FEDERAL COURT OF AUSTRALIA

Nithianantha v Commonwealth of Australia [2018] FCA 2063

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| File number(s): |  |
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| Judge(s): | **FARRELL J** |
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| Date of judgment: | 18 December 2018  |
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| Catchwords: | **ADMINISTRATIVE LAW** – Judicial Review – Professional Services Review Scheme under Part VAA of the *Health Insurance Act 1973* (Cth) – where Professional Services Review Committee found applicant doctor engaged in “*inappropriate practice*” as defined in s 82(1)(a) – where Committee found that applicant engaged in a prescribed pattern of services by rendering more than 80 services on each of 20 or more days in the review period – where Committee found that there were no exceptional circumstances under reg 11(b) of the *Health Insurance (Professional Services Review) Regulations 1999* (Cth) because there was not an absence of other medical services for the applicant’s patients – whether the Committee erred by finding an alternative medical centre provided a readily and reasonably available alternative for the applicant’s patients – whether applicant bears the burden of proving the existence of exceptional circumstances – whether reg 11(b) required the Committee to consider whether alternative medical services were available on each and every day in the review period – whether the Committee impermissibly considered practice management considerations **ADMINISTRATIVE LAW** – Judicial Review – Professional Services Review Scheme under Part VAA of the *Health Insurance Act* – procedural fairness – where Committee called a witness to give evidence which contradicted the applicant’s evidence a week before the last day of hearing – where notice did not encompass all evidence given by the witness at the hearing – where Committee relied on the witness’ evidence to find that exceptional circumstances did not exist – whether the Committee was required to give the applicant a further opportunity to respond to witness’ evidence – whether the finding was an adverse conclusion which was not obviously open on the known material**HEALTH LAW** – *Health Insurance (General Medical Services Table) Regulations 2012* (Cth) – construction of reg 2.15.1 and MBS item 597 – whether urgency is assessed when a practitioner determines to make an attendance or whether it is assessed at the time of an examination of the patient Conclusion: application dismissed  |
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| Legislation: | *Administrative Decisions (Judicial Review) Act 1977* (Cth) ss 5, 6 *Health Insurance Amendment (Professional Services Review) Act 2012* (Cth) Sch 2 cl 3, s 3*Health Insurance Act 1973* (Cth) Pt VAA, ss 3, 4, 10, 79A, 80, 81, 82, 82A, 93, 95, 97, 101, 102, 103, 106, 106A, 106B, 106G, 106H, 106KA (repealed), 106KD, 106KL, 106TA, 106U, 160U*Judiciary Act 1903* (Cth) s 39B *Health Insurance (General Medical Services Table) Regulations 2012* (Cth) Sch 1 Pt 2 item 597, reg 2.15.1 *Health Insurance (Professional Services Review) Regulations 1999* (Cth) regs 10, 11  |
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| Cases cited: | *Assistant Commissioner Condon v Pompano Pty Ltd* (2013) 252 CLR 38; [2013] HCA 7*Australasian Meat Employees’ Union v Fair Work Australia* (2012) 203 FCR 389; [2012] FCAFC 85*Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321*Bell IXL Investments Ltd v Life Therapeutics Ltd* (2008) 68 ACSR 154; [2008] FCA 1457 *Luxton v Vines* (1952) 85 CLR 352*Commissioner for Australian Capital Territory Revenue v Alphaone Pty Ltd* (1994) 49 FCR 576*Hatcher v Fry* (2009) 183 FCR 1; [2009] FCA 1573*Minister for Immigration and Border Protection v SZSSJ* (2016) 259 CLR 180; [2016] HCA 29*Minister for Immigration and Citizenship v SZMDS* (2010) 240 CLR 611; [2010] HCA 16*Minister for Immigration and Multicultural Affairs v Al-Miahi* [2001] FCA 744*Minister for Integration and Citizenship v SZGUR* (2011) 241 CLR 594; [2011] HCA 1*Oreb v Willcock* (2005) 146 FCR 237; [2005] FCAFC 196*Saeed v Minister for Immigration and Citizenship* (2010) 241 CLR 252; [2010] HCA 23*Sagar v O’Sullivan* (2011) 193 FCR 311; [2011] FCA 182*Sevdalis v Director of Professional Services Review (No 2)* [2016] FCA 433*Sevdalis v Director of Professional Services Review* [2017] FCAFC 9*SZNKV v Minister for Immigration and Citizenship* [2010] FCA 56 *Tisdall v Webber* (2011) 193 FCR 260; [2011] FCAFC 76*Wecker v Secretary, Department of Education, Science and Training* (2008) 168 FCR 272; [2008] FCAFC 108 |
| Date of hearing: | 26 September 2017 |
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| Date of last submissions: | 29 September 2017 |
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| Registry: |  |
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| Division: |  |
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| National Practice Area: | Administrative and Constitutional Law and Human Rights |
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| Category: | Catchwords |
|  |  |
| Number of paragraphs: | 194 |
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| Counsel for the Applicant: | Dr J Lucy  |
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| Solicitor for the Applicant: | Unsworth Legal Pty Ltd |
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| Counsel for the First Respondent: | Ms K Stern SC with Mr D Hume |
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| Solicitor for the First Respondent: | Clayton Utz |
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| Counsel for the Second Respondent: | The Second Respondent submitted save as to costs  |

ORDERS

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|  | NSD 752 of 2017 |
|   |
| BETWEEN: | MANUKHARAN NITHIANANTHAApplicant |
| AND: | COMMONWEALTH OF AUSTRALIAFirst RespondentPROFESSIONAL SERVICES REVIEW COMMITTEE NO 936Second Respondent |

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| JUDGE: | FARRELL J |
| DATE OF ORDER: | 18 december 2018 |

THE COURT ORDERS THAT:

1. The application is dismissed.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

REASONS FOR JUDGMENT

FARRELL J:

# Introduction

1. The applicant is a general practitioner who has practised in Blackwater, Queensland since 2008. Blackwater is a coal mining community about three hours’ drive from Rockhampton. His practice was the North Blackwood General Practice (or **NBGP**). There was one other medical practice in Blackwater, the Blackwater Health Care Centre (or **Centre**)the principal of which was a Dr Mehrul Huda (sometimes spelled “Hudda”).
2. In the period 1 May 2013 to 30 April 2014 (**review period** or **relevant period**), the applicant provided 80 or more professional services on each of 20 or more days.
3. On 14 October 2015, the Director of Professional Services Review established a professional services review committee PSRC No 936 (**Committee**) comprising three general practitioners under s 93 of the *Health Insurance Act 1973* (Cth) and made a referral to the Committee to investigate whether the applicant had engaged in “inappropriate practice”.
4. The Committee held hearings on 3-4 and 17-18 March and 7 April 2016. The applicant appeared on each day with his solicitor, **Mr Davey**.
5. The Committee received written submissions from the applicant on 23 March 2016, 22 April 2016 and 17 June 2016 in relation to its draft report on 30 November 2016 (see below).
6. The applicant’s oral evidence to the Committee is recorded in its interim and final reports. His evidence about his practice includes the following:
7. The opening hours for the North Blackwood General Practice (sometimes referred to as the “NBGP”) during the review period were 8 am to 12 pm (with a lunch break between 12 noon and 1.30 pm); 1.30 pm to 4.30 pm (with a tea break between 4.30 pm and 5.30 pm) and 5.30 pm to 7.30 pm or 8 pm on Tuesday, Wednesday and Thursday and occasionally on Monday. There were three practice nurses who worked between 8.30 am and 4.30 pm. There was also a practice manager and between two and four administrative staff. There were no allied health professionals employed by the practice, but three firms of allied health visited the practice and used its consulting rooms to deliver services. It had the standard array of GP consulting room equipment, between two and three consulting rooms. One room was equipped with a resuscitation trolley and there was a procedure room with equipment suitable for trauma such as fracture, bleeding and would management and basic procedures such as removal of foreign bodies.
8. The applicant was generally the only doctor practising at the clinic during the review period. Two other doctors practised: one who functioned as his supervisor and mentor visited once a month for a practising period and a teaching period. Another acted as a locum at the hospital and had private practice sessions at the practice part time; he would be there for up to two weeks for a month.
9. After hours care at the practice was advertised by signage, through local hospitals and on a web site and social media; patients contacted him by mobile phone. He lived within two kilometres from his practice and it would take him less than five minutes to get from his home to the practice during the after-hours period and the Hospital was two or three minutes away from his practice. He would see patients from all of the local mines. The mines were between 30 and 45 minutes away and injured workers would generally be transported to his practice by private vehicle.
10. In the final and draft reports, the Committee found that the applicant engaged in inappropriate practices in that:
11. He rendered services on each of 28 days during the review period identified in Appendix 6 of the report in circumstances that constituted a prescribed pattern of services;
12. He provided services in respect of five Medicare Benefits Schedule (**MBS**) items: 23, 36, 160, 597 and 707 which “would be unacceptable to the general body of general practitioners”.

# Application

1. The applicant has applied to the Court under s 5 and s 6 of the *Administrative Decisions (Judicial Review) Act 1977* (Cth) and s 39B of the *Judiciary Act 1903* (Cth) to review findings in the Committee’s draft and final reports that he engaged in inappropriate practice:
2. In that he rendered services on each of 28 days during the review period identified in Appendix 6 of the reports in circumstances that constituted a “prescribed pattern of services”; and
3. In connection with providing 84% of the MBS item 597 services the subject of referral No 936.
4. MBS item 597 relates to urgent attendances after hours and its full text is set out at [167] below.
5. The applicant says that he is aggrieved because those findings were adverse to him and expose him to the risk of directions being made against him by the Determining Authority in a final determination pursuant to s 106TA and s 106U of the *Health Insurance Act*.
6. The applicant does not challenge the Committee’s findings in relation to MBS items 23, 36, 160 and 707 which encompass findings of inadequate clinical input, failures of record-keeping, double-billing and failure to meet the MBS item descriptor. The applicant also does not challenge the Committee’s finding that he had inadequate clinical input and record keeping in relation to claimed MBS item 597.

# Background

1. Part VAA of the *Health Insurance Act* contains a scheme for reviewing and investigating the provision of services by, among others, general practitioners to determine whether the practitioner has engaged in “inappropriate practice”. If a professional services review committee finds that a practitioner has engaged in “inappropriate practice”, the Determining Authority decides what actions to take; that may include reprimands, orders for repayment of Medicare benefits or disqualification: s 160U(1) of the *Health Insurance Act*.
2. Under s 82(1)(a) of the *Health Insurance Act*, a general practitioner engages in “inappropriate practice” if his or her conduct “would be unacceptable to the general body of general practitioners”. Under s 82(1A) of the *Health Insurance Act*, a practitioner engages in “inappropriatepractice” if some or all of the services rendered or initiated constitute a “prescribed pattern of services”.
3. Sections 81 and 82A of the *Health Insurance Act* provide that the circumstances which constitute a “prescribed pattern of service” are prescribed by the regulations. Under reg 10 of the *Health Insurance (Professional Services Review) Regulations 1999* (Cth), the provision of 80 or more medical services on each of 20 or more days in a 12 months period constitutes a “prescribed pattern of services”. This will not be inappropriate practice if 80 or more services are rendered on a particular day in the relevant period and if a professional services review committee could reasonably conclude that, on that day, exceptional circumstances existed that affected the rendering or initiating of the services: s 82(1B) of the *Health Insurance Act*.
4. Section 82(1D) of the *Health Insurance Act* provides that “exceptional circumstances” include but are not limited to circumstances that are prescribed by the regulations. Regulation 11 *Health Insurance (Professional Services Review) Regulations 1999* defines “exceptional circumstances” as (a) an unusual occurrence causing an unusual level of need for professional attendances; or (b) an absence of other medical services for patients of the person under review during the relevant period, having regard to the location of the person’s practice and characteristics of the person’s patients.
5. Section 4(1) of the *Health Insurance Act* provides that regulations may prescribe a table of medical services that sets out, relevantly, items of medical services and rules for interpretation of the table. From the beginning of the review period until 27 November 2013, MBS item 597 was described in Part 2 of Sch 1 to the *Health Insurance (General Medical Services Table) Regulations 2012* (Cth). The regulations which replaced them were relevantly the same for the rest of the review period. I will refer to both sets of regulations as the ***GMST Regulations***. MBS Item 597 and reg 2.15.1 of the *GMST Regulations* are set out at [167] and [168] below.
6. On 9 December 2015, the Committee wrote to the applicant attaching a notice of hearing which advised that a hearing would be held on 3-4 March, 17-18 March and 7-8 April 2016 and on “any other subsequent hearing dates which may be necessary to fully consider the matter” and of the MBS items in relation to which there would be investigation. The letter advised of the process which would be followed.

