Dear Honourable Members of the Committee,

1. I make this submission in a number of capacities : as a Medical specialist; as a recipient of three post graduate specialist qualifications as a previous GP which, in 1986/7, brought me into contact with the PSR predecessor; as a respected interventional radiologist; as an international speaker on interventional chronic pain conferences and national musculo-skeletal specialist conferences; as a member of public; Medicare recipient; patient of several very good doctors; as a friend of numerous doctors who have aired concerns they have with the PSR system; and as someone who is able to freely speak without fear of persecution by the PSR (unlike most, if not all, of the 100-200 doctors with whom I have spoken regarding the present PSR situation).

2. As a result of the above experiences, my direct contact with this disgraced PSR and previous contact with its predecessor, many conversations I have been involved in with many doctors (mostly GPs), I have researched the legislative basis for the creation, investigations and operation of the PSR. I am very familiar without being in any way expertly proficient at interpreting legislation as a result of over 5 years of being a Government Medical Officer and Commonwealth Medical Officer in the 1980s. I am also proficient with interpreting the evidence base in medicine which I have noted to be missing from the PSR verdicts, invoking 'ratio decidendi', and its ramifications and associations within Superior Courts In short, the *ratio* in *Donoghue v. Stevenson* would be that a person owes a duty of care to those who he can reasonably foresee will be affected by his or her actions.

3. I will state from the outset that I, and all reasonable persons, would agree with the need for auditing of doctors' claims (as do ALL of the doctors with whom I have spoken). Accountability is important in all aspects of life as well as finance, politics as well as health politics. Accountability is properly imposed on all those in positions of power and as such the power of doctors to enable the the therapeutic transfer and bill accordingly. This then may be extended by logical development from a valid premise to proper billing to any third party such as any politically appointed Insurer Authority in Australia, HIC, Medicare proper. Morally ethical and fiscal **accountability must however extend across both sides of the insurer provider equation** and the PSR watchdog instrument must show the same high levels of accountability as that expected of doctors in all avenues of medicine and health care politics.

4. This submission will simplify and perhaps explain how proper logical development of an invalid premise can result in improper aspects and malfeasance by legislated anomaly:

- change is required,
- change is required urgently,
- should change occur then it must address the fundamental shortcomings.

Fundamental shortcomings may be considered under the following headings:

1. Legislation as it stands;
2. Omnipotent Legislative Interpretation is facilitated by the legislation as it stands;
3. Privacy & Doctor Patient Privilege;
4. **Accountability** and transparency of the PSR instrument
5. All doctors including the PSR must practice and embrace the modern paradigm of **EBM**
6. All contact points with PSR must have **mandated union representation**. Legalese is less able to contribute in real terms.

5. The Therapeutic Mandate which is universally seated with doctors individually and severally - but doctors only - not some insurance company whether government backed or anyone else.
6. History: medicare and the watchdog instrument have **no standing in medicine** and should not go directly to the public with often wholly simplified and or wrong statements of mis-fact or mis-statements of the evidence base.

Background:

The PSR was created by the Wooldridge - Richardson government in close and classified drafting collusion with the AMA of 1994\5 to mitigate what was proposed as an enormous financial over-extension and risk overexposure mismatch that could not be brought under "control" by the prior generations of the PSR. Though the AMA makes much of the PSR being a per group there is in fact very little evidence of three - one directors deputy director and two subservient members - them being anything close to the legislated descriptor of the general body of peers. There is no evidence that the PSR has saved any monies at all and has certainly cost the doctors and community dearly. There remains substantial unlikelihood that a chair and two underling committee appendees - often from the AMA itself ...why on this side of the bench if they are the doctors association...- can be approximated to the general body of peers and that this opinion based backwardness is anything other than an invalid premise off which to develop the local determinations for so called peer review. Confounding factors are rife and the assumptions exponent-ed to bias. That the AMA created this flawed monstrosity is bad enough but that they continue to thumb its importance to fairness and doctor doctor privilege is extraordinarily uncaring given the reality of the situation. The AMA may find it difficult given their reticence to transparently and clearly define their perceived role against the PUR without sufficient - any open forum nor widely publicized disclosure to the membership of this counter-intuitive sitting with the prosecution with open and wide disclosure. Our membership - the Australian Doctors Union - do not have any evidence that they - the AMA - sit with the PUR while there is substantial evidence that they sit against and receive vicarious honors for this and other gratifying and self-ingratiation behaviours. Certain elements of their membership may want blood for this misrepresentation or deceit. This is ACCC non-disclosure of mission critical information for a doctor who may be considering joining the AMA.

I will endeavor to make clear how these each contribute to an unnecessary, unhelpful and improper imbalance of power in the watchdog /appellant relation in investigation [PSR vs PUR] and prosecution [legislated watchdog instrument vs. appellant] even when the committee/ director/ chair structure **is** legally appointed (and recent events might suggest this may only be a hypothetical situation).

