"But I am bound upon a wheel of fire, that mine own tears do scald like moulten lead"

"Time shall unfold what plaited cunning hides"

I am a procedural rural GP living and working in a busy river town in northern Victoria. I work in both Victoria and NSW. I graduated MB BS in 1979, I have Diplomas in Obstetrics, Anaesthetics and Child Health and I am a Fellow of the Australian College of Rural and Remote Medicine. I have been working in rural medical practice for 26 years – both in private medical practice and as a visiting medical officer at our local hospital. I am happily married and have 5 children.

I write to you to outline my concerns with my recent involvement with the Medicare Australia audit process, which, in turn, led to my experience with the PSR. The stress – professional, personal, family and emotional - was overwhelming. I wish to present the Senate Committee with my concerns relating to the processes surrounding my investigation and, in particular, the ability of the Director to both ignore and/or dismiss evidence from all sources presented to him by my legal team.

The process for me commenced with an unheralded visit from a Medical Advisor appointed by Medicare Australia. This 'peer' was an elderly, part-time, **non-procedural** GP from urban Melbourne. The questions asked by him in relation to my statistical profile generated by my medical practice are best summed up by his inability to understand how I could be an anaesthetist and a GP. He questioned the number of pre-anaesthetic visits that appeared on my profile and which was greater than the statistical norm. Evidence was

presented to him to show that the only way I saw such patients was at the request/direction of my local hospital or in an emergency situation whilst working on-call for the local hospital. Both the Medical Advisor and the PSR Director chose to question the validity of such visits in spite of written evidence supplied by my local hospital. This is but one example demonstrating the inability of the Medical Advisor to comprehend the nature and demands of procedural general practice in a rural setting. As a result of his report I was referred to the State Director and then directly to the PSR.

The PSR process began with a demand to furnish ALL records relating to 200 patients over a given period. This required many hours of work over and above the normal commitments to my medical practice. At no stage did the PSR request patient consent for these records. Letters of explanation and support needed to be obtained from; my local hospital administration, my local Division of General practice, and 4 local Aged Care Facilities. The workload and hours required to comply with the demands of the PSR was onerous but I complied fully as I had absolutely nothing to hide and I believed I had done nothing wrong except work extremely hard. I complied fully and completely with all requests made by the PSR. I was confident that I had acted appropriately at all times and I was not fraudulent.

Throughout the entire PSR investigation I insisted that no fraudulent activity had taken place. My concern is with the interpretation of the words 'inappropriate practice'. My understanding, as a citizen, is that individuals are considered to be 'innocent until proven guilty'. **It is my view that the practise of the PSR is to presume guilt based upon statistical analysis from Medicare Australia.** Statistical analysis always excludes commonsense and

collective human experience. The practice of medicine is individualised and does not always conform to mathematical/statistical analysis.

The PSR process allows the Director to make unilateral decisions re inappropriate practice, which are not based on evidence and argument but based on his, and his alone, interpretations of the CMBS item numbers/descriptors. His interpretations can be at odds with Medicare Australia's interpretations and advice. A media release in December 2008 by Minister Roxon (appendix 1) explained her concerns regarding compliance with the increasingly complex CMBS Schedule and, in particular, long consultation items C & D, and chronic disease management Item no's in relation to Team Care Arrangements (no 723).

The 80/20 'rule' was unknown to me but the nature of my Practice was such that in school holidays many of my colleagues with school age children took family holidays – no locums were available and the patient workload for me would therefore increase significantly for 12 weeks of the year. With no school-age children I was working during these periods of high demand – my town is a tourist destination and the population expands during school holidays – and it was not hard to break the 80/20 'rule'. I live in a country town – I mix with my patients in a variety of social settings (supermarket, the main street, the football, the library etc) – what is one to do when patient number 81 presents at my surgery? The Director of the PSR suggested that: 1. Do not see them; 2. Refer them to the casualty department of the local hospital (on-call demands may mean that I would have to see them anyway in my capacity as the on-call VMO); and, 3. "Tell them that their issue is not with me but with the government of the day".

