

PROFESSIONAL SERVICES

No. 3 of 1997

REVIEW TRIBUNAL

Between: **Dr. Thuryrajah Retnaraja**  
Applicant

and:

**Louise Helen Margaret  
Morauta**

Respondent

Tribunal: The Hon. Mrs Margaret Lusink, President  
Dr. Peter Joseph, Member  
Professor Priscilla Kincaid-Smith, Member

Dates of Hearing: 18 November 1997  
19 November 1997

Date of Decision: 3 September 1998

### Decision

The Final Determination made herein by the Respondent the 11 August 1997 is affirmed.

Margaret Lusink (sgd)  
(Margaret Lusink)  
(President)

**1. Proceedings**

On 29 March 1996 the Health Insurance Commission ("HIC") pursuant to its powers under s.86 of the Health Insurance Act 1973 ("the Act") referred the conduct of Dr Thuryrajah Retnaraja to the Director of the Professional Services Review ("DPSR"). The Director, following the legislative guidelines, convened a Committee which, after a hearing, made a finding that Dr. Retnaraja had engaged in inappropriate practice as defined in s.82(1) of the Act. A final determination was made by the Determining Officer, and on 26 August 1997 a Request for Review of that determination was sent to the Minister by the solicitor for the applicant. The review took place in Adelaide on 18 and 19 November 1997.

It is a matter of regret that almost two and a half years since the date of the referral by the HIC. The explanation is a long delay between the Committee report and the Final Determination, the introduction of the Health Insurance Amendment Act (No.1) 1997, a decision of Davies J in the Federal Court of Australia on 11 December 1997 in Yung's case (NG 705 of 1996) and the decision on appeal on 15 May 1998 of the Full Federal Court (NG 11 of 1998). At the conclusion of the hearing of the review, written argument was provided on the amendments to the Act. Further submissions on the effect of the Federal Court judgments were finalised on 11 August 1998.

**2. Historical Background**

Dr Retnaraja is aged 66. He is married with three sons two of whom are medical students. He is a vocationally registered medical practitioner who graduated in Singapore in 1958. He practised in Malaysia for about the next thirty years, both for the

Government and in private practice. In 1976 he was registered by the Medical Board of South Australia and two years later obtained registration with the General Medical Council in London. He came to Australia permanently in 1990 where he commenced practice at Roxby Downs later attending Modbury Hospital and the Queen Victoria Hospital. In 1991 he was employed at Munno Para, Elizabeth in South Australia, by the All Care Medical Group and the following year he opened his present sole general medical practice at Craigmare, a suburb about 27 kms north of Adelaide.

Dr Retnaraja first came to the attention of the HIC during the year 1993 showing patient services at 5774. In March 1995 he received a letter from Dr Ross Williams the HIC medical adviser which set out certain concerns of the Commission relating to his practising profile. The doctor sought legal advice and subsequently there was correspondence between his solicitors and the HIC. On 4 September 1995 Dr Retnaraja was told that a recommendation would be made that his case be referred to the Director of the Professional Services Review (DPSR). This referral was made on 29 March 1996 and a committee was set up a month later.

### **3. The Referral**

The referral to the DPSR on 29 March 1996 designated the referral period as being from 1 July 1994 to 30 June 1995 and related to:

*".....all Medicare services rendered by Dr Retnaraja from his practice location in the State of South Australia."*

The reasons for the referral are encapsulated in paragraph 3 which reads:

*"3. The HIC is concerned that Dr Retnaraja has provided an inappropriate high average number of services per patient. The proportion of long consultations in respect of total services rendered is also of concern. In addition the HIC is concerned that the high level of home visits and multiple servicing may be inappropriate for the care of these patients."*

The concerns fell into four categories:

- (i) the high average number of services per patient
- (ii) the high proportion of long consultations
- (iii) the high number and rate of home visits
- (iv) the high number of multiple services

The HIC believed that some of the services, some of the long consultations and some of the home visits "would not be reasonably medically necessary for the care of his patients" and with regard to the multiple services it noted "that some of the services rendered to members of the same family on the same day may not be reasonably medically necessary for the care of these patients."