I will endeavor to make clear how these changes will, in fact, be cost-effective for this and future governments;

I will endeavor to make clear certain negative ramifications should this Senate leave the Federal Government vulnerable;

I will endeavor to make clear certain negative ramifications if this Inquiry fails to take decisive action to amputate denial of natural justice permanently changeable in the highest of courts for the foreseeable future; and

I will provide simple submissions incorporating logical evidence based substitutions to effect proper policing able to distinguish 'good doctoring from bad' which is a necessary but not sufficient condition in order to achieve certainty of justice and effective policing outcomes.

If one would commence an inquiry, reference to the PSR website and Annual Reports is a good place to start. Notwithstanding recent court cases that have gone against the PSR, the most recent I am aware of because of the published proceeding Full Federal Court, NSW, on 28 July 2011 in Kutlu v Director of Professional Services Review [2011] FCAFC 94. This has documentation at the highest legal level though there were numerous other breaches of the legislation being committed as commonplace with less powerful documentation which I will touch on when requested. (I will not disclose these issues at this time, as I believe they will likely provide legal grounds for actions in the future.)

6. Perhaps the most disgraceful legislation, the *Health Insurance Amendment Act 2011* colloquially termed the "Medicare CEO Notice". Particularly the requirement to supply electronic or other data regarding private patient doctors recordings and at complete juxta-position to widely held privacy and doctor patient confidentiality protocols and legally specified rights. Specifically, the gross invasion of privacy that destroys the doctor-patient confidentiality is appalling and will only have adverse effects on the community. See the 'news papers' on our governments claimed desire for protection of privacy in

light of media transgressions overseas. Alarmingly, this is specifically and precisely counterpoint to our present governments actual behaviour by constitution and royal assent of this bill right here in Australia. As a priority, this must be amended to involve judicial authority for cases which are all but proven.

7. The evidence shows and it is also widely and correctly held that when a person or group of persons are not certain of confidentiality, it is innate to human nature to restrict information feed and/or conceal self -implication, contacts whether real or potential, embarrassing or otherwise sensitive details. Any legislative appendment to this effect would not be supported by the evidence and thus not in the individual or collective's best health interest. This mitigates all the long established and evidential effort to track and monitor infective diseases (which are the 21st century scourge) not to mention ethically and morally re-pungent interference with legislated, moral and ethical doctor patient privilege constructs. It is clear that the intrusive nature of this unnecessary and recently transited royal assent as yet another obscenely intrusive privacy erosion by counter productive enhancement completely non-evidence based PSR's power requirements. People may withhold certain details which may have, if known, afforded the treating doctor sufficient information to appropriately and effectively treat the underlying condition. HIV or other serologies are exposed to non-doctors. It must be understood that the holder of said Notice is not required to be a doctor and is therefore not bound by doctor patient confidentiality in any specific sense. This is wildly erratic of the designer and marvelously misguided legislative drafters notwithstanding and whoever the proposed final recipient within Orwellian Organs of Medicare of these e-data may or might on any one working day be [doctor or otherwise]. e-data cannot be destroyed in the most fundamental way that spoken of hand written datas may. Wiki-leaks showed the world that the most sensitive of e-data are vulnerable despite the full force of western governments to secure. The evidence shows that hundreds of e-leaks of medical data occur every year with only the vast minority being realized for what they truly and potentially perpetrate. In practice, concealed information results in exponentially further tests requirements, referrals to other practitioners etc – all of which attract Medicare rebates/expenses. To be clear, this is a polynomial /exponent relation. If one simply does not disclose [for whatever reason] the history of physical trauma [say] because one worries that the government access could leak today or anytime in the future linking an incident or link a perceived transgression to a police incident or 'affair de cour' then the investigative costs literally increase in a polynomial or exponent of the otherwise simple medical decision making. It is not unheard of for such mis-informations to result in tens of thousands [or more] of dollars of unnecessary and time consuming investigations when the honest truth would have got the answer in a moment for less than a hundred bucks.

8. I am positive this Senate Committee will hear more from other parties about the privacy issue, and I sincerely hope you realize that you cannot overstate the deep and disgusting hypocrisy this will promulgate in the eyes of Mr. Jo Average and most particularly [in my experience] on behalf of and by his wife and kids in the wider community. The public are initially disbelieving and then appalled as they discover magnificence of this governmental mis-appropriation for the non -evidence backwardness that is our present watchdog. Backward because they have not even embrace the rigor of objectivity required to practice medicine. We are but interpreters expert in the evidence base and our opinions are nowhere of value unless couched in that evidence base. This legislative incursion across privacy has the potential to be remembered as the greatest and most flagrant hypocrisy well after it is inevitably replaced...what sound minded individual would tolerate that - particularly when the idea of rorters ripping of millions is, in fact, not established in evidence but seems promulgated in the backwardness of 'policy-based opinion' and 'opinion-based policy' rather and evidence-based policy. Evidence in science is real to the degree that it is supported. Words (opinions based in words rather than sound methodological development of valid premises) are the privations of the languages, arts and law but not medicine and science.

