to the first plaintiff's expertise at the time he posted that response.

372. In the same category, the first defendant submitted that the first plaintiff had provided an incorrect response on the BFD Facebook group page to a post enquiring whether an HHMR could be done at a patient's home. The first plaintiff was not cross-examined on this issue. There was no admissible evidence as to the accuracy or otherwise of the first plaintiff's response. As such, this example does not inform me as to the first plaintiff's expertise.

373. However, I am satisfied that there is evidence to support the first defendant's submission that the first plaintiff was not an expert in either the MBS or the Health Act at the time of the Publications.

374. On 14 August 2017, the first plaintiff made the 80/20 Rule post on the BFD Facebook group page. I have outlined the relevant post and the evidence on this issue at paragraphs 91-99 herein.

375. I accept the evidence of Dr Kelly that the purpose of the 80/20 Rule is to identify possible over-servicing by doctors, that generally doctors who breach the rule are over-servicing and that applications for exemptions for special circumstances usually fail. The first plaintiff agreed with a proposition that a breach of the rule would result in a professional review of a practitioner's services.

376. The first plaintiff explained that by his post, rather than endorsing a breach of the rule, he was merely expressing the view that one should not worry about such a breach if they could justify it. I accept that evidence, given the language used in the post. However, after it was suggested to the first plaintiff in cross-examination that a practitioner who exceeded the 80/20 Rule had engaged in inappropriate practice he said:[222]

> Thanks for enlightening. Again, yes, I was made aware about this one so I read about this and, as I said, it was just a thought that why should we worry.

377. The ramifications for doctors who breach the 80/20 Rule are serious. In my view, the casual and somewhat flippant nature of the first plaintiff's post indicates a lack of understanding of those serious ramifications and therefore a lack of a proper understanding of the 80/20 Rule at the time he made the post, namely on 14 August 2017.

378. Aspects of the evidence given by the first plaintiff and Dr Kelly at trial assist me to better understand the first plaintiff's depth of understanding and knowledge of the MBS at the time of the Publications. However, I am mindful that the first plaintiff has stepped back from presenting the ProMBS workshops and as such, his knowledge **at trial** as to specific matters pertaining to the MBS may not reflect the knowledge he held as at the time of the Publications, when he was focussing on the MBS and it was at the forefront of his mind. Further, I accept the evidence of both the first plaintiff and Dr Kelly that the text of the slides containing the case scenarios was supplemented by additional verbal advice.

379. As such, I accept that some of the criticisms made of the first plaintiff with respect to his current ability to answer MBS specific questions is irrelevant to a consideration of his level of expertise as at September 2017.

380. However, the first plaintiff gave evidence that the criteria that needed to be satisfied for a patient to qualify for a mental health care plan was that set forth in DSM 5. He was asked whether he was aware that the MBS criteria for mental health was actually ICD10, not DSM 5 and his answer was:[223]

> I think I'm aware of it but it just slipped my mind then.

381. The first plaintiff said that he could not, at present, remember the exact wording from the MBS online book. He acknowledged that he was a doctor that did mental health care plans.[224]

382. The following exchange then occurred in cross-examination:[225]

17. But you can't remember that it's the ICD10.

1. I cannot remember the full version of the ICD10.

383. The first plaintiff's answer to this question was non-responsive. He was not being asked to recite ICD10 or even to refer to specific aspects of it. The line of questioning related to whether he knew that ICD10 was the relevant mental health criteria, rather than DSM 5 as he had stated. In my view, this was a poor attempt by the first plaintiff to justify a lack of knowledge of the relevant criteria. The use of mental health care plans was a particular area of interest to the first plaintiff in early 2017 and he acknowledged that he used them in practice.

384. During cross-examination, the first plaintiff and Dr Kelly acknowledged that the MBS related content of some of the case scenarios was inaccurate (rather than the clinical content). In that respect, I refer to the evidence given by the first plaintiff (and Dr Kelly) with respect to case scenarios 30, 32 and 43. Although the case scenarios were reviewed and in certain circumstances corrected after the initial ProMBS workshop, if the first plaintiff was an appropriate expert in this field, noting he devised the case scenarios, one would not expect three such errors in the content of those materials.

385. In cross-examination, the first plaintiff was unable to explain the Multiple Services Rule. While he claimed to have previously had such knowledge, Dr Kelly considered this rule should be common knowledge for medical practitioners who do procedures. The first plaintiff used his experience doing procedures and charging for them to explain his prior use of combination billing in practice. I consider the first plaintiff's inability to recall that rule demonstrates a lack of expertise in the MBS and the Health Act.

386. Further, both Dr Kelly and Ms Cheah gave evidence that they expected the clinical content of the case scenarios to be accurate. I accept that evidence.

387. Several of the scenarios contained clinical errors. More importantly, the first plaintiff did not have an understanding of the necessity for such clinical accuracy, instead focussing only on the MBS learning point in each case scenario. This is indicative of the first plaintiff's inexperience in the provision of such education.

Summary

388. The case scenarios were prepared over a relatively short period of time, and in the context of the first plaintiff having had modest exposure to the MBS in his short working life as a general practitioner in Australia. The first plaintiff continued to work full time for Primary Health while devising the case scenarios, meaning he had limited available time to devote to the task at hand.

389. I find that although the first plaintiff had some understanding of the MBS, sufficient to devise the case scenarios, when the evidence is considered as a whole, I am satisfied that it

demonstrates, and I find, that at the time of the Publications, the first plaintiff did not have the depth of knowledge and understanding of the MBS and the Health Act, or experience associated with their use in practice, to be considered an expert in those areas.

Claim in Defamation – Issues in Dispute - Liability

390. Defamation is the tort of damaging another person's reputation by the publication of defamatory material. It comprises the following legal elements:

1. There must be a communication or publication;
2. The communication or publication must be to a third party;
3. The communication or publication must bear a defamatory meaning; in other words, the words complained of by the plaintiff must be reasonably capable of conveying any or all of the defamatory imputations as alleged;
4. The plaintiff must be clearly recognised or identified as the person so defamed; and
5. There must be no lawful excuse to justify the defamation.

391. The claim in defamation is pleaded for and on behalf of only the first plaintiff, albeit the relief sought in Part 3 of the Second Statement of Claim makes no specific reference to whether damages for defamation are sought by the first and/or second plaintiff.

392. The second plaintiff is a corporation. Pursuant to s 9 of the Act, a corporation has no cause of action for defamation in relation to the publication of defamatory material about it, unless the corporation was an 'excluded corporation' (as defined) at the time of publication. There was no evidence led on this issue.

393. I have proceeded on the basis that the claim in defamation is pursued solely by the first plaintiff.

Publication – to a Third Party

394. Publication is a 'bilateral' act, in that it is not enough for material to be disseminated; it must also be comprehended by one or more persons other than the plaintiff.

395. In *Dow Jones & Company Inc v Gutnick,*[226] the majority (Gleeson CJ, McHugh, Gummow and Hayne JJ) said:

> Harm to reputation is done when a defamatory publication is comprehended by the reader, the listener, or the observer. Until then, no harm is done by it. This being so it would be wrong to treat publication as if it were a unilateral act on the part of the publisher alone. It is not. It is a bilateral act - in which the publisher makes it available and a third party has it available for his or her comprehension.

396. Further, in *Dow Jones* the majority held: [227]

> It is only when the material is in comprehensible form that the damage to reputation is done and it is damage to reputation which is the principal focus of defamation, not any quality of the defendant's conduct. In the case of material on the World Wide Web, it is not available in comprehensible form until downloaded on to the computer of a person who has used a web browser to pull the material from the web server. In the case of material on the World Wide Web, it is not available in comprehensible form until downloaded on to the computer of a person who has used a web browser to pull the material from the web server.

397. As such, publication occurs when material that has been uploaded or posted on the internet is accessed and/or downloaded.

398. In *Al-Amoudi v Brisard*, [228] Gray J, sitting in the High Court of England and Wales, held that there is no presumption of law that substantial publication occurs by the mere uploading of material to the internet. The publication must be established affirmatively by evidence showing that individual persons accessed the material or a sufficient platform of facts must be established making it possible for the court to draw the inference of publication.

399. In *Sands v Channel Seven Adelaide,* Bleby J followed *Al-Amoudi* in holding that there is no presumption of substantial publication in respect of internet publications. His Honour said that '[I]t is for the plaintiff to prove that the material in question was accessed and downloaded.'[229]

400. I am satisfied from the evidence of Ms Anand and Dr Rewal and an assessment of the screenshots containing images of the Posts and Comments, that those publications were accessed, in each instance, by a third party (or parties) other than the first plaintiff.

401. I am satisfied from the evidence of Dr Kelly that the First Email was published to him, and from the evidence of Dr Kelly and Ms Cheah that the Second Email was published to them.

402. The defendants admit a phone call was made to Ms Rauda (and therefore published).

Publication – By Whom/Responsibility

Posts

403. In the Defence, the defendants:

. admit the first defendant is the sole director of the second defendant.[230]

. admit that the second defendant is a company registered in South Australia.[231]

. admit that they (collectively) operate the BDF Facebook group, that the group has approximately 9,400 members[232] and that it is closed to those who are not medical practitioners.[233]

. plead that only registered medical practitioners are invited to (and can join) as participants. [234]

. plead that the first defendant approves membership of the BFD Facebook group when a person produces evidence that they are a registered medical practitioner.[235]

. plead that the BFD Facebook group provides a forum for the confidential sharing of information relating to and affecting members of the Facebook group in their practice as medical practitioners.[236]

. admit that the Posts were published by the first defendant on the BFD Facebook group page. [237]

404. I am satisfied that insofar as there has been publication of the Posts (and Comments made in response thereto) by the first defendant, she did so not only in her personal capacity but as the sole director and undisputed guiding mind of the second defendant, whose Facebook group page was the forum for any such publication.

405. I am satisfied that there was publication of the First, Second and Third Posts by the defendants.

Comments

406. The Comments were not made by the first defendant, but they were uploaded by others on the BFD Facebook group page, being a page operated by the defendants. The issue for determination is whether either defendant is liable as a secondary publisher of the Comments.

407. The distinction between primary and secondary publication and the elements of each were considered by Blue J in *Duffy v Google*:[238]

> At common law, a person who participates in the publication of a work is a publisher. In the simplest case of defamatory words spoken by A to B or written in a letter by A given to B, A is the creator, producer, director and conveyor and the sole publisher of the defamatory words. In more complex cases, publication is a process that may for example be instigated by a creator, produced by a second person, directed by a third person and conveyed by a fourth person. Participants in the publication of a written work such as a book or newspaper include the author, publisher and vendor of the work.
>
> Primary and Secondary participants
>
> At common law, a distinction is drawn between a primary or principal participant and a secondary or subordinate participant. A primary participant is liable for a publication regardless of whether she or he knows or ought to know of the defamatory matter within the work. A

> secondary participant is not liable for a publication if he or she did not know and could not with the exercise of reasonable diligence have known of the defamatory matter.
>
> ...
>
> The fact that a search engine operator or website forum host is only a secondary publisher is now well established.
>
> Under the secondary publisher doctrine, a secondary participant is not liable for a publication if he or she did not know, and could not with the exercise of reasonable diligence have known, of the defamatory matter. The onus of proof lies on the secondary publisher to prove no actual or constructive knowledge of the defamatory matter.
>
> (citations omitted)

408. The defendants did not file a Defence to the Second Statement of Claim, which introduced the allegations pertaining to the Comments.
409. When the defendants published each of the First, Second and Third Posts, they did so knowing that attached to each such post was either a Comments box and/or a facility for readers to 'like' or 'reply' to the post, and that any such comments, replies or likes (if made) would be available to BFD Facebook group members to access and/or read.
410. Although there was limited evidence on this issue, it is apparent from reading the screenshots of the Posts and Comments that the first defendant had the ability to control what was published on this forum, in the sense that she could remove members from the Group and/or 'blank out' information posted.
411. I am satisfied that as the operator of the BFD Facebook Group page, the first defendant assumed the responsibility of monitoring what comments were posted on that page and to remove anything inappropriate.
412. From the screenshots, I am satisfied that each of the Comments in the terms as pleaded, was published. I am further satisfied that in providing the forum for which the Comments were made, the defendants participated in the publication of the Comments as secondary publishers.
413. A secondary publisher can avoid liability for such publication if they establish that they did not know, and could not with reasonable diligence have known, that the offending words were within the relevant material.
414. From the screenshots of the Comments, it is apparent that the first defendant responded by post to at least one of the Comments (and to further comments made by others with respect to certain of the Comments).[239] The material reads as if it was a running communication between the various BFD Facebook group members, including the first defendant.

415. In my view, it is inconceivable that the first defendant (and therefore the second defendant) did not know about the existence of the Comments and/or of the defamatory matter contained therein.

416. The defendants are liable as secondary publishers of the Comments.

Emails

417. The first defendant identified herself in the First Email as the director of the second defendant. I am therefore satisfied that the publication of the First Email was made by the first defendant in her capacity as director of the second defendant such that both defendants are responsible for the publication of that email.

418. Although the first defendant did not include that same information in the Second Email, it is clear from the evidence that this email was sent by the first defendant is response to the request by Dr Kelly, via email dated 11 September 2017, for her to provide evidence of the allegations contained in the First Email. Further, the defendants admit that the Second Email was sent by the first defendant in her capacity as director of the second defendant.[240]

419. I am therefore satisfied that the publication of the Second Email was made by the first defendant in her capacity as director of the second defendant such that both defendants are responsible for the publication of that email.

Phone Call

420. The defendants admit that the first defendant made the Phone Call to Ms Rauda and that she did so in response to an email sent by AOGP to recipients interested in attending the plaintiff's MBS seminar in Melbourne.

421. Although there was limited admissible evidence as to the content of the Phone Call, the subject of the Phone Call was that of the plaintiffs and AOGP running MBS seminars, and thus undertaking an activity in competition with the second defendant. Further the Phone Call was made in the context of the first defendant having sent the First and Second Emails in her capacity as director of the second defendant. I am therefore satisfied that the Phone Call was also made by the first defendant in her capacity as the director of the second defendant and that as such, both defendants are responsible for its publication.

Identification of the First Plaintiff

422. The first plaintiff was expressly named in the First Post, the First Email and the Second Email.

423. By reference to the admission made by the defendants,[241] the Phone Call was made by the first defendant in relation to an email which had been sent to recipients interested in attending a ProMBS workshop in Melbourne. As such, I am satisfied that the Phone Call identified the first plaintiff.

424. As outlined in *Bruce v Odhams Press Ltd*:[242]

> Defamatory statements which are in the air, as it were, and do not appear by their words to refer to the plaintiff, have got to be made referable to the plaintiff by reason of special facts and circumstances which show that the words can be reasonably construed as relating to the plaintiff.

425. Although the first plaintiff was not expressly named in the Second Post, and only his first name was used in the Third Post, having regard to the context, forum, content and timing of those two posts, I am satisfied that a reasonable reader would construe the Second Post as relating to the subject of the First Post, who was identified therein as the first plaintiff. I am further satisfied that a reasonable reader would construe the Third Post as relating to both the first plaintiff's public response, which identified him, and the First and Second Posts.

426. None of the Comments expressly named the first plaintiff, however, when read in context, being part of the same Facebook thread as the First, Second and Third Posts, I am satisfied that a reasonable reader would construe those publications as relating to the subject of the First Post, who was identified therein as the first plaintiff.

427. The first plaintiff is clearly recognised or identified as the person referred to in each of the Publications.

Are the Publications Defamatory?

428. The test for whether a published matter is capable of being defamatory is what ordinary reasonable people would understand by the matter complained of.[243]

429. In *Jones v Skelton*[244], the Privy Council said:

> It is well settled that the question as to whether words which are complained of are capable of conveying a defamatory meaning is a question of law, and is therefore one calling for decision by the Court. If the words are so capable then it is a question for the jury to decide as to whether the words, do, in fact, convey a defamatory meaning. In deciding whether words are capable of conveying a defamatory meaning the Court will reject those meanings which can only emerge as the product of some strained or forced, or utterly unreasonable interpretation ... the test of reasonableness guides and directs the Court in its function of deciding whether it is open to a jury in any particular case to hold that reasonable persons would understand the words complained of in a defamatory sense.

430. The question of whether an allegation concerning a person's conduct or capacity in his profession is defamatory is to be assessed against the general test for defamatory material.

431. In *Radio 2UE Sydney Pty Ltd v Chesterton,* the majority of the High Court, said:[245]

> The concept of "reputation" in the law of defamation comprehends all aspects of a person's standing in the community. It has been observed that phrases such as "business reputation" or "reputation for honesty" may sometimes obscure this fact.
>
> In principle therefore the general test for defamation should apply to an imputation concerning any aspect of a person's reputation. A conclusion as to whether injury to reputation has occurred is the answer to the question posed by the general test, whether it be stated as whether a person's standing in the community, or the estimation in which people hold that person, has been lowered or simply whether the imputation is likely to cause people to think the less of a plaintiff.
>
> An imputation which defames a person in their professional or business reputation does not have a different effect. It will cause people to think less of that person in that aspect of their reputation.
>
> ...
>
> The general test for defamation is relevant to all imputations which are said to have injured a plaintiff's reputation in some respect. The likelihood that the ordinary reasonable person may think the less of a plaintiff because of the imputations is assessed by reference to that person's general knowledge and their knowledge of standards held by the general community, as they may apply to what is said about the plaintiff. Because such a person can be expected to apply the standards of the general community, he or she may be described as "decent". The standards are not to those of a moral or ethical kind. That a particular imputation may not require the application of a community standard does not render the general test inapplicable. The inquiry as to the effect upon reputation remains.

432. In *Trkulja v Google LLC*, the High Court observed:[246]

> The ordinary reasonable person is not a lawyer who examines the impugned publication over-zealously but someone who views the

> publication casually and is prone to a degree of loose thinking. He or she may be taken to "read between the lines in the light of his general knowledge and experience of worldly affairs", but such a person also draws implications much more freely than a lawyer, especially derogatory implications, and takes into account emphasis given by conspicuous headlines or captions. Hence as Kirby J observed in *Chakravarti v Advertiser Newspapers Ltd*, '[w]here words have been used which are imprecise, ambiguous or loose, a very wide latitude will be ascribed to the ordinary person to draw implications adverse to the subject". (citations omitted)

433. The mode or manner of publication is a relevant consideration, and the context in which the publication is made is, of course, relevant in determining what a fair-minded ordinary reasonable person in the general community would understand the published words to mean.

434. In *Roberts v Rossiter*[247] the Full Court of the South Australian Supreme Court affirmed the principle that an implication may be defamatory whether or not it is believed by the person to whom it is published.

435. The plaintiffs' claim that the Publications have the following natural and ordinary meanings, namely that the first plaintiff:[248]

1. is dishonest and untrustworthy;
2. has broken the law;
3. is unethical, or has acted unethically;
4. has knowingly engaged in misleading and deceptive conduct;
5. has knowingly passed off the work of BFD as his own;
6. has stolen the first defendant's or the second defendant's intellectual property;
7. is not knowledgeable nor fit to be running seminars in respect of Medicare billing;
8. has acted recklessly or fraudulently regarding Medicare;
9. has acted recklessly or fraudulently regarding his taxation obligations;
10. acts only in his own interests;
11. is lacking in judgment;
12. is a criminal; and
13. is a scumbag.

436. Turning to each of the Publications, noting only the alleged content of the Phone Call is in dispute:

First Post

437. I consider the ordinary reasonable reader would inevitably conclude from reading the First Post that the first plaintiff had stolen material held under copyright by the second defendant (being material he had obtained from either attending a BFD conference, or from the First

Defendant or from information shared from the BFD Facebook group page), and had used that material when presenting workshops, for profit, in Adelaide under the name of the second plaintiff.

438. The use of another person's intellectual property constitutes a statutory offence. I am satisfied that the ordinary reasonable reader of the First Post would conclude, from reading the First Post, that the first plaintiff is dishonest and untrustworthy,[249] has broken the law,[250] is unethical or has acted unethically,[251] has knowingly passed off another's work as his own,[252] has stolen the first or second defendant's intellectual property,[253] acts only in his own interests (in that he is willing to break the law for his own personal financial advantage)[254] and is lacking in judgment.[255] I am satisfied that such imputations arise from the First Post and are defamatory of the first plaintiff.

Second Post

439. The conclusions and imputations that arise from the First Post, also arise from the Second Post. In addition, the use of the terminology 'he stole the IP', conveys the imputation that the first plaintiff is a criminal.[256]

440. The imputations that arise from the Second Post are clearly defamatory of the first plaintiff.

Third Post

441. The same conclusions and imputations that arise from the Second Post, also arise from the Third Post, and are defamatory of the first plaintiff.

Comments

442. Dealing with each of the Comments; I am satisfied that when viewed in context, an ordinary reasonable reader of each of the Comments would conclude as follows:

1. From reading the First Comment – that the first plaintiff had breached copyright and that therefore, the first plaintiff is dishonest and untrustworthy;[257] has broken the law,[258] is unethical, or has acted unethically,[259] has knowingly passed off the work of BFD as his own, [260] has stolen either the first or second defendant's intellectual property,[261] acts only in his own interests[262] and is lacking in judgment.[263]

2. From reading the Second Comment - that the first plaintiff had stolen and used the defendants' intellectual property, and therefore the same imputations arise from this Comment as arise from the First Comment. In addition, an imputation arises from this comment that the first plaintiff is a criminal.[264]

3. From reading the Third Comment - that the first plaintiff had breached the second defendant's copyright and therefore the same imputations arise from this Comment as arise

from the First Comment.

