

PROFESSIONAL SERVICES  
REVIEW TRIBUNAL

No 5 of 1997

BETWEEN : **MICHAEL JACOB BAR-MORDECAI**  
Applicant

AND : **DAVID TREVOR GRAHAM**  
Respondent

TRIBUNAL : The Hon A.R. Neaves, President  
Dr Peter Joseph, Member  
Dr Dana Wainwright, Member

DATE : 9 October 1998

**DECISION**

The Determination made herein by the respondent and dated 26 September 1997 is set aside.

.Alan R. Neaves. (sgd)  
(Alan R. Neaves)  
President

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### **REASONS FOR DECISION**

#### **THE TRIBUNAL:**

##### **Nature of the Proceeding**

The Tribunal has before it the request made by Dr Michael Jacob Bar-Mordecai (“the applicant”) pursuant to subs. 114(1) of the Health Insurance Act 1973 (Cth) (“the Act”) that the determination made by David Trevor Graham (“the respondent”) under ss. 106T and 106U of the Act and dated 26 September 1997 be referred to a Professional Services Review Tribunal for review. That request was forwarded by the Minister for Health and Family Services to the President of this Tribunal pursuant to subs. 115(1) of the Act.

##### **History of the Matter**

2. On 13 May 1996, Dr R.P. Tomlins, who described himself as Medical Director and Manager, Professional Services Branch, signed a document referring to the Director of Professional Services Review “the conduct of Dr Michael Jacob Bar-Mordecai in relation to whether he has engaged in inappropriate practice in connection with the rendering of services as defined by the Act”. In signing the document, Dr Tomlins purported to act on behalf of the Health Insurance Commission (“the Commission”) and in pursuance of s.86 of the Act. The fact that the referral was made by Dr Tomlins and not by the Commission itself does not affect the validity of the referral or what was done pursuant to it: see subs. 86(5) of the Act, a provision which was inserted by item 5 in Schedule 1 to the Health Insurance Amendment Act (No 1) 1997 (Cth) and which came into operation on 6 November 1997.

3. The document identified the referred services (see subs. 87(1) of the Act) as “all services rendered by Dr Bar-Mordecai from his practice location in the State of New South Wales during the period of 1 July 1994 to 30 June 1995, inclusive”.

4. The reasons for the decision to refer were summarised in paragraph 3 of the document in the following terms:

“The Health Insurance Commission is concerned that Dr. Bar-Mordecai has provided an inappropriately high average number of services per patient. The proportion of long and prolonged consultations in respect of total services rendered is also of concern. In addition, the Health Insurance Commission is concerned that the high volume of multiple servicing and family servicing and the inappropriate use of item 30219 would not be acceptable to the general body of general practitioners.”

5. The document continued:

“4. High Proportion of Long and Prolonged Consultations:

During the referral period, Dr Bar-Mordecai provided 1,141 (item 36) level C consultations and (item 54) long consultations, and 259 (item 44) level D consultations and (item 57) prolonged [consultations]. The Health Insurance Commission believes that some of the services rendered by Dr Bar-Mordecai would not be reasonably medically necessary for the care of his patients.

5. High Volume of Multiple Servicing and Family Servicing:

During the referral period Dr Bar-Mordecai rendered two (2) or more consultations to persons listed on a single Medicare card on the same day on 680 occasions. On one occasion Dr Bar-Mordecai rendered as many as 5 consultations to persons listed on the same Medicare card on the one day. The Health Insurance Commission is concerned that some of the services rendered to patients on the same day may not be reasonably medically necessary for the care of these patients.

6. Inappropriate Use of Item 30219:

During the referral period Dr Bar-Mordecai rendered 154 items 30219 (incision with drainage of haematoma or furuncle, small abscess or similar lesion) to 85 patients at a cost to Medicare of \$2,078.10. There is a concern as to exactly what Dr Bar-Mordecai is incising (possibly something very small) which other providers would normally address on a consultation basis. Dr Bar-Mordecai rendered a consultation plus item 30219 together on 269 occasions. The Health Insurance Commission is concerned that some of the services rendered to patients may not be reasonably medically necessary for the care of these patients.

7. High Average Number of Services Per Patient:

In the referral period, Dr Bar-Mordecai provided an average of 4.68 services per patient which places him on the 88th percentile of all active general practitioners in Australia. The Health Insurance Commission believes that some of the services rendered by Dr Bar-Mordecai would not be reasonably medically necessary for the care of his patients.”

6. Paragraph 8 of the document identified in 8 subparagraphs the material which the Commission took into account in forming a view about the appropriateness of the applicant’s practice. Included in the material was a document described as “Dr Bar-Mordecai’s submission of 21 October 1994”. The referral document continued:

“9. For these reasons, the Health Insurance Commission has formed the view that Dr Bar-Mordecai’s conduct in connection with the rendering of Medicare services constitutes inappropriate practice.”

7. The document then set out further material relating to the applicant and his practice under the following headings and sub-headings:

- Background of Referred Person
- Details of Health Insurance Commission Concerns:
  - Rendered Services
  - High Proportion of Long/Level C and Prolonged/Level D Consultations
  - High Volume of Multiple Servicing and Family Servicing
  - Inappropriate Use of Item 30219
  - High Average Number of Services Per Patient
- Other Details of Dr Bar-Mordecai’s Practice:
  - Initiation of Diagnostic Imaging
  - Specialist Referrals
  - Flow-on Costs Generated by Dr Bar-Mordecai
- Chronological Record of this Referral

8. Annexed to the referral document were 7 attachments and 10 reports. It will be necessary to refer to some of the material in these annexures later in these reasons.

