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Without prejudice

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# SUBMISSION
# REVIEW OF THE PROFESSIONAL SERVICES REVIEW (PSR) SCHEME
# (THE PATIENT VIEW)

**Executive Summary:**

I. Problems with Medicare/PSR Audit Scheme

II. Assessment of the Time and Content of the Consultation

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## I PROBLEMS WITH MEDICARE/PSR AUDIT SCHEME

1) "Rorting" of Medicare despite sensationalist articles appearing in the mainstream press is an infrequent phenomenon as agreed by all major players, such as AMA, RACGP, Specialists' Colleges and other medical organisations and fraternities as well as the Medicare and even Professional Services Review who investigate these cases. Considering that there is an ample confirmation of this in the PSR Director's Annual Reports, his Reports to the Profession and his press releases as well as in the Medicare own publications, the very low occurrence of deliberate dishonesty among the practicing doctors can be regarded as a fact.

2) However, of serious concern, also identified and agreed upon by all major players, is a common doctors' problem of interpreting extremely complex rules and ambiguous equivocal descriptors of Medicare Schedule for the purpose of itemisation of their services. The morass of Medicare claiming rules incepted many good doctors, causing concern among patients and anxiety among the medical profession.

3) It is against this major picture that the following comments about the Medicare/PSR system are made:

    a. The current, monstrous system of audit is disproportional to the task at hand, which it is supposed to carry out,

    b. The system is unnecessarily complicated and expensive, considering that the government own budgeting of 2500 extra audits for total cost $76.9m puts a cost of single audit at $30,760,

    c. It unnecessarily duplicates and interferes with regulatory powers of other governmental bodies, like AHPRA, Departments of Health and Aging, Drug & Poison Bureaus, Infection Control Units, Health Complaints Commissioner, various Accreditation entities as well as the Police and Local Government law enforcement units.

    d. It also unnecessarily duplicates and interferes with the regulatory mechanisms and checks imposed on medical practitioners by their professional Colleges, Associations, Practice Divisions, Continuous Medical Education and Craft groups.

    e. The powers of the PSR and Medicare Investigative Branch seem excessive and open to the bureaucratic abuse, allowing for the investigator, the prosecutor and the judge to be the same person or group of persons,

**f. The claim of the PSR Director and PSR Committees that they are peers and represent the point of view of majority of general practitioners, is imposed on a doctor without any real evidence or test proving it. Actually, considering how frequently PSR opinions differ from the opinions of other peers quite opposite may be suspected. The "holier than thou" attitude of the PSR seems to be entrenched and unshakable and any suggestion of an independent scrutiny of their claim is outright rejected.**

**g. The lack of independent scrutiny of the investigative officers of PSR and Medicare Investigative Branch seem to allow impunity, denial of natural justice and promote the culture of procedural unfairness. Of special concern is entrenched practice of ignoring and/or dismissing any external evidence, questioning the validity of interpretations, assumptions, opinions and charges of the Medicare/PSR investigators, so they do not affect expedient convictions.**

**h. The current PSR law seem to allow denial of basic rights and unfair treatment of both, patients and doctors. It is especially worrying when it occurs in regards to patients who after all were the ones intended to be protected by the system.**

**i. In particular the PSR scheme in its current form and practice allow that:**

> **i. the doctors are denied their citizen's right to be judged fairly, i.e. accordingly to the proven factual evidence against them, and instead are audited and judged on the basis of some general statistics which consider both, exceptionally good and exceptionally bad doctors, as "outliers", deserving the stressing experience of authoritarian investigation without evidence based recourse to the court system,**
>
> **ii. the doctors are not only made to fund the Medicare Audit Initiative but also to provide substantial revenue, in line with the budgetary modelling, aided by PSR 100% conviction rate,**
>
> **iii. the patients, despite not being guilty or charged with anything, have their confidential clinical records seized, searched, copied and stored in secret without their knowledge and consent, and without any recourse normally awarded by the Privacy Commissioner,**

**iv. the innocent patients upon PSR judgements are not infrequently denied longer consultations, more expensive pathology or radiology referrals and treatments, and in effect undeservedly are the ultimate target of the health service restricting and in effect rationing measures,**

**v. the patients are completely omitted and actually deliberately excluded from any participation in the Medicare/PSR investigations not withstanding that they the receivers and the best witnesses of the services provided,**

