FEDERAL COURT OF AUSTRALIA

Pathmanathan v Healthscope Operations Pty Ltd [2020] FCA 65

|  |  |
| --- | --- |
| File number: |  |
|  |  |
| Judge: | **STEWARD J** |
|  |  |
| Date of judgment: | 6 February 2020 |
|  |  |
| Catchwords: | **PRACTICE AND PROCEDURE** – application for summary judgment – application for summary dismissal – where applicant accredited at a hospital owned and operated by the respondent – where hospital terminated the applicant’s accreditation – unlawful discrimination – where applicant alleged discrimination on the basis of race, sex, age and imputed disability – where complaint to the Australian Human Rights Commission terminated on the basis that there was “no reasonable prospect of the matter being settled by conciliation” – where applicant alleged breach of contract – whether a contract existed between the applicant and respondent – whether the respondent breached the terms of alleged contract – whether the respondent failed to afford procedural fairness – where applicant alleged breach of confidence – where applicant alleged breach of the *Privacy Act 1988* (Cth.) – where applicant alleged invasion of privacy – where applicant alleged respondent is liable for defamation – where applicant alleged respondent is liable for negligence – whether the respondent has no reasonable prospect of successfully defending the proceeding – whether the applicant has no reasonable prospect of successfully prosecuting the proceeding |
|  |  |
| Legislation: | *Age Discrimination Act 2004* (Cth.)  *Australian Human Rights Commission Act 1986* (Cth.) ss. 11, 46PO  *Disability Discrimination Act 1992* (Cth.)  *Federal Court of Australia Act 1976* (Cth.) s. 31A  *Privacy Act 1988* (Cth.)  *Racial Discrimination Act 1975* (Cth.)  *Sex Discrimination Act 1984* (Cth.)  *Federal Court Rules 2011* (Cth.) rr. 16.21, 26.01  *Limitation Act 2005* (W.A.)  *Limitation of Actions Act 1958* (Vic.) |
|  |  |
| Cases cited: | *Australian Securities and Investments Commission v. Cassimatis* (2013) 220 FCR 256  *Crayford Freight Services Ltd v. Coral Seatel Navigation Co* (1998) 82 FCR 328  *Crowe v. Mercy Health and Aged Care Central Queensland Ltd* [2001] QSC 384  *Day v. Lynn* [2003] FCA 879  *Fortron Automotive Treatments Pty Ltd v. Jones (No 2)* [2006] FCA 1401  *Grosse v. Purvis* [2003] QDC 151  *Jefferson Ford Pty Ltd v. Ford Motor Company of Australia Ltd* (2008) 167 FCR 372  *Page v. Healthscope Operations Pty Ltd* [2016] NSWSC 1608  *Pathmanathan v. St John of God Healthcare Inc* [2019] FCA 1460  *Pisano v. Health Solutions (WA) Pty Ltd* [2014] WASC 356  *Smith Kline & French Laboratories (Australia) Ltd v. Secretary, Department of Community Services and Health* (1990) 22 FCR 73  *Spencer v. Commonwealth* (2010) 241 CLR 118  *Wride v. Schulze* [2004] FCAFC 216  *Zippo Manufacturing Co v. Jaxlawn Pty Ltd* [2011] FCA 1125 |
|  |  |
| Date of hearing: | Determined on the papers |
|  |  |
| Date of last submissions: | 6 September 2019 |
|  |  |
| Registry: |  |
|  |  |
| Division: |  |
|  |  |
| National Practice Area: |  |
|  |  |
| Category: | Catchwords |
|  |  |
| Number of paragraphs: | 121 |
|  |  |
| Counsel for the Applicant: | The applicant filed written submissions on her own behalf |
|  |  |
| Counsel for the Respondent: | Ms. N. Hickey |
|  |  |
| Solicitor for the Respondent: | MinterEllison |

ORDERS

|  |  |  |
| --- | --- | --- |
|  | | VID 133 of 2018 |
|  | | |
| BETWEEN: | DR AJINTHA PATHMANATHAN  Applicant | |
| AND: | HEALTHSCOPE OPERATIONS PTY LTD  Respondent | |

|  |  |
| --- | --- |
| JUDGE: | STEWARD J |
| DATE OF ORDER: | 6 FEBRUARY 2020 |

THE COURT ORDERS THAT:

1. Pursuant to s. 31A of the *Federal Court of Australia Act 1976* (Cth.) and r. 26.01 of the *Federal Court Rules 2011* (Cth.), the proceeding be dismissed.
2. The applicant’s interlocutory application dated 6 October 2018 be dismissed.
3. The applicant’s application for an extension of time to file a defamation claim be dismissed.
4. The name of the respondent be amended to “Healthscope Operations Pty Ltd”.
5. Order 2 of the orders made on 8 March 2019 be vacated.
6. The parties are to confer on the issue of costs and within 14 days they are to file agreed orders or, if no agreement is reached, submissions of no more than two pages in length.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

REASONS FOR JUDGMENT

STEWARD J:

1. Doctor Pathmanathan (the “Doctor”) was an accredited medical practitioner at Mount Hospital, a private hospital in Perth, which is owned and operated by the respondent (“Healthscope”). In September 2015, the Doctor’s accreditation was terminated by the general manager of Mount Hospital on the ground that she had failed to meet the continuous disclosure requirements of the Healthscope Limited Hospital By-Laws (the “By-Laws”). The Doctor contends that this was not the real reason for the termination of her accreditation. Subsequently, in 2017, the Doctor purported to make complaints to the Australian Human Rights Commission (the “Commission”) against Healthscope under the *Disability Discrimination Act 1992* (Cth.) (the “*Disability Discrimination Act*”), the *Sex Discrimination Act 1984* (Cth.) (the “*Sex Discrimination Act*”), the *Racial Discrimination Act 1975* (Cth.) (the “*Racial Discrimination Act*”) and the *Age Discrimination Act 2004*(Cth.) (the “*Age Discrimination Act*”). In the result, given the nature of the matters raised in the Doctor’s complaint, the Commission formed the view that only the claim made under the *Disability Discrimination Act* was relevant and could proceed as a complaint.
2. On 14 December 2017, a delegate of the President of the Commission terminated the Doctor’s complaint against “Healthscope Operations Pty Ltd, trading as Healthscope Ltd” pursuant to s. 46PH(1B)(b) of the *Australian Human Rights Commission Act 1986* (Cth.) (the “*AHRC Act*”) as she was satisfied that there was “no reasonable prospect of the matter being settled by conciliation”. The Doctor subsequently commenced proceedings in this Court pursuant to s. 46PO of the *AHRC Act*. In brief compass, the Doctor now makes various allegations against Healthscope including breach of contract, unlawful discrimination, breach of confidence, breach of the *Privacy Act 1988* (Cth.) (the “*Privacy Act*”), “invasion of privacy”, defamation and negligence.
3. Before me are two primary applications: the Doctor’s application for summary judgment; and Healthscope’s application for summary dismissal of the Doctor’s claims or, in the alternative, an order that the Doctor’s pleading be struck out in full. The parties have agreed that the applications should be determined on the papers.
4. For the reasons that follow, the Doctor’s application is refused and Healthscope’s application for summary dismissal is granted.

## Applicable Legislative Provisions and Principles

1. Section 46PO of the *AHRC Act* provides that an application alleging unlawful discrimination can be made to this Court. Significantly, in some cases, as here, leave is not required to commence such an application where a complaint has been terminated by the President of the Commission because he or she is satisfied that there is “no reasonable prospect of the matter being settled by conciliation”. Section 46PO relevantly provides:

**Application to court if complaint is terminated**

(1) If:

(a) a complaint has been terminated by the President under section 46PE, paragraph 46PF(1)(b) or section 46PH; and

(b) the President has given a notice to any person under subsection 46PH(2) in relation to the termination;

any person who was an affected person in relation to the complaint may make an application to the Federal Court or the Federal Circuit Court, alleging unlawful discrimination by one or more of the respondents to the terminated complaint.

Note: Part IVA of the *Federal Court of Australia Act 1976* allows representative proceedings to be commenced in the Federal Court in certain circumstances.

(2) The application must be made within 60 days after the date of issue of the notice under subsection 46PH(2), or within such further time as the court concerned allows.

(3) The unlawful discrimination alleged in the application:

(a) must be the same as (or the same in substance as) the unlawful discrimination that was the subject of the terminated complaint; or

(b) must arise out of the same (or substantially the same) acts, omissions or practices that were the subject of the terminated complaint.

(3A) The application must not be made unless:

(a) the court concerned grants leave to make the application; or

(b) the complaint was terminated under paragraph 46PH(1)(h); or

(c) the complaint was terminated under paragraph 46PH(1B)(b).

### Summary judgment

1. Section 31A of the *Federal Court of Australia Act 1976* (Cth.) (the “*FCA Act*”) relevantly provides:

**Summary judgment**

(1) The Court may give judgment for one party against another in relation to the whole or any part of a proceeding if:

(a) the first party is prosecuting the proceeding or that part of the proceeding; and

(b) the Court is satisfied that the other party has no reasonable prospect of successfully defending the proceeding or that part of the proceeding.

(2) The Court may give judgment for one party against another in relation to the whole or any part of a proceeding if:

(a) the first party is defending the proceeding or that part of the proceeding; and

(b) the Court is satisfied that the other party has no reasonable prospect of successfully prosecuting the proceeding or that part of the proceeding.

(3) For the purposes of this section, a defence or a proceeding or part of a proceeding need not be:

(a) hopeless; or

(b) bound to fail;

for it to have no reasonable prospect of success.

1. Rule 26.01(1) of the *Federal Court Rules 2011* (Cth.) (the “*Rules*”) relevantly provides:

**Summary judgment**

(1) A party may apply to the Court for an order that judgment be given against another party because:

(a) the applicant has no reasonable prospect of successfully prosecuting the proceeding or part of the proceeding; or

(b) the proceeding is frivolous or vexatious; or

(c) no reasonable cause of action is disclosed; or

(d) the proceeding is an abuse of the process of the Court; or

(e) the respondent has no reasonable prospect of successfully defending the proceeding or part of the proceeding.

1. It has been said that the tests under s. 31A and r. 26.01 concerning the availability of summary judgment are, in the main, identical: *Zippo Manufacturing Co v. Jaxlawn Pty Ltd* [2011] FCA 1125 at [20] per Gordon J. In that respect, the following principles guide a consideration of an application for summary judgment or summary dismissal:
2. the legislative purpose of s. 31A is to strengthen “the power of the court to deal with unmeritorious matters by broadening the grounds on which federal courts can summarily dispose of unsustainable cases”: Second Reading Speech of the *Migration Litigation Reform Bill 2005* (Cth.);
3. the moving party bears the onus of persuading the court that the opponent has no reasonable prospect of success: *Australian Securities and Investments Commission v. Cassimatis* (2013) 220 FCR 256 at 271 [46] per Reeves J.; *Crayford Freight Services Ltd v. Coral Seatel Navigation Co* (1998) 82 FCR 328 at 333 per Burchett, Ryan and Marshall JJ.;
4. assessment of whether a proceeding or a part of a proceeding has no reasonable prospect of success will necessarily require: (i) identification of the cause of action pleaded; (ii) identification of the pleaded facts said to give rise to that cause of action; (iii) a review of the evidence (if any) tendered in support of the claim for judgment; (iv) identification of the defence pleaded; (v) identification of any facts pleaded which are said to give rise to the defence; and (vi) a review of the evidence (if any) tendered in defence of the claim: *Jefferson Ford Pty Ltd v. Ford Motor Company of Australia Ltd* (2008) 167 FCR 372 at 406-407 [126] per Gordon J.;
5. once a moving party has established a *prima facie* case that the opponent has no reasonable prospect of success, the opposing party must respond by pointing to specific factual or evidentiary disputes that make a trial necessary; general or non-particularised denials will be insufficient to defeat the motion; *Jefferson Ford Pty Ltd* at 407 [127] per Gordon J. citing *Fortron Automotive Treatments Pty Ltd v. Jones (No 2)* [2006] FCA 1401 at [22] per French J. (as his Honour then was);
6. summary disposition of a proceeding is authorised on a variety of bases. It will, for example and without limitation, be appropriate in a case: (i) in which the pleadings disclose no reasonable cause of action and their deficiency is incurable; (ii) in which there is unanswerable or unanswered evidence of a fact fatal to the pleaded case and in any case which might be propounded by permissible amendment; or (iii) that is “frivolous or vexatious or an abuse of process”: *Spencer v. Commonwealth* (2010) 241 CLR 118 at 131 [22] per French C.J. and Gummow J.;
7. the determination of a summary dismissal application does not require a mini‑trial based upon incomplete evidence to decide whether a proceeding is likely to succeed or fail at trial. Instead, it requires a critical examination of the available materials to determine whether there is a real question of law or fact that should be decided at trial: *Cassimatis* at 271 [46] per Reeves J.; and
8. an application for summary dismissal is likely to succeed if the moving party is able to demonstrate that the applicant’s success in the proceeding relies upon a question of fact that can be truly described as “fanciful, trifling, implausible, improbable, tenuous or one that is contradicted by all the available documents or other materials”: *Cassimatis* at 272 [47] per Reeves J.