9. On 12 June 1996, after the applicant has been given an opportunity to make written submissions stating why the referral should be dismissed, the Director of Professional Services Review, Dr A. J. Holmes, signed an instrument under ss. 93 and 95 of the Act setting up Professional Services Review Committee No. 14 (“the Committee”) to consider whether the applicant had engaged in inappropriate practice. The Committee comprised a chairperson and two members. The chairperson was described as a medical practitioner, each of the two members being described as a vocationally registered general practitioner.

10. Pursuant to s.102 of the Act, the Committee, by a document dated 8 July 1996, gave the applicant notice of a hearing to be held on 8 August 1996. The document required the applicant to appear and give evidence at the hearing and to produce the documents referred to in a schedule to the notice. The schedule described certain of the documents to be produced in the following terms:

“Thirty clinical records in respect of the exploratory random sample drawn from the preliminary random sample in accordance with s.106K of the Act relating to the following class of services during the period of the referral:

Long and prolonged consultations  
(Medicare Benefits Schedule Book items 54 and 57)

Thirty clinical records in respect of the exploratory random sample drawn from the preliminary random sample in accordance with s.106K of the Act relating to the following class of services during the period of the referral:

Level C and D consultations  
(Medicare Benefits Schedule Book items 36 and 44)

Thirty Clinical records in respect of the exploratory random sample drawn from the preliminary random sample in accordance with s.106K of the Act relating to the following class of services during the period of the referral:

Incision with drainage of haematoma or furuncle, small  
abscess or similar lesion  
(Medicare Benefits Schedule Book item 30219)”

Details of the patients to whom the services were rendered and the dates of the services were set out in other documents attached to the notice of hearing.

11. The schedule also required the production of:

- Clinical records for 5 families chosen from the “top 40 family servicing report”;
- Clinical records for 3 families chosen from the “top 40 multiple servicing report”; and
- Clinical records for 5 patients chosen from the “top 40 patients listed in the PIRT report”.

The three reports referred to were documents annexed to the referral document.

12. By letter dated 7 August 1996, the applicant made lengthy submissions to the Committee in relation to the subject matter of the Committee’s inquiry. The letter stated that “relevant medical documentation that your Committee will require to review the

quality and associated costs of my medical servicing for the period 1.7.94 to 30.6.95” was enclosed. The letter also stated:

“I hereby notify you that I will definitely not attend your review on the 8.8.96 at 10.30 am, and I hereby confirm that the documents produced for this review are a bona fide copy of my computerised patient documentation. These have been given to Anne Selvidge, Secretary, Professional Services Review No 14 on 7.8.96. All my medical documentation has been computerised since 1.8.1984.”

13. The Committee hearing took place on 8 August 1996. Contrary to the statement made in his letter dated 7 August 1996, the applicant did attend the hearing. He gave evidence (not on oath or affirmation) and addressed the Committee.

14. Pursuant to s.106L of the Act, the Committee gave to the Determining Officer a written report dated 20 January 1997. The Committee unanimously found that the applicant’s conduct “in connection with the rendering of services the subject of the Referral from the Health Insurance Commission was, in the Committee’s opinion, unacceptable to the general body of medical practitioners practising in general medical practice in Australia”. The Committee, therefore, concluded that the applicant had engaged in inappropriate practice as defined in s.82(1)(a) of the Act.

15. Dr L.H.M. Morauta, who then held the position of Determining Officer, made a draft determination pursuant to subs. 106S(1) of the Act. The applicant was then afforded an opportunity to make written submissions suggesting changes to the draft determination. The applicant took advantage of that opportunity, forwarding to the respondent written submissions dated 19 August 1997 and 22 September 1997. He had previously submitted written submission dated 1 May 1997.

16. On 26 September 1997, pursuant to s.106T of the Act, the respondent made a final determination in accordance with s.106U of the Act relating to the applicant. The final determination, having recited that the Committee had found that the applicant had engaged in inappropriate practice as defined in s.82 of the Act, directed that:

“i) in accordance with paragraph 106U(1)(b) of the Act, Dr Bar-Mordecai be counselled by the Director of Professional Services Review or the Director’s nominee;

ii) in accordance with paragraph 106U(1)(c) of the Act, Dr Bar-Mordecai repay to the Commonwealth the amount of:

- (a) \$60,355.30 being an amount equivalent to the Medicare benefits paid for 30% of the inappropriate services rendered during the period of the referral under items 23, 24, 36, 37, 44 and 47 in Group A1 of Part 2 of the General Medical Services Table and items 53, 54, 57, 59, 60 and 65 in Group A2 of Part 2 of the General Medical Services Table; and

(b) \$1,524.45 being an amount equivalent to the Medicare benefits paid for 75% of the inappropriate services rendered during the period of the referral under item 30219 (incision and drainage of haematoma, furuncle, small abscess or similar lesion) in Group T8 of Part 2 of the General Medical Services Table;

and that the Medicare benefit that would otherwise be payable for those services cease to be payable;

iii) in accordance with paragraph 106U(1)(g)(i) of the Act, Dr Bar-Mordecai be disqualified for a period of 6 months from the time when this determination takes effect in respect of the provision of all services to which an item relates in Group A1 of Part 2 of the General Medical Services Table; and

iv) in accordance with paragraph 106U(1)(h) of the Act, Dr Bar-Mordecai be fully disqualified for a period of 4 months from the time when this determination takes effect.”