Privacy erosion to the most prized social covenants of our society (the doctor-patient confidentiality) will inevitably incur and be liable in tort or like. This is particularly so given that there is little of any consistent evidence that the watchdog saves even a single dollar in the medium to long term. Worse still is evidence that **this non-evidence based [the committees and chairs and the director have nowhere [ever] referred to the literature** - apart to a somewhat infantile two line reference by Hon Dr. AJ Holmes when he submitted that there is no definition of appropriate practice but that note-taking is critical to the therapeutic exchange cited BMC (British Medical Council) booklet, which is neither peer reviewed and quite simple a resident handbook akin to that given to beginner doctors by helpful hospital *charge de fair*] in the summary or other aspects of the decisions the way EBM (Evidence Based Medicine) doctors can and regularly do in submissions for any and all respected peer reviewed publications] watchdog changed doctors behaviours as well as their billings in a real and demonstrable way. Were this to occur in accordance with the evidence then this may actually promote best practice and the Hippocratic ideals captured therein.

9. However, the legislation and operations of the PSR are sub-standard in many more ways than just the invasion of privacy aspect. The biggest, most obvious flaws in the operations are the denial of procedural fairness. Legislation, investigative powers or procedures of this nature should NOT be accepted, tolerated or permitted within Australia – and I am sure will not be backed by the Superior Courts as more matters become resolved in such forums.

10. Another example of the unnecessarily draconian powers drafted into the PSR legislation by AMA at the behest of and intimate, if not strict confidential collusion, with the government of the day (1994/5) the PSR has adopted is the fact that ALL aspects of the audit, investigation, interview, review, hearing/appeal and sentencing are done under the banner of “PSR”. There is absolutely no genuine external agency involved, hence the Director of the PSR has a bias in ALL matters. This, too, is in breach of ‘The Bias Rule’ and the ‘Appearance of Bias’ – as defined in the Federal Government’s website,
http://www.ag.gov.au/www/agd/agd.nsf/Page/Securityvetting_Whataretheprinciplesofnaturaljustice

11. As far as “agreements” or “settlements” are concerned, I ask the senate to seriously **consider whether or not the doctors involved entered their “settlements” of their own free will**, or under duress or coercion. This is important as it goes to motivation and statistical prejudice. The NAME and SHAME anomaly came about as a result of the director of the times navel gazing. it must be noticed the enormity of such interpretive largess. In criminal or common law courts the charges are laid before the actual court inquiry and the PUR has a right to cross examine the evidence as presented by the prosecution. None of this applies in this legislation which facilitates perfect conviction rates unfettered by evidence, cross examination or appeals in evidence, science or natural justice incursions. One must be mindful, of course, that the person under review (PUR) has almost invariably been properly advised by their legal rep. who is really obliged to state the facts approaching 100% conviction topping out to that perfect 100% figure over the last 3 years, that any further action WILL COST financially and emotionally and very, very unlikely to be successful. Where is the free will and voluntary choice free from a grossly coercive statistic properly supplied by attendant legalese ?

If a police officer of this simple mind game asks one to accompany them to the police station, then advises them that they’ll be arrested if they decline, then the person has been found to have acted under duress if they ‘voluntarily’ accompany the officer – I cannot see how this scenario differs. Now if that police officer had the powers of the PSR which they certainly (and thankfully) do not, the person pulled over for speeding may presume that they would be availed of their speed transgression...to wit the PSR reply is typically "I don't have to tell you" which is precisely correct under this PSR legislation. Subsequently the PUR, who we naturally suspect of being a speeder because well...he was pulled over and...while mere mortals make mistakes there is a certainty of a degree of culpable driving when you are pulled over... we know that while normal police make mistakes and can be corrupt and do things wrong or wrongly the PSR evidently do not ...for there is no presumption of innocence in the PSR court...finally the driver might rebuke since he presumes he has rights and asks if he was being charged...again the PSR answer is typically and absolutely accurately "we don't have to tell you" which is incredibly accurate and incredibly morally unethical as they do not have to charge anyone before dragging them into court with no charge at all though the familiar muse of the chief convictor has long

been expressed as 'a lingering concern'.

