

PROFESSIONAL SERVICES)
REVIEW TRIBUNAL)

No. 1 of 2001

BETWEEN: WILVENE LESLEY
EVYLINE HILL

Applicant

AND: ALAN KEITH

Respondent

TRIBUNAL: The Honourable A.R. Neaves, President
Dr P. Joseph, Member
Dr D. Wainwright, Member

DATE: 3 July 2001

DECISION

The Determination made herein by the respondent and dated 5 January 2001 is affirmed.

.....

(Alan R. Neaves)

President

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REASONS FOR DECISION

THE TRIBUNAL:

Nature of the Proceeding

The matter before the Tribunal is the review, upon the request of Dr Wilvene Lesley Evyline Hill (“the applicant”) of the final determination relating to the applicant made by Alan Keith (“the respondent”) and dated 5 January 2001. The matter arises under provisions of the Health Insurance Act 1973 (Cth) (“the 1973 Act”), the Health Insurance Amendment Act (No 1) 1977 (Cth) (“the 1997 Act”) and the Health Insurance Amendment (Professional Services Review) Act 1999 (Cth) (“the 1999 Act”) to which reference will be made later in these reasons. At the outset,

however, it is to be noted that, although Part VA of the 1973 Act pursuant to which this Tribunal was established and its proceedings regulated was repealed by item 63 of Schedule 1 to the 1999 Act (a provision which commenced on 1 August 1999), item 65 of that Schedule (which also commenced on that date) provides, *inter alia*, that the repeal does not apply in respect of a matter that, before the commencement of the Schedule, was referred under section 86 of the 1973 Act by the Health Insurance Commission (“the Commission”) established by the Health Insurance Commission Act 1973 (Cth) to the Director of Professional Services Review appointed under section 83 of the 1973 Act and that the 1973 Act as in force immediately before the commencement of Schedule 1 to the 1999 Act continues to apply in respect of any such matter. It was not contended by either party that the present matter is other than such a matter.

The Applicant

2. The applicant was born in 1942. She graduated MBBS within Adelaide University in 1964. She worked as an intern at the Royal Adelaide Hospital and then at Hill Crest, a psychiatric hospital, for a year. She gained membership (subsequently upgraded to a fellowship) of the Royal Australian College of General Practitioners by examination in 1973. She is also a Fellow of the Australian College of Nutritional and Environmental Medicine and a member of the Australian Society of Environmental Medicine.

3. The applicant practised at Olinda and Wantima in Victoria and spent several years overseas. She then practised at Kilsyth and at Ringwood in Victoria. She is not vocationally registered.

4. The applicant asserted that, during the whole of the referral period and at all material times since, the clinic at which she worked was owned by AMS Health Services Pty Limited and that she was an employee of that company. Search of the records of the Australian Securities and Investments Commission made on behalf of the Committee revealed that AMS Health Services Pty Limited was registered in the State of Victoria on 21 December 1995 as a proprietary company limited by shares. Only 1 share had been issued, that share being beneficially held by Daniel John Robin

Clifford whom the Committee found was the applicant's son. From 21 December 1995 to 30 September 1997 the only director of the company and its secretary was Daniel John Robin Clifford. Thereafter the only director was Alicia May Clifford, the applicant's daughter, who was also the company's secretary.

5. In support of her contention that she was at all relevant times an employee of AMS Health Services Pty Limited, the applicant produced a document described as "Employment Agreement" hearing date 5 December 1995. The Committee clearly and justifiably had reservations concerning the authenticity of this document.

6. The applicant was counselled on 6 June 1996 by a Health Insurance Commission Medical Adviser.

The Referral

7. On 14 August 1997, Dr A.J. Parkes, who described himself as Manager, Professional Services Branch of the Commission, signed a document referring to the Director of Professional Services Review "the conduct of Dr Wilvene Lesley Evelyne Hill in relation to whether she has engaged in inappropriate practice, in connection with the rendering and initiation of services, as defined by the Act pursuant to subsection 86(1) of the Act". The references to the Act are references to the 1973 Act. In signing the document Dr Parkes described himself as the delegate of the Commission.

8. As to the validity of the referral and what was done pursuant to it, reference should be made to item 5 of Schedule 1 to the 1997Aact which came into operation, so far as that item is concerned, on 6 November 1997. That item inserted in section 86 of the 1973 Act the following subsection:

"(5) If, after 30 June 1994 but before the commencement of this subsection, a member of the Commission's staff (within the meaning of the Health Insurance Commission Act 1973) purported to refer conduct of a person to the Director under this section, then for all purposes:

(a) the referral is taken to be, and always to have been, made by the Commission; and

(b) all proceedings, matters, acts and things taken, made or done (or purporting to have been taken, made or done) because of the referral are taken to have, and always to have had, the same force and effect as they would have, or would have had, if the referral in fact had been made by the Commission.”