### Strike Out

1. Rule 16.21 of the *Rules* relevantly provides:

**Application to strike out pleadings**

(1) A party may apply to the Court for an order that all or part of a pleading be struck out on the ground that the pleading:

(a) contains scandalous material; or

(b) contains frivolous or vexatious material; or

(c) is evasive or ambiguous; or

(d) is likely to cause prejudice, embarrassment or delay in the proceeding; or

(e) fails to disclose a reasonable cause of action or defence or other case appropriate to the nature of the pleading; or

(f) is otherwise an abuse of the process of the Court.

1. In *Wride v. Schulze* [2004] FCAFC 216, the Full Court of this Court referred to the following principles governing strike-out applications at [26]:

In *National Mutual Property Services (Australia) Pty Ltd v Citibank Savings Ltd* (1995) 132 ALR 514, Lindgren J said at 529:

In *Allstate Life Insurance Co v Australia & New Zealand Banking Group Ltd* (13 September 1994, Fed C, unreported) Beaumont J quoted withapproval the following summary of the general principles governingstrike-out applications (at 24, from the editorial note at (1992) 66 ALJ 47on *Lonrho plc v Tebbitt*, *The Times*, 24 September 1991):

(1) A ‘reasonable cause of action’ means one with some chance of success if regard be had only to the allegations in the pleadings relied upon by the claimant; in such a case, the claim cannot be struck out: *Davey v Bentinck* [1893] 1 QB 185.

(2) The mere fact that the case appears to be a weak one is not of itself sufficient to justify the striking out of the action: cf *Wenlock v Moloney* [1965] 1 WLR 1238.

(3) Normally, the power to strike out should be exercised only in plain and obvious cases, where no reasonable amendment could cure the alleged defect: cf *Hodson v Pare* [1899] 1 QB 455.

(4) It goes without saying that if a substantial case is involved in the claim, the power to strike out cannot be exercised.

(5) Where a point of law has to be decided, and the judge is satisfied that this can be done by him appropriately, thereby avoiding the necessity of, and expense in going to trial, he is entitled to determine the point: cf *Williams & Humbert v W & H Trade Marks* [1986] AC 368.

1. I respectfully adopt the foregoing principles.

## Procedural History

1. The procedural history of this matter is somewhat convoluted. It is necessary to set out a brief overview as the sequencing of the filed originating documents and pleadings bears some importance to the disposition of the applications before me.
2. On 13 February 2018, the Doctor commenced the proceeding by an Originating Application (without an accompanying statement of claim).
3. On 7 October 2018, the Doctor lodged an (amended) Originating Application and filed an interlocutory application seeking summary judgment. She relied upon r. 26.01(1)(e) of the *Rules*, contending that “[o]n the basis of material factual evidence and for justice to occur I do not believe the respondents have reasonable prospects of success”. In support of the application, the Doctor filed an affidavit she had affirmed on 3 October 2018.
4. On 16 July 2019, the Doctor filed an Amended Originating Application, accompanied by a document entitled “Amended Statement of Claim” (the “July Statement of Claim”) (together, the “July Filings”). These documents were filed almost four months late without explanation. Healthscope indicated to the Court that it opposed the late filing of the July Filings at a mention on 24 July 2019. It subsequently withdrew its opposition.
5. On 23 August 2019, responding to the July Filings, Healthscope filed an interlocutory application seeking summary judgment pursuant to s. 31A(2) of the *FCA Act* and r. 26.01 of the *Rules* or, in the alternative, a strike out of the July Statement of Claim pursuant to r. 16.21 of the *Rules*. The application was supported by an affidavit sworn by Ms Claire Fogarty (the current general manager of Mount Hospital) on 23 August 2019 and an affidavit affirmed by Ms Jenny McKenzie (solicitor for Healthscope) on 23 August 2019. Healthscope also filed written submissions in support of its application, in response to the Doctor’s application for summary judgment and in opposition to the Doctor being granted an extension of time to bring a defamation claim.
6. On 6 September 2019, the Doctor filed her written submissions in support of her application for summary judgment dated 6 October 2018, in response to Healthscope’s application and in support of her being granted an extension of time to bring a defamation claim. In addition, without leave of the Court, the Doctor filed another iteration of the “Amended Originating Application” and the “Amended Statement of Claim” (together, the “September Filings”) purportedly to plead “two additional causes of action” in light of Ms Fogarty’s affidavit. Further, the Doctor altered the named respondent from “Healthscope Operations Ltd” to “Healthscope Ltd and Healthscope Operations Pty Ltd” (I shall address this issue below). The Doctor also filed an affidavit she had affirmed on 3 September 2019.
7. In determining the applications before me, I will not have regard to the September Filings save to a limited extent where appropriate. That is so because leave was not formally sought to file those documents and because both the Doctor’s and Healthscope’s interlocutory applications pre‑date the September Filings.

## The Identity of the Respondent

1. By a letter sent to my Chambers in October 2019, the Court was informed that the Doctor identified the respondent as “Healthscope Operations Ltd” in the Originating Application filed on 13 February 2018, however there is presently no such Australian company by that name. The company that owns and operates Mount Hospital has changed its name on a number of occasions since October 2010. From 12 October 2010 to 24 June 2014, the company was named “Healthscope Limited”. From 25 June 2014 to 6 November 2014, the company was named “Healthscope Operations Limited”. Since 7 November 2014, the company has been named “Healthscope Operations Pty Ltd”. The solicitors for the respondent thus submitted:

On the basis of our understanding that [the Doctor] intended to commence proceedings against the company that owned and operated Mount Hospital at all relevant times, we consider the name of the respondent should be changed to Healthscope Operations Pty Ltd to avoid confusion with its parent company (the current name of which is Healthscope Limited).

1. I interpolate here that “Healthscope Operations Pty Ltd” was identified by the Commission as the relevant entity against which the Doctor’s complaint was lodged. There is no mention of the parent company.
2. In response, the Doctor sent a letter to the Court which relevantly provided:

I would like to correct the statement that the filing was made against the company that owns and operates Mount Hospital – that is in fact incorrect. The matter is intended against the organisation that is responsible for the decision to issue a termination and lifetime nationwide ban on my accreditation (i.e. restricting my employment opportunities).

It is unclear whether the decisions made were by those representing and thereby in effect across Healthscope Operations Pty Ltd or the parent company Healthscope Ltd.

…

In the latest submission dated 6 September 2019 his Honour has been asked to pierce the corporate veil.

(Emphasis in original.)

1. Based on the September Filings, it appears the Doctor now wishes to bring her claim against *both* Healthscope Ltd and Healthscope Operations Pty Ltd. As will become apparent, it is unnecessary for me to form any concluded view concerning whether the parent of the company that owns and operates Mount Hospital should be joined as a party to this proceeding. I am otherwise satisfied that an order should be made to amend the name of the respondent to “Healthscope Operations Pty Ltd” to reflect the change in company name that occurred on 7 November 2014. This was the name of the company which was the subject of the complaint made to the Commission.

## Background

1. I now turn to a chronology of the events that culminated in the commencement of this proceeding. The facts are drawn from documentary evidence which was not seriously challenged save for where I specifically note that the parties are in dispute.
2. At the relevant time, the Doctor was an accredited medical practitioner in Western Australia across several hospitals owned and operated by different entities.
3. On or around 7 November 2011, the Doctor applied for accreditation at Mount Hospital in order to obtain authorisation to treat patients at that hospital. In making that application, the Doctor acknowledged that she had received a copy of the By‑Laws and agreed to abide by them. Additionally, she acknowledged that Mount Hospital’s General Manager(s), its officers and the Medical Advisory Committee(s) and its/their Credentials Committee(s) could seek information about her “past experience, clinical performance, current fitness and current insurance/indemnity status”.
4. On 9 November 2011, Ms Jade Phelan, the then general manager of Mount Hospital, advised the Doctor by letter that she had been granted temporary accreditation in a particular area of specialisation, subject to her signing and returning a copy of the letter as confirmation of her acceptance and agreement to abide by the By-Laws. The Doctor signed the letter and then returned it to Ms Phelan.
5. On 24 February 2012, Ms Phelan advised the Doctor by letter that she had been granted permanent accreditation at Mount Hospital. The letter similarly required the Doctor to confirm her acceptance and agreement to abide by the By-Laws. It is undisputed that she accordingly did so.
6. The aforementioned By-Laws (adopted on 1 July 2012) form an important plank of the Doctor’s claims. It is common ground that the By-Laws played a significant role in governing the relationship between the parties. The legal characterisation of the By-Laws is, however, a matter of controversy.
7. The By‑Laws are set out in a lengthy document. The “Foreword” to the By-Laws relevantly provides:

The Healthscope Limited Hospital By-Laws are the formal expression of the relationship between the accredited health professionals and the hospital …

The relationship between Healthscope Hospitals and accredited doctors is based on mutual recognition of, respect for and support for each other’s clinical and commercial objectives.

1. In amplification, the document states:

**What are these By-Laws?**

3 These By-Laws are created by Healthscope Limited [ACN 006 405 152, now named “Healthscope Operations Pty Ltd”] to assist in understanding some important current policies of its Board of Directors. They indicate how those policies are proposed to be carried into effect by the Healthscope Company that owns or operates each Healthscope Hospital, and in particular, by the General Manager of each hospital.

4 These By-Laws are intended by Healthscope Limited to be adopted by every Healthscope Company that owns or operates a Healthscope Hospital.

5 These By-Laws are intended for use by both Healthscope Company employees and also by Health Practitioners who are accredited with respect to a Healthscope Hospital.

…

**What are the purposes of these By-laws?**

9 These By-Laws have many purposes. Specifically they:

9.1 serve to maintain and improve the safety and quality of the delivery of hospital services;

9.2 protect Healthscope Hospitals and their Accredited Health Practitioners by ensuring that the environment in which hospital and medical services are delivered supports and facilitates both safety and quality;

9.3 define the relationship between a Healthscope Hospital and its Accredited Health Practitioners and serve to clarify the mutual prerogatives and obligations of those parties; and

9.4 assist in compliance with Commonwealth and State laws, regulations and standards …

**What do the By-Laws contain?**

…

11 These By-Laws contain policies on the following:

11.1 the terms and conditions on which Health Practitioners will be accredited;

11.2 the processes that lead to Accreditation and defining the ‘Scope of Practice’ of Accredited Health Practitioners;

11.3 the role of the Medical Advisory Committee and its sub-committees in the processes of Accreditation at Healthscope Hospitals;

11.4 the administrative and clinical responsibilities of Accredited Health Practitioners.

