PROFESSIONAL SERVICES REVIEW TRIBUNAL

No 4 of 1997

BETWEEN : **DR JUAN SABAG**
Applicant

AND : **LOUISE HELEN MARGARET MORAUTA**
Respondent

TRIBUNAL : The Hon A.R. Neaves, President
Professor D. Tiller, Member
Dr N. McH. Ramsey, Member

DATE : 19 June 1998

DECISION

The Determination made herein by the respondent and dated 7 August 1997 is set aside and in lieu thereof a Determination is made directing that:

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

(b) in accordance with paragraph 106U(1)(c) of the Act, the applicant repay to the Commonwealth the amount of $37,492.70 being an amount equivalent to the Medicare benefits paid in respect of the services rendered during the period of referral under items 18232, 18252, 18254, 18256, 18258, 18260, 18276, 18282, 18286 and 18290 in Group T7 of Part 2 of the General Medical Services Table and that any Medicare benefit that would otherwise be payable for those services cease to be payable;

(c) in accordance with subparagraph 106U(1)(g)(i) of the Act, the applicant be disqualified for a period of 12 months from the time when this determination takes effect in respect of

the provision of all services to which an item in Group T7 of Part 2 of the General Medical Services Table relates.

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

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REASONS FOR DECISION

THE TRIBUNAL:

Nature of the Proceeding

This is a proceeding under Division 3 of Part VA of the Health Insurance Act 1973 (Cth) ("the Act"). It comes before the Tribunal by virtue of the Minister for Health and Family Services having, pursuant to subs. 115(1) of the Act, forwarded to the President the request made on behalf of Dr Juan Sabag ("the applicant") pursuant to subs. 114(1) of the Act that the determination made by Ms Louise Helen Margaret Morauta ("the respondent") and dated 7 August 1997 be referred to a Professional Services Review Tribunal for review. The respondent made that determination as the Determining Officer appointed under subs. 106Q(1) of the Act. It is described as a final determination and was made pursuant to ss. 106T and 106U of the Act.

History of the Matter

2. On 26 June 1996, a document was signed by Dr R.P. Tomlins who described himself as Medical Director and Manager, Professional Services Branch. In signing the document Dr Tomlins purported to act on behalf of the Health Insurance Commission and pursuant to s. 86 of the

Act. The effect of the document was to refer to the Director of Professional Services Review "the conduct of Dr Juan Sabag in relation to whether he has engaged in inappropriate practice, in connection with the rendering of services, as defined by the Act". Pursuant to subs. 87(1) of the Act, the document identified the referred services as "all services rendered by Dr Sabag from his practice location in the State of New South Wales during the period of 1 July 1994 to 30 June 1995, inclusive". The document summarised the reasons for the decision to refer in the following terms:

> "The Health Insurance Commission is concerned that Dr Sabag has rendered an inappropriately high proportion of long and prolonged consultations, and a high average number of services per patient. In addition, the Health Insurance Commission is concerned about Dr Sabag's rendering of regional or field nerve blocks."

3. The validity of the referral and what was done pursuant to it is not compromised by reason of the circumstance that the referral was made by Dr Tomlins and not by the Commission itself: see subs. 86(5) of the Act, a provision which was inserted by item 5 in Schedule 1 to the Health Insurance Amendment Act (No 1) 1997 (Cth) and which came into operation on 6 November 1997.

4. The referral document and its attachments set out in considerable detail the material the Commission took into account in forming the view that Dr Sabag's conduct in connection with the rendering of Medicare services constituted inappropriate practice. Included in the material were reports dated 21 August 1995 and 17 June 1996 furnished to the Commission by Emeritus Professor T.R. Cramond and a report dated 10 June 1996 furnished to the Commission by Dr N.C. Whitby. It will be necessary to refer to some of this material later in these reasons.

5. On 26 July 1996, after the applicant had been given an opportunity to make written submissions stating why the referral should be dismissed, the Director of Professional Services Review, Dr A.J. Holmes, signed an instrument under ss. 93 and 95 of the Act setting up Professional Services Review Committee No 17 ("the Committee") to consider whether the applicant had engaged in inappropriate practice. The Committee comprised a chairperson and two members. The chairperson was described as a medical practitioner, each of the two members being described as a vocationally registered medical practitioner.

6. The Committee held a hearing on 28 August and 4 September 1996 at which the applicant gave evidence (not on oath or affirmation) and addressed the Committee. He also provided documentary material to the

Committee before and during the hearing. Evidence (not on oath or affirmation) was also given at the Committee hearing by Dr John Ditton and Professor Michael Cousins in relation to pain management and the use of regional or field nerve blocks and by Mrs Eleanor Nasimento, a part-time unregistered nurse employed at the applicant's surgery.

7. Subsequently, the applicant furnished to the Committee a written submission dated 24 September 1996.

8. Pursuant to s. 106L of the Act, the Committee gave to the Determining Officer a written report dated 13 November 1996. The Committee unanimously concluded that the applicant's conduct in connection with rendering the services the subject of the referral was unacceptable to the general body of medical practitioners practising in Australia and that the applicant had, therefore, engaged in inappropriate practice as defined in s. 82 of the Act, the relevant provision of that section being paragraph (1)(a).