17. By letter dated 20 October 1997 addressed to the Minister for Health and Family Services, the applicant sought a review of the final determination made on 26 September 1997. The applicant set out in an attachment to the letter 75 “grounds” on which the review was sought. Much of the material set out in the attachment is discursive and argumentative. Much of it is irrelevant to any issue that this Tribunal has to decide. It misconceives the true function of the Determining Officer under the legislation. Some of the comments can only be described as offensive to those to whom they refer. Others of the comments border on the irrational. In summary, many of the so-called grounds are based on the content of the Entry Standards for General Practice Accreditation 1996 of the Royal Australian College of General Practitioners. There is little, if any, reference to the requirements of the Medicare legislation. As the applicant appeared in person before the Tribunal and was not legally represented, confining his submissions to matters relevant to the issues properly before the Tribunal presented some difficulty.

18. The applicant’s request for a review of the final determination was subsequently forwarded to the President of this Tribunal.

### The Applicant

19. The following statement with respect to the applicant’s training and qualifications is taken from the Committee’s report:

“1. Dr Bar-Mordecai is a medical practitioner who graduated from the University of New South Wales in 1975. He spent some time in America while he was an undergraduate and obtained qualifications as a pharmacist from Sydney University in 1968 but his registration has now lapsed.

2. Dr Bar-Mordecai commenced practice in September 1977 and has a solo practice at 212 Clovelly Road, Clovelly, New South Wales. Before this, he consulted at 22 Birriga Road, Bellevue Hill, New South Wales.
3. Dr Bar-Mordecai became vocationally registered on 28 February 1995.
4. Dr Bar-Mordecai is a general medical practitioner and therefore a specialist for the purposes of Part VAA of the Act.”

Clovelly is an eastern suburb of Sydney approximately 6 kilometres from the centre of the City.

20. Almost all the Medicare services provided by the applicant during the referral period were billed directly to Medicare by the applicant and the relevant Medicare benefits were paid to him.

21. On 7 October 1994, that is during the period that became the referral period, the applicant was visited by a Health Insurance Commission Medical Adviser. The matters discussed included the high services per patient, the high frequency of long and prolonged consultations, the high number of claims under item 30219, multiple consultations on the same day, the claiming of surgical procedure item 30117 with a consultation and the number of patients receiving frequent services. The Medical Adviser made a written report on the visit and it was in response to that report that the applicant wrote the document dated 21 October 1994 referred to in paragraph 6 of these reasons.

22. The number of patients to whom the applicant provided Medicare services during the referral period was 2,131.

#### Role of the Tribunal and the Legislation

23. On 19 June 1998, a Professional Services Review Tribunal, differently constituted, published reasons for its decision upon the review of a determination made under ss. 106T and 106U of the Act in relation to Dr Juan Sabag. In those reasons, the Tribunal set out its understanding of the role of the Tribunal in reviewing such a determination and set out relevant provisions of the legislation.

24. We agree with what the Tribunal there said and would wish these reasons to be read as if paragraphs 16 to 25 inclusive of the reasons in the matter of Dr Sabag were incorporated herein.

#### Material before the Tribunal

25. It is a matter of considerable concern to the Tribunal that the five volumes of material forwarded to it pursuant to section 115 of the Act do not contain the whole of the material that was before the Committee. In particular, the following material, although referred to in material that was before the Committee, is not included in the volumes:

- The key to enable patients to be identified referred to under the heading “Random Sampling” in the referral document.
- The preliminary random sample in accordance with s. 106K of the Act relating to long and prolonged consultations (items 54 and 57) referred to in Schedule 1 to the Notice of Hearing dated 8 July 1996.
- The preliminary random sample in accordance with s. 106K of the Act relating to Level C and D consultations (items 36 and 44) referred to in Schedule 1 to the Notice of Hearing dated 8 July 1996.
- The clinical records relating to long and prolonged consultations (except those in relation to four patients identified by PIN 205327128, 202455589, 205634670 and 200554336) identified in Schedule 1 (including its attachments) to the Notice of Hearing dated 8 July 1996.
- The clinical records relating to Level C and D consultations (except those in relation to one patient identified by PIN 201724231) identified in Schedule 1 (including its attachments) to the Notice of Hearing dated 8 July 1996.
- The clinical records for the five families identified in Schedule 1 to the Notice of Hearing dated 8 July 1996 under the description “Clinical records for the following families chosen from the ‘top 40 family servicing report’”.
- The clinical records for the three families identified in Schedule 1 to the Notice of Hearing dated 8 July 1996 under the description “Clinical records for the following families chosen from the ‘top 40 multiple servicing report’”.
- The clinical records relating to one of the five patients identified in Schedule 1 to the Notice of Hearing dated 8 July 1996 under the description “Clinical records for the following patients chosen from the ‘top 40 patients listed in the PIRT report’”.
- The written submission of the applicant dated 23 August 1996 referred to in the Committee’s report dated 20 January 1997 in subparagraph 5 under the heading “Evidence on which the facts are based”.