The referral then set out the matters which the HIC had taken into account in forming a view about the "appropriateness of Dr Retnaraja's practice." These included the average servicing patterns of all general practitioners in Australia, the findings of the Interpractice Comparison Survey conducted by the Royal Australia College of General Practitioners, the findings of the survey, Morbidity and Treatment in General Practice in Australia, the requirements of section 3 of the Act in respect of clinical relevance, and the written opinion of Dr Fiona Joske a consultant to the HIC.

Paragraph 9 concluded the referral with these words:

*"For these reasons the Health Insurance Commission has formed the view that Dr Retnaraja's conduct in connection with the rendering of Medicare services constitutes inappropriate practice."*

#### **4. The Final Determination and Grounds of Review**

The hearing by PSR Committee No 10 took place on 4 June and 26 June 1996 and their report provided on 22 October 1996 concluded with a finding that the conduct of Dr Retnaraja was unacceptable to the general body of medical practitioners practising in general medicine in Australia. The final determination made as a result of this finding, and upon which this review was sought, was dated 11 August 1997. It reads as follows:

*"..(i) in accordance with paragraph 106U(1)(b) of the Act Dr Retnaraja be counselled by the Director, Professional Services Review or the Director's nominee;*

*(ii) in accordance with paragraph 106U(1)(c) of the Act, Dr Retnaraja repay to the Commonwealth the amount of \$55,115.90 being an amount equivalent to the Medicare benefits paid for 35% of the inappropriate services rendered during the period of the referral under items 23, 24, 36 and 37 in Group A1 of Part 2 of the General Medical Services Table.*

*(iii) in accordance with subparagraph 106U(1)(g)(i) of the Act, Dr Retnaraja be disqualified for a period of 6 months from the time when the final 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 Retnaraja be fully disqualified for a period of 2 months from the time when the final determination takes effect.*

The grounds upon which the Request for Review of this determination were based were set out at length and attached to the letter sent to the Minister 26 August 1998. They are dealt with in detail later, but briefly they alleged that the determination was in error being based as it was on a flawed finding of inappropriate practice by the Committee. On behalf of the doctor it was said that there was a failure to identify or specify particular patients and their treatment, consider details about the practitioner's conduct, records, and medical judgment, and there was a lack of understanding of his unique patient profile and difficulties. It was further alleged that the Committee failed to identify or give adequate weight to the medical necessity for home visits and multiple services. It was suggested that the Committee had not complied with the rules of natural justice and the final determination by the Determining Officer was manifestly excessive and not justified on the material available. Finally, the allegation was that the "broad brush" approach which was adopted was "wrong in law and contrary to the provisions of the Act."

## **5. The Medical Practice at Craigmore**

### **(i) Profile of the Practice**

The Doctor told the Committee that he worked from 9 am until "7, 8 or 9 or however long it takes" seven days a week and had only had two weeks holiday since 1992. He has little if any contact with his peers, practises as an isolated sole practitioner, and does not

belong to any medical college or professional association. He does minimal medical reading and has not been involved in any postgraduate work.

It is unfortunate that when the doctor first came to Australia his introduction to the practice of medicine was in a 24 hour clinic. He subsequently worked as a locum in which it is alleged many home visits were conducted, and the use of parental pethidine was common. Against this background, it is perhaps not surprising, but it is unfortunate, that when he set up his practice at Craigmore, he had very little understanding of the Medicare system, billing and the obligations of medical practitioners participating in the scheme.

Dr Retnaraja told the Committee that when he commenced independent practice he saw a "niche market" for home visits, especially as his patients were largely disadvantaged, both socially and economically, and had little transport. He stated that his patients had more complex medical conditions than average and they came to him because of their dissatisfaction with management plans at other surgeries.

The practice was identified as having a relatively small number of families who attracted almost 50% of the doctor's services. There was a pattern of pethidine addiction with consequent demand for services -

Patient numbers and services were disclosed as:

Patient base	678	-	25 percentile of all active practitioners average patient base - 1202
Services	5513	-	8.13 services per patient -

above 99 percentile of all  
active general practitioners.

Home visits	1602	-	30% of all consultations
Multiple services	173	-	doubles
	61	-	triples
	28	-	quadruples

(ii) The Environment

The Committee in its excellent report has set out the physical environment of the practice at Craigmore which is a suburb of approximately 32,000 with no significant ethnic bias. The surgery consists of one consulting room which includes facilities for examinations, a reception room and a waiting area. As described to the Committee the facilities are rather basic with no provision for sterilisation of instruments. Dr Retnaraja performs a few surgical procedures on the premises.