9. The respondent, pursuant to subs. 106S(1) of the Act, made a draft determination. The applicant was then afforded an opportunity to make written submissions suggesting changes to the draft determination. The applicant took advantage of that opportunity and his solicitors furnished a written submission to the respondent.

10. On 7 August 1997, pursuant to s. 106T of the Act, the respondent made a final determination in accordance with s. 106U of the Act relating to the applicant. The final determination, having recited that the Committee had found that the applicant had engaged in inappropriate practice as defined in s. 82 of the Act, directed that:

> "i) in accordance with paragraph 106U(1)(b) of the Act, Dr Sabag 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 Sabag repay to the Commonwealth the amount of $148,769.95 being an amount equivalent to the Medicare benefits paid for 50% of the inappropriate services rendered during the period of the referral under items 36, 37, 44 and 47 in Group A1 of Part 2 of the General Medical Services Table and for [sic] the Medicare benefits paid for 75% of the inappropriate services rendered during the period of referral under items 18232, 18252, 18254, 18256, 18258, 18260, 18276, 18282, 18286 and 18290 in Group T7 of Part 2 of the General Medical Services Table; and that any

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

iii) in accordance with subparagraph 106U(1)(g)(i) of the Act, Dr Sabag be disqualified for a period of 12 months from the time when the final determination takes effect in respect of the provision of all services in Group A1 or Part 2 of the General Medical Services Table and all services to which an item relates in Group T7 of Part 2 of the General Medical Services Table;

iv) in accordance with paragraph 106U(1)(h) of the Act, Dr Sabag be fully disqualified for a period of 6 months from the time when the final determination takes effect."

It appears that, although the determination is dated 7 August 1997, it was not received by the applicant until 14 August 1997.

11. By letter dated 10 September 1997 addressed to the Minister for Health and Family Services, the solicitors for the applicant requested, pursuant to s. 114 of the Act, that the final determination be referred to a Professional Services Review Tribunal for review. The letter stated the following as the grounds on which the request was made:

" • The Committee failed to conduct proceedings and make its determination in accordance with the principles of 'reasonable satisfaction' per the dicta of Mr Justice Dixon in Briginshaw-v-Briginshaw 1938 60 CLR 336-362.

• The Committee and the Determining Officer failed to follow the sampling procedure in accordance with Sections 106G to 106K of the Health Insurance Act 1973.

• The Committee and the Determining Officer failed to properly detail their adverse findings where it was not clear as to what Dr Sabag is alleged to have done or not to have done.

• The Committee and the Determining Officer took into account irrelevant considerations in regard to prior discussions between Dr Sabag and the Health Insurance Commission.

- The Committee and the Determining Officer found that Dr Sabag had inappropriate training to perform certain nerve block procedures however they failed to provide evidence that these procedures were not performed or inappropriately charged for.

- The Committee and the Determining Officer failed to consider essential matters before imposing repayment and disqualification on Dr Sabag, including the extent of his culpability, whether he was likely to repeat his conduct, the detriment it may cause him and the impact on his practice and patients."

12. On 11 September 1997, the request was forwarded to the President of this Tribunal.

<u>The Applicant</u>

13. The following statement with respect to the applicant's training, qualifications and experience, which was not the subject of critical comment before us, is taken from the Committee's report:

"1. Dr Sabag immigrated to Australia in 1969. In 1972 he attended the University of Sydney but with personal distractions had difficulty with the course and returned to full time employment as a factory hand and taxi driver. In 1974 he returned to Bolivia, South America, where he attended La Paz University. In 1977 he graduated and, on his return to his family in Australia, passed the medical examinations. At that time, Dr Sabag began working at Lidcombe Hospital in the Department of Surgery.

2. Subsequently, Dr Sabag spent a year in Broken Hill Hospital and commenced FMP training. He did some rural rotation in general practice. He also did six months at Bloomfield Hospital (psychiatry), Orange, NSW. After fulfilling the requirements of the Family Medicine Program, Dr Sabag entered general practice in the Sydney suburb of Fairfield in 1980.

3. In 1985, Dr Sabag returned to South America, where he spent four weeks with a colleague in a 'major teaching hospital'. He returned to Australia where he began to practise more musculo-skeletal work. Following this, he

spent three weeks in Havana, Cuba and undertook two courses, one in cardiology and one in rheumatology.

4. Dr Sabag told the Committee that it was during these periods in South America and Cuba that he received some training in nerve block procedures.

5. Dr Sabag says he has attended a number of post-graduate medical education courses, both locally and internationally. Although Dr Sabag told the Committee that he has a particular interest in cardiology, musculo-skeletal pain, dermatology and counselling, he has not taken part in any formal education program in Australia in relation to these interests.

6. Dr Sabag claims he is fluent in Spanish, Portuguese, Italian and English and believes that some patients come from distant areas to see him because he can communicate in these languages.

7. Dr Sabag is a general practitioner (he became vocationally registered on 8 December 1989) and therefore a specialist for the purpose of Part VAA of the Act."

14. During the referral period, the applicant conducted a sole practice at the Fairfield Shopping Centre, Fairfield. All the Medicare services provided by the applicant during the referral period were billed directly to Medicare by the applicant and the relevant Medicare benefits were paid to him.