1. I note at this point that neither party asserted that the relationship between Healthscope and the Doctor was one of employer and employee.

### The Event

1. On 28 October 2014, an event took place involving the Doctor (the “Event”) at a hospital operated by St John of God Healthcare Inc (the “SJOG Hospital”). In the related proceeding *Pathmanathan v St John of God Healthcare Inc* [2019] FCA 1460, I did not describe that Event in any detail because it was both “unnecessary and undesirable” to do so. What occurred during the Event is very much disputed. The same reasoning for not describing the details of the Event applies here. Suffice to say for the moment, what allegedly occurred was indeed very serious. It led to the Doctor’s temporary suspension at the SJOG Hospital. It also led to the imposition of conditions on the Doctor’s registration for a period of time by the Western Australia State Board of the Medical Board of Australia (the “Board”).
2. On 23 November 2014, the Doctor informed Ms Phelan and Dr Gregory McGrath (Director of Medical Services at Mount Hospital) by letter that her clinical privileges had been suspended at the SJOG Hospital “pending the satisfactory resolution of two issues”. In her letter, the Doctor described the Event and another incident involving a patient. She explained that the Event transpired as a result of an “error of judgement” and assured that she would not engage in such conduct in the future. The Doctor now claims that she was “placed under duress to sign and send the letter” by her legal representatives at the time.
3. On 4 December 2014, prompted by a telephone query from “Metro Anaesthesia Group” (a third party), Mr Marc Foley, deputy general manager of Mount Hospital, sent an email to Ms Phelan to ask whether the Doctor’s accreditation at Mount Hospital was going to be suspended. On the same day, by return email, Ms Phelan informed Mr Foley that the Doctor’s accreditation had been suspended at the SJOG Hospital but had not been suspended at Mount Hospital. She noted, “[i]t shouldn’t be discussed with the anaesthetists as it is confidential”. Mr Foley responded as follows:

[The practice manager of Metro Anaesthesia Group] simply said that [the Doctor] has been suspended at [the SJOG Hospital] however had not heard that she had been suspended elsewhere, however ‘some of their other anaesthetists’ had said that she had been suspended at [Mount Hospital]. As a result she wanted confirmation as the dr is booked to work with some outer surgeons in the coming month.

(Errors in original.)

### Hollywood Private Hospital undertakings

1. On 5 December 2014, the Director of Medical Services at Hollywood Private Hospital – a hospital operated by Ramsay Health Care, not Healthscope – sent a letter to the Doctor setting out a series of undertakings in respect of her accreditation at that hospital. Those undertakings included monthly meetings with a mentor in her area of specialisation, written feedback being sought from co-workers at the hospital regarding the Doctor’s performance, notifying a senior medical practitioner of additional sessions (organised through the Doctor’s practice) for “monitoring purposes only without restriction to practice or taking up lists”, and a commitment to improve in “documentation, handover, availability, distraction in theatre and the use of non‑standard [medication]”. These undertakings were arranged following the Doctor disclosing her suspension at the SJOG Hospital and were to be reviewed “after 12 months or sooner should the need arise”.
2. The significance of these undertakings at Hollywood Private Hospital will become evident in due course.

### The immediate action condition

1. On 19 December 2014, in response to the Event, the Board decided to impose the following condition on the Doctor’s registration with immediate effect:

The Practitioner will not practise as a medical practitioner until she has undergone a health assessment and has been deemed fit to return to practise by the Board.

This is often referred to in the evidence as the “suspension” imposed by the Australian Health Practitioner Regulation Agency (the “Agency”).

1. On 23 December 2014, the Doctor sent a letter to Ms Phelan (copying in Dr McGrath) which relevantly provided:

In compliance with my continuous disclosure obligations, I advise that on 22 December 2014, I received notice from the Australian Health Practitioner Regulation Agency that the Medical Board of Australia (**Board**) had decided to impose a condition on my registration pursuant to section 158 of the Health Practitioner Regulation National Law …

That decision was made on 19 December 2014, although I did not receive notice of it until 22 December 2014.

The Board has also decided to refer me for a health assessment, which I understand is in the process of being arranged.

I do not believe that I am suffering from any health issue that would detrimentally affect my ability to practise.

This will mean that I will not be undertaking any work at the Hospital until either:

1. The relevant health assessment has occurred, and the Board decides that I may return to practice;

2. The decision is set aside on appeal or the Board revokes the condition.

I am presently considering whether or not to appeal the relevant decision.

I will keep you informed of any developments in relation to these issues.

1. On 27 December 2014, Ms Phelan informed the Doctor that, as a result of the notification, Mount Hospital had deactivated the Doctor’s accreditation in its system pending removal of the condition from her registration.
2. On 10 February 2015, the Board decided to remove the condition imposed on the Doctor’s registration.
3. On 11 February 2015, the Doctor sent an email to Ms Phelan (copying in Dr McGrath and Mr Foley) to advise that the “APHRA [sic] Health Committee … decided to remove the condition imposed via immediate action on 19 December 2014”. She inquired as to the procedure for reactivating her accreditation at Mount Hospital.
4. On 20 February 2015, Ms Phelan sent a letter to the Doctor confirming that Mount Hospital had reactivated her accreditation in its system.

### Non-disclosure regarding Bethesda Hospital and South Perth Hospital

1. At the start of 2015, unbeknownst to Healthscope, the Doctor’s accreditation was suspended at two hospitals – Bethesda Hospital and South Perth Hospital – by reason of her failure to advise hospital administration of the suspension imposed by the Agency in December 2014. Those hospitals were not owned and operated by Healthscope.
2. On 24 June 2015, a telephone call took place between Ms Phelan and the Doctor concerning her accreditation at other hospitals. In the Doctor’s affidavit affirmed on 3 October 2018, she deposed:

On 24 June 2015, the Mount Hospital general manager telephoned me briefly and was satisfied with my response regarding the oversight in not disclosing the Bethesda Hospital and South Perth Hospital suspension … The reasons explained being two‑fold:

a. Failure of [MDA National Insurance] solicitors to advise the requirement to disclose this suspension to Mount Hospital.

b. I did not have any regular lists at the hospital for over a year and did not foresee working at those hospitals. Therefore, the suspension was not materially relevant to my commercial and clinical practice.

(Errors in original.)

During the same call, Healthscope asserts that Ms Phelan asked the Doctor whether there had been any change to her accreditation at Hollywood Private Hospital. Contrastingly, the Doctor asserts that “[n]o discussion regarding the Hollywood undertakings took place”.

1. On 28 July 2015, the Doctor sent an email to Dr McGrath attaching a letter dated 27 July 2015. The letter relevantly stated:

Dear [Dr McGrath]

My solicitors have been regularly corresponding with [the Agency] on my behalf, and at this stage, we have reached a possible resolution of the investigation, involving the proposed imposition of a caution and several conditions on my registration for a 6‑month period.

I have until 1 August to respond to the proposal, and either agree, or to propose an alternative resolution.

[The Doctor then set out four conditions proposed by the Agency.]

In order that I can respond to [the Agency’s] proposal, I write to ask whether you could provide me, as soon as possible, a short report about your knowledge of my work during the last 9 months whilst I worked at the Mount Hospital. In particular, if you are able to comment on my professional conduct to date since I resumed my practice at Mount Hospital post [the Event].

I propose to provide your report to [the Agency] by 1 August. It may be that the 9 months supervision/mentoring we have already undergone will satisfy it and mean there is no further requirement for further supervision.

I will not be repeating the same mistake I made in relation to [the Event]. I also certainly won’t, and would never, do anything to harm my patients whom I take great care with.

…

(Errors in original.)

1. On 29 July 2015, Dr McGrath sent an email to Ms Phelan raising concerns regarding the letter he had received from the Doctor. The email relevantly stated:

In [the letter] you will see [the Doctor’s] reference to a 9 month mentoring supervision already undertaken.

When I discussed this with [the Doctor] per phone yesterday she acknowledged that the supervision/mentoring was undertaken at Hollywood …

[The Doctor] denied any restriction to her practice at Hollywood, however I am not cognizant to what her declarations in the past to you have been.

There appears to be a prima facie contradiction here.

…

I wonder if you have received full disclosure of the nature of her supervision at Hollywood.

She has subsequently asked for a letter of support from me to state her practice at Mount has been unblemished, however I do not believe I am in a conscionable position to provide such a letter.

I personally would not wish to be party to her efforts to extenuate the proposed [Agency] conditions.

(Errors in original.)

1. On 11 August 2015, Dr McGrath sent an email to Ms Phelan which relevantly stated:

On [the Doctor], I suggest we (you and/or me) write her to seek she waive her right to privacy so I may write to Dr S Crocker to ask [him] directly the nature of the supervision [the Doctor] received and what undertakings she gave to Hollywood and Osborne Pk Hospital exec and assess that with what [the Doctor] said to you when you spoke to her.

[The Doctor] should also inform us of what undertakings [the Agency] recommend she abide by and for what duration.

That unless she commits to provide this information, her credentialing should be suspended until resolved to your satisfaction.

I would not recommend she work here if [the Agency] require further practice supervision – such that I gather she is attempting to fight.

I would recommend immediate suspension of credentialing if you feel she has been dishonest with her reporting to you of her supervision at Hollywood.

I am concerned [the Doctor] has demonstrated an unacceptable frequency of poor decision making which has the potential to put patients at risk.

(Errors in original.)

1. Later that evening, the Doctor sent an email to Ms Phelan and Dr McGrath which relevantly provided:

As you may be aware [the Agency] had removed my suspension a while back however have been reviewing/investigating my practice since with reference to [the Event].

We have come to the final stages of this process with them and they will be making a decision today. I believe they will advise me of the outcome within the next two weeks. The Mount Hospital has also been listed as a practice location and as such they may be in touch directly with yourselves. In any case I will advise you of the outcome as soon as I hear. There will be at the very least some undertakings which I have voluntarily offered for a period of time.

### Further conditions on the Doctor’s registration

1. On 18 August 2015, the Doctor was informed that the Board had imposed further conditions on her registration. Those conditions were published online by the Agency on the National Register of Health Practitioners as follows:

Effective 11 August 2015, this registration is subject to conditions that relate to personal health. Further details are not publicly available due to privacy considerations.

Effective 11 August 2015, this registration is subject to the following conditions:

1. The Practitioner must nominate a registered medical practitioner to act as her supervisor, for approval by the Board, who must be senior to her by position or years of experience (Supervisor).

2. The Practitioner must only practise as a medical practitioner under indirect supervision by the Supervisor. For the purposes of this condition, indirect supervision is defined as being primarily in person and, in circumstances where the Supervisor is not physically present, they must always be contactable by telephone.

…

(the “August Conditions”)

The Doctor’s registration details (including the August Conditions) were downloaded, printed and placed on Mount Hospital’s accreditation file relating to the Doctor.

1. On 20 August 2015, Ms Phelan sent an email to Mr Richard Townsend, the perioperative services manager at Mount Hospital, which stated:

Due to recent conditions imposed on [the Doctor’s] medical board registration, she can no longer anaesthetise at the Mount Hospital.

Can you please communicate this with your theatre managers so they are aware.

The Doctor contends that on the same day, during a telephone call, Ms Phelan suspended her accreditation at Mount Hospital immediately without any discussion. Healthscope does not concede that the Doctor’s accreditation was suspended on this date.