9. The document identified the referred services (see subsection 87(1) of the 1973 Act) as “all services rendered and initiated by Dr Hill from her practice locations in the State of Victoria during the period of 1 January 1996 to 31 December 1996, inclusive”. Those practice locations were identified as:

366 Maroondah Highway, Ringwood;
16 Collins Place, Kilsyth; and
8 Glendale Circuit, Kilsyth.

10. The reasons for the decision to refer were stated in paragraph C of the document in the following terms:

“The Health Insurance Commission is concerned that the high average number of services per patient and the high usage of items 12000 and 12003 by Dr Hill may be inappropriate, contain insufficient clinical input, or may not be reasonably medically necessary for the care of her patients.

The nature of this concern regards the professional quality of the services provided. The professional quality of a rendered service may also be reflected in the pattern of initiated services, such as prescribing, pathology or diagnostic imaging ordering, and specialist referrals. The Health Insurance Commission’s concerns, therefore, also extend, in this case, to initiated services.

Health Insurance Commission concerns include:

1. High Average Number of Services Per Patient:

During the referral period Dr Hill provided 10,647 services to 1,086 patients. Of these 6,749 were surgery consultations and 1,519 home visits. Dr Hill has

an average of 9.80 services per patient, which was more than the average services per patient provided by 97% of all other medical practitioners in Australia.... The Health Insurance Commission believes that some of the services rendered by Dr Hill may not be reasonably medically necessary for the care of her patients.

2. High use of skin sensitivity testing (items 12000 and 12003):

During the referral period Dr Hill rendered item 12000 (skin sensitivity testing – 1 to 20 allergens) 1,902 times to 549 patients placing her substantially above the 99th percentile for item 12000 (319). Dr Hill rendered item 12003 (skin sensitivity testing – 20 + allergens) 212 times to 156 patients placing her above the 95th percentile for item 12003 (110) of all other medical practitioners in Australia....

For these reasons the Health Insurance Commission has formed the view that Dr Hill's conduct in connection with the rendering and initiation of Medicare services may constitute inappropriate practice.”

11. The document set out further material relating to the applicant and her practice under the following headings:

- Background of Dr Hill
- Health Insurance Commission Assessment
- Details of Health Insurance Commission Concerns
- Other Details of Dr Hill's Practice
- Chronological Record of this Referral

12. Annexed to the referral document was a summary of the referred material together with 4 attachments and 7 reports. The attachments were described as:

- Census data
- Explanation of Artificial Neural Net
- Past counselling report dated 27 August 1990
- Journal articles and extracts

The 7 reports were described as:

- Daily items report – PIRD
- Monthly items report – PIRT
- Top 40 multiple servicing report
- Top 40 family servicing report
- Pharmaceutical benefits report
- Pathology, Diagnostic Imaging and Specialist Referral report and graphs
- Summary of estimated time report

13. A copy of the referral document and its annexures was sent to the applicant who was, by a notice dated 14 August 1997, invited to make written submissions to the Director of Professional Services Review, within 14 days, stating why the Director should dismiss the referral without setting up a Committee (see subsection 88(2) of the 1973 Act). The applicant responded to the invitation and furnished a lengthy submission to the Director of Professional Services Review.

Professional Services Review Committee

14. On 12 February 1999, the Director of Professional Services Review, Dr A.J. Holmes, signed an instrument under sections 93 and 95 of the 1973 Act setting up Professional Services Review Committee No. 102 (“the Committee”) to consider whether the applicant had engaged in inappropriate practice.

15. The Committee comprised a Chairperson and two members. The Chairperson was described in the instrument setting up the Committee as a Deputy Director of Professional Services Review and a medical practitioner, each of the two members being therein described as a general practitioner.

Hearing by the Committee

16. Pursuant to section 102 of the 1973 Act, the Committee, by a document dated 3 March 1999, gave the applicant notice of a hearing to be held on 8 April 1999. The notice stated that, if necessary, the hearing would be adjourned to a later date. The document required the applicant to produce on or before 5 pm on 15 March 1999 the documents referred to in Schedule 1 to the notice and to appear and give evidence at the hearing. The Schedule described the documents to be produced in the following terms:

“Complete and original documents for the patients on the attached list/s – these are patients to whom Dr Wilvene Lesley Evelyne Hill rendered services.

All practice appointment books, day books and attendance registers for Dr Wilvene Lesley Evelyne Hill for the Referral Period.”

There was only one list attached to the Schedule. It identified by name, in alphabetical order, 644 patients. It also showed each patient’s address, sex and date of birth. A letter dated 3 March 1999 which was signed by the Secretary to the Committee and accompanied the notice of hearing contained the following paragraph:

“The reference to ‘documents’ in the Notice of Hearing includes original clinical records, progress notes, specialist reports, pathology/diagnostic imaging results and any other document which relates to your treatment of the patients listed.”

17. Following representations to the Secretary of the Committee by Ms Alicia Clifford, the applicant’s daughter and practice manager, concerning the extraction of the patient’s medical records required by the notice of hearing dated 3 March 1999, the applicant was informed that the Committee had reduced the list of patients whose records were required to 159, the name of each of those patients, his or her address, sex and date of birth being given on a revised list. The date for production of those records was extended to the close of business on 22 March 1999. An amended notice of hearing was issued on 23 March 1999.

