INDIVIDUAL PRIVATE SUBMISSION TO

THE SENATE INQUIRY INTO

THE PROFESSIONAL SERVICES REVIEW

SCHEME.

FROM

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BASED ON HIS EXPERIENCE

AS

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IN WESTERN AUSTRALIA.

My name is Warwick Ruse. I am a specialist gastroenterologist. I have been the deputy director for PSR in Western Australia since the scheme began. Before that, I was a Committee member in the old Medicare Schedule Committee of Inquiry for Western Australia. I have chaired most of the PSR enquiries in Western Australia, and several in other states.

My comments are from the perspective of an individual PSR "insider". They are not an official PSR response. They begin with an introduction and then tackle the Terms of Reference. They are based on years of worrying about performing the process fairly, and thinking about the broad sweep, and detail, of the process.

Introduction.

I think it important to begin with my viewpoint on the purpose and origins of the PSR. I believe it is shared by the vast majority of my fellow deputy directors, and panel members. The deputy directors meet every year to discuss how the process could be improved. There are very few unexplored underlying assumptions.

MEDICARE PAYS REAL MONEY TO DOCTORS, FOR SERVICES TO PATIENTS, THROUGH A THIRD PARTY NOT PRIVY TO THE CONSULTATION. DO I SMELL PINK BATTS?

Medicare rebates are provided by the taxpayer. Medical services are provided by doctors to patients. Doctors charge patients directly, or bulk bill. The Medicare rebates assist patients in settling their medical financial obligations. They also play a major part in the cash flow of a practice, and a doctor's income.

Medicare rebates represent a significant outlay for the taxpayer. Medical services are provided by a multitude of doctors. To assist their patients they have to categorise the service they have provided in such a way that a Medicare rebate can be allotted to it. The default Medicare position is to accept the doctor's categorization. Medicare trusts doctors.

Some Medicare item descriptors have very detailed and specific requirements. However the bread and butter service items are deliberately broad and non specific, because that is the nature of the doctor patient relationship.

MEDICARE MONEY COULD BE MISDIRECTED.

It was recognised early, both by the taxpayer paymaster and the AMA, representing the body of medical practitioners, that genuine misunderstanding regarding the appropriate descriptor might arise. It was also recognised that there might be "gaming" of the broad based descriptors, with subsequent fee creep higher than was considered appropriate by the Paymaster and the AMA.

As I understand it, it was this real-life understanding of aspects of human nature (ignorance and deceit) that led the AMA to cooperate in setting up the PSR. Both sides accepted that only other doctors could pass a peer opinion on whether or not an individual doctor's categorisation of a service would be considered acceptable, and therefore appropriate, by their peers.

MEDICARE MONEY COULD BE REWARDING POOR PROFESSIONAL PRACTICE.

Another problem was to ensure that Medicare rebates were being paid for consultations with an appropriate professional component.

Patients have their own perspective in judging their satisfaction with a medical consultation. It does not usually include an assessment of the actual professional component. The nature of a profession is

possession of knowledge and skills unavailable to those in the general population who need it. A very high volume of standard consultations in any day raises at least the possibility that professional corners might be being cut. An individual patient would not know whether corners were cut in her case. Very high rates of prescriptions of potentially addictive drugs raise concerns as to whether an appropriate professional input, in terms of attempting other lines of treatment, has been made. An individual patient might only be concerned by the discomfort of withdrawal.

On first principles both Medicare and the AMA realistically faced the possibility that a small number of doctors with poor professional input might be claiming Medicare rebates for delivery of unprofessional services. However such practitioners might be detected, their detection is important for the safety of Australian patients, and the integrity of Medicare (as payment for legitimate services only). They could only be recognized if peer reviewed by fellow doctors.

Outright fraud, and non-completion of specified descriptor requirements, could be investigated by appropriate non-medical persons. They might require access to patient medical records for audit.

IS MEDICARE PROFILING? IS IT JUSTIFIED?

The next question was where the limited resources for such peer review should be applied. Should a random sample of all doctors receiving Medicare rebates be subjected to peer review each year? This would be egalitarian, but not really realistic or productive. Most would be found blameless after a harrowing and expensive exercise. Was there any profiling which might indicate a group with a higher probability of inappropriate categorization or inadequate professional input?