12. The documented, illegal mis-appointment of Committee Members has recently been examined. Some context is important here. The recently beefed up full time staff for the PSR juxtaposed to the PUR virtually always working a full time job, understandably stressed and without any representation from their AMA association despite a general presumption that the AMA would do so - a point not lost on some members who claim that this may breach full disclosure regulations with recent ACCC submissions to that effect. Perhaps this is just not properly addressed in the AMA advertising to the public and paid up constituency. On the other hand, the evidence nowhere suggests proper monitoring and proper jurisprudence of a form expected when such an imbalance of power exists. To be clear, there is no evidence of the departure from legal appointment being revealed as part of the normal and proper self revelation of mistakes such as that required of doctors as part of the ethical basis of their relationship with other doctors and patients alike. Nor is there strong evidence of any self-regulation, exercise of proper due diligence, ethical auditing or arms length credentialing or site accreditation. These latter points are mandated upon all doctors - even those working in this heaven sent and stupendously self-assured prosecutorial nirvana. Jurisprudence and proper judicial caution and self-monitoring by the authority itself may therefore be considered suboptimal by some, deficient by others and completely absent to those who have been laid waste by their convincingly self important but nowhere strong in evidence-based medical synthesis colleagues- Kutlu v Director of Professional Services Review [2011] FCAFC 94. This was resolved against the PSR. There are many further avenues for other appellants to examine in the higher courts – and they are being advised accordingly. The evidence is that this has at least the potential to cost the government of the day a significant amount of money and votes. Yet the director has submitted recent and prior annual reports with the terse and perhaps under-considered or even inaccurate descriptor of "nil" as the published response to the heading designated "Contingencies". I run a private diagnostic company and a private public funded research Institute. I have also been instrumental in creating public companies. When the contingencies to shareholders do not speak to real evidence and misgivings are potentially avoided rather than alerted to the stakeholders of the kind lauded to herein then the stakeholders and shareholders alike have a right to ask, and if unsatisfied seek recompense. It is clearly insufficient for shareholders and in this case treasury stakeholders to substantially pay up for reporting errors of the Director if this were the case. But with upward of 17-25 staff and only 50 cases per year the director is most certainly in the best position to advise the government accordingly. Perhaps, however this was a mis-spoken factual inexactitude similar to the 'clerical error' euphemistic descriptor he retorted of his recent illegal mis-appointment of committee members and chairs exposed in recent media.

13. I accept that the inception of the PSR and original legislation may have started out in good faith and while wildly ill-conceived, the drafting may have been well-intentioned, however what has transpired has left a stain on the history of Australian privacy and a formidable disturbance to doctor-patient confidence. It has caused damage specifically and unavoidably to patient confidence and confidentiality as well as the enshrined doctor-patient privilege underpinning the EBM therapeutic transfer strongly supported in evidence.

On the other hand, I briefly allude to the grossly imbalanced procedural fairness within the confines of the omnipotent PSR vs stressed, hard working PUR who finds him of herself stranded without any Union representative nor association support (despite the allusion to support promulgated by or alluded to without full disclosure of AMA interrogatory). Hence, the overhaul MUST occur and must address legislated removal of inability to appeal in evidence, cross-examine in evidence, have reasonable time to prepare similar to that afforded to others considered guilty of a felony [rather than the 14 days that some specialists had to gather and collate and annotate 400-500 publications required to represent the full evidence base for and against safety and the complex decision making underpinning best practice. to wit the director in his pomposity elected to completely ignore to the collapse of the evidence based doctors defense case. Finally, the legislation as it stands is specifically perverse and contrary to all other natural evidentiary appellate courts or courts of appeal where the **charges must be laid first.** Any medical construct must have no more or less rights than any other court. Hence any new construct must be brought into line with normal natural justice precepts, and ban omnipotence under the act and

restore culpable regard for process in evidence and the effects of the decisions seen in *Donoghue v. Stevenson* in the snail in a bottle item of common law president. To rid the system of the corruptive powers and restore faith, honour and replace lawful thuggery with evidence based medicine precepts objectifying the endpoint to best practice rather than the indefinable opinions of inappropriate practice.

14. As I have briefly explained a couple of aspects of the way the PSR conducts/operates itself in investigations, I am sure you will hear many more appalling actions first hand from doctors who have felt victimised /persecuted by the process.

15. In fact, I submit to you that the operational activities and methods of the PSR inevitably but unnecessarily polarized the medical profession against what is clearly a non-evidence based PSR locked in archaic backwardness out of step with international best practice and medicine itself . EBM is medicine today and the future. Opinions about all aspects of medicine are defined and definable in evidence reducing the subjective descriptor of best practice to one of objective beauty. Best practice (as opposed to the null hypothesis of inappropriate practice is most clearly defined in evidence and nowhere else does objectivity flourish in such a prevalence specific fashion, grand and testable [falsifiable in the Emmanuel Kantian sense]. This point was not lost on the prior director Dr. AJ Holmes who stated for the record that inappropriate practice was indefinable. So the membership of the Australian Doctors Union have banded to together to strongly advocate objectification of culpable subjectivity which is challangable in tort accessing the coffers of the treasury by **replacing the subjective bar** of *"inappropriate practice according to the bulk of the general peer group"*...**with the objective EBM measure of** *"best practice - or departures therefrom - definable in evidence and against the Evidence Base and all syntheses thereof"***.**

Objectification is required is to bring the policing watchdog into the 21st century by mandating the EBM precept to underpin all evidence for and against. **This will objectively facilitate the most fundamental requirement...that of distinguishing a good doctor working very hard from a bad doctor billing very hard**.