(iii) The Administration

(a) The staff:

When Dr Retnaraja was in practice at All Care Medical Centre, prior to opening his own surgery, he had a patient, a Mrs P., who was an admitted pethidine addict. She had had experience as a medical receptionist and when Dr Retnaraja was leaving he asked her to come with him as his practice manager. This she did, remaining in the doctor's employ until 1995.

During the referral period Mrs P's family was the highest serviced of Dr Retnaraja's patients receiving in total 833 services, of which Medicare was billed for 612 on her behalf. This number was partially accounted for by two authorised pethidine injections per day. Her working conditions were very flexible, as it was conceded that there were occasions when her capacity to work was affected by her health. Originally she worked as the practice manager with a staff of three, did the staff training and was sometimes assisted by the doctor's wife who was described as her understudy.

Description of the day to day administration was vague. It is fair to say organisation was minimal and staff varied. What is clear is that of two other casual staff, one, who is the sister of Mrs P suffered from alcoholism and migraines and on occasions had to be sent home because of the smell of alcohol on her breath. Medicare was billed for 29 services to this lady, 19 of which were home visits. The family of a second part-time receptionist is noted as having been ranked 4 in the HIC data of the most frequently serviced families (the list is ranked in decreasing order of multiple services) and received 150 services in the referral period of which Mrs H the receptionist, personally accounted for 132. Upon hearing her history of multiple medical conditions and her treatment under a psychiatrist for pain relief, Mrs H was described by a member of the Committee as an "absolute disaster". The practice is now staffed by two part-time casual receptionists.

(b) The billing:

The billing of Medicare was "bulk" billing save for one patient who was an exchange student from America.

The Committee asked the doctor extensive questions about how the practice was administered, how the levels of service were estimated and how the appropriate fee was

arrived at in relation to the service received. The applicant agreed that during the referral period the billing system was largely in the hands of the staff who had a system of "buzzing" at five minute intervals during consultations. He said that he differentiated between short or long consultations "by what the receptionist tells me." Dr Retnaraja told the Committee that he has now taken over the whole financial management of the practice. The Committee concluded that the doctor had a complete lack of understanding of the concept of the various types of consultations, and that he did not appreciate the Medicare schedule or the relevance of particular levels of service to particular types of treatment. These conclusions were validated by a perusal of the billing pattern which disclosed:

- \* no "A" or "D" consultations the Committee expressed surprise that no level "A" consultations were recorded particularly in view of multiple injection services
- \* level "B" most common
- \* level "C" 1345 services - a higher number than 90 percentile of active general practitioners

Dr Retnaraja received from Medicare during the referral period \$159,330.25 for the 5513 services given to 678 patients. This is at the level of billing of 75 percentile of active general practitioners. The Committee found that despite having a patient base which was approximately half the size of the average patient base for practitioners at the 25th percentile of all active general practitioners, Dr Retnaraja's Medicare billing was equivalent to the 75th percentile for active general practitioners.

The Committee concluded that despite the applicant's explanation that his patients mainly suffered from multiple psychological and social problems, and therefore required extended visits, his billing was unacceptable in that he lacked understanding of the Medicare Benefits Schedule, he was unable to explain his role in verifying accounts and his method of completing Medicare vouchers for home visits was unsatisfactory.

## **6. The Committee Hearing**

As an administrative tribunal the approach to be taken on review is limited and must not be treated as a judicial review. However, as stated by Davies J in *McIntosh v Minister for Health* (1986) 17 FCR 463 the Tribunal does have an obligation to determine whether or not to accept the recommendation of the Committee. Our role has been set out by President A.R. Neaves in *Sabag v Morauta* PSRT No. 4 of 1997, 19.6 1998 at page 16 where it is made clear that a tribunal, whilst unable to set aside a decision of a Committee if it decides that the conduct of the proceedings were infected with legal error, must exclude from its consideration any material which may otherwise be relevant, if there has been a denial of procedural fairness.