Medicare deals with a huge volume of statistics regarding doctor claims. Because of varying individual doctor work patterns the frequency distribution for each item is not the classical bell shaped curve. There is a long right tail. Some of those doctors might just have chosen to work very long hours (for standard consultation item outliers). Some might have a particular clientele of patients generating a lot more than the average number of specific investigations or treatments.

However, as a doctor's position on the curve moves further right, it was assumed that the <u>possibility</u> of inappropriate categorisation, of consultation items, or inappropriate use of investigations or treatments, or inappropriate professional input, because of time constraints, (all potentially present anywhere in the curve) might be rising. I think that assumption, as a basis for further enquiry, but not a final judgement, was appropriate. The amount of sub standard professional practice that I have seen in my Committee work is, I am sure, much higher than that seen in more statistically ‘normal’ practitioners.

DO MEDICARE’S CURRENT REFERRALS TO PSR DETECT ALL POSSIBLE INAPPROPRIATE PRACTICE?

I presume that it was from such considerations that the need for firm but sensitive peer review of individual doctors whose Medicare statistics were unusual, and could not be explained by an initial interview with a Medicare medical officer, arose.

However, it is true that an inappropriately practicing but relatively lazy midrange doctor would not be picked up by the current Medicare processes, and would probably continue quietly providing low volume inappropriate care all his life. The only reason for him to be detected would be if he came to the attention of a Medical Board because his poor professional input led to patient misadventure.

Dredging the right hand end of the curve will always find some but not all of the targets. It was merely hoped, on quite sensible grounds, that the detection rate out there would be higher than in the middle. You had to start somewhere.

AM I A VIGILANTE JUDGE IN A KANGAROO COURT? OR JUST VIGILANT IN TRYING TO PROVIDE PROPER PEER REVIEW? ONLY A GINGER CAN CALL ANOTHER GINGER GINGER.

So, like all such PSR Panel member “insiders”, I was a nominee for a job where the doctor under review was in no way considered as possibly “guilty” of any crime or breach of statutory law. The problem was assessing whether the delivery of the service whose rebate was claimed from Medicare had the appropriate professional component, and fulfilled the requirements of the descriptors. Where those requirements are the general consultation services, it is the difficult, but not impossible , task of applying the spirit of the descriptor to the conduct of the doctor. Any doubt goes in favour of the doctor.

How some doctors get to be referred to a PSR Committee by Medicare is beyond the purview of PSR and its medical panel members. It does not seem to be encompassed by the current Terms of Reference.

I now turn to the Terms of Reference:

Term of Reference a(i). criteria for selection of the executive and constituent members encompassing their <u>experience in administrative review proceedings</u>.

I'm not sure what this means, or refers to. The only medical executive is the Director. The rest of the full time executive are career public servants, mainly (in my experience) of the highest quality in terms of knowledge of their job. That includes the possibility of administrative review by appeal judges. Their instinct is to avoid such review by doing their job, and seeing the Committees do theirs, properly in the first place.

If the part time Panel members are the "constituent members" under consideration, then it is fair to say that their experience in administrative review proceedings is probably limited, on their appointment. They will have been nominated to the AMA by either the local AMA branch, or a specialist society. Some of my original fellow deputy directors had had experience in their local medical board. All are nominated because they are willing to assist, are active in mainstream medical organizations, and have knowledge of the theory and realities of their particular branch of medical practice. We are not all born with natural inquisitorial skills or forensic abilities. Active medical practice does not bestow them.

However this is well recognised by the PSR, and actively corrected before any one gets on a Committee. I have had multiple courses in the legal underpinnings of the scheme and, much more important, how natural justice should be applied in peer review. In my time we were privileged to be instructed by George and Felicity Hempel, George a retired judge at the time and Felicity now on the bench in Victoria.

As most of us were keenly aware of the short and long term effects of a PSR enquiry on the doctor involved, we took it all very much to heart. Certainly in my own enquiries, where my fellow Panel members may not have assisted on the same number of Committees as myself, I am constantly reminding them that this is peer review of a fellow doctor. In that review the standard applied is not that of final examinations or indeed of the individual Committee members’ clinical practice. The standard applied is the lowest possible which can still be considered adequate professional practice.