18. The notice of hearing dated 3 March 1999 gave the following particulars of the matter to which the hearing was to relate:

“The hearing concerns your conduct in relation to whether you have engaged in inappropriate practice as defined by the Health Insurance Act 1973 in connection with all services rendered by you during the Referral Period from your practice locations in the State of Victoria.

The level of your clinical input and the clinical relevance of the referred services is of particular concern to the Committee”.

The accompanying letter stated:

“As a guide, some of the issues the Committee will be interested in are:

- your practice arrangements, i.e., the type of practice/patients;
 - the content of the services which you rendered (as per the Referral);
- and
- your understanding of your professional responsibilities under the Medicare programme.”

19. By letter dated 22 March 1999 addressed by the Secretary to the Committee to the applicant, the applicant was informed that the Committee was principally concerned with services rendered by her under items 12000 and 12003 and with services provided to the top 5 families contained in the multiple servicing report annexed to the referral document. Those concerns were also re-stated in the amended notice of hearing dated 23 March 1999.

20. The hearing by the Committee commenced on 8 April 1999 and continued on 18 May 1999 and 21 September 1999. The applicant attended on each occasion but walked out of the hearing on 8 April 1999 when refused an adjournment after the Committee had been sitting for an hour. On that occasion the applicant was accompanied by her husband, Dr John Clifford, and her daughter and practice

manager, Ms Alicia Clifford. The applicant was accompanied on 18 May 1999 by her husband and on 21 September 1999 by her husband and her legal adviser.

21. In addition to receiving a large number of documents and questioning the applicant, the Committee heard evidence from two witnesses, Linda Richards and Carolyn Lorraine Bell. Although a summons to attend and give evidence before the Committee on 21 September 1999 was issued to the applicant's daughter and to 5 of the applicant's patients, none of those persons attended before the Committee.

The Committee's Report

22. Pursuant to section 106L of the 1973 Act, the Committee gave to the Determining Officer a written report dated 13 April 2000.

23. After referring to the review process and to the applicant's personal and practice information and her patient services, the Committee discussed at length the conduct of the hearing before it which resulted in the Committee being provided with no medical records of any of the patients to whom the applicant rendered services during the referral period and, in particular, no medical records of any of the 159 patients identified in the attachment to Schedule 1 to the Notice of Hearing dated 23 March 1999. It also resulted in the Committee being given no information as to the medical history, medical condition, examination of the patient, diagnosis, treatment or management plan of any of those patients. The steps which the Committee took to obtain the clinical records of the 159 identified patients appears from the material that is before the Tribunal and is summarized in the Committee's report. We have had regard to the whole of that material but we do not find it necessary to repeat it all in these reasons.

24. In relation to the absence of any clinical notes, the Committee did not believe the applicant's claim that she could not produce clinical records for her patients because the records were in the ownership and control of AMS Health Services Pty Limited or that the records had been destroyed. Having regard to what it regarded as the confusing and contradictory evidence before it, the Committee considered that

there were three possibilities, any of those possibilities being unacceptable to medical practitioners generally. The three possibilities were:

“Dr Hill has had access to her notes at all times but has knowingly entered into an arrangement that had the intentional effect of preventing a proper examination of her conduct; or

Dr Hill made clinical notes but did not have access to them thereafter; or

Dr Hill did not make clinical notes at any time during the Referral Period and therefore there is nothing to produce.”

25. The Committee referred in some detail to examples of the applicant’s failure to give meaningful and responsive answers to the Committee’s questions concerning patients to whom she rendered services during the referral period.

26. The Committee discussed the available patient servicing data to which some reference will be made later in these reasons. While accepting that the family which we have later called “the S. family” may have had medical conditions that required more attendances than the average patient, the Committee did not believe that on 244 days during the referral period it was medically necessary to see two or more members of the family. So far as the applicant’s treatment of the patient E.J.S., a member of that family, is concerned, the Committee stated that it knew of no medical condition or conditions that would necessitate the number of services that were shown to have been rendered to that patient. It found that the level of servicing was not justified and concluded that the applicant had exploited a dependency in the patient that the applicant had actively encouraged. The Committee was also of the opinion that the applicant’s conduct in relation to her rendering of home visits to other members of the S. family amounted to inappropriate practice.

27. The Committee considered there was no clinical necessity for the high number of services rendered to the patient J.C.M., a member of the family we have later called “the M. family”. It concluded that the level of servicing was not justified and viewed the frequency of servicing of that patient as indicative of dependency. The

Committee could see no medical justification for the rendering of almost daily consultations (excluding weekends) to this patient nor for the number of occasions (24) when the applicant rendered more than one consultation to the patient on the same day.

28. Paragraphs 134 and 135 of the Committee's report, with initials substituted for the names of the patients, read:

"134. On average, Dr Hill attended patients E.J.S. and J.C.M. approximately 10 and 5 times per week, in E.J.S.'s case as long or prolonged home visits. She attended C.H.McH, E.L.M., L.E.M., J.E.S., A.M.M., I.D.J., T.I.S. and K.M.S. between 1½ and 3 times per week on average, frequently as long or prolonged consultations. No satisfactory justification for these levels of servicing was provided to the Committee. The Committee concludes that these levels of servicing inappropriately encouraged patient dependence on Dr Hill.