It is clear that the actions of the PSR have created an adversarial relationship between them and PURs. They are unnecessarily and unnaturally over-powerful and skewing the just balance of power within the interrogation in a perversely unfair way. But worse than that, they are actually quite ineffectual at actually being able to do the job of a discerning policeman...WHY?.....

The answer probably has something to do with flourishing subjectivity of opinion-based medicine and opinion-based policy as a substantial generator of excruciating randomness and non-specific falsifiability of the watchdogs 'bite'. This **Director has never made any effort to change** to EBM or utilize the colleges that would have safeguarded his opinion based policy by couching it in evidence. Webber has specifically grown this business of 'kill at any cost' without at any time referring to the paradigm of Evidence and Evidence Based Medicine. Webber has not made the efforts to keep up and bring his team in line with evidence nor shown any appreciation for the importance of the evidence base. Perhaps the Director actually believes that the evidence base is subjunctive to his opinion. This position cannot be supported in evidence anywhere else in the world making it unlikely, though of course not impossible. *It is possible, that he may in fact be the Oracle.* That the evidence is very strong against this, does not completely disprove the possibility of a unique ability on his part, but just makes it substantially less likely than a chance of one across any inner product space of the entire Millennium.

Certainly our PSR under the Director has never felt moved to reference his summary judgement in evidence. Such a clear reference to the evidence base would be akin to a judiciary preamble citing precedent and relevant common law. Basing judgements in Evidence and couching determinations in evidence and against the evidence base provides clarity and *raison d'etre* for the conviction. While it may not be able to explain 100% perfect conviction under this directorship it would have certainly protected the public dollar from future action in a substantial risk mitigation way. The brave and confident may still explain to the government who entrusted the office with unfettered legals, support and uniquely powerful legislation and interpretive freedom and immunity and funding and personal income above any other public servant particularly when performance bonuses are taken into account. The prudent credentialing of office is vital for protecting the treasury dollar which may be otherwise

risked because of lack of referenced support in data and against the evidence base of EBM and objective best practice. This single step by prudent legislative drafter would mitigate and substantially avoid a future charge of inexactitude and reparation charges. It also would protect from charges of bias by objectifying his rationale in evidence from the literature. It is not clear why neither the drafting nor the subsequent directorships had not sought to embrace this universal standard. It is not clear why the committee was not briefed on appropriate practice of their position and in the interpretation of the evidence base. It is not at all clear that the PSR has embraced evidence based medicine like the rest of the international medical community. It would certainly have been useful to strengthen their position against the charges of bias or other improprieties now being levied and against this Independent Authority.

16. For this reason alone, the legislation needs to be amended/repealed/replaced. I also submit to you that the investigative and operational procedures employed by the PSR MUST also be overhauled. Please also mandate proper union representation at each and every PSR/PUR contact point. The membership of the Australian Doctors Union generally see the rights afforded to criminal and common law or civil courts with considerable envy. This is in absolute contra-position to bleating fear mongering of the AMA who can be seen to repeatedly sub-serve fear in the minds of doctors that the 100% conviction [or perhaps assassination if it is to be 100%] PSR is completely done away with. We the ADU, on the other hand feel that PUR be afforded many more rights if they were charged by police in the courts rather than this co-seated committee bench PSR-AMA collusion. It is clear that 100% conviction indicates a flawed system rather than a perfect system. This bleating AMA PSR collusion favours a self serving status quo which has brought us to this impossible point. The ADU is of the view that any PUR would be almost certainly better off if afforded the rights given to any other of our community. Specifically the right to appeal in evidence would be an enormous benefit afforded to bikie gangs and their lawyers but not us. And on that point, why is that legislation designed to target bikie gangs, and other illegal organisations, permits them to have legal representation and defense, yet this system was specifically designed to avoid PURs having legal defense ? (it says so in the PSR webiste, policies and references)

17. To overhaul the operations and procedures of PSR investigations does not need to be a difficult, complex or unique set of guidelines. Given the nature of their work, and the likelihood of matters being contested, and ultimately ending up in court, the logical and obvious implications are for the investigators to follow established legal protocols such as Judges Rules, Natural Justice, Rule of Bias, admissibility of evidence and so forth.

18. Naturally, I realize the first response to the suggestion of change is resistance, however a quick, albeit superficial review of the performance and perception of the PSR may assist. The PSR does not get, nor deserve, assistance, cooperation and/or respect from the doctors they are auditing. As a direct result, their auditing processes have been modified in a draconian fashion in order to compel information be passed over. The chances of a successful, unbiased, fair outcome in a situation where conflict is inevitable are minimal.