26. It is imperative, if a Tribunal is to review on the merits the report of a Committee set up under s. 93 of the Act, that the Tribunal have before it the whole of the material that was before the Committee. In the present case, the deficiencies were remedied, but only to a limited extent, by the applicant making available to the Tribunal some of the clinical notes to which reference has been made in the preceding paragraph.

### The Committee's Report

27. As has already been mentioned, the referral document identified the matters of concern to the Commission as being:

- The high proportion of Long and Prolonged consultations.
- The high volume of multiple servicing and family servicing.
- The inappropriate use of item 30219.
- The high average number of services per patient.

28. The Committee, however, expressed its findings under four headings, namely:

- Long Consultations;
- Procedures for which Item 30219 was Claimed;
- Services per Patient;
- Consultations during the Aftercare Period.

The Committee explained that it did not consider one of the concerns of the Commission as expressed in the referral document, namely the concern as to the high volume of multiple servicing and family servicing.

29. Under the heading, "Long Consultations", the Committee noted that the applicant's consultations appeared to be "significantly longer than would be expected" and assigned as reasons that contributed to that apparent phenomenon:

- the extensive questioning of patients and the entry of the relevant data into his computerised record system during the course of the consultation;
- the fact that the applicant appeared to take a longer time to do simple dressings and procedures, including the provision of routine injections, than would reasonably be expected of a competent medical practitioner; and

- the applicant's practice of personally routinely dressing patients' wounds twice per day for the duration of the management of the wound.

The Committee noted that the applicant's records very seldom supported the level of consultation that he claimed and concluded that the applicant "did not always bill the correct level of attendance".

30. In relation to the services for which payment under item 30219 had been claimed, the Committee expressed its concern that some of the services rendered "may not have been reasonably medically necessary for the care of his patients". It expressed the belief that the applicant's stance of claiming a procedural item number for a lesion of any size was contrary to the intention of the item number and could not be condoned. Further, the Committee said, the applicant was "unable to demonstrate that his behaviour of incising comedones and herpetic blisters offers a benefit to patients", the Committee expressing the belief that the incising of such lesions was clinically unnecessary. The view was also expressed that to see a patient every day to have the procedure repeated was medically unnecessary.

31. In relation to the number of services per patient, the Committee concluded that the applicant could not justify the frequency of his consultations either on the documentation provided by him to the Committee or otherwise. The Committee could not accept that it was justified to charge a separate fee for removal of ear wax from asymptomatic patients.

32. The Committee also concluded from its examination of the applicant's records that he had charged Medicare for consultations within the aftercare period (see subs. 3(5) of the Act).

33. The Committee states in its report that, in reaching its findings, it had regard to all of the evidence before it including the applicant's medical and practice records. However, from a perusal of the transcript of the hearing by the Committee, it is apparent that members of the Committee questioned the applicant in relation to only 14 patients. In its report the Committee makes specific reference to only three of those patients. Further, in relation to some of the services to those patients that are specifically referred to in the report, the applicant was not asked for any explanation.

#### Analysis of the Material before the Tribunal

34. One of the matters of concern to the Commission was expressed in the referral document to be "the proportion of long and prolonged consultations in respect of total services rendered" by the applicant during the referral period. The number of consultations (surgery and home visits) provided during that period was 8,902.

35. From the referral document and its annexures, details of the distribution of the consultation services for which the applicant claimed payment of Medicare benefits

appear. The applicant became a vocationally registered medical practitioner on 28 February 1995 and the Daily Items Report, one of the annexures to the referral document, shows that prior to 6 March 1995 the items in Group A2 of Part 2 of the General Medical Services Table (items 52, 53, 54, 57, 59, 60 and 65) were the relevant items under which the applicant might bill Medicare. On and after that date, the items in Group A1 of Part 2 of that Table (items 3, 4, 23, 24, 36, 37, 44 and 47) were the relevant items. The distribution of the consultation services is shown in the following table:

	<b>Level A or Brief</b>	<b>Level B or Standard</b>	<b>Level C or Long</b>	<b>Level D or Prolonged</b>	<b>Total</b>
Surgery Consultations	-	6,761	1,141	259	8,161
Home Visits	-	697	33	11	741
<b>Total</b>	-	<b>7,458</b>	<b>1,174</b>	<b>270</b>	<b>8,902</b>
Percentage	-	83.78%	13.19%	3.03%	100%

36. At the material time, the relevant items in Group A2 of Part 2 of the General Medical Services Table were:

- Item 52: Brief Consultation at consulting rooms of not more than 5 minutes duration.
- Item 53: Standard Consultation at consulting rooms of more than 5 minutes duration but not more than 25 minutes duration.
- Item 54: Long Consultation at consulting rooms of more than 25 minutes duration but not more than 45 minutes duration.
- Item 57: Prolonged Consultation at consulting rooms of more 45 minutes duration.
- Item 58: Brief Home Visit of not more than 5 minutes duration.
- Item 59: Standard Home Visit of more than 5 minutes duration but not more than 25 minutes duration.
- Item 60: Long Home Visit of more than 25 minutes duration but not more than 45 minutes duration.
- Item 65: Prolonged Home Visit of more than 45 minutes duration.