## 25 February 2016 invitation to provide submissions

1. On 25 February 2016, the Committee wrote to the applicant in the following terms:

… I write to invite you to provide any written submission or other information upon which you wish to rely in relation to the Committee’s investigation of PSRC Referral No 936 relevant to the issue of whether you engaged in inappropriate practice as defined by subsection 82(1A) - (1D) of the *Health Insurance Act 1973*.

…

The Committee would be assisted by your response to the following:

1. Do you accept that you rendered the number of professional attendances on each of the 39 dates listed in Table 12A? If not, please explain why.

2. Do you claim that exceptional circumstances existed on one or more of the dates listed in Table 12A? If so, what are the exceptional circumstances and when did the exceptional circumstances exist?

The Chair of the Committee, … , has instructed me to invite you to provide any written submission or other information in relation to the matters outlined above on or before 4:00 pm on 11 March 2016.

Once your submissions are received, the Committee will consider these prior to the hearing. During the hearing the committee will receive any oral evidence and further submissions you may wish to make.

## The 23 March 2016 submissions

1. The applicant provided written submissions on 23 March 2016 following the grant of an extension of time to do so.
2. The applicant acknowledged to the Committee that he had provided more than 80 services on each of more than 20 days in the review period and had therefore engaged in a “prescribed pattern of services” within reg 10. The applicant submitted that “exceptional circumstances” existed on each of those days so that he had not engaged in “inappropriate practice”. He said that this was because there was “an absence of other medical services” for his patients on each of these days within reg 11(b), having regard primarily to the location of his practice and the characteristics of his patients. He acknowledged that he bore the onus of establishing that.
3. He said that “Table 12A – Summary of days when 80 or more verified professional attendances were rendered by [the applicant]” was not accurate about the dates on which services were provided because many of those services were claimed by the practice on dates which were different (sometimes by many months) after the dates on which the services were rendered so that some of the services fell outside the review period.
4. He submitted that during the review period:
5. It was the height of the mining boom. There was a permanent population of approximately 6,000 to 7,000 and approximately 2,000 fly-in people. There were eight open cut coal mines in the area which operated 24 hours a day seven days a week. Blackwater was a designated Area of Need and District of Workforce Shortage, that is, a geographic area that had less than the national average of general or other non-specialist medical practitioners. His patients were remote mining and farming people who resided in Blackwater.
6. His practice was the North Blackwater General Practice. He was the only general practitioner who practised and resided in Blackwater on a full-time basis.
7. There were three other general practitioners who practised on a limited basis in Blackwater.
8. Dr Hudda primarily performed mining medical examinations. He saw a limited number of routine general practice patients during limited hours. He closed the practice at midday on Wednesday and Friday so that he could return to his home in Rockhampton. He did not practice on weekends or public holidays. He did not provide after-hours cover and he was not on call when he was in Rockhampton. He did not take new patients unless they were associated with industrial medicine.
9. Dr Timothy Smith did not reside in Blackwater but performed a fly-in/fly-out locum tenens role at the Blackwater Public Hospital for one week per month. In that time he would also attend to supervision commitments to the applicant. He practiced from the North Blackwater General Practice two days per month.
10. The third practitioner was Dr Vinay Timothy who commenced in Blackwater in late 2013. He was then conditionally registered because he was an overseas trained medical practitioner and therefore had a limited practice.
11. The next closest medical practices were in Emerald (an hour away) and Rockhampton (three hours away).
12. The Blackwater Public Hospital operated on the basis that there was one medical practitioner available to see patients. Not infrequently, it was “absent medical cover”. Patients would be admitted and reviewed by a nurse, and if necessary, electronically by a medical practitioner physically located in Emerald. The applicant ceased to provide services there in November 2013 although his contract expired in January 2014. Other medical practitioners who provided services there did so on a locum tenens basis.
13. He did not practise in a group practice with multiple partners or associates assisting him and he did not have the ability to refer patients to a large tertiary hospital.
14. He was not able to divert his telephone to a deputising medical practitioner during the hours of 6 pm and 8 am on each of Monday to Thursday or 6 pm Friday to 8 am Monday.
15. He could not advise his patients to call an ambulance because Blackwater only has one with one paramedic, and it services an area with a radius of 100 km.
16. There was an objective absence of other medical services having regard primarily to the location of the applicant’s practice and to the characteristics of his patients.
17. Exceptional circumstances existed and they affected the rendering of MBS services on each and every day in question. In the circumstances in which his clients required attention there was no real alternative.
18. By reference to the Full Court’s decision in *Oreb v Willcock* (2005) 146 FCR 237; [2005] FCAFC 196, the applicant submitted that (among other things):
19. Most significantly, the factors identified in reg 11(b) are deemed to be exceptional circumstances by operation of the legislation; it is not a matter for the Committee to consider whether or not in its view those matters might be considered exceptional.
20. It falls to Dr Nithianantha to establish that there was an absence of medical services for his patients having regard to the location of his practice and the characteristics of his patients.
21. In relation to whether or not the exceptional circumstances impacted upon the provision of services, Lander J found at [203] that it is possible that the circumstances could operate over the whole of the period and still be exceptional. The applicant claimed that that was the case in this matter.
22. The position contemplated by Black CJ and Wilcox J at [12] – “The absence of other medical services may conceivably be solely a function of location, for example, the practitioner may be the only practitioner in a remote location. The patients in such a place may have no particular ‘characteristics’ at all, other than that they live in that location” – was the case in Dr Nithianantha’s matter.
23. He also relied on Black CJ and Wilcox J at [14] and [16] for the propositions that concepts of foreseeability and avoidance are immaterial, so is practice management. The focus of reg 11 is the need of the patients, not the management skills of the practitioner.
24. By reference to the Full Court’s decision in *Tisdall v Webber* (2011) 193 FCR 260; [2011] FCAFC 76 (***Tisdall v Webber***), the applicant:
25. Noted that in *Tisdall v Webber*, the Committee identified by reference to data from Medicare Australia that on each of the 66 days on which Dr Tisdall rendered more than 80 professional services there were between three and seven other medical practitioners who worked in the local postcode area and rendered medical services and during the review period there were 10 medical practitioners who rendered medical services. On that basis, the committee inferred that there was no absence of medical services and Dr Tisdall had not demonstrated that exceptional circumstances existed.
26. Noted that the Full Court found that the committee was in error in making that inference in relation to whether the other practitioners would have had capacity to see Dr Tisdall’s patients on the 66 days, on the basis that that was the important practical question.
27. Noted that the Full Court found at [86] that “Committee members are not entitled to make findings of fact informing its state of non-satisfaction of those statutory factors based upon assumptions of likely capacity and likely disposition to see patients, unsupported by actual evidence, or simply based upon inferences from known statistics which did not reveal facts about the reasons for statistical rates of attendance.” (Emphasis in submission).
28. Submitted that (as written):

Unlike the case of Tisdall, Dr Nithianantha did not have 10 medical practitioners practising in his one local postcode area.

There were objectively no alternate medical practitioners available to see his patients. Moreover, as the Full Court made clear, it was as much a question for patients as to whether they were prepared to see another medical practitioner as it was as to whether or not other medical practitioners had an actual capacity and the inclination of those patients.

In our submission, PSRC No. 936 would find there was an absence of other medical services available to the patients of Dr Nithianantha. In the event PSRC No. 936 was to determine otherwise, we submit it would fall into appealable error.

In terms of the requirements of placita (i) of Regulation 11(b) namely, the location of the practice, we submit it is clear from the foregoing that the NBGP is located in a remote rural location which the Commonwealth had prior to the relevant time designated as an Area of Need and also a District of Workforce Shortage and therefore, having regard to those facts alone, there was an absence of medical services for the patients of Dr Nithianantha.

Having regard to placita (ii) of Regulation 11(b) we submit the characteristics of Dr Nithianantha’s patients are self-evident. That is, they were at the relevant time, largely remote rural mining and farming persons. Moreover, they were all residents of Blackwater.

…

**Did those exceptional circumstances affect the rendering of services by Dr Nithianantha?**

In short, for all of the reasons identified herein the answer is yes because in circumstances where patients required attention there was no real alternative and as the Full Court has made abundantly clear, the question relates to the need of the patients and not whether Dr Nithianantha may have been better able to arrange his Practice or to better limit his availability to those patients.

In our submission, PSRC No. 936 would fall into error if it found there was no absence of alternate medical services and that the absence of medical services did not affect the rendering of services by Dr Nithianantha **during the entire Review Period**.

[Emphasis added]

1. Provided with the 23 March 2016 submissions was a document dated 9 March 2016 containing answers to questions put to Kevin John Cracknell, a Central Highlands Regional Councillor. Mr Cracknell said that during the review period:
2. Apart from the applicant, there was one other general practitioner in Blackwater, Dr Hudda, who had employed a new overseas doctor as well. He understood that Dr Hudda worked Mondays-Fridays, primarily in industrial medicine and he travelled to his home in Rockhampton regularly.
3. The height of the mining boom “put a great strain on not only the community services but also the medical practitioners. It was often very difficult to get a Doctor’s appointment when you required it unless it was an emergency”.
4. If the applicant restricted his patient numbers or took time off, Mr Cracknell was not aware there were other doctors to see these patients. The local hospital had severely restricted staff numbers so that their services were limited strictly to severe emergencies only. “Dr Hudda’s surgery had its own patients and was also hard to get an appointment with and only worked standard hours”.
5. Thanks to the applicant, there were additional GP services, after-hours GP services, trauma management for the community and the mines, a full range of allied health services, skin screening and skin cancer procedures and pregnancy management which alleviated the burden of driving long distances for antenatal clinics.

## Notice on 1 April 2016 that a witness would give evidence

1. On 1 April 2016, the Committee gave the applicant notice by email to Mr Davey that it proposed to call a witness to give evidence by telephone. Relevantly, the email provided (as written):

One of the submissions you made was that exceptional circumstances applied in the context of the rendering of services by Dr Nithianantha because there were no alternative medical practitioners available to see his patients.

In researching this issue, I have spoken to the person who was the practice manager for the Blackwater Health Care Centre. She advised that, during the period of from 1 May 2013 to 30 April 2014:

* the Blackwater Health Care Centre was accepting new patients and had not closed its books;
* there were two fulltime doctors practicing at the Centre;
* the Centres standard opening hours were from 8:30 am to 5:30 pm; and
* anyone requiring GP assistance out of hours would have been referred to the local hospital, where there was a doctor available.

Given this information, the Committee proposes to obtain evidence from this person to this effect via telephone call at the hearing next Thursday. We are flagging this issue for you so that you can consider whether you would like to pose questions to this person or make submissions to the Committee on this issue.

1. The applicant contends that the Committee did not alert him to the conclusions it proposed to draw from the witness’ evidence nor did it invite him to lead any evidence in response.

