Structural Fixes for PSR

The Problem

It seems beyond question and quite indubitable that in general doctors should have the same rights as the rest of the community when they go to court, in the case of PSR, over the major issue of their professional integrity and competence and accuracy of billing procedures.

Indeed in that Habeus Corpus guarantees to all citizens a right of fair trial this would seem to be guaranteed to doctors by the foundational documents of the Australian Constitution and its essential underlying and accompanying documents.

The main issues with the PSR process are:

1) All committees **invent rules** as they go along, as per the medicolegal indemnity insurance companies
2) PSR committees make **numerous errors of fact** and medical judgement
3) Since there are **no written guidelines** for many medical tasks the process is inherently open to idiosyncratic subjectivism and discrimination. Groupthink almost invariably sets in during committee deliberations.
4) At no point is the PSR committee's case subject to legal testing as commonly occurs during questioning in **cross-examination** in court.
5) No opportunity for **merit review** of the PSR case occurs either before the final report is issued or afterwards by way of appeal.
6) At present PSR committee hearings move seamlessly and silently from being an **"investigation" to a "prosecution"**. The former is relatively benign whilst the latter carries serious legal implications and professional risk. One direct implication of this is that NONE of the normal safeguards and rights for persons under prosecution are afforded doctors who are drawn into this pillory system.
7) Committees should be made up of doctors with **relevant experience** for the person under review. Most doctors to come before committees are general practitioners. Not all GP's are alike e.g. skin cancer, men's health, women's health, musculoskeletal, pain and addiction medicine disciplines. When committees do not have skills in these areas they really do not know what they are talking about.
8) There is widespread confusion in the medical profession about the **80/20 rule.** Virtually all doctors think this relates to 80 consultations on 20 days per year. However the relevant metric is services rather than consultations which is very different. Even medical indemnity lawyers cannot explain this to their client doctors on occasion.
9) **Double jeopardy** presently exists where doctors proceed automatically from PSR to AHPRA after their five year case with PSR has ended. No other group in the community is subject to double jeopardy in this manner. This occurs at AHPRA's behest rather than PSR's. Nevertheless it should be stopped.
10) At present the procedure after a successful court appeal is re-referral back into the PSR process. In practice this means that one is either **guilty now or guilty later**. The only way to escape from this system is to die.
11) **Legal precedent** is not presently acknowledged by PSR. The salience of previous cases which are of particular relevance should be allowed.

The Cure

Correcting these invariable tendencies would require several corrections to structure and standard procedures including:

1) Have a judge preside at all proceedings. His role would be to weigh evidence and administer the rules of evidence.
2) It needs to be explicitly stated that all forms of relevant evidence are admissible including from:
    a. Patients
    b. Specialists
    c. Experts
    d. Professional leaders
    e. Published literature

    This is important as for many years the paper by Robin Bell "Protecting Medicare" [A] was hosted on the PSR website which on its pages 68-69 forbade such evidence
3) Introduce a distinction between the investigation part of the committee hearings and the prosecution part.
4) Merit review is key and foundational to the establishment of a fair and just system. There should be opportunity for merit review after the investigation stage of the hearings and after the prosecution phase begins and / or the draft and final reports are written.
5) Merit review needs to be allowed on appeal after the final report has issued.
6) Merit review would include an opportunity for cross-examination of the PSR committee's case both before and after the final report has issued.
7) Doctors with relevant subspeciality and volume professional credentials should be used on such committees to avoid false comparisons between apples and oranges.
8) There is widespread confusion in the medical profession in relation to the 80/20 rule. Since an 80/20 violation is cause for immediate referral to PSR Medicare could do much more to clear up this critical point and it is vitally important that a campaign of education for the profession be undertaken in this regard.
9) End double jeopardy between PSR and AHPRA.
10) Change the rules so that a court victory over PSR ends the process of endless trial.
11) Specifically allow for the citation of relevant legal precedents and in particular those involving the same doctor.
12) Immediate relief and procedural correction to cases presently in the system.
13) Consideration be given to retrospectivity to suspect cases, particularly those under Dr Julie Quinlivan.
14) Section 106ZR relating to the non-publication of proceedings needs to be clarified. Does it or does it not imply the imprisonment of doctors seeking assistance and advice with their cases?
15) At present PSR is targeted mostly at the top 1% of the bell curve. However there may be good and sound reasons that some practices are there, such as clinical excellence and shortage of a relevant medical workforce. Once practice have been assessed and vindicated by PSR they should be granted a lifetime indemnity to further prosecution by PSR. They have shown their worth. Their value to the community is obvious. Further regulatory harassment int this way is strongly contraindicated.

[A] Bell R. Protecting Medicare services: trials of a peer review scheme. *J Law Med*. Aug 2005;13(1):29-105.