19. The mere fact that 56 of the last 56 cases that have been determined before the PSR Committee have ALL been found in favour of the PSR does not mean the system works. On the contrary, it signifies the system may be irreparably dysfunctional and lopsided. The fact that the PSR can ‘hear evidence as it sees fit’ has been met with unjust consequences. This has been taken by the PSR to mean that they can ignore, discard or omit defense evidence by a PUR. These are just a couple of cursory issues that are symbolic of an inherent, systemic abuse of process and power.

20. So rife is the arrogance, abuse of power, dereliction of obligations and complacency for regulations and so prolific is its occurrence, that the Minister has not even adhered to their responsibilities – nor the senior executive of the PSR. Whilst many may want to argue this point, I refer this Inquiry to the findings and comments in Kutlu v Director of Professional Services Review [2011] FCAFC 94.

21. As stated earlier, this level of arrogance and autonomy cannot be allowed to continue. It must be eradicated by any and all means necessary. The organisational culture of the PSR must not be

permitted, by person or planning, to transfer to a lawfully operating, functioning, accountable body designed to effectively audit the doctors' Medicare claims.

22. Whilst paragraph 21 may seem extreme, I submit that so too are the clear, unambiguous words used in the findings of the aforementioned case – and the subsequent ramifications of same (which, at this point in time remain to be seen, but will be elaborated on shortly).

23. In terms of "planning" as referred to in paragraph 21, I submit that the planning of new appropriate, sufficient, balanced, lawful legislation must be conducted in consultation with as many stakeholders as possible. Consultation on legislation and operations MUST include many more organisations, groups and individuals than merely the Australian Medical Association (AMA) – whose senior management stood to gain/benefit from the formation of the PSR and the skewed practices developed within the PSR. (Were they not the majority of people appointed on Committee's and/or Determining Authorities ? Were the determining authorities properly convened and appointed...or did they receive the same treatment as the committee membership and chair persons or directors deputations. Did they receive remuneration for such roles ? Why do they sit on the panel against the PUR instead of at his or her side at all encounters as would be naturally expected of a representative association...particularly one that does not disclose that they explicitly do not sit on the side of the PUR which may be a significant non-disclosure...?) Have the DA been properly and legally elected and re-elected to their position of extremely prejudicial power.

24. Furthermore, input should also be sought from police officers, forensic accountants, barristers and solicitors to establish due process, procedural fairness/natural justice, negate the Rule of Bias, comply with the Judges Rules and rules of admissibility of evidence etc. The investigating body must only be allowed to use lawful and ethical practices in order to obtain evidence.

25. Another aspect that should be incorporated involves having separate investigators, prosecutors and adjudicators – not all from under the single banner, at present the PSR. This could instantly negate any defence or argument surrounding bias issues.

26. By conducting the investigation 'properly', matters of clear deception and/or fraud could then easily (and inexpensively so far as the Federal Government is concerned) be referred to police for criminal proceedings, whereby all previously obtained evidence is admissible.

27. Whilst it has already been acknowledged that the changes proposed in this submission will cost money to materialise, there are a few simple facts which prove that this money NEEDS to be spent AS A COST-SAVING EXERCISE, if nothing else. FACT – because of the arrogance and inattention/neglect of details/procedures, the Full Federal Court, on 28 July 2011, awarded a substantial amount of costs (associated with legal proceedings) against the Federal Government, via the PSR. FACT - the wording in the verdict handed down in Kutlu v Director of Professional Services Review [2011] FCAFC 94 is so strong that there are clearly going to be other ramifications as a result of it. FACT – many doctors who have been persecuted by the PSR since 2000 ARE looking at their legal options, secure in the knowledge that the precedent has now been set, and costs will likely go against the PSR in all other similar matters they fail to resolve without court intervention. FACT – many doctors ARE already exploring other legal options available to them in regards to seeking much, much more money from the flawed PSR. FACT – more doctors WILL be successful (it may only be 'forecast' at this stage, but you watch it materialise into fact as other proceedings reach the verdict/s !)

28. I submit to you that the current PSR has no faith or respect to lose; the current PSR has **no goodwill to forfeit**; the current PSR has no legal credibility; the current PSR has unlawfully convened many, if not all, Committees for many years; the current PSR will now become a litigant lawyers paradise; the current PSR will have no way of stopping other PURs similarly proving their Committee had unlawfully been established/convened; the current PSR will be ordered to pay costs for many other PURs cum Appellants; the current PSR is now vulnerable to innumerable court cases, fees and costs – with no real or substantive benefit to the taxpayers of Australia.