1. On or around 1 September 2015, Ms Phelan forwarded to Dr Coglin, the Chief Medical Officer of Mount Hospital, email correspondence from the Doctor concerning the removal of the condition imposed on 19 December 2014. In response, Dr Coglin wrote:

None of this gives me any idea of the reasons why [the Agency] imposed conditions on 11 August 2015. We need to ask her.

Ms Phelan responded:

Good point. I will formally ask her via letter.

1. On 4 September 2015, the Doctor’s solicitors at the time sent a letter to Ms Phelan and Dr McGrath which relevantly provided:

Based on my conversations with [the Doctor], I understand that once you have received the details of the conditions imposed on her practice by [the Agency], you will consider the conditions and then contact [the Doctor] to discuss their implementation and her compliance, as well as her ongoing work and practice arrangements at the Hospital.

I understand Mount Hospital has been supportive to [the Doctor] during the period since [the Event], her [Agency] suspension and the ongoing Board investigation …

… I understand there has recently been an issue raised as regards her status and accreditation at other sites, which you had enquired about, and which [the Doctor] would like to ensure is clarified with you.

As I understand [the Doctor] has advised you, she was suspended from both Bethesda and South Perth Hospitals in January and February 2015, after failing to advise them of the [Agency] suspension in December 2014. As she had not worked with either of those Hospitals prior to the [Agency] suspension for between 6 to 12 months, [the Doctor] did not report it to them. This was an error, which she regrets. At this point, those suspensions remain in place, however [the Doctor] shortly intends to make a request of Bethesda Hospital to re-instate her accreditation there, and as to South Perth, intends to surrender, or resign, her accreditation. As regards Hollywood Private Hospital, in December 2014, [the Doctor] reached agreement with the Director of Medical Services to continue work (once the [Agency] suspension was lifted) on the basis of some agreed conditions or undertakings.

A copy of the letter ultimately agreed is enclosed. The arrangement presently remains in place, and I understand she continues to enjoy the support of the Hollywood administration and staff during this time.

As part of the agreed conditions, [the Doctor] met and communicated regularly with Dr Steve Watts, and a copy of Dr Watts [sic] corresponding report for his work with [the Doctor] to date is enclosed for your information. She met with Dr Watts on 22 June 2015, and understood this to be for a review and evaluation of her performance while under those conditions, and she incorrectly formed the conclusion that based on her performance and his evaluation, the Hollywood conditions would come to an end effective 22 June 2015. This conclusion was based on feedback she received, and also the fact that in the letter, conditions were to remain in place for “up to” 12 months, and therefore, could come to an end sooner.

I understand she subsequently spoke to you on 24 June 2015, when she was completing an anaesthetic list, and she advised you she had indeed been suspended at Bethesda and South Perth Hospitals many months prior. As to her arrangements with Hollywood, [the Doctor] instructs she does not specifically recall discussing Hollywood Hospital with you, but when she spoke to you, she was under the impression her conditions with Hollywood were no longer applicable in any event. However, this was not in fact the case, and when [the Doctor] sought formal written confirmation on 27 July 2015 that the restrictions had been lifted effective 22 June 2015, the Director of Medical Services at Hollywood responded clarifying that the undertakings associated with her accreditation would be reviewed after 12 months by the credentials committee. This means they remain in place, although she has since been advised that in light of the recent [Agency] decision, the conditions will now [be] reviewed at an upcoming medical advisory committee.

[The Doctor] did not subsequently relay to you last month the continuing nature of her agreement with Hollywood, and apologises for that oversight. We are instructed it was unintentional and reflective simply of time pressures, her administrative load and the brief and unexpected discussion she says she had with you in June 2015, in relation to her accreditation status at other sites.

1. On 7 September 2015, the Doctor emailed Ms Phelan and Dr McGrath to request a meeting to “clarify any misunderstandings to date and also discuss my work at The Mount Hospital”. She noted that “Mount Hospital has been very supportive to me through what has been a difficult period”. On 12 September 2015, Ms Phelan forwarded this email to Dr Coglin to which he replied “Gimme a break. Talk Monday”.
2. On 9 September 2015, the Doctor’s solicitors sent an email to Ms Phelan and Dr McGrath attaching a letter setting out all the August Conditions and the Board’s reasons for decision.
3. On 14 September 2015, the Doctor claimed that she made an appointment with Ms Phelan but this was allegedly cancelled by Ms Phelan moments before the meeting.
4. On 17 September 2015, the Doctor’s solicitors sent an email to Ms Phelan and Dr McGrath advising that, in line with the August Conditions, the Board had approved the Doctor’s nominated supervisors on the previous day. With respect to Mount Hospital, Dr Peter Honey had been approved to supervise the Doctor.

### Decision to terminate accreditation at Mount Hospital

1. On 22 September 2015, Ms Phelan sent a letter to the Doctor advising that she had decided to terminate her accreditation at Mount Hospital by reason of the Doctor’s failure to comply with her continuous disclosure requirements under the By-Laws. Ms Phelan relied on the following clauses of the By-Laws:

**Termination of Accreditation**

88 The General Manager of a Healthscope Hospital may, by written notice, immediately terminate an Accredited Health Practitioner’s Accreditation in respect of that hospital if:

…

88.5 the General Manager forms the view that the Accredited Health Practitioner has failed to meet the continuous disclosure requirements of these By-Laws;

…

**Continuous Disclosure Requirements**

126 An Accredited Health Practitioner must keep the General Manager of every Healthscope Hospital in respect of which he or she has been accredited continuously informed of every fact and circumstance which has a material bearing upon:

126.1 the Credentials of the Accredited Health Practitioner;

126.2 the Scope of Practice of the Accredited Health Practitioner;

126.3 the ability of the Accredited Health Practitioner to safely deliver health care services to his or her patients within that Scope of Practice; and

126.4 the ability of the Accredited Health Practitioner to satisfy a medical malpractice claim made against him or her by a patient.

127 Without limiting clause 126, an Accredited Health Practitioner must advise the General Manager of the Healthscope Hospital(s) in respect of which he or she has been accredited if:

…

127.5 his or her appointment to, accreditation at or scope of clinical practice at any other facility, hospital or day procedure centre *is altered in any way* or becomes subject to any conditions or restrictions;

…

(Emphasis added.)

1. Ms Phelan reasoned that the Doctor had failed to comply with cl 127.5 as follows:

… You did not inform me that you had been de-credentialed at Bethesda Hospital or South Perth Hospital until I telephoned you in June 2015 to enquire into the status of your accreditation at those hospitals. You have also had restrictions on your accreditation/scope of practice at Hollywood Private Hospital since December 2014. You did not disclose this to me at the time the restrictions were imposed/agreed, nor when I gave you the opportunity to disclose this during our telephone conversation in June 2015. At that time, you denied that your accreditation at Hollywood Private Hospital was subject to any restrictions. I only became aware that your accreditation/scope of practice at Hollywood Private Hospital was subject to restrictions after you inadvertently sent an email to Dr McGrath that you had intended to send to your supervisor, Dr Watts [of Hollywood Private Hospital]. I did not become aware of the precise details of the matter until I received [the Doctor’s solicitor’s] email on 4 September 2015. By this time the restrictions had been in place for over eight months. Your failure to disclose the restrictions on your accreditation at Hollywood Private Hospital appears to have been intentional rather than inadvertent.

It is for these reasons that I have decided to terminate your accreditation.

The Doctor was also informed that she had a right to appeal the decision within 30 days of receiving the letter.

### Appeal process

1. On 21 October 2015, the Doctor wrote to Ms Phelan advising that she intended to appeal the decision to terminate her accreditation.
2. On 17 December 2015, Dr Coglin sent a letter to the Doctor advising that he, as Chief Medical Officer of Mount Hospital, would determine her appeal pursuant to cl. 102 of the By-Laws. He also set out in that letter the nature of the appeal, the procedure for the appeal and the evidence to be considered when determining the appeal. That evidence was said to be comprised of: (i) the records held by Mount Hospital relating to the circumstances leading to the Doctor’s termination; (ii) any evidence contained in the submission that Dr Coglin would request from the general manager regarding the basis upon which she formed the view that the Doctor’s accreditation should be terminated; (iii) any evidence contained in the submission that Dr Coglin would request from the Doctor regarding the basis upon which the general manager formed her view to terminate the accreditation; (iv) any evidence which the Doctor provided during a meeting with Dr Coglin; and (v) any independent expert or corroborating evidence which Dr Coglin obtained in order to inform himself on issues raised by the general manager or the Doctor in their respective submissions.
3. Thus, in accordance with the appeal procedure set out in cll. 109 to 113 of the By-Laws, the following occurred:
   1. on 5 January 2016, Ms Phelan provided submissions to Dr Coglin explaining the basis of her decision to terminate the Doctor’s accreditation at Mount Hospital. After outlining the non-disclosures regarding Bethesda Hospital, South Perth Hospital and Hollywood Private Hospital, she expressed:

… the events show [a] repeating pattern of non-disclosures over a prolonged period in circumstances where [the Doctor] had already been suspended by two hospitals due to her failure to adhere to continuous disclosure requirements. She must have been aware of the gravity of non-disclosure.

…

As you are aware, the continuous disclosure requirements in the [By‑ Laws] are critical to the hospital’s operation. The hospital must ensure that all accredited health practitioners are authorised to undertake clinical practice that is properly delineated, based on their credentials, competence, performance and professional suitability. This is essential for the consequential delivery of high quality and safe health care to patients at the hospital.

I pause here to observe that, in my view, breach of the continuous disclosure requirements of the By-Laws by an accredited health practitioner is not a trivial or mere technical slip. It goes to the ability of the hospital to assess whether an accredited health practitioner is fit to treat safely patients at the hospital. It goes to the hospital’s duty of care to its patients. In that respect, the Doctor never denied that she had failed to make continuous disclosure as required with respect to her suspensions at Bethesda Hospital and South Perth Hospital. Rather, she sought to lay blame at the feet of her solicitors. She also downplayed the importance of the need to disclose to Mount Hospital the undertakings in relation to her accreditation at Hollywood Private Hospital (see below).

* 1. on 19 February 2016, the Doctor provided submissions in reply to Dr Coglin which relevantly stated:

… throughout the period of since 28th October 2014 up to October 2015 I was acting on the advice and instructions of MDA and their appointed lawyers … Compliance with hospital by-laws of the different hospitals was the responsibility of MDA and their appointed lawyers …

The Hollywood Hospital undertakings were designed to be supportive and plainly states was for monitoring purposes only and not restrictive on my practice. It was an undertaking not a restriction, conditions or any other adverse qualification to my employment conditions …

I did not disclose the [Bethesda Hospital and South Perth Hospital] suspensions previously as I had in all honesty believed that it was the legal responsibility of MDA and their lawyers to make all disclosures required by the by-laws of the several hospitals that I was working at. It was never my intention to mislead the Mount Hospital as I felt they were supportive of my practice.

… It is clear that Mount Hospital administration was aware of my undertakings at Hollywood Hospital from February 2015. However, [Ms Phelan] herself may not have been informed by the other administrators.

… [Ms Phelan] has confused “undertakings” as meant in writing … with the words “conditions” and “restrictions” and used these interchangeably and thereby misrepresenting the facts. I signed undertakings which strictly was not intended to restrict my scope of practice nor my practice in any other way …

(Errors in original.)

1. On 22 February 2016, Dr Coglin sent an email to several colleagues, including general managers of other hospitals, in the Healthscope group which stated:

[The Doctor] has had her accreditation terminated at the Mount. She is currently appealing against her termination.