## Hearing on 7 April 2016

1. The witness was **Ms Martin**. She gave evidence by telephone on the last day of the hearing, on 7 April 2016. While she was giving evidence, Ms Martin made reference to the records of the Blackwater Health Care Centre. Mr Davey took the opportunity to ask Ms Martin some questions.
2. Her evidence was that during the review period:
* She was the full time practice manager at the Blackwater Health Care Centre and she had worked there for approximately 30 years.
* The practice at the Blackwater Health Care Centre was open from 8.30 am to 5.30 pm Monday to Friday.
* The practice accepted new patients.
* The practice would accept patients who were the regular patients of “the other general practice in Blackwater”.
* The practice accepted urgent patients.
* There were two doctors working at the practice during the review period (Dr Vinay Timothy and Dr Shahoy Jenn). Dr Hudda had left Blackwater by then but she did not know the date on which he left. In this context the following interchange occurred:

Mr Davey: On the basis that they were both conditionally registered, who was supervising them?

Ms Martin: It would have been Dr Hudda.

Mr Davey: From Rockhampton.

Ms Martin: Yes.

Mr Davey: So did he come to the practice for the purpose of supervising them at all?

Ms Martin: Well he wouldn’t have left them until they had levels – you know, the right level of supervision.

Mr Davey: Okay.

Ms Martin: I really need to check that one ---

Mr Davey: I’m not being critical but I had understood that the purpose of this was for you to give evidence in respect of the review period.

Ms Martin: Yes. Well, I had the review period wrong. I had it from 2014 to 15 and I did have no idea what questions were going to be asked of me.

* After house coverage utilised an answering machine which directed patients to the hospital or an after-hours mobile phone which was directed to one of the doctors of the practice.
* The doctors randomly worked on Saturdays but it was not constant during 2013.
* There was no personal relationship between applicant’s practice and the Blackwater Health Care Centre.
* She did not know that an identified person who was a patient of the Blackwater Health Care Centre and well known to her had attended the North Blackwater General Practice as a patient.
1. After Ms Martin withdrew, the applicant said:

… We are in a small – this evidence caught us and I said caught me by surprise, but my concern is – how do I put it. We’re in a small town. There’s no other way of putting it, we’re in a small town. I have always been brought up to think you don’t – how do you say, apply tension within the functionality of a town. I guess I just wanted to state my concern as to (a) whether this sort of – my concerns are one of confidentiality which I understand there’s jurisdiction to protect, but (b) also – let’s just say I don’t want Glenda to feel terrible if that even makes sense as to being dragged into this.

1. Near the end of the hearing on 7 April 2016, the Committee Chair advised that there would not be a further hearing day and that, in preparing the report “the committee will take into consideration all the material before it, both oral and written” and that the Committee understood that “you [the applicant] intend to make written submissions, and we will give you until 22 April to make those written submissions”. The applicant was given the opportunity to address the Committee in final submissions before the hearing was closed and took that opportunity. Mr Davey indicated that he saw no need for him to do so and that he would address issues in written submissions.

## The applicant’s submissions of 22 April 2016

1. On 22 April 2016, Mr Davey sent a written submission to the Committee addressing (among other things) aspects of Ms Martin’s evidence. The submissions in this regard were:
2. At no time before or during the hearing was a statement of Ms Martin’s evidence provided to the applicant, albeit that the 1 April 2016 email was sent;
3. Ms Martin did not turn her mind to the actual review period. Rather, she prepared her evidence on the basis that she was looking at the period from 1 May 2014-30 April 2015. “On that basis, she was required to seek to revisit her position whilst on the telephone and in doing so, to seek to ensure no doubt that she was being accurate”.
4. The fact that Dr Huda had left Blackwater and was supervising two conditionally registered doctors from Rockhampton is further evidence of the absence of other medical services for the applicant’s patients and he relied on that in support of his submissions in relation to exceptional circumstances.
5. Ms Martin gave evidence that the Blackwater Health Care Centre operated between 8.30 am and 5.30 pm Monday to Friday and the after-hours arrangements referred patients to the Hospital. The Committee acknowledged (through those assisting it) that the Hospital had a policy of not seeing general practice patients. That is unsurprising when the Hospital is staffed only with one locum tenens medical practitioner at any point in time and that practitioner is often on “fatigue” and not able to see patients.
6. Ms Martin’s evidence was that the Blackwater Health Care Centre *regularly* saw patients from the North Blackwater General Practice but refused to accept the opposite. That evidence defies belief and should not be afforded weight. Having regard to the Blackwater Health Care Centre’s opening hours and the Hospital’s policy towards seeing general practice patients, the only other option for residents of Blackwater was to seek treatment from the applicant.
7. Despite that evidence, the applicant submitted a selection of requests from patients from the Blackwater Health Care Centre for the transfer of medical records to the North Blackwater General Practice. Indeed, Ms Martin had attended the North Blackwater General Practice with an identified person who she knew to be a patient of the Blackwater Health Care Centre and the applicant was forced to put that to her in questioning.
8. Ms Martin’s evidence that Dr Huda had left Blackwater by the start of the review period and was residing permanently in Rockhampton did not accord with the applicant’s unchallenged evidence based on his conversations with Dr Huda during the review period. Ms Martin was either confused or Dr Huda misled the applicant at the time.
9. Before Ms Martin gave her evidence, the applicant had established objectively that exceptional circumstances existed.

## Invitation concerning clinical records

1. By letter dated 8 June 2016, the Committee invited the applicant to provide “information or submissions” in relation to his clinical records for identified patients for whom he rendered an MBS item 597 service. The letter noted that a feature of the “Best Practice” system for record keeping used by the applicant indicates the time and date a record was open and the period for which it was open in relation to individual patients. Mr Davey responded by letter dated 17 June 2016.

## Draft report

1. By letter dated 12 October 2016, the Senior Case manager for the Committee sent a **draft report** to Mr Davey.
2. Paragraphs [48]-[54], which are relevant to MBS item 597 are set out at [169] below:
3. The Committee summarised Ms Martin’s evidence at [80] as follows:

Ms Martin advised that she was the practice manager for the Blackwater Health Care Centre for the Review Period and had worked at this practice for approximately 30 years. She advised:

* During the Review Period the practice was open from 8:30 pm to 5:30 pm, Monday to Friday;
* The practice accepted new patients and undertook urgent consultations during the Review Period;
* After-hours coverage utilised an answering machine which directed patients to the hospital or an after-hours mobile phone which was directed to one of the doctors of the practice;
* There were two doctors working at the practice during the Review Period; Dr Vinay Timothy and Dr Shahoy Jenn; and
* The two doctors were conditionally registered and were supervised by Dr Huda.
1. At [81], the Committee noted that Dr Nithianantha addressed Ms Martin’s evidence in the April submissions. The Committee then said:

82. Dr Nithianantha noted that Ms Martin had originally considered that she was questioned about the period 1 May 2014 to 30 April 2015, rather than the specified Review Period (ie 1 May 2013 to 30 April 2014). Dr Nithianantha noted ‘*On that basis, she was required to seek to revisit her position whilst on the telephone and in doing so, to seek to ensure no doubt that she was being accurate*’. The Committee agrees with this point but notes that Ms Martin was able to access computer systems to verify her evidence while she was asked questions by the Committee and by Dr Nithianantha’s legal representative, Mr Andrew Davey. Therefore, the Committee considers that her former misunderstanding did not affect her evidence concerning the Review Period.

83. Dr Nithianantha also made submissions concerning the fact that the doctors at the Blackwater Health Care Centre were conditionally registered and that they were supervised by Dr Huda, who had left Blackwater. Dr Nithianantha contended that this somehow established ‘*further evidence of the absence of other medical services*’. The Committee does not accept that the fact of a doctor being conditionally registered meant that there was an absence of medical services in the area. Further, the supervision of conditionally registered practitioners does not require the physical presence of the supervising practitioner. Accordingly, the Committee rejects this argument.

84. Dr Nithianantha also notes Ms Martin’s evidence of the opening hours for the Blackwater Health Care Centre and contends that the Hospital had a policy of not seeing general practice patients and that the practitioner at the hospital was often on “fatigue”. The Committee notes that Dr Nithianantha’s evidence about the capacity of the Blackwater Health Care Centre was contradicted by Ms Martin. The Committee notes Ms Martin’s evidence that, in addition to directing the patient to the hospital, the practice utilised an after-hours phone manned by a doctor of the Blackwater Health Care Centre. The Committee considers that this evidence does not support Dr Nithianantha’s assertion that there was an absence of medical services in the area.

85. Dr Nithianantha also made submissions that the practice also regularly saw patients in the Blackwater Health Care Centre. Dr Nithianantha also stated that Ms Martin ‘*categorically disavowed any knowledge*’ of this. The Committee does not find it surprising that Ms Martin would be unaware of the practices of patients who decided to see Dr Nithianantha, as it would also conclude that Dr Nithianantha is unlikely to have a definitive understanding of the patients that choose to consult doctors at the Blackwater Health Care Centre. The Committee also considers this issue to be irrelevant and does nothing to establish whether or not there was an absence of medical services in the area.

86. In his submissions, Dr Nithianantha also contended that ‘*many of the patients of the Blackwater Health Care Centre formally requested the transfer of their medical record and therefore care*’ to Dr Nithianantha’s practice. Dr Nithianantha contended that Ms Martin would have been the person to transfer the records, she should have known about transfer and ‘*chose not to indicate (at all or in answer to specific questions …* ’. The Committee notes, however, that this question was not put to Ms Martin either by the Committee nor by Dr Nithianantha’s legal representative, Mr Davey. Insofar as this issue was canvassed, the Committee notes the following exchange recorded in the official transcript:

Mr Davey: Can I ask you this, during the Review Period, doing the best you can, you're aware Dr Timothy would refer patients to Dr Nithianantha, weren’t you?

Ms Martin: Dr who?

Mr Davey: Dr Timothy - - -

Ms Martin: Yes.

Mr Davey: - - - would refer patients of his or of the practice where you practised (indistinct) - - -

Ms Martin: Yes.

Mr Davey: - - - to the other general practice in town.

Ms Martin: At that - was that - which doctor are we talking about?

Mr Davey: Dr Nithianantha. You were aware that happened, weren’t you?

Ms Martin: No.

Mr Davey: Would you accept from me it did?

Ms Martin: Was he working at the hospital or the other - - -

Mr Davey: He was working at the hospital and in general practice in - - -

Ms Martin: We would have referred - if we couldn’t deal with anything at that time, you know, like medically, we would have referred them straight to the hospital, yes.

Mr Davey: So you’re telling the committee that on no occasion did Dr Timothy ever contact Dr Nithianantha in his capacity as a general practitioner and refer a patient to him. Is that your evidence?

Ms Martin: No, I don’t know that.

Mr Davey: Right, thank you.

Ms Martin: I’d have to look at the file.

Mr Davey: Thank you. You gave some evidence in answer to a question from the chairperson a moment ago about the fact that your practice was prepared to accept patients from the other general practice in town.

Ms Martin: Yes, we do.

Mr Davey: And you would accept that that position worked the opposite way as well, wouldn't you?

Ms Martin: Well, I’m not sure what the other practice would do. Sometimes they’d fit it in, a patient, sometimes they didn't. I have no idea what the other practice did, but I know that we saw patients who phoned us and asked for an appointment from the other practice.

87. As is evident from the above, Ms Martin indicated that she was unaware that Dr Timothy had referred patients to Dr Nithianantha’s practice or that he had had communications with Dr Nithianantha. Ms Martin also indicated that she was unaware as to whether Dr Nithianantha’s practice would accept patients from the Blackwater Health Care Centre. More importantly, Ms Martin was not asked, nor did she make any statements about, the extent to which files were transferred to Dr Nithianantha’s practice. The Committee also advises that a transfer of a medical record does not necessarily mean a transfer of care. The original records stays with the practice and a copy is sent.