135. The Committee considers that this conduct in connection with rendering of services to these patients would be unacceptable to the general body of general practitioners in Australia and to the general body of the members of the profession of medicine in Australia."

29. The Committee found it inconceivable that the level of servicing to three families (to which we will refer as the S. family, the M. family and the R. family) could be justified on the basis of clinical necessity. The Committee saw this level of servicing as further evidence of the applicant promoting patient dependency.

30. The Committee found that the applicant had engaged in inappropriate practice in connection with the rendering of some of the services that were the subject of the referral from the Commission. The Committee summarised its conclusions in paragraphs 136-138 of its report in the following terms:

"136. After considering the Referral and all the evidence before it, and after applying its combined body of knowledge, the Committee has concluded that

Dr Hill's conduct, in relation to the referred services considered by the Committee (and particularly those identified in Attachment 11 as underlined items), would be unacceptable to the general body of general practitioners practising in Australia and to the general body of the members of the profession of medicine in Australia.

137. The Committee therefore concludes that Dr Hill has engaged in inappropriate practice as defined in section 82 of the Health Insurance Act 1973.

138. Having regard to the available evidence, each of the members of the Committee views Dr Hill's conduct as seriously inappropriate in relation to the referred services. In arriving at this view, which is based on wide professional experience, each member had particular regard to the following:

- the extraordinary number of services, especially home visits, rendered to a narrow group of patients;
- Dr Hill's failure to maintain accessible records of relevant services; and
- her apparent inability to recollect any relevant clinical information about her patients."

The Final Determination

31. On 5 January 2001, the respondent, who described himself as "Determining Officer by virtue of a Ministerial appointment made in accordance with section 106Q of the Act" signed a document described as "Final Determination, Section 106T, Health Insurance Act 1973". The document recited that the Committee had found that the applicant had engaged in inappropriate practice as defined in section 82 of the 1973 Act and directed that:

"(1) in accordance with paragraph 106U(1)(a) of the Act, Dr Hill be reprimanded by the Director, Professional Services Review, or the Director's nominee;

(2) in accordance with paragraph 106U(1)(b) of the Act, Dr Hill be counselled by the Director, Professional Services Review, or the Director's nominee; and

(3) in accordance with paragraph 106U(1)(h) of the Act, Dr Hill be fully disqualified for a period of 18 months from the time when this determination takes effect.”

Attached to the final determination was a statement of reasons.

Request for Review of Final Determination

32. By letter dated 7 February 2001 addressed to the Minister for Health and Aged Care, Goddard Elliott, Solicitors, sought on behalf of the applicant a review of the final determination made on 5 January 2001.

33. The request for review of the final determination was subsequently forwarded to the President of this Tribunal.

Relevant Legislative Provisions

34. Prior to the date of the Committee's report, the 1999 Act, to which some reference has already been made, came into operation. The amendments made by that Act to the 1973 Act included:

- A provision (see item 44 of Schedule 1) repealing section 106L (providing for the Committee to give to the Determining Officer a written report setting out its findings);
- A provision (see item 47 of Schedule 1) repealing section 106Q pursuant to which the respondent had been appointed as the Determining Officer and repealing section 106R (providing for a copy of the Committee's report to be given to the person under review), section 106S (providing for the making of a draft determination) and section 106T (providing for the making of a final determination);

- Provisions (see items 48, 49 and 53 of Schedule 1) amending section 106U (providing for the content of determinations).

However, item 65 of Schedule 1 to the 1999 Act (to which some reference has already been made) provides that the amendments made by that Schedule do not apply in respect of a matter that, before the commencement of the Schedule, was referred under section 86 of the 1973 Act by the Commission to the Director of Professional Services Review appointed under section 83 of the 1973 Act and that the 1973 Act as in force immediately before the commencement of Schedule 1 to the 1999 Act continues to apply in respect of any such matter. As previously mentioned, it was not contended by either party that the matter presently before the Tribunal is other than such a matter.

35. Part II of the 1973 Act deals with “Medicare Benefits”. Subsection 10(1) provides that where medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, Medicare benefit is payable in respect of that professional service. The expression “eligible person” includes (see section 3) an Australian resident, an expression which is itself defined in section 3. The expression “professional service” includes (see section 3) a service (other than a diagnostic imaging service as defined) to which an item in the General Medical Services Table prescribed under section 4 relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner. A “clinically relevant service” (see again section 3) is, so far as material for present purposes, a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

36. Part VAA creates a scheme under which a person’s conduct can be examined to ascertain whether inappropriate practice as defined in section 82 is involved and provides for action that can be taken in response to inappropriate practice (subsection 80(1)). In identifying the text of relevant sections within Part VAA of the Act, a number of amendments effected by the 1997 Act and the 1999 Act must be disregarded as those amendments do not apply to a matter, such as the present, which was referred under section 86 of the 1973 Act before the respective dates of commencement of those amending Acts. In what follows the provisions of the 1973

Act are stated in the form relevant to the resolution of the issues that arise in this review.