It is therefore necessary for a tribunal to look to the conduct of the proceedings by the Committee as despite the limitation on its powers, a decision could not be made against

a practitioner on review of a final determination based on a Committee finding, unless it was satisfied that the Committee hearing was procedurally fair.

The majority judgment in *Adams v Yung* on appeal in the Full Federal Court at p.20 approved the comments of Davies J in *McIntosh v Minister for Health* (1986) 17 FCR 463 where his Honour said that tribunals had an obligation to determine whether or not to accept the recommendation made by the Committee.

If it is to fulfil this task it is incumbent upon a tribunal to first ascertain that the proceedings were fair, and then ask a number of questions including:

- \* did the Committee stay within the terms of the referral?
- \* were the concerns of the HIC expressed in the referral dealt with by the Committee in its report?
- \* did the Committee follow a valid sampling procedure, either formally or informally, but in either event, sufficient for it to conduct a "useful sample analysis? (see majority judgment *Yung's case* NG 11 of 1998.)
- \* did the Committee having looked at an acceptable sample of services, examine the practitioner's conduct in respect of those services?
- \* did the Committee state clearly the findings of inappropriate practice which it made?

(i) Were the proceedings fair?

(a) Notice

On 1 March 1995 a letter was sent to Dr Retnaraja by Dr A.R. Williams, a Medical Adviser to the HIC stating that the Commission was concerned about a rate of re-servicing of patients, a high figure for benefits per patient and "data which reflects an extraordinary rate of family servicing in a number of instances."

It was suggested that a meeting should take place. The doctor consulted his solicitor and after correspondence, a meeting was held on 11 April 1995. Dr Williams on 24 April, forwarded a written record of that interview to Dr Retnaraja. The record shows that the applicant was fully informed of the concerns of the HIC. These included services to patients which were higher than usual, the number of long consultations, and levels of servicing including levels of re-servicing. The doctor was told further that his conduct would be unlikely to be supported on peer review.

On 9 June 1995 Dr Retnaraja, whilst not conceding that it was necessary to do so, through his solicitor, agreed to "implement changes to seek to meet areas of the Health Insurance Commission's concerns without prejudicing patient care." The applicant was told that a practice profile would be obtained and then consideration given by the HIC as to whether Dr Retnaraja should be referred to the DPSR. On 4 September 1995 the doctor was advised that there was insufficient change in the pattern of practise and the matter would be being referred to the DPSR.

On 15 May 1996 the PSR sent a Notice of Hearing to the applicant advising that the hearing had been fixed before PSR Committee 10 on 4 June 1996. Attached were two schedules, one setting out documents to be produced and the other briefly setting out the

referral period and the fact that the referral concerned whether there had been inappropriate conduct in the rendering of Medicare services. On 24 May the applicant requested a postponement which apparently was not granted.

Apart from notices given to the applicant during a visit by Dr Williams, counselling, and at preliminary meetings prior to the referral, it is necessary to examine the conduct of the hearing by the Committee to determine whether the proceedings were fair, that the doctor was made aware at all times of the allegations made that he understood those allegations, the possible ramifications of adverse findings, and most importantly that he was given an opportunity to answer what was put to him.

(b) The Hearing

The hearing commenced with an opening statement by the Chairman which could leave the applicant in no doubt as to the procedure, the scope of the hearing and the possible result of an adverse finding. The Chairman and the two members were courteous, considerate and patient, understanding and making allowances for Dr Retnaraja who they recognised was doubly disadvantaged by the stress of an investigation by his peers in a language which was not his first language. Towards the end of the first day the Chairman made a long and careful statement, going through again the four main matters of concern which led to the referral, saying that a second hearing day would be required and asking Dr Retnaraja to provide any further written material which he would like the Committee to consider on the resumed hearing. He was also requested to produce evidence concerning his recent alleged changed practice conduct. He was told what further evidence the Committee would be seeking.

On the resumed hearing a written submission sent by Dr Retnaraja to the Committee in the interim was considered. It is clear from that document that the doctor fully

understood the matters which were of special worry to the Committee, and he answered those concerns in detail. In his summing up at the conclusion of the hearing on the final day, Dr Rice, the Chairman replied to all the practitioner's arguments and left no doubt as to the views of the Committee. The doctor was then told that he had a further 10 days to submit any further matters for consideration.

