# Chapter 4

## Operating procedures of the PSR

### Natural Justice and Procedural Fairness

4.1 The principles of natural justice and procedural fairness were discussed at length in submissions. The suggestion that the PSR process did not provide these protections was at the heart of much of the criticism of the scheme. Criticism of the scheme focussed around the following questions:

(a) Do practitioners under review receive adequate information of the concerns of PSR and/or Medicare Australia and at what stage in the process?

(b) Does the practitioner under review have adequate opportunities to respond to the concerns raised in the PSR process and/or by Medicare Australia?

(c) Are practitioners under review afforded sufficient legal assistance?

(d) Is the appeals process fair and accessible?

4.2 The first of these issues was discussed in numerous submissions and during the public hearings. There were accusations that practitioners under review did not have any detailed knowledge of the concerns raised by PSR or Medicare, and therefore could not defend or explain their conduct in relation to those concerns. In the committee's view, if true this would certainly qualify as a denial of natural justice.

4.3 The AMA acknowledged in their submission that some doctors are claiming that natural justice was not always provided:

> In recent years, the PSR process has suffered from a perceived failure to afford natural justice to the Person Under Review (PUR). AMA members who have been reviewed by the PSR have complained that:
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> (i) PURs could not prepare adequately for the Director’s investigation because they were not informed about what services were being investigated and why;
>
> (ii) PURs were not given a clear explanation of the review process and their rights at the beginning of an investigation;
>
> (iii) PSR Committees were comprised of medical practitioners who have not practised for some time or who practised in a different specialty to the PUR;
>
> (iv) the initial meeting between the PUR and the Director was intimidating. Further, the AMA identified a lack of consistency in the procedures followed at these meetings.

(v) written decisions made by the Director or Committee did not appear to consider evidence the PUR had provided during the review, or explain how the evidence was considered, or why it was dismissed; and

(vi) written decisions did not actually explain the reasons for the decision of the Director or Committee.[1]

4.4 The Medical Defence Organisations, Avant and MDA National were critical in their appraisal of whether the PSR process in particular afforded natural justice to their clients.

4.5 Avant submitted that:

> There is an opportunity for reform to the PSR Scheme to overcome actual and perceived unfairness...Reform is desirable to improve the procedural fairness of PSR's process for the person under review and to protect the reputation of the PSR as a legitimate peer review scheme.[2]

4.6 MDA National submitted, both in their written submission and during the public hearing that:

> review meetings between the director and the practitioner under review often do not meet the requirements for procedural fairness in that practitioners are not provided with sufficient information to understand the case against them, nor are they provided with adequate opportunity to reply to such charges.[3]

4.7 The ADU criticised the lack of natural justice. Dr Reece claimed the PSR was:

> refusing to attach weight to any form of evidence on behalf of defendant doctors, [it] does not even make the charges at stake explicit until it is too late to mount any form of defence and does not allow doctors meaningful legal representation.[4]

4.8 Dr Masters, also from the ADU, targeted his criticisms towards both Medicare Australia and PSR for not providing enough information at the start of the process:

> It is very difficult if you disagree with anybody in the PSR process to actually state your case and have the ability to cross-examine them about what they actually want. I see the big problem here is at the very first step. When the audit starts from Medicare, there is no actual guide from Medicare that you have done anything wrong.[5]

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1 Australian Medical Association (AMA), *Submission 13,* pp 1-2.

2 Avant, *Submission 10,* p. 4.

3 MDA National, *Proof Committee Hansard,* 23 September 2011, p. 15.

4 Australian Doctors' Union (ADU), *Proof Committee Hansard,* 23 September 2011, p. 2.

5 Australian Doctors' Union (ADU), *Proof Committee Hansard,* 23 September 2011, p. 3.

4.9 Dr Caska of the ADU also commented on an issue raised by Avant in their submission[6] that PSR cases are prejudged:

> The doctor seems to be presumed guilty and knows there is no real or practical avenue for appeal or review.[7]

4.10 Dr Brazenor from the ADU contributed:

> ...there is never a stated process. They tell me that, if you are investigated by the tax office, first you get a frank statement of the concerns and, in the same envelope, you get an explanation of the due process. Neither of these things was accorded to any of my three colleagues until right at the end, when they said, 'Right, we've got you. Here are the concerns. Your interview with the director is next Tuesday'—and that is as close as they got to due process.[8]