37. Section 82 provides that a practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Professional Services Review Committee could reasonably conclude that, if the practitioner is a specialist, the conduct would be unacceptable to the general body of the members of the specialty in which the practitioner was practising when he or she rendered or initiated the services. The expression "service" is defined in subsection 81(1) to include a service for which, at the time it was rendered or initiated, Medicare benefit was payable. Subsection 81(2) provides that, for the purpose of Part VAA, general medical practice is to be taken to be a specialty and medical practitioners practising in general medical practice are to be taken to be specialists in that specialty.

38. Under section 106L, if the person under review was a practitioner and a specialist when the referred services were rendered or initiated, the Committee is required to give to the Determining Officer a written report setting out its findings on whether the practitioner's conduct in connection with rendering or initiating the referred services was, in the Committee's opinion, unacceptable to the general body of the members of the specialty in which the practitioner was practising at that time.

39. If the Committee's report contains a finding that the person under review has engaged in inappropriate practice in connection with rendering or initiating some or all of the referred services, the Determining Officer must make a draft determination in accordance with section 106U and, after giving the practitioner an opportunity to make written submissions suggesting changes to the draft, make a final determination in accordance with that section (sections 106S and 106T).

40. Section 106U provides for the content of determinations. A determination must contain one or more of the prescribed directions. These include a reprimand, counselling, repayment to the Commonwealth of the whole or part of the Medicare benefit that was paid in respect of services "in connection with which the person under review is stated in a report under section 106L to have engaged in inappropriate practice" and disqualification wholly or partially. Under subsections 106U(3) and (4)

as amended by items 21 and 22 of Schedule 1 to the 1997 Act, a direction for partial or full disqualification (paragraphs 106U(1)(g) and 106U(1)(h)) must specify a period of disqualification of up to 3 years to start when the determination takes effect.

Role of the Tribunal

41. The role of the Tribunal (see section 116 of the 1973 Act) is to review the final determination dated 5 January 2001. By virtue of section 119 of that Act, the Tribunal is required to consider the matter to which the determination relates having regard to the grounds set out in the request dated 7 February 2001, the documents forwarded by the Minister with the request and any addresses made to the Tribunal during the proceedings on the review and, where the determination consists of a final determination under section 106T, to affirm or set aside the determination, or set aside the determination and make any other determination that the Determining Officer is empowered to make under that section. The Tribunal's role is not, however, confined to reviewing the appropriateness of the directions given by the Determining Officer under section 106U but extends to a review of the material that was before the Committee and the Committee's findings as set out in its report. In reviewing the material that was before the Committee, the Tribunal having no power to receive further material, it is incumbent upon the Tribunal to exclude from its consideration any material that was otherwise relevant to an aspect of the investigation that the Committee was empowered to conduct but in relation to which there was a denial by the Committee of procedural fairness to the applicant. The Tribunal is also bound, as was the Committee, to confine its review to matters that are the subject of the referral.

Analysis of the Material before the Tribunal

42. During the referral period the applicant rendered a total of 10,647 services to 1,086 patients at a cost in Medicare benefits of \$281,052.97. The Daily Items Report, one of the annexures to the referral document, shows that between January and August 1996 the items in Group A2 of Part 2 of the General Medical Services Table (comprising items 52-99) were the relevant items under which the applicant characterised the services she rendered by way of surgery and hospital consultations

and home visits. Between September and December 1996, the items in Group A1 of Part 2 of that table (items 1-51) were the relevant items for those services.

43. The services rendered by the applicant during the referral period may be summarised as follows:

Surgery consultations (items 23, 36, 44, 52, 53, 54, 57)	6,749
Home visits (items 24, 37, 47, 59, 60, 65, 97)	1,519
Hospital consultations (items 33, 89)	115
Skin sensitivity tests using 1-20 allergens (item 12000)	1,902
Skin sensitivity tests using more than 20 allergens (item 12003)	212
Prolonged professional attendance of 3 to 4 hours (item 162)	1
Other (items 12015, 16000, 16500, 30026, 50124)	149
Total	10,647

44. Some further details of the surgery consultations and home visits are shown in the following table:

	Brief or Level A	Standard or Level B	Long or Level C	Prolonged or Level D	Total
Item numbers	3,4,52,58	23,24,53,59	36,37,54,60	44,47,57,65, 97	-
Surgery Consultations	2	5,576	547	624	6,749
Home Visits	-	952	206	361	1,519
Total	2	6,528	753	985	8,268

45. 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 service 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.

46. 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 than 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.

Item 97: Emergency attendance after hours at a place other than consulting rooms.

47. A description of each of the other items referred to in the table in paragraph 43 is as follows:

Item 162: A prolonged professional attendance for a period of not less than 3 hours but less than 4 hours where the patient is in imminent danger of death, the patient is receiving continuous life-saving emergency treatment, the constant presence of the medical practitioner is necessary for the treatment to be maintained and the attention rendered in that period is to the exclusion of all other patients.

Item 12015: Epicutaneous patch testing.