4. From reading the Fourth Comment – that the first plaintiff was rude and had taken advantage of the second defendant's Facebook group page. The imputations that arise from this Comment are that the first plaintiff is dishonest and untrustworthy,[265] is unethical or has acted unethically,[266] acts only in his own interests[267] and is lacking in judgment.[268]

5. From reading the Fifth Comment – that the first plaintiff had disrespected the first defendant in that he had used knowledge she had shared with him. The imputations which arise from this comment are that the first plaintiff is dishonest and untrustworthy[269] and is lacking in judgment.[270]

6. From reading the Sixth Comment – that the first plaintiff was a scumbag, namely an evil and contemptible person. The imputations that arise from this comment are that the first plaintiff is dishonest and untrustworthy,[271] is unethical, or has acted unethically,[272] acts only in his own interests,[273] is lacking in judgment[274] and is a scumbag.[275]

7. From reading the Eighth Comment – that the first plaintiff was not the type of person who would apologise if he was in error or had made a mistake. From this comment, the imputation arises that the first plaintiff is lacking in judgment.[276]

443. The imputations which I have identified as arising from the Comments are defamatory of the first plaintiff.

444. I am not satisfied that any of the defamatory imputations as pleaded arise from the Seventh Comment.

First Email

445. I consider the ordinary reasonable reader of the First Email would inevitably conclude that the first plaintiff had stolen material held under copyright by the second defendant, and had used that material in the presentation of an MBS workshop.

446. The same conclusions and imputations that arise from the Second Post, also arise from the First Email and are defamatory of the first plaintiff.

Second Email

447. The Second Email is detailed and contains numerous allegations of incompetence and lack of knowledge on the part of the first plaintiff.

448. By the natural and ordinary meaning of the words used in the Second Email, I am satisfied that the imputations that arise from the First Email, also arise from the Second Email. In addition, the following imputations arise, namely; that the first plaintiff knowingly engaged in misleading and deceptive conduct in that he 'misrepresents himself as an expert',[277] is neither knowledgeable or fit to be running seminars in respect of Medicare billing[278] and that he

endorses the breaking of taxation laws and over servicing of patients (or, put another way, that he has acted recklessly or fraudulently regarding Medicare and his taxation obligations).[279]

449. These imputations are clearly defamatory of the first plaintiff.

Phone Call

450. I note my earlier findings at paragraphs 204-206 herein. The defendants admit the Phone Call included a statement that 'AOGP's reputation is going to be ruined in her (the first defendant's) eyes'. I am satisfied that the imputation that arises from the Phone Call is that the first plaintiff is a person of poor reputation, such that in associating itself with the first plaintiff, AOGP will destroy its own reputation. This imputation is defamatory of the first plaintiff.

451. Such imputation is not expressly pleaded, however I am satisfied that it is of the same shade or nuance as the imputations pleaded at paras.15.1, 15.2 and 15.3 of the Second Statement of Claim.

Defences – Pleadings/Law

452. The defendants bear the onus of establishing any defence as pleaded on the balance of probabilities.[280]

453. The defendants plead that:

. insofar as the imputation pleaded at paragraph 15.5 of the Statement of Claim (namely that the first plaintiff 'has knowingly passed off the work of BFD as his own') is conveyed by any of the Publications, the imputation is true or substantially true.[281]

. insofar as the First, Second and/or Third Posts and/or the First and/or Second Emails give rise to any imputations as pleaded, the imputations are subject to qualified privilege either under the common law and/or pursuant to s 28 of *Defamation Act 2005* (the Act).[282]

. insofar as the Publications give rise to any of the imputations as pleaded (save for the imputation pleaded at paragraph 15.5), the imputations were an expression of opinion or were in the nature of fair comment.[283]

454. Pursuant to s 22 of the Act, a defence under the Act is in addition to any other defence or exclusion of liability available to the defendants apart from under the Act, including under the general law.

Defence of Justification

455. At common law, it is a defence if the imputations complained of are true in substance and in fact.

456. As outlined in *Chase v Newsgroup Newspapers Ltd*:[284]

> For such a plea to succeed, there must be a final finding on the merits by a court (usually a jury) on admissible evidence that the defamatory

> 'sting' of the allegation complained of is objectively true as a matter of fact. The defendant does not have to prove that every word he/she published was true. He/she has to establish the 'essential' or 'substantial' truth of the sting of the libel. To prove the truth of some lesser defamatory meaning does not provide a complete defence.

457. Section 23 of the Act states:

> It is a defence to the publication of defamatory matter if the defendant proves that the defamatory imputations carried by the matter of which the plaintiff complains are substantially true.

458. Pursuant to s 4 of the Act, 'substantially true' 'means true in substance or not materially different from the truth'.

459. Despite the more extensive matters addressed in the Plaintiffs' Outline of Argument and Closing Submissions, the defendants only plead the defence of justification with respect to the defamatory imputation pleaded at paragraph 15.5 of the Second Statement of Claim. The defendants do not plead this defence with respect to any of the other alleged defamatory imputations arising from the Publications, nor do the defendants rely on the defence of contextual truth with respect to the imputations generally.

460. The defence of justification is confined solely to the imputation that the first plaintiff 'has knowingly passed off the work of BFD as his own'.

461. I refer to my findings at paragraphs 313-314 herein.

462. There is no evidence that the second defendant holds intellectual property rights which would prevent a competitor from presenting seminars addressing the use of the MBS and/or combination billing in a general sense.

463. There is insufficient evidence as to the content of the BFD Conference materials, the content of the BFD Facebook group page and/or what precisely was said at the first plaintiff's meeting with the first defendant on 7 April 2017, to support a finding that the content of the initial ProMBS workshop (and/or the fracture blog) was the same as (or even contained similarities with) that material.

464. Even if the first plaintiff only learned of the possible use of various MBS item numbers (either alone or in combination) from his interactions with the defendants, in my view the first plaintiff's subsequent creation of any scenarios or examples using such item numbers, either alone or in combination, does not amount to the use of BFD's work, in the sense as expressly stated by the defendants in the various Publications, namely use of material held under copyright by BFD.

465. The defendants have not established on the balance of probabilities that the imputation in the Publications that the first plaintiff has 'knowingly passed off the work of BFD as his own' is substantially true.

Defence of Qualified Privilege

466. The defendants plead that the imputations conveyed in the Publications are subject to qualified privilege at common law and/or under s 28 of the Act.

467. In *Duffy v Google Inc*, Blue J set out the elements of the common law defence as follows: [285]

> The common law defence applies when:
>
> 1. the work is published on an occasion of qualified privilege;
> 2. the defamatory passage is sufficiently connected to that occasion; and
> 3. the occasion is used for the purpose of the privilege.
>
> The onus in relation to the first and second elements lies on the defendant and the onus in relation to the third element (commonly called "malice") lies on the plaintiff.
>
> The underlying rationale for the existence of the defence is public policy, namely that on the occasions protected by privilege it is in the public interest that freedom of communication be given priority over the right of the individual to protection against loss of reputation.
>
> The categories of occasions of qualified privilege are not closed and are informed by the underlying rationale but are not subsumed by merely considering what might be in the public interest in a particular case.
>
> Two categories traditionally formulated are first, a communication by a person having a legal or moral duty to communicate it to a recipient having a reciprocal duty or interest to receive it and secondly, a communication to a recipient having a legitimate interest in receiving it by a person having a reciprocal interest in communicating it. These two categories of their nature usually apply to communications to a limited class and not to the world at large.
>
> (Footnotes/citations omitted)

468. As Kourakis CJ said in *Google Inc v Duffy*:[286]

> The definition of an occasion of qualified privilege by reference to a 'legitimate interest' in the making and receiving of the communication

> allows courts, using traditional common law methods, to determine the denotation of the word *interest* and, accordingly, the occasions on which freedom of communication will be given priority over the right of the individual to protection against loss of reputation.

469. In *Stephens v West Australian Newspapers Ltd*, Brennan J, in addressing common law privilege, referred to what was said in *Webb v Times Publishing Ltd*[287] by Pearson J, namely:[288]

> One has to look for a legitimate and proper interest as contrasted with an interest which is due to idle curiosity or a desire for gossip.

470. Further, in *Bashford v Information Australia (Newsletters) Pty Ltd*, Gummow J referred to what was said by Dixon J in *Guise v Kouvelis*,[289] namely:[290]

> The very width of the principles governing qualified privilege for defamation makes it more necessary, in deciding how they apply, to make a close scrutiny of the circumstances of the case, of the situation of the parties, of the relations of all concerned and of the events leading up to and surrounding the publication.
>
> Hence, the caution by Jordan CJ in *Andreyevich v Kosovich* that in order for the defendants to succeed in the defence of qualified privilege:
>
> It was necessary that **they should show by evidence** that both the givers and the receivers of the defamatory information had a special and reciprocal interest in its subject matter, of such a kind that it was desirable as a matter of public policy...that it should be made with impunity, notwithstanding that it was defamatory of a third party. (citations omitted).
>
> (my emphasis)

471. However, qualified privilege gives no licence to defame. As outlined by the High Court in *Bashford*:[291]

> If the occasion is privileged the further question which arises is whether 'the defendant has fairly and properly conducted himself in the exercise of it'...If the judge rules that the occasion is privileged, 'the burden of showing that the defendant did not act in respect of the

reason of the privilege, but for some other and indirect reason, is thrown upon the plaintiff.'

472. As to the statutory defence of qualified privilege, s 28 of the Act provides as follows:

> **28—Defence of qualified privilege for provision of certain information**
>
> (1) There is a defence of qualified privilege for the publication of defamatory matter to a person (the *recipient*) if the defendant proves that—
>
> (a) the recipient has an interest or apparent interest in having information on some subject; and
>
> (b) the matter is published to the recipient in the course of giving to the recipient information on that subject; and
>
> (c) the conduct of the defendant in publishing that matter is reasonable in the circumstances.
>
> (2) For the purposes of subsection (1), a recipient has an apparent interest in having information on some subject if, and only if, at the time of the publication in question, the defendant believes on reasonable grounds that the recipient has that interest.
>
> (3) In determining for the purposes of subsection (1) whether the conduct of the defendant in publishing matter about a person is reasonable in the circumstances, a court may take into account—
>
> (a) the extent to which the matter published is of public interest; and
>
> (b) the extent to which the matter published relates to the performance of the public functions or activities of the person; and
>
> (c) the seriousness of any defamatory imputation carried by the matter published; and
>
> (d) the extent to which the matter published distinguishes between suspicions, allegations and proven facts; and

(e) whether it was in the public interest in the circumstances for the matter published to be published expeditiously; and

(f) the nature of the business environment in which the defendant operates; and

(g) the sources of the information in the matter published and the integrity of those sources; and

(h) whether the matter published contained the substance of the person's side of the story and, if not, whether a reasonable attempt was made by the defendant to obtain and publish a response from the person; and

(i) any other steps taken to verify the information in the matter published; and

(j) any other circumstances that the court considers relevant.

(4) For the avoidance of doubt, a defence of qualified privilege under subsection (1) is defeated if the plaintiff proves that the publication of the defamatory matter was actuated by malice.

(5) However, a defence of qualified privilege under subsection (1) is not defeated merely because the defamatory matter was published for reward. (my emphasis)

473. As the first defendant did not give evidence and the defendants did not call any evidence, there is very little admissible evidence before the court relevant to the defence of qualified privilege, either at common law or pursuant to s 28 of the Act.

Posts/Comments

474. The defendants did not file a Defence to the Second Statement of Claim, meaning nothing in the Defence addresses the allegations relating to the Comments. However, in my view the same considerations that apply to a consideration of the defence of qualified privilege with respect to imputations conveyed by the Posts, would also arise if a defence was pleaded with respect to imputations conveyed by the Comments.

475. The defendants pleaded that the recipients of the Posts, being members of the BFD Facebook group, had an interest or apparent interest in having information about the plaintiff's business practices as they were potential customers of that business.[292]

476. Turning first to the defence at common law.

477. It is arguable that the members of the BFD Facebook group had an apparent interest in receiving information as to the legitimacy, standard and quality of continuing education offered to medical practitioners by providers such as the plaintiffs. It is arguable that such members had an apparent interest in knowing whether any such continuing education would offer them something different in terms of content to that which was provided by BFD, either via its conferences or the sharing of information on the Facebook group page. There is a cost attached to attending such education, both in terms of the time to attend and the fee charged to attend.

478. However, the first defendant gave no evidence to support a finding, on the balance of probabilities, that she had a reciprocal interest in communicating that information and/or a legal, moral and social duty to publish the defamatory matters contained in the Posts and Comments.

479. As the defendants have the onus of establishing that the publications were made on an occasion of qualified privilege, the defendants failure to call any evidence on this issue is critical. I am not satisfied, in the absence of such evidence, that the defendants have discharged that onus.

480. Turning to the availability of the statutory defence.

481. Again, it is arguable that the recipients of the Posts and Comments had an apparent interest in having the information contained in the Posts and Comments.

482. However, pursuant to s 28(2) of the Act, the defendant must believe on reasonable grounds that the recipient has such an apparent interest. The first defendant gave no evidence to support such a finding.

483. Further, pursuant to s 28(3) of the Act, the defendants must prove that their conduct in publishing the defamatory material was reasonable in the circumstances, having regard to the circumstances listed therein.

484. The Posts (and Comments) contained serious defamatory imputations, the essence of which was that the first plaintiff had stolen BFD's intellectual property and had used it when delivering his own seminars.

485. There was no admissible evidence to support a finding that at the time of the publication of the Posts and/or the Comments the first defendant knew of the content of the initial ProMBS workshop.

486. There was no evidence that the first defendant attended the initial ProMBS workshop, nor any evidence from the first defendant outlining if and/or how she became aware of the content of any such workshop.

487. At trial, the defendants submitted that the plaintiffs had used information from the BFD Facebook Group page and reproduced it in the 'fracture blog' which promoted the ProMBS workshop. In the Second Email, the first defendant stated: 'If it had not been for plagiarism of a doctor's quote from our BFD page I would not have even looked further at his posts or the program he is running'. She went on to say in that email:

> ...I am not doubting that he has produced 50—100 cases to give examples of medicare Billings and that these may be correct and legal – I **suspect** that many of these cases have come from our BFD page and from questions raised and answered by doctors on the page, not from his research as he has indicated. (my emphasis)

488. As previously stated, there was no admissible evidence to support a finding that the fracture blog was in fact plagiarised from the BFD Facebook group page.

489. There was no evidence that the first defendant had 'looked further into the program (the first plaintiff was) running'.

490. There was simply no admissible evidence to support a finding that when the Posts (and the Comments) were published, the first defendant had any reasonable basis for making the allegations contained therein, and/or had made any attempt to verify the truthfulness of the allegations contained therein and/or had any material basis for believing the allegations contained therein were true.

491. The first plaintiff gave evidence that the first defendant sent private messages to him via Facebook Messenger prior to publishing the First and Second Posts, wherein she alleged he had stolen BFD material and used that material when delivering the second plaintiff's workshops. He gave evidence that he managed to reply to those messages at about 9:30 or 9:40pm that same day, but could not reply earlier as he was working.[293]

492. Screenshots of the private messages exchanged between the first plaintiff and the second defendant are reproduced at pages 45-51 of Exhibit P1. Although the precise time the first private message was sent by the first defendant to the first plaintiff is not known, it must have been at or prior to 9:49pm on 9 September 2017.[294]

493. By reference to the content of the First Post, the first defendant claims to have made that Post about one hour after sending private messages containing similar allegations to the first plaintiff. There was no evidence that at the time the first defendant sent the First Post she was aware if the first plaintiff had even seen or read her private messages.

494. In sending the First and Second Posts only an hour after she sent the private Facebook messages to the first plaintiff, without giving him appropriate time to respond, the first defendant did not make any reasonable attempt to obtain (let alone publish) a response from the first plaintiff to the allegations contained therein.

495. After receiving the first plaintiff's public response (reproduced at paragraph 182 herein), the first defendant published the Third Post, including the further allegations of IP theft.[295]

496. Even if the evidence, taken at its highest, supports a finding that the first defendant held a **suspicion** that the first plaintiff may have used BFD material in the presentation of the initial ProMBS workshop, the allegations made by her were made as statements of fact. The allegations in the Posts and the Comments were serious, going to the very core of the first plaintiff's integrity.

497. The defendants had no reasonable basis to publish the allegations contained in the First, Second or Third Posts, or the Comments, as required pursuant to s 28(3) of the Act.

First Email

498. The evidence establishes that AOGP and the second plaintiff delivered the ProMBS seminars in partnership and that the first defendant knew of this.
499. As such, despite the absence of any oral evidence given by the first defendant, I am satisfied that if the first plaintiff had taken material held under copyright by BFD and used it in any ProMBS workshop delivered in partnership with AOGP, this is information in which Dr Kelly, as CEO of AOGP, being the recipient of the First Email, had an interest. That interest had both a financial/economic and legal basis in the sense that as CEO of AOGP one would reasonably expect Dr Kelly to be concerned to ensure it did not participate in any commercial activity which damaged its professional reputation and/or exposed itself to the risk of legal action for breach of intellectual property rights.
500. I am further satisfied, despite the absence of oral evidence from the first defendant, that she also had an interest in publishing the relevant matter, namely to prevent any breach by AOGP of copyright held by the second defendant.
501. In my view, the First Email was published on an occasion of qualified privilege as understood in accordance with the common law.
502. As outlined in *Bashford*, reiterated by Kourakis CJ in *Google Inc v Duffy*, the question then arises, have the defendants fairly and properly conducted themselves in the exercise of any occasion of qualified privilege.[296] Put another way, was the occasion used for the purpose of the privilege, or for some other or indirect purpose? This necessarily involves a consideration of the issue of malice.
503. Malice is a particular state of mind at the time the publication takes place. Proof of express malice destroys qualified privilege. Express malice is any improper motive or purpose that induces the defendant to use the occasion of qualified privilege to defame a plaintiff.
504. In *Horrocks v Lowe*, Lord Diplock said:[297]

> The commonest case is where the dominant motive which actuates the defendant is not a desire to perform the relevant duty or to protect the relevant interest, but to give vent to his personal spite or ill-will towards the person he defames. If this be proved then even positive belief in the truth of what is published will not enable the defamer to avail himself of the protection of the privilege to which he would otherwise have been entitled.

505. In *Roberts v Bass*,[298] the majority of the High Court referred to a defendant's primary motive in publishing the impugned words, saying:

> An occasion of qualified privilege must not be used for a purpose or motive foreign to the interest that protects the making of the statement. A purpose or motive that is foreign to the occasion and actuates the making of the statement is called express malice ... Accordingly, for the purpose of that privilege, express malice is any improper motive or purpose that induces the defendant to use the occasion of qualified privilege to defame the plaintiff .... Even if the defendant believes that the defamatory statement is true, malice will be established by proof that the publication was actuated by a motive foreign to the privileged occasion.

506. Malice may be found even if a defendant does not know the statement is untrue if he or she is recklessly indifferent whether it is true or false. As stated by Brett LJ in *Clarke v Molyneux*:[299]

> [I]f it be proved that out of anger, or for some other wrong motive, the defendant has stated as true that which he does not know to be true, and he has stated it whether it is true or not, recklessly, by reason of his anger or other motive, the jury may infer that he used the occasion, not for the reason which justifies it, but for the gratification of his anger or other indirect motive.

507. Malice is to be distinguished from other states of mind such as carelessness, impulsiveness, pig-headedness, excessive zeal or a failure to arrive at rational conclusions. It may be inferred from evidence of spite or ill-will and the inclusion of irrelevant or extraneous matters on occasions of qualified privilege can furnish evidence of malice. However, the courts have made it clear that a court ought to be slow to draw the inference that a defendant was actuated by an improper purpose, thus depriving him or her of the protection of the privilege. [300]

508. What is relevant is the defendant's state of mind at the time of the publication of the defamatory material. In determining that state of mind, a defendant's conduct after the publication of the defamatory material may provide evidence of malice if it is probative of his or her state of mind at the time of publication.[301]

509. In *Roberts v Bass*, the High Court considered the issue of 'wilful blindness' on the part of a defendant:[302]

> In exceptional cases, the sheer recklessness of the defendant in making the defamatory statement, may justify a finding of malice. In other cases, recklessness in combination with other factors may persuade the court that the publication was actuated by malice. In the law of qualified privilege, as in other areas of the law, the defendant's

> recklessness may be so gross as to constitute wilful blindness, which the law will treat as equivalent to knowledge. “When a person deliberately refrains from making inquiries because he prefers not to have the result, when he wilfully shuts his eyes for fear that he may learn the truth”, said this Court in *R v Crabbe* “he may for some purposes be treated as having the knowledge which he deliberately abstained from acquiring.” In less extreme cases, recklessness, when present with other factors, may be cogent evidence that the defendant used the occasion for some improper motive. This is particularly so when the recklessness is associated with unreasoning prejudice on the part of the defendant.

510. The plaintiffs submitted that malice could be inferred from the defendants’ failure to call evidence. Further, they submitted it could be inferred from the fact the first defendant did not attend the initial ProMBS workshop, did not seek the first plaintiff’s side of the story and refused the first plaintiff’s offer to observe his workshop material.
511. The plaintiffs also referred to conduct engaged in by the first defendant after the publications were made, as evidence of her state of mind at the time of the publications.
512. The plaintiffs referred to a private Facebook message sent by the first defendant to the first plaintiff on 10 February 2019, attaching a link to an article published on an Australian Doctor website about this action.[303] The message read:[304]

> The fun begins. A public forum that will be provided with evidence of over servicing and tax evasion. Are you sure this is what you want? Once listed for trial it’s an open court for anyone to attend to listen to evidence.

513. In addition, the plaintiffs submitted that an email sent by the first defendant to the first plaintiff on 25 October 2017, wherein she urged him to ‘reconsider the repercussions of legal action and the public damage it could do to your reputation’ demonstrated that she had an improper purpose for making the publications.[305]
514. It was submitted that I should infer from all of the evidence that the motive for all of the publications (not just the First Email) was simply to eradicate the second plaintiff as a competitor of the second defendant.
515. The first defendant did not give evidence and thus was not subjected to cross-examination. Nevertheless, I do not doubt that the first defendant is passionate about the proper education of medical practitioners with respect to the MBS and fiercely protective of the brand she has developed.
516. The evidence suggests that the first defendant is an impulsive person, quick to judgment and quick to act. She had spent time meeting with the first plaintiff and assisted him with the provision of the ‘cheat sheets’. She may well have felt affronted and aggrieved when she

learned that someone she had personally assisted in this way, had set up a business in direct competition to hers. However, the first defendant gave no evidence to this effect.