4.11 The issue of practitioners being of the view that they had no choice but to enter into a negotiated agreement concerned the committee. Mr Watt from the ADU suggested that:

> ...it was a coercive process, with Dr Webber himself admitting, and again I am quoting: 'I informed them'—the person under review—'the process is long and very stressful.' How much free will have you got going into that? That is persuasive, intimidatory and threatening. You cannot voluntarily enter into an agreement if there is a threat hanging over your head.[9]

4.12 Dr Webber addressed the perception that there are a lack of options available to a practitioner under review, and went further to suggest that often it is the legal representative of the practitioner who requests a negotiated agreement:

> It is almost universal that submissions in the review process are constructed and sent by their legal representatives, with the doctor's input, and it is not uncommon for the concluding paragraph to request a section 92 agreement if I am not going to dismiss somebody. So, in fact, these section 92 agreements are asked for almost universally.[10]

4.13 Dr Webber continued that negotiated agreements are only entered into if, in his judgement, the inappropriate practice is minor in nature:

> ...it has been my practice to offer a 92 agreement only where there has been relatively minor inappropriate practice—certainly, inappropriate practice that has not put anybody at risk—and where the practitioner had insight into their behaviour and had demonstrated a change in behaviour...However, if

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6 *Submission 10*, p. 10.

7 Australian Doctors' Union (ADU), *Proof Committee Hansard,* 23 September 2011, p. 3.

8 ADU, *Proof Committee Hansard,* 23 September 2011, p. 4.

9 ADU, *Proof Committee Hansard,* 23 September 2011, p. 6.

10 Dr Webber, *Proof Committee Hansard,* 22 September 2011, p. 8.

> significant inappropriate practice has been found early on, then I would not entertain the idea of a 92 agreement with the practitioner at all.[11]

4.14 The committee accepts that the powers vested in the Director of the PSR under the Act are substantial. However the role of the Determining Authority in ratifying, or rejecting the section 92 Agreements, and its willingness to do so, albeit on a small number of occasions,[12] would suggest that sufficient checks and balances are in place to prevent any abuse of the Director's powers.

4.15 The PSR submission focussed on changes made to the process of the Scheme. It concentrates on the draft guidelines agreed with the AMA and DoHA, and it acknowledges that:

> The PSR process set out in Part VAA of the Act has the potential to be confusing to some practitioners who are referred to the Scheme.[13]

4.16 The PSR and Medicare have rebutted the concerns around the issues of whether the practitioner under review has been informed of the matters of concern, and also whether the practitioner has the opportunity to respond to any matters that may amount to inappropriate practice. Medicare submitted evidence in response to a request by the committee which states that:

> Health practitioners are informed of the specific concerns when first contacted by a Medicare Medical Adviser by telephone to arrange a time for an interview. The letter confirming the interview also lists the concerns and is accompanied by the health practitioner's claiming data.
>
> A Medicare Medical Adviser details the concerns at the interview with reference to the health practitioner's claiming profile. The interview allows the health practitioner the opportunity to clarify the concerns and provide information that may explain the concerns.[14]

4.17 The PSR response to Questions on Notice sets out the opportunities for the practitioner to respond to the concerns:

> A practitioner who goes through the full PSR process will have at least eight opportunities to make submissions and explain their practice in light of the concerns that have been identified. These are:
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> - A written submission and interview process through Medicare Australia's practitioner review program
> - A verbal submission at the Director's review meeting
> - A written submission on the Director's findings contained in the s89C report

11 Dr Webber, *Proof Committee Hansard,* 22 September 2011, p. 8.

12 PSR, *Proof Committee Hansard,* 23 September 2011, p. 56.

13 PSR, *Submission 24,* p. 7.

14 Dept. of Human Services (DHS), answer to question on notice, 26 September 2011 (received 5 October 2011).

- Written submissions prior to the committee hearing
- Verbal and written submissions at the Committee hearing and written submissions following the hearing
- A written submission on the Committee's Draft Report
- A written submission on the Committee's Final Report
- A written submission on the Determining Authority's Draft Determination[15]

4.18 The PSR additional response to questions posed by the committee sets out the process through which feedback and reasons for decisions are communicated to the practitioner:

(a) Once the Director determines to undertake a review, a notice of this decision is sent to the practitioner. This letter contains a paragraph or list, under the heading "Decision to Undertake a Review" that details the concerns that may suggest that inappropriate practice may have occurred.