88. Dr Nithianantha included in the April Submissions six ‘*Medical Record Release Forms*’ requesting the transfer of records from the Blackwater Health Care Centre to Dr Nithianantha’s practice. The Committee considers that it would not be unusual for patients to transfer from one practice to another and this may occur for any number of reasons. To this extent, the Committee does not consider that forms indicating that 6 patients had transferred to Dr Nithianantha’s practice during the Review Period lends much weight to Dr Nithianantha’s argument that there was an absence of medical services in the district.

89. The Committee also notes Dr Nithianantha’s comments in the April Submissions as to whether Dr Huda resided in the Blackwater area during the Review Period. In short, Dr Nithianantha highlighted the inconsistency between his own evidence and Ms Martin’s evidence about this fact. The Committee does not consider this fact to be particularly relevant to the issues at hand and has formed the opinion that Dr Nithianantha may not necessarily have known the residential status of Dr Huda.

90. The Committee, in its analysis of whether Dr Nithianantha’s provision of a prescribed pattern of services was affected by exceptional circumstances must make factual determinations regarding subsection 82(18) and regulation 11(a) and 11(b).

91. The Committee has carefully considered Dr Nithianantha’s submissions regarding the availability of medical services in Blackwater during the Review Period, including the testimonial provided by Mr Cracknell. The Committee has also carefully reviewed the evidence provided by Ms Martin regarding the capacity and willingness of the Blackwater Health Care Centre to provide medical services during the Review Period. The Committee notes that the evidence of Ms Martin is at odds with much of the evidence provided in support of Dr Nithianantha, at least with respect to the key issues at hand. The Committee does not consider that Dr Nithianantha or Mr Cracknell attempted to misrepresent the situation in Blackwater but the Committee is of the opinion that Ms Martin is better placed to provide advice as to whether the Blackwater Health Care Centre was in a position to provide medical services to the Blackwater community during the Review Period. The Committee also notes that Ms Martin was able to (and actually did) check the records for Dr Huda’s practice to confirm her evidence while she was being questioned by the Committee and Mr Davey.

92. For this reason, the Committee is of the view that the Blackwater Health Care Centre was available to provide medical services to patients of Dr Nithianantha during the Review Period. That being the case, the Committee concludes there was not an absence of other medical services for patients of Dr Nithianantha during the Review Period and, consequently, exceptional circumstances did not exist within the meaning of section 82 of the Act.

## The applicant’s 30 November 2016 submissions

1. Mr Davey provided the Committee with written submissions in response on 30 November 2016. In that submission, the applicant noted (among other things):
2. His uncontradicted evidence concerning the unavailability of the Blackwater Hospital to provide services to general practice patients. That is, that there was a locum doctor “on rotation” from Emerald and he was on fatigue for 12 hours in every 24 hour period.
3. The option offered by the Blackwater Health Care Centre was not, on any sensible view, an option at all because:
* None of Ms Martin’s evidence is capable of permitting a factual finding that there was not an absence of medical services available for the applicant’s patients.
* Perhaps more significantly, there is no evidence that indicates the number of services each of the two conditionally registered medical practitioners practising from the Blackwater Health Care Centre actually provided during the review period or their capacity to provide services on the days on which the applicant rendered more than 80 professional attendances. There is no evidence that they were even in Blackwater on those days.
* Even if the conditionally registered medical practitioners were available and willing to provide services on those days within a reasonable time, it begs the question of whether the applicant’s patients would have been willing to see one of them.
1. In respect of 11 of the 28 days on which the applicant purportedly provided more than 80 professional attendances, the services which pushed his daily total up to or over 80 were all after-hours items. That was significant because:

… First, if Dr Nithianantha refused to see those patients to whom he rendered an after-hours service (on the days when he rendered in excess of 80 professional attendances) and instead told them to go to the hospital, the reality is, the hospital would have been unable to deal with that number of in effect, general practice consultations especially in circumstances where the locum was most likely on fatigue.

Secondly, the effect of the preliminary finding of PSRC No. 936 in respect of the breach of the 80/20 Rule is to suggest that it is unacceptable to the general body of general practitioners to assess a patient during the after-hours period regardless of whether or not it is urgent (or even to determine the urgency), if the practitioner may have already rendered 79 professional attendances that day and notwithstanding the fact that there may be no other medical services available and that the practitioner is familiar with the patient and their specific medical conditions. With respect, those two factors demonstrate an absence of other medical services for Dr Nithianantha’s patients.

On that basis, the only possible other medical services which may have theoretically been available to see Dr Nithianantha’s patients were the Conditionally Registered medical practitioners from the Blackwater Health Care Centre who would have themselves been required to attend upon the patient during that after-hours period if they were in fact minded to do so. With respect, there is absolutely no objective evidence before PSRC No. 936 which permits a factual finding that those practitioners would have been available to see the patient at the time in question.

In our submission, there was clearly an objective absence of other medical services for Dr Nithianantha’s patients during the Review Period and more-specifically and clearly, on the actual days in question.

1. The Committee impermissibly had regard to issues which amount to practice (or patient number) management strategies. It is inappropriate to suggest that, in order to avoid a possible breach of the 80/20 rule that there was a genuine option for the applicant’s patients to:
* “Go without” medical services; or
* Attempt to obtain medical services on the following day or next business day; or
* Hope that during the after-hours period one of the two conditionally registered medical practitioners from the Blackwater Health Care Centre *may* have been available *and* prepared to see them; or
* Hope that during the after-hours period an ambulance would actually be available to respond to a “000” call within a reasonable period of time and that it would not have to by-pass the Blackwater hospital and proceed to Emerald, an hour’s drive away.
1. The words of the descriptor for MBS item 597 services are met at the time the service is requested and not after the service has been provided. The relevant time is when the telephone contact (at which the service is requested by the patient and it is determined by the practitioner that it is either urgent requiring attendance or it is not) is made, at least during the after-hours period. There is great debate and clear confusion about this issue within the profession and the Government. Having regard to that factor, the applicant’s interpretation of the item descriptor would not amount to conduct which the general body of his peers would find unacceptable so that “inappropriate practice” is not made out.
2. The applicant relied on advice from the Provider Services Branch of the Department of Human Services on 16 May 2016 that the requirement in point (b) of items 597-600 was a follows:

Our understanding of this requirement is that the medical practitioner makes a prospective assessment of a patient’s condition before deciding whether to return and re-open the consulting rooms or to advise the patient to wait until the start of the next in-hours period for a consultation.

It would not relate to a retrospective decision as to the urgency of treatment after examination of the patient’s condition.

## Final report

1. The Committee’s findings are set out in its **final report** dated 13 April 2017 and they are relevantly the same as those set out in the draft report. Having said that, at [15], the Committee noted that it had regard to the submissions on the draft report provided on 30 November 2016 and there was new material addressing those submissions after [96]. The new material recommenced after [96] at [1] and I will refer to these paragraph numbers as “new”.
2. At new [3], the Committee summarised the issues raised by the applicant in relation to a prescribed pattern of services as follows:
* Whether there was sufficient evidence that alternative medical services were available during the review period;
* The weight that could be given to Ms Martin’s evidence;
* Whether there is a need to address specifically each of the days where a prescribed pattern of services existed during the review period;
* The availability of the locum at the hospital;
* Whether patients would agree to be treated by the conditionally registered medical practitioners;
* The effect of after-hours services on the prescribed pattern of services;
* Whether the Committee adopted the practical approach to the test referred to by the Full Court in *Tisdall v Webber* at [28];
* Whether the Committee focused on issues pertaining to practice management.
1. The Committee addressed the question of whether there was sufficient evidence of alternative medical services at new [5]-[13]. The Committee noted the applicant’s claims that: “At best there was only a theoretical possibility” that medical practitioners from the Blackwater Health Care Centre were available on the 28 days in question during the review period. The evidence of actual availability was “at best equivocal”, given the competing evidence of Ms Martin on one hand and the applicant and Mr Cracknell on the other. The actual position was not resolved when the Committee “made a factual finding that all three witnesses were attempting to be helpful and honest in evidence” so that it was equally open to the Committee to find an absence of medical services: new [5]-[6].
2. The Committee found that that argument did not stand up to scrutiny. Ms Martin was in “a far better position” to give evidence about the circumstances at the Blackwater Health Care Centre than the applicant and “certainly Mr Cracknell”. In this respect, the Committee found that Ms Martin’s evidence was unequivocal and to the effect that that practice had not closed its books, it was available to take new patients and it had after-hours arrangements in place: new [7]. In these proceedings, the applicant maintains that this finding does not address the limits of Ms Martin’s evidence because it did not go to the ready and reasonable availability of medical services for the applicant’s patients, particularly in the after-hours period.
3. The Committee noted the applicant’s reliance on *Tisdall v Webber* and his assertion that the Committee had made assumptions about likely capacity and likely disposition of doctors at the Blackwater Health Care Centre to see patients and that its conclusion was “unsupported by actual evidence” and based on “speculation, guesswork or mere assumption”: new [8]. The Committee:
4. Noted the applicant’s submission that no evidence was presented about the number of services actually provided by the two conditionally registered practitioners on the days that there was a prescribed pattern of services or whether they were even in Blackwater on those days: new [9].
5. The Committee found that the applicant misconstrued the test for determining whether exceptional circumstances exist. At new [11], the Committee said:

Most notably, the test outlined in paragraph 11(b) of the PSR Regs revolves around determining whether there was an absence of other medical services with regard to the location of the practice and the characteristics of the patients. Ms Martin’s evidence, which was given in circumstances where she was able to view the records of the Blackwater Health Care Centre, was that the practice was available to patients during the period in question and consequently, the Committee is of the view that there was no absence of medical services.

While admitting of the possibility that the Committee may have been employing shorthand, the applicant maintains the contention that the Committee applied the wrong test by looking to see if the Blackwater Health Care Centre was available to patients generally and that the Committee failed to consider whether the services of the Blackwater Heath Care Centre were available to deal with the applicant’s patients.

1. In relation to the applicant’s argument that the conditionally registered practitioners were the only theoretically available services and that they would have been required to attend after-hours but there was “no objective evidence” that permits a factual finding that they would have been available to do so, the Committee disagreed with that claim and went on to say at new [13]:

Ms Martin gave evidence to the Committee that the medical practitioners were available during the period in question and that the practice had not closed its books. Moreover, Ms Martin advised that the Blackwater Health Care Centre provided after hours cover via an answering machine which directed patients to the hospital or an after-hours mobile phone, which was manned by one of the doctors in the practice.

The applicant maintains that this evidence does not justify the conclusion reached by the Committee.

1. The Committee dealt with the issue of the weight to be given to Ms Martin’s evidence at new [14]-[15] and found as follows at new [15]:

The Committee notes that while there is no legal onus of proof in Committee proceedings, once a prescribed pattern of services has been found to exist there is a practical or evidentiary onus on Dr Nithianantha to establish that there was an absence of alternative medical services for his patients [relying on *Oreb v Willcock* [2005] FCAFC 196]. In light of the evidence presented by Dr Nithianantha and the evidence of Ms Martin, the Committee cannot be reasonably satisfied that exceptional circumstances existed. In fact, the Committee does not consider that the evidence before the Committee established that there was an absence of alterative medical services available to his patients. While the evidence of Dr Nithianantha and Mr Cracknell contradicts that of Ms Martin, the Committee considers that Ms Martin was in a better position to establish whether or not Blackwater Health Care Centre was in a position to provide medical services to Dr Nithianantha’s patients.