**vi. the doctor/patient relationship is eroded by the government interference,**

**vii. the idea of patients' right to choose their own treatments or request some tests and investigations does not rest well with the PSR and is outright dismissed, allowing for a free reign of the governmental fiscal policy.**

**4) The distinct lingering impression that one gets looking at the system of Medicare/PSR investigations is that although not immediately perceived, its main function is really to coerce medical practitioners, under the threat of audit and repayment, to provide their patients with cheaper service alternatives. As the result medical practitioner's situation becomes akin to the situation of a car repairer who is told by the car insurer to provide "reasonable" (read: "cheap") fix to the damaged car and disregard the driver demands for the "best" (read: "expensive") restorations. The difference is that in the case of a car insurance clients can easily change their insurer if they become unhappy with the insurer's cost minimizing behaviour, whilst in the case of health care unhappy patients can do very little to change the universal health insurer, whose behaviour exerts fiscally restrictive pressure on their doctor.**

**5) All surveys of the patients' opinions indicated that they want relaxed, not rushed, comprehensive, and longer medical consultations where their health problems and concerns can be properly reviewed and addressed. This is at odds to the repeated Medicare/PSR threats of investigation of GPs who do "too many" longer consultations and confirms that despite vehement denials the Medicare/PSR audits are underpinned by the fiscal policy of the government.**

6) **The current practice of PSR to seize read and store confidential clinical records behind the back of the patient and without neither patient notification nor consent is abhorred and resented by every patient who learns about it. The attached patient petitions are self-evident. Many of the patients express the indignation that whilst their homes cannot be entered and personal belongings searched without judicially issued search warrant, they seem to be subjected to a similar search of their personal medical records despite the fact that they are not guilty or suspected of anything. They consider the Medicare/PSR search of their personal records kept at the doctor surgery akin to someone breaking into their post office box or their safe box at the bank in order to search their contents.**

7) **Most of patients does not feel reassured that the Medicare/PSR access officials are doctors and actually prefer that they were not, so that the meaning of words like "STOP" (i.e. Suction Termination of Pregnancy) or "lupus" (i.e. syphilis) or "OCD" (i.e. obsessive compulsive disorder) would not be readily cognized. They are quick to point out that normally medical records cannot be sent by their doctor to other doctors without the patient's written consent. My conversation with the doctors, Transport Accident Commission, WorkSafe and a plethora of insurance companies confirmed that they are governed by the same standard need for a written patient's consent if his or her medical records are to be transferred and/or accessed. Even in the case of court subpoenas the medical records are usually kept confidential and unopened by the Court Registrar until the judge, upon hearing parties submissions, decides if the files' contents should be open and accessed.**

8) **Even the most powerful doctor regulating institution such as AHPRA, which has the ultimate power to remove practising rights and deregister the doctor, asks the patient for a consent in order be able to access their medical records (see attached de-identified copy of AHPRA request for patient consent to access their medical records in the course of a complaint investigation). In this context patients refuse to understand why Medicare/PSR should be treated differently by the law and be excluded from the requirement of patient consent.**

## II ASSESSMENT OF THE TIME AND CONTENT OF CONSULTATION

1) **Having read the 2009 AMA Submission to the Senate Community Affairs Committee Inquiry into Compliance Audits on Medicare Benefits (attached) one becomes extremely surprised why this sensible submission, especially in regards to the importance of protecting confidentiality of patient's medical records and integrity of doctor/patient relationship was not listened to and supported by the legislators.**

2) **The current community and doctor groups concerns about the Medicare/PSR investigations are nothing but the direct result of successively increased draconian powers of the Medicare and PSR. I appears that the Parliament was misled to trust bureaucracy assurances that the good will and self-restraint in the name of natural justice and procedural fairness would prevail in their use of this legislation.**

3) **It is understandable that the government wants to protect public from bad, dishonest doctors, who defraud Medicare, however the methods employed to identify such doctors are unnecessarily heavy handed, ineficient and forbiddingly expensive.**