15. In July 1986, the applicant had been visited by a Health Insurance Commission Medical Adviser. The subjects discussed included his high servicing rate, his high average rate of initiating pathology services and the concepts of excessive servicing and clinical necessity. In July 1988, investigation officers spoke to the applicant concerning a possible breach of subs. 20A(1) of the Act - charging a fee when bulk billing the patient. At the applicant's request a Health Insurance Commission Medical Adviser visited him in December 1988. On 4 January 1995, that is during the period that became the referral period, the applicant was visited by Dr K. Facer, a Health Insurance Commission Medical Adviser, because of:

- the high proportion of level C and level D consultations compared to the number of level B consultations;

- a significant number of patients requiring frequent long consultations;

- frequent use of items requiring injection by anaesthetic agents into major nerves; and

- the applicant's understanding of item 18290 (cranial nerve other than trigeminal, destruction by neurolytic agent).

Role of the Tribunal

16. The Tribunal's role is not confined to reviewing the appropriateness of the directions given by the respondent under s. 106U of the Act but extends to a review of the material that was before the Committee and the Committee's findings as set out in its report. It is open to the Tribunal to take a different view from that taken by the Committee. It is not, however, within the functions of the Tribunal to consider and determine whether the report of the Committee should be set aside on the basis, if such could be established, that the conduct of the proceedings by the Committee was infected with legal error. The consideration and determination of that issue is a matter falling within the judicial power and is a matter for curial proceedings, not proceedings before an administrative body such as the Tribunal. However, in reviewing the material that was before the Committee, the Tribunal having no power to receive further material, it will be incumbent upon the Tribunal to exclude from its consideration any material which was otherwise relevant to an aspect of the investigation that was conducted by the Committee 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. What is said above is based on the Tribunal's understanding of what is said in the reasons for judgment of Burchett and Hill JJ in Adams v Yung (Federal Court of Australia - 15 May 1998 - unreported)

The Legislation

17. According to its long title, the Health Insurance Act 1973 (Cth) is "An Act providing for Payments by way of Medical Benefits and Payments for Hospital Services and for other purposes". Part II of the 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. To interpret some of the expressions used in that subsection it is necessary to refer to the definition of those

expressions in s 3 of the Act. The expression "eligible person" includes an Australian resident, an expression which is itself defined in s.3. The expression "professional service" includes a service (other than a diagnostic imaging service as defined) to which an item in the General Medical Services Table prescribed under s. 4 of the Act relates, being a “clinically relevant service” that is rendered by or on behalf of a medical practitioner. A “clinically relevant service” is, so far as is 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.

18. Part VAA (ss. 80-106ZR) creates a scheme under which a person's conduct can be examined to ascertain whether inappropriate practice as defined in s. 82 is involved and provides for action that can be taken in response to inappropriate practice (s. 80). Section 82, in the form in which it stood prior to 6 November 1997, provided that a practitioner engaged 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 subs. 81(1) to mean a service for which, at the time it was rendered or initiated, medicare benefit was payable and to include a prescribing of a pharmaceutical benefit by a medical practitioner. Prior to 6 November 1997, subs. 81(2) provided that, for the purposes of Part VAA, general medical practice was to be taken to be a specialty and medical practitioners practising in general medical practice were to be taken to be specialists in that specialty.

19. As has already been mentioned, under s. 86 of the Act, the Commission may refer to the Director of Professional Services Review (“the Director”) the conduct of a person relating to whether the person has engaged in inappropriate practice in connection with rendering or initiation of services. It is sufficient if the referral specifies that it relates to services rendered or initiated by a practitioner that are services provided within a specified location (subs. 87(1)). The Director is required by subs. 89(1) either to dismiss the referral (which he or she must do if satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice in connection with the referred services - s. 91) or set up a Committee to consider whether the practitioner has engaged in inappropriate practice (which he or she must do unless satisfied that there are insufficient grounds on which a Committee could

reasonably find that the person under review has engaged in inappropriate practice in connection with the referred services - s. 93).

20. If a Committee is set up and it appears to it that the person under review may have engaged in inappropriate practice in connection with rendering or initiating the referral services, the Committee must hold a hearing at which evidence is given and documents are produced to it (s. 101).

21. Prior to 6 November 1997, subdivision C of Division 4 of Part VAA provided that, in the circumstances there stated, the Committee might, in making findings on the conduct of the person under review in connection with the referred services, base its findings wholly or partly on its findings on his or her conduct in connection with a sample of those services (subs. 106H(1)). Subdivision C of Division 4 of Part VAA was repealed with effect from 6 November 1997 (see Health Insurance Amendment Act (No 1) 1997 (Cth) s. 3 and item 12 in Schedule 1).

22. Under s. 106 L in the form which it took prior to 6 November 1997, if the person under review was a practitioner and a specialist when the referred services were rendered or initiated, the Committee was 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 speciality in which the practitioner was practising at that time.

23. 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 s. 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.