1. The Committee dealt with the question raised by the applicant of whether the Committee was required to direct its review at each of the relevant days when the applicant rendered the prescribed pattern of services at new [16]-[18]. The Committee noted that that approach may have logic but referred to the comments of Lander J in *Oreb v Willcock* at [198]-[200] as follows:

Section 106KA(2) requires an inquiry into whether, on a particular day or particular days during the relevant period, exceptional circumstances existed. That again is directed to the particular day or days.

Regulation 11(b), however, directs the inquiry into the absence of other medical services for the general practitioner’s patients “during the relevant period”.

The relevant period is the period referred to in s 106KA(1), which is the whole of the period being the period of 12 months over which the prescribed pattern of services is said to have occurred.

1. The Committee found, at new [18], that the approach suggested by the applicant misconstrues the test in reg 11(b).
2. The Committee dealt with the applicant’s contentions concerning the availability of a locum at Blackwater Hospital at new [19]-[21] as follows:
3. The Committee found that there was no evidence presented as to the hours on which the locum would be “on fatigue” so that in focusing on the after-hours period, the applicant’s submissions were “somewhat misleading”. The applicant acknowledged that there was an ambulance available to residents at Blackwater or alternative medical services if the call was triaged as category 1 or 2.
4. The locum at the hospital was not the only option available to patients having regard to Ms Martin’s evidence that the Blackwater Health Care Centre had an answering machine which directed enquiries to the hospital or to an after-house mobile phone manned by a medical practitioner.
5. The Committee addressed the question of whether the applicant’s patients would agree to be treated by conditionally registered medical practitioners at new [22]-[26]. It first noted the applicant’s reliance on the finding in *Tisdall v Webber* that many factors impact on resolving the question of whether there was an alternate medical practitioner available. The Committee noted that there was no evidence introduced that “this might be the case”. Having regard to the applicant’s actual submission, I take this finding to mean that there was no evidence that the applicant’s patients would not agree to be treated by a conditionally registered medical practitioner. The Committee then went on to note comments made by Dowsett J in *Hatcher v Fry* (2009) 183 FCR 1; [2009] FCA 1573 at [19] and [21] as follows:

To treat preference as a characteristic for the purposes of reg 11 would seriously undermine the underlying purpose of the regulation and the Act.

To avail oneself of the benefit of the provision a practitioner would have to show that a group of his or her patients consulted him because they share a particular characteristic. A characteristic is not merely a preference. If a practitioner regularly attracts Chinese-speaking patients, for whatever reason, then that may be a characteristic of his or her patients. If he or she regularly attracts patients whose primary concern is about skin complaints, then that may be a characteristic of his or her patients.

On that basis, at new [26], the Committee considered that a reluctance to consult conditionally registered medical practitioners reflects a preference, rather than a characteristic for the purposes of reg 11(b)(i).

1. The Committee addressed the applicant’s submissions in relation to the effect of after-hours services on the prescribed pattern of services and the applicant’s claim that in 11 of the 28 days that formed the pattern the number of services was pushed over the “applicable threshold” by after-hours items at new [27]-[30]. The Committee noted that:
2. On each day on which the applicant engaged in a prescribed pattern of services, he rendered a number of health assessment or chronic disease management items, and on most of those days he rendered both; and
3. There was no requirement that those items be completed on a particular day so that the applicant’s claim that he rendered more than 80 services on the days in question simply because he rendered after-hours consultations on certain days was not correct.
4. The Committee referred to submissions in relation to the *Tisdall v Webber* “practical approach” to determining whether there was an absence of alternative medical services at new [31] and set out a summary of Greenwood J’s reasons in *Tisdall v Webber* at [28]:

‘whether a patient of Dr Tisdall would have been able, reasonably, to see another medical practitioner rather than Dr Tisdall’ and ‘(m)any considerations may be relevant to that question but they include questions of access to alternative practitioners, the location of the practice of an alternative medical practitioner, the hours during which such a practitioner might be available and the patient numbers or patient cohort seeking access to the alternative medical practitioner.’

1. The Committee stated that it was aware that the applicant’s practice was more remote than Dr Tisdall’s practice, a matter which the applicant had raised. It found (at new [33]) that the evidence presented by Ms Martin supports a conclusion that there were alternate medical services available to the applicant’s patients during the review period.
2. The Committee addressed the applicant’s submission that it had had improper regard to practice and patient management strategies in considering whether exceptional circumstances existed, at new [34]-[35]. The Committee rejected the applicant’s submissions. It found that, as acknowledged by the applicant, to the extent any comments of this kind were made during the hearing and in the draft report, they related to the rendering of urgent after-hours services and in those instances it was directly relevant to consider whether the patient had an urgent need for treatment. Consequently it would be appropriate to consider whether treatment could be deferred until the after-hours period had expired.
3. The Committee dealt with submissions made by the applicant in relation to the test laid down in the MBS descriptor for item 597 at new [58]-[62] of the final report. It noted the applicant’s submission that the test in the descriptor is prospective in nature and would be met at the time of the initial telephone contact with the patient. The Committee again rejected that interpretation at new [59].
4. The Committee rejected the applicant’s interpretation on the basis that the general body of practitioners would determine whether the item descriptor was satisfied at the time the item was billed, that is, after the service was rendered. It found that a medical practitioner would not be in a position to know what the patient’s condition was at the time of initial contact. The patient’s condition would only become evident upon examination. It would not be possible to know whether the patient required urgent treatment until an examination had been undertaken. The Committee noted that the item does not say “urgent assessment for treatment”, as would be required if the applicant’s interpretation were to be applied. The Committee noted that the email on which the applicant relied in support of his view was dated 16 May 2016 (see [38(6)] above), after the review period had expired, so that it would have been impossible for him to have relied on that advice. It also noted that the identity of the recipient of the advice had been removed from the copy provided to the Committee so that there was nothing to indicate that the advice had been provided to the applicant. In any event, the Committee considered the advice to be incorrect.

# Grounds of Application

1. By an email to chambers, the solicitors for the second respondent confirmed that it had no objection to an amendment to the applicant’s pleaded grounds which was attached to the reply submissions and that position was reconfirmed at the hearing. The solicitors also advised that the parties had been in discussions and there was no dispute as to the admissibility of evidence filed in the proceedings or as to factual matters disclosed in those affidavits.
2. The applicant describes the pleaded grounds as being the “exceptional circumstances ground”, the “procedural fairness ground” and the “wrong question ground”.

# Legislation

1. It is useful at this point to set out some relevant provisions of the *Health Insurance Act* and regs 10 and 11 of the *Health Insurance (Professional Services Review) Regulations* in full.
2. Section 3 of the *Health Insurance Act* relevantly contains the following definitions:

***clinically relevant service*** means a service rendered by a medical … practitioner that is generally accepted in the medical … profession … as being necessary for the appropriate treatment of the patient to whom it is rendered.

…

***professional service*** means:

(a) a service … to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner;

…

1. Section 10 of the *Health Insurance Act* relevantly provides as follows:

**Entitlement to Medicare benefit**

(1) Where, on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, any medicare benefit calculated in accordance with subsection (2) is payable, subject to and in accordance with this Act in respect of that professional service.

…

(2A) Without limiting the generality of regulations for the purposes of paragraph (2)(aa), the regulations may prescribe services for the purposes of that paragraph by identifying, in the table, the services concerned.

…

1. Relevantly to that definition, item 597 is set out at [167] below and reg 1.15.1167 of the *General Medical Services Table* is set out at [168] below.
2. Sections 79A and 80 of the *Health Insurance Act* set out the object of Part VAA and the main features of the professional services review scheme as follows:

**79A Object of this Part**

The object of this Part is to protect the integrity of the Commonwealth medicare benefits and pharmaceutical benefits programs and, in doing so:

(a) protect patients and the community in general from the risks associated with inappropriate practice; and

(b) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

**80 Main features of the Professional Services Review Scheme**

(1) This section summarises the main features of the Professional Services Review Scheme established by this Part.

(2) The Professional Services Review Scheme is a scheme for reviewing and investigating the provision of services by a person to determine whether the person has engaged in inappropriate practice.

(3) The Chief Executive Medicare can request the Director to review the provision of services by a person and the Director must decide whether to undertake a review.

(4) Following a review, the Director must:

(a) decide to take no further action in relation to the review; or

(b) enter into an agreement with the person under review; or

(c) make a referral to a Committee.

(5) If the Director enters into an agreement with the person under review, the agreement must be ratified by the Determining Authority before it takes effect. Having an agreement ratified avoids a Committee investigation.

(6) A referral to a Committee initiates an investigation by the Committee into the provision of the services specified in the referral. The Committee can investigate any aspect of the provision of the referred services and its investigation is not limited by any reasons given in a request for review or a Director’s report following a review.

(7) Committee members must belong to professions or specialities relevant to the investigation.

(8) Committees can hold hearings and require the person under review to attend and give evidence. Committees also have the power to require the production of documents (including clinical records).

(9) Committees can base findings on investigations of samples of services.

(10) If a Committee finds that the person under review has engaged in inappropriate practice, the finding will be reported to the Determining Authority. The Determining Authority decides what action to take.

(11) Provision is made throughout the scheme for the person under review to make submissions before key decisions are made or final reports are given.

(12) A Committee cannot make a finding of inappropriate practice unless it has given the person under review:

(a) notice of its intention to do so; and

(b) the reasons for the finding; and

(c) an opportunity to respond.

1. Section 81(1) of the *Health Insurance Act* contains the following definitions:

***Committee*** means a Professional Services Review Committee set up under section 93.

***Committee investigation*** means an investigation by a Committee under Division 4.

***Determining Authority*** means the Determining Authority established by section 106Q.

…

***Director*** means the Director of Professional Services Review appointed under section 83.

…

***findings***, in relation to a draft report or final report of a Committee, means the Committee’s findings as to whether the person under review engaged in inappropriate practice in the provision of some or all of the services specified in the referral made to the Committee.

…

***service*** means:

(a) a service that has been rendered if, at the time it was rendered, Medicare benefit was payable in respect of the service; or

(ab) a service that has been initiated (whether or not it has been or will be rendered) if, at the time it was initiated, medicare benefit would have been payable in respect of the service had it been rendered at that time; or

(b) a service rendered by way of a prescribing or dispensing of a pharmaceutical benefit …

…

Section 81(2) of the *Health Insurance Act* provides as follows:

*Meaning of* ***provides services***

For the purposes of this Part, a person *provides services* if the services are rendered or initiated by:

(a) the person; or

(b) ...

(c) a practitioner employed or otherwise engaged by a body corporate of which the person is an officer.

1. Section 82 of the *Health Insurance Act* provides as follows:

**82 Definitions of inappropriate practice**

*Unacceptable conduct*

(1) A practitioner engages in inappropriate practice if the practitioner’s conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that:

(a) if the practitioner rendered or initiated the services as a general practitioner—the conduct would be unacceptable to the general body of general practitioners; or

…

*Prescribed pattern of services*

(1A) Subject to subsections (1B) and (1C), a practitioner engages in inappropriate practice in rendering or initiating services during a particular period (the relevant period) if the circumstances in which some or all of the services were rendered or initiated constitute a prescribed pattern of services.

(1B) A practitioner does not, under subsection (1A), engage in inappropriate practice in rendering or initiating services on a particular day during the relevant period if a Committee could reasonably conclude that, on that day, exceptional circumstances existed that affected the rendering or initiating of the services.

(1C) Subsection (1B) does not affect the operation of subsection (1A) in respect of the remaining day or days during the relevant period on which the practitioner rendered or initiated services even if the circumstances in which the services were rendered or initiated on that day or those days would not, if considered alone, have constituted a prescribed pattern of services.

(1D) The circumstances that constitute exceptional circumstances for the purposes of subsection (1B) include, but are not limited to, circumstances that are prescribed by the regulations to be exceptional circumstances.