517. The First Email was sent at 9:56pm on 9 September 2017. This was **before** the first plaintiff's public response.

518. The first plaintiff also sent a series of private messages to the first defendant by way of explanation. The time and date the first plaintiff sent his first such message is uncertain, but it must have been **after** 9:49pm on 9 September 2017 at which time the first defendant sent a private message to the first plaintiff which stated:[306]

> I am also having my lawyer issue you with a breach of copyright AND have emailed Tim Kelly.

519. I find that the First Email was sent **before** the first defendant had received the first plaintiff's private message by way of explanation. Given the seriousness of the allegations contained therein, the first defendant published the First Email before making any reasonable attempt to obtain the first plaintiff's response to the allegations.

520. If, in fact, the First Email was sent after the first defendant had received the first plaintiffs' private messages by way of explanation, the First Email contained no reference to that explanation.

521. The First Email threatens legal action against the first plaintiff, thus giving the impression that there is a legitimate basis for the making of the serious allegations of breach of copyright, in the absence of the first defendant having any reasonable basis for the making of the allegation at that time.

522. The language used in the First Email is informative. The email requests 'AOGP disengage with (the first plaintiff's) services' rather than simply requesting AOGP cease using BFD material in the presentation of its workshops.

523. The language used by the first defendant in the private messages she exchanged with the first plaintiff is also informative as to her intention in sending not only the First Email, but the Publications generally. Throughout those messages the first defendant ignored the first plaintiff's explanations and despite not having any actual knowledge of the content of the initial ProMBS workshop, continuously threatened legal action, unless the workshops were withdrawn.

524. After carefully considering the evidence, I am satisfied that the plaintiffs have established that the first defendant's motive in sending the First Email was not to prevent AOGP from breaching BFD copyright, but rather to prevent the first plaintiff from competing against the second defendant in the presentation of workshops educating medical practitioners as to the use of the MBS.

525. I reject the defendants' claim to qualified privilege at common law with respect to the defamatory matter contained in the First Email.

526. As to the statutory defence, as with the Posts and Comments, pursuant to s 28(3) of the Act, the defendants had no reasonable basis to publish the allegations contained in the First

Email.

Second Email

527. The Second Email was published both to Dr Kelly and Ms Cheah and was sent in response to Dr Kelly's request for evidence to substantiate the allegations in the First Email. However, the Second Email went well beyond this and was used by the first defendant as a vehicle to attempt to discredit the first plaintiff, both personally and professionally.

528. As to the common law defence, the issue then arises, was the publication made on an occasion of qualified privilege, in the sense that both the defendants and the recipients of the defamatory matter had a reciprocal interest in that information.

529. The first defendant knew that AOGP and the second plaintiff had agreed to deliver the ProMBS workshops in partnership. AOGP has a history of delivering education to medical practitioners and therefore it follows that AOGP had an interest in ensuring that its partners in the delivery of any such education had both appropriate expertise and professional integrity.

530. If the first plaintiff was not knowledgeable or fit to be running MBS workshops and/or endorsed the breaking of taxation laws and/or the over-servicing of patients, I am satisfied that this is information in which Dr Kelly, as CEO of AOGP, and Ms Cheah, AOGP's Business Manager, the recipients of the Second Email, had an interest (or an apparent interest).

531. However, pursuant to the common law, there must be a legitimate and **reciprocal** interest in both the making and receiving of the communication for it to be subject to qualified privilege. The first defendant gave no evidence to support a finding that she had such an interest in the making of the communication.

532. In the Second Email, the first defendant outlined information she had ascertained from her personal dealings with the first plaintiff and his involvement as a former BFD Facebook group member, which she considered demonstrated that he:

1. misrepresented himself as an expert and was not knowledgeable in the use of the MBS and the *Health Act*, and the Regulations thereunder, such that he was not an expert in that area;
2. was lacking in knowledge and insight generally;
3. endorsed the breaking of taxation laws;
4. may be defrauding Medicare by over-servicing of patients; and
5. had behaved unprofessionally.

533. While I am satisfied that Dr Kelly and Ms Cheah had a legitimate interest in such information, given their respective roles at AOGP and the second plaintiff's partnership with AOGP, in the absence of further admissible evidence, I am not satisfied that the defendants, as competitors of the plaintiffs in the relevant market, had a reciprocal interest in such information.

534. The defence of qualified privilege at common law must fail with respect to the imputations arising from the Second Email.

535. As to the statutory defence, the defendants must establish that their conduct in publishing the information was reasonable in the circumstances, having regard to the matters set forth in s

28(3). These include, relevantly, the seriousness of the defamatory imputation(s), the sources of the information published and the integrity of those sources and whether the publications include the first plaintiff's side of the story.

536. As outlined by White J in *Hockey v Fairfax Media Publications Pty Ltd*, when dealing with an equivalent statutory provision:[307]

> [227] In *Morgan v John Fairfax and Sons Ltd (No 2)* (1991) 23 NSWLR 374 at 3878, Hunt AJA identified a number of matters bearing upon the requirement of reasonableness in the former s 22(1)(c), which can be summarised as follows:
>
> (1) The conduct must have been reasonable in the circumstances to publish each imputation found to have been in fact conveyed by the matter of which complaint is made. The more serious the imputation conveyed, the greater the obligation upon the respondent to ensure that its conduct in relation to the publication was reasonable;
>
> (2) If the respondent intended to convey any imputation in fact conveyed, it must (subject to some limited exceptions) have believed in the truth of that imputation;
>
> (3) If the respondent did not intend to convey any particular imputation in fact conveyed, it must establish:
>
> (a) subject (to the same exceptions) that it believed in the truth of each imputation which it did intend to convey; and
>
> (b) that its conduct was nevertheless reasonable in the circumstances in relation to each imputation which it did not intend to convey but which was in fact conveyed;
>
> (4) The respondent must also establish:
>
> (a) that, before publishing the matter of which complaint is made, it exercised reasonable care to ensure that it got its conclusions right, (when appropriate) by making proper inquiries and checking on the accuracy of its sources;
>
> (b) that its conclusions (whether statements of fact or expressions of opinion) followed logically, fairly and reasonably from the information

> which it had obtained;
>
> (c) that the manner and extent of the publication did not exceed what was reasonably required in the circumstances; and
>
> (d) that each imputation intended to be conveyed was relevant to the subject about which it is giving information to its readers.

537. White J also noted that:[308]

> ...reasonableness should not be interpreted as requiring a counsel of perfection, given that the predicate on which it operates is that the imputations in question are not true and that the conduct of the defendant is accordingly not beyond criticism.

538. For the (further) reasons set out hereunder, I am not satisfied the defendants have established that their conduct in publishing the defamatory matter was reasonable in the circumstances.

First Plaintiff's Expertise and Knowledge of the MBS/Health Act (and in General)

539. Much of the cross-examination of the first plaintiff (and Dr Kelly) had, as its focus, the accuracy of the content of the scenarios used in the initial ProMBS seminar. However, there was no evidence that at the time the first defendant sent the Second Email she had any knowledge whatsoever of the content of that seminar.

540. As such, although there was some admissible evidence to support a finding that some of the content of the initial ProMBS seminar was inaccurate, both from a clinical and MBS perspective, the first defendant did not exercise reasonable care to ensure her conclusions were right, by making any proper enquiries and/or checks with respect to the accuracy of the content of the initial ProMBS workshop, before sending the Second Email. Had the defendants informed themselves of the content of that workshop before sending the Second Email, that evidence would have been relevant to a determination of this issue.

541. As previously outlined in the discussion at paragraphs 366-377 herein, the allegations in the Second Email as to the plaintiff's knowledge, insight and expertise, had as their basis the examples referred to in that email. There was no other evidence as to the source of those allegations.

542. When considered in conjunction with the oral evidence at trial, I am satisfied the 80/20 Rule post demonstrates a lack of understanding by the first plaintiff of that Rule and therefore of the Health Act. However, the material available to the first defendant on this issue was an isolated post, absent any other explanation or clarification.

543. The defence of qualified privilege is predicated on the assumption that the defamatory imputations are not true. However, the first defendant did not give evidence as to what was her belief in the truth of any imputation conveyed in the Second Email and/or to outline what steps she had obtained to check on the accuracy of her sources.

544. As was the case in *Echo Publications v Tucker*,[309] although the conduct of the defendants in publishing these defamatory imputations **may** have been reasonable, there was no evidence from the first defendant as to her actual assessment of the relevant source material. She was the party in the position to lead evidence as to many circumstances relevant to the issue of reasonableness but did not do so.

Breach of Taxation Laws

545. The only basis for the first defendant's allegations that the first plaintiff endorsed the breaking of taxation laws is her interpretation of the tax post he made on the BFD Facebook group page on 22 July 2017. The tax post is reproduced at paragraph 89 herein.

546. The first defendant reproduced the first paragraph of the tax post in the Second Email. She referred to it as indicating that the first plaintiff believed it was 'fine to break tax law' and questioned his 'knowledge and ethics in regards to his own tax matters and the 'advice' he (was) giving others'.

547. There was no evidence that the first defendant had any particular knowledge or expertise in the area of taxation law.

548. There was no evidence that established whether the recommendations made by the first plaintiff in the tax post did in fact constitute any violation of taxation law, nor that the first plaintiff had ever broken any taxation law.

549. There was no evidence that the first plaintiff had held himself out to have any particular knowledge or expertise in the area of taxation law, to anyone, whether it be the members of the BFD Facebook group or otherwise, such that any comments he made on such topic could be interpreted as constituting the provision of expert taxation advice.

550. There was no evidence that the first defendant had exercised reasonable care to ensure she got her conclusions right, by making proper enquiries and checking on the accuracy of those sources. Her conclusion that the first plaintiff considered it fine to break taxation laws did not flow logically, fairly and reasonably from the wording of the tax post. The allegation was serious and exceeded what was reasonably required in the circumstances.

Suspected Medicare Fraud via Over-Servicing

551. In the Second Email, the first defendant outlined the 80/20 Rule post and her views as to its use by Medicare as an automatic warning of over-servicing.

552. Thereafter, she set forth an example of a post made by the first plaintiff on the BFD Facebook group page that she stated indicated he 'may be defrauding medicare by

overservicing', namely his response to a question by another member as to 'how often can you bill a case conference per patient? TIA'. The first plaintiff's response was:[310]

> Govt and Medicare recommends 5 times a year. But ideally there is no limit if you could justify it.

553. I have outlined the evidence given by the first plaintiff and Dr Kelly on both of these topics at paragraphs 96-99 and 101 herein.
554. This is the only admissible evidence on these specific issues.
555. While the 80/20 Rule post arguably demonstrates the first plaintiff's lack of knowledge of the importance of compliance with that rule and the consequences for practitioners who breach that rule, I am not satisfied that it provides a reasonable basis for the serious allegation made by the first defendant namely, that he 'may be defrauding medicare by over-servicing.'
556. There was no evidence led to rebut the first plaintiff's evidence that in certain circumstances and with the right patient, more than five case conferences per year could be billed for that patient.

Unprofessional Behaviour in General

557. As with the other matters, there was simply no appropriate basis for the first defendant to make these allegations at the time she sent the Second Email.

Summary – Second Email

558. I am not satisfied that the defendants have established that their conduct in publishing the defamatory matter in the Second Email was reasonable in the circumstances as required by s 28(3) of the Act. If I am wrong in this respect, for the same reasons as outlined above with respect to the First Email, I am satisfied that the publication of the Second Email was actuated by malice, thus meaning the defence of qualified privilege is not available to the defendants.

Summary of Findings – Qualified Privilege

559. Both the common law and statutory defence of qualified privilege must fail insofar as the defendants seek to rely on it with respect to the imputations arising from the Posts, the Comments, the First Email and the Second Email.
560. The defendants did not seek to rely on this defence with respect to any imputations arising from the Phone Call.

Defence of Fair Comment or Honest Opinion

561. The defendants plead that insofar as the Publications give rise to any of the imputations as pleaded (save for the imputation pleaded at paragraph 15.5), the imputations were an

expression of opinion or were in the nature of fair comment.[311]

The Common Law Defence

562. At common law, it is a defence to an action in defamation that the words complained of are honest comment on a matter of public interest. In *Spiller v Joseph*, the five elements of the defence were described as follows:[312]

1. the comment must be made in the public interest;
2. the comment must be recognisable as comment, as distinct from an imputation of fact;
3. the comment must be based on facts or other proper material or material subject to privilege;
4. the comment must explicitly or implicitly indicate, at least in general terms, the facts upon which it is based; and
5. the comment must be objectively fair – in other words, could any fair minded person honestly express that opinion on the proved facts, even if the opinion is exaggerated, prejudiced or obstinate.

563. The common law defence can be defeated by proof of malice.

564. In *Channel Seven Adelaide Pty Ltd v Manock (Manock),* Gleeson CJ observed: [313]

> So long as a reader (or viewer, or listener) is able to identify a communication as a comment rather than a statement of fact, and is able to sufficiently identify the facts upon which the comment is based, then such a person is aware that all that he or she has read, viewed or heard is someone else's opinion (or inference, or evaluation or judgment).

565. The actual language used and the context in which it is used must be taken into account. [314]

566. A statement of fact is generally not comment, although a statement of inference, conclusion, criticism, judgment or observation is capable of being comment.[315] A comment can be made by stating a value judgment and can also be made by stating a fact if it is a deduction from other facts.[316]

567. In *Manock*, Gummow, Hayne and Heydon JJ (the majority) referred to what was said by Field J in *O'Brien v Marquis of Salisbury*,[317] namely:[318]

> [C]omment may sometimes consist in the statement of fact, and may be held to be comment if the fact so stated appears to be a deduction or conclusion come to by the speaker from other facts stated or referred to by him, or in the common knowledge of the person

> speaking and those to whom the words are addressed and from which his conclusion may be reasonably inferred. If a statement in words of a fact stands by itself naked, without reference, either expressed or understood, to other antecedent or surrounding circumstances notorious to the speaker and to those to whom the words are addressed, there would be little, if any, room for the inference that it was understood otherwise than as a bare statement of fact.

568. The First Post, Second Post and First Email each read as a dogmatic statement of fact and contain no further information upon which that statement of fact is based. The common law defence of fair comment does not apply to these publications and any imputations arising therefrom.

569. The Third Post was published in response to the first plaintiff's public post, which outlined his side of the story. To be understood it needs to be read in that context. The Third Post similarly reads as a statement of fact, but goes somewhat further in that information specific to the first plaintiff's interactions with the defendants are outlined, thus seemingly providing, to the reader, a potential factual basis for the statement of fact to be an opinion.

570. For the comment to be 'fair', the opinion must be one that a fair-minded person may reasonably form upon the facts on which it is put forward as being based. The majority in *Manock* reiterated the test set forth by Jacobs and Mason JJA in *O'Shaughnessy v Mirror Newspapers Ltd*,[319] namely:[320]

> [D]efamatory matter which appears to be a comment on facts stated or known but is not an inference or conclusion which an honest man, however biased or prejudiced, might reasonably draw from the facts so stated or known will not be treated as comment.

571. Importantly, the common law rule is that where the comment is based on facts, the facts must be truly stated. Unless the facts are true, the comment cannot be fair.[321]

572. Any comment (or opinion) in the Third Post is based on facts which the defendant has not proved to be true, namely that the first plaintiff 'took the information and quoted from the BFD workshop, Facebook page and conference'.

573. The defamatory imputations arising from the Third Post are not protected by the common law defence of fair comment.

574. The Comments were made by others who were responding or reacting to the First and Second (and possibly Third) Posts and should be read in that context. [322] In my view, each of the Comments reads as if it is a deduction or conclusion that has been made by their respective authors based on their reading and interpretation of the facts in the Posts which precede those comments. However, as those comments are based on facts which the defendants have not proved to be true, or other proper material, the defamatory imputations arising from the Comments are not protected by the common law defence of fair comment.

575. The Second Email was written by the first defendant in response to the request by Dr Kelly to provide evidence in support of the allegations contained in the First Email. As previously stated, in the Second Email, the first defendant identified various examples that she considered demonstrated that the first plaintiff had misrepresented himself as an expert and was not knowledgeable in the use of the MBS and the Health Act, was lacking in knowledge and insight generally, endorsed the breaking of taxation laws, may be defrauding Medicare by over-servicing of patients and had behaved unprofessionally.

576. In the Second Email, she stated; 'I will give you some examples of his lack of insight and knowledge and hopefully this will enable you to make an educated risk management decision before I proceed further'. She went on to say, with respect to the 50-100 cases produced by the first plaintiff, 'I **suspect** that many of the cases have come from our BFD page and from questions raised and answered by doctors on the page, not from his research as he has indicated.'

577. In my view, the words complained of in the Second Email are recognisable as comments, as distinct from imputations of fact and the comment(s) explicitly or implicitly indicate, at least in general terms, the facts upon which they are based.

578. Similarly, having regard to the admissions in the Defence as to the content of the Phone Call, I am satisfied that the words complained of therein are recognisable as comments.

579. However, the first defendant did not call any evidence to establish that the comments in either the Second Email or the Phone Call were made in the public interest, nor did the defendants provide particulars in the Defence as to what was any matter of public interest upon which they relied.[323]

580. In *Bellino v Australian Broadcasting Corporation*,[324] Dawson, McHugh and Gummow JJ described a matter of public interest as the actions or omissions of a person or institution engaged in activities that either inherently, expressly or inferentially invited public criticism or discussion.

581. The notion of public interest for this purpose is not to be narrowly confined. However, as the author of *Defamation Law*[325] has observed:

> [A distinction is to be drawn between] criticism directed towards the plaintiff's public conduct and the ascription of base or improper motives to the plaintiff. The former is more readily defensible as fair comment than the latter. If a publisher intends to impute base or improper motives to the plaintiff, he or she should ensure that such an imputation can be drawn from the factual substratum.
>
> (Citations omitted)

582. I do not accept that the first defendant's views as to the first plaintiff's expertise, honesty, integrity and/or reputation are matters of 'public interest'.

583. Further, as previously stated, I am satisfied that the publication of the defamatory imputations in the Second Email was actuated by malice.

584. The defendants have not established the common law defence of fair comment or honest opinion with respect to the defamatory imputations arising from any of the Publications.

The Statutory Defence

585. Section 29 of the Act states:

> **29- Defences of Honest Opinion**
>
> (1) It is a defence to the publication of defamatory matter if the defendant proves that—
>
> (a) the matter was an expression of opinion of the defendant rather than a statement of fact; and
>
> (b) the opinion related to a matter of public interest; and
>
> (c) the opinion is based on proper material.
>
> (2) It is a defence to the publication of defamatory matter if the defendant proves that—
>
> (a) the matter was an expression of opinion of an employee or agent of the defendant rather than a statement of fact; and
>
> (b) the opinion related to a matter of public interest; and
>
> (c) the opinion is based on proper material.
>
> (3) It is a defence to the publication of defamatory matter if the defendant proves that—
>
> (a) the matter was an expression of opinion of a person (the *commentator*), other than the defendant or an employee or agent of the defendant, rather than a statement of fact; and
>
> (b) the opinion related to a matter of public interest; and
>
> (c) the opinion is based on proper material.

> (4) A defence established under this section is defeated if, and only if, the plaintiff proves that—
>
> (a) in the case of a defence under subsection (1)—the opinion was not honestly held by the defendant at the time the defamatory matter was published; or
>
> (b) in the case of a defence under subsection (2)—the defendant did not believe that the opinion was honestly held by the employee or agent at the time the defamatory matter was published; or
>
> (c) in the case of a defence under subsection (3)—the defendant had reasonable grounds to believe that the opinion was not honestly held by the commentator at the time the defamatory matter was published.
>
> (5) For the purposes of this section, an opinion is based on *proper material* if it is based on material that—
>
> (a) is substantially true; or
>
> (b) was published on an occasion of absolute or qualified privilege (whether under this Act or at general law); or
>
> (c) was published on an occasion that attracted the protection of a defence under this section or section 26 or 27.
>
> (6) An opinion does not cease to be based on proper material only because some of the material on which it is based is not proper material if the opinion might reasonably be based on such of the material as is proper material.

586. The First Post, Second Post and First Email are statements of fact. The statutory defence of honest opinion does not apply to any defamatory imputations arising therefrom.
587. Any comments (or opinions) in the Third Post and/or as expressed in the Comments were not based on proper material as required by s 29(1)(c), having regard to s 29(5) of the Act.
588. As to the Second Email and the Phone Call, the defendants have not established that the comments expressed therein related to a matter of public interest.
589. The statutory defence of honest opinion does not apply to the defamatory imputations arising from any of the Publications.

Claim arising from Tort of Interference with Contractual Relations

590. The plaintiffs claim that when the first defendant made the Publications, she knew that the first and/or second plaintiff were involved in a contractual relationship with AOGP pertaining to the delivery of the ProMBS workshops. The plaintiffs claim that by the First and Second Emails and the Phone Call, the defendants, through the conduct of the first defendant, were attempting to convince AOGP to withdraw from its agreement with the second plaintiff, thus directly interfering with and hindering the performance of that contractual relationship.[326]

591. The defendants deny this claim.

592. In the Plaintiff's Closing Submissions and Outline of Argument, it is submitted that the plaintiffs will be entitled to damages if they establish that:

1. The first defendant was aware of the existence of the second plaintiff's contract with AOGP; [327] and
2. The first defendant's actions as pleaded (namely the sending of the First and Second Emails and making the Phone Call) were intended to induce AOGP to breach that contract with the second plaintiff. [328]

593. I was not directed to any South Australian authorities on this tort.

594. The existence and nature of this tort was discussed in length by the House of Lords in *OBG Ltd v Allen*.[329]

595. Lord Hoffmann outlined the origins of the tort, noting that liability for inducing breach of contract had been established in *Lumley v Gye,*[330] a case concerning a singer who had been engaged to perform by a theatre, but was persuaded by another theatre owner to perform instead at another venue. The singer breached her contract with the first theatre, but it was the actions of the second theatre owner which had induced her to do so.