Item 16000: Administration of a therapeutic dose of a radioisotope.

Item 16500: Antenatal attendance.

Item 30026: Repair of recent wound of skin and subcutaneous tissue or mucous membrane.

Item 50124: Aspiration of, or injection into, joint or other synovial cavity.

48. Another of the annexures to the referral document, referred to as the “Monthly Items Report – PIRT”, sets out, in relation to each of the 40 most frequently serviced of the applicant’s patients, the services 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) surgery consultations and home visits rendered to the top 10 patients (identified here only by their initials) during the referral period together with the number of hospital consultations and other services rendered by the applicant to those patients during that period:

Patient and Rating	Surgery Consultations			Home Visits			Hospital Consultations	Other	Total
	Standard or Level B	Long or Level C	Prolonged or Level D	Standard or Level B	Long or Level C	Prolonged or Level D			
1. E.J.S.	5	1	1	1	142	338	-	2	490
2. J.C.M.	232	18	4	-	-	-	-	-	254
3. C.H.McH.	25	111	9	-	1	-	-	1	147
4. E.L.M.	12	1	-	118	-	1	-	-	132
5. L.E.M.	11	1	-	112	-	-	-	-	124
6. J.E.S.	7	-	-	43	2	3	40	-	95
7. A.M.M.	94	1	-	-	-	-	-	-	95
8. I.D.J.	2	5	1	71	11	4	-	-	94
9. T.I.S.	3	-	-	73	1	1	8	1	87
10. K.M.S.	8	3	1	65	2	-	6	2	87
TOTALS	399	141	16	483	159	347	54	6	1,605

49. Thus, the applicant rendered to 10 patients during the referral period 556 surgery consultations and 989 home visits making a total of 1,605 services.

50. The Top 40 Multiple Servicing Report, also annexed to the referral document, shows the number of services rendered by the applicant during the referral period to various patients or groups of patients ranked from 1 to 40 in descending order of multiple services rendered. It is sufficient for present purposes to refer to the groups of patients ranked 1, 2, 3 and 4. The Committee concluded that the patients ranked 4 formed part of the family group ranked 1 and included in the report a composite statement of the services rendered to those ranked 1 and 4. This family group is here referred to as the S. family. We refer to the group ranked 2 as the M. family and the group ranked 3 as the R. family.

51. The S. family consisted of 8 members to whom the applicant rendered 1,102 services, of which all but 141 services were home visits, at a cost in Medicare benefits of \$50,506.65. As appears from the table in paragraph 48 of these reasons, the applicant rendered to E.J.S. a member of that family, 481 home visits (1 Standard or Level B, 142 Long or Level C and 338 Prolonged or Level D). As the Committee observed, there were only 6 of the days in the referral period when the patient was visited by the applicant that she did not receive a Prolonged or Level D home visit. On 146 days the applicant rendered two services to the patient, the two services being, in the main, a Long or Level C and a Prolonged or Level D home visit. The Committee also observed that on most occasions that the applicant attended E.J.S., she also attended one or more of the other 7 members of the family group. Those 7 members, identified only by their initials, and the number of services they received are shown in the following table:

Name	Services
E.L.M.	132
L.E.M.	124
J.E.S.	95
T.I.S.	87
K.M.S.	87
K.B.S.	64
T.K.S.	23
TOTAL	612

52. The Committee's report contains the following paragraph (par. 102):

"The Committee notes that almost all of the services rendered by Dr Hill to the S family were provided at the S home. During the 366 days of the Referral Period, Dr Hill rendered home visits to one or more of the S family on 346 days. Ms E.J.S. was seen by Dr Hill on 342 of those days. Dr Hill did not render services to any member of the family on only 17 days, including a ten-day period from 27 September 1996 to 6 October 1996. The Committee notes that this period fell during the end of third term school holiday period in Victoria which in 1996 went from 21 September to 6 October".

53. There were 8 members in the M. family to whom the applicant rendered 456 services at a cost in Medicare benefits of \$9,176.90. As appears from the table in paragraph 48 of these reasons, the applicant rendered to J.C.M., a member of that family, 254 of those services, all surgery consultations, predominantly Standard or Level B.

54. The R. family consisted of only 2 members. To them the applicant rendered 125 services at a cost in Medicare benefits of \$3,363.70.

55. The services provided by the applicant to the three family groups mentioned accounted for over 22% of the Medicare benefits paid in respect of services rendered by the applicant during the referral period. Out of the total Medicare benefits paid in respect of services rendered in the referral period of \$281,052.97, the benefits paid in respect of services to the three families mentioned totalled \$63,047.25 (see the Committee's report, par. 126).