1. Section 82A of the *Health Insurance Act* defines a “prescribed pattern of services” as follows:

**82A Meaning of prescribed pattern of services**

(1) The circumstances in which services are rendered or initiated by a practitioner constitute a prescribed pattern of services if they are circumstances prescribed by the regulations for the purposes of this section.

(2) The circumstances prescribed may relate to services of a particular kind or description that are rendered or initiated by:

(a) practitioners in a particular profession; or

(b) an identified group or groups of practitioners in a particular profession.

(3) The circumstances prescribed may include the rendering or initiation of more than a specified number of services, or more than a specified number of services of a particular kind, on each of more than a specified number of days during a period of a specified duration.

1. Regulations 10 and 11 of the *Health Insurance (Professional Services Review) Regulations* provide as follows:

**10 Circumstances constituting a prescribed pattern**

For section 82A of the Act, the circumstances in which services that are professional attendances constitute a prescribed pattern of services are that 80 or more such services are rendered on each of 20 or more days in a 12 month period.

**11 Exceptional circumstances**

For subsection 82(1D) of the Act, the following circumstances are declared as constituting exceptional circumstances:

(a) an unusual occurrence causing an unusual level of need for professional attendances;

(b) an absence of other medical services, for patients of the person under review during the relevant period, having regard to:

(i) the location of the practice of the person under review; and

(ii) characteristics of the patients of the person under review.

1. In relation to the conduct of the referral, the following provisions of the *Health Insurance Act* were drawn to the Court’s attention:
2. If the Director makes a referral to a Committee, the Director must prepare a written report in respect of the services to which the referral relates, giving reasons why the Director thinks the person under review may have engaged in inappropriate practice in providing services. A copy of the report must be attached to the referral and given to the Chief Executive Medicare and the person under review: s 93(6) and (7).
3. The Chairperson of the Committee must convene the first meeting of the Committee within 14 days after the appointment of the Committee members (although failure to do so does not render anything done by the Committee invalid). The Chairperson must also convene such other meetings of the Committee as necessary for the efficient conduct of its affairs: s 97.
4. The Committee may hold hearings and it must do so if it appears to the Committee that the person under review may have engaged in inappropriate practice in providing the referred services: s 101.
5. If the Committee proposes to hold a hearing, it must give the person under review written notice of the time and place proposed, at least 14 days before the proposed hearing. The notice must give details of the referred services and it may require the person to appear at the hearing and give evidence: s 102.
6. In relation to the hearing, the person under review has the right to attend the hearing, to be accompanied by a lawyer or another adviser, to call witnesses to give evidence (other than as to his or her character), to produce written statements as to character, to question a person giving evidence at the hearing, to address the Committee on questions of law arising during the hearing and after the conclusion of evidence, and to make a final address to the Committee on questions of law, the conduct of the hearing and the merits of matters to which the hearing relates. The lawyer may give advice to the person under review, address the Committee on questions of law and after the conclusion of the hearing, make a final address to the Committee on questions of law, the conduct of the hearing and the merit of the matters to which the hearing relates: s 103.
7. The procedures for the conduct of hearings is within the discretion of the presiding member of the Committee. The Committee is not bound by the rules of evidence but may inform itself of any matter in any way it thinks appropriate. The presiding member may adjourn the hearing from time to time as he or she thinks fit: s 106.
8. Evidence may be taken on oath or affirmation: s 106A.
9. The Committee may, for the purposes of Subdiv 4B of Part VAA, summon a person (other than the person under review) to appear at a hearing to give evidence and produce documents referred to in the summons: s 106B.
10. It is the duty of a Committee to carry out its functions so that its final report is given to the Determining Authority within 6 months of the day on which the referral was given to the Committee or (if the Chairperson or in the Chairperson’s absence another Committee member so requests) a further period of up to 3 months allowed by the Director. There are other circumstances in which a request for extension might be made which are not here relevant: s 106G.
11. Before the Committee makes a finding of inappropriate practice, it must: notify the person under review of its intention to do so, provide the person with the reasons on which the Committee intends to base its finding; and give the person under review an opportunity to respond: s 106H(4). The Committee complies with these requirements if it provides a draft report to the person under review in accordance with s 106KD: s 106H(5).
12. The Committee must prepare a written draft report of preliminary findings setting out those findings and its reasons for them. Unless there is no finding of inappropriate practice, the Committee must give a copy of the draft report to the person under review together with a notice inviting the person to make written submissions suggesting changes within one month: s 106KD.
13. After the month, after taking into account any submission made to the Committee by the person under review, the Committee must prepare a final report setting out (where the Committee is unanimous, as here), the Committee’s findings. It must not include a finding of inappropriate practice unless the finding and the reasons for it were included in the draft report. The Committee must give copies of the final report to the person under review and the Director and give a copy of the final report to the Determining Authority not earlier than one month after it was given to the person under review: s 106KL.

# Exceptional circumstances ground

1. The applicant says that the Committee erred in coming to the conclusion that the Blackwater Health Care Centre was available to provide medical services to the applicant’s patients in the review period on three bases.
2. The **first basis** for this claim is that the Committee failed to consider and determine according to law whether medical services at the Blackwater Health Care Centre were a readily and reasonably available alternative for the applicant’s patients. This formulation relies on *Tisdall* *v Webber* at [28] per Greenwood J and [111]-[112] per Buchanan J, Tracey J agreeing.
3. The **second basis** for this claim is that the inference that the doctors at the Blackwater Health Care Centre had capacity and were reasonably available to the applicant’s patients within a reasonable time either during opening hours or after-hours was not open to the Committee to make from Ms Martin’s evidence.
4. The **third basis** for this claim is that the Committee failed to consider whether another medical practitioner was available to see the applicant’s patients on *each* of the days on which the applicant claimed that “exceptional circumstances” existed.

## Submissions on first and second bases

### Applicant’s submissions

1. There is considerable cross-over in the applicant’s submissions between the first and second bases. Accordingly, I will summarise the applicant’s submissions on these bases together.
2. The applicant says that the Committee applied the wrong test in reaching its conclusion at [92] of the draft and final reports that there was “no absence of medical services” for the applicant’s patients in the review period and consequently exceptional circumstances did not exist within the meaning of s 82 of the *Health Insurance Act*.
3. The applicant submitted that even though the Committee identified the correct test at new [31], being that set out in *Tisdall v Webber* at [28] (see [51] above), it failed to apply it. The applicant does not dispute that the Committee referred to his submissions in relation to the correct test to be applied (at new [22]-[26] and new [31]-[33] of the final report). The applicant says that the Committee did not focus on the issue of the availability of medical services from the perspective of the applicant’s patients at any point in its reasoning. Despite the reference to the applicant’s patients at new [15], there is no reference to those patients in the “cut and paste” material from the draft report at [80]-[92] (which is the same in the final report) and there is nothing in the material that preceded [92] which supports the conclusion reached in it. (See [37] above for [92] and new [15] of the final report at [45] above.)
4. The applicant says that the reference to the applicant’s patients at new [15] does not indicate that the Committee applied the test in *Tisdall* *v Webber* at [28]. Rather, it demonstrates that it did not because it does not address whether the services of the Blackwater Health Care Centre were reasonably and readily available to the applicant’s patients. This was particularly so in the face of uncontradicted evidence that:

(a) The Review Period was at the height of the mining boom and the community was very busy with mining and construction workers, permanent residents and transient workers.

(b) Dr Nithianantha saw patients from all the mines, including injured workers transported to his practice. There were eight open-cut mines in the vicinity, which operates 24 hours per day, seven days per week.

(c) Dr Nithianantha’s practice was growing rapidly at the start of the Review Period.

(d) There were very limited medical services available at Blackwater Hospital which had extended periods with no doctor present. It had one locum who practised there who was on “fatigue” (i.e. not working) for more than 12 hours per day. It was “dwindling into a very minimalistic emergency, critical emergency only service.”

(e) Blackwater had one ambulance and one paramedic servicing an area with a radius of 100 km.

(f) There were only two medical practices in Blackwater during the Review Period, Dr Nithianantha’s practice and Blackwater Health Care Centre.

(g) It was often difficult to get a doctor’s appointment during the Review Period, unless it was an emergency.

(h) The Blackwater Health Care Centre closed at 5.30pm each day, whereas Dr Nithianantha’s practice was open until 7.30pm or 8pm on three to four days per week.

(i) Blackwater is a remote location. It was designated, by the Department of Health, as a District of Workforce Shortage and an Area of Need.

(j) Blackwater has a population of about 5,500 permanent residents and 2,000 to 3,000 workers who fly in and fly out. There were also five to six towns within an hour’s drive of Blackwater and there were mines, 30 to 45 minutes away.

(k) The Blackwater Health Care Centre had two doctors working at the practice (although sometimes only one) and, generally, Dr Nithianantha was the only doctor working in his practice. That is, there were generally three general practitioners to service between 5,500 and 8,500 people and sometimes only two.

1. The applicant acknowledges that it was open to the Committee to conclude from Ms Martin’s evidence that the Blackwater Health Care Centre was in a position to provide medical services to the Blackwater community (or at least part of it) during the review period, and admits that it did provide such services.
2. The applicant says, however, that Ms Martin’s evidence was limited and did not extend to the issue of whether the Blackwater Health Care Centre had capacity and was reasonably available to provide services to the applicant’s patients, and the Committee failed to consider this. The applicant says that the closest that Ms Martin’s evidence came to addressing the Centre’s capacity to see the applicant’s patients was her statement that the Blackwater Health Care Centre was prepared to do so.
3. The applicant says that the Committee rejected unchallenged evidence that it was hard to get an appointment at the Blackwater Health Care Centre and no other practice or hospital in Blackwater had any latent or actual capacity to provide services to the applicant’s patients on the relevant days in the review period.
4. The applicant says that the Committee “tacked on” the new section of its final report dealing with the applicant’s submissions in relation to the draft report and, to the extent that it reveals a different reasoning process from that at [80], [84], [91] and [92], that material should be treated with caution because the Committee repeated [80]-[92], which do not refer to *Tisdall v Webber*, “as though they were unproblematic”. He says that the new material repeats the Committee’s preference for Ms Martin’s evidence over that of the applicant and Mr Cracknell (his evidence being that it was difficult to get an appointment unless there was an emergency) and stated at [7] that her evidence was unequivocal and to the effect that the Blackwater Health Care Centre had not closed its books, was available to take on new patients and had after-hours arrangements in place.
5. The applicant says that Ms Martin’s evidence did not address the Blackwater Health Centre’s capacity to see the applicant’s patients within a reasonable time and her evidence did not contradict Mr Cracknell’s evidence on that point. The Committee did not ask Ms Martin whether the Blackwater Health Care Centre had capacity to see the applicant’s patients within a reasonable time and her evidence did not extend that far. While the Committee noted that Ms Martin gave evidence by reference to practice records, it did not ask her how busy the practice was, how difficult it was for a patient of another practice to get an appointment or the availability of its doctors to see patients of another practice after-hours. All of those matters should have been dealt with if the Committee applied the test in *Tisdall v Webber* at [28].
6. The applicant also submitted that the Committee failed to deal adequately with the submission made on 30 November 2016 that there was no evidence that doctors from the Blackwater Health Care Centre were available to see his patients. The submission referred specifically to 11 of the 28 days in which he provided more than 80 professional services, where the services in excess of the cap were all after-hours items (see [38(3)] above).
7. He says that the Committee’s response, that he need not have provided a number of those services on those days, suggested that it took into account an irrelevant circumstance, practice management measures, that the Committee was suggesting that Dr Nithianantha should have billed for services on a day they were not provided, a practice which would have been unlawful or the response simply does not make sense.
8. The applicant says that the only evidence of the ready availability of the Blackwater Health Care Centre to see patients was given by Mr Cracknell. The Committee did not (as submitted by Ms Stern SC for the respondents) reject Mr Cracknell’s evidence. Rather, it accepted Mr Cracknell as a witness of truth and, while it did not expressly say that it accepted his evidence, it simply preferred Ms Martin’s on the basis that she was better placed to know the circumstances of the Blackwater Health Care Centre.
9. In reply to Ms Stern’s oral submissions, the applicant submitted that while it might be accepted that Mr Cracknell lacked Ms Martin’s detailed knowledge, that would only be relevant if his evidence conflicted with hers, but it did not. Mr Cracknell’s evidence was consistent with the applicant’s unchallenged evidence about the population in Blackwater, the fact was that there were only two practices in town and that the town had been classified as an Area of Need and District of Workforce Shortage.
10. The applicant submits that, while it might be inferred from the provision of an after-hours mobile phone number for a doctor from the Blackwater Health Care Centre that the person could get in touch with a doctor from that practice, the inference that that doctor would provide a medical service and not leave a patient “high and dry” is not available. A factual scenario consistent with Ms Martin’s evidence is that a doctor would have given advice but if the patient needed medical attention, he would have advised the patient to go to the hospital. That would be consistent with the fourth dot point of the Committee’s email to Mr Davey dated 1 April 2016 (which the applicant takes to have come from information provided by Ms Martin) (see [26] above); the inference that the doctor would have provided a medical service is conjecture and the Committee’s finding at [92] of the draft and final report was speculative.