596. Lord Hoffmann noted that the basis of the decision in *Gye* was the general principle that a person who procures another to commit a wrong incurs liability as an accessory. He said:[331]

> ...[T]he important point to bear in mind about *Lumley v Gye* is that the person procuring the breach of contract was held liable as accessory to the liability of the contracting party. Liability depended upon the contracting party having committed an actionable wrong...

597. In proving the act of persuasion, it is necessary to show that the intention behind the act was to deprive the plaintiff of the benefit of the contract, or that the act was done in the knowledge that that would be the outcome. Lord Hoffmann said:[332]

> To be liable for inducing breach of contract, you must know that you are inducing a breach of contract. It is not enough that you know that you are procuring an act which, as a matter of law or construction of

> the contract, is a breach. You must actually realise that it will have this effect. Nor does it matter that you ought reasonably to have done so.

598. More recently, in *Donaldson v Natural Springs Australia Ltd*, Beach J said:[333]

> First, there must be a contract. Second, the defendant must know that such a contract exists. Third, the defendant must know that if one of the contracting parties does or fails to do a particular act, that conduct will be a breach of contract. Fourth, the defendant must intend to induce or procure that contracting party to breach the contract by doing or failing to do that particular act. Fifth, the breach must cause a loss or damage to the plaintiff. Sixth, no defence of justification should be applicable.

599. The relevant contract for the purposes of a consideration of this claim must be the Collaborative Partner Agreement (the Agreement).

600. Although there was no evidence from which I can make a positive finding as to the end date of that contract, there being no evidence dealing expressly with the issue as to when the workshop evaluation was completed, the terms of that agreement were re-negotiated **after** the Publications, meaning it must have still been in force as at the date the first defendant sent the Emails and made the Phone Call.

601. By reference to the First Post, the first defendant knew that the first plaintiff was running MBS workshops under the name of the second plaintiff. The wording of the First Email establishes that the first defendant was aware that the first plaintiff and AOGP were running a workshop together. Although the first defendant did not have express knowledge of the terms of any contract entered into by AOGP and the first (and/or second) plaintiff, I am satisfied that the first defendant knew that a commercial relationship existed between AOGP and either the first plaintiff and/or the second plaintiff, such that she must have known that the first and/or second plaintiff had entered into a contract with AOGP related to the delivery of (at least one) workshop pertaining to the MBS.

602. In the First Email, the first defendant requested AOGP ‘disengage with (the first plaintiff’s) services’. I am satisfied that by the language used by the first defendant in the First Email her clear intention, by that email, was to induce AOGP to take positive steps to dissociate itself from the first plaintiff and not to continue to work with him in the delivery of education to medical practitioners.

603. The Second Email contains statements relating to AOGP’s association with the first plaintiff and the negative impact that continued association will have on AOGP. I am satisfied that the first defendant’s purpose and intention when sending the Second Email was to discredit and disparage the first plaintiff, in order to convince AOGP to discontinue running any MBS workshops with the first (and/or second) plaintiff. I am also satisfied that the same intent lay behind the making of the Phone Call.

604. I am satisfied that in sending the First and Second Emails and making the Phone Call, the first defendant's intention was to induce AOGP to act in a way which would result in the first plaintiff (and/or the second plaintiff) losing the benefit of its contract with AOGP, as a result of AOGP discontinuing its commercial association with him/them.

605. In the pleadings, the plaintiffs also relied on the content of an email sent by the first defendant to the first plaintiff on 25 October 2017 as establishing the first defendant's intention to interfere with the contractual relationship. That email included the following statement:

> I will also be adding AOGP into the case – which is something they wish to avoid.

606. The full text of that email was tendered as part of Exhibit P1.[334]

607. When the email is considered in its entirety, it is apparent that the intention of that email was to convince the first plaintiff not to proceed with his intended legal action against her and includes a threat that if the action was to proceed, she would involve AOGP in it. There is nothing in this email which in my view can be construed as a direct (or even indirect) interference in the first or second plaintiff's contractual relationship with AOGP. Rather, the intention and purpose of this email was to attempt to persuade the first plaintiff not to pursue this action.

608. However, it is apparent from the authorities that a critical element of the tort is that it **procures a breach of contract resulting in loss and damage to the plaintiff**.

609. The plaintiffs submitted that the second plaintiff had suffered loss in that AOGP executed a new agreement with the second plaintiff on less favourable terms and that the agreement between AOGP and the second plaintiff had lapsed on 31 December 2018 and had not been renewed.[335]

610. In the Second Statement of Claim, it is pleaded that the defendants' conduct has caused loss to the second plaintiff particularised as:[336]

1. The Second Plaintiff suffered economic loss from the cancellation of seminars as a result of the emails and the Publications.
2. The Second Plaintiff received fees in respect of the First Plaintiff presenting the seminars and the First Plaintiff was subsequently removed as the presenter following the emails and the Publications.
3. The Second Plaintiff and AOGP entered into a new arrangement following the emails and the Publications whereby the Second Plaintiff's share of the profits from the seminars was reduced.

611. As such, any alleged claim for losses arising from the fact that the contract between AOGP and the second plaintiff was not re-negotiated beyond the end of 2018, was not pleaded. However, for the reasons outlined below, I am not satisfied that there is any causal link between

that unilateral decision made by the first plaintiff and any interference by the defendants in the parties' contractual relationship.

612. Further, the **conduct** relied upon by the plaintiffs and pleaded as constituting an interference in the contractual relationship between the second plaintiff and AOGP is the conduct particularised in paragraph 21 of the Second Statement of Claim, which makes no reference whatsoever to the Posts or the Comments. Any alleged loss must relate to the conduct which comprises the tort. The only conduct which could constitute the tort is the defendants' publication of the First and Second Emails.[337]

613. Importantly, the necessity for there to be a breach of contract, resulting in loss, was not addressed by the plaintiffs. There was no evidence whatsoever that on the basis of the matters outlined in the First and/or Second Emails (or the Phone Call) that AOGP acted in breach of its contract with the second plaintiff (or vice versa), namely a breach of the Agreement. As foreshadowed by the terms of that Agreement, the first workshop being successful, they continued to work together thereafter.

614. In my view, that is the end of the matter. The plaintiffs have not established that the first defendant's conduct in sending the First and Second Emails and/or in making the Phone Call procured any breach of the contract between AOGP and the second plaintiff.

615. However, if I am wrong about that, the plaintiffs must prove they have suffered loss and damage, and a causal link between that loss and damage and the defendants' interference in the contractual relationship.

616. For the reasons which follow, I am not satisfied that the plaintiffs have established that they suffered any loss and damage as a result of the defendants' interference in the contractual relationship between AOGP and the second plaintiff.

Damages

Claim

617. The plaintiffs claim damages in respect of the defamation (and, to the extent that such amounts are not so recovered in defamation, in respect of the tort of interference with contractual relations) including:

. $**100,000.00 to $150,000.00** in respect of non-economic loss;

. **$12,500.00** in respect of past economic loss, comprising:

Loss of profit from cancelled seminars of $6,000.00;

Loss of venue hire fees of $4,500.00; and

Loss of presenter's fees for upcoming, scheduled seminars of $2,000.

$60,268.00 in respect of future economic loss, comprising:

Loss of opportunity from new clients of $40,000.00 and

Loss of presenter's fees and profits for upcoming, unscheduled seminars of $20,268.00.

618. In addition, the plaintiffs claim aggravated damages, interest and costs.

Preliminary Observations

619. The claims for damages in defamation and interference in contractual relations are pleaded as alternative claims. However, the legal and/or evidentiary basis for a claim for damages for non-economic loss arising in respect of the latter claim were not addressed by the plaintiffs.

620. Further, the claim for loss of opportunity relates to opportunities the plaintiffs may have had, but claim to have now lost, with new clients, namely clients **other than AOGP**. There can be no causal link between any such alleged loss and any interference by the defendants in the contractual relationship between AOGP and the second plaintiff. This claim is misconceived insofar as it is claimed by way of loss arising from that alleged tort.

General Damages

621. An award of general damages in defamation is made to compensate for hurt to the first plaintiff's feelings, for harm to his reputation and to vindicate his reputation.

622. The plaintiffs claim that as a result of the Publications, the first plaintiff has suffered serious injury to his personal and professional reputation, and has suffered considerable embarrassment and distress.[338] The plaintiffs seek an award of damages for non-economic loss within a range of $100,000 to $150,000.

623. Damages in defamation are to be assessed pursuant to the common law, subject to the modifications legislated in the Act.

624. Section 32 of the Act provides that the award of damages must be such as to ensure that there is an appropriate and rational relationship between the harm sustained by the plaintiff and the amount of damages awarded.

625. Pursuant to s 33, unless the court is satisfied an award of aggravated damages is warranted, the maximum amount that may be awarded for damages for non-economic loss in defamation proceedings is **$407,500**.[339]

626. Section 34 provides that the court is to disregard malice or other state of mind of the defendant at the time of the publication or any other time, 'except to the extent that the malice or other state of mind affects the harm sustained' by the plaintiff.

627. In assessing the general damages to which the first plaintiff is entitled, I have relied on the principles set out by Blue J in *Duffy v Google Inc (No 2),* namely:[340]

> General damages in defamation address three overlapping aspects of compensation for harm: compensation for hurt to the plaintiff's feelings and damage to the plaintiff's reputation and compensation to vindicate

the plaintiff's reputation.

In Uren v. John Fairfax and Sons Pty Ltd, Windeyer J said:

When it is said that in an action for defamation damages are given for an injury to the plaintiff's reputation, what is meant? A man's reputation, his good name, the estimation in which he is held in the opinion of others, is not a possession of his as a chattel is. Damage to it cannot be measured as harm to a tangible thing is measured. Apart from special damages strictly so called and damages for a loss of clients or customers, money and reputation are not commensurables. It seems to me that, properly speaking, a man defamed does not get compensation for his damaged reputation. He gets damages because he was injured in his reputation, that is simply because he was publicly defamed. For this reason, compensation by damages operates in two ways- as a vindication of the plaintiff to the public and as consolation to him for a wrong done. Compensation is here a solatium rather than a monetary recompense for harm measurable in money. The variety of the matters which, it has been held, may be considered in assessing damages for defamation must in many cases mean that the amount of a verdict is the product of a mixture of inextricable considerations.

In *Broome v Cassell & Co*, Lord Hailsham said:

In actions of defamation and in any other actions where damages for loss of reputation are involved, the principle of restitutio in integrum has necessarily an even more highly subjective element. Such actions involve a money award which may put the plaintiff in a purely financial sense in a much stronger position than he was before the wrong. Not merely can he recover the estimated sum of his past and future losses, but, in case the libel, driven underground, emerges from its lurking place at some future date, he must be able to point to a sum awarded by a jury sufficient to convince a bystander of the baselessness of the charge...

and Lord Diplock divided heads of damage into (1) ordinary, (2) aggravated and (3) exemplary and said:

The harm caused to the plaintiff by the publication of a libel upon him often lies more in his own feelings, what he thinks other people are

thinking of him, than in any actual change made manifest in their attitude towards him. A solatium for injured feelings, however innocent the publication by the defendant may have been, forms a large element in the damages under head (1) itself even in cases in which there are no grounds for `aggravated damages' under head (2)...

In *Carson v John Fairfax and Sons Limited Carson*, Mason CJ, Deane, Dawson and Gaudron JJ said:

Specific economic loss and exemplary or punitive damages aside, there are three purposes to be served by damages awarded for defamation. The three purposes no doubt overlap considerably in reality and ensure that "the amount of a verdict is the product of a mixture of inextricable considerations". The three purposes are consolation for the personal distress and hurt caused to the appellant by the publication, reparation for the harm done to the appellant's personal and (if relevant) business reputation and vindication of the appellant's reputation. The first two purposes are frequently considered together and constitute consolation for the wrong done to the appellant. Vindication looks to the attitude of others to the appellant: the sum awarded must be at least the minimum necessary to signal to the public the vindication of the appellant's reputation. "The gravity of the libel, the social standing of the parties and the availability of alternative remedies" are all relevant to assessing the quantum of damages necessary to vindicate the appellant.

and Brennan J said:

Although damages are awarded to vindicate the plaintiff's reputation, damages are not awarded as compensation for the loss in value of a plaintiff's reputation as though that reputation were itself a tangible asset or a physical attribute which, once damaged, is worth less than it was before. In order to achieve the purpose of vindicating reputation, damages for defamation are quantified by reference, inter alia, to what is needed to achieve that purpose: those damages are not quantified by reference to a depreciation in the value of a plaintiff's reputation. Other heads of damage are compensation for the external consequences produced by the publication of the defamation and "a solatium" for the plaintiff's internal hurt, that is, for the complex of reactions that the plaintiff has experienced as the result of the

publication and its external consequences.

...

The *consequences* of publication include not only the insult publicly inflicted on the plaintiff but also the effect of the defamation on those to whom it is published, any diminution in the regard in which the plaintiff is held by others, any isolation produced (causing the plaintiff to be "shunned or avoided" is the traditional formula) and any conduct adverse to the plaintiff engaged in by others because of the publication of the defamatory matter. Damages are awarded also for the plaintiff's injured feelings, including the hurt, anxiety, loss of self-esteem, the sense of indignity and the sense of outrage felt by the plaintiff. Indeed, all those objective consequences and those subjective reactions which flow naturally from the publication of the defamatory matter are relevant factors. Of course, the subjective reactions are often produced by the objective consequences of the publication. The two categories are not cumulative heads of damage but descriptions of kinds of intangible factors which must be taken into account in assessing damages.

...

Damages by way of vindication of reputation are not added to the damages assessed under other heads. Although an award of damages operates "as a vindication of the plaintiff to the public and as consolation to him for a wrong done", as Windeyer J said [in *Uren v. John Fairfax and Sons Pty. Ltd*.], the dual operation of an award does not require cumulative components of damages. The same sum can operate as vindication, compensation and solatium, for "the amount of a verdict is the product of a mixture of inextricable considerations". The amount assessed under other heads may itself be sufficient in aggregate to provide the vindication required. The extent of the overlap depends on the circumstances. But the award in total must be sufficient to satisfy the purposes for which damages for defamation are awarded: vindication of reputation, compensation for injury to reputation and solatium for injured feelings.

In *Ali v Nationwide News Pty Ltd*, Tobias and McColl JJA said:

> The harm caused to the plaintiff by the publication of the defamation often lies more in his own feelings, what he thinks other people are thinking of him, than in any actual change made manifest in their attitude towards him. Thus '[a] solatium for injured feelings, *however innocent the publication by the defendant may have been, forms a large part in the [general compensatory] damages'.*
>
> The harm caused by the defamatory publication does not end at the time of publication but encompasses continuing harm including ongoing hurt feelings during and up to the conclusion of the litigation by the plaintiff seeking vindication.[341]
>
> (citations omitted)

628. It is also well established that it is not necessary to prove actual damage to one's reputation to be awarded general damages for defamation.[342]

629. In assessing general damages, the court is to have regard to factors which include the nature and gravity of the defamatory matters, the context and mode of publication, the extent of the publication (in terms of the number and class of recipients and their relationship, if any, to the plaintiff, and the period over which the matters were published) and the social standing of the plaintiff.

630. The defendants have not, in any way, mitigated the damage caused by the defamatory material by way of an apology or a correction.[343] On 18 September 2017, the first plaintiff served a Concerns Notice on the defendants, inviting them to make amends. They declined to do so.

631. The defendants' conduct during the course of this litigation is also relevant in assessing the quantum of general damages, albeit I am conscious that the plaintiffs also pursue aggravated damages.

632. The First Email was published only to Dr Kelly, the Second Email to both Dr Kelly and Ms Cheah and the Phone Call to Ms Rauda, although the AOGP Board were subsequently informed of the fact of the Emails and Phone Call and the allegations contained therein.

633. I am satisfied from the evidence of Dr Kelly and Ms Cheah that they both rejected the allegations made by the first defendant in the Emails and the Phone Call as being untrue and unsubstantiated. Both Dr Kelly and Ms Cheah were clear in their evidence that despite the Publications, AOGP was eager to continue its involvement in offering the ProMBS workshops in partnership with the second plaintiff and, in fact, continued to do so successfully for a period thereafter.

634. Dr Kelly said that the first defendant had simply not provided any evidence to AOGP to support her allegation that the first plaintiff had engaged in IP theft and he considered the

Second Email was simply a personal attack on the first plaintiff. Ms Cheah felt sad for the first plaintiff and what he had gone through.

635. However, that does not detract from the impact those particular publications had on the first plaintiff in terms of hurt feelings, humiliation and distress, particularly having regard to the fact the audience for such publications was his first (and only) client in the area of MBS education. Although the letter from AOGP dated 21 September 2017 requiring the first plaintiff to execute the indemnity was written in supportive terms, I do not doubt that he felt significant embarrassment and anger at having had his integrity challenged, having AOGP embroiled in dealing with the first defendant and being required to execute that indemnity.

636. As to the Posts and Comments, it was submitted that having been made on the BFD Facebook group page, these publications were made to a forum which included the first plaintiff's peers, being medical practitioners interested in learning about the MBS, and thus his core market. It was submitted that these were the very people to whom the first plaintiff's reputation as a business-man was the most important. It was further submitted that due to the 'grapevine effect' the imputations gained currency beyond the BFD Facebook group and immediate friends and family and into the wider medical profession, albeit there was no evidence called on that specific issue.

637. The defendants admitted they operated a Facebook Group with approximately 9,400 members at the time of the Publications, with that membership increasing to approximately 11,900 members as at 8 December 2017.[344] The group was closed to persons other than registered medical practitioners.

638. The defendants did not file a Defence to the Second Statement of Claim, which contained an amended pleading that the BFD Facebook group had 24,000 members. However, the plaintiffs did not produce any evidence to support the allegation that the BFD Facebook group had 24,000 members, either at the time of the Publications or at any other time.

639. Included in Exhibit P1 are various private posts exchanged between the first plaintiff and the first defendant. In a private post made at or about the time of the Posts (ie around 9 September 2017), the first defendant made reference to 'the 10,000 doctors on BFD'.[345] In the Second Email, the first defendant stated; 'Business for Doctors has a social media page with nearly 10,000 members'.

640. As such I find that as at September 2017, the BFD Facebook group had a membership of approximately 10,000 registered medical practitioners. There was insufficient evidence for me to make a finding as to the total of the BFD Facebook group membership as at the end of November 2018, or at present. Although there was no evidence as to the demographics of the membership of the BFD Facebook group, I have assumed it comprises members based Australia-wide.[346]

641. I accept that the BFD Facebook group members were, by the very fact of that membership, interested in increasing their knowledge of the MBS, and therefore I am satisfied they did form a part of the plaintiffs' target market. However, I am mindful that such audience was already aligned with BFD and therefore an audience which may have been more difficult

for the plaintiffs to penetrate, when compared to the many other general practitioners in Australia who were not (and are not) BFD Facebook group members.

642. The group was being fostered and supported by the defendants, who were running MBS seminars in competition with the second plaintiff. Many of the BFD members who posted comments in response to the Posts, did so in a manner which reflected not only their professional support of the first defendant, but their personal support of her.

643. Dr Rewal gave evidence that the Posts were still on the BFD Facebook group page as at 30 November 2018, being some 14 and a half months after they were published. I accept that evidence, which was not challenged. The defendants ought to, but did not, remove the offending material until at least that date, despite these proceedings being on foot.

644. The plaintiffs did not call any evidence as to how the BFD Facebook group page worked in practice, other than the brief evidence given by the first plaintiff ‘s wife that she saw the Posts when she was checking her Facebook. There was no evidence as to how she received notification of the Posts or, for example, whether a BFD Facebook group member received a notification (and if so, potentially how) every time a new post or comment was made on the Facebook group page.

645. There was no evidence as to what a member would see on the page if, for example, they only looked at the page a week (or a month or three months or 12 months) after the Posts and Comments were published. Would they need to scroll back through all the subsequent posts and comments made to see the Posts and Comments? Was there a way to search through the page to find a reference to the first plaintiff’s name? How much information has been posted on the Facebook Group page since 9 September 2017 (and up to and including 30 November 2018), which may be relevant in terms of assessing the likelihood of members both seeing and reading the Posts and Comments?

646. From the screenshots of the Posts and Comments included in Exhibit P1, it is apparent from that material that, for example, the First Post was the subject of, at least, 20 comments, [347] the Second Post of at least three comments[348] and the Third Post of at least three ‘likes’. [349] The fact the Comments were made in response to the Posts (thus in turn generating further comments) demonstrates that numerous BFD members read the Posts.

647. Although there were only eight Comments pleaded, the screenshots depict those and other comments made by members in response to both the Posts and the Comments. Many of those screenshots are duplicated. I estimate that 52 comments (including the Comments) were made in direct response to the First and Second Posts and/or Comments, from **32** different BFD members. Of those comments, 50 were from writers generally expressing their support for the first defendant and/or disapproval of, criticism of and/or contempt for the first plaintiff. One reader took a more cautious approach, by posting:

> Has someone actually been to the course? Or has it been assumed that he attended therefore he is plagiarising?[350]

> Just asking because that's a big accusation. That email looks pretty damning.[351]

648. It is not possible from the screenshots to determine on what time or date each comment was made, nor was there any evidence as to the date upon which the screenshots were taken.

649. Save for what can be gleaned from the screenshots, the court was not provided with any evidence as to how many members actually accessed and/or read the Posts (and/or the Comments) and/or whether it was, in fact, possible for that information to be obtained by reference to the internal operation of a Facebook group page such as that operated by the first defendant on behalf of BFD. As such, the possible reach of the Posts and Comments in terms of the potential for reputational damage, beyond that of the 32 members who are known to have read (at least some of) the Posts and/or Comments, is uncertain.