She advises me of her intention to move to Sydney. Remarkably she tells me that she is seeking accreditation at some of HSO’s Sydney hospitals eg POWP and Norwest. It goes without saying that under no circumstances should she be offered or even considered for accreditation at your hospital.

The Doctor was subsequently refused accreditation at the following Healthscope hospitals: Norwest Private Hospital (on 24 March 2016); Sydney Southwest Private Hospital (on 9 June 2017); and Prince of Wales Private Hospital (on 7 August 2017).

1. On 17 March 2016, the Doctor emailed Dr Coglin requesting that they meet to “resolve this issue with haste”. A meeting was scheduled to occur on 5 April 2016, however, on 4 April 2016, the Doctor cancelled the meeting and asked whether she could bring a support person to the rescheduled meeting. In reply, Dr Coglin proposed a meeting in Sydney on 28 April 2016 and indicated that he was amendable to the Doctor being “accompanied by an appropriate support person”. The Doctor agreed to the date and proposed to bring a solicitor to the meeting (but not in the capacity of her legal representative). Dr Coglin responded, “I am sorry but it is not acceptable to me that you be accompanied by a solicitor, whatever he is held out to be”. I note parenthetically that cl. 110 of the By-Laws clearly provides that an appellant is not entitled to legal representation or have a legal representative present when making any oral submission to the Chief Medical Officer as part of the appeal process. In a further email, Dr Coglin stated, “I am available to meet with you at 0800 on 28 April at the … Prince of Wales Private Hospital”.
2. On 21 April 2016, the Doctor sent an email to Dr Coglin and Dr Steve Watts of Hollywood Private Hospital in which she forwarded an email that Dr Watts had sent to her earlier in the year on 23 February 2016. That email stated:

Dear [Dr Coglin],

With regards to our meeting next week I have spoken to Dr Steve Watts who is the author of the Hollywood undertakings (note they were not a restriction to practice).

Please find below an email from him with regards to communication with Mount Hospital administration regarding the undertakings.

…

------ Forwarded message ------

…

Hi [the Doctor]

Looking back in my diary, I [(Dr Watts)] can state with some certainty that the discussion call I had with the Mount was shortly before 5pm, 30 April 2015. The call was from Dr McGrath, and lasted over 45 mins. I had previously discussed your situation informally with Steve Same as a HOD heads-up (probably a month prior). Both docs were made aware of the welfare management plan agreed to between yourself and Hollywood.

1. On 27 April 2016, the Doctor sent an email to Dr Coglin which relevantly stated:

In terms of the meeting tomorrow my intention is to seek your help in re-establishing my practice …

I hope that with your leadership and sphere of influence you may be able to help me not only at the Mount Hospital but also in other Healthscope institutions and in Sydney.

The Doctor also attached a document entitled “Summary of AHPRA facts” which stated, amongst other things, the following regarding the Event:

… the patient was not neglected at any time. Further there was no protocol or policy found was breached. Having said this I made full and frank admission and accept that it was a lapse of judgement that should not have happened and certainly will never do again. On personal reflection I had consider the event a foolish thing …

(Errors in original.)

1. On 28 April 2016, the Doctor did not attend the meeting at the planned time. She said, “I thought we had scheduled for 10:30am”. In a subsequent email, she wrote:

I am very sorry about the meeting today …

In coming to the meeting today I just merely wanted to ask you for your help. I have been through a great ordeal over the last 19mnths since the incident putting my career and life into a tailspin …

I hope you can help me re establish.

(Errors in original.)

1. On 7 May 2016, the Doctor sent an email to Dr Coglin requesting an estimate as to when he would deliver a decision on the appeal.
2. On 1 June 2016, Dr Coglin sent a letter to Doctor informing her that he had decided to dismiss her appeal on “the basis of the information particularized in my letter to you of 17 December 2015”. His reasons for decision were as follows:

* in or about December 2014 your accreditation at Hollywood Private Hospital was varied by the imposition of certain conditions or undertakings.
* you did not disclose the imposition of these conditions or undertakings to the General Manager of the Mount Hospital.
* your failure to make this disclosure was a breach of s. 127.5 of the Healthscope Limited Hospital By-Laws.
* on the basis of the evidence available to the General Manager in September 2015 it was reasonably open to the General Manager to find that you had breached the By-Laws and proportionate for the General Manager to terminate your accreditation.
* I have reason to believe that you may have breached your disclosure obligations with regard to your accreditation status at Bethesda and South Perth Hospitals. I have not given this matter further consideration as your failure to disclose matters relating to Hollywood Private Hospital justify the decision of the General Manager to terminate your accreditation and my decision to dismiss your appeal.

Dr Coglin also stated:

I further advise that having had your accreditation at the Mount Hospital terminated for cause, it is unlikely [that] an application for accreditation at another hospital owned or operated by Healthscope Limited will be successful.

1. Thereafter, the Doctor took no steps to challenge the validity of the dismissal of her appeal.

### The Doctor’s complaint to the Commission

1. Over a year later, on 31 August 2017, the Doctor lodged a complaint against Healthscope with the Commission alleging sexual harassment, sex discrimination, marital status discrimination, racial discrimination, age discrimination and victimisation. Her complaint relevantly stated:

The ultimate reason for the Mount Hospital administration termination was likely due to perceived disability secondary to [the Agency] events.

The conduct of my colleagues and the director of medical services was likely due to other reasons as ticked above. Each colleague having their own reason to discriminate and bully out of practice.

1. On 28 September 2017, Dr Coglin, on behalf of Healthscope, responded to the complaint in a letter addressed to the Commission. Healthscope vehemently denied that it had imputed a mental health disability to the Doctor. It denied that its termination of the Doctor’s accreditation and subsequent refusal to accredit her at other Healthscope hospitals was for discriminatory reasons. The letter relevantly stated:

At no time did [the Doctor] disclose to the hospital nor did the Hospital become aware from [the Agency] or by other means of the nature of her health condition.

…

Effective 11 August 2015, [the Agency] imposed further conditions on [the Doctor’s] medical registration including the following:

*Effective 11 August 2015, this registration is subject to conditions that relate to personal health. Further details are not publicly available due to privacy considerations.*

Again, at no time then or since was the Mount Hospital aware of the nature of the “personal health” issue(s) referred to nor did the hospital hold the belief that [the Doctor] suffered from a “mental health disability” as referred to in your letter to me.

In August 2015, [the Doctor’s] accreditation at another Perth hospital was subject to the imposition of conditions. [The Doctor], by her own admission, failed to disclose this to Mount Hospital. Such failure was a breach of her continuous disclosure obligations under the Healthscope Limited Hospital By-Laws. As a consequence of this breach, her accreditation to practise at the Mount Hospital was terminated by the General Manager. [The Doctor] appealed against the General Manager’s decision. Her appeal was unsuccessful. The letter advising her of the outcome of her appeal included the following:

*“I further advise that having had your accreditation at the Mount Hospital terminated for cause it is unlikely that an application for accreditation at another hospital owned or operated by Healthscope will be successful.”*

The Healthscope Limited Hospital By-Laws contain the following provision:

“*If the General Manager of a Healthscope Hospital terminates an Accredited Health Practitioner’s Accreditation in respect of that hospital (****first hospital****) and the Health Practitioner is an Accredited Health Practitioner who is accredited with respect to any other Healthscope Hospital (****other hospital****), the Health Practitioner’s Accreditation at the other hospital is contemporaneously terminated*”.

The advice given to [the Doctor] was a clear reflection of the principle that if a doctor is terminated at one Healthscope hospital, he/she should not hold accreditation at another. To do otherwise would be nonsensical.

[The Doctor] moved to Sydney. Ignoring the advice she had been given, she proceeded to apply for accreditation at a number of Healthscope hospitals, including Sydney Southwest Private Hospital, Prince of Wales Private Hospital and Norwest Private Hospital. Unsurprisingly, these applications were unsuccessful. [The Doctor] now alleges that her termination at the Mount Hospital and her failure to gain accreditation at other Healthscope hospitals were the consequence of unlawful discrimination. Healthscope categorically denies these allegations, for which no evidence has been produced.

…

At no time prior to receipt of [the Doctor’s] complaint to the Commission has Healthscope been in possession of information suggesting that [the Doctor] suffers from a disability. At no time has Healthscope held the belief that [the Doctor] suffers from a disability …

…

There is a perfectly logical, consistent and lawful explanation for [the Doctor’s] treatment by Healthscope, namely, that her accreditation at the Mount Hospital was terminated as a consequence of her admitted breach of the conditions of her accreditation. Further, she insisted on applying for accreditation at other Healthscope hospitals with total disregard for the advice given to her that such applications were likely to be unsuccessful. I note that there are 420 public and private acute medical/surgical hospital in NSW alone where [the Doctor] could seek to practise in addition to the 3 Healthscope hospitals where she has been refused accreditation.

1. On 14 December 2017, as aforementioned, a delegate of the President of the Commission terminated the Doctor’s complaint alleging disability discrimination. The allegations of discrimination on the other grounds were not considered as forming part of the complaint as the Commission could not discern how the relevant provisions under the *Sex Discrimination Act*, *Racial Discrimination Act* and *Age Discrimination Act* were applicable to the matters raised by the Doctor. The delegate’s letter relevantly stated:

In the complaint form, you ticked the boxes alleging sexual harassment, sex discrimination, marital status discrimination, racial discrimination, age discrimination and victimisation. However it is unclear how the relevant provisions under the *Sex Discrimination Act 1984* (Cth), *Racial Discrimination Act 1975* (Cth) and *Age Discrimination Act 2004* (Cth) were applicable to the matters raised in your complaint. As such, your complaint was accepted and progressed as a complaint under the [*Disability Discrimination Act*] only.

## The proceeding before this Court

1. The Doctor has at all times represented herself. Even after taking that factor into account, with great respect, her claims were vague, confusing, conclusionary and dispersed across multiple documents. The preponderance of the affidavit material and exhibits filed by the Doctor has, I find, often been irrelevant, misconceived, inadmissible and/or scandalous.
2. As best as can be discerned, the Doctor’s claims are as follows:
   1. breach of contract and failure to afford procedural fairness;
   2. unlawful discrimination and unfair dismissal;
   3. breach of confidence, breach of the *Privacy Act* and invasion of privacy;
   4. defamation; and
   5. negligence.

Given the great deal of overlap between the issues raised by the applications for summary judgment, I shall structure my reasons according to the above claims.

### Breach of contract and failure to afford procedural fairness

#### Breach of contract

1. The Doctor’s breach of contract claim, as best as I can understand them, essentially raises two issues:
2. *first*, whether a contract existed between the parties; and
3. *secondly*, if a contract did exist between the parties, whether Healthscope breached its terms.
4. As to the first issue, no document(s) expressly constituting any written agreement executed between the parties was tendered in evidence by the Doctor. Nor did she plead or lead evidence about the possibility of an oral contract. The Doctor relied on the By-Laws as “evidencing” or “constituting” the contract. Healthscope submitted that the arrangement between the parties was in the nature of a “conditional licence”. The Doctor’s accreditation, it was said, did not give rise to a contract and did not “contractually oblige Healthscope to enforce the By‑Laws for [the Doctor’s] benefit”. In support of its position, Healthscope cited the decision of Wilson J. in *Page v. Healthscope Operations Pty Ltd* [2016] NSWSC 1608. That case turned upon whether or not a contract existed between a specialist anaesthetist and the private hospital in which the anaesthetist was accredited to practise. The anaesthetist contended that his reaccreditation by the hospital was a contract, expressly constituted by the correspondence surrounding his accreditation, the By-Laws under which the defendant conducted its business, the Codes of Conduct of the defendant, and various policy documents referred to in the Codes. Her Honour held that a contract did not exist between the parties reasoning as follows at [63]‑[66] and [79]:

… the plaintiff’s agreement to abide by the By-Laws was no more than a promise he made to gain conditional access to the [Hospital]. The defendant gave no promise or guarantee of anything of value in return for the plaintiff’s promise. Indeed, whether the plaintiff could in fact access the [Hospital] was still dependent upon the General Manager giving authority for that to occur, authority which was not bought by the tender of any real consideration by the plaintiff. There was no obvious commercial relationship between the plaintiff and defendant.