56. Having received a copy of the referral document and its annexures and having given consideration to their contents, the applicant, as has previously been mentioned, furnished a lengthy submission to the Director of Professional Services Review stating why the Director should dismiss the referral without setting up a Committee. In that submission the applicant made reference to what she regarded as particular features of her practice in the following terms:

“For fourteen years I have been a medical practitioner in a private primary-care allergy unit. I have been in private medical practice for over 30 years and during this time have gained extensive experience in primary medical care. I am a Fellow of the Australasian College of Nutritional and Environmental Medicine and am also a member of the Australian Society of Environmental Medicine. I obtained my Fellowship of the Royal Australian College of General Practitioners eight years after qualifying as a medical practitioner in 1964. Patients are referred to my practice by general practitioners or other medical personnel, or they contact the practice directly for an appointment. I provide a broad range of high quality allergy patient care. A very small proportion of my practice is made up of general practice patients, most of whom I have treated for many years. To some of these patients, as well as to some patients suffering from serious and on-going allergy-related conditions, I provide high quality management of chronic illness which necessitates spending significantly longer time with individual patients. I retain an interest in obstetrics and some patients return to me for family medicine problems, however, this constitutes a small proportion of the total services rendered by me. My patients are my first priority and I provide to them scientifically sound up-to-date high quality clinical care relevant to their condition, and I

strongly deny and resent the assertion that my care for my patients is in fact ‘inappropriate practice’.

....

Patients in the allergy component of my practice fall broadly into two categories:

1. Those with straightforward allergy problems, such as allergic rhinitis, dermatitis or angioedema, etc. Depending on the presenting symptoms, these patients may need to undergo allergy testing. The results of the testing performed indicate the need for further treatment, which may include a series of desensitising injections. Just as it is recognised that psychiatric patients may need weekly therapy and, therefore, Psychiatrists average a greater number of services per patient per year than do general practitioners, the Commission needs to recognise that patients presenting with allergic symptoms need to undergo a course of testing and treatment that involves more services per patient per year than an average general practice patient.
2. Those with complex and/or chronic illnesses. These patients do not form the majority of my total number of patients, but for obvious reasons require far more investigations and services per patient than does an average general practice patient. Because of the number of services per patient that is required for high quality care of people with these illnesses, even a small number of patients can heavily skew aggregate statistics”

57. Having made those assertions, one would have expected the applicant to speak knowledgeably to the Committee about the medical conditions with which patients presented to her, the examination and tests she performed, the diagnosis she reached, the treatment she prescribed and the clinical necessity for that treatment to be rendered for the appropriate care of the patient. One would also have expected that the applicant would have presented to the Committee material justifying her conduct in the case of identified patients. Nothing of the kind, however, occurred. On the contrary, the applicant deliberately avoided giving any material to the Committee that would assist it in reaching a determination. Scarcely a single direct, meaningful or responsive answer was made to the questions asked of her by members of the Committee. So much is clear from a study of the transcript record of the proceedings

before the Committee. The Committee, of course, had the added advantage of observing the applicant's approach to the investigation which the Committee was charged with undertaking and to her demeanour in dealing with the questions put to her.

Consideration of the Issues

58. We are in no doubt that the applicant and her daughter embarked on an orchestrated programme of obfuscation and obstruction designed to ensure that the Committee was denied access not only to the medical records of any patient but also to any material whatsoever relating to any patient's medical condition or treatment. That scenario, studiously followed by the applicant in the proceedings before the Committee, provided the foundation for the primary submission put to the Tribunal by counsel for the applicant that the material set out in the referral document and its annexures and such other material as was before the Committee was not sufficient to justify the conclusion reached by the Committee that the applicant had engaged in inappropriate practice in relation to some of the services the subject of the referral. Indeed, counsel went so far as to submit that, in the absence of any clinical records, there was no material before the Committee, and, therefore, no material before this Tribunal, which would support a finding of inappropriate practice on the part of the applicant.

59. We do not agree. There was, in our opinion, ample evidence before the Committee to justify the conclusion it reached. Earlier in these reasons we have referred to material concerning the services rendered to the 10 most frequently serviced of the applicant's patients and to the services rendered to the S., M. and R. families (with particular reference to the services rendered to the patients E.J.S. and J.C.M.). The number, nature and frequency of the services rendered to those patients was extraordinary and such that the members of the Committee, all very experienced general practitioners, could conceive of no medical condition or conditions that would justify the levels of servicing of those patients. The situation was such that, in the absence of any explanation of the circumstances in which the applicant may have considered the pattern of servicing to be appropriate or any attempt by her to justify

the clinical necessity for the services or any of them, the case against the applicant was overwhelming.

60. Counsel for the applicant also submitted that it was not appropriate for the Committee to find that the situation in relation to the applicant's clinical records would be unacceptable to medical practitioners generally (see paragraph 24 of these reasons). This was, so it was submitted, because the Committee had not made a finding of fact which of the three possibilities postulated by the Committee as being the only possible explanations for the absence of any clinical records being produced to it correctly reflected the situation. We regard this submission is unsustainable.

61. Astounding as it may seem, counsel for the applicant seriously contended that the Committee, in the exercise of its powers under sections 105A and 106B of the 1973 Act, could have required the hospital or hospitals to which some of the applicant's patients had been admitted during the referral period to produce relevant hospital records of those patients. Counsel asserted that the Committee would have known that "some patients had been referred to hospitals" because the applicant had given evidence to that effect. Asked to identify that evidence, counsel could refer the Tribunal only to the following exchange in the course of the proceedings before the Committee on the last day of the hearing, 21 September 1999:

“DR EDWARDS: Dr Hill, you mentioned that you referred patients to hospital.