The 80/20 'rule' was formulated based on submissions from the AMA and the RACGP, both of which are metro-centric organisations and not representative of rural and remote general practitioners.

The Mental Health Descriptors, at the time of my investigation, were new and both very complex and open to interpretation – at this time there was no pre-existing peer review or practice experience available to measure compliance.

Therefore, there were no reference points – the judgement of my 'inappropriate practice' with regard Item 2713 could not be compared/profiled to anything.

A selection of my patients were interviewed by representatives of the PSR and my understanding from the Director was that all patients were seen as per Item no claimed and all were satisfied with the services rendered. When we photo-copied the records, at PSR request, contemporaneous notes had been made on the computer records/nursing home records for all 200 patients. There were no claims made by me for patients not seen.

The Interview With the Director

This stage in the process required attendance in Melbourne for a meeting with the Director and my legal team (Solicitor and Barrister). For a country GP, this required 1day out of my Practice and a 410k return journey. The interview itself was not consistent with any legal hearing and it was not clear to me as to the significance of this meeting in relation to the ultimate determination made by the Director. It is this meeting which ultimately determines your 'fate'. It was clear to myself, my wife and my legal team, that he appeared to disregard evidence based on formal written submissions and my verbal explanations.

Of great concern to us was that during the meeting the Director had a pre-occupation with lifestyle issues such as the length and nature of holidays and the work-life balance. This is clearly outside his brief and has nothing to do with Medicare.

In rural medical practice, issues relating to areas such as drug'/alcohol use, relationship issues, gambling etc, are highly confidential and extremely sensitive – the aide memoir 'long chat' was used by me when counselling patients. The clock on my computer was always turned on and consultation times were therefore logged and Level C and D Items were charged according to the CMBS descriptors. This was dismissed by the Director, his argument being that such notes did not fulfil his interpretation of the descriptors for Items C and D, and in spite of computer records demonstrating long consultation times. The CMBS descriptors clearly state 'complexity or time-based'. In some instances consultation notes would need to be completed and letters and templates created after the consultation (at night or on weekends) – this was because of time constraints or if I was called away to an emergency or to the obstetric ward. Procedural General Practice means that consultations can often be interrupted for an Obstetric or Anaesthetic procedure and it therefore does not conform to straightforward rooms-based consulting. We were able to demonstrate that there were a number of claims for normal consultations (Level B) that had been undercharged – they were long consultations and could have been charged at level C or D. All arguments/ evidence were rejected by the Director.

I was made to feel like a criminal and yet I could demonstrate to the PSR audit that all patients were seen on the day of claim and the services rendered to them were satisfactory. In spite of this I was offered a negotiated settlement

based on the Director's individual interpretation of the CMBS Schedule. This process took over my life for more than 2 years and it has haunted me since – it was emotionally, personally and financially draining. When confronted with the Director's decisions – both the repayments demanded and the suspensions from Medicare – I was 'gutted'. A decision then needed to be made as to whether to fight on through the committee stage of the PSR (3 'peers') and/or legally at the Federal Court. The financial and emotional stress in fighting on had to be weighed up against settling and agreeing to have behaved in 'Inappropriate Practice' so as to end the matter. Legal counsel was sought and a settlement acknowledging 'Inappropriate Practice' was made on the basis that it was too expensive and stressful for myself and for my family to continue. The Director had to agree that no fraudulent activity had taken place. This negotiated position was reluctantly agreed to in the face of the 'damage' that had already occurred – it was not worth continuing to fight.