(b) The Director's Review meeting invitation outlines to the PUR that the purpose of the meeting is to discuss the reasons for the practitioner's referral to PSR and the findings of the Director's review of medical records. In changes introduced in 2011 this letter now also contains excerpts of the practitioner's clinical records, that the Director has reviewed and may demonstrate the nature of the concerns.

(c) Following the review meeting the practitioner receives an 89C Report which details the concerns that remain following the review of the medical records and the review meeting. These concerns are set out in relation to each specific MBS or PBS item and generally ranges from 2 to 5 pages in length. The 89C report specifically details the Director's preliminary findings and invites the practitioner to respond to these findings.

(d) If the matter is referred to a Committee, the Director must produce a section 93 report and provide it to the practitioner. This report details the reasons why the Director thinks the practitioner may have engaged in inappropriate practice. Under the heading "Discussion and Findings" the Director details the findings of concern that has resulted in the committee referral. These are further spelled out in a following section headed "Reasons for making the Referral" which contains a list of concerns that the Director is referring to the Committee.[16]

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15 PSR, answer to question on notice, 23 September 2011, p. 5 (received 29 September 2011).

16 PSR, answer to question on notice, 23 September 2011, p. 4 (received 29 September 2011).

4.19 Given the PSR's admission that the process is long and very stressful[17] and the significant potential consequences for practitioners, it is not acceptable for any practitioner under review not be afforded the basic information that explains the process at the commencement of the review.

4.20 The committee accepts the AMA's appraisal that there have been concerns around the natural justice of the PSR procedures to date, while recognising that there is a legitimate argument to be had over whether these concerns were actual, or perceived. Nonetheless the overhaul of the procedures in the March 2011 guidelines implies a tacit admission that procedurally there was significant scope for improvement.

4.21 The committee is encouraged by the steps that have been taken by the PSR, DoHA and the AMA to address concerns around the information provided to the practitioner at all stages in the process, including broadening the explanations for decisions taken.

**Recommendation 4**

**4.22 The committee recommends that the March 2011 changes be reviewed one year after their implementation and this should be carried out in consultation with all relevant medical professional bodies, and other key stakeholders such as the MDOs and consumer representative organisations. The findings of the review should be publicly available.**

### *Legal representation*

4.23 The committee heard from a number of witnesses concerned that the practitioner under review was disadvantaged by not having a legal representative to argue their case. Two MDOs pursued this argument in their written submissions and in the public hearing.

4.24 MDA National told the committee:

> They [practitioners] can be accompanied by a person who can have legal qualifications but they cannot make presentations or representations to the committee except on advice from that advisor. The lawyer cannot make submissions or representations. It would be our view that, in improving the power imbalance, as it were, and the need for more of the image that procedural fairness has been granted, perhaps there should be some consideration to formal legal representation being allowed in some circumstances.[18]

4.25 Avant argues that the situation where the practitioner under review is only accompanied by a lawyer and not represented:

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17 Dr Webber, *Proof Committee Hansard,* 22 September 2011, p. 2.

18 MDA National, *Proof Committee Hansard,* 23 September 2011, p. 21.

> ...creates very significant barriers to the PUR effectively adducing any evidence in their defense as the PUR is nervous, inexperienced and often fatigued by extended questioning which can continue for days...[19]

4.26 The committee notes ADU's statement that the process 'does not allow doctors meaningful legal representation'. However, the PSR's own guide states that 'We advise you to engage a medical defence organisation and /or lawyer to assist you through the PSR process'.[20] In evidence, the former PSR Director Dr Webber noted:

> Most of the people that are before the PSR are represented by their MDUs with legal advice. It is almost universal that submissions in the review process are constructed and sent by their legal representatives, with the doctor's input...[21]

4.27 Dr Cootes, the Acting Director of the PSR also refuted any implication that the practitioner under review did not have access to legal advice:

> ...practitioners appearing before PSR do have access to legal advice—PSR actually advises practitioners to obtain legal advice. Around 80 per cent of the correspondence that goes out of PSR to a practitioner under review is conducted through a legal adviser to the practitioner. At PSR committee hearings, practitioners are able to be accompanied by and advised by their legal adviser. So practitioners under review do have legal advice.[22]