650. I note that the defendants published the first plaintiff's response to the First and Second Posts, being the precipitant for the publication of the Third Post. There was no evidence as to the period of time during which the first plaintiff's response was published on the page, and whether it too was still able to be seen and read by members as at 30 November 2018. The court was not privy to any further comments made thereafter by members, namely once they had had the opportunity to read the first plaintiff's explanation and to hear his side of the story. Of course, the Third Post (made in response thereto) was itself defamatory and repeated the previous allegation of IP theft.

651. The plaintiffs relied, predominantly, on the decisions of interstate courts, by way of comparison. Each case turns on its own facts, and although I will not recite the authorities relied upon by the plaintiffs, I have considered them when approaching my assessment, based on the facts that I have found proved.

652. I was referred to a decision of the New South Wales Court of Appeal in *Crampton v Nugawela*,[352] a case involving the defamation of a medical practitioner by another such practitioner.

653. Although aspects of that case mirrored the case at hand, in that case the court was satisfied that as a result of the defamation, Dr Nugawela had lost what was a pre-eminent position in the field of medical informatics in Australia, and that it had destroyed a successful professional body that he had created.

654. The defendants pleaded that the first plaintiff was not and is not well known in the Australian medical community and did not have an established reputation that could be damaged by the Publications, insofar as they conveyed the imputations.[353]

655. I refer to my findings as to the first plaintiff's level of expertise in the MBS and the Health Act as at the time of the Publications. The first plaintiff was not a pre-eminent leader in this field at the time of Publications, as Dr Nugawela was. This was his first forte into the area of education of medical practitioners, in an area where he had developed some degree of knowledge, over a short period of time.

656. I am not satisfied that at the time of the Publications the first plaintiff had an established reputation in Australia as a provider of education to general practitioners on the MBS.

657. The first plaintiff gave limited evidence as to his current professional activities. As at the time of the Publications he had been a resident in Australia for approximately ten years, and had only just been awarded his fellowship of the Royal Australasian College of General Practitioners. He had worked in a variety of different roles, but as a general practitioner in private practice for approximately three years only.

658. There was no evidence to support a finding that the first plaintiff was, at the time of the Publications, well known in his professional field, through his involvement with other professional bodies, community work or the like.

659. Nevertheless, I accept that the defamatory imputations conveyed by the Publications were serious and had the ability to cause significant damage to the first plaintiff's reputation as a person, as a general practitioner, and in the field of the delivery of continuing education on the MBS to medical practitioners. I accept that these allegations and the forum in which they were made had the ability to be spread by grapevine, beyond the group to which they were made, and that they may emerge at some time in the future.

660. Despite my observations as to the first plaintiff's credibility, I accept his evidence that when he first learned of the Posts and the Comments, he was very shaken, upset and hurt at having been called a scumbag, a cheat and a liar and was concerned at what others would think of him.

661. I also accept that particularly in the immediate aftermath of the Publications, and in the context of having to explain himself to AOGP and sign the indemnity, the first plaintiff felt sad, downcast and embarrassed, not only for himself but for his wife. I accept that he could not sleep for several nights. I accept the observations of both Dr Rewal and the first plaintiff's wife that since the Publications the first plaintiff has been more introverted and less outgoing.

662. The first plaintiff gave evidence that in his culture, it was dishonourable to be called a cheat or a liar, and I accept that evidence. I accept and find that this has added to the hurt and humiliation he experienced as a result of the Publications. Having said that I am mindful that the evidence demonstrates that the first plaintiff has demonstrated dishonesty in the past. Nevertheless, the accusations of IP theft made by the first defendant were serious, and without any legitimate foundation. The award of damages made must vindicate the plaintiffs by demonstrating the baselessness of that allegation.

663. I accept that the first plaintiff remains distressed and upset as a result of the Publications and the impact they had on the way others, including his peers, may perceive him. However, there was no medical evidence presented to the court to support a finding that this distress has impacted on the first plaintiff's ability to work or to undertake his usual activities. He returned to present a successful ProMBS workshop in Melbourne in February 2018 and presented again at ProMBS workshops in July and August 2018. He intends to return to the delivery of MBS education once these proceedings are finalised.

664. The first plaintiff gave evidence that he continued to work as a general practitioner and it was submitted he ran his own medical practice, suggesting that the first plaintiff remains capable of undertaking a difficult and stressful occupation.
665. Doing the best I can on the available evidence I assess general damages arising from the defendant's defamation of the first plaintiff in the sum of **$40,000**.

Aggravated Damages

666. In the subject case, I am satisfied that by the Publications, the first defendant accused the first plaintiff of 'IP theft' in that he had passed off the work of BFD as his own; she made that accusation not having any reasonable grounds for believing it was true and careless or not caring whether it was true or false and persisted with that allegation over a period of several years, including up to the trial date.
667. Although the first defendant may have acted, in part, for professional and altruistic purposes, I am satisfied that a primary purpose for her so acting was to advance her own personal interests, and those of the second defendant, by seeking to extinguish the plaintiffs as competitors in the area of MBS education.
668. In determining that the first plaintiff is entitled to aggravated damages, I have taken into consideration the judgment of Blue J in *Duffy*, where he said: [354]

> Aggravated damages in defamation are compensatory and not punitive and are awarded "to reflect conduct by the defendant which aggravates the injury and increases the harm done to the [plaintiff]".
>
> Aggravated damages may be awarded for defamation when the defendant's conduct of the defence (or other conduct at or after the publication) is lacking in bona fides, improper or unjustifiable.
>
> Such conduct may include a failure to apologise or persistence in a plea of justification, but only if the defendant's conduct in failing to apologise or persisting in the plea of justification is lacking in bona fides, improper or unjustifiable.
>
> ***Failure to Apologise***
>
> Merely not to apologise is not positive or active conduct and cannot in itself be in bad faith, improper or unjustifiable. Something more is required. For example, if the original publication was made maliciously, a failure to apologise might be regarded as a continuation of the malice and hence lacking in bona fides, improper or unjustifiable.

(citation omitted)

669. I note the findings I have made above with respect to the defendant's conduct and her purpose and intent in sending the First and Second Emails.
670. As previously stated the Posts were still accessible on the BFD Facebook group page as at 30 November 2018, more than a year after they were published and despite these proceedings having been on foot since 18 October 2017.
671. The first defendant continued to taunt the first plaintiff, for example by threatening to subpoena his billings from practice,[355] and sending him the link to an article written about these proceedings, while threatening to produce evidence of his 'over servicing and tax evasion'.[356]
672. The defendants ultimately produced no evidence at trial, despite relying on the defences as outlined above.
673. I am satisfied that an award of aggravated damages is warranted. I award aggravated damages in the sum of **$10,000.00**.

Economic Loss

674. It is well established that in order to prove loss by way of special damage arising from defamation, a plaintiff need only prove, on the balance of probabilities, that the defamatory imputations were a cause of the loss (rather than 'the' cause).[357]
675. Counsel for the plaintiffs submitted that there was authority to support the proposition that in a case such as the present, having regard to the nature of the defamatory imputations and 'the obvious impact these would have on the Plaintiff's business, the courts will readily infer some measure of economic loss'.[358] Counsel relied on what was said by the Full Court of the South Australian Supreme Court in *Selecta Homes and Building Co Pty Ltd v Advertiser-Weekend Publishing Co Pty Ltd* to support that proposition.[359]
676. However, those findings were made in the context of a claim made by Selecta Homes for general damages for reputational damage which Selecta Homes had sought to prove by reference to material, including expert accounting evidence, which suggested there had been a downturn in sales following the publications in question. There was no claim for 'special damage' in addition to general damages, and the claim in defamation was being made by a corporation.
677. The Full Court referred to what was said by Winneke J in *Feo v Pioneer Concrete (Vic) Pty Ltd*, namely:[360]

> The true view is, in my opinion, that where a corporation has been slandered in the way of its business, the slander is actionable per se, and it is unnecessary to either allege or prove special damage. That

> does not mean that the presumed damage to its reputation can only be compensated if calculable in precise money terms. As Ormiston JA said in *Kay v Chesser* (at 58-59 [12]), damages are not to be assessed for injury to the company's 'reputation as such', but are to be assessed 'having regard to financial and commercial considerations by which a corporation's reputation is ordinarily assessed'. In some cases the damages assessed may only be nominal; particularly where the court cannot be satisfied that the nature of the defamatory imputation, or the breadth of its publication, has caused significant harm to the trading reputation of the corporation defamed. However, that is not to say that the defamatory publication is not actionable at the suit of the corporation. If no proof is tendered of specific loss, the assessment of damages is to be made on the material available to the court and the view which it forms of the loss likely to have been suffered by the company as a consequence of the defamatory material which it finds to have been published of and concerning the entity in the way of its business: cf *Australian Broadcasting Corporation v Comalco Ltd* (1986) 12 FCR 510 per Neaves J at 588 and Pincus] at 604.

678. In this case, the plaintiffs do not seek damages of a general kind for loss of business. Rather the plaintiffs claim to have incurred specified or identified economic losses. As outlined in *Andrews & Anor v John Fairfax & Sons Ltd & Ors,*[361] in doing so, the plaintiffs must show that the loss was caused by the defamatory publication.

679. It does not, in my view, follow that absent proof of such loss, an additional award for such damage, going beyond an award of damages for reputational loss by way of general damages, is justified.

680. It remains for the plaintiffs to prove that they have suffered a loss and that the defamatory imputations (and/or the interference in contractual relations) were a cause of that loss.

681. The plaintiffs' claim for damages for economic loss comprises of:

1. Lost profit from three cancelled ProMBS workshops in the sum of $6,000.
2. Loss of presenter fees of $2,000.
3. Loss of venue fire fees of $4,500.
4. Loss of opportunity to make profit from new clients of $40,000.
5. Loss of profits and presenter fees from upcoming, unscheduled ProMBS workshops of $20,268.

682. I will deal with each of these claims in turn, although there is a degree of overlap in some.

Cancellation of ProMBS Workshops

683. The first three components of the claim for economic loss relate to losses allegedly incurred due to the cancellation of **three** ProMBS workshops.[362]

684. Although it is not entirely clear from either the evidence or submissions, I presume those three workshops are those which had been planned for Melbourne in October 2017 ('Melbourne 2017'), Sydney in November 2017 ('Sydney 2017') and Sydney in March 2018 ('Sydney 2018'), all of which were cancelled.[363]

685. The plaintiffs claim $6,000 for lost profit arising from the cancellation of these workshops. The only documentary evidence to support that claim is that contained in the document entitled 'Pro MBS workshop net position as at 14 August 2018'. In addition, Ms Cheah gave brief evidence as outlined at paragraph 255 herein.

686. I assume the claim is predicated upon the assertion that, on average, net revenue from each ProMBS workshop in 2018 was about $4,000, with the second plaintiff's share being 50%, namely $2,000. If three workshops were cancelled, then, following that line of reasoning, the second plaintiff's loss of profit equates to $6,000.

687. In addition, the plaintiffs claim to have suffered a loss of venue hire fees arising from these cancellations, totalling $4,500. Ms Cheah confirmed that there were no cancellation fees incurred for the cancellation of Melbourne 2017 or Sydney 2017, with a cancellation fee of **$4,497.89** incurred with the Hilton for Sydney 2018. There was no other evidence to the contrary.

688. I have previously discussed the evidence given by the first plaintiff, Dr Kelly and Ms Cheah with respect to the further proposed ProMBS workshops and the cancellation of any such workshops.

689. The defendants denied that any workshops were cancelled either as a result of any alleged defamation of the first plaintiff by the defendants or any interference by the defendants in the contractual relationship between AOGP and the second plaintiff. Rather, the defendants submitted that the workshops were cancelled because of a lack of interest from potential registrants, entirely unrelated to the alleged defamation and/or any contractual interference by them. They submitted the lack of interest was a product of AOGP's limited interstate market reach, due both to the limited number of interstate medical practitioners on AOGP's database and the difficult market conditions encountered by all education providers in these (and other) states.

690. Both Dr Kelly and Ms Cheah gave evidence as to the AOGP database, as outlined at paragraphs 66-67 herein.

691. The first plaintiff claimed the two workshops were cancelled in late 2017 because of the first defendant's bad mouthing of him and the impact on his reputation, and his hearsay evidence of alleged calls being made to AOGP saying 'AOGP is cheat and this is very unprofessional for AOGP to do that'.

692. Dr Kelly's evidence only went so far as to say that 'Melbourne 2017' was cancelled due to lack of interest, although it can be implied from his evidence that the level of expression of interest for 'Melbourne 2017' displayed immediately before the Publications, did not then

translate into a similar number of registrations after the Publications. There were nine expressions of interest in evidence pertaining to 'Melbourne 2017', and Dr Kelly believed there had been 11 or 12 in all. I accept Dr Kelly's evidence that thereafter, AOGP received only one registration for 'Melbourne 2017'.

693. From that evidence, it is possible to infer that there may have been some impact on potential attendee numbers for 'Melbourne 2017' following the Publications. However, there was no evidence from either Dr Kelly or Ms Cheah addressing what percentage of expressions of interest for any particular ProMBS workshop in fact translate to registrations, for those workshops which have, in fact, proceeded. There was no other evidence from which a comparison could be made to support a finding that, on average, a certain number of expressions of interest for a workshop translates into a certain number of registrants.

694. There was no evidence as to how many people ever registered for 'Sydney 2017', or whether AOGP opened registrations for that workshop before making the decision to cancel it.

695. There was also no evidence as to precisely when the decision was made to cancel either 'Melbourne 2017' or 'Sydney 2017', although it was a decision only made after the Publications.

696. Ms Cheah gave evidence that AOGP made a decision to **defer** 'Melbourne 2017' and 'Sydney 2017' to 'let it all settle down' having regard to what had happened with the first defendant, in terms of her having published the Facebook Posts. When Ms Cheah's evidence is considered as a whole I consider that in using those words she meant to also include the Emails and the Phone Call. I accept that evidence.

697. As such, I accept that there was a causal link between the cancellation of those **two** proposed workshops and the **Publications.** However, there was no evidence to support a finding that in cancelling these proposed workshops there was any breach of the Agreement by either party.

698. The evidence establishes, and I find, that in lieu of 'Melbourne 2017', a ProMBS workshop was held in Melbourne on 17 February 2018, being only four months thereafter.

699. The February 2018 Melbourne workshop was the first ProMBS workshop to be held after the Publications. The first plaintiff presented at that workshop. The first plaintiff described this as a 'good event' and Ms Cheah said that there had been a 'good response' to that workshop.

700. Despite the lack of evidence verifying the authenticity of the document entitled 'Pro MBS workshop net position as at 14 August 2018', I accept that the net revenue from that rescheduled Melbourne workshop was $29,923.81. After expenses of $13,761.44, this resulted in a net profit of $16,162.38, with that profit shared equally between AOGP and the second plaintiff.

701. That net profit from that workshop was therefore more than that achieved with respect to the initial ProMBS workshop ($15,451). There was no material in evidence to suggest the profit achieved from that workshop was less than may have been foreshadowed by any business plan or market research conducted before the Publications.

702. I find that the February 2018 Melbourne workshop effectively replaced the cancelled 'Melbourne 2017'. As such, while I accept that the delay in holding a ProMBS workshop in

Melbourne was caused by the Publications, I find that the second plaintiff received the benefit of the profit from that rescheduled workshop in any event.

703. I accept there was a delay of about four months in the holding of that workshop, meaning it is possible that the opportunity to hold another profitable ProMBS workshop in Melbourne was lost.

704. However, there was no evidence as to the viability of presenting more than two ProMBS workshops in Melbourne during any four, six or 12-month period. For example, there was no evidence that as at September 2017, AOGP had undertaken any business plan (or market research) which supported the holding of more than one ProMBS workshop in Melbourne (or indeed any capital city) in any four, six or 12-month period.

705. I note that a further ProMBS workshop was held in Melbourne on 11 August 2018.[364] The net revenue from that workshop was $18,861.70, which after expenses of $13,205.90 resulted in a net profit of only $5,655.80. As the reduction in net profit was due to a reduction in revenue, this suggests there were significantly fewer paying attendees at the August 2018 workshop, when compared to the February 2018 workshop.

706. In the absence of more evidence to establish that holding an additional ProMBS workshop in Melbourne during any relevant period would have, in fact, been profitable, I simply cannot make a finding on the balance of probabilities that the opportunity to hold another profitable ProMBS workshop in Melbourne was lost. The reduced profit achieved from the August 2018 Melbourne workshop strongly supports a finding that there is a degree of market saturation and that there is a limit to the number of profitable ProMBS workshops that can be held in any one city over any relevant period.

707. Put another way, I am not satisfied that in deferring ‘Melbourne 2017’ by four months, the second plaintiff suffered any loss in profit.

708. At its highest, the second plaintiff’s loss is confined to that arising from the four-month delay in the second plaintiff having the benefit of any net profit from the replacement Melbourne workshop. There was no evidence tendered as to relevant interest rates or the like from which any such loss could be properly calculated. Even if a generous interest rate of 5% is applied to the second plaintiff’s profit share from that seminar ($8,081.19), for four months, this results in a sum of only $135.

709. Although the expenses incurred for the February 2018 and August 2018 Melbourne workshops were similar, there was no evidence as to whether, for example, air fares and/or venue hire fees may have been less or more expensive in October 2017, compared to February 2018. Given the very small sums involved I cannot be satisfied on the balance of probabilities as to what, if any, profit may have been lost by the second plaintiff arising from the deferral of ‘Melbourne 2017’.

710. I accept the evidence of Ms Cheah and find that there was no venue hire fee incurred following the cancellation of ‘Melbourne 2017’.

711. In lieu of ‘Sydney 2017’, a further workshop was planned to take place in Sydney in March 2018 (Sydney 2018). I accept the evidence of Ms Cheah that no venue hire fees were incurred

following the cancellation of 'Sydney 2017'.

712. I accept Ms Cheah's evidence that 'Sydney 2018' was also cancelled and that as a result, AOGP incurred a cancellation fee from the Hilton pertaining to venue hire for that event in the sum of $4,497.89.

713. Neither the first plaintiff nor Dr Kelly gave evidence as to why 'Sydney 2018' was cancelled. The only evidence on that issue came from Ms Cheah. In response to a question in cross-examination as to what was the level of interest with respect to that proposed workshop, Ms Cheah said:[365]

1. ...I think Sydney, Sydney is just a really hard market to penetrate.

17. Do you believe that's because your database doesn't have a lot of doctors from that area or is there another reason why you think it was hard to penetrate.

1. We - when the first Sydney workshop didn't go ahead what we did was we went through looking up general practices in Sydney and tried to get, you know, some - some general practices will have like an information email or something and we put that - we actually manually put that in our database to try and increase the - increase our database.

17. So it wasn't an unexpected result, knowing that it was a difficult market.

1. Yeah.

714. In an email Ms Cheah sent to the Hilton, Sydney, dated 16 March 2018, Ms Cheah advised 'unfortunately they were not able to secure sufficient registrations to run the workshop', although she enquired as to whether there was any possibility of rescheduling the event to May or June. The Hilton was unable to accommodate that request.[366]

715. Ms Cheah also gave evidence that a workshop planned for Perth in 2018 was cancelled and she agreed with a proposition that the Perth market was another hard market to enter into.[367]

716. I find that a majority (70%) of the AOGP database as at July 2017 comprised South Australian based medical practitioners. There was no evidence as to precisely what percentage of the database comprised NSW based practitioners, however the evidence given by Ms Cheah that AOGP went to the trouble to generically add Sydney based practitioners to that database supports a finding that the lack of a database for potential registrants residing in the Sydney region was likely to have been a significant contributing factor to the cancellation of 'Sydney 2018'.

717. There was no evidence that there had ever been a profitable ProMBS workshop held in Sydney. As such, there is simply insufficient evidence to support a finding that the second plaintiff suffered a loss of profit arising from the cancellation of either 'Sydney 2017' or 'Sydney 2018'.

718. The second plaintiff's share in the cost of venue hire for the cancelled Sydney 2018 workshop was $2,248.95, being 50% of $4,497.89. However, to be compensable, the plaintiffs must establish that it is more likely than not that the defamation (or contractual interference) was a cause of that loss. Ms Cheah agreed that the Sydney (and Perth) markets were very

difficult to penetrate. The February 2018 Melbourne workshop was even more successful than the initial ProMBS workshop, being inconsistent with a finding that the level of interest for such workshops at that time was impacted by the Publications.

719. I am not satisfied on the balance of probabilities that either the defamation or any contractual interference by the defendants was a cause of the cancellation of 'Sydney 2018'.

Summary

720. The plaintiffs have not established that they suffered any loss of profit or venue hire fees as a result of the cancellation of any ProMBS workshops.

Presentation Fees

721. In his opening address, counsel for the plaintiffs submitted that the first plaintiff received $2,000 by way of a speaking fee for each ProMBS workshop. However, there was very little evidence led in support of this issue.

722. There is no reference in the Agreement to speaking fees, nor any documents in existence which establish that the first plaintiff ever negotiated with AOGP to be paid a speaking fee per workshop, over and above his profit share.

723. None of the first plaintiff's taxation returns were in evidence.

724. The income taxation return and financial statements for the second plaintiff for the financial year ending 30 June 2018 were in evidence.[368]

725. The second plaintiff declared a taxable income of $14,216 for the 2018 financial year. Gross income was stated as $37,637.33, with expenses of $23,421.53, resulting in Profit from Ordinary Activities before tax in the sum of **$14,215.80**.

726. The second plaintiff received **$8,270** by way of net profit from the initial ProMBS workshop in September 2017. By reference to the document 'Pro MBS workshop net position as at 14 August 2018', the second plaintiff's profit share from 1 January 2018 to 30 June 2018 was **$5,945.21**. This sum is consistent with the profit outlined in the second plaintiff's 2018 taxation return and financial statements.