My punishment was based upon 'incomplete record taking and misinterpretations of Item numbers 723 and 2713' – according to the interpretation of the Director. I was also suspended from Medicare from using long consultation item numbers for 6 months. It remains my view that this was manifestly excessive. An attempt was made by my legal team to negotiate this settlement based on my full compliance with all aspects of the process. This was rejected. No prior warnings were ever issued and this was the first time that I had been required to attend the PSR in 26 years of General Practice. At no stage during the interview with the Director, nor prior to it, was disqualification from Medicare ever mentioned as a possible consequence.

My concerns are with the unfettered powers given to the Director to make unilateral decisions that do not appear to be based on legal arguments or facts.

Contact with other medical practitioners since my review has revealed apparent inconsistencies in judgements, determinations and penalties. The Law requires payment of the full costs of the Federal Court to be borne by the medical practitioner should that be the avenue of appeal. The latest judgements have been greater than $750,000 – this was not affordable to us and hence influenced our decision to accept a negotiated settlement. Following this there was a requirement to repay the penalty in full within 30 days from the date of the 'Letter of Recovery' from Medicare. My legal team received this letter over the January holiday period when their offices were closed – thirty days for me was then reduced to 20 by the time the letter was actually received. Furthermore, Medicare Australia requires you to complete a statutory declaration outlining the reasons why you might need to pay the amount in instalments (eg, your financial circumstances) and should this be agreed to then interest would also apply. Interest is charged to the balance of the repayment owing after each instalment is paid – Medicare will charge interest at the 90 day bank-accepted bill rate less 10 basis points.

Peer review should be transparent and appropriate – peers should be colleagues engaged in similar practice, Rural GP Proceduralists should review rural GP Proceduralists.

Patient outcomes are never assessed or taken into consideration when you are accused of overservicing by the PSR. Your previous unblemished career is never taken into consideration and your good-standing in the community seems to count for nothing.

Doctors should have the opportunity to change their behaviour should they come to the attention of Medicare – appropriate warnings should be made **before** any PSR is embarked upon.

Punishment should not be determined by a single Director but should be referred to proper legal process. The entire process should be transparent.

I do not believe that the Director of the PSR has any right to impose his view of the work/life balance on any Practitioner bought before him. Whilst I acknowledge he has a right to such views, the 'evangelical' way in which he attempted to 'enlighten' me was not part of his brief. I am uncertain as to what qualifications he has in order to judge my medical practice as a 'peer' as I have no knowledge of his clinical background.

Life is usually about compromise - this was rejected by the Director in my case. I made a decision to get on with my life. My 'crime' was to work too hard.

APPENDIX 1

'ATTACHMENT 6'

THE HON NICOLA ROXON MP

Minister for Health and Ageing

MEDIA RELEASE

9 December 2008

Medicare – Slashing Red Tape and Boosting Prevention

Prevention will be given a boost, and red tape for doctors will be slashed in a review of Medicare items due to be finalised by March 2009.

Complex red tape that has stood in the way of longer GP consultations will be removed as part of the review.

This will help more Australians gain access to vital prevention advice in areas like diabetes prevention, quitting smoking and avoiding obesity.

In the last decade of the Liberal Government, the number of primary care Medicare items more than tripled from 66 to a massive 247 .And yet just the top 10 of these items make up 92 per cent of all Medicare claims for primary care services.

The Medicare schedule is now as thick as a phonebook.

This has left GPs battling a crippling red tape burden, taking valuable time away from treating patients.

The review has identified a number of areas for action. The Rudd Government will now conduct consultations with the profession on the details of the changes.

The new simplified schedule will come into force on 1 July 2009. The changes will be Budget-neutral.

This review is being undertaken alongside development of the National Primary Health Care Strategy, which includes a focus on how to use our health workforce more effectively, and how to better encourage prevention.

Any more significant changes to the Medicare schedule that are necessary will be examined in light of this strategy, a draft of which is to be delivered to the Minister in mid-2009.

This review will focus on removing red tape, encouraging prevention and simplifying the schedule.

Immediate action to remove red tape

As a downpayment on future action, the Rudd Government will slash red tape from the chronic disease management allied health items.