4.28 Dr Ruse responded to the claims principally made by Avant and cited in paragraph 4.25 above, that procedures employed by the PSR during Committee hearings place the practitioner under review in an exposed or vulnerable position. He explained the conditions in the PSR Committee from the Panel's perspective:

> The suggestion, which has been made in several places, that the PUR is somehow intimidated by not being allowed sufficient breaks is just not true. We have secretarial staff, we have our own lawyers, we have three doctors who know that they are peer reviewing a fellow human being. We often suggest to a doctor that they might like a break and, if you want to get into the mechanics of the committee hearing later, certainly in my committees we call a break of about 10 minutes in every hour.[23]

4.29 The committee heard conflicting evidence whether the practitioner under review is disadvantaged by not having a lawyer representing them in the PSR committee stage and questions whether this would actually hinder the analysis of clinical practice that is the purpose of this stage. The committee reiterates the position that all submitters appear to support regarding the PSR process: that it is a

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19 Avant, *Submission 10,* p. 12.

20 Professional Services Review, *Your Guide to the PSR Process,* 12 July 2011, http://www.psr.gov.au/docs/publications/Your%20Guide%20to%20the%20PSR%20Process%2012July2011.pdf (accessed 6 October 2011), p. 25.

21 Dr Webber, *Proof Committee Hansard,* 22 September 2011, p. 8.

22 PSR, *Proof Committee Hansard,* 23 September 2011, p. 46.

23 PSR, *Proof Committee Hansard,* 23 September 2011, p. 48.

peer review scheme, not a court. As the Acting Director of PSR said: 'it is a professional review system where professionals are given the opportunity to explain their practice to a committee of peers'.[24] If lawyers were to take over and represent their clients, rather than simply advise them (as is currently the case), it would no longer be peer review. The committee did not receive evidence to support such a radical revision of the scheme.

4.30 The committee also heard evidence that the PSR Committee should be chaired by a legal officer. The Committee, whilst appreciating the concerns and calls for a legally qualified person to be involved in the process, remains ambivalent to the suggestion.

**Recommendation 5**

**4.31 The Committee recommends that the government liaise further with stakeholders to ascertain the desirability for a legally qualified person to be involved in the PSR process.**

## The Appeals process and accountability of the PSR

4.32 Since the abolition of the PSR Tribunal and subsequent creation of the Determining Authority (DA) in 1999 practitioners can appeal against PSR decisions to the Federal Court by way of seeking a judicial review of decisions at any stage under the *Administrative Decisions (Judicial Review) Act 1977*. There is a wide range of reasons for which review can be sought:

> i. the decision was not authorised by the Health Insurance Act 1973
>
> ii. the decision involved an error of law
>
> iii. that a breach of the rules of procedural fairness/natural justice occurred
>
> iv. that the procedures required by law were not observed
>
> v. that irrelevant considerations were taken into account or there was a failure to take relevant considerations into account
>
> vi. that the exercise of power by the decision maker was so unreasonable that no reasonable person could have so exercised it.[25]

4.33 The PSR Tribunal was removed from the process following the Report of the Review Committee in 1999 in which it recommended:

> ...the removal of the PSR Tribunal from the process in recognition that review on the merits of the final determination is not appropriate in a scheme in which the key judgment is a professional judgment by the practitioner's peers about the practitioner's conduct. The right of review on points of law by the courts will, of course, be retained.[26]

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24 PSR, *Proof Committee Hansard,* 23 September 2011, p. 45.

25 PSR, *Submission 24*, pp 12–13.

26 PSR, *PSR Review Committee Report*, 1999, p. 2.

4.34 Avant were explicit in their desire for the reintroduction of a merits-based appeal process by commenting:

> Judicial review, though essential, is no substitute for relatively quick, cheap and fair merits review...
>
> If it is the merits of the matter rather than the fairness of the process which is truly at issue for the PUR it is advantageous to all parties to have the issue resolved by way of merits review rather than potentially more legally-convoluted judicial review proceedings.[27]

4.35 The committee is not persuaded by this argument for the same reasons that it does not consider it within the spirit of the peer review process to have a non-peer of the practitioner deciding on whether inappropriate practice has occurred. Moves in this direction can only be considered if there is a willingness to abandon peer review as the fundamental principal of the scheme. As noted earlier in this report, the committee did not receive evidence indicating that any major stakeholders would support such a shift.