DR HILL: Yes.

DR EDWARDS: Which hospitals did you refer patients to in 1996?

DR HILL: I do not have the details, but if I can list the hospitals that I generally refer to, then it is possible that any of them – the Royal Melbourne, the Alfred, Monash Medical, St Vincent's, Box Hill, William Angliss, Maroondah.

DR EDWARDS: Just to be more specific, which hospitals do you admit to for which you bill the patients yourself?

DR HILL: Any of the private hospitals in the area.

DR EDWARDS: And could you just run through the names of those ones for me, please?

DR HILL: AMS would bill for any services that I saw the patients in Knox Private, Mitcham, Ringwood Private and this is from recall and I am not saying that I have had patients in any of them in the referral period. Lilydale, Warburton. I cannot think of any more offhand.”

62. There is nothing in the transcript record of the proceedings before the Committee to suggest that the applicant had herself made any attempt to obtain hospital records to assist her recollection of the medical condition or treatment of any of her patients. She did not suggest that the Committee would be assisted by obtaining such records, and she did not provide the Committee with the necessary detail to enable it to do so.

63. We regard this contention as quite unrealistic. The applicant gave no evidence to the Committee identifying any patient whom she had admitted to hospital, the name of the hospital concerned, the date of admission or the medical condition that required hospitalisation. The most that the Committee could have discerned from the material before it was that the applicant had rendered hospital consultations (items 33 and 89) to a limited number of patients. In any event, the absence of any hospital records could have no bearing on the Committee’s findings in relation to patients, including E.J.S. and J.C.M., who were not hospitalised during the referral period.

64. A further submission by counsel for the applicant was that a number of adverse conclusions had been drawn by the Committee in relation to the applicant without those matters being put to her during the course of the hearing. We consider that there is no substance in this submission. Further, we are unable to accept the submission made on behalf of the applicant that the Committee “trespassed outside the terms of reference and thus exceeded its jurisdiction by including prejudicial remarks on matters outside the terms of the referral”.

65. Counsel for the applicant also contended that the Committee’s report was flawed because it failed to deal with the criticisms made by the applicant, particularly in the submission made by her to the Director of Professional Services Review, of the statistical material contained in the referral document and its annexures. The focus of that criticism, as we understand it, was that it was inappropriate for the Commission

to compare the applicant's practice profile with that of the general body of general practitioners in Australia or that of the general body of vocationally registered general practitioners in Australia, the applicant contending that her practice during the referral period was not comparable to that of those with whose practice profile her profile had been compared.

66. The short answer to this submission is that the Committee's conclusion that the applicant had engaged in inappropriate practice was not dependent upon any such comparison as that which the applicant criticised. The Committee's conclusion was based on the number, nature and frequency of the services rendered to the patients whom the Committee identified in its report. No challenge was ever made by the applicant to the correctness of the relevant material as contained in the referral document and, particularly, in its annexures.

67. In the result we have reached the firm conclusion that the applicant's conduct in connection with rendering some of the services the subject of the referral amounted to inappropriate practice within the meaning of that expression as defined in subsection 82(1) of the 1973 Act. We are, of course, unable, on the available material, to relate that conclusion to particular services rendered to identified patients other than those identified by the Committee in its report or to a specific proportion of the total number of services rendered by the applicant during the referral period. As von Doussa J explained in Retnaraja v Morauta (1999) 93 FCR 397 at pp.410-412, it is not necessary to do so: it is sufficient if the ultimate conclusion that a practitioner has engaged in inappropriate practice relates the conduct constituting the inappropriate practice to a finding that some of the services referred would be unacceptable to the general body of members of the specialty in which the practitioner was practising at the relevant time. Beaumont J took a similar approach in Adams v Yung (1998) 83 FCR 248 at pp.283-4 and the decision in Tankey v Adams [1999] FCA 683 and, on appeal, (2000) 104 FCR 152 is consistent with that view.

68. It remains to consider the appropriateness of the directions set out in the final determination dated 5 January 2001. Those directions are set out in paragraph 31 of these reasons.

69. The findings that have been made of inappropriate practice reflect very serious concerns as to the conduct of the applicant in carrying on her practice. The applicant has given no indication of a willingness to change her method of practice so as to accord more closely with what would be acceptable to the general body of general practitioners. Nothing that has been put to the Tribunal convinces us that we should vary the directions given by the respondent.

Conclusion

70. For the reasons set out above, the final determination made by the respondent on 5 January 2001 is affirmed.

Counsel for the applicant:	Mr M. Crennan and Ms K. Anderson
Solicitors for the applicant:	Goddard Elliott
Counsel for the respondent:	Mr N. Green Q.C. and Ms F. McLeod
Solicitors for the respondent:	Minter Ellison
Dates of hearing:	5 and 6 April 2001
Place of hearing:	Melbourne
Date of decision:	3 July 2001

This and the preceding 29 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 3rd day of July 2001.
DATED this 3rd day of July 2001.

.....
 Registrar