My Committees take great care in trying to ensure that the doctor under review understands exactly what knowledge the Committee needs of what the doctor did during a consultation or service under review.

I'm sure the Senate Enquiry is aware of the long train of court challenges, based both on broad legal and constitutional principles, and the details of individual Committee hearings, over the last 15 years. In terms of ongoing service in PSR, much of our training was devoted to the effects of these challenges,

successful or not. We were made very aware that any finding might end up in an administrative review. We therefore based the conduct of the Committee hearing, and the content of the report, accordingly.

Term of Reference a.(ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise.

Once again I am a little unsure of what this means. The Committee has at least 2 members drawn from the same speciality as the doctor under review. The Deputy Director, whatever his or her medical discipline, as Chair, is to see fair play and natural justice. Whatever his or her discipline, a Deputy Director has a crash course in the core elements of general practice in this work. General practice is assumed to be one speciality among the many medical disciplines.

I wonder if this Term is in response to individual medical practitioners, in any discipline, who apply non-mainstream medical theories or philosophies to patients who are unsatisfied with orthodox care, and feel that the panel members involved are not truly their peers. This is a fair concern, but needs further exploration. (See also discussion on Term of Reference d).

If a Committee wishes to get expert advice it can commission an expert witness. Equally the doctor under review is entitled to call the Committee's attention to his belief of singularity, and call his own expert witnesses.

In my experience any findings of inappropriate practice by doctors in such self perceived specialised areas were not based on disagreement with the theoretical underpinning of their specialised practice, but the core medical competence and conduct involved in their consultations. It is impossible to give examples without breaching confidentiality of individual hearings.

The Committees tended to take the view that if the doctor was claiming rebates for medical services, then their basic medical professional input (history, examination, recording of findings, tackling of bread and butter medical problems like hypertension or diabetes in the consultations) could still be judged by the standards of the general body of (usually) general practice.

In some areas the doctor under review, following his non orthodox model of management, initiated under Medicare investigations not justified under the Medicare descriptors. Whatever the theoretical reasons for initiating such investigations, the Committee had no choice but to find the conduct unacceptable. Such descriptors are binding on all who claim the items. (See Other Matters, Descriptors)

Term of Reference a.(iii) accountability of all parties under the Act.

The Act, and the protocols of the PSR derived from the Act, seem to me to provide adequate accountability. During a hearing the doctor under review is given every opportunity to explain what happened, and why. Facts are obtained on how the practitioner operated, and sometimes why. However debate on the Committee's assessment of appropriate conduct is not entered into during a Committee hearing.

It is in a Draft Report, where a finding of inappropriate practice has been made, that the Committee reasoning is laid out for the first time, with reference to the evidence available in the transcript.

The doctor under review is encouraged to bring forth reasons why the finding should be changed and the Committee always considers them before making a Final Report.

The Committee Is ultimately accountable to the doctor under review, to give a fair and unbiased hearing, and to the general body of practitioners, to judge by their broadest and lowest standards. The very existence of the PSR implies awareness that good professional practice takes many forms, but so

does inappropriate professional practice. Both can be recognized by peers, even if the sample of reviewing peers does not embrace in its own practice a particular mode of what is still recognized as good. That is one of the underpinnings of any form of peer review or conduct tribunal. Good practice is a smorgasbord at which no one can eat everything. Bad practice however is not allowed on the table as an option for any one.

Term of Reference (b) current operating procedures and processes used to guide Committees in reviewing cases;

I am assuming that the Senate Enquiry has read "Your Guide to the PSR Process", which is available for the medical profession on the PSR website. I believe the operations outlined there, if that is the point of this Term of Reference, are adequate. They are machinery manoeuvres, administrative requirements under the Act. Each Committee uses them to properly structure finding its own way in each particular peer review hearing.

Committees know that they are embarking on peer review of fellow medical practitioners. There are no “charges to be answered" or laws that have been potentially breached. The Deputy Director who chairs each Committee, particularly when his fellow Committee members might be inexperienced in PSR work, has to keep this constantly in mind.