29. Aside from the snowball that has been set in motion regarding the establishment of PSR Committees, the PSR is also open for further court action as a result of the clear, unambiguous wording of the Kutlu judgment – claims such as pain, suffering, damage to reputation, loss of quality of life, loss of income etc etc etc .... and all from an unlawfully structured mechanism ?!

30. Nothwithstanding the sizeable claims that could, and will in the opinion of the ADU membership, be brought against the PSR for reasons discussed in paragraph 29, but I also understand the family and legal representatives of Dr Peter Tisdall may also have grounds to take action, albeit posthumously on the doctor's behalf. Perhaps the Senate Committee could take the time to see the approximately 1500 people who have rallied to show their support, admiration and respect for the doctor since his passing on 26 June 2011 – and about 15 years into disputes with the PSR ! Why have they persecuted, and defamed (by taking out advertisements in local papers) a dedicated doctor who clearly provided his community with the care, support and time that they needed and/or deserved ?

31. Or is the problem also that the current PSR cannot distinguish between a good doctor and a bad doctor ? Merely identify a statistical anomaly ?

- Hide quoted text –

32. Again, notwithstanding previously mentioned claims that will soon be made against the PSR, however doctors who have been coerced into making repayments to Medicare may now also become entitled to have those repayments re-imbursed. The body which forced them to make the repayments had been illegally convened/established, hence (per Kutlu v Director of Professional Services Review [2011] FCAFC 94) all subsequent resultant actions become null and void.

33. I submit that this Senate Inquiry Committee needs to direct a way to be negotiated such that PURs who fall into this category can re-negotiate new "settlements", or agreements whereby the PURs are satisfied with the outcome. I also submit that failure to do so will have two consequences : 1. Court action will be taken and the Federal Government will be substantially more 'out of pocket'; and 2. Good doctors will either leave the profession, take early retirement or stop bulk-billing (especially in remote and/or minority/ethnic group regions). I have heard talk of this being planned by some, if this Committee cannot take the required action and to the required extent.

34. I submit to you that these arguments have demonstrated the real, urgent need for change. I also submit that the longer this system is allowed to operate in such an unethical and unjust manner, the more claims there will be, the more court cases they'll lose etc etc The referrers in my regional well used to their interventional radiologist and nuclear specialist and to this end I do a lot of work for a very specific set of conditions included under the heading of chronic pain. I have international publications being reviewed at present and soon to be published on this and other subjects. I collect all our data and have the largest study of its kind in some areas of imaging. None the less my practice is 'a basket case' since Webbers hench-men locked in on my referrers - have continued to badger my referrers. I am looking a loosing 10 years of work to pay off equipment. Radiology is like buying new color TVs - not worth anything after removed from the shop floor nor for sale on the open market.

35. I submit that these reasons, apart from the moral, ethical and legal arguments JUSTIFY a complete overhaul of the entire process. Any expense incurred will be more than made up for in savings in the future. That is, stop losing court cases, stop having to pay others' legal costs, stop having the repay 'fines', stop having to pay punitive damages and there will be obvious savings ! Develop and employ strategies and change mechanisms immediately and stop handing out money. The "change" will start paying for itself from Day One. Can you afford NOT to change ?

36. "Change" does not mean for a second rescinding any or all rights to audit doctors' claims. That is not what I, the doctors I am liaising with, or the general public want to see happening. There should be no amnesty period, despite there not being a body in place at the time to conduct the audits. New legislation, when formulated correctly and with appropriate consultation and input from as many

stakeholders as possible, should be made retrospective, such that the legislation can be enforced back to the same date that the old, flawed Act/Regulations is repealed.

37. No doctor I know wants there to be “no accountability”. On the contrary, not only do they insist doctors must be accountable for their actions, but so too must the body who audits and investigates the doctors. I do not consider that too much to ask.

38. In fact, what the doctors I know are trying to protect and preserve include things like: bulk-billing; health services, particularly GPs available for people in rural areas (for example, Kyabram); doctors to be able to conduct their business/es in peace, and without fear of persecution, bullying, intimidation, harassment or defamation (the effects of these issues will also be discussed shortly); and they also want to utilise their knowledge and skills to best serve their patients – if that means the GP orders/conducts some tests to save their patient time/money with referral/waiting time to specialists, then I am here to tell you that that is exactly what patients want !

39. In terms of retaining bulk-billing, many doctors are now considering ceasing the practice, as it only attracts more PSR attention to them. They will have more patients wanting to see them. More patients equates to more Medicare codes. More Medicare codes equates to a statistical anomaly. Statistical anomalies equate to irregularities when Medicare ‘screens’ clinics. This then introduces the corrupted practices of the PSR, which in turn introduces “audit anxiety”.