37. At the material time, a Level A Consultation (items 3 and 4) was a professional attendance by a general practitioner (at consulting rooms or home visit) for an obvious problem characterised by the straightforward nature of the task that required a short patient history and, if required, limited examination and management. A Level B Consultation (items 23 and 24) was a professional attendance by a general practitioner (at consulting rooms or home visit) involving taking a selective history, examination of the patient with implementation of a management plan in relation to one or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which certain other items applied. A Level C Consultation (items 36 and 37) was a professional attendance by a general practitioner (at consulting rooms or home visit) involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems, and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which certain other items applied. A Level D Consultation (items 44 and 47) was a professional attendance by a general practitioner (at consulting rooms or home visit) involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems, and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementation of a management plan.

38. Another of the annexures to the referral document, referred to as the “Daily Item Report - PIRT”, sets out in relation to each of the 40 most frequently serviced of the applicant’s patients, the services claimed by the applicant to have been rendered to that patient during the referral period. The following table shows, in summary form, the number of Standard (including Level B), Long (including Level C) and Prolonged (including Level D) consultations claimed to have been rendered to each of those patients during the referral period at the applicant’s surgery or by home visit:

Patient	Consultations			Total
	Standard or Level B	Long or Level C	Prolonged or Level D	
1	67	4	3	74
2	73	2	-	75
3	65	3	-	68
4	52	7	2	61
5	47	2	-	49
6	51	8	-	59
7	50	1	-	51
8	44	-	1	45
9	42	4	1	47

10	47	2	-	49
11	46	2	-	48
12	25	16	4	45
13	38	5	-	43
14	36	5	-	41
15	22	12	4	38
16	30	2	1	33
17	35	2	-	37
18	30	3	1	34
19	27	2	2	31
20	30	-	-	30
21	34	-	-	34
22	25	8	1	34
23	35	-	-	35
24	11	2	-	13
25	21	4	4	29
26	32	2	-	34
27	27	4	-	31
28	24	-	-	24
29	24	3	2	29
30	23	5	-	28
31	23	3	1	27
32	27	-	-	27
33	24	5	-	29
34	29	1	-	30
35	25	-	-	25
36	19	-	-	19
37	19	5	3	27
38	23	1	-	24
39	21	1	-	22
40	22	4	-	26
Total	1,345	130	30	1,505
%	89.4%	8.6%	2.0%	100%

39. An analysis of other of the statistical information forming annexures to the referral document would, it may be assumed, result in comparable percentages for other patients or groups of patients.

40. The basis for the concern expressed by the Commission in the referral document is to be found in paragraph 40 of the referral document which reads:

“40. It must be noted that Dr Bar-Mordecai rendered a much higher percentage of Level C/long, Level D/prolonged and emergency consultations. Whereas in the AMTS, 6% of services fell into these categories, 17.5% of Dr Bar-Mordecai’s consultations were of the longer and more complex type”.

The reference to AMTS is a reference to the survey “Morbidity and treatment in general practice in Australia 1990-1991” conducted by Bridges-Webb et al in the Family Medicine Research Unit, University of Sydney.

41. While the disparity in the percentages to which the Commission drew attention may be thought to provide an adequate reason for the Commission’s concern, such disparity, of itself, provides no basis for concluding that the applicant had engaged in inappropriate practice. It would be fair to assume that the Committee took that view for its finding of inappropriate practice was not based on that disparity. Instead, the Committee addressed the question whether, accepting that the applicant had actually spent the time he claimed to have spent on the consultations (whether Standard/Level B, Long/Level C or Prolonged/Level D), the service that the applicant rendered at those consultations justified the level at which the consultation was billed to Medicare.

42. The strongest argument in support of the conclusion to which the Committee came that the applicant did not always bill the correct level of attendance is to be found in what the applicant had to say as to the manner in which he carried on his practice.

43. A convenient commencing point in examining this aspect of the matter is the response of the applicant dated 21 October 1994 to which reference is made in paragraph 6 of these reasons. That document contained the following statements:

“I agree that I take full patient histories, especially with respect to promotional health aspects and social aspects . . . the histories are gathered as a minimum assessment in the delivery of health care from a holistic patient approach so that a medical practitioner assessing the patient has access to patient information at a glance and can be more sensitive to patient needs in the delivery of the health care. More practical reasons for the data collection is that every so often dramatic revelations come to hand that need immediate action . . .

As to the frequency of long and prolonged consultations, I am proud of the fact that I spend many of my hours constructively, collecting patient data, assessing patients and actioning their perceived needs and actioning my own needs to

improve their health care eg. for obesity treatment coupled with alcoholism, depression, chocooholism or marijuana abuse. I have taken the liberty to document my successes and failures and am computerised to the 11th degree to be able to produce statistically significant results on my patient population.

It is my intention to continue to service patients with long and prolonged consultations irrespective of the cost - which your department elected to bear - rather than be paid privately by patients or private health funds.”

44. In his submission to the Committee dated 7 August 1996 which is referred to in paragraph 12 of these reasons, the applicant elaborated upon the manner in which he conducted his medical practice during the referral period. The submission refers in some detail to the development, implementation and enhancement of an integrated computerised medical records system called the Eveline Medical Billing, Record and Information System (EMBRIS). Some extracts from the submission follow:

“EMBRIS. . . . allows me to practice a more sophisticated type of health care, where statistically from thousands of patient data I can infer the future trends and hopefully fix several variables of data e.g. Religion, and its level of observance, educational status and intelligence and then change variables to gauge the effects of changes on a particular variable.