24. The provisions of Part VAA of the Act to which reference has been made were inserted in the Act by the Health Legislation (Professional Services Review) Amendment Act 1994 (Cth) and came into operation on 1 July 1994. In support of the motion moved by him in the House of Representatives on 30 September 1993 that the Bill which proposed to insert Part VAA in the Act be read a second time, the Parliamentary Secretary to the Minister for Health made the following statements:

> "The new measures in this bill are necessary because the existing mechanisms for dealing with overservicing have come under question and have not been shown to be effective.
> ....
>
> A major factor in the inability to impose penalties commensurate with the extent of a practitioner's overservicing is the current lack of power to make decisions on the extent of overservicing on the basis of generalised evidence. At present judgments about overservicing can only be made on the basis of individual services, that is, recovery of benefits and the imposition of penalties can only be made in respect of each service separately determined to have been excessive."

One of the provisions of the Act as it then stood that was repealed by the amending statute was the provision in s. 104 that required that, in a case where the Committee, in its report, expressed the opinion that a practitioner had rendered excessive services (that expression being a reference to professional services being services in respect of which medicare benefit had become or might become payable and which were not reasonably necessary for the adequate medical care of the patient concerned (subs. 79(1B)), the report identify those services.

25. It is apparent, however, from the judgment of the Full Court of the Federal Court of Australia in Adams v Yung (supra) that the amendments made by the Act of 1994 fell short of remedying the perceived mischief or defect for which the provisions previously in force had not provided. For the Court there held that it is incumbent upon a Professional Services Review Committee set up under ss 93 and 95 of the Act, at least in a case where the conduct alleged to constitute inappropriate practice is expressed in terms of a concern that the practitioner would not be able to provide an appropriate level of clinical input when consistently rendering high numbers of services or when regularly working excessive hours, to relate any conclusion it reaches, as to inappropriate practice to specified services, being some or all of the services the subject of the referral. At pp. 18-19 of their joint reasons for judgment in that case, Burchett and Hill JJ said:

> "It is true that the sampling procedure introduced in the 1993 Bill to which the Second Reading Speech was addressed, permits necessary extrapolation from a sample to the referred services. It does not follow from that that a committee is not required to reach an ultimate conclusion about specified services. Its task is to consider the matter in the referral which is the conduct in respect of specified services. Although no doubt inferences can be made

> from a sample to a totality of services, that does not take away from the requirement of the ultimate conclusion to relate the issue of conduct either to some or all of those services."

The Committee's Report

26. The two most significant features of the applicant's conduct that led the Committee to conclude that he had engaged in inappropriate practice were the high number of regional or field nerve blocks rendered by the applicant during the referral period and the high proportion of level C and level D consultations he rendered during that period. To the material relating to these two aspects of the applicant's conduct we now turn.

Regional or Field Nerve Blocks

27. In relation to the applicant's rendering of regional or field nerve blocks during the referral period, the referral document stated:

> "During the referral period Dr Sabag performed regional or field nerve blocks (items within the range 18232 to 18290) 382 times. Dr Sabag rendered item 18286 (lumbar or thoracic nerves, injection of an anaesthetic agent (paravertebral sympathetic block)) 159 times, compared with the second ranked provider in Australia who provided 15. Dr Sabag rendered item 18290 (cranial nerve other than trigeminal, destruction by neurolytic agent) 101 times. This compares with the second ranked provider of item 18290 in Australia who provided this service on 53 occasions. In terms of all active general practitioners in Australia, only 12 practitioners provided item 18290 during the referral period. The Health Insurance Commission is concerned that some of the services rendered by Dr Sabag would not be reasonably medically necessary for the care of his patients."

28. During the referral period, Medicare benefits were paid to the applicant in respect of the undermentioned services falling within Group T7 of Part 2 of the General Medical Services Table:

Item	Service	Patients	Services	Benefits
18232	Intrathecal, epidural or caudal injection of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies.	1	1	$61.00
18252	Cervical plexus, injection of an anaesthetic agent.	49	54	$3,309.20
18254	Brachial plexus, injection of an anaesthetic agent.	2	2	$122.80
18256	Suprascapular nerve, injection of an anaesthetic agent.	8	9	$342.45
18258	Intercostal nerve (single), injection of an anaesthetic agent.	6	6	$228.00
18260	Intercostal nerves (multiple), injection of an anaesthetic agent.	1	1	$54.40
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels).	45	48	$3664.45
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure.	1	1	$61.80
18286	Lumbar or thoracic nerves, injection of an anaesthetic agent, (paravertebral sympathetic block)	134	159	$14,307.75
18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent.	91	101	$15,340.85
-	-	-	382	$37,492.70

29. The referral document made extensive reference to a report dated 17 June 1996 of Emeritus Professor T.R. Cramond and a report dated 10 June 1996 of Dr N.C. Whitby, those reports discussing the rendering by the applicant of regional or field nerve blocks. Professor Cramond had extensive experience in anaesthetics and pain management. Dr Whitby had long experience as a general practitioner. Both Professor Cramond and Dr Whitby raised serious concerns as to the appropriateness of the applicant's conduct in relation to the provision of regional or field nerve blocks. The reports highlighted the applicant's inability clearly to identify, either in the conversation he had with the Commission's Medical Adviser on 4 January 1995 or in his correspondence with the Commission, the exact nature of the services he claimed to have provided and for which he claimed payment under the items identified in the above table, or the circumstances in which those services were performed, or the substances he claimed to have injected.