Where we have the advantage of our own legal counsel, they often keep both chair and members on course. That course is to first establish what happened in clinical encounters. This knowledge belongs to the doctor under review. The job of the Committee is to sympathetically extract it. Then, and only then, and only by the Committee as peers, can it be established whether it would be considered appropriate or inappropriate by the general body of practitioners in the discipline.

The purpose of the multi-day Committee hearing is to establish what happened in a sample of services provided at least 1 year before. It is vital that the doctor under review is given a full opportunity to understand what facts the Committee wants to know and give them. If there are other facts about his conduct he thinks they need to know, the Committee should invite his further submission, and hear him out. In my experience, the Committee does.

Term of Reference (c) procedures for investigating alleged breaches under the Act

The area to which the PSR is directed is peer review. Since its resources, financial and panel member availability, are limited, they need to be focused. However they must not be restricted.

Using the term “alleged breaches” may be misleading. Fraud, and criminal activity as defined in the Act, would be alleged breaches requiring to be investigated. The person so charged would know what particularized illegal activity was suspected.

Peer review in PSR is allowed to cover all the clinical services in the period of review. A much smaller sample is taken, and initially assessed in detail, for assessment of impropriety. If it is found, the sample can be used to calculate possible pro rata recovery of benefits obtained for the presumed total of inappropriate services over a year.

However the Committee, in its attempts at assessing the professional component of those individual sampled services, may need to look at other services on other occasions, whose records are available in the year in question, to establish context. In addition, the experienced peer eye, running over a patient record following one trail, may distinguish another pattern requiring separate assessment for appropriate professional input.

It would be against the spirit and purpose of the entire PSR process for that capacity to be lost because of confusion between a narrow criminal type hearing of an alleged and specified breach of a

Commowealth Act and a wide ranging peer review authorized by an Act of the Commonwealth, in my opinion.

How Medicare conducts its own investigations to establish who might require PSR review is a separate field of possible enquiry by the Senate. At the moment, PSR can only act on Medicare referrals. Once triggered, the assessment is penetrating and rigorous.

Term of Reference (d) pathways available to practitioners or health professionals under review to respond to any alleged breach.

I am not sure whether this, and *Term of Reference* c, follow from confusion regarding peer review and investigation of possible criminality. The pathways currently available are laid down in the Act, and expanded in "Your Guide to the PSR".

The Committee has to establish whether practice was inappropriate. The point of the hearings is to establish the facts of the practice, in the conduct of the delivery of services. Only the doctor under review knows them. Only with sympathetic questioning from the Committee can he reveal what they need to know. It is a mantra to finish the questioning on each service with "Is there anything else you wish to tell us about this service, Doctor? Was there anything different about the circumstances?"

Once facts are established, the Committee has to consider appropriateness. Its standards are to be those it believes are the minimal standards still acceptable to the general body of its discipline.

Where the problem is less than appropriate professional input into standard medical problems, the views of the doctor under review (who presumably at the time believed his practice to be of adequate professional calibre) must be weighed by the Committee against its assessment of the general body's opinion. There is no room for debate. The Committee is there to arbitrate.

Where the problem is possibly using an inappropriate item, the Committee must fairly weigh the descriptor, the facts as established from the record, and any other explanation provided by the doctor.

Often, in my experience, the Committee openly asks "Why did you not use another item?" Sometimes the doctor under review concedes "I should have". Sotto voce it may more often be "I wish I had".

They must then balance this information against what they believe would be the opinion of the general body who might use those descriptors differently. Once again, there is no further "pathway for response" in terms of debate. Only the doctor knows what he did, and why. For the purposes of peer review, only the Committee knows the feeling of the general body.

However, this Term of Reference may be related to the appearance of 'unorthodox' medical practitioners before a Committee (see comments on Term of Reference a(ii)).

Where the problem is an unusual pattern of practice based on a minority view of disease causation or treatment, the Committee is faced with a very difficult problem in determining whether it is per se inappropriate. All new treatments were once a minority view. The early adopters are at least trying to help their patients. Whether one GP in one clinic, rather than an academic research department, is the place for testing cutting edge changes in practice requires separate debate in the wider medical community.