. . . . .

The computerised medical records allows [sic] me on a mini scale to develop Health Policy and determine and identify statistically important health variables.

. . . . .

I attempt to take a full medical history on each patient that enters my hallowed portals. That medical history includes a social, nutritional, substance abuse, sexual, educational, smoking, alcohol and a family history and more as my needs for history taking dictate

. . . . .

As to the clerical arrangements in the practice - the clerical efforts required are minimal because of the nature of the EMBRIS programming. There is an integrated medical Billing Module as well as a medical information and assessment module totally integrated into EMBRIS with approximately 400 painted screens embracing General Practice eg. Pain protocol or examination of the back protocol. There is a medical information module embracing current General Practice Procedures, protocols for assessment and treatments that span megabytes of information.”

45. The submission proceeds to set out in great detail the “data sets of information” that the applicant seeks to obtain from his patients. The data embraces 68 sets of information, the full extent of which appears from the extract from the submission that is set out in the Schedule to these reasons. The subject matter of those questions is so broad that by asking the questions of each patient the applicant would clearly be seeking to elicit information that was not clinically relevant to the medical condition from which the patient was suffering. It may be noted, in passing, that, in the course of his oral submissions to the Tribunal, the applicant said that the “data sets of information” had, since the referral period, been increased from 68 to 160.

46. The submission of 7 August 1996 also states that the patient’s medical history may be obtained in one sitting or in one or more consultations and that all promotional health parameters and variables are upgraded periodically as well as family history where possible. The document further states that the applicant sees approximately 1,000 new patients per year and that with every new patient he takes a medical history that may last for 30 to 90 minutes and this whatever be the medical condition with which the patient presents. The document continues:

“With each patient encounter, promotional health is addressed where the needs arise, all variable medical documentation is revised eg. in Family History all ages of family members are updated along with any new important medical condition they may have encountered following the previous documentation. The medical record is thoroughly perused and enquires made as to the status of each current medical problem prior to inquiry as to the patient’s presenting symptoms, signs and relevant medico clinical presentation.”

47. What is said in the documents to which reference has been made is to be read in conjunction with the statements made by the applicant to the Committee in the course of the hearing on 8 August 1996 to the effect that every consultation was timed and that he used the Medicare item numbers according to time and not content. From this material, a group of medical practitioners with extensive experience in general practice, as the members of the Committee were, could properly conclude that it would not be appropriate for the applicant, in assessing the level at which Medicare should be billed for the consultation, to include the time taken to question the patient on many of the topics identified in the list of 68 questions to which reference has been made and to record the patient’s answers and could properly infer that the applicant has charged a number of consultations at levels higher than were justifiable.

48. The difficulty is, however, that the Committee did not identify even one instance in which this unacceptable practice had occurred. Nor has an examination of the material before us enabled any such instance to be conclusively established. From the clinical records that are available to us it is possible to identify 17 patients who, during the referral period, appear to have been asked a substantial number of the questions included in the list of 68 to which reference has been made. It is also possible to say, in respect of 7 of those patients, that a Long or Level C consultation was charged in respect of the

attendance at which the questions were asked and, in respect of 4 of those patients, a Prolonged or Level D consultation was charged. In the case of 6 patients, the material available does not show whether any charge was made or at what level. In those cases where a charge was clearly made, it may have been open to the Committee, upon appropriate enquiry, to conclude that, if the time taken to question the patient and record the answers were excluded from the consultation time, a lower level of charge would have been appropriate having regard to the medical service that was provided on the relevant occasion. The material is not, however, sufficiently detailed to enable a clear finding to be made to that effect.

49. In relation to the other matters on which the Committee relied in concluding that the applicant did not always bill the correct level of attendance, the Committee's finding was based on an overall picture of the conduct of the applicant's practice during the referral period derived from its assessment of the whole of the material before it and its consideration of how the conduct of the applicant in carrying on his practice in that fashion would be viewed by the general body of general practitioners in Australia. The Committee did not, however, identify the number or proportion of the relevant services rendered by the applicant that were charged for inappropriately. Nor does the material before us enable the deficiency to be remedied.

50. In relation to the other grounds on which the Committee found the applicant to have engaged in inappropriate practice, namely its finding in relation to the services for which payment under item 30219 was claimed, the number of services per patient and the claiming of consultations within the aftercare period, a similar difficulty arises. In relation to these grounds, the Committee based its findings on an overall picture as to the conduct of the applicant's practice derived from its examination of the applicant's medical records and the general statements made by the applicant. The Committee, however, did not identify the number or proportion of the relevant services rendered by the applicant that were billed inappropriately. Again, the material before us does not allow the deficiency to be remedied.

### **Conclusion re Inappropriate Practice**

51. In the light of the majority judgment in Adams v Yung (Federal Court of Australia - 15 May 1998 - unreported), we can only conclude that the material before us is not sufficient to sustain a finding that, during the referral period, the applicant's conduct was such as to amount to inappropriate practice as defined in s.82 of the Act.

52. Having reached that conclusion upon an examination of the whole of the material before us, it is unnecessary to consider whether some of that material should have been excluded from consideration because of an alleged denial on the part of the Committee of procedural fairness to the applicant.