30. Much of the hearing time before the Committee was devoted to an examination of the applicant's conduct in relation to the provision of regional or field nerve blocks. In addition to what the applicant had to say on this subject, the Committee had the benefit of hearing Dr John Ditton and Professor Michael Cousins. Part of the material before the Committee took the form of a dialogue between the applicant and each of those persons. The Committee also had before it the clinical records it had required the applicant to produce.

31. During the course of the hearing before the Committee, the applicant acknowledged that he had not, at any time during the referral period, performed the service to which item 18290 in the General Medical Services Table refers in that, at no time in that period, had he injected a neurolytic agent. It also appears from the material before the Committee that, in claiming to have performed the service to which item 18290 refers, he had incorrectly regarded the lesser occipital nerve as a branch of the accessory (eleventh cranial) nerve. The applicant also acknowledged in the course of his evidence before the Committee that the claims under items 18232 and 18282 had been incorrectly made.

32. It is also of some significance that, although the applicant admitted that he had been informed by Dr Facer in the interview on 4 January 1995 that, as he was not using a neurolytic agent, he had incorrectly claimed to have performed the service to which item 18290 refers and asserted that he had not claimed under the item since being so informed, the material before the Committee shows that on four occasions between 4 January and 30 June 1995 he claimed to have performed the service to which that item relates.

33. Upon a consideration of the whole of the material before the Committee, we are satisfied that the applicant lacked the knowledge, training, skill and expertise:

- to assess the appropriateness, including the clinical necessity, for the treatment of a patient presenting with chronic pain of carrying out a regional or field nerve blocking procedure of the kind to which the items in the General Medical Services Table identified above relate;

- to understand and appreciate fully the severity of the risks to the patient inherent in carrying out those procedures;

- to carry out the procedures which were described by Professor Cousins as "amongst some of the most hazardous procedures that are carried out within the specialist anaesthesia area"; or

- to manage effectively and efficiently any complications that might arise as a result of carrying out the procedures involved in providing the services to which the items in the General Medical Services Table relate.

Further, the applicant did not, at the relevant time, have immediate access to the resuscitation and recovery facilities that would be necessary in the event that complications arose as a result of the carrying out of the procedures that the applicant claimed he was performing.

34. It may well be that, as the applicant claimed, his patients received instantaneous pain relief as a result of the procedures he performed, but that circumstance does not, of itself, support the applicant's claim that he was performing the services to which the relevant items relate. In our opinion, the conclusion is inescapable that the descriptions in the General Medical Services Table of the services to which the relevant items relate are not accurate descriptions of the services which the applicant was providing to his patients. The procedures which he performed were simple nerve blocks of an infiltration type in which a local anaesthetic or other agent was injected through a needle placed by reference to the point of pain or tenderness identified to the applicant by the patient. Those procedures do not answer the description in the items identified in the table set out earlier in these reasons.

35. We are satisfied that the applicant's conduct in connection with rendering the referred services insofar as those services were claimed to

involve the provision of regional or field nerve blocks as identified above would, in terms of subs. 82(1) of the Act, be unacceptable to the general body of general medical practitioners and that such conduct amounts to inappropriate practice within the meaning of that expression in the Act. We should add that, in our opinion, the applicant was made fully aware of the matters that were the subject of concern in regard to the rendering of regional and field nerve block services and that he had ample opportunity to deal with those concerns before the Committee.

High Proportion of Level C and Level D Consultations

36. In relation to the proportion of long and prolonged consultations claimed by the applicant to have been rendered by him during the referral period, the referral document stated:

> "During the referral period of 1 July 1994 to 30 June 1995, Dr Sabag rendered 7,836 services of which 7,335 were consultations, including home visits. 84% of all consultations were level C consultations (items 36, 37) and 3% of all consultations were level D consultations (items 44, 47). During this period Dr Sabag provided up to 20 services per day on 89 occasions, between 21 to 40 services per day on 164 occasions, between 41 to 60 services per day on 44 occasions and between 61 to 80 services per day on 1 occasion, in an average working day of 10 to 12 hours. Time calculations suggest that Dr Sabag would have needed to spend more than 13.3 hours on 45 days of direct patient contact to provide these services in accordance with the Medicare Benefits Schedule ..."

The 7,836 services referred to were rendered to 1,380 patients.

37. The referral document also gave the following details of the distribution of the consultation services (surgery and home visits) during the referral period for which the applicant claimed payment of Medicare benefits:

	Level A	**Level B**	**Level C**	**Level D**	**Total**
Surgery Consultations	0	924	6,188	189	7,301
Home Visits	0	1	2	31	34
Total	0	925	6,190	220	7,335

38. At all times during the referral period, the service to which items 36 and 37 (level C) applied was described as a professional attendance

(not being a service to which any other item applied) by a general practitioner involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, or a professional attendance of less than 40 minutes duration involving components of a service to which item 44 or 47 applied.

39. At all times during the referral period, the service to which items 44 and 47 (level D) applied was described as a professional attendance (not being a service to which any other item applied) by a general practitioner involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration for implementing a management plan.

40. Items 36 and 44 applied when the professional attendance was at consulting rooms: items 37 and 47 when the professional attendance was other than an attendance at consulting rooms, an institution, a hospital or a nursing home.