727. As at the trial date, the second plaintiff had not lodged its 2019 taxation return. Draft financial statements for 2019 show gross income in the sum of $17,357.87, expenses of $11,189.95, resulting in a net profit before tax of **$6,167.92**.[369]

728. There is no documentary evidence that assists to determine if the first or second plaintiff ever received speaking fees over and above the profit share from the ProMBS workshops.

729. When asked to explain what income he received from the initial ProMBS workshop, the first plaintiff made no mention whatsoever of deriving any speaking fee. He said he could not remember what speaking fee he got to present at the workshop held in Melbourne in February 2018.[370]

730. The first plaintiff gave the following evidence-in-chief:[371]

17. You also claim loss of presenter fees and profits from upcoming and unscheduled seminars. Are they the ones that were with AOGP.
1. Yes.
17. How have you calculated that.
1. It was just my average calculation based on how the first one went. And we expected that if out of them, all those conferences or seminar, I would've probably made that much money.

731. Dr Kelly was asked if in addition to the net profit distributed as between AOGP and the second plaintiff from the initial ProMBS workshop, whether there was an additional speaking fee for the plaintiff and he said 'I don't think so.' [372]
732. During the evidence given by Dr Kelly about the re-negotiation of the arrangements between AOGP and the second plaintiff in 2018, Dr Kelly was asked if the first plaintiff was to receive a speaking fee. He said:[373]

> I think that year – you might have to ask our business manager, but I think that year he was going to receive speaker fees...

733. Dr Kelly was not asked what sum was negotiated with respect to any such speaker fee.
734. Ms Cheah was not asked whether the first or second plaintiff received any speaking fee for the initial ProMBS workshop. However, when asked about the terms of the re-negotiated agreement made between AOGP and the second plaintiff in 2018, she said there was a speaking fee of $150 per hour, and that each workshop went for seven to eight hours. However, when asked if the first plaintiff received any fee for speaking at the ProMBS workshops at which he presented in 2018 she said:[374]

> So all that's come from the share of profit that we were going to share at the end of the year.

735. Ms Cheah was not asked to explain this evidence further.
736. In the absence of further evidence to support a finding that either plaintiff was entitled to a presentation fee in addition to profit share, I cannot be satisfied of the same on the balance of probabilities.
737. If I am wrong about that, for reasons already stated, 'Melbourne 2017' was replaced with the successful February 2018 Melbourne workshop. Any potential loss of presentation fees from 'Melbourne 2017' was recovered from the successful February 2018 Melbourne workshop. There was no evidence to support a finding that there was ever sufficient interest to enable a ProMBS workshop to be successfully held in Sydney.
738. I am not satisfied that the plaintiffs have established any claim for damages for 'loss of presenters' fees for upcoming, cancelled seminars' whether as a result of any alleged interference by the first defendant in the contractual arrangements between AOGP and the second plaintiff or the defendants' defamation of the first plaintiff.

Losses from Upcoming Unscheduled Seminars

739. The plaintiffs claimed a sum of $20,268 for 'loss of presenters' fees and profits from upcoming unscheduled seminars'.

740. The only evidence as to how this sum was calculated came from the first plaintiff, namely: [375]

17. You also claim loss of presenter fees and profits from upcoming and unscheduled seminars. Are they the ones that were with AOGP.

1. Yes.

17. How have you calculated that.

1. It was just my average calculation based on how the first one went. And we expected that if out of them, all those conferences or seminar, I would've probably made that much money.

741. There was no other evidence as to how the sum of $20,268 was calculated. Neither the Plaintiffs' Closing Submissions, nor the Plaintiffs' Outline of Argument provide any further assistance in this regard.

742. I assume this claim relates to the first plaintiff's inability to earn either profit or presentation fees from unscheduled ProMBS workshops during the period from late February 2018 to 30 June 2018, and from August 2018 to date.

No Presentations late February 2018-30 June 2018 – Dispute with Primary Health

743. The first plaintiff presented at the successful ProMBS workshop in Melbourne on 17 February 2018, but did not present again until a ProMBS workshop in Adelaide on 21 July 2018. His last ProMBS presentation was in Melbourne on 11 August 2018.

744. For the reasons that follow, I find that the first plaintiff agreed not to present at any further ProMBS workshops from late February 2018 until after 30 June 2018, so as to resolve an unrelated dispute he had with Primary Health. I am not satisfied therefore that the defamation and/or any alleged interference in the second plaintiff's contractual relationship with AOGP caused such loss.

745. To understand the dispute with Primary Health, it is important to consider the contractual arrangements in place between Primary Health and the first plaintiff (and other entities related to the first plaintiff) as at 2017/2018.

746. In about June 2014, the first plaintiff and two companies associated with him, R & R Southern Medical Practice Pty Ltd (R & R Southern) and RNR Adelaide Pty Ltd (RNR) entered into a Contract with Idameneo (No.123) Pty Ltd (Primary). Pursuant to that contract, R & R Southern agreed to sell to Primary the medical practice owned by it, conducted through the first plaintiff, including the goodwill of that practice as generated by the first plaintiff. In exchange, the first plaintiff and Primary agreed to execute a Performance Guarantee, and Primary and RNR agreed to execute a Practitioner Contract.

747. It was a term of the contract that RNR conduct its incorporate medical practice and procure the first plaintiff to render medical services, only at new premises at Royal Park (run under the 'Primary Health Care' banner) for a period of at least five years from the Commencement Date of that contract (subject to certain defined exceptions).[376]

748. The contract required the first plaintiff to effectively work full time at the Primary Health Care Royal Park practice, with a requirement that he work no less than 45 hours per week for 48 calendar weeks per financial year until he attained FRACGP and that thereafter he work no less than 50 hours per week for 48 calendar weeks per financial year, with those conditions subject to other stringent requirements.[377]

749. The contract included a restraint of trade whereby the first plaintiff, R & R Southern and RNR agreed not to 'render medical services' at any place within a certain radius of the premises where R & R Southern conducted its old practice at Woodcroft, or the Royal Park practice, for a certain defined period.

750. The parties were required to give certain warranties including:[378]

> (g) none of the Old IMP, the New IMP, or the Doctor is involved in, or aware of, any dispute or current or threatened proceedings or arbitration relating to the practice, any asset of the practice, any past or present employee of the practice, any past or present patient of the practice, or any medical service rendered by the Doctor;
>
> ...
>
> (i) there is nothing in relation to any of the Old IMP, the New IMP or the Doctor which would adversely affect the business or reputation of the Purchaser;

751. The contract required the first plaintiff to be an employee of RNR.

752. Pursuant to the Practitioner Contract, Primary agreed to provide services and facilities to enable RNR to conduct an incorporated medical practice, through the first plaintiff, at the Royal Park Practice, upon certain terms and conditions. Those services included the necessary space within the premises, plant and equipment, provision of staff and contractors, provision of stationary, electricity and the like. Those services were not to be used for any other purpose. [379]

753. Pursuant to clause 7.1 of the Practitioner Contract:[380]

> As between the Company on the one hand and the IMP and the Doctor on the other, the IMP and the Doctor are jointly liable for, and by this Deed indemnify the Company against, any liability whatever arising from the Doctor rendering medical services as a consequence of the IMP being a party to this Deed or otherwise in connection with

> this Deed or other acts or failure to act on the part of the Doctor or the IMP, whether of a medical service nature or otherwise.

754. On 21 February 2018, Primary Health sent a letter to the first plaintiff (via email) signed by their Head of Legal and Legal Counsel in the following terms:[381]

> We act on behalf of the Institute.
>
> The Institute is aware that you have published and sold education material (including an educational workshop on or about 2 September 2017) titled "ProMBS" relating to efficient and accurate MBS billing.
>
> We are instructed that this material appears to be substantially similar to material owned and published by the Institute on its websites, which it makes available to its members (including yourself) to assist them in their billings. We confirm that the Institute holds copyright in this material and that it has at no time waived its copyright in this material, nor has it permitted you to use its material for any commercial purpose.
>
> Publication of material in which the Institute holds copyright is in contravention of Division 2 of the *Copyright Act 1986* (Cth).
>
> Accordingly, we are instructed to request that you deliver to the Institute all copies of any material which was published or presented in relation to the "ProMBS" workshop for our review by no later than **7 March 2018** in order to confirm that no such breach has occurred.
>
> The Institute reserves all of its rights, including its right to make an application seeking orders for preliminary discovery.
>
> We look forward to hearing from you.

755. The first plaintiff gave evidence that he was told by Simon Cross at Primary Health, that the first defendant had told Primary Health that he had taken copyright material both from her and from Primary Health to use in his ProMBS workshop, being the source of the claims made in this letter.

756. That evidence is hearsay. There was no admissible evidence to support that claim. Although an email from the first plaintiff to Mr Cross dated 22 February 2018 is in evidence,[382] and in that email the first plaintiff set forth what he 'understood' to have occurred and sought

confirmation of that, any response to that email from Mr Cross was not in evidence. Mr Cross was not called to give evidence.

757. However, it is apparent from correspondence between the first plaintiff and Mr Cross exchanged in late February and early March 2018 that Primary Health required the first plaintiff to withdraw from the advertised ProMBS workshops and that the first plaintiff then did so, thus resolving the threatened copyright dispute between them. The first plaintiff also undertook not to personally present at the ProMBS workshops until after his engagement with Primary Care had ended or until he had reduced his hours working at the Royal Park practice. [383]

758. The first plaintiff gave evidence that he was very shaken in the first few days after the Publications and when asked why he had stopped presenting the MBS workshops in February 2018, he initially blamed it on his mood, what he described as his depression and just wanting to avoid anything to do the MBS, given what had happened.

759. However, the first plaintiff eventually gave quite clear evidence that he had ceased presenting the ProMBS workshops because he was required to do so by Primary Health. Primary Health required the first plaintiff to cease presenting the ProMBS workshops and for his name to be removed from all marketing associated with those workshops until his contract with them expired, which by agreement, was a year earlier than had been anticipated, namely on 30 June 2018.

760. Primary Health were delivering education on the MBS to general practitioners in competition with both the plaintiffs and the defendants.

761. The Primary Health contracts produced by the plaintiffs do not include any express restraint of trade clause which would operate so as to have prevented the first plaintiff from offering education on the MBS in competition with them.

762. In a letter written by the first plaintiff to Primary Health dated 6 March 2018,[384] the first plaintiff referred to his understanding that the intellectual property he created vested in him. He referred to a potential option to resolve the dispute, namely that he work reduced hours and ‘be permitted to operate my own business without paying the percentage split to Primary Health’, albeit it was not an option he considered appropriate.

763. I consider it likely that the tendered documents contain only portions of the relevant communications that passed between Primary Health and the first plaintiff pertaining to the dispute. While it is not strictly necessary that I make findings as to the nature of the dispute and what caused it, it is likely that the dispute was multi-faceted, and that while the first plaintiff remained working in a full-time capacity with Primary Health they did not support him working in his own business as well, potentially taking his focus away from his contracted role, and deriving income which was not being shared with them from a business in competition with their own.

764. As outlined, it was suggested by the first plaintiff that the first defendant had been instrumental in causing the dispute, in that she had informed Primary Health that the first defendant was using Primary Health material in the ProMBS workshops. There was insufficient admissible evidence for me to make such a finding on the balance of probabilities. However,

the claim did not include any plea to the effect that the defendants had defamed the first plaintiff by way of publications made to Primary Health, or had interfered in his contractual relationship with Primary Health, in any event.

765. There was no evidence to support a finding that the dispute with Primary Health was caused by the Publications.

766. There was some other evidence, albeit imprecise, as to why the first plaintiff temporarily ceased presenting the ProMBS workshops in February 2018.

767. Ms Cheah said that the first plaintiff was unavailable to present at the Creswick ProMBS workshop in April 2017 and when asked why that was she said he was busy.[385]

768. In the context of a discussion about both the change in the plaintiffs' contractual arrangements with AOGP and the rebranding of ProMBS to remove the second plaintiff's name from the AOGP website, Dr Kelly said that the first plaintiff 'told me he was feeling stressed by it all and that it was better that he, he not be involved up-front'.[386]

769. However, it is clear and I find that the second plaintiff's name was removed from the ProMBS promotional material, because of the first plaintiff's unrelated dispute with Primary Health.

No Presentations since August 2018

770. The first plaintiff has not presented at a ProMBS workshop since August 2018 and the second plaintiff did not renew the agreement with AOGP beyond 31 December 2018.

771. The only evidence as to why the first plaintiff had ceased to give any ProMBS presentations since August 2018 came from the first plaintiff, namely:[387]

> ...My term with Primary finished on 30 June, so after that I was free, so I did this 21 July 2018 in Adelaide. When I went there then I was told that somebody has complained to the AOGP again and AOGP has come to do an audit. So all these things just keeps on making my wound grow, I did it very well, it went very well, people who had been practising for 30 years, they were really surprised at how come there is these type of item number which is available and they never knew about it. So I had ... review and I think on 11 August '18 as well, I did one presentation and I just said that look, I cannot keep on doing it with this much stress, so I decided to just pull out.

772. However, the first plaintiff made it clear that he intended to resume presenting MBS workshops 'once this court case gets settled'.[388]

773. All of the evidence was to the effect that the first plaintiff made a unilateral decision to cease presenting the ProMBS seminars as of August 2018. There was no evidence to support a finding that AOGP were not prepared to continue their involvement with the plaintiffs as a result of the Publications, indeed, the evidence was to the contrary.

774. I am satisfied that the RACGP conducted a 'face to face' audit of the ProMBS workshop conducted in Adelaide in July 2018 and that the first plaintiff presented at that workshop. As previously stated, the results of that audit were mostly positive, with the auditor noting that the 'the event was professionally run, with knowledgeable presenters'. She also stated 'Great that there was such a strong focus on the case scenarios'.[389]

775. As the ProMBS workshops are accredited, there is always a possibility that they will be audited to ensure they comply with RACGP accreditation criteria. This remains the case and was the case irrespective of the Publications.

776. I accept that the fact the audit was undertaken in July 2018 was stressful for the first plaintiff and that it is possible it may have contributed to his decision to cease MBS presentations as of August 2018.

777. However, there is no medical evidence to support a finding that the first plaintiff has been unfit to continue presenting MBS workshops because of any psychological illness or injury. I accept his counsel's submissions that since July 2018 the first plaintiff has continued to work as a general practitioner, and runs a medical practice at Glenelg.[390] Although there was no evidence led as to the first plaintiff's responsibilities and workload arising from such employment, it is important to assess the claim in the context of him now having taken on the responsibility of running that clinic.

778. The first plaintiff did not cease presenting ProMBS workshops immediately after the July 2018 audit. He also presented at a further ProMBS workshop in Melbourne in August 2018 and only ceased presenting thereafter, almost a year after the Publications. There was no evidence to suggest this workshop was also audited.

779. I also note that the net profit from that workshop was considerably less than that achieved for the earlier February 2018 Melbourne workshop. There can be no doubt that the time demands associated with preparing for and attending such workshops must be significant. The second plaintiff's profit share from the **two** workshops in July and August 2018 was only $6,167.93.

780. I have already outlined the reservations I have as to the first plaintiff's credibility. I am simply not satisfied that any alleged loss he may have suffered due to his decision to step back from presenting the ProMBS workshops as of August 2018, was caused by the Publications, or any interference by the defendants in the contractual relationship between the second plaintiff and AOGP.

781. There was no evidence led as to whether and/or on what terms AOGP would be prepared to renegotiate with the second plaintiff to renew their agreement in the future. However, Dr Kelly said that AOGP did not currently have an agreement with the second plaintiff 'because we've been waiting for things to settle down, really, and Rajan said his attention is otherwise diverted.'[391]

782. Ms Cheah was asked why the agreement with the second plaintiff and AOGP ended as at 31 December 2018 and she said:[392]

> I think he wanted to make sure that everything settled before and, I don't know.

783. The evidence supports a finding that the first plaintiff intends to return to presenting MBS workshops once these proceedings are finalised. There was no evidence to support a finding that AOGP was unwilling to renegotiate the agreement as from the end of 2018, or would be unwilling to do so in the future.

784. I am not satisfied that the plaintiffs have established a causal link between the first plaintiff's unilateral decision to 'pull back' from the ProMBS workshops as of late 2018, and any alleged contractual interference by the first defendant and/or the defendant's defamation of the first plaintiff.

Re-negotiation of the Contract on Less Favourable Terms

785. The plaintiffs' claim for loss of profit from unscheduled ProMBS workshops is in part based on an allegation that the defamation and/or the contractual interference caused AOGP to re-negotiate its contract with the second plaintiff on less favourable terms.

786. As previously outlined, the Collaborative Partner Agreement between AOGP and the second plaintiff (the Agreement) was to develop and deliver the **initial** education workshop to optimise earnings through correct and effective use of MBS item numbers. It was intended the Agreement would end on the 'Completion of Workshop Evaluation'.

787. The Agreement outlined an intention for the parties to continue to 'work together' to deliver workshops relating to the correct and effective use of the MBS, if the initial workshop was successful. It expressly stipulated that the success of the initial workshop would be evaluated to decide on how future education sessions can be delivered.

788. Pursuant to the Agreement, the second plaintiff was to receive 60% of any net profit 'from the workshop' and AOGP was to receive 40%. By reference to the Agreement, it is clear that this profit share related only to the net profit derived from the **initial workshop**, being the subject of the Agreement.

789. By the express wording of the Agreement, that profit share was determined having regard to the parties' respective contribution in terms of 'initial investment' in the project, which, as I have already stated, included the first plaintiff estimating that input by reference not only to the actual hours he spent creating the content and the number of hours he expended in undertaking the NVI course.

790. The evidence of the first plaintiff, supported by that of both Dr Kelly and Ms Cheah, was that the initial ProMBS was successful, such that further seminars were planned and scheduled. However, there was no evidence directed specifically to the issue as to when any 'workshop evaluation' was **completed**, being relevant to determine the 'end date' of the Agreement.

791. As the initial workshop was considered to be successful, the parties then continued to work together to deliver ongoing education pertaining to the MBS, as was foreshadowed in the

Agreement.

792. I am satisfied that the Agreement was renegotiated in (about) early 2018, such that each party was to receive 50/50% of the net profit.[393]

793. The first plaintiff gave evidence that the contract was re-negotiated to increase AOGP's share of net profit to 50% because AOGP 'had to work on it a lot more compared to (what) they thought'. He suggested this was because of additional work arising from the Audits.[394]

794. Neither Dr Kelly nor Ms Cheah gave any evidence to support the plaintiffs' allegation that the Agreement was renegotiated as a result of the first defendant's direct interference in the contractual relationship, through the sending of either the First or Second Emails or the making of the Phone Call.

795. Dr Kelly gave the following evidence on this issue:[395]

17. At some point were the - following these interactions, how did the business arrangements change with Dr Anand.

1. They changed in the next year, in 2018 we renegotiated another arrangement but really Rajan had to pull back from being involved. He was feeling - I can't speak for him, but he told me he was feeling stressed by it all and it was better that he, he not be involved up-front. We - from our perspective, AOGP wanted to avoid association with any legal battles or things like that, so we asked to remove IQMed from branding and things like that in terms of the workshop but Rajan still, we renegotiated the 50/50 profit-sharing arrangement -

796. As previously stated, the first plaintiff gave evidence that he withdrew from his involvement in the delivery of the ProMBS seminars and his name was removed from the AOGP website following an agreement he reached with Primary Care arising from their claim that he had 'stolen their idea' (Primary's idea) and was presenting it as his own seminar.[396]

797. Ms Cheah confirmed that the contract was re-negotiated but gave no evidence as to **why** the second plaintiff's net profit share pursuant to the re-negotiated contract reduced from 60% to 50%.

798. She gave evidence that both Dr Kelly and Dr Boda 'did a significant amount of work' in tidying up the case scenarios prepared by the first plaintiff and giving peer-to-peer review, to ensure the workshop was good value for practitioners.[397]

799. Dr Kelly gave evidence that 'it was quite a bit of work for us' (meaning AOGP) to give the first plaintiff feed-back on the draft case scenarios.

800. I do not doubt that the fact of the Emails and Phone Call also resulted in additional workload to AOGP. However, the evidence given by Dr Kelly and Ms Cheah as to what role Dr Kelly and Dr Boda played in putting together the ProMBS workshops and the extent of their input is consistent with the first plaintiff's own evidence, namely that it was more work for AOGP than they had anticipated.

801. I am not satisfied on the balance of probabilities that the defamation and/or any contractual interference caused the reduction in the second plaintiff's profit share in the re-negotiated agreement.

Summary

802. I am not satisfied that the first plaintiff was entitled to any speaking fees from the ProMBS workshops in addition to the profit share arrangements already outlined.
803. I am not satisfied that the plaintiffs have established on the balance of probabilities that either the defamation and/or any alleged interference in the second plaintiff's contract with AOGP caused the first plaintiff to temporarily cease presenting ProMBS workshops from February 2018 to July 2018, or from mid-August 2018 to date.
804. If I am wrong about that, there is insufficient evidence upon which I can reasonably assess what, if any, profit has been lost by the second plaintiff as a result. Although the plaintiffs relied upon the average profit earned from ProMBS workshops during 2018 to calculate the alleged loss, both Dr Kelly and Ms Cheah gave evidence that the ProMBS workshops have continued to be held since August 2018. There was no evidence as to the profitability or otherwise of any such ProMBS workshops, being directly relevant to an assessment of the plaintiffs' alleged loss.
805. I am not satisfied on the balance of probabilities that the defamation and/or any contractual interference caused the reduction in the second plaintiff's profit share in the re-negotiated agreement.
806. I am not satisfied that the plaintiffs have proved the loss as claimed for 'loss of presenters' fees and profits from upcoming unscheduled seminars'.

Loss of Opportunity to Obtain New Clients

807. The first plaintiff gave evidence, which was not supported by any other evidence, that in September 2017, being after the Publications, he had discussions with another health network about doing a presentation for them, in conjunction with AOGP. He said:[398]

> They told me that they have about 400 plus GPs who would be happy to come to a similar seminar if I could do it at a rebateable price. So I went back to AOGP we did some calculation and we were thinking that we could make around $40,000 if I do a presentation for their GPs.