4.36 The committee does note that there is ready recourse to the courts, which play a role in ensuring procedural fairness and ensuring the PSR complies with its legislation. Indeed, the extensive use of the courts since the scheme's inception illustrates that PSR decisions are routinely challenged in this way. Up to May 2007, there had been around 60 court cases involving the PSR scheme, several of which led to reviews and refinements of the PSR's procedures.[28] Between 2006 and 2011 there were 14 Federal Court appeals.[29] The committee also notes that the Scheme itself has been subject to continual review and the PSR submission points out that the Scheme and its enabling legislation has been amended on a number of occasions in response to either court cases or as a result of reviews of the process:

> The PSR Scheme has continued to evolve since its inception. Legislative amendments were made in 1997, 1999, 2002 and 2006 to strengthen and clarify the professional review process and address evidentiary difficulties. Comprehensive reviews conducted in 1999 and 2006 by Government and key stakeholders also made recommendations to refine the administration of the Scheme and improve its legal effectiveness and transparency.[30]

4.37 The High Court has on several occasions upheld the constitutional validity of the PSR scheme,[31] most recently in the case *Wong v Commonwealth of Australia;*

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27 Avant, *Submission 10,* p. 15.

28 Professional Services Review, *Review of the Professional Services Review Scheme, Report of the Steering Committee*, May 2007, http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed 5 October 2011), pp. 30, 69–71.

29 PSR, *Submission 24*, p. 13.

30 *Submission 24*, p. 6.

31 Robin Bell, 'Protecting Medicare services: trials of a peer review scheme', *Journal of Law and Medicine*, vol. 13, 2005, p.40.

*Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee.*[32]

4.38 The committee is of the view that the structure of the PSR must provide sufficient checks and balances to prevent any single participant in the Scheme from exercising undue power. In the case of the role of Director, Dr Webber was asked specifically if too much power lay with that role. He replied:

> Any case that proceeds from a decision of the director—in other words, either a negotiated agreement or a decision to send someone to a committee—is overseen by other people. If I, as director, were to enter into an agreement with a practitioner, that agreement and all the documentation that supported it is ratified. It has to be ratified by the determining authority—a completely separate body. If I send someone to a committee, the committee obviously has oversight of that, which is then also reviewed by the determining authority. The only absolute discretion I have is to dismiss somebody.[33]

## Sanctions available to the Determining Authority

4.39 The committee heard evidence from MDA National who said in their written submission:

> Some of the repayments of Medicare benefits claimed are substantial; for example, in 2008-09 one practitioner was required to make a repayment of $1,202,872.40 and in 2009-10 another practitioner was required to repay $473,203.05. MDA National further notes that some practitioners have only received a percentage of the Medicare benefits, indeed in some cases we understand only 20%, and yet the practitioner is required to repay 100% of the MBS benefits. To date, MDA National is not aware that the PSR has prosecuted a person who is an officer of a body corporate who causes a person to engage in inappropriate practice, despite its ability to do so under the Act.[34]

4.40 The committee was concerned by this allegation that a practitioner would be required to repay more than they actually received from Medicare and explored the issue with MDA National in its public hearing. Professor Rait explained:

> The specific situation I can think of is that, for example, in my own practice a proportion of my fees are diverted to the practice and retained by the practice group. In other words, in the event that someone has paid for a service and it goes to the practice, they may not actually personally receive all the proceeds of that because of their particular practice structure or the fact that they are employed by a practice organisation.[35]

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32 *Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee* No. 309 [2009] HCA 3 (2 February 2009)

33 Dr Webber, *Proof Committee Hansard,* 22 September 2011, pp 5-6.

34 MDA National, *Submission 5,* p. 4.

35 MDA National, *Proof Committee Hansard,* 23 September 2011, p 18.

4.41 The example provided describes internal financial arrangements of a medical practice. The committee is of the view that the onus lies with the medical practitioner to negotiate the financial ramifications of an adverse PSR finding within his or her practice, and this is not the responsibility of the Determining Authority. The committee received no other evidence suggesting that the Determining Authority had required payment beyond what the practitioner received from Medicare Australia.