Accreditation gave the plaintiff no rights or entitlements. He had no right to practice within the Hospital; he was not guaranteed any work within the Hospital, or that there would be patients for him to treat; he was not guaranteed the allocation of any particular level of access to theatre time. It was entirely open to the defendant to accredit the plaintiff, but then withhold the General Manager’s authority for him to enter and practice within the Hospital.

The plaintiff’s promise to abide by rules of conduct, the By-Laws, was not given in exchange for any promise of value from the defendant. In short, I am unable to conclude that there was consideration.

In the absence of real consideration, there cannot be a contract.

…

Having considered the evidence, I have concluded that the reaccreditation agreement was an agreement in the nature of a conditional license granted by the defendant to the plaintiff, such that the plaintiff was accredited to enter the Hospital and provide therein medical services within his area of expertise, subject to a separate authority from the General Manager so to do. The accreditation did not give rise to a contract, and did not contractually oblige the defendant to enforce the Code of Conduct and associated policies for the plaintiff’s benefit.

1. The Doctor submitted that *Page* was wrongly decided and relied upon the decision of McKechnie J. in *Pisano v. Health Solutions (WA) Pty Ltd* [2014] WASC 356. In that case, an orthopaedic surgeon contended that a decision by the defendant to reappoint him as a “credentialled” practitioner with clinical privileges at one of its health campuses amounted to an agreement. It was said that three documents constituted the contract: a medical staff accreditation form for reappointment as a Credentialed Practitioner with the health campus; an email and letter from the health campus stating that the surgeon was re-credentialled; and the health campus’ by-laws. His Honour found that the three documents relied on by the surgeon did create an “agreement between [the surgeon] and [the health campus]” such that the parties were bound to comply with the health campus’ by-laws. With great respect, the reasons underpinning that conclusion were not entirely clear to me.
2. The Doctor also submitted that a contractual agreement existed between the parties because of the definition of “practitioner agreement” which was inserted into the *National Health Act 1953*(Cth.) by the “*Health Legislation (Private Hospitals* [sic] *Reform) Amendment Act 1995*”. This submission is, with respect, misconceived as the statutory definition of “practitioner agreement” was predicated on the existence of an established agreement between a medical practitioner and hospital in the first place. In any event, it has no relevance to the Doctor’s case as the definition was repealed by the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* (Cth.), prior to the Doctor seeking accreditation at Mount Hospital in 2011.
3. Given the state of the pleadings and the materials before me, and the difficulties of comprehension they present, I very much doubt whether a contract existed between the parties. In any event, even if I were to accept the Doctor’s case at its highest in respect of the first issue – that is to say, assuming that a contract existed between the parties that bound them to comply with the terms of the By-Laws – I am persuaded that the contention that Healthscope breached the By-Laws has no reasonable prospect of succeeding for the purposes of s. 31A of the *FCA Act*. With respect, I agree with Healthscope’s submission that the nature of the alleged breaches is opaque. As best as can be discerned, the Doctor complains about: (i) an alleged suspension on 20 August 2015 in breach of cll. 82 to 84 of the By‑Laws and, in particular, the failure of Ms Phelan to provide written notice of the alleged suspension; (ii) the quality of the reasons given by Ms Phelan for termination; and (iii) the time taken to conclude the appeal process.
4. Clauses 82 to 84 of the By-Laws provide:

**Suspension of Accreditation by General Manager**

82 In consultation with the Chairperson of the [Medical Advisory Committee], the General Manager of a Healthscope Hospital may suspend an Accredited Health Practitioner’s Accreditation in respect of that hospital if the General Manager forms the view that:

82.1 to do so would be in the interests of patient care or safety;

82.2 to do so would be in the interests of staff welfare or safety;

82.3 serious and unresolved allegations have been made in relation to the Health Practitioner;

82.4 the Accredited Health Practitioner has breached any General Conditions or Special Conditions of Accreditation;

82.5 the conduct of the Accredited Health Practitioner compromises the efficient operation or the interests of the hospital; or

82.6 there are other unresolved issues in respect of the Accredited Health Practitioner that the General Manager, the Board of Healthscope Limited and/or the Board of the Healthscope Company that owns or operates the hospital in question consider are a ground for suspension.

83 The General Manager must not suspend an Accredited Health Practitioner’s Accreditation unless the General Manager reasonably believes that the cause of the suspension can be resolved, and in a timely manner.

84 The General Manager must notify an Accredited Health Practitioner in writing of:

84.1 the suspension of his or her Accreditation, including the period of it and reasons for it;

84.2 any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed;

84.3 the Health Practitioner’s right to appeal the General Manager’s decision to suspend the Health Practitioner’s Accreditation.

1. With respect, each of those three contentions is relevantly hopeless for the following reasons:
2. *first*, the evidence simply does not support the proposition that the Doctor was subject to a “suspension” of her accreditation at Mount Hospital by reason of what occurred on 20 August 2015. In simple terms, the power to suspend was not exercised; rather, during this period the Doctor was not entitled to practise pursuant to the August Conditions imposed on the Doctor’s registration by the Board. In my view, Ms Phelan’s email to Mr Townsend advising that the Doctor could no longer anaesthetise at Mount Hospital was merely a reaction to the Board’s decision. In other words, due to the conditions on the Doctor’s registration, she could not practise as a medical practitioner at Mount Hospital *unless* the Board approved a supervisor who was an accredited health practitioner at Mount Hospital. She therefore could not practise at Mount Hospital at that time without breaching the conditions of her registration. Hence, the Doctor was not subject to a formal suspension at Mount Hospital so as to engage the terms of cll. 82 to 84. In my view, what occurred on that date was a necessary product of the Board’s decision regarding the Doctor’s capacity to practise. It placed the parties in a holding pattern pending the Board’s approval of an appropriate supervisor at Mount Hospital (which in effect protected the Doctor from being in breach of her registration conditions). So much is evident from the letter sent by the Doctor’s solicitors to Ms Phelan and Dr McGrath on 4 September 2015, which relevantly stated:

Based on my conversations with [the Doctor], I understand that once you have received the details of the conditions imposed on her practice by [the Agency], you will consider the conditions and then contact [the Doctor] to discuss their implementation and her compliance, as well as her ongoing work and practice arrangements at the Hospital.

The foregoing does not, in my view, point towards an unjustified suspension unilaterally brought about by the general manager of Mount Hospital in the way contended for by the Doctor. I am therefore satisfied that the contention that Healthscope breached cll. 82 to 84 of the By‑Laws has no reasonable prospect of success;

1. *secondly*, I am satisfied that the claim that Ms Phelan’s reasons for terminating the Doctor’s accreditation were in breach of the By-Laws or otherwise “misleading, misrepresentative and a *non-sequitur*” (to use the Doctor’s language) has no reasonable prospect of success. In compliance with cl. 88, Ms Phelan provided written notice of the termination to the Doctor (letter dated 22 September 2015); she provided clear reasons for the termination (with an evidentiary basis) pursuant to cl. 88.5; and notified the Doctor of her right to appeal the decision. There is simply no evidence to support the Doctor’s assertion that the reasons Ms Phelan disclosed in the letter should not be accepted on their face. The Doctor’s case rose no higher than merely asserting that the reasons were “misleading and dishonest” and a work of “legal sophistry”; and
2. *thirdly*, I do not think the time taken to conclude the appeal process (approximately seven months) constitutes a breach of the terms of the By-Laws. That claim is relevantly hopeless and is bound to fail. References to time limits in the By-Laws in relation to the appeal process are not prescriptive; open‑ended language such as “as soon as practicable” (cll. 101 and 102) and “within a time period the Chief Medical Officer considers reasonable” (cl. 109) is used. Examining the timeline of events, I can see no failure on the part of Healthscope to meet that standard. Indeed the Doctor herself contributed to the appeal process being extended: she rescheduled the meeting on 5 April 2016 and failed to attend the meeting on 28 April 2016. Dr Coglin notified the Doctor of his decision on 1 June 2016.
3. For the foregoing reasons, the breach of contract claim has no reasonable prospect of success and ought to be summarily dismissed.

#### Failure to afford procedural fairness

1. The Doctor also claimed that she was not afforded procedural fairness by Healthscope. The source of this obligation was not clearly articulated by the Doctor. In its written submissions, Healthscope drew the Court’s attention to *Crowe v. Mercy Health and Aged Care Central Queensland Ltd* [2001] QSC 384. That was an interlocutory decision made in proceedings commenced by a physician seeking a declaration that the revocation of his clinical privileges was void or legally invalid on the basis that he was denied natural justice. Dutney J. said at [18]:

It is not clear to me that the Mater hospital should be treated differently from a body such as a turf club which operates under a governmental authority. The legislation governing the operation of a private hospital is complex. For example, it can operate lawfully only while it is the holder of a license under Part 3 Division 4 of *The Health Act 1937* (Qld). *The Health (Private Hospitals) Regulation 1978* requires the licensee of the hospital to report monthly in relation to patients and maintain prescribed records of treatment. *There is in my view a strong argument to be made that the requirements of natural justice as they relate to a private hospital should be more closely aligned with the requirements relating to public authorities rather than those relating to purely private associations. Particularly might this be so where the matter in issue concerns the income and livelihood of the complainant*. Of course, as in many cases where a breach of natural justice is alleged it is only the first step to determine that the complainant is entitled to natural justice. It is also necessary in cases where the distinction between purely private and public powers is blurred to determine the content of the rules of natural justice in the particular case.

(Emphasis added.)

1. In view of the above, taking the Doctor’s case at its highest, and assuming that Healthscope as an owner and operator of a private hospital was obliged to afford her procedural fairness in the application of the By-Laws, I am satisfied that such an obligation was met. In the (amended) Originating Application dated 6 October 2018, the Doctor claimed:

54. The entire process of suspension, termination and appeal was significantly biased on the basis of surreptitious and frankly disclosed information which was unfairly used to my disadvantage. Further bias existed due to race, sex, age and disability discrimination as outlined above.

55. The decision-maker during potentially the suspension, definitely the termination and appeal process was one and the same individual. There was no independence, separation of powers or accounting for conflicts of interest.

56. The evidence to support the decision does not exist as outlined above. The decision was knowingly made on biased and fundamentally misconceived basis. The termination and holding of this as a lifetime nationwide ban were a circumstance of *mens rea* and of significant consequence to practice my vocation and my standing … both professionally and personally.

57. There was no genuine or good faith inquiry into the matters in dispute. Due to the significant imbalance in power, failure to provide a meaningful opportunity to appeal particularly in relation to the imputed lack of honesty and [the Agency] conditions. I was not afforded a fair opportunity to respond to the genuine reasons giving rise to the suspension and termination.

(Errors in original.)

1. The foregoing allegations are simply not borne out in the evidence. I have otherwise found the Doctor’s conclusionary statements and conjecture as to what occurred during the termination and appeal process to be unhelpful. By way of illustration, the Doctor invited the Court to draw the following inferences:
   1. that Dr Coglin, as opposed to Ms Phelan, was the real decision-maker who determined to terminate the Doctor’s accreditation. The Doctor contended that the email Dr Coglin sent to Ms Phelan on or around 1 September 2015 – wherein he wrote “[n]one of this gives me any idea of the reasons why [the Agency] imposed conditions on 11 August 2015. We need to ask her” – betrayed his true decision-making role; and
   2. that Dr Coglin held contempt towards and was prejudiced against the Doctor on the basis of race, age, gender and imputed disability because of the email he sent to Ms Phelan wherein he wrote “Gimme a break” in response to a forwarded email from the Doctor.