41. The services to which the above items applied are to be contrasted with the services constituting level A and level B consultations. At the relevant time a level A consultation (items 3 and 4) was a professional attendance by a general practitioner 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 while a level B consultation (items 23 and 24) was a professional attendance by a general practitioner involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 44 or 47 applied.

42. It should be noted that, in her report dated 10 June 1996, Dr Whitby said:

> "In the referral period 1st July, 1994 to 30 June, 1995, Dr Sabag rendered 7836 services of which 7335 were consultations.
>
> Eighty four percent of all consultations were Level C Consultations and 3% of all consultations were Level D Consultations.

> This is a most unusual servicing pattern for a Vocationally Registered General Practitioner and would be unacceptable to the wider body of such doctors. It is inconceivable that, in a practice providing 7836 services only 17% lay in the under 20 minute time range."

It may have been more precise to say that of the total number of consultations (7,335), only 13% (925) were in the under 20 minute time range. We share Dr Whitby's incredulity at the situation disclosed by the figures.

43. An examination of the Daily Items Report in respect of the referral period, a document that was before the Committee, shows that during the period 1 July 1994 to 4 January 1995, the day on which the applicant was visited by Dr Facer, the applicant claimed to have rendered 4,437 level C consultations but only 10 level B consultations. After the visit by Dr Facer, there was some change to the pattern. In the period from 5 January to 30 June 1995, the applicant claimed in respect of 1,753 level C consultations and 915 level B consultations. The pattern, particularly in the earlier period, reinforces the opinion expressed by Dr Whitby.

44. One of the annexures to the referral document set out, in relation to each of 40 of the applicant's patients, the services claimed by the applicant to have been rendered to that patient during the referral period. The following table shows, in summary form, the number of level C surgery consultations (item 36) claimed to have been rendered to each of those patients and, in relation to some of the patients, a comment upon the frequency of the consultations:

Patient	Number of Consultations	Comment
1	65	47 in period 20 July to 31 October 1994 including 21 in August 1994 and 14 in October 1994.
2	48	43 in period 13 October to 31 December 1994 including 13 in October 1994,18 in November 1994 and 12 in December 1994.
3	38	18 in period 21 November to 22 December 1994.
4	56	26 in period 8 July to 25 August 1994.
5	57	39 in period 11 October to 15 December 1994.
6	38	
7	34	
8	27	
9	34	23 in a period 21 July to 31 August 1994.
10	25	
11	26	
12	35	29 in period 12 October to 7 December 1994.
13	30	
14	21	17 in period 5 to 24 September 1994.
15	8	There were also 20 level B consultations in the referral period. 26 consultations took place in period 14 February to 10 April 1995.
16	28	20 in period 16 September to 28 October 1994.
17	30	
18	26	
19	24	
20	7	There were also 24 level B consultations during the referral period. 21 consultations took place in period 21 April to 11 June 1995.
21	19	There were also 10 level B consultations in the referral period.
22	22	
23	12	There were also 10 level B consultations in the referral period.
24	24	
25	18	
26	22	
27	25	
28	23	
29	18	
30	23	
31	19	
32	25	
33	19	
34	23	
35	17	
36	22	
37	8	There were also 15 item 47 consultations in the referral period.
38	23	15 in period 1 September to 5 October 1994.
39	23	
40	19	

45. The Committee had before it the clinical records that it had required the applicant to produce. Included in that material were the clinical records relating to 8 of the patients included in the above table.

An examination of these records (which relate to the patients numbered 2, 11, 16, 21, 22, 35, 38 and 39 in the table) shows them to be deficient in that, in relation to the periods which they cover, there is, in some instances, no notation of any service being provided on the date for which an item 36 consultation was charged while in other instances the notation fails to provide an appropriate basis upon which the charging of an item 36 consultation could be justified.

46. Another table in the material before the Committee listed 30 randomly selected item 36 services for which the applicant claimed medicare benefit during the referral period. Clinical records in respect of the patients to whom 27 of those services were rendered were before the Committee. In 17 instances, the clinical record does not support the service being classified as an item 36 consultation. Another table listed 30 randomly selected item 44 services for which the applicant claimed benefit during the referral period. Clinical records in respect of the patients to whom 25 of those services were rendered were before the Committee. In 19 instances the clinical record does not support the service being classified as an item 44 consultation.

47. Another of the annexures to the referral document, described as an Extended Time Report, showed, on a daily basis, the number of services claimed by the applicant to have been rendered and an estimate of the time of direct patient contact which the rendering of those services would have required. An analysis of the information disclosed by the annexure shows that the rendering of those services necessitated very long hours of direct patient contact, very often on consecutive days. By way of example, during the week commencing on Monday, 14 November 1994 the number of level C consultations said to have been rendered and the time required to render those services assuming each consultation to have been no longer than the minimum time required to justify charging a level C consultation were:

Date	No. of Consultations	Time Required
14 November	59	19 hrs 40 minuts
15 November	37	12 hrs 20 minutes
16 November	37	12 hrs 20 minutes
17 November	40	13 hrs 20 minutes
18 November	44	14 hrs 40 minutes
19 November	25	8 hrs 20 minutes

The times set out above take no account of the time spent in rendering services other than level C consultations on the days in question or time

spent in carrying out administrative tasks, in travelling or in the ordinary course of living.

48. It should also be noted that the accuracy of the data contained in the referral document and its annexures was not challenged or disputed before the Committee, the respondent or this Tribunal.