### **The Determination**

53. The operative text of the final determination made by the respondent on 26 September 1997 is set out earlier in these reasons. Directions were given under paragraphs (b), (c), (g)(i) and (h) of subs. 106U(1) of the Act.

54. In the light of the conclusion that the material does not support a finding that during the referral period the applicant's conduct amounted to inappropriate practice as defined in s.82 of the Act, the final determination cannot stand.

### **Conclusion**

55. For the reasons set out above, the determination made by the respondent on 26 September 1997 is set aside.

### **THE SCHEDULE**

#### EXTRACT FROM DR BAR-MORDECAI'S SUBMISSION DATED 7 AUGUST 1996 DEALING WITH HIS HISTORY TAKING

*“To sensitise me to my patient's needs and their past history, social history and various other relevant medical and sociomedical events I enquire about the following data sets of information that I feels [sic] are relevant to the patient population at large.*

1. *Marital Status, eg. Married, single, defacto, divorced, engaged, and the number of previous long term associations*
2. *Alcohol usage - the amount consumed per period of time.*
3. *Tabacco [sic] usage - the number of cigarettes consumed per day and of course the options of 'Nil and never' or the cessation age, etc.*
4. *The blood group of the patient.*
5. *The Rh of the patient.*
6. *The immunisation status of the patient to tetanus over the last 10 years.*
7. *The religion of the patient, e.g. Roman Catholic and the degree of religious observance, e.g. nominal, moderate or devout.*
8. *The next of kin of the patient with the relative's telephone number.*
9. *The Country of birth of the patient. If the patient was an immigrant to Australia than [sic] the emigration date.*

10. *The daily, weekly or monthly exercise that the patient performs with specifications of the type of exercise and the duration of time performed.*

11. *Nutrition - whether the patient is a vegetarian, vegan or has a full meat diet.*

12. *The pensioner or health care benefit no. - so that this may automatically be encrypted on each computer generated patient prescription.*

13. *The private Health Insurance status of the patient.*

14. *The current patient occupation.*

15. *The dental hygiene - how often the patient brushes his teeth per day.*

16. *The patients home, mobile and work telephone numbers.*

*All the above criteria are updated with each patient encounter - and patients are encouraged to modify their lifestyles appropriately.*

17. *Hand domination - right or left handed.*

18. *Living accommodation - Own unit, own home, rented unit, rented room etc.*

19. *Shower/bathing frequency - e.g. 1 shower per day, 1 shower per week etc.*

20. *Nervous tics - e.g. Eye blinking, twitching, repetitive hand movements etc.*

21. *Nutritional abuse, e.g. of chocolate, coca cola, sweets, biscuits [sic], lollies.*

22. *Substance abuse - the use of heroin, cocaine, marijuana, speed, ecstasy [sic].*

23. *Marijuana usage - the amount of marijuana used per unit of time and the frequency of usage.*

24. *The happiness status of the patient - 5 levels are defined a. Ecstatic, b. Happy, c. Content, d. Sad, e. Miserable*

25. *Personal wealth - The approximate wealth of the person, e.g. \$100,000.00. This item has been poorly implemented because everyone lies and is resentful to disclose their monetary wealth or their inherited wealth.*

26. *Inherited Wealth - poorly implemented - and many respondents have lied.*

27. *The initial date that the questions were asked. Modification dates are not retained by the System. With the passage of time and changes of life circumstances the information changes and the persons dynamic status changes appropriately.*

28. *Frequency of inebriation e.g. Once per week, twice per week, once per month or nil and never and numerous variations.*

29. *Euthanasia acceptance with the term defined and affecting only the patient rather than a generally accepted belief for others (The Nazi factor).*
30. *Living partners - Members that live in the same household e.g. Family, son, daughter, Father etc.*
31. *Family type e.g. Nuclear family, extended family, blended family, single parent family etc.*
32. *Tertiary Entrance [sic] rank - if the patient sat for the HSC.*

*By this time most patients feel that they have disclosed a great deal about themselves - and wonder how this pertains to their health care. I take the example of personal wealth and if the patient is insolvent, and destitute there will be a 99% chance that the prescription will be thrown out and not taken to the chemist. If the patient is solvent and can afford the prescription there will be a 20% chance that he/she will have the script dispensed. I explore with the patient how change may be effected and I take the initiative to implement change in the patient and improve the health care outcome of the patient and record my findings in the medical record appropriately and encourage patients to instigate change where appropriate.*

33. *Ethnicity e.g. White, Coloured, Black, Asian, Eurasian, etc.*
34. *Hobbies - Non cardiac e.g. Bridge, knitting, reading etc.*
35. *Aerobic sporting activities e.g. Football, cricket, basket ball etc.*
36. *Intelligence quotient - Only recorded as slow learner with patients with low IQs not to offend.*
37. *Educational attainment e.g. Primary, school certificate, HSC, University.*
38. *Social deviance - History of burglaries, shoplifting, bank robing [sic] etc.*
39. *School finishing age e.g. age 10, 16, 18, etc.*
40. *Pets currently kept at home e.g. Dog cat, snake, rabbit etc.*
41. *The amount of leisure time that the person has. Defined criteria for this exist.*
42. *Number of hours per week spent on watching television.*
43. *Transit time spent per day in a car, bus, train etc. on a regular basis.*
44. *Employment status e.g. Unemployed, part-time employed, employed.*