Counsel for the applicant argued that his client had been denied procedural fairness by the Committee. A number of conclusions drawn by the Committee in relation to individual patients were stated to be unfair because the committee had failed to give to the applicant specific details of their reasoning leading to those conclusions.

In *Minister for Health v Thomson* (1985) 8 FCR 213 Beaumont J with whom Wilcox J agreed, had this to say at p.224:

*"The submission of the respondent is tantamount to saying that the rules of natural justice insist that the Committee should not proceed to a conclusion until it had first shown a draft of its report to the respondent and invited his comments thereon. In my opinion, the application of notions of fairness in the present circumstances does not require such an extreme step..."*

Further examples of alleged procedural unfairness were led on behalf of Dr Retnaraja. These included the examination by the Committee of clinical notes for two families and three individuals and the conclusions arrived at, and an alleged failure by the Committee to descend to sufficient detail to permit identification in a justifiable way of a number of relevant services.

We are of the opinion that the Committee did everything possible to ensure that the proceedings were conducted in a fair manner. The Members were well aware of the

apparent intimidatory nature of such a peer review, and commented upon it. All demonstrated a genuine understanding of Dr Retnaraja's position. They were prepared to extend the scope of the investigation and invited the doctor to bring more patient records when it was found that the records before them related very largely to patients being treated for chronic pain.

He was invited to nominate any patients "...that you feel we would gain something from studying in more depth..." The applicant did not take the opportunity to widen the sample. Whilst his counsel felt that more consideration should have been given to the trauma to the doctor caused by fraud charges against him which were subsequently dropped, we believe the matter was dealt with appropriately by the Committee. We would accept the submission of Counsel for the Determining Officer that the proceedings at the Committee stage were fair, adequate notice was given and the doctor had every opportunity to answer all matters raised.

(ii) Did the Committee Stay Within the Terms of the Referral?

Burchett and Hill JJ in the majority judgment in Adams and Yung.....looked at the status of a referral and said at p.15

*"...a referral is not merely the instrument which initiates the series of administrative inquiries which*

(in the present case were undertaken)

*It also provides the framework in which those inquiries are to be held..."*

Their Honours on the following page spelt out the function of the Committee saying:

*The function of the Committee therefore, and the hearing it is required to undertake on the evidence given and the documents produced is limited to considering the matters that are the subject of the referral s. 101(2). The Committee's report is confined to the referred services and the practitioner's conduct in relation with them s.106L(1)(a)*

The specific concerns of the HIC in the referral were dealt with in detail in the Committee's report. They concluded:

A High average number of services per patient:

Dr Retnaraja believed that his complex patient profile was responsible for the large number of services per patient. The Committee did not accept that saying that Dr Retnaraja appeared to believe that an authority for narcotic administration superseded the need to exercise clinical judgment. In support of this and other conclusions reached, the Committee referred to clinical notes, and to a total of 873 services.

B High proportion of long consultations:

1,345 consultations, being 24.8% of his total consultations were billed as level C consultations. The Committee concluded that time alone was the sole determinant of the level of consultation. The Committee believed that many of the items were mis-categorised leading to financial benefit to the practitioner. They believed that some on-going minor services should have been more appropriately billed as level A items.

C High number and rate of home visits:

The Committee were worried that despite a practice based on so few patients 1602 home visits were claimed. The doctor's explanation of socio-economic disadvantaged patients was not accepted. The Committee substantiated their conclusion with several examples including visits to one family six times on Christmas Day during the referral period Medicare not only being billed for the consultations as a long visit but each consultation also including the travelling time component.

D High number of multiple services:

Multiple services were charged on 796 occasions. The Committee considered that many of these were opportunistic and medically unnecessary.

On page 12 of the Committee's report, "Other Problems in the Practice" were considered. These included staffing issues, billing procedures, lack of a narcotic drug register, medical records, clinical acumen and prescribing habits. Whilst it was argued that these were matters outside the ambit of the referral in the particular circumstances of this case they were closely related to, and inseparable from the concerns expressed.