### Respondents’ submissions

1. The respondents submit that the first basis should be rejected on the facts. They say that the Committee directed itself to the question of whether alternate medical services were reasonably available at new [31] where it cited *Tisdall* *v Webber* at [28] and that was the focus of its consideration of “exceptional circumstances” at [64]-[92] and new [1]-[35] of the final report. They say that in light of Ms Martin’s evidence, it was open to the Committee to find that during the relevant period a patient of the applicant would have been able to see a doctor from the Blackwater Health Care Centre during and after business hours, including in urgent circumstances.
2. The respondents characterise the second basis as being basically a “no evidence” or “unreasonableness” contention in relation to the finding at [92] of the draft and final reports. They say that the authorities establish that the bar for challenge such a finding is high and the onus is on the person contending for it, relying on *Sagar v O’Sullivan* (2011) 193 FCR 311; [2011] FCA 182 at [61]. They submit that considerable caution needs to be exercised before making such a finding, relying on *Australasian Meat Employees’ Union v Fair Work Australia* (2012) 203 FCR 389; [2012] FCAFC 85 at [92] per Flick J.
3. The respondents submit that even a “slight” evidentiary basis will be sufficient to support the finding, relying on *SZNKV v Minister for Immigration and Citizenship* [2010] FCA 56 at [37] per Kenny J. They say that here the evidence was more than “slight”.

## Third basis

1. In this regard, the applicant noted that the Committee quoted from the passages in *Oreb v Willcock* at [198]-[200] in which Lander J contrasted the language of s 106KA(2) of the *Health Insurance Act* (analogous to the current terms of s 82(1B), which requires an enquiry about whether exceptional circumstances existed on particular days) with reg 11(b) (which directs an inquiry into the absence of other medical services “during the relevant period”). The applicant says that the Committee failed to quote from the next following paragraph which “undermined the Committee’s conclusion”. Justice Lander said at [201]:

The inquiry in reg 11(b) is in relation to the whole of the period under review, not simply the particular day or days. However, because the purpose of assessing exceptional circumstances is to determine whether any of the days which otherwise form part of the prescribed number of days under s 106KA(1) should not be reckoned, in the end result, the inquiry under reg 11(b), although over the whole period, must relate to the particular day or days.

1. The applicant also relies on *Oreb v Willcock* at[203] per Lander J (words in bold relied on in the submission):

For example, the general practitioner might practise in a remote country area which cannot attract any other general practitioners for the whole period under investigation. If that is so, the general practitioner has, without more, satisfied reg 11(b) to the extent that he or she has established an absence of other medical services for patients of that general practitioner during the relevant period, having regard to the location of that general practitioner’s practice. If the general practitioner can also establish that the characteristics of his or her patients has impacted upon the absence of other medical services then the general practitioner will have made out that exceptional circumstances exist. Therefore, it seems to me that it is possible that the circumstances contemplated in reg 11(b) could operate over the whole of the period and still be exceptional circumstances because, as I have said, reg 11(b) deems those circumstances to be exceptional. Whilst those circumstances might exist over the whole period**, the question for the decision-maker is still whether they operated on the particular day or days which have been reckoned as determining the pattern of services**.

1. The applicant submitted that while circumstances may exist over the whole of the relevant period, when making a positive finding that other medical services were available to his patients, the Committee was required to consider whether those services were available “on the particular days during the relevant period”, having regard to the express language of s 82(1B).
2. The applicant noted Ms Martin’s evidence that on some days, only one of the general practitioners in the Blackwater Health Care Centre might be available, while the other “took a week off”. He says that the Committee gave no consideration to availability of services on the particular days in question. Rather, the Committee accepted the evidence that there was an after-hours machine and “simply assumed” that alternative medical services were available for the applicant’s patients on all relevant occasions.
3. The respondents point out that the Committee responded to the applicant’s post-hearing submissions in the material after [92] in the final report. It expressly addressed the submission that there was no evidence to suggest that practitioners from the Blackwater Health Care Centre were available to provide medical services on the 28 days in question and rejected it (see new [13] at [44] above).
4. The applicant made extensive written submissions in reply to Ms Stern SC’s oral submissions in relation to Lander J’s observations in *Oreb v Willcock* at [208] which were as follows:

If the general practitioner can establish that there was an absence of medical services for the general practitioner’s patients for the reasons in reg 11(b) during the relevant period the practitioner must then establish that that absence affected the general practitioner’s rendering or initiating of services. The committee will proceed on that inquiry as it would on the “exceptional circumstances affect” inquiry or the “reg 11(a) affect inquiry”. The “affect” again need not be dominant. The general practitioner must merely establish that there was an “affect”.

1. Ms Stern relied on *Oreb v Willcock* at [219]-[224] in which Lander J described the required process as being: First establish whether “exceptional circumstances” exist either because they have some feature that was exceptional or because they fall within either or both of the paragraphs of reg 11. If the circumstances identified by the medical practitioner rely on reg 11, it is not necessary to establish that they may otherwise be regarded as exceptional. Second, if the medical practitioner has made out that “exceptional circumstances” exist during the review period, the Committee must then consider whether those circumstances affected the general practitioner’s rendering or initiating of services. Last, if the Committee is satisfied of those things, it must next consider whether the circumstances affected the rendering or initiating of services by the general practitioner on a particular day or days which were identified by the Committee as being the day or days which constituted the prescribed pattern of services.
2. Ms Stern submitted that here the situation was the converse: the Committee found that there were was no absence of medical services in the whole of the review period and that meant that there was nothing to “take back” to see whether it operated on particular days. That is, as the finding covered the whole period, it wholly disposed of the applicant’s contention that exceptional circumstances existed. Ms Stern submitted that the Committee’s finding was open because of Ms Martin’s evidence. In her written submissions, Ms Stern also pointed out that the Committee expressly rejected the argument that there was no evidence that practitioners from Blackwater Health Care Centre were available on the 28 particular days: see new [13].
3. In response to Ms Stern’s submissions, the applicant said (among other things) in the written submissions in reply to Ms Stern’s oral submissions:

The Committee made a positive factual finding that there were alternative medical services available to Dr Nithianantha’s patients. This is different from rejecting a claim that there was an absence of medical services because either placita (i) or (ii) of regulation 11(b) did not apply. Clearly, the remote location of Dr Nithianantha’s practice and the characteristics of his patients (they included miners) supported the claimed absence of other medical services. It was only because the Committee found that the Blackwater Health Care Centre was in fact available to provide services to Dr Nithianantha’s patients that it concluded that regulation 11(b) did not apply. In these circumstances, the Committee was required to have regard to whether those services were in fact available on each of the 28 days on which Dr Nithianantha provided more than 80 services. This was particularly so, given Ms Martin’s evidence that there was occasionally only one practitioner available at her practice instead of the usual two.

This approach gives proper acknowledgement to Lander J’s injunction that the inquiry under regulation 11(b) must relate to the particular day or days (at [201]). It is also consistent with his Honour’s comment in [203], when considering regulation 11(b), that “[w]hilst [exceptional] circumstances might exist over the whole period, the question for the decision-maker is still whether they operated on the particular day or days which have been reckoned as determining the pattern of services”. Paragraphs [223]-[224] should be understood in the context of his Honour’s emphasis throughout his judgment on the need to consider individual days when considering exceptional circumstances under regulation 11(b).

## Consideration

1. The applicant concedes that he provided more than 80 professional attendances on more than 20 days in the review period. He relied expressly on reg 11(b). He did not claim that there were “exceptional circumstances” on any other basis. The manner in which the applicant put his case before Ms Martin gave her evidence was as set out in his submissions dated 23 March 2016 which are summarised at [20]-[25].

### Tisdall v Webber

1. Much of the argument revolved around the authority of *Tisdall* *v Webber* and it is instructive to consider the reasoning in that case in some detail.
2. The Committee’s report did not set out [28] in its entirety, it is worth setting it out in full here. It appears under the heading “The notion of ‘absence’” in Greenwood J’s judgment and states:

The primary Judge at [19] regarded the notion of “absence”, in its statutory setting, as extending beyond a literal absence and connoting a lack of “readily or reasonably available” alternative medical services for Dr Tisdall’s patients having regard to the Regulation 11(b) factors. As Buchanan J observes, that formulation of the statutory concept of absence (accepted by the appellant) is consistent with the “practical approach” to Regulation 11(b) adopted by Dowsett J in *Hatcher v Fry* [2000] FCA 1573; (2000) 183 FCR 1 at [16] in formulating the question to be asked by a Professional Services Review Committee, namely (as applied in this case), if a patient of Dr Tisdall on the relevant days during the referral period could not have seen Dr Tisdall within an appropriate timeframe (that is, within a reasonable timeframe) would the patient have been able, reasonably, to consult another medical practitioner? An answer to that question will involve consideration of the elements of a counter-factual contention based upon an assumption that the patient could not have seen Dr Tisdall. The question, of course, for the Committee is slightly different to that formulated by Dowsett J. It is whether, having regard to the relevant factors, the Committee can be affirmatively satisfied by Dr Tisdall (having regard to the body of evidence put to it for adjudication by the Committee members as general practitioners), on the matter of objective counter-fact, whether a patient of Dr Tisdall would have been able, reasonably, to see another medical practitioner rather than Dr Tisdall. Many considerations may be relevant to that question but they include questions of access to alternative practitioners, the location of the practice of an alternative medical practitioner, the hours during which such a practitioner might be available and the patient numbers or patient cohort seeking access to the alternative medical practitioner.

1. It is also useful to consider Dr Tisdall’s circumstances as accepted by the committee in his case and the basis on which it declined to accept that he had made out “exceptional circumstances” on relevant days. Justice Buchanan directed attention to those matters at [100]-[101] as follows:

101 As to those matters the Committee:

* accepted that there was a chronic doctor shortage in rural Australia and that Kyabram and its surrounding area suffered from a relative shortage of doctors;
* accepted that there was a lack of co-operation between Dr Tisdall and a number of other doctors in Kyabram during the relevant period;
* referred to evidence supporting the proposition that other doctors in Kyabram had closed their books (and made no reference to evidence to the contrary);
* accepted that some doctors in Kyabram may have had limited hours of practice;
* accepted that alternative psychiatric, counselling and radiology services were limited for Dr Tisdall’s patients;
* appeared to accept that Dr Tisdall had a reputation for caring for the underprivileged;
* appeared to accept that a large proportion of the Aboriginal, Turkish and Italian communities around Kyabram saw Dr Tisdall; and
* appeared to accept that Dr Tisdall bulk billed a large number of his patients, typically less well-off members of the community.