45. *Number of hours worked per week to generate an income. e.g. 40.*
46. *Number of hours spent studying per day, week or month.*
47. *Political affiliation - presently those tracked are the Nazi Party members, and membership to any political body frowned on by society, etc, where affiliation of the patient has been associated with socially deviant acts such as burning a school down etc and involvement in numerous legal altercations thereafter that has involved the family members usually the parents to a greater extent.*
48. *Age of retirement - if applicable.*

*All the above are of a personal nature and allow me as a medical practitioner to be more sensitive to the patient and the advise [sic] the patient accordingly. For example, if the patient is penniless, the patient will discard the prescription and the treatment prescribed will not come to fruition.*

*Following the above a sexual history cum relationship history is elicited. This has required great tact and delicacy and has estanged [sic] numerous patients in the past. But the means have justified the ends in terms of delivering a superb health care to those patients who have been lucky enough to have been recipients of my health care for more than two decades.*

48. *Partner status - Two options only i.e. Partnered or unpartnered.*
49. *Sexual preference - e.g. Homosexual, bisexual or heterosexual.*
50. *Partner satisfaction - there are 5 levels extending from perfect relationship to hateful relationship.i.e. Perfect, peaceful, tolerant, incompatible or hateful.*
51. *Current sexual partner/s e.g. Wife, wife and mistress, etc.*
52. *Partner assault - where the patient has been physically abused by the partner. All patients are serously [sic] warned that physical abuse will not be tolerated and legal action will ensue if I am notified.*
53. *Coitus frequency per unit time e.g. per day, per week, per month etc.*
54. *Spontaneous penile or clitoral erection without intercourse or masturbation.*
55. *Orgasm frequency - this is expressed as a percentage.*
56. *Orgasm quality - there are 4 levels.*

- 57. *Age of Masterbation [sic] onset.*
- 58. *Current masturbation frequency e.g. 2\*/day; 1\*/month.*
- 59. *Age of sexual abuse.*
- 60. *Age of rape.*
- 61. *Age of sexual onset.*
- 62. *Number of homosexual experiences and ages.*
- 63. *Number of long term relationships.*
- 64. *Marital History e.g. M\*D\*De\*W meaning  
Married\*Divorced\*Defactoed\*Widowed*

*By this time most patients have felt totally exposed and some will admit to sexual abuse, rape, homosexuality or several homosexual experiences.*

*One adult male admitted to sexually abusing SEVERAL twelve year old schoolgirls and was promptly sent for psychiatric assessment and therapy. The punitive legal approach was not embraced due to the high office of the patient and due to the scandal it would have caused and the adverse repercussions on the young ladies that had already suffered sexual abuse and the adverse publicity that the NSW education department would have had to endure for many years to come. The case was appropriately suppressed [sic] from the public - Thank god. The adult male patient has been rehabilitated and removed from being at risk to any young ladies.*

*All patients are also asked*

- 64. *Sensitivity history e.g. Dust, milk, pollen, wheat, etc.*
- 65. *Operation history e.g. Appendectomy age 5; Termination age 18; always with the age of onset.*
- 66. *Serious illness history e.g. Meningitis age 3; Asthma age 5; always with the age of onset.*
- 67. *Allergies to medications e.g. to penicillin etc.*
- 68. *Family history that currently includes:*

*Father - and his status, i.e. alive or died; his age or age at death, the year he died or if alive this year is recorded. the Fathers past serious illnesses, or genetic illnesses and if relevant the cause of death. Whether the father divorced the mother and the type of relationship they had.*

*Mother - with all the above parameters.*

*Siblings - with all the above parameters.*

*Partner - with all the above parameters - and with widowed partners; the date at which the partner died.*

*Children - Each child as each sibling is listed separately and described according to the above criteria.*

*At this stage the active medical problems that the patient has presented to this surgery in the past are reviewed individually and chronologically (not possible with a paper system).*

*Then, promotional health is addressed as the clinical needs of the patient dictate.*

*At this stage a progress note may be generated for the reason the patient attended the surgery. On most occasions a progress note is generated of the encounter. On some occasions progress notes have not been generated and no documentation of the encounter exists.*

*In view of the absence of any patient/medical practitioner confidentiality a decision was taken by me following my MSCI investigation and various health care complaint unit investigations - all of which were a waste of my time and fruitless - that confidential medical patient information that may be deleterious [sic] to the patient NOT be recorded and in fact forgotten in order to protect the privacy of the patient. Such documented notes in the Eveline Medical Billing Record and Information system are designated by the caption 'Counselling' and that's it. With all your HIC expertise and experience you will find the consultations very difficult if not impossible to assess - as I feel the certain information must NEVER be devulged [sic] to any other person or government agency under whatever guise."*

The applicant appeared in person.

Counsel for the respondent	:	Ms R.M. Henderson and Mr C. Colbourne
Solicitor for the respondent	:	Australian Government Solicitor
Dates of hearing	:	6 and 7 April 1998
Date of decision	:	9 October 1998

This and the preceding 24 pages comprise the decision and the reasons for decision of the Professional Services Review Tribunal constituted by The Hon A.R Neaves, Dr P. Joseph and Dr D. Wainwright given on the 9th day of October 1998.

Dated this 9th day of October 1998

Diane Popple (sgd)  
Registrar