For the applicant it was argued that the Committee took into account matters outside the referral which could not be related to inappropriate practice in relation to specified services. It was alleged that some issues were included that should not have been, or were excluded when relevant. These were the fraud charges against Dr Retnaraja and his wife, questions relating to management plans, inadequate records, the fact that Dr Retnaraja believed that time alone was the determinant of the level of the consultation and that the doctor was reluctant to use consultation by telephone. We do not agree that the Committee dealt inappropriately with any of these issues.

A new argument relating to the Committee's obligation to keep within the terms of the referral was introduced in the last written submission of the applicant. It reads:

*"3.4 The applicant further submits that as the Referral for the purposes of section 87(1) of the Act related to all Medicare services rendered by Dr Retnaraja from his practice location (Springvale Medical Centre Cnr Zurich and California Roads, Craigmore, South Australia) in the State of South Australia between 1 July 1994 to 30 June 1995, the consideration by the Committee of the home visits was outside the scope of the Referral being services rendered at the residences of the patients and not services being rendered from his practice location (Vol 3 p 241 and Vol 1 p 34.)"*

The reply of the Determining Officer is as follows:

*"The Determining Officer submits that this includes services rendered on home visits while practising from that location. Dr Retnaraja only had one practice location and it was the provider number for his practice at that location which he used when he billed all Medicare services included in the Referral, including home visits. These home visits were clearly services rendered from that practice location.*

*2. That the Referral was intended to allow the Committee to consider Dr Retnaraja's home visits is confirmed by the third reason to refer Dr Retnaraja set out in the Referral at Volume 3 page 242, under the heading "High Number and Rate of Home Visits."*

The Tribunal prefers and accepts the reasoning and conclusion of the Determining Officer.

(iii) Did the Committee follow the Correct Procedures Sufficient for it to Conduct a "Useful Sample Analysis"?

The question of sampling was one of the most difficult and contentious matters attempted to be remedied by the original amendments. The problems associated with the previous scheme based on excessive servicing, proved ineffective because of the impracticability of examining all services. The PSR Scheme adopted the approach that Committees were to consider the conduct of persons under review and to reach findings on that conduct rather than the appropriateness or otherwise of individual services. One of the flaws in the amendment has been the difficulty of application of a concept where the recouping of moneys for the Government aligned with inappropriate clinical and professional behaviour.

Another inherent fault has been a lack of definition as at what point servicing stops being good patient care and becomes inappropriate. In what has turned out to be an abortive effort to deal with the latter, sampling according to a prescribed legislative process was an option in which a Committee could indulge if it chose (see s.106H(1)).

*"the Committee may base its findings wholly or partly wholly or partly on its findings on his or her conduct in connection with a sample of those services.*

The legislative provisions for sampling were repealed in the November 1997 amendments having been found to be unworkable. The submission of Dr Retnaraja received on 20 July 1998 in paragraph 2.2 reads:

*"2.2 In relation to 2.1.3(b)*

(which referred to the medical records for 30 home visits and 30 level C consultations among the evidence on which the Committee in its report based its findings)

*the Committee in its report stated the records were examined only to obtain a "snapshot" of the practice and was not a formal sampling process referred to in section 106H of the Act."*

This was a misconception of the position.

"Snapshot" literally means (OED) "rapid casual photograph, taken with small hand camera." Whilst it was suggested for the applicant that the word as used conveyed the impression that the Committee took a quick or cursory look at the practice, the transcript demonstrates that this was not so. The investigation was thorough and detailed. Sampling according to the legislative provisions was never mandatory.

On behalf of the applicant it was argued that the Act does not permit a "broad brush approach (unless sufficiently and properly capable of quantification)". It was said that the Committee failed in its procedure to descend to sufficient detail to permit identification in a justifiable way of the number, or proportion, of the relevant services rendered by the applicant that constituted "inappropriate practice." The report was alleged to have been flawed because it did not properly particularise inappropriate services to enable the Determining Officer to quantify for the purposes of a direction under s.106U(1)(c).

The total number of services rendered during the referral period was 5513. The doctor was requested to produce at the hearing records of three groups of patients included in

which were records of families who received a very high number of services. The groups were:

- \* those who received services on 18 July and 19 September 1994
- \* those receiving home visits
- \* those who received level C services.