49. Having regard to the material to which we have referred, it cannot seriously be suggested that the applicant was not fully aware of the matters that were the subject of concern in relation to the high proportion of level C and level D consultations for which he had been paid Medicare benefits.

50. It is clear from the answers that the applicant gave to questions put to him by members of the Committee that he had a far from complete understanding of the requirements of the General Medical Services Table insofar as the various levels of consultations are concerned and of the requirement that the time spent in carrying out a procedure which is covered by an item in the Table is not to be included in determining the time of any consultation occurring on the same occasion.

51. In the course of the hearing by the Committee, the applicant agreed that certain services which had been charged as level C consultations should have been charged as level B consultations.

52. In explanation of the high proportion of level C and level D consultations, the applicant pointed to the fact that many of his patients were of Latin American origin and had suffered severe trauma in their country of origin, that many of his patients came long distances to consult him and that his patients included a substantial number suffering anxiety or depression. He said of many of his patients that they consulted him "just for talk" and that "they don't come to tell you they got severe physical problems". He placed considerable store on his interest in counselling.

53. It must be said that for the most part the clinical records produced to the Committee do not reflect that counselling took place or the subject matter discussed nor do they support the view that in the particular instance there was a clinical necessity to spend considerable time with the patient. Indeed, speaking generally, the records produced do not for the most part record the history taken from the patient, the diagnosis made or the nature of any management plan formulated or implemented. The records really give no insight at all into the kind of problems to which counselling might have been directed and provide no foundation for the repeated consultations which are said to have been necessary and which in many instances took place on consecutive days.

Conclusion re High Proportion of Level C and Level D Consultations

54. A group of medical practitioners with extensive experience of general practice could, from an examination and analysis of the material to which we have referred, draw an overall picture of the conduct of the applicant's practice during the referral period and discern its essential features. They could also consider how the conduct of the applicant in carrying on his practice in that fashion would be viewed by the general body of general practitioners. In particular, having regard to the large number of level C and level D consultations in respect of which Medicare benefits were paid, the nature of the service which the General Medical Services Table requires to be performed in order that a consultation qualify as a level C or level D consultation and the time that would be required each day to carry out the services for which benefit was claimed, such a group could reasonably conclude that the applicant's ability to function effectively and efficiently would be, to a greater or lesser extent, thereby impaired.

55. However, in the light of the judgment in Adams v Yung (supra), we can only conclude that the material that was before the Committee cannot be read as satisfying the statutory test of inappropriate practice as it does not 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 constitute inappropriate practice as defined in s. 82 of the Act.

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

The Determination

57. The operative text of the final determination made by the respondent on 7 August 1997 is set out earlier in these reasons. Directions were given under paragraphs (b), (c), (g)(i) and (h) of subs. 106U(1) of the Act.

58. We support the direction given under paragraph 106U(1)(b) that the applicant be counselled by the Director of Professional Services Review or the Director's nominee. We believe that some assessment of the applicant's clinical practice should be part of any counselling process. The problem could be referred to the Royal Australian College of General

Practitioners or the New South Wales Medical Board, both of whom are addressing the issue of assessment of cometence.

59. At the time when the final determination was made, paragraph 106U(1)(c) of the Act permitted a direction to be given that the person under review repay to the Commonwealth an amount equivalent to any Medicare benefit paid "for inappropriate services" (whether or not the Medicare benefit was paid to the person), and that any Medicare benefit that would otherwise be payable for those services cease to be payable. The expression "inappropriate service" was defined in subs. 106U(5) to mean "a service in connection with which the person under review is stated in a Committee's report under section 106L to have engaged in inappropriate practice".

60. By the amending provisions which came into operation on 6 November 1997, subs. 106U(5) was repealed and paragraph 106U(1)(c) amended. Under the provisions now in force, a direction may be given under paragraph 106U(1)(c) -

> "that the person under review repay to the Commonwealth the whole or a part of the Medicare benefit that was paid (whether or not to the person under review) in respect of services that:
>
> (i) were rendered by:
>
> (A) the person under review; or
>
> (B) an employee of the person under review; or
>
> (C) ...; and
>
> (ii) are services in connection with which the person under review is stated in a report under section 106L to have engaged in inappropriate practice;
>
> and that any Medicare benefit that would otherwise be payable for the services cease to be payable."

61. We do not find it necessary, in the circumstances of this case, to determine whether the Tribunal should apply the provisions as they stood at the time the final determination was made or the provisions as they now stand.

62. The language in which the determination under paragraph 106U(1)(c) is cast suggests that the respondent took the view that the

Committee had stated in its report that the applicant had engaged in inappropriate practice "in connection with" each and every service rendered by the applicant during the referral period under items 36, 37, 44 and 47 in Group A1 of Part 2 of the General Medical Services Table and items 18232, 18252, 18254, 18256,18258, 18260, 18276, 18282, 18286 and 18290 in Group T7 of Part 2 of that Table. We agree that the effect of the Committee's report is to find that the applicant's conduct in connection with each and every service said to have been rendered by him during the referral period under the items identified above in Group T7 of Part 2 of the General Medical Services Table amounted to inappropriate practice. In case a contrary view of the Committee's report may be taken, we should place on record our unanimous finding that, on the evidence before the Committee, the applicant's conduct in connection with rendering those services and each and every one of them was unacceptable to the general body of general medical practitioners.