4) **The main question at the heart of this consideration is how one can best assess the time and content of a consultation?**

    a) **AMA in its 2009 submission on page 10 states that: *"the only indicator of time spent with the patient will be doctor's notes in the patient's record reflecting what happened during the consultation,"* but on page 3 asserts that the patient record: *"is not primarily a record of Medicare items associated with the patient's care and it is essentially an unsuitable document to be used for an administrative check of the ascription of those items by Medicare Australia".***

    b) **Further in the same submission AMA postulates that: *"The patient medical record was not intended to be the source to meet Medicare Australia's compliance obligations, rather it is the record keeping tool which assists the doctor meet the ongoing medical care needs of the patient"* and expands that: *"Whereas doctors record the ongoing care of a patient in a separate and confidential medical record, they do not necessarily prepare that record primarily to satisfy an administrative requirement from Medicare Australia to substantiate the ascription of a particular Medicare item to any particular service".***

    c) **In the past when Medicare descriptors of short, standard, long and prolonged consultation were solely time based the assessment of the item use was relatively straight forward and basically involved measuring of the time of consultation. Unfortunately at that time only minority of medical practices were fully computerised and therefore the measuring of consultation time was manual and unreliable. Currently, with most medical practices using computer software such as Medical Director, the time if consultation can be automatically recorded and easily used for itemisation and accounting. Considering that the most recent change to the Medicare descriptors substantially decreased the emphasis on the descriptive content of the consultation in ascribing items, one is tempted to suggest that by continuing this**

**trend and making consultation items solely dependent on the time spent with the patient the itemisation could be made automatic and without fault, thus removing the need for the government to access confidential clinical information which measure is universally resented.**

d) **It is of significant concern that notion of the patient witness statement aided by the access to their own medical record has not been thought of by the AMA and the government. In the opinion of the author the time and content of the consultation can be provided quite well by both, the doctor and the patient who attended at the consultation. Both may need aide memoire in the form of medical record to recall the details required by the audit. Utilizing patient witness accounts would have following advantages:**

   i) **It will provide additional source of verifiable audit information without the need for the disclosure of the confidential medical records by the third party,**

   ii) **It may obviate the need for time and money consuming sifting through general mundane medical information and concentrate only on that which is relevant to the audit,**

   iii) **It may decrease remote, clinically detached and thus unreliable interpretation of medical records by a third party who did not participate in the consultation,**

   iv) **It may provide information which is not in the medical record thus removing current unjust punishment of very good doctors only because they are poor writers,**

   v) **It may provide the doctor and the auditor with evidence which would be voluntarily provided and patient sensitive,**

   vi) **It may pave a way to alternative sourcing of audit relevant information without breaching confidentiality of medical records.**

5) **AMA in the past seemed paranoid that through this approach a patient would learn that his or her doctor is investigated. They almost seemed to justify that somehow breaching confidentiality of the patient's record was a lesser evil than letting patients' know that their doctor is investigated.**

6) **The author does not agree with this approach. The patients have the unquestionable right to know what the government is doing to their doctor, "in order to protect them". The patient health care is dependent on the doctor and since these audits have potential to severely disrupt the health services provided by the doctor, they should not be conducted "in the interest of the patient" secretly, behind the patient's back.**

7) **Actually my conversations with the doctors who were investigated did not indicate that they were against informing and involving their patients – to contrary they felt that the universal exclusion of the patients' witness accounts and testimonies by the PSR amounted to the deliberate, procedurally unjust exclusion of exonerating them evidence.**

## III PATIENT REQUESTS FOR NOT WRITING DOWN THEIR CONFESSIONS

1) **AMA in their 2009 Submission on page 2 stated categorically that: *"The integrity of the confidentiality of the patient medical record is absolutely essential to developing, enhancing and underpinning the therapeutic relationship. This confidentiality secures the necessary trust and openness that characterises the ongoing communication between doctors and their patients to optimise patient care".***

2) **One must agree that in the above context the therapeutic relationship and ultimately patient care will inevitably suffer if the government gets free hand to breach both, the integrity and the confidentiality of the doctor/patient relationship.**

3) **Recent seizures of medical histories from one of the doctors surgery allowed the PSR's to pry into information concerning sodomisation of children by a Jewish Rabbi, learn details of an abduction and rape of a young girl by drug addicts and access confessions of despair, crime and sexual difficulties of an invalid. As the result the future care of these patients would be jeopardised.**

4) **It is again postulated that for the purpose of checking the correctness of ascription of the Medicare items the breach of confidentiality of patients records and unashamed reading the details of most inner confessions of sick people is not warranted and should not be easily permitted.**

5) **An alternative approach, where the patient consent and involvement is sought early and audit relevant information rapidly verified by the patient should be considered.**