These inferences are untenable.

1. Based on the documentary evidence, Ms Phelan, in her capacity as general manager of Mount Hospital and pursuant to the By-Laws, terminated the Doctor’s accreditation for reasons laid bare in the letter dated 22 September 2015. The Doctor appealed that decision and Dr Coglin complied with the process under the By-Laws. He was transparent about what information would inform his decision on the appeal; he invited Ms Phelan to provide submissions to justify her decision to terminate the Doctor’s accreditation; he sent a copy of those submissions to the Doctor and requested her submissions in reply; he attempted to hold a meeting with the Doctor to enable her to provide oral submissions; and he considered the evidence before him in reaching his decision. The Doctor was not ambushed or taken by surprise during the appeal process; she was a participant in the process from its genesis to its completion.
2. The Doctor also submitted that Dr Coglin was biased based on the content of his email dated 22 February 2016. Specifically, the Doctor contended that Dr Coglin’s instruction to the general managers of other Healthscope Hospitals that “under no circumstances should [the Doctor] be offered or even considered for accreditation at your hospital” was indicative of him prematurely making his mind up on the appeal. This submission is defeated by cl. 94 of the By‑Laws which provides a legitimate explanation as to why Dr Coglin made that statement. That clause – reproduced in Dr Coglin’s letter dated 28 September 2017 above – provides that termination of accreditation at one Healthscope hospital results in the contemporaneous termination of accreditation at other Healthscope hospitals. As a corollary, it stands to reason that whilst the Doctor’s accreditation remained terminated at Mount Hospital, it was open for other Healthscope hospitals to refuse to accredit her.
3. Having afforded procedural fairness, Dr Coglin formed the view that the Doctor’s accreditation at Hollywood Private Hospital was “varied by the imposition of certain conditions or undertakings” (the existence of which was not disputed even if the Doctor objects to the label of “conditions”), and that those undertakings were not disclosed to Ms Phelan in accordance with the continuous disclosure obligations under the By-Laws. In view of the evidence, the contention that Dr Coglin’s decision to dismiss the appeal was a product of bad faith, unlawful discrimination, bias or “*Wednesbury* unreasonableness”, to use the Doctor’s language, is bound to fail. The decision was not made arbitrarily in the absence of probative evidence. Nor was the decision designed to restrict the Doctor’s trade so as to constitute a “lifetime nationwide ban” on her accreditation or to systematically defeat her employment opportunities. The decision was based upon the Doctor’s objective failure to make disclosure under the By‑Laws, and nothing else. That the Doctor’s career has declined so sharply since the Event and the consequential events is very troubling, but that does not mean Dr Coglin personally set out to achieve that end.
4. For the foregoing reasons, the claim respecting a denial of procedural fairness has no reasonable prospect of success and ought to be summarily dismissed.

### Unlawful discrimination and unfair dismissal

#### Unlawful discrimination

1. The Doctor claimed that Healthscope engaged in unlawful discrimination on the basis of race, sex, age and imputed disability. In her July Statement of Claim, the Doctor pleaded:

46 As the chronology sets out the decision to suspend and terminate the Applicant’s practice was based upon the disability imputed by the [Agency] website and written publications which the Respondents have avail of. As the prior rumours and misrepresentation of the Hollywood undertakings as a “welfare management plan” were validated by the [Agency] publications, the fact remains the Respondent discriminated upon the basis of an imputed disability.

…

48 The unlawful discrimination on the basis of age, sex and race against the Applicant, a young brown female in appearance, previously mitigated by her standing as a doctor and [specialist], a standing and mitigating factor now lost as a result of the actions … [of] the Respondent. The effect leads to a compounding of the severity of the unlawful discrimination against … the Applicant.

49 The Applicant’s complaint based on unlawful discrimination was accepted by the [Commission]. The commission accepted that the Respondent had discriminated against the Applicant on the basis of imputed disability unlawful discrimination …

(Errors in original.)

1. In response, Healthscope submitted:

There is “no suggestion whatsoever that Healthscope imputed any disability to [the Doctor]”. To the contrary, [the Doctor] has in various parts of her materials compared the conduct of Mount Hospital favourably against that of [the SJOG Hospital]:

Commendably [Healthscope] displayed independent corporate leadership in the early stages when under inducement from staff and accredited practitioners at [SJOG] to restrict the Applicant’s employment opportunity, [Healthscope] refused to carry out those express or implied wishes.

The Amended [Originating Application] refers at [19] to the effect of the [Agency] material referencing the [Doctor’s] “personal health”. However, any causation between this allegation and the conduct of Healthscope is neither alleged nor established.

1. In my view, this claim goes no further than the Doctor inviting the Court to engage in speculation, conjecture and the drawing of untenable inferences. By way of illustration, the Doctor invited the Court to draw the following inferences:
   1. that Ms Phelan engaged in unlawful discrimination (and breached confidence) by downloading and printing the Doctor’s registration details from the Agency’s public website; and
   2. that Dr Coglin had engaged in “unlawful discrimination on the basis of an intersection of personal attributes – imputed disability, race, age, gender and desire to cover up sexual harassment” as he is, to use the Doctor’s language, “an old powerful white man, driven by profit and prone to lying and deception”.

These inferences are scandalous and untenable.

1. There is simply no direct or indirect evidence to support the conclusion that the decisions to terminate the Doctor’s accreditation and dismiss her appeal were the product of unlawful discrimination on the basis of race, sex, age and/or imputed disability. And I would not otherwise infer it.
2. Additionally, the Commission did *not* make a positive finding that the Doctor was subject to unlawful discrimination because of an imputed disability as contended for by the Doctor. The Commission possesses no such power: see s. 11 and Pt. IIB of the *AHRC Act*. The Commission merely progressed the complaint under the *Disability Discrimination Act* because the Doctor’s other allegations under the *Sex Discrimination Act*, *Racial Discrimination Act* and *Age Discrimination Act* were not found to be sufficiently articulated in her complaint form.
3. For the foregoing reasons, the claims of unlawful discrimination have no reasonable prospect of success and ought to be summarily dismissed.

#### Unfair dismissal

1. The Doctor also initially claimed that she was unfairly dismissed but withdrew this cause of action, accepting that the Court does not have jurisdiction to hear this claim as the matter has not been previously heard by the Fair Work Commission: ss. 370 and 778 of the *Fair Work Act 2009* (Cth.).

### Breach of confidence, breach of the Privacy Act and “invasion of privacy”

#### Breach of confidence

1. The Doctor claimed that she was subject to “malicious and discriminatory communications on the grounds of her race, sex, age and imputed disability (after February 2015), multiple breaches of confidentiality and privacy within the medical and local Western Australia (WA) community”. She also claimed that “clandestine communications” occurred between Healthscope and staff at other healthcare groups citing “communications” that occurred on “4 December 2014, February to April 2015 and June 2015”.
2. Healthscope submitted that the “claim for breach of confidence is not exposed with any level of particularity capable of leading to an assessment of it”. It contended that neither the Doctor’s pleadings (filed prior to the September Filings) nor the affidavits filed by her contain evidence of matters necessary to: (i) specifically identify the information said to be the confidential information; (ii) demonstrate the necessary quality of confidentiality; (iii) prove that the information was received in circumstances such as to import an obligation of confidence; and (iv) prove that there is actual or threatened misuse of that information, without the Doctor’s consent: *Smith Kline & French Laboratories (Australia) Ltd v. Secretary, Department of Community Services and Health* (1990) 22 FCR 73 at 87 per Gummow J. I respectfully agree with Healthscope.
3. Healthscope also submitted that having regard to the nature of the By-Laws and the public interest in ensuring patient welfare, certain communications about matters concerning practitioners are authorised. I infer that it also relies on the Doctor’s acknowledgement and agreement in the application for accreditation that Mount Hospital’s General Manager(s), its officers and the Medical Advisory Committee(s) and its/their Credentials Committee(s) could seek information about her “past experience, clinical performance, current fitness and current insurance/indemnity status”.
4. Faced with the vagueness of the global terms and sweeping statements used by the Doctor in her pleadings, I shall have recourse to the September Filings to a limited extent. As aforementioned, leave to file the September Filings was not formally sought. However, acknowledging that the Doctor is self‑represented and is not legally trained, I am willing to consider the additional material in the September Filings to the extent that they may illuminate the action for breach of confidence. In the “Amended Originating Application” dated 6 September 2019, the Doctor claimed:

26. … Prior to and subsequent to [the Event], the Respondents published confidential commercial and clinical practice information to third parties. For instance:

a. On various dates prior to [the Event] including but not limited to 17 October 2012, 23 December 2013 and 7 October 2014, likely as a response to receiving adverse information regarding the Applicant’s medical registration, the Respondents checked, downloaded and filed the Applicant’s medical registration;

b. On 8 November 2014, [SJOG] maintained a handwritten record of a telephone call between them and the Respondents’ hospital. It is clear that defamatory representation of the Applicant’s clinical practice and breach of confidential patient information had occurred therein. This information was subsequently misused during the regulatory process.

27. Repeated occasions of breach of confidence occurred with information misused to discriminate, damage the Applicant’s reputation and employment opportunities. These include but are not limited to the following:

a. On 4 December 2014, staff from Metro Anaesthesia group telephoned the Respondents to induce it to suspend the Applicant’s accreditation;

b. On 17 February 2015, it is more than probable that SJGHC telephoned the Respondents in an attempt to induce the restriction of the Applicant’s trade;

c. In March or April 2015, the Respondents received confidential information regarding the Applicant’s practice which gave the false impression that she was subject to a “welfare management plan” at a hospital at which she was working. The Respondents then misused this information to impute a disability to the Applicant and terminate her practice;

d. On 11 June 2015, a similar breach of confidence appears to have taken place. At the very least to inform the Respondents of actions taken by third party hospitals in response to the regulatory process the Applicant was being tortured with;

e. In July 2015, the Respondents’ Medical Director revealed he had been in receipt of “rumours” regarding the Applicant. However, he (i) failed to disclose them to the Applicant and even (ii) used the information to defame the Applicant and restrict her employment opportunities and ability to form a legal defence;

f. On 11 August 2015, the Respondents’ Medical Director misused the malicious gossip received and the advice from the Neurosurgeon to (i) cast aspersions against the Applicant’s clinical practice and (ii) advise the Respondents to suspend or terminate the Applicant's accreditation and deny her employment opportunities.

1. With respect, the September Filings go no further in assisting the Doctor to establish the elements in a breach of confidence claim. Nor do the Doctor’s written submissions which relevantly stated:

The Respondent claims the breach in confidence is not exposed adequately to dodge the cause of action.

The hospital on numerous occasions since as early as 17 October 2012 received confidential information about and thereby owned by the Applicant.

It can be inferred from surrounding communications the information received and transmitted to the Respondent was defamatory, adverse or malicious in nature and used to induce the Respondent to place restrictions on the Applicant’s accreditation and or publish the defamatory material further, i.e., trade, by third parties.