63. We are, however, unable to agree that the Committee's report states that the applicant had engaged in inappropriate practice in connection with each and every service said to have been rendered during the referral period under items 36, 37, 44 and 47 in Group A1 of Part 2 of the General Medical Services Table. Nor, in our view, is the material that was before the Committee sufficient to support such a statement or, indeed, a finding that any specific services constituted inappropriate practice as defined in s. 82 of the Act.

64. It follows that the direction given by the respondent under paragraph 106U(1)(c) of the Act must be set aside insofar as it directs repayment of Medicare benefit paid in respect of services rendered under items 36, 37, 44 and 47 in Group A1 of Part 2 of the General Medical Services Table. We are, however, of the view that the appropriate direction to be given under that paragraph in respect of the services rendered under the identified items in Group T7 of Part 2 of the General Medical Services Table is that the applicant repay to the Commonwealth an amount equivalent to the Medicare benefits paid for 100% of those services. That amount is $37,492.70.

65. The direction under paragraph 106U(g)(i) fixed the period of disqualification in respect of all services in Group A1 of Part 2 of the General Medical Services Table and all services in Group T7 of Part 2 of that Table as the period of 12 months from the time when the final determination takes effect. The period fixed under paragraph 106U(h), that is to say the period during which the applicant is to be fully disqualified, is the period of 6 months from that time.

66. In the written submission dated 24 September 1996 furnished by the applicant to the Committee after the conclusion of the hearing, the applicant stated that he had been called to meet the delegate of the Medical Board of New South Wales on that day. The submission included the following:

> "(1) In relation to nerve blocks, I have already stopped such procedures and am abandoning this mode of practice without having experienced one single case of morbidity to all the patients I used such procedure.
>
> (2) Alternative treatment methodology will be implemented and I will leave the part of pain management to the management clinic when required.
>
> (3) The itemisation for consultation will have an immediate review preventing [sic] the quality of care to my patient is not affected. For instance, I will consider appointment system.
>
> (4) A most meticulous record system, just started to adjust."

67. Upon being informed that the submission made on the applicant's behalf to the respondent in relation to the draft determination contained material relating to the review conducted by the Medical Board of New South Wales into the applicant's practice, we received, over the objection of counsel for the respondent, a copy of that submission. We did so on the basis that the material was before the respondent when the final determination was made and was relevant to a review of the exercise by the respondent of the discretion conferred by paragraphs (g)(i) and (h) of subs. 106U(1) in that it related to a change in the conduct of the applicant's practice occurring after the date of the Committee's report. The submission contains the following statement in relation to the applicant's performance of regional and field nerve blocks:

> "The Committee saw fit to refer this issue to the New South Wales Medical Board pursuant to Section 106P(1) of the Act. It is noted that the NSW Medical Board reviewed the matter and placed certain restrictions on Dr Sabag's practising certificate including that he not perform the various nerve blocks."

No further material is available to the Tribunal concerning the review conducted by the Medical Board of New South Wales.

68. Notwithstanding the restriction placed on the applicant's practising certificate, we are of opinion, having regard to the seriousness of the findings concerning the applicant's conduct in relation to the rendering during the referral period of regional and field nerve blocks, that the applicant's disqualification in respect of the provision of all services to which an item in Group T7 of Part 2 of the General Medical Services Table relates for a period of 12 months from the time when the final determination takes effect is appropriate. However, in the light of what has been said, the direction that the applicant be disqualified for a period of 12 months from the time when the determination takes effect in respect of all services in Group A1 of Part 2 of the General Medical Services Table must be set aside as must the direction under paragraph 106U(1) (h) of the Act.

Conclusion

69. For the reasons set out above, we set aside the determination made by the respondent on 7 August 1997 and in lieu thereof make a determination directing that:

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

(b) in accordance with paragraph 106U(1)(c) of the Act, the applicant repay to the Commonwealth the amount of $37,492.70 being an amount equivalent to the Medicare benefits paid in respect of the services rendered during the period of referral under items 18232, 18252, 18254, 18256, 18258, 18260, 18276, 18282, 18286 and 18290 in Group T7 of Part 2 of the General Medical Services Table and that any Medicare benefit that would otherwise be payable for those services cease to be payable;

(c) in accordance with subparagraph 106U(1)(g)(i) of the Act, the applicant be disqualified for a period of 12 months from the time when this determination takes effect in respect of the provision of all services to which an item in Group T7 of Part 2 of the General Medical Services Table relates.

Counsel for the applicant:	Mr M.B. Smith
Solicitors for the applicant:	Tress Cocks & Maddox
Counsel for the respondent:	Ms R.M. Henderson
Solicitor for the respondent:	Australian Government Solicitor
Dates of hearing:	26 and 27 February 1998
Place of hearing:	Sydney
Date of decision:	19 June 1998

The preceding 27 pages comprise the decision and the reasons for decision of the Professional Services Review Tribunal constituted by The Hon A.R. Neaves, Professor D. Tiller and Dr N. McH. Ramsey given on the 19th day of June 1998.

Dated this 19th day of June 1998

Diane Popple
Registrar