808. He said this was an expected net profit of $40,000, to be split between the second plaintiff and AOGP.[399]
809. The plaintiffs did not call evidence from anyone at the 'other health network'. Neither Dr Kelly nor Ms Cheah gave any evidence to support the plaintiffs' allegation.
810. Having regard to my reservations as to the first plaintiff's credibility, based in part upon the lie he told in his NVI presentation as to having struck a similar deal, in the absence of further supporting evidence, I cannot accept the first plaintiff's evidence on this issue.

811. I am not satisfied on the balance of probabilities that the plaintiffs have established any alleged loss of opportunity.

Summary

812. I assess damages in respect of the defamation in the sum of $50,000 comprising:

General Damages $40,000

Aggravated Damages $10,000

Economic Loss Nil

TOTAL $50,000

813. I make no award of damages for any alleged interference by the defendants in the contractual relationship between the second plaintiff and AOGP.

Orders

1. Judgment in favour of the first plaintiff as against the defendants in the sum of $50,000.
2. The second plaintiff's claim is dismissed.
3. I will hear the parties as to interest and costs.

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[1] As pleaded in the Second Statement of Claim (Second SOC) at [1.4], but noting that as per Exhibit P1 item 13, the first plaintiff's wife, Ridha Anand, signed a Collaborative Partner Agreement on 18 May 2017 in the purported capacity of Director of the second plaintiff.

[2] Noting that the term 'Publications' was defined in the Statement of Claim to include only the Posts, the Emails and the Phone Call. The Statement of Claim was amended in July 2019, at which time the definition of 'Publications' was extended to include 'the Comments'. The defendants did not file a defence to the Second Statement of Claim.

[3] Excluding documents 16, 21, 23, 24, 41, 49, 52, 57, 67-72, 77, 80-82, 84, 85, 88, 90, 91, 93-95, 98-101.

[4] T 12.11-21.

[5] T 104.8-105.9.

[6] Plaintiffs' Closing Submissions at [10] and [66].

[7] T 81.29-31.

[8] T 110.32-33; 154.20.

[9] T 115.28-29.

[10] T 14.28-15.7.

[11] Noting that in the Plaintiffs' Closing Submissions at [18] and [19] it is submitted that the plaintiff attended a Webinar conducted by Primary Health on 2 March 2017 regarding changes to the MBS following an update to the schedule in November 2016. The first plaintiff did not give specific evidence to this effect, although an email pertaining to this Webinar was in evidence at Exhibit P1 item 34 pp 94-95. There was no evidence that the first plaintiff received the 'slides' from that Webinar said to be included in Exhibit P1 – noting that photocopies of the slides were on pages not tendered.

[12] T 82.15-31.

[13] T 164.20-25.

[14] T 164.26-32.

[15] T 39.3-26.

[16] Exhibit P1 item 29 p 84; T 15.15-16.19.

[17] Exhibit P1 item 1 pp 1-2.

[18] Exhibit P1 item 2 p 4; item 31.

[19] Exhibit P1 item 2 p 3.

[20] Exhibit P1 item 2 p 4.

[21] See Exhibit P1 Item 30 p 86 being notes prepared by the plaintiff as part of his presentation.

[22] T 29.18-20; T 29.36-30.5.

[23] Noting that included in Exhibit P1 at p 155 is a signed statement from Dr Bruce Miller dated 7 May 2019. Dr Miller was not called to give evidence and no explanation was given as to why. In the circumstances, I have disregarded this statement.

[24] T 88.9-89.32.

[25] Exhibit P1 item 9 p 14.

[26] T 24.34-37.

[27] T 78.32-34.

[28] T 23.13-24.23.

[29] T 175.36-176.9.

[30] T 195.23-30.

[31] T 164.36-165.16.

[32] T 25.35-26.14.

[33] Any such survey was not in evidence.

[34] Exhibit P1 item 12 p 19-26.

[35] T 166.32-35.

[36] Exhibit P1 item 13 pp 27-28.

[37] Exhibit P1 item 13 p 28.

[38] Exhibit P1 item 73 p 343.

[39] T 174.1-12.

[40] Exhibit P1 items 78, 79, 86, 87, 89 and 92.

[41] Exhibit P1 item 78 p 374.

[42] Exhibit P1 item 86 p 386.

[43] Exhibit P1 item 87 p 387.

[44] T 70.31-71.5.

[45] Exhibit P1 item 89 p 389.

[46] T 146.2-32.

[47] T 146.33-147.14.

[48] T 155.11-156.8.

[49] T 178.1-13.

[50] T 180.16-24.

[51] Exhibit P1 item 92 p 392.

[52] T 71.21-35.

[53] T 30.27-31.12.

[54] Exhibit P1 item 11 p 18.

[55] Exhibit P1 item 3 pp 5-7 and item 59 p 190.

[56] T 33.16-18.

[57] T 47.20-30.

[58] T 49.26-50.6.

[59] T 97.10-32.

[60] Exhibit P1 item 6 pp 9-11.

[61] T 33.32-34.4.

[62] T 166.6-13.

[63] T 37.1-38.2.

[64] T 38.3-9.

[65] T 34.36-35.1; T 38.10-16.

[66] T 50.28-36.

[67] T 50.1-27.

[68] T 38.17-32.

[69] T 94.5.

[70] T 51.21-29.

[71] T 77.28-78.13.

[72] T 85.1-87.3.

[73] T 95.31-96.23.

[74] T 87.11-26.

[75] T 157.33-36.

[76] T 162.23-163.10.

[77] T 166.17-167.15.

[78] T 114.21-115.5.

[79] T 176.16-20.

[80] T 196.6-10.

[81] Exhibit P1 item 61 p 255.

[82] T 118.7-13.

[83] T 120.7-28.

[84] T 181.28-182.6.

[85] Exhibit P1 item 61 p 208.

[86] T 121.18-38.

[87] T 183.21-24.

[88] T 137.19-138.11.

[89] Exhibit P1 item 61 p 209.

[90] T 122.1-25.

[91] Exhibit P1 item 61 pp 213-214.

[92] T 122.29-35.

[93] T 122.36-123.14.

[94] T 126.15-30; T 129.10-28.

[95] T 183.30-184.2.

[96] T 184.17-18.

[97] Exhibit P1 item 61 pp 214-215.

[98] T 125.1-26.

[99] T 125.27-31.

[100] Exhibit P1 item 61 p 253.

[101] T 131.2-132.5.

[102] T 181.26-27.

[103] Exhibit P1 item 61 pp 228-229.

[104] T 134.18-22.

[105] T 134.28-135.16.

[106] T 137.1-7.

[107] T 139.12-13.

[108] T 179.17-19.

[109] Exhibit P1 item 61 pp 226-227.

[110] T 182.7-11.

[111] Exhibit P1 item 61 p 216.

[112] T 183.8-17.

[113] T 184.19-33.

[114] T 184.34-38.

[115] T 185.1-12.

[116] T 185.13-22.

[117] T 93.13-19.

[118] T 176.10-15.

[119] T 195.31-196.2.

[120] T 34.24-31. The first plaintiff did not say whether he was referring to Dr Kelly, Dr Boda or both of them in his reference ‘to him’.

[121] T 93.20-22.

[122] T 40.4-7; T 28.23-26.

[123] T 166.1-5.

[124] T 188.25-29.

[125] T 196.19-197.25.

[126] T 189.5-32.

[127] Exhibit P1 item 56 pp 156-173.

[128] Noting such sum is in fact less than the combined estimated initial investment of IqMed and AOGP as set forth in the Agreement ($13,500 + $14,600 = $28,100).

[129] Exhibit P1 item 37.

[130] T 165.35-37.

[131] T 190.23-37.

[132] Exhibit P1 item 14 p 29.

[133] Exhibit P1 item 14 p 31.

[134] Exhibit P1 item 14 p 42.

[135] Exhibit P1 item 14 p 44.

[136] Exhibit P1 item 14 pp 29-44.

[137] Exhibit P1 item 17 p 53.

[138] Exhibit P1 item 17 p 53.

[139] Exhibit P1 item 18 pp 54-56.

[140] Exhibit P1 item 39 pp 109-110.

[141] Defence; Part 2 at [14.2].

[142] Defence; Part 2 at [14.3].

[143] Defence; Part 2 at [14.4].

[144] Defence; Part 2 at [14].

[145] See Exhibit P1 item 15 p 45.

[146] T 43.30-44.28.

[147] T 54.31-35.

[148] T 54.36-55.18; Exhibit P1 item 14 p 42.

[149] T 55.21-56.11.

[150] T 72.2-8.

[151] T 157.20-30.

[152] T 158.16-38.

[153] T 203.4-10.

[154] T 167.16-26.

[155] T 168.1-9.

[156] T 174.13-20.

[157] Exhibit P1 item 17 p 53.

[158] Exhibit P1 item 22 pp 62-63.

[159] T 168.22-32; Exhibit P1 item 22 pp 62-63.

[160] Exhibit P1 item 97 pp 400-401.

[161] Exhibit P1 item 97 p 400.

[162] Exhibit P1 item 97 p 399.

[163] T 174.31-175.7.

[164] T 169.25-170.5.

[165] T 192.6-8.

[166] T 200.26-29.

[167] T 193.8-15.

[168] T 61.13-28.

[169] T 61.6-15; T 61.22-31.

[170] T 67.9-26.

[171] T 67.38-68.1.

[172] T 67.27-29.

[173] Exhibit P1 item 47 p 129.

[174] T 68.1-5.

[175] T 60.31-61.5.

[176] T 61.30-63.18.

[177] T 101.1-9.

[178] T 68.13-28.

[179] T 56.12-21.

[180] T 72.12-14.

[181] T 171.1-22.

[182] T 170.6-27.

[183] T 189.5-190.1.

[184] Exhibit P1 item 56 pp 156-173, noting one of the emails is reproduced twice in this bundle.

[185] T 190.2-16.

[186] T 195.4-14.

[187] Exhibit P1 item 51 p 143.

[188] T 190.38-191.2.

[189] T 190.17-37.

[190] T 191.28-33.

[191] T 197.26-33.

[192] T 195.11-14; Exhibit P1 item 51 p 143.

[193] T 197.34-198.10.

[194] T 196.14-18.

[195] T 198.21-30.

[196] T 191.23-26.

[197] T 171.31-37.

[198] T 173.24-26. There was no evidence as to the result of the third audit conducted by the Australian College of Rural and Remote Medicine.

[199] Exhibit P1 item 40 pp 111-114.

[200] Exhibit P1 item 50 pp 134-142.

[201] T 19.38-20.5.

[202] See Dr Kelly's evidence at T 167.11-15.

[203] T 27.35-28.19.

[204] T 38.4-9.

[205] See [244] and [246]-[249].

[206] T 101.1-9.

[207] See discussion at [343]-[347] herein.

[208] Acknowledging that the BFD Conference 2017 Terms and Conditions include at condition 8, under the heading 'Rights', a statement that 'The Company reserves all rights to protect its content, intellectual properties and copyrights under Australian and international law' – however there was no evidence as to what such 'content, intellectual properties and copyright' in fact comprised.

[209] Noting that the first plaintiff gave evidence he never applied to become a member of the BFD Facebook group, instead stating that someone else put his name forward to the group. This evidence was not challenged, however insofar as the first plaintiff may have intended, by such evidence, to suggest that he was not in any way involved with the process by which he became a member of that group, I reject that suggestion, given his claimed interest in the MBS at, and prior to, this time.

[210] Exhibit P1 item 3 pp 5-7.

[211] Exhibit P1 item 59 p 190.

[212] For example, Scenario 3, Exhibit P1 item 61 pp 209-210.

[213] T 86.37-38.

[214] T 87.1-3.

[215] Exhibit P1 item 61 pp 222-223.

[216] T 100.18-101.5.

[217] T 81.23-24.

[218] T 114.18-30.

[219] Exhibit P1 item 78 p 374.

[220] T 147.27-31; T 148.22-24.

[221] See discussion at [100]-[101] herein.

[222] T 146.20-22.

[223] T 81.8-10.

[224] T 81.15-19.

[225] T 82.1-2.

[226] (2002) 210 CLR 575 at [26].

[227] Ibid at [44].

[228] [2006] EWHC 1062; [2007] 1 WLR 113 at [33]- [34] citing *Steinberg v Pritchard Englefield & Anor* [2005] EWCA Civ 288 and *Loutchansky v Times Newspapers Ltd (No 2)* [2001] EMLR 876.

[229] [2009] SASC 215; (2009) 104 SASR 452 at [391].

[230] Defence; Part 1 at [2].

[231] Defence; Part 1 at [3].

[232] Noting that at Defence; Part 2 at [7.1] the defendants also plead that they cannot admit the number of BFD group members as at 28 September 2017, but say that as at 8 December 2017 the BFD Facebook group had approximately 11,900 members.

[233] Defence; Part 1 at [4].

[234] Defence; Part 1 at [4.1].

[235] Defence; Part 1 at [4.2].

[236] Defence; Part 1 at [4.3].

[237] Defence; Part 2 at [1], [3] and [5].

[238] [2015] SASC 170; (2015) 125 SASR 437 at [169]- [170] and at [236]-[237].

[239] See Exhibit P1 item 14 p 31 (noting the Second Post was, in effect, a response to a comment made by a third person to one of the pleaded Comments) and p 34.

[240] Defence; Part 2 at [10].

[241] Defence; Part 2 at [13].

[242] [1936] 1 KB 697 at 705, per Greer LJ.

[243] *Jones v Skelton* [1963] 1 WLR 1362 at 1370; *Radio 2UE Sydney Pty Ltd v Chesterton* [2009] HCA 16; (2009) 238 CLR 460 at 466-467.

[244] (1963) 1 WLR 1362 at 1370 - 1371. See *Favell v Queensland Newspapers Pty Ltd* [2005] HCA 52 at [9]- [12].

[245] *Radio 2UE Sydney Pty Ltd v Chesterton* [2009] HCA 16; (2009) 238 CLR 460 at 477, 484.

[246] [2018] HCA 25 at [32].

[247] (1984) Aust Torts Reports 80-678.

[248] Second SOC; Part 2 at [15].

[249] The imputation pleaded at Second SOC; Part 2 at [15.1].

[250] The imputation pleaded at Second SOC; Part 2 at [15.2].

[251] The imputation pleaded at Second SOC; Part 2 at [15.3].

[252] The imputation pleaded at Second SOC; Part 2 at [15.5].

[253] The imputation pleaded at Second SOC; Part 2 at [15.6].

[254] The imputation pleaded at Second SOC; Part 2 at [15.10].

[255] The imputation pleaded at Second SOC; Part 2 at [15.11].

[256] The imputation pleaded at Second SOC; Part 2 at [15.12].

[257] The imputation pleaded at Second SOC; Part 2 at [15.1].

[258] The imputation pleaded at Second SOC; Part 2 at [15.2].

[259] The imputation pleaded at Second SOC; Part 2 at [15.3].

[260] The imputation pleaded at Second SOC; Part 2 at [15.5].

[261] The imputation pleaded at Second SOC; Part 2 at [15.6].

[262] The imputation pleaded at Second SOC; Part 2 at [15.10].

[263] The imputation pleaded at Second SOC; Part 2 at [15.11].

[264] The imputation pleaded at Second SOC; Part 2 at [15.12].

[265] The imputation pleaded at Second SOC; Part 2 at [15.1].

[266] The imputation pleaded at Second SOC; Part 2 at [15.2].

[267] The imputation pleaded at Second SOC; Part 2 at [15.10].

[268] The imputation pleaded at Second SOC; Part 2 at [15.11].

[269] The imputation pleaded at Second SOC; Part 2 at [15.1].

[270] The imputation pleaded at Second SOC; Part 2 at [15.11].

[271] The imputation pleaded at Second SOC; Part 2 at [15.1].

[272] The imputation pleaded at Second SOC; Part 2 at [15.3].

[273] The imputation pleaded at Second SOC; Part 2 at [15.10].

[274] The imputation pleaded at Second SOC; Part 2 at [15.11].

[275] The imputation pleaded at Second SOC; Part 2 at [15.13].

[276] The imputation pleaded at Second SOC; Part 2 at [15.11].

[277] The imputation pleaded at Second SOC; Part 2 at [15.4].

[278] The imputation pleaded at Second SOC; Part 2 at [15.7].

[279] The imputations pleaded at Second SOC; Part 2 at [15.8] and [15.9].

[280] Noting that although some of the imputations are to the effect that the first plaintiff is guilty of conduct which comprises a criminal offence, recent authorities have confirmed that that there is no third or intermediate standard of proof lying somewhere between the civil standard of balance of probabilities and the criminal standard of beyond reasonable doubt, nor is there some spectrum of standard where the more serious the allegation the more a fact finder is required to approach the criminal standard – see *Fleming v Advertiser-News Weekend Publishing Company & Anor* [2016] SASCFC 109 at [102]- [105] and [108] and *Eustice v Channel Seven Adelaide Pty Ltd & Ors* [2020] SASC 4 at [97]- [98].

[281] Defence; Part 2 at [15.1].

[282] Defence; Part 2 at [15.2] and [15.3].

[283] Defence; Part 2 at [15.4].

[284] [2002] EWCA Civ 1772 at [34].

[285] [2015] SASC 170 at [389]- [393].

[286] [2017] SASCFC 130 at [246].

[287] [1960] 2 QB 535, 569.

[288] [1994] HCA 45; (1994) 182 CLR 211, 244.

[289] [1947] HCA 13; (1947) 74 CLR 102, 116.

[290] [2004] HCA 5; (2004) 218 CLR 366, 417.

[291] [2004] HCA 5; (2004) 218 CLR 366 at [22].

[292] Defence; Part 2 at [15.2(a)].

[293] T 43.2-26; T 47.1-31.

[294] See time of second message reproduced on p 45 of Exhibit P1.

[295] As previously stated, although it is pleaded and admitted that the Third Post was sent on the same day as the First and Second Posts, if the Third Post is read in conjunction with the first plaintiff's post to which it is responding, (noting that stated 'last night was very sad for me to see people calling me a scumbag cheat etc'), both that response and the Third Post must have been sent the day **after** the First and Second Posts.

[296] [2017] SASCFC 130 at [255].

[297] [1975] AC 135 at 150.

[298] [2002] HCA 57; (2002) 212 CLR 1 at [75].

[299] (1877) 3 QBD 237 CA at 247.

[300] *Horrocks v Lowe* [1975] AC 135 at 150-152; *Hughes v Risbridger* [2010] EWHC 491 (QB) at [24].

[301] *Herald & Weekly Times Ltd v McGregor* [1928] HCA 36; (1928) 41 CLR 254.

[302] [2002] HCA 57; (2002) 212 CLR 1 at [75].

[303] T 64.33-65.34.

[304] Exhibit P1 item 53 p 146.

[305] Exhibit P1 item 26 p 69.

[306] Exhibit P1 item 15 p 45.

[307] [2015] FCA 652 at [227].

[308] [2015] FCA 652 at [228].

[309] [2007] NSWCA 320.

[310] Exhibit P1 item 92 p 392.

[311] Defence; Part 2 at [15.4].

[312] [2010] UKSC 53.

[313] [2007] HCA 60; (2007) 232 CLR 245 at [4].

[314] *Smith's Newspapers Ltd v Becker* [1932] HCA 39; (1932) 47 CLR 279 at 302-304.

[315] *Kemsley v Foot* [1952] AC 345 at 356, 357.

[316] *Channel Seven Adelaide Pty Ltd v Manock* [2007] HCA 60; (2007) 232 CLR 245 at [35].

[317] (1889) 6 TLR 133 at 137.

[318] *Channel Seven Adelaide Pty Ltd v Manock* [2007] HCA 60; (2007) 232 CLR 245 at [35].

[319] (1970) 72 SR (NSW) 347 at 361.

[320] [2007] HCA 60; (2007) 232 CLR 245 at [90].

[321] *Goldsborough v John Fairfax & Sons Ltd* [1934] NSWStRp 43; (1934) 34 SR (NSW) 524 at 532.

[322] Noting the time and date each Comment was posted is unclear from the evidence.

[323] Noting that at Defence; Part 2 at [15.2] and [15.3], the relevant 'interest' for the purposes of the defence of qualified privilege is referred to as an interest in the plaintiff's business practices.

[324] [1996] HCA 47; (1996) 185 CLR 183 at 215.

[325] David Rolph, *Defamation Law* (Lawbook Co, 2016) at 13.70 and authorities there cited.

[326] Second SOC; Part 2 at [21].

[327] Relying on the authority *in Pata Nominees Pty Ltd v Durnsford Pty Ltd* [1988] WAR 365 at 374.

[328] Relying on the High Court authority of *Zhu v Treasurer of the State of New South Wales* [2004] HCA 56.

[329] [2007] UKHL 21; [2008] 1 AC 1.

[330] [1853] EngR 15; (1853) 2 E & B 216.

[331] [2007] UKHL 21; [2008] 1 AC 1 at 18-19.

[332] [2007] UKHL 21; [2008] 1 AC 1 at 29.

[333] [2015] FCA 498 at [206], applied in *Talacko v Talacko* [2015] VSC 287.

[334] Exhibit P1 item 26 p 69.

[335] Plaintiffs' Closing Submissions at [114] and Plaintiffs' Outline of Argument at [90].

[336] Second SOC; Part 2 at [21.6].

[337] Noting my earlier findings as to the content of the Phone Call.

[338] Second SOC; Part 2 at [16].

[339] South Australian Government Gazette No.25 30 May 2019 p 1678.

[340] [2015] SASC 206 at [93]- [98].

[341] [2015] SASC 206 at [90]- [98].

[342] *Bristow v Adams* [2012] NSWCA 166 at [20]- [31].

[343] Section 36(1)(a) and (b) *Defamation Act 2005 (SA).*

[344] Defence, Part 1 at [4] and Part 2 at [7.1].