Records which were produced at the hearing included the following families. These families had received a total of 2076 services shown as follows:

Family	Number of services
1	833
2	255
3	188
4	175
5	114
6	112
7	104
8	145 (not investigated by Committee as known to one of members)
9	150

From this total of 2,076, patient number 6 whose records were not available and patient number 8, the Committee dealt with 1819 out of 5513 services on a patient base of 678 patients. The Determining Officer submitted that as this represents 32.99% of the services performed during the referral period.

Counsel for the doctor refuted this saying that the Committee looked only at a few families and investigated too few patients. The profile of this particular practice was however an unusual one. It was a relatively small number of families who attracted almost 50% of Dr Retnaraja's total services and it was a practice which followed a particular pattern of pethidine addition and demand for services. The first reference to "families" came in the letter to the applicant by Dr Williams of 1 March 1995 in which he said inter alia:

*"...a matter of equal concern relates to data which reflects an extraordinary rate of family servicing in a number of instances.."*

Whilst it is true that the Committee did focus on a reasonably small number of families, that was because when the records were requested for two particular days, the list, and the HIC records for those days, predictably turned up families with attendances over the referral of 833 and 255 respectively. Whilst the Committee went into great detail about the servicing of all patients whose records were before them, certain records were returned to the doctor at the conclusion of the first day's hearing, at his request.

As has been stated the doctor was invited to produce records of patients of his own choosing to enlarge the sample but his Counsel believed this to be unfair, saying:

*"If the Committee chooses to only select a few families and nail their colours to those few families, what does a doctor do in that situation?...there is no obligation on a practitioner to then call all the patients in because the Committee is not going to do it."*

The question of the lengths to which a Committee should go in investigating individual cases has been the subject of much judicial comment. In the judgment of Pincus J in *Taylor v Minister of Health* (1989) 23 FLR 53 his Honour dealt with one of the earlier schemes where it was provided that a report should identify "the excessive services" reference was made to a 1964 decision in a case of Perkins where Sugerman J said:

*"...the nature and degree of specificity which is necessary where specification is required are, as I have said, dependent upon subject matter, circumstances and purpose. It is not to be suggested that every attendance out of many thousands or every patient out of hundreds needs to be dealt with individually. It cannot be expected that every attendance or the treatment accorded to every patient will be examined into separately. Such a task could never be completed, nor for a tribunal possessing the committee's expert qualifications, would it be necessary."*

In Yung's case, Burchett and Hill JJ concluded that the Committee did not attempt to make any "Useful Sample Analysis" where they considered only the patients seen on one day in the twelve month period and did not consider the medical records that were made available to it in other periods. We are satisfied that in the particular circumstances of this case, the Committee in carefully assessing 1819 services from a total of 5,513, reviewed an appropriate sample sufficient to satisfy the requirements of the legislation as it has been interpreted by the majority of the Full Bench of the Federal Court of Australia.

The remaining questions are whether the Committee then examined the practitioner's conduct in respect of the services which it had reviewed and whether, having done so, it clearly stated the findings of inappropriate practice which it made.

It was not in dispute that the services took place on particular dates, but long and detailed questioning by the Committee raised significant doubts about the content of many of Dr Retnaraja's consultations. The Committee report at page 40 noted the following as paraphrased:

- \* the clinical notes for three patients (with a total of 211 services) do not reveal any medical condition(s) of ongoing significance to justify this rate of servicing
- \* the clinical notes relating to three other patients (with a total of 232 services) do not demonstrate the appropriateness of this servicing frequency
- \* three further patients (with a total of 430 services) had chronic pain syndrome which the Committee believed played only some part in those abnormal servicing frequencies

The Committee recorded that unsatisfactory explanations were given by the doctor, finding the above level of servicing to be unacceptable "when there is no medical justification for providing the services."

At another point in the report it was said that the applicant made little attempt to establish a management plan for patients with chronic pain syndrome who required regular relief "via narcotic regimes such as pethidine." He was also criticised for allowing himself to be "demand driven" to see patients without appraisal of the clinical need for such attendances.