The general body is not perfect in its own orthodox practice. The medical literature has many surveys showing that orthodox recommended interventions are not applied by all members of the general body of orthodox doctors to all their patients who should, under current recommendations, be receiving them.

If a Committee feels that it is looking at an unusual treatment or approach, or the doctor under review claims it is, and it is provided after perfectly adequate standard medical assessment, I feel the Committee should be open with the doctor. It is probably not appropriate to debate new approaches in the PSR peer review environment. However, if there is an organized body involved in the new approach it would seem only fair for the doctor under review to nominate what that body is, and ask that a senior medical person involved be called as a witness expert in what the body believes. Video linking would not be impossible in this day and age.

It would probably best be done towards the end of the hearing. The Committee would still be able to quiz that reference person on how core orthodox medical methods are incorporated into the new regime. It would also establish whether the beliefs and practices of the doctor under review are in accord with the new mode of professional thought. It would then be a matter of fine judgement to pass any opinion on use of minority, but not singular, treatment as inappropriate in itself. There might still be legitimate concerns with the standard medical inputs. They should, in my personal opinion, be the only reasons for a finding of inappropriate practice.

The doctor under review may have a much more idiosyncratic belief in what appears to be an unorthodox line of treatment. It may be buttressed by a collection of papers and references but with few or no fellow adherents, and no organized body. If it was recommended to the patient after an appropriate orthodox medical assessment, the Committee would, in my opinion, still be justified in its own assessment of the judgment of the general body regarding the appropriateness of that aspect of professional input, particularly if it seemed to involve risk to the patient, or squandering of Medicare resources.

If either class of doctor provided inappropriate core medical input into a service, that could be quite fairly judged by the standards of the general body for such core medical inputs.

It has been fairly common over the last 10 years, I understand, for Committees to find that practitioners marching to the beat of an unorthodox or individual theoretical drum have sufficient evidence of inappropriate professional input in the very basic elements of a consultation to reach an “inappropriate practice” judgment without having to require the Committee to hear in detail lengthy explanations of the theoretical underpinning, or make a response. An initial hearing of the rationale is necessary for natural justice, but it need not be repeated for each case.

Comment in a Final Report on the doctor holding such unorthodox beliefs may accompany a Committee finding of inappropriate behaviour at a more basic clinical level. Such comment would be for the information of the Determining Authority.

Term of Reference (e) the <u>appropriateness of the appeals</u> process

Points of law, and neglect of natural justice, are rightly appealable , in the judicial system.

However, peer review by definition depends on the reviewers doing their utmost to be fair to the doctor under review, while still doing their duty to the profession and the community in ensuring that Medicare rebates are claimed appropriately, and for services with appropriate professional input. I presume that is why, providing the <u>process</u> has been fair, the peer review judgment <u>product</u> is accepted, in PSR and other professional areas, as final. Otherwise there would be an endless reiteration of “do it again” with a different set of peers.

It is the Minister’s responsibility to get the PSR peer reviewers, as representative of the general body, right first time round. The alternative is the unwelcome possibility of unilaterally appointed tribunals perceived by the profession to be working to government agendas or quotas, and with ethical lawyers trying their hardest to work all courts of appeal to do the best for their oppressed clients.

I hope the Senate Enquiry will receive, and if necessary seek out, the opinions of lawyers and medical defence organizations, who have seen the system at work over its lifetime, on these matters of fairness and appeals.

Term of Reference (f) other matters.

1 .DESCRIPTORS: POSSIBLE IMPROVEMENT?

I understand the Department of Health and Ageing jealously guards the privilege of actually drafting descriptors, without further input from professional bodies, or indeed the PSR which might later have to use them in judging appropriate input. That is obvious in some unrealistic descriptors which could not, however, be ignored by a Committee. They might be treated with disdain by the general body of the profession. A Committee has to abide by what is written. If it is not written with real life clinical input, it becomes impossible for a Committee to do justice to a doctor under review.

Item 132 demands from consultant physicians a management plan, which, in my opinion as a physician and a PSR Deputy Director, would be impossible to fulfil. It includes (Explanatory Notes A.12) written elaboration of risk assessment, all management options and decisions. This would, from the PSR viewpoint, demand seeing almost a complete transcript of the interview which led to the management plan. Medication report requirements include alternatives, options, and adverse effects and possible interactions. The latter usually occupy several pages in MIMS for each drug involved. Longer term management plan must include actions to be taken in the future if the clinical situation changes ie a complete natural history of the disease, as it applies to all past known sufferers.