1. It is not sufficient for the Doctor merely to assert confidentiality in respect of unspecified information, “rumours” or “malicious gossip” and ask the Court to leap to the conclusion that there has been a breach of confidence on Healthscope’s part. This in and of itself is fatal to the claim. Quite apart from that, I note that the identity of the party against which the Doctor levels the breach is at times unclear as some of the allegations relate to Healthscope being in receipt of “confidential information” *simpliciter.* Additionally, in one instance, the Doctor refers to Healthscope being in receipt of “confidential patient information” which potentially presents issues respecting standing. I am otherwise satisfied based on the evidence that the contended breach of confidentiality has no reasonable prospect of succeeding. The Doctor’s case rose no higher than mere assertion.

#### Breach of the Privacy Act and “invasion of privacy”

1. With the greatest respect, the alleged breach(es) in respect of the *Privacy Act* are in effect entirely unparticularised. In her written submissions to the Court dated 6 September 2019, the Doctor submitted:

The Applicant contends the failure of the [Office of the Australian Information Commissioner] to investigate the Applicant’s privacy complaint whether due to discrimination and/or corruption, the Applicant should not be denied her privacy rights and the ability to seek justice for violations of those rights and breaches.

1. Healthscope submitted as follows:

Briefly, whilst not articulated in [the Doctor’s] Amended [Originating Application], the relevant factual matters are that:

(a) [The Doctor] submitted an access request to Healthscope on 3 August 2017 for all of her personal information held and/or handled by Healthscope and its hospitals.

(b) In January 2018, [the Doctor] lodged a complaint with the Office of the Australian Information Commissioner (**OAIC**), alleging that Healthscope had provided access to a portion of the information it held about her, but that there was further personal information that had been withheld.

(c) Healthscope subsequently provided [the Doctor] with access to all relevant personal information, and gave written reasons for not releasing certain documents containing her personal information that are subject to exceptions in APP 12.3 in the *Privacy Act*.

(d) On 25 September 2018, the OAIC confirmed that Healthscope had performed all of its necessary obligations under the *Privacy Act* and that a decision had been made under s41(2)(a) of the *Privacy Act* to decline to investigate [the Doctor’s] complaint on the grounds that Healthscope had adequately dealt with the complaint. Consequently, the OAIC did not make a determination in relation to [the Doctor’s] complaint.

1. Healthscope submitted that the Doctor does not have standing under the *Privacy Act* because the OAIC dismissed the Doctor’s complaint without making a determination. It follows, it was said, that she cannot bring a claim in this Court to enforce a determination pursuant to s. 55A of that Act.
2. I respectfully agree that the Doctor does not have standing, which serves as a complete answer to this claim. In *Day v. Lynn* [2003] FCA 879, Stone J. helpfully explained at [50]:

The jurisdiction of this Court in relation to breaches of the *Privacy Act* is limited. The scheme of the *Privacy Act* is for complaints about such breaches to be made to the Privacy Commissioner who will investigate the complaint and make a determination; ss 36 and 52. Determinations of the Privacy Commission are not binding or conclusive between any of the parties to determination; s 52(1B) but there is provision in s 55A for certain persons to seek to enforce a determination in this Court or in the [then] Federal Magistrates Court. *There is however no provision in the Privacy Act for a breach of the Privacy Principles to be directly actionable in this Court*; *Ibarcena v Templar* [1999] FCA 900 at [8]-[9] per Finn J. See also *Gao v Federal Privacy Commissioner* [2001] FCA 1683, at [10] per Ryan J; upheld by the Full Court in *Gao v Federal Privacy Commissioner* [2002] FCAFC 128. The principles were also accepted by Goldberg J in *Gao v Federal Privacy Commissioner* [2002] FCA 823, at [22]-[23].

(Emphasis added.)

1. For completeness, I note that the Doctor appears to assert a separate “actionable right of a person to privacy”, relying on the decision of Skoien S.J. in *Grosse v. Purvis* [2003] QDC 151. It is unnecessary for me to say whether a tort of invasion of privacy should be recognised by Australian law because the Doctor has provided no meaningful exposition of the particulars which might satisfy the elements of such a cause of action. Again, I am confronted with conclusionary and vague statements about the Doctor’s privacy being breached without more.
2. For the foregoing reasons, the claims respecting breach of the *Privacy Act* and invasion of privacy have no reasonable prospects of success and ought to be summarily dismissed.

### Defamation

1. The Doctor requires an extension of time as a cause of action for defamation is not maintainable if brought after the end of a limitation period of one year running from the date of the publication of the material complained of: Uniform Defamation Laws (see for example, s. 15 of the *Limitation Act 2005* (W.A.); s. 5(1AAA) of the *Limitation of Actions Act 1958* (Vic.)).
2. In the “Amended Originating Application” dated 16 July 2019, the Doctor relevantly claimed:

31. The Applicant did not deserve to be subject of malicious gossip, misrepresentation of confidential personal and commercial information or clandestine communications that the Respondent’s staff were aware of and partook in. Evidence suggests this communication took place at least on 8 December 2014, 4 December 2014, February – April 2015, June 2015 and September 2015 and possibly on more occasions giving rise to a pattern of defamatory communications.

32. The Applicant did not deserve to have her reputation tarnished and falsely imputed disability and be made vulnerable to a toxic medical culture which the Respondent actively participated in.

(Errors in original.)

1. In the “Amended Originating Application” dated 6 September 2019, the Doctor further claimed:

31. … the Applicant was defamed by staff and accredited medical practitioners at the Respondents’ institutions in repeated publications. In particular:

a. The Applicant was subject to malicious gossip, misrepresentations and breaches of confidence and privacy attacking her professional and personal reputation;

b. Her clinical competence, professional conduct and judgment were attacked on multiple occasions;

c. Her health was mischaracterised, and she was imputed with a disability.

32 The Applicant in particular relies on the Respondents’ suspension and termination of her accreditation as constituting a defamatory act in itself:

a. The Respondents made fraudulent allegations about the Applicant attacking her honesty and integrity, i.e. her character. This goes to the heart of a medical professional’s identity;

b. The Respondents’ nationwide lifetime termination of the Applicant’s accreditation indicated that there was something concerning about her personal or professional life. This was despite the fact that the termination was (i) not based on any objective truthful evidence of wrongdoing and (ii) in any event disproportionate to the non‑disclosure issues on which the Respondents relied in its termination decision.

1. Healthscope submitted that the Doctor’s purported defamation claim suffers from myriad problems, including:

(a) the failure to specify the essential elements of the cause of action, namely, the material complained of, publication, identification, and that any imputations have defamatory meaning;

(b) the failure to identify the date of the offending material, which means the maximum three year extension available from the date of publication may have already expired (see, for example, s.23B(2) [*Limitation of Actions Act 1958* (Vic.)]);

(c) no Concerns Notice prior to issuing;

(d) the failure to identify the relevant jurisdiction given that such claims are state and territory based; and

(e) [the Doctor’s] delay in seeking such an extension, exemplified by her failure to meet the court ordered requirements for filing her revised pleadings.

1. I broadly agree with Healthscope’s submissions. The Doctor has not provided the Court with a reason as to why it was unreasonable for her to have commenced an action in defamation in relation to the matter complained of within one year from the date of publication. Moreover, the pleaded case has no reasonable prospect of success. In my view, and with respect, the Doctor’s allegations rose no higher than asserted characterisations of outcomes and communications which were disagreeable to her as defamatory. Her claim is thus misconceived and lacks substance. There is otherwise simply no direct evidence of Healthscope defaming the Doctor.
2. For the foregoing reasons, the Doctor’s application for an extension of time to file a defamation claim is dismissed.

### Negligence

1. Finally, in the Originating Application dated 6 October 2018, the Doctor claimed that Healthscope was liable in negligence as follows:

**Negligence: Vicarious liability and non-delegable duty**

70. The respondent is held vicariously liable for the actions of its staff.

71. The respondent is held to owe a non-delegable duty to me as the accredited practitioner. This scope of this common law duty includes the following provisions to be relied upon: -

a. Competent staff to be educated to ensure a transparent, accountable and non-discriminatory workplace. Staff who do not engage in malicious conduct

b. A safe place of work to ensure that the conduct of its employees and other accredited practitioners does not cause harm, undermine or sabotage my workplace environment; and

c. A safe system of work which includes the duty to warn of potential danger and circumstances which may undermine or sabotage the workplace environment.

…

73. The breach in non-delegable duty occurred in:

a. Engaging in communications without my knowledge or consent that communicated information whether true or not was sensitive, intended to undermine my reputation, health, and practice as a [specialist].

b. The communications were either between hospital entities which were commercially independent and bound to hold information confidential or between staff members who should not have been privy to nor in receipt of this confidential and sensitive information

c. The task of a Specialist … is a high risk one involving numerous parties in a team environment both in the operating theatre and outside the theatre.

…

e. The trust and therefore my health safe workplace relationships is undermined when staff engage in malicious rumours, backstabbing and secret conversations.

…

h. As per [the By-Laws] (mutual prerogatives out of respect for each other’s clinical and commercial objectives) – The hospital had a duty to protect me and my reputation against my misinformation, falsity or malicious rumours.

74. The breach of duty by the hospital directly fuelled rather than diminished the malicious rumours engaged in by the wider medical community at the other two healthcare institutions I worked at – [SJOG] and Ramsay Healthcare Australia hospitals.

(Errors in original.)

1. The status of the Doctor’s claim in negligence is somewhat complicated by the sequencing of her filed originating documents and pleadings. The claim remains relevant so far as it relates to the Doctor’s application for summary judgment dated 6 October 2018, but not beyond that point. That is because the Doctor did not press the claim in the July Filings which superseded the Originating Application dated 6 October 2018. (Consequently, Healthscope did not seek summary dismissal of the claim in negligence.) The claim was subsequently agitated in the September Filings but leave was not granted to the Doctor to amend her July Filings. The claim is therefore not before the Court save to extent that it must be considered for the purposes of the Doctor’s application for summary judgment.
2. Given that Healthscope was not the Doctor’s employer, it is not clearly established that it owed her a non-delegable duty of care. The question then becomes whether Healthscope did owe her such a duty, the content of that duty and whether it was breached. It is unnecessary for me to express a view about the first two issues because the alleged breaches are so vague, generalised and sweeping in their terms to be capable of assessment let alone justify the Court awarding the Doctor summary judgment. As to the vicarious liability claim, the Doctor has in no way elucidated with sufficient specificity the alleged torts committed by Healthscope’s employees. There is otherwise simply no evidence which would support the Doctor’s two-fold negligence claim. Again, the Doctor’s case rose no higher than mere assertion.
3. For completeness, I note that the Doctor alleged in her September Filings that Healthscope was negligent in providing a safe workplace which consequently “emboldened” a neurosurgeon at Mount Hospital to sexually harass her. This allegation is unrelated to the subject matter of the Doctor’s complaint regarding the (alleged) suspension and termination of her accreditation at Mount Hospital. It does not form part of the controversy that falls for adjudication by this Court pursuant to federal jurisdiction.

## Conclusion

1. Before concluding these reasons for judgment, I wish to make the following observations. I accept that the Doctor has been personally wounded by the consequences which have flowed from the Event. I have no reason to doubt that the Doctor feels deeply aggrieved and therefore desires a remedial response. However, not every perceived grievance visited upon a person translates into a cause of action in law. As I have previously said, bringing a suit in person is a serious matter – it requires an arguable factual and legal foundation. It should be steadily borne in mind that there are necessary limitations on what may properly be adjudicated on by a Court.
2. For the reasons given, I hold that the Doctor has no reasonable prospect of successfully prosecuting the proceeding. It follows that the Doctor’s application for summary judgment is refused and Healthscope’s application for summary dismissal is granted.
3. I will hear from the parties about the issue of costs.

|  |
| --- |
| I certify that the preceding one hundred and twenty-one (121) numbered paragraphs are a true copy of the Reasons for Judgment herein of the Honourable Justice Steward. |

Associate:

Dated: 6 February 2020