[345] Exhibit P1 item 15 p 47.

[346] Noting the defendants are based interstate and although there was no specific evidence on this issue, BFD had a focus on educating practitioners about the MBS, being of relevance to doctors who practice throughout Australia.

[347] Exhibit P1 item 14 p.29.

[348] Exhibit P1 item 14 p.31.

[349] Exhibit P1 item 14 p 44.

[350] Exhibit P1 item 14 p 30, to which the first defendant does not appear to have responded.

[351] Exhibit P1 item 14 p 31, written by same member as above.

[352] [1996] NSWSC 651; (1996) 41 NSWLR 176.

[353] Defence; Part 2 at [16.2].

[354] [2015] SASC 206 at [81]- [84].

[355] Email dated 25 October 2017; Exhibit P1 item 26 p 69.

[356] Message dated 10 February 2019; Exhibit P1 item 53 p 146.

[357] *Chakravati v Advertiser Newspapers Limited* (1998) 193 CLR 519 at [177], *Selecta Homes and Building Co Pty Ltd v Advertiser-Weekend Publishing Co Pty Ltd* [2001] SASC 140; (2001) 79 SASR 451 at [143].

[358] Plaintiffs' Outline of Argument at [100]; Plaintiffs' Closing Submissions at [125].

[359] [2001] SASC 140; (2001) 79 SASR 451 at [163]- [171].

[360] [1999] VSCA 180; [1999] 3 VR 417 at 433-434 [57].

[361] [1980] 2 NSWLR 225 at 251-252.

[362] Plaintiffs' Closing Submissions at [126.1].

[363] Noting there was evidence that a seminar planned for Perth in 2018 was also cancelled.

[364] Exhibit P1 item 51 p 143.

[365] T 197.34-198.10.

[366] Exhibit P1 item 27 p 71.

[367] T 198.23-26.

[368] Exhibit P1 items 74 and 76 pp 346-352 and pp 360-371.

[369] Exhibit P1 item 75 pp 353-359.

[370] T 61.26-31.

[371] T 74.2-10.

[372] T 165.35-38.

[373] T 169.35-38.

[374] T 190.17-37, and in particular at lines 34 to 37.

[375] T 74.2-10.

[376] Exhibit P4, Sale of Practice clause 4.2(a).

[377] Exhibit P4, Sale of Practice clause 4.2(b) and (c).

[378] Exhibit P4, Sale of Practice clauses 6.1(g) and (i).

[379] Exhibit P4, Provision of Services to Incorporated Medical Practitioner clauses 3 and 6.

[380] Exhibit P4, Provision of Services to Incorporated Medical Practitioner clause 7.

[381] Exhibit P1 Tab 43 p 120.

[382] Exhibit P1 item 44 p 121.

[383] Exhibit P1 item 44 pp 120-128.

[384] Exhibit P1 item 46 pp 127-128.

[385] T 191.18-19; T 196.14-18.

[386] T 169.28-29.

[387] T 68.15-28.

[388] T 72.12-14.

[389] Exhibit P1 item 50 pp 134-142, noting this document is undated.

[390] Plaintiffs' Outline of Argument at [9].

[391] T 170.1-3.

[392] T 191.32-33.

[393] T 169.25-70.5; T190.17-37.

[394] T 60.31-61.5, noting neither Dr Kelly nor Ms Cheah gave such evidence, and if it was to be suggested that any audits were initiated by the first defendant's complaints to the RACGP (noting such a finding cannot be made on the admissible evidence), that conduct was not pleaded as that relied upon by the plaintiffs with respect to this tort.

[395] T 169.23-34.

[396] T 61.30-63.18.

[397] T 192.20-26.

[398] T 73.18-23.

[399] T 73.24-28.

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New, improved dummies guide to gaming the MBS (not)

By
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Ed's note: This piece about decoding the MBS so as to help GPs make money while staying out of trouble was originally published on Tuesday.

Since then (it's always the way) we've heard back from the RACGP with answers to our questions, namely: does the college continue to endorse (through the awarding of CPD points) the ProMBS workshops, and why doesn't it do the job itself of clarifying the MBS to members?

While there may be more to be said, and we will come back to this topic, their response is an important addition, so we're running it in full here while the original piece is unchanged below.

From president Dr Karen Price on the MBS:

> Our recent member census has affirmed what we know, that MBS issues are one of the biggest concerns for GPs.
>
> The RACGP isn't currently authorised to interpret the MBS, which is why we cannot provide guidelines to our members. We continue to advocate strongly with the Department of Health for general practice specific information and education regarding the MBS.

And from the RACGP:

MBS interpretation is a legal issue which medical defence organisations (MDO) are appropriate for. Medicare is ultimately legal legislation for a contract to access a government funded health insurance scheme. We continue to negotiate this legislation federally and continue to work with our MDO colleagues and the department of health to minimise misinterpretation of the law.

We have also hosted webinars on the topic with presenters from the department of health.

And on CPD quality control:

The RACGP does not "endorse educational material". Our accreditation process evaluates an the educational validity of an activity against the CPD Educational Standards.

Quality Assurance Assessments (QAA) are routinely conducted for quality assurance of CPD activities, and in the event a complaint is received. This may be either a paper-based review of the activity or a face-to-face review. In general terms, the QAA will review the documentation (slides, program outline, evaluations etc) and may also include RACGP representatives attending the activity. The QAA considers the educational structure of the activity and that the content is evidence-based and relevant to general practice.

In March 2018 a face-to-face QAA was conducted for ProMBS Benefits Workshop, conducted by AOGP following a complaint that raised concerns about the approach to MBS billing presented during the course. The RACGP Program Co-ordinator and a senior GP attended. The role of the Program Coordinator was to review the educational components and the GP to assesses content from a GPs perspective. The content is always considered routinely as part of the QAA process. It passed the audit, with minor amendments to processes recommended.

In 2020, the RACGP introduced revised CPD Education Standards for the conduct of CPD activities by CPD Education Providers. In addition, a new accreditation process was introduced whereby all CPD Accredited Activities (former Category 1) are reviewed by a Program Coordinator before approval as a RACGP CPD Accredited activity. The QAA process described above remains in place as a further quality control.

The process in 2018 was to conduct routine QAAs on both Category 1 and Category 2 activities, and in response to a complaint. CPD Education Providers were required to adhere to guidelines for the conduct of CPD activities, and the RACGP offered training to the Providers Education Activity Representative.

The original piece starts here:

On a windy, chilly Melbourne afternoon in June 2017, one of the breakout rooms at the Royal Automobile Club of Victoria was packed with GPs.

Like the Nirvana show at the very first Big Day Out in Sydney, most patrons had abandoned the concurrent sessions for the main gig. It was stuffy, dimly lit and, by the time proceedings started, overcrowded. There was a buzz in the room about the session. One of the other presenters had even left their largely empty session, curious to see to what was going on.

The session was about how to "optimise" your Medicare billing. It was the main marketing hook for the inaugural Business for Doctors (BFD) summit, an organisation that had started life as a Facebook group started by a then GP registrar, Dr April Armstrong, and the presenter of the "Nirvana" session.

BFD had been started on the pretext that "most doctors" were having their personal business incomes "whittled away by accounting and investment advisory fees" and paid "substantially more taxes than required", but by sharing peer knowledge over the BFD Facebook network, they could tap into much of that knowledge for free, and "optimise their relationships with their professional advisors".

A few people in that session reported uneasiness at some of the slides in presentation. One, though not labelled in that manner, was described by the presenter enthusiastically as her "pack and stack" method of combination billing. Other elements of the presentation were described by one participant as "pretty edgy" in terms of where the PSR might sit.

For the avoidance of any doubt, there is nominally nothing wrong with describing a technique to optimise your medicare billings as "pack and stack", and the view that the presentation seemed to be on the edge to some attendees probably just shows how confused some doctors can get on where the line is on how they should interpret their MBS billing.

In fact, it raises a very important question for all GPs in how they bill the MBS. Who is the arbiter of where the line is or not, and how is it made perfectly clear to GPs where those lines exist?

As far as we can tell, Dr Armstrong is not a formally qualified educator or a financial advisor and she has no qualifications as a specialist in educating doctors about the MBS. When she started BFD she was a registrar.

But her workshops do attract RACGP and ACRRM CPD points, so they have in effect been endorsed by the two educational colleges for GPs.

Dr Armstong has simply studied the MBS herself, likely taken a few tips from other institutions which have attempted "optimisation interpretation" on behalf of the doctors that work for them, and mashed it together in her own interpretation of what you can and can't do.

Dr Armstrong isn't the only organisation attempting to interpret things for GPs in what is a pretty tricky game given how aggressive we are seeing the PSR get in the past few years and how confused some doctors become on receiving a nudge letter.

Many of the corporates put their own interpretations together and educate their doctors en masse, and other small outfits have a go every now and then, some of which clearly have an understanding of the MBS and its interpretation that isn't so good.

Other than the CPD endorsement, which some GPs might take as offering some form of cover, the BFD workshops, and the many others like them around the country are largely "buyer beware".

The premise for groups trying to make money out of demystifying the MBS isn't such a bad one.

Although all the information to manage the MBS is mostly publicly available, it is a very complex regime, there are no guidelines or standards available and agreed upon by the major medical colleges and peak bodies and the MBS is constantly changing (eg, the new telehealth items and the 12 month rule).

Having someone do the hard work of reading all the material, interpreting it for you, and offering you some shortcuts when you are already stressed and busy trying to make ends meet does make some sense.

The problem is, what if your presenters aren't interpreting things properly?

It will not be a defence in a PSR hearing that you attended a workshop that was approved for RACGP or ACRRM points.

A recent SA Supreme court case between Dr Armstrong and a doctor who claimed she was defaming him by claiming he was stealing all her course IP, has made this pretty clear – although this wasn't the point of the court case. **The judgement in the case from March last year is HERE** and it's an interesting (very long) read. In a nutshell, the judge found the plaintiff, Dr Rajan Anand, was defamed and Dr Armstrong had to pay damages of $50,000 – but neither party came out of it well.

Both the doctors' courses were RACGP and ACRRM endorsed for CPD points. When *Australian Doctor* asked the RACGP if they were happy with their assessment of the courses, given the outcomes of the court case (more on that below), the RACGP said their processes were good and they were happy.

Without some agreed upon standards by the major educational and compliance groups, which somehow is synchronised with the MBS and the Department of Health (DoH), which they regularly deal with – they spent months negotiating with the DoH on the **latest round of nudge letters** – then the system allows just about anyone, doctors and non doctors (sometimes advisory firms will try to fill the vacuum here) to put on a course.

None are formally qualified in any formal way to teach anyone, and only ever endorsed by the educational colleges loosely via CPD points approval. There is no co-ordination between the providers to co-ordinate and make content consistent – in fact, there is often fierce and ugly competition, as the SA court case has revealed.

BFD didn't ever make much if any money from its Facebook group. That was a community creation play to feed its revenue model of workshops. Once again, there is nothing wrong with doing this.

BFD has made most of its money from running seminars, workshops and conferences for GPs, most of which have as a continuing central theme "optimising" a GP's interaction with the MBS.

GPs don't like paying for education as a rule. Most medical education they get is either very inexpensive or free. But they pay a lot to go to BFD conference (the next one will cost you nearly $1000 for a day) , which goes some way to explaining how much need there is for a better understanding of MBS claiming and the increasing fear they are experiencing in PSR compliance activities.

The buzz from the first BFD conference spread and by 2019, the business of "educating" doctors on quick fixes, guides and "cheat sheets" for getting more out of the MBS was big.

So big that other groups started springing up around BFD (although it's probably relevant there were many before as well).

Fast forward to 31 March last year, and some of the ugly underbelly of these businesses was exposed for all to see in the judgement of the SA Supreme Court case for defamation brought by Dr Rajan Anand, an Adelaide, against Dr Armstrong for defamation.

The story of this case **has been excellently reported recently by** ***Australian Doctor*** and we can recommend it as a good read.

It's a rollicking yarn and a bit of a Greek tragedy.

Although Dr Anand technically won the case and was awarded $50,000 in damages, both he and Dr Armstrong lost big time in the court of public opinion. The judge was scathing of both the defendant and the plaintiff.

If you have the time it's one of those rare judgements – all 60,000 words of it – which is worth reading raw for even more of the gory detail. **HERE** it is again.

The *Australian Doctor* story is focussed mostly on the silliness of two doctors taking each other to court when both had reasons to run a mile from the sort of publicity such a court case would almost inevitably bring to their businesses and their understanding of how business and the law actually works. And why the RACGP endorsed both their educational programs, and continues to do so (Dr Anand is no longer involved with the ProMBS program, which he developed with the company Adelaide to Outback GP), despite the court findings.

We have asked the RACGP about these endorsements and will update this story when we receive a response.

But the case has significant lessons for the profession in how it attempts to sort out the multiple issues of MBS compliance and "PSR anxiety". The latter is rapidly rising among all GPs, as they struggle to interpret what the government means so they properly stay on the right side of PSR.

The judge in this case did her homework unusually well and stated that Dr Anand seemed to have very little expertise to be running workshops on the MBS.

She cited several instances where Dr Anand had provided materials he did not understand properly and probably should not have been teaching. She stated that it was clear he was "not an expert" on the MBS.

One example was Dr Anand's understanding of the 80/20 rule.

In 2018 shortly before he ran his own course he posted on the BFD Facebook page:

> "Just a thought, why do we have to worry about audit? 60 or 70 services or 80 – as long as you can justify your consult and you are doing it rightly – why should one worry?"

The judge noted that the post, made just a month before he put on his first workshop, demonstrated virtually no understanding of the 80/20 rule, or just how much trouble a GP might get into for breaching it.

The judge didn't point out that the post being allowed on the BFD website when it was so ill-informed might be a good demonstration of the downside of social media and peer-to-peer medical education.

Sometimes things are posted which are wrong, and they aren't moderated for some reason, in which case other site members can end up using it as some form of advice. Nearly all these sites will post a disclaimer saying that aren't licensed to provide any financial or other advice and users must be cautious when reading posts and using them. But as things go with most social media sites (it took one person 17 hours to read all the Ts and Cs on Facebook) no one reads the fine print.

The judge made no assessment of the quality of Dr Armstrong's expertise and BFD, which wasn't relevant in the defamation case.

Notably, the judge found that Dr Armstrong presented no evidence to prove her original social media claim that Dr Anand had stolen her IP, which might be the biggest irony of the case.

If that had been established, it might not have reflected well on the quality of BFD's material.

Are the BFD workshops presenting worthwhile expertise and IP then?

No one knows because there is no semblance of a compliance regime for monitoring the activity of educating doctors on using the MBS.

Dr Anand claimed he couldn't continue to present his workshops because Dr Armstrong's defamation had damaged his reputation so much it became impossible to get enough people to go to his workshops and the business was no longer viable.

But the judge found that the most likely reason Dr Anand had ceased providing the workshops was that he had been working for Primary Healthcare (now Healius Medical Centres), supposedly fulltime, and was under investigation by that group for both potentially using their MBS education material without permission, and conducting workshops when he was contracted to them fulltime.

Notably, when the case first hit the papers, Primary Healthcare dropped that part of its investigation that was claiming he was using their material. Why would Primary Healthcare do this? Perhaps they didn't want the material in the spotlight of the DoH or the PSR.

The only other assessment of BFD material has been made by the RACGP and ACRRM in the form of their CPD endorsement.

Both colleges **also continue to endorse ProMBS courses**, according to its website.

Can GPs stake their livelihoods billing the MBS according to advice given by any of these third parties?

Accreditation comes with the risk of audit, as the judge noted.

But what standards are they being held to? Where is the governance regime for educators?

Why can any corporate, or any non professional educator set up camp, imply they are experts, put on workshops which are effectively endorsed by the colleges for CPD, use marketing hooks to get GPs to attending their workshops – some examples of which follow – with no robust governance over activities that can land a GP in PSR or tax trouble?

Part of a BFD promotion. Was MBS compliance ever optional?

None of this says that some of these educators and workshops aren't providing good advice.

But at the end of the day they are all providing GPs with a form of financial advice.

They are interpreting how you can bill the MBS which in way which can make a meaningful difference to the income of a GP.

In the case of BFD, it's largely in the mission statement that heads their Facebook listing.

The smart word in this statement is “accessing”.

Anyone can help you “access” the right professional financial advice.

But there are pretty strict laws about how much advice you can give in a financial context in Australia.

This is not to say that any groups providing advice to doctors about how they manipulate their MBS billing would fall into ASIC’s very strong Australian Financial Services advice regime.

It almost certainly wouldn’t.

But it’s certainly adjacent to some of the most strict regulatory and governance oversight we have in the country.

So why is the profession remaining so *laissez faire* about the whole thing?

The following is an opening excerpt of what you would need for ASIC to grant you an Australian Financial Services licence give financial advice in this country:

An AFS licence authorises you and your representatives to provide financial services to clients.

You provide financial services if you:

- provide financial product advice to clients for example, giving a recommendation to clients or the general public about which financial product they should purchase.
- deal in a financial product for example, buying or selling shares on behalf of a client or issuing interests in a managed investment scheme.
- make a market for a financial product for example, where you regularly quote prices at which people can buy or sell financial products.

And so on … if you want the rest of the definition you can find it **HERE**.

It’s hard to see that you could shoehorn what a group offering “MBS optimisation advice” into ASIC’s definition of requiring an AFS licence.

But there is adjacency in what they do, which is give regular advice to doctors on how to optimise their processes, using a fixed methodology (a product?) in order to extract more income from the MBS.

Remember "pack and stack".

It is described today by BFD as *"Combination Billing – a revolutionary method of spending more time with patients and providing comprehensive care and maximising patient rebates for services"*.

This sounds just a little like a product. Certainly, Dr Armstrong thought enough of her revolutionary method that she decided to defame Dr Anand in order to protect it.

Is it unique IP that is describing a form of financial product?

No one is making any meaningful judgement on behalf of GPs in this respect.

It's all still floating in the wind for GPs to take or leave.

And with it they are clearly taking or leaving some risk to themselves.

There is no overseeing body to give them some sort of governance cover on this vital and stressful part of their lives.

"PSR anxiety" is a real and growing issue for the profession.

The latest round of nudge letters on the telehealth 12 month rule, sent to around 1000 GPs last month, demonstrates just how easy it is to fall foul of Department of Health fine print, and interpretations.

Most of the doctors caught out who spoke to *TMR* had no sense at all of the eventual DoH interpretation of the rule. Some have to now pay back a lot of money, on what seems like a crazy interpretation (**but that's another story**).

So long as this dynamic exists in the market, operators have a legitimate mandate to have a go at interpreting this stuff for GPs. That market is lots of confused and increasingly scared doctors, many struggling to make ends meet.

But none of these operators would provide any form of defence if you have taken their 'product' advice, interpreted it, and fallen foul of the DoH or the PSR in some way.

That would especially be the case now, based on much of the material in the judgement of the SA defamation case of Anand Vs Armstrong, in which the court dissected to some degree both operators and found them both in some way wanting.

So why won't the colleges band together with one or two other relevant bodies, and the MBS, and put together a series guidelines or standards, which they can update each year, and when any major MBS changes take place (such as telehealth items), which GPs can rely on in making their judgements around MBS billing procedures?

The answer isn't clear.

We've asked the RACGP why they won't and we'll give you that answer when we get it.

Some insight might be gleaned from an article by the now defunct *Medical Observer Magazine* which quoted the colleges then president as saying that it was not the responsibility of the college to interpret the MBS.

That article was published 10 years ago.

Way before the college shifted its thinking to becoming advocacy body one the primary objectives of which is to ensure that GPs are paid properly.

Surely if this is a primary objective of the college now, then one way of making certain that a GP's pay is optimised is to take on the process of developing effective education and standards around MBS billing.

It would be a lot of work, but given how much "PSR anxiety" is starting to impact on their members (not a lot of members are directly affected but the fear factor in the PSR tactics is high and widespread), surely it would be a service that members would value a lot.

And if there is an agreed set of standards by the colleges and several other bodies, made in some sort of co-operation with the DoH, surely that might help the DoH, and eventually remove the need for a fear-based PSR regime to exist.

One theory is that below the waterline the RACGP is comfortable with the system as it currently exists.

While on the one hand the college will occasionally rail against the PSR and the DoH's notorious program of nudge letters, on the other it significantly endorses the PSR process by providing senior members of its leadership to sit on the three person PSR peer review panels which provide de facto

advice to the body on the profession's view of a doctor's behaviour.

It's hard to see how those two activities aren't compromised by each other in some way.

A similar problem to the one doctors and the education providers are encountering with the PSR was encountered by the accounting profession many years ago, except instead of the having the PSR as the sheriff of proper practice, accountants' clients were facing off to the ATO.

In the end all the competing accounting groups formed a body that developed universal standards for accounting, which all accountants could rely on, and which, in large part the government and the ATO would defer to when cases were on the edge.

It isn't a perfect system, but it's a system of compliance that protects accountants and their clients to a much greater degree than what existed previously, and it saves an enormous amount of time and stress for a whole lot of groups trying to interpret tax accounting laws.

Surely the GP profession should be thinking more carefully about some sort of regime that emulates the objectives of what the accountants have done.

At the end of the day, interpreting what the DoH is trying to get at in the MBS, and optimising it is perhaps one of the most important parts of running a GP business.

This is why businesses like ProMBS, BFDs and many others exist and sometimes thrive.

At the end of the day, as well as practice management, it's a form of financial advice.

If you spend the time to read the Anand vs Armstrong case, one of the big lessons it is sending the profession is that this part of the profession is far from professional.

And it's GPs who are at the business end of the problem.

The next BFD workshop is in Bunbury, WA, on 3 June apparently, if you're interested.

(Note: Since publishing this story this morning (May 5) all advertising and marketing for the Bunbury event seems to have been removed from both the BFD website and Facebook site. The material was there yesterday (May 4). No explanation has been provided for its removal).