**6) The PSR Director recently advised that if a patient asks that the intimate contents of his or her admissions and confessions made during the counselling session are not recorded in detail (so that they cannot be accessed by any third party, including the Medicare and PSR), the patient must bear the full cost of such counselling without any eligibility for Medicare rebate.**

**7) This draconian PSR interpretation of the Medicare descriptors deeply concerns the author of this submission as it has a potential to severely affect patients care and has already drawn protest of patients (see attached Statutory declarations).**

**IV <u>SUMMARY:</u>**

**1) Every system of autocratic political coercion is based on the perceived fear of legalised authoritarian unjust investigation and punishment.**

**2) In democracy the laws, especially these which deal with the investigative and punitive powers of government agencies, must not only provide natural justice and procedural fairness but must appear to support them.**

**3) This does not seem to be the case with current Medicare/PSR piece of legislation which appears to sacrifice principles of natural justice and procedural fairness for the sake of expedient, trouble-free convictions. The Medicare/PSR investigative officers, considering the gravity of their function, must be made subject to rigorous checks and their actions and decisions must be subject to the independent scrutiny and verification free of political influence.**

**4) The reference to the evidence based medicine and truly independent arbitration must be available early and if proves unsuccessful both Medicare/PSR and Practitioner Under Review should have recourse to the formal judicial review before the Federal Court of Australia.**

**5) Consecutive changes to the Medicare/PSR piece of legislation resulted in excess (and abuse) of power, lack of bureaucratic accountancy and blatant injustice against both, doctors and patients, whose right to natural justice and procedural fairness were routinely violated, ignored, disregarded and disposed off for the sake of expeditious prosecuting.**

**6) The penalties imposed by the system, such as restrictions on the length of consultations or on ordering some tests were also nothing but an undeserved punishment of the patients. The requirement of repayment of the Medicare benefits paid for pathology or radiology services by the GP who ordered**

**them in good faith, without any perceivable personal gain and out of his or her concern for the patient does not seem to be just and certainly should not be described as "repayment", considering that this benefits were never paid to the GP in the first place.**

7) **The current PSR laws that allow the investigator, the prosecutor and the judge to be the same must be immediately abolished as undemocratic and unconstitutional.**

8) **New laws must be developed in close engagement with and active partnership with the people they are designed to protect. In this context the current practice of exclusion of the stake holder patient from involvement and provision of witness' input into the audit is unthinkable and should be stamped out and replaced with a system where the patient is actively involved and aided by his or her own medical record in providing necessary audit information without the need for a third party to pry into his or her personal confidential record.**

9) **New laws must enshrine and actively protect the universal, sacred concept of confidentiality of the patient record and integrity of the doctor/patient relationship. They must allow doctor to have discretional right to grant the patient request for total privacy and not write details of confidential counselling if such measure is in the patient interest and therapeutically justified, without the patient penalty of having to pay for such consultations out of pocket.**

10) **The new laws must recognise that since medical records belong to the patient, an unauthorised access to them represents nothing but a violation of the patient's right akin to any search, involving patient property.**

11) **The only circumstances where medical records can be seized and examined without the patient's written consent by the third party must be those where an official search warrant is sought and obtained as a last resort measure after judicial assessment of the case. Anything short of this is nothing but the violation of the natural justice, of procedural fairness and of the Australian constitutional guarantees.**

**Respectfully yours,**

## V ATTACHMENTS:

1) **AMA Submission to the Senate Community Affairs Committee, Inquiry into Compliance Audits on Medicare Benefits, April 2009,**
2) **The Australian "GPs anxious over Medicare watchdog",**
3) **6 minutes "GPs being 'paranoid' about Medicare audits",**
4) **Medical Observer "'Defensive medicine' no excuse, despite GP being sued',**
5) **AHPRA de-identified standard request for the patient consent to access medical record,**
6) **Statutory Declaration of Paul Egan, 11 August 2011,**
7) **Statutory Declaration of Krystyna Widera, 8 August 2011,**
8) **Statutory Declaration of Nahapet Amiryan, 8 August 2011,**
9) **Statutory Declaration of Tatiana Grosheva, 8 August 2011,**
10) **Letter of Anna Zamecznik, 12 August 2011,**
11) **Letter of Peter and Lydia Spitz,**
12) **Patient Petitions (five).**