40. The use of “statistical outlier status” must be couched in the contextual relevance of the specific elements of the practice or PUR. Over reliance on the statistical power is a junior high school treatise which seems lose on the PSR some of which may never have studies statistical analysis to even the junior high level. Future applications need to take into consideration certain significant factors – such as the profile of the practice. That is, a rural doctor with no other doctors for several hours around (such as Dr Tisdall) will see all manner of patients – possibly in high, seasonal volumes; a doctor who specializes in one particular aspect (such as Dr Masters, Caloundra) will process more claims of that nature than usual – people are traveling to that doctor for THAT treatment, not a regulation consultation; a doctor who converses with minority groups (such as Dr Waluk) will have very high volumes of ethnic patients, many of whom will also travel vast distances to see ‘their’ doctor; if a doctor/practice utilizes their own knowledge, skills and resources to perform the required tests there (instead of referring the patient elsewhere, where they have to wait for an appointment, start the history again, then pay an unnecessary gap) – they will have ‘unusual’ claims statistics. Broad consultation in the development of the current model would have identified these issues before they became major legal issues.

41. Prior to the introduction of the use of “statistical outlier status” being the screening tool, was any research done to show that doctors identified by “statistical anomaly” were more likely to commit fraud than someone who hid in the middle of the pack ? What is so damming about statistical outlier status ie. 5 % of the population are there all the time. Perhaps instead, it indicates the doctor/practice may fall into one of the above mentioned categories ? there is in fact no strong evidence that links medifraud and statistical outlier status. So counter to the dogma statistical outlier status must be defined as just that. It is likely that medifraud is perpetrated elsewhere and has remained untouched by theses plod police of the PSR.

42. Discouraging doctors from bulk-billing and discouraging doctors from using their full skill sets will soon prove to be very counter-productive to the country. As an aging population, you must accept that means more people will have more medical conditions and need to see more doctors (not less – stop them from leaving the profession).

43. As mentioned in paragraph 39, there are adverse health effects being suffered as a result of the performance of the PSR. Such is the extent of the problem that a study is now being conducted into the nature, effect, symptoms and effects of the PURs’ health and productivity.

44. One would think that any governance of the health industry would be mindful of health issues, yet the PSR under its inherent guidance by the AMA have overlooked such 'trivialities'. How could the AMA do that ? Furthermore, where is the full disclosure of the seating arrangements for the PSRAMA when the PUR is facing the bench... the ADU has evidence that the AMA ie the association trusted to look after the doctors rights and issues in this and all situations actually regularly crosses the floor to sit with the prosecution. Where is the disclosure to the rank and file membership that this is where they sit rather than on the side of the doctor or PUR.

45. The AMA has, by whatever reason or method, placed itself (as an organisation) in an untenable position. On the one hand they advertise that they represent doctors' interests, but on the other hand they sit on the illegal Committees that coerce money from the doctors. I will leave it to the Senate Inquiry Committee members to examine the founding issues, members and so on; and to draw their own inferences on who became involved and at what point, or under whose recommendation/guidance/sponsorship. (I also think the AMA needs to have a good look at itself, its positions and its responsibilities – the AMA must choose which side of the fence they sit on – or perhaps it's just an over-ambitious few who need to self-assess ?) I understand the ACCC have also been asked to look into the aforementioned alleged breach of the *Trade Practices Act.*

46. This submission has clearly, categorically and comprehensively demonstrated how the PSR is failing in its objectives (notwithstanding the fact that they have NEVER recouped even their own budget, let alone 'recovered' more money for Medicare ! – but I'm certain your inspection of the REAL figures (not just the 'take home' pay scales, the full remuneration packages) will show you what I am referring to.)

47. This submission has also demonstrated how and why the PSR has developed such an autonomic organisational culture that it refuses to operate within the parameters of the law – as evidenced in Kutlu v Director of Professional Services Review [2011] FCAFC 94.

48. This submission has clearly identified and indicated the subsequent ramifications of the Kutlu case, and the associated costs and consequences.

49. This submission has demonstrated why the legislation, the structure, the organisation and operations of the PSR have failed and MUST be completely overhauled.

50. This submission has given practical advice with whom to consult, and what principles must be maintained when new legislation and/or governing body is developed.

51. This submission has demonstrated that any costs outlaid in the establishment of such new entities will, in fact, serve to save the Federal Government – in the short, medium and long terms.

52. As a member of the public I want bulk-billing to continue. As a patient I want confidentiality between doctors and their patients and I want my doctor to be healthy and focused on their patients – not distracted or afflicted because of PSR bullying. As a former GMO and CMO and as a group member involving over 200 doctors, I am appalled at the devastating manner which the Federal Government has treated the medical fraternity. As a taxpayer of Australia I definitely want all claims to Medicare to be able to be fully scrutinized, however natural justice must be accommodated. As someone who has provided a submission to this Inquiry, I sincerely hope each and every member of the Committee fulfills their obligations to the Australian people and takes the appropriate, necessary action.

53. This submission has been provided without prejudice, bias or self-promotion or gain.