## 7. The Final Determination

The Determining Officer having received from the Committee a report which finds that a practitioner has practised inappropriately, and having complied with the legislative procedures relating to, and including preparation of a draft determination, must then make a final determination under s.106T. This determination must contain one or more of the directions in s.106U which include reprimand, counselling, repayment of Medicare benefits received and disqualification partially, or wholly. These directions are imposed both to protect the community and its health and to safeguard the Commonwealth against abuse of the system by the medical profession. The Tribunal reviewing a determination is directed as to procedure in ss.118 and 119 the review being limited as therein set out. Section 119(1)(b)(ii) gives the Tribunal authority to affirm or set aside the determination and make any other determination that the Determining Officer is empowered to make, and the decision of the Tribunal on the review is taken to the determination of the Determining Officer.

The Determining Officer is not limited to events which have occurred during the referral period but may take into account (although not receive further evidence) relevant matters raised by the doctor on receipt of the draft determination. Any reformation by a medical practitioner is a relevant factor to which regard should be had in the exercise of the discretion which s.106U confers.

Their Honours in the majority decision in Yung's case in citing Mason J in *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24 had this to say at page 21:

*"...However, nothing in the statutory scheme suggests that the administrative decision of the determining officer should be exercised without regard to events known at the time of the decision. It has long been accepted as a*

*general principle that administrative decisions should be made on the best and latest information available..."*

To deal with this question first : Counsel for Dr Retnaraja submitted that following counselling with Dr. Williams in April 1995 the doctor had set about changing the way he practised medicine, and whilst there was delay in implementing change the Committee accepted the explanation given for that delay. The Determining Officer took this matter into account, however the records were incomplete and there were no records of attendances and services for the locum practice in which the doctor now works part-time.

The applicant in reply to the draft determination again reiterated the matters set out in the Request for Review and argued throughout the hearings. These have all been dealt with again in the determination. It was alleged that the Determining Officer did not give proper weight to the socio-economic position of the patients, that it was a deliberate policy to give the practice a "home visit focus", that the doctor himself did not prescribe addictive drugs which were administered, but they were given on specialist advice and that the records had been investigated thoroughly by the Federal Police and no faults found. Finally it was argued that the Respondent should have placed more weight on the trauma which Dr. Retnaraja had undergone at the time of the police investigation.

It was said that a broad brush approach had been adopted incorrectly in determining that the amount to be reimbursed to Medicare was 35% of the inappropriate services rendered. Finally it was argued that the penalties imposed were draconian, harsh and oppressive.

## **8. Conclusion**

The Grounds for Review and all the arguments provided on behalf of both parties have been comprehensive and far ranging. Every point which could have been made for Dr. Retnaraja has been put and dealt with in detail by the Committee, by the Determining Officer and finally by this Tribunal within the authority of its legislative parameters. The Respondent has provided a comprehensive determination setting out with care reasons for the conclusions reached. She has dealt with all matters necessary to support her decision, and amended the final determination in favour of Dr. Retnaraja as a result of considering his view of the draft document. Section 106U(1)(c) having now been repealed former doubts about what may be ordered by way of refund have been removed. We do not accept that the sanctions imposed were excessive in the circumstances and they are considerably less than may be imposed in future.

It is not proposed to deal with arguments that arose early in the hearing relating to an application to suppress the doctor's name, or retrospectivity of amending legislation as they are no longer relevant.

The Tribunal has noted Dr. Retnaraja's references from prestigious sources in Malaysia and, to some extent, we understand how he has got into his present unfortunate situation. However, we cannot allow those considerations to over ride our very real concern for the medical care of the community, nor can the law negate its role to protect abuse of the Medicare system.

For the reasons set out above, the final determination made herein by the respondent on 11 August 1997 is affirmed.

The litigation has been difficult and protracted. We are most grateful for the able assistance given by both Counsel.

Solicitor for the applicant : Mr T.R. Groom

appearing as Counsel

Solicitor for the applicant : T.R. and K. Groom  
Counsel for the respondent : Ms R.M. Henderson  
Solicitor for the respondent : Australian Government  
Solicitor  
Dates of hearing : 18 -19 November 1997  
Date of decision : 3 September 1998

This and the preceding 28 pages comprise the decision and the reasons for decision of the Professional Services Review Tribunal constituted by The Hon M. Lusink, (President), Dr P. Joseph, (Member) and Professor P. Kincaid-Smith, (Member) given on the 3rd day of September 1998.

Dated this 3rd day of September 1998

.....Diane Popple (sgd).....  
Registrar