Item 23, the work horse general practice consult, and item 36, more highly paid, differ only in their descriptors in taking more or less than 20 minutes. There is no reference to guide a PSR Committee to making a judgment on whether, from what they have gleaned, what was claimed as Item 36 SHOULD have taken more than 20 minutes. There is no requirement to have available an on-the-day diary where time in and out were recorded.

As it stands a doctor could quite openly say that every 36 might have been a 19 minute 23 in other hands, but his work practices made him a bit slower, or more thorough, or sensitive to the patient's needs, and that's why he ticked the only difference in the 2 boxes, on a genuine difference in time taken. Was he wrong?

I would encourage the Senate enquiry to seek from Dr Tony Webber, the outgoing Director, his thoughts on whether there could be a more fruitful co operation between the Department, PSR and the various specialty bodies in terms of drafting and signing off on descriptors that are meaningful to practicing doctors, and give PSR Committees something solid and practical to go on.

As I write this, 5 years of PSR work, which cost the taxpayer about (very roughly) $50 million, appears to be going down the drain because the Department of Health and Ageing ignored its statutory responsibility to remind its Liberal and Labor Ministers to formally consult with organized medicine in the form of the AMA in the matter of PSR appointments. Perhaps some soul searching regarding its self perceived omniscience and professionalism might spill over into MEANINGFUL co operation by the Department with organized medicine in descriptor creation and correction?

2 . ADEQUATE AND CONTEMPORANEOUS RECORDS.

Some doctors found to have practiced inappropriately feel it is all due to excessive nitpicking concern with their records. Some records in general practice are of minor clinical episodes that, as expected, quickly came to nothing. Others are milestones in the many long marches of chronic disease. Why all the fuss? Shall good doctors be crucified on a paper cross? I expand here on medical records.

A PSR Committee has been required since 1999 to consider "whether or not a practitioner has kept adequate and contemporaneous records" when reaching a decision on inappropriate practice (p34 MBS 2010). The doctors using Medicare have been warned of this in the Schedule of Benefits since 1999.

The criteria are laid down (G 15.1) as:

To be ***adequate***, the patient or clinical record needs to:
- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered (my emphasis) or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, (my emphasis) can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or
initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

These minimum requirements are not just a bureaucratic burden imposed by Medicare, unrelated to good professional practice. They are independently required by standard setters, to ensure continuity of care for patients. They are also necessary for the defence of any doctor caught up in formal investigations of patient misadventure by a Medical Board or Coroner. Since neither patient nor doctor know the hour or the day that a headache and rash will be due to early meningococcal disease, or a middle aged "indigestion" be a coronary in disguise, every apparent bread and butter problem at initial presentation deserves, and requires, notes of relevant clinical information, ie positive and negative symptoms and examinations and a differential diagnosis.

These would enable "another practitioner", (or a coroner, or a Board) RELYING ON THE RECORD, to rapidly come up to speed with what another professional actually observed and considered in a patient now not following the original diagnosis. That original diagnosis might have been justified, at the time, but that justification can only be assessed by knowing the inputs. Making such inputs on paper or computer is a useful check on diagnostic inertia, particularly on a busy day. A record consisting of a one word diagnosis, and treatment for that diagnosis, is not enough.

Some doctors at Committee hearings justify records from which a fellow doctor could not, from the record, understand the previous service and effectively undertake ongoing care by saying: "I'm the only doctor, so I'll be there the next day", or "He's a long standing patient, I know the case" or "I never record normal findings (but trust me, I always check)". The mandated minimum standard is not the current doctor's alleged encyclopaedic memory, 24/7 availability for the last 30 years, or assumed doing of everything appropriate, every time and to everyone, (pan professional persistent perfection) but recording only the exciting positives. It is the hypothetical "another practitioner, relying on the record", who should have haunted every consultation since 1999.