4.42 The committee notes that a section 92 agreement reached with the Director of the PSR may include agreement to repay part or all of the Medicare benefits received in relation to Medicare benefits paid for practices which the person under review agrees were professionally inappropriate. It does not allow for the amount to be more than was originally paid. Section 106U of the Act places the same limitation on the Determining Authority.

4.43 The committee notes that if a doctor does not believe their practice was inappropriate, then they may reject a proposed section 92 agreement in favour of seeking the support of a committee of their peers regarding their practice. The Senate committee would expect that advisers from medical defence organisations would also be able to give an assessment, based on experience, of whether the doctor's practices would be likely to secure peer support. The committee agrees that where MBS items have been inappropriately used, it is appropriate that one option available to the Determining Authority be that the money be repaid.

*Part VII authority*

4.44 In his evidence the Chairman of the Determining Authority, Dr Nicolas Radford, requested that the committee explore the powers under Part VII of the Act to disqualify practitioners from the PBS:

> There is only one other thing I might say with regard to an item which the committee might feel it would like to address, and that is the matter of the part VII authority. At the moment, the matter of drug prescribing is only usually handled as part of the spectrum of inappropriate practice with regard to clinical services. If, say, we had a doctor who was prescribing vast amounts of opiates improperly, it is not open to us to disqualify that practitioner from prescribing certain drugs. We can only revoke the authority to prescribe all drugs as pharmaceutical benefits, and that is a very, very blunt and heavy instrument, so blunt that—I would have to research it, but I think it has been seldom if ever applied.

4.45 The committee agrees that this is a sanction that should be available to the Determining Authority, and concurs with the Chairman that Part VII should be reviewed to allow more flexibility in its application.

**Recommendation 6**

**4.46 The Committee recommends that the Commonwealth government review the legislation to allow the Determining Authority greater flexibility in its sanctions with regard to PBS items.**

## The challenge of corporate medical practice

4.47 Dr Webber, the former head of the PSR, remarked on the role of corporate medical practice during his opening statement:

> As you know, there has been an explosion in medical knowledge and technology since Medibank was first introduced in 1973 and, of course, the business of medicine has been altered forever by the entry of corporatised medicine practising for a third party profit...
>
> As for the future, I can certainly see PSR—and this may be somewhat controversial—having an own-motion ability to investigate scams and unacceptable corporate behaviour, of which I have seen significant examples, to prevent an escalation of this sort of inappropriate clinical behaviour.[36]

4.48 His observations were followed up during evidence:

> Senator ABETZ: ... In your opening statement you referred to corporatised medicine and unacceptable corporate behaviour. Has the PSR prosecuted any person who is an officer of the body corporate?
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> Dr Webber: Sadly, no, because the legislation makes it very difficult to do so. It talks about the ability to take action against an employer of a practitioner if that employer has directed the employee to practice inappropriately. However, it is silent about a contractor. Because many of the practitioners working in the corporatised medical field are working under contracts, the owner of the practice is not able to be followed up.[37]

4.49 The AMA's guide indicates that the 'overwhelming majority of Corporate contracts will define [a doctor's] status as that of independent contractor'.[38] The Kit advises doctors to:

> remain on your guard to ensure that your clinical independence is not compromised indirectly through influences on referral patterns, changes to throughput of patients or various financial inducements.[39]

4.50 The committee received no evidence from other organisations on this point. However, given that corporate medical practice is growing, and with independent contractors central to its workforce, Dr Webber's concern should not be overlooked. It would seem anomalous for the legislation to allow the PSR to act against an employer, but not a contracting corporation, even though the pressures each might be exerting on medical professionals could be similar in nature.

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36 Dr Webber, *Proof Committee Hansard*, 22 September 2011, pp. 2–3.

37 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 4.

38 Australian Medical Association, *Corporatisation of General Practice: Decision Support Kit for Doctors*, August 2010, http://www.ama.com.au/node/5997 (accessed 6 October 2011), p. 22.

39 Australian Medical Association, *Corporatisation of General Practice: Decision Support Kit for Doctors*, August 2010, http://www.ama.com.au/node/5997 (accessed 6 October 2011), p. 28.

**Recommendation 7**

**4.51 The committee recommends that the Commonwealth government review the PSR's enabling legislation, to ensure that the PSR can effectively pursue abuse of the MBS or PBS systems, regardless of the structure of employment of the person under review.**

**Senator Rachel Siewert**
**Chair**