If there is no record, no one else can rely on it. The Committee is quite justified in putting itself in the place of the "other doctor" and from the records alone trying the thought experiment of "Could I have continued care in the next few days building on this consultation? Do I know how the initial diagnosis and treatment plan was arrived at? ". "Was there a fever, or normal temperature, raised or normal blood pressure, rapid or normal pulse, other abnormal or significant normal finding, or significant negative or positive history, WHICH WAS RECORDED AS SUCH yesterday, and could thus assist me in today's assessment of significant change?"

In any acute clinical situation, the actual facts required, positive and negative, are usually 5-10 clinical observations. They can usually fit into a short sequence of abbreviations recognizable to any fellow practitioner. If a doctor could show a sequence of hieroglyphics in the record that seemed to fulfil those requirements, a Committee would probably allow that as just appropriate. If they were very idiosyncratic for the "other doctor" to follow, that would be pointed out for the future. A PSR Committee is often a place of useful, if painful, professional education.

I doubt that any professional standard setting organization, or medical defence organization, would consider these requirements as oppressive, excessive or an unnecessary drag on core good practice. I doubt that any Board or Coroner confronted with the absence of a record of significant necessary findings or actions would automatically accept assurance that those findings were however obtained, and were normal, or the actions performed.

That is, however, usually the default position of those doctors seen in PSR with inadequate contemporaneous records. It is, in my opinion, not to be instantly accepted by a Committee as justification. The Committee is justified in that situation in searching in the records available for exceptions to this convenient assumption. The more exceptions found, the less weight to be placed on the alleged "rule".

If there is a consistent shortfall in required clinical information, then the records are evidence of inappropriate clinical practice. The standard of the general body is sufficient clinical input information to satisfy the Board, the Coroner and the next link in the clinical continuity chain. Clinical information is not required just for the doctor who is expecting to see the patient again tomorrow, as a sort of optional aide memoire. It is for the doctor who might need to take over unexpectedly. It is for the future investigation of occasional misadventures, and no one knows when they will be. Although Medicare has made it a matter to be considered in the assessment of inappropriate practice, so have the Medical Boards and the profession's standard setters.

Sorting this out may appear to the doctor involved, who does not see it in these terms, as "excessive concern with their records".

3 . MAINTAINING PEER BALANCE IN THE DEPUTY DIRECTORS.

The original Deputy Directors were appointed as such. They were drawn from both General Practice and the surgical and medical specialities. Some had experience on Medical Boards, which was immediately useful. Others had been examiners in standard setting organizations, or active in medical politics. That experience, in eliciting information from doctors under stress, or the influence of strong emotions, was a useful background to the subsequent training in natural justice and administrative review.

Most Committee hearings have been of GP doctors under review. This means that mainly GP panel members have had active experience of the Committee process. They have seen a variety of Deputy Directors in action, and learnt , I imagine, what to do, and how to do it better. Most specialist panel members would have only had one or two Committee experiences.

The first generation of Deputy Directors is now retiring. The job description for their replacements calls, rightly, for Committee experience. That will be largely held by GP members. Where some past GP doctors under review have questioned having a non GP Chair, specialists in the future may object to having a GP Chair.

Specialist representative organizations may feel there should be more of their members, active as Panel members, and in the ranks of the Deputy Directors.

I don't think that can be. You can't get Committee experience in hearings outside your discipline. I don't think any Deputy Director should be appointed without significant Committee experience. It is important that the PSR executive has a say in who is appointed as a Deputy Director, with the benefit of having seen them in action as Committee members.

Peer review by Committee members from the discipline is vital for the justice, and credibility, of the process. Oversight by the Chair is slightly different. Natural justice, making primus inter pares work when dealing with two other medical Committee members, and fairness to the doctor under review are a different language to medical expertise or examining students or post grads.

I am reminded of the Australian merchant bank that wanted to expand into Japan. They started by trying to teach their specialized bankers fluent Japanese. After some fruitless years they switched to Japanese economics graduates, and rapidly taught them the details of merchant banking. Much more successful.

I think any specialist bodies who feel their members under review need a Deputy Director from the same discipline might keep that in mind. An experienced Deputy Director will run a fair hearing of a doctor from another discipline, and make the most of the specialized input from "once in a life time" Panel members from that discipline.