102 However the Committee declined to accept that those matters, in the circumstances, constituted exceptional circumstances or made out a case of exceptional circumstances under reg 11(b). One essential ingredient in the Committee’s reasoning appears to have been its conclusion (or assumption) that other practices or practitioners would probably have had the capacity to see additional patients on each of the 66 days in question and would not have refused to see Dr Tisdall’s patients on those days. Those findings were supported by observations that other practitioners also bulk billed “a significant proportion of their patients”. The figures given by the Committee suggested that during the referral period in general, and on the 66 days in question in particular, other medical practitioners in the region bulk billed at the rate of about 46% (compared to Dr Tisdall’s rate of about 73%).

1. It is useful to set out Buchanan J’s consideration at [110]-[113]:

110 In *Hatcher v Fry* (2009) 183 FCR 1, Dowsett J dealt with the issue expressly, saying (at [16]):

16 In my view the regulation dictates a practical approach to the availability of other medical services. Within Australia it can hardly be said that anybody has no access to medical services. For a person in Roma there would always be the option of travelling to Brisbane for such services. However such a requirement might not be practicable simply because the requirement for such services might not justify the journey. In other cases that solution would not enable the patient to obtain the required services in a suitable timeframe. In others it would simply involve too much of a disruption to a patient’s day-to-day life. On the other hand, it is conceivable that in a small country town having, say, two medical practitioners, both may be so busy that neither is, in a practical sense, able to fit in the other’s patients other than by seeing more patients in the same timeframe. The question to be addressed is simply whether or not, if a patient could not have consulted the applicant within an appropriate timeframe, he or she would reasonably have been able to consult another medical practitioner. Such an enquiry involves consideration of the geographical locations of other practitioners, the hours during which they were available and their history of patient numbers.

111 Similarly, in the present case the primary judge said (at [19]):

19 In my view, the relevant sense of “absence” extends beyond a **literal**, physical absence of other medical services available to Dr Tisdall’s patients. In the context of Reg 11, the term connotes a lack of readily or reasonably available alternative medical services for those patients, bearing in mind, as contemplated by sub-paragraphs (i) and (ii) of Reg 11(b), the location of the practice at issue, and the characteristics of the relevant patients. For there to be an absence in this sense, it is not sufficient that the alternative services be merely limited, as the Second Committee was prepared to find they had been.

[Emphasis in original]

112 Counsel for Dr Tisdall accepted the primary judge’s statement as a correct construction of reg 11(b). Counsel for the respondents was more circumspect, suggesting simply that it was a matter for the Full Court to decide. However, she made no submission suggesting that any other construction should be preferred. In my view, the approach taken by the trial judge is consistent with that taken by Dowsett J and is to be preferred to any strict, literal, meaning requiring that no services at all be available. Accordingly, the question for attention is whether alternative services would have been available to Dr Tisdall’s patients within a reasonable time.

113 In my view, the Committee did not apparently adopt, nor did it address, a test framed in that way or to that effect. In particular, it said nothing to dispel the suggestion inherent in the evidence of a number of witnesses, that requiring a patient to wait for days to see another doctor, if Dr Tisdall was available promptly, was an unreasonable delay. There was a significant body of reasonably uniform evidence put before the Committee by Dr Tisdall to the effect that: there was a serious shortage of medical practitioners in and around Kyabram; doctors in the two other practices in Kyabram had limited their hours, their preparedness to see new patients and their preparedness to see Dr Tisdall’s patients in particular; patients were required to wait days to see doctors other than Dr Tisdall; and Dr Tisdall was prepared to go out of his way to accommodate their circumstances. In addition, he was more prepared than other doctors in the area to bulk bill and to see patients from disadvantaged groups. The evidence was given, on oath or affirmation, by the following people:

* Mr Wayne Sullivan, Chief Executive Officer of the Kyabram and District Memorial Community Hospital (“the Hospital”);
* Ms Jean Courtney, Director of Nursing at the Tongala and District Memorial Aged Care Service and a member of the Board of the Hospital;
* Mr Michael Robertson, Chief Executive Officer of the Murray Plains Division of General Practice (of which all Kyabram general practitioners were active members);
* Dr Ian Collie, a pharmacist in Kyabram practising in the vicinity of Dr Tisdall’s surgery;
* Mr Brian Thomson, Manager of the Ngwala Willumbong Co-operative Limited, an indigenous organisation which conducts the Percy Green Memorial Alcohol and Drugs Centre; and
* Mr Nilgun Atalmis, a Turkish interpreter in Shepparton.
1. At [114], Buchanan J set out excerpts of the unchallenged evidence given in support of Dr Tisdall. Mr Sullivan gave evidence that other doctors had closed their books and some people had had to see doctors outside the community or wait a few days to get in except in an emergency. Mr Robertson’s evidence was that there were 17,000 people living in the catchment area and nine doctors, which created an acute shortage and it could take “many days” to see a doctor even when it was urgent. Dr Collie’s evidence was that there was always a critical shortage of doctors in the region and as a result Dr Tisdall saw a number of patients who were unable to obtain medical services; the other doctors had closed their books and had shorter hours than Dr Tisdall, they had half a day off during the week and ran a roster for out of hours consultations. This was made worse by considerable friction between Dr Tisdall and the other doctors in the area who would not see his patients and refused to include him in their after-hours roster so that Dr Tisdall had not only to see his own patients at his surgery but also cover his own hospital and after-hours consultations. Mr Thomson’s duties included securing medical services for residents who were predominantly Aboriginal, some of whom came to the Drugs and Alcohol Centre after being released from prison. He said he had difficulty securing appointments because of the shortage of doctors in the region and the lack of doctors prepared to bulk bill or because the doctors refused to see patients with drug and alcohol problems. Residents would have to wait seven to 10 days to see a doctor in Shepparton, if a doctor was willing to see them. Dr Tisdall would see those patients, bulk bill, had an understanding of drug and alcohol addicted people and Aboriginal people generally, he would see them with little delay and out of hours and on Saturdays when they required medication urgently. Mr Atalmis said that it was difficult for Turkish people to see a doctor anywhere in the region because of the shortage of doctors and if Dr Tisdall was unprepared to see them, they were unlikely to be able to find another doctor when they required treatment.
2. It is in those circumstances that Buchanan J found the relevant committee’s dealt with the assessment of Dr Tisdall’s case by making a “speculative assumption that on each of the days in question other practices were open, their practitioners had capacity to see additional patients and would have been prepared to do so”. They did not explain how that assessment was made, the committee simply declared that it did not accept that other practitioners would have refused to see Dr Tisdall’s patients, there was no direct evidence to support that declaration and the committee did it by “some process of inference from statistics supplied by Medicare”: [116]-[117].
3. It is notable that at [124], Buchanan J recognised that in proceedings of this kind, findings of fact made by the committee are not reviewable, but the question of whether there is any evidence of a fact is a question of law, as is the question whether a particular inference may be drawn from facts, citing *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 at 355, 367-368 and *Kostas v HIA Insurance Services Pty Ltd* (2010) 241 CLR 390; [2010] HCA 32 at [33], [91]. At [125], his Honour also accepted that the question whether a conclusion is reached by a process of faulting reasoning, or is illogical, is not necessarily the same question as whether there is some evidence to support a finding of fact or from which an inference may be drawn and supported the position espoused by Greenwood J in *Wecker v Secretary, Department of Education, Science and Training*  (2008) 168 FCR 272; [2008] FCAFC 108 at [95]-[100], relying on the Full Court’s decision in *Minister for Immigration and Multicultural Affairs v Al-Miahi* [2001] FCA 744 at [34] as follows:

The question whether there is any evidence of a particular fact is a question of law. Likewise, the question whether a particular inference can be drawn from facts found or agreed is a question of law. That is because, before the inference is drawn, there is a preliminary question as to whether the evidence reasonably admits a different conclusion. Accordingly, in the context of judicial review, the making of findings and the drawing of inferences in the absence of evidence is an error of law. On the other hand, there is no error of law simply in making a wrong finding of fact. Even if the reasoning whereby the Court reached its conclusion of fact were demonstrably unsound, that would not amount to an error of law. A party does not establish an error of law by showing that the decision-maker inferred the existence of a particular fact by a faulty process, for example by engaging in an illogical course of reasoning. Thus, at common law, want of logic is not synonymous with error of law. So long as the particular inference is reasonably open, even if that inference appears to have been drawn as a result of illogical reasoning, there is no place for judicial review because no error of law has taken place - *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321 at 355–6.

1. His Honour noted that in a case of suggested illogicality or faulty reasoning, the decisive test is not whether there was an error of logic or reasoning, but whether there was no foundation for the conclusion reached, citing the reasoning of Crennan and Bell JJ in *Minister for Immigration and Citizenship v SZMDS* (2010) 240 CLR 611; [2010] HCA 16 at [130]-[131], [135]. At [128] of *Tisdall v Webber*, Buchanan J noted that:

It is important to bear in mind also that the inferential process is not one where speculation, guesswork or mere assumption is accommodated. So far as the work of courts is concerned, where the application of judicial method is expected, the process of drawing an inference from available facts is not to be equated with conjecture, surmise or guesswork. The arbitrary selection of one possibility over others from an available number of possibilities by such a method is not merely lacking in logic; it fails to conform to the necessity that inferences be drawn on matters of legitimate deduction, based as probative values.

1. At [129]-[130], his Honour noted that in *Bell IXL Investments Ltd v Life Therapeutics Ltd*  (2008) 68 ACSR 154; [2008] FCA 1457 at [14], Middleton J observed that while it may sometimes be difficult to distinguish between conjecture and inference, the distinction is important. Conjecture, though plausible, is still a guess, while an inference is a deduction from evidence and can reasonably be treated as part of the legal proof to be considered in making a factual determination. That is a fundamental principle authoritatively established: see *Luxton v Vines* (1952) 85 CLR 352 at 358. His Honour concluded at [131] that:

… However, a speculative conclusion, even if not truly based on inferential reasoning, must still conform to the necessity that it be reasonably open on the material before the tribunal. Even though the Committee was not bound by the rules of evidence, and was entitled to inform itself as it thought appropriate (s 106 of the Act), that did not mean that it could draw inferences, or jump to conclusions, which the available material did not adequately support.

### The question of the burden of establishing exceptional circumstances

1. It is useful to note that, although the regulations considered by the Committee in this case were relevantly the same as those considered in *Tisdall v Webber* and *Oreb v Willcock*, s 106KA(2) of the *Health Insurance Act* was not in exactly the same form as s 82(1B) which now replaces it. Justice Buchanan set out the terms of s 106KA(2) in *Tisdall* *v Webber* at [95] as follows:

**106KA Patterns of services**

…

(2) **If the person under review satisfies the Committee** that, on a particular day or particular days during the relevant period, exceptional circumstances existed that affected the rendering or initiating of services by the person, the person’s conduct in connection with rendering or initiating services on that day or those days is not taken by subsection (1) to have constituted engaging in inappropriate practice.

1. Unsurprisingly, having regard to the language of s 106KA(2), in *Tisdall v Webber* at [108], Buchanan J accepted that Dr Tisdall bore the onus of persuading the Committee that there was an “absence” of service available to his patients which affected his own provision of services, relying on *Oreb v Willcock* at [204]-[205], [208] and [223]. The language of s 82(1B) is not express as to onus; the question is whether, on the evidence before it, a Committee could reasonably conclude that on the day that the practitioner rendered or initiated more than 80 services exceptional circumstances existed that affected the rendering or initiating of those services.
2. Section 82(1B) was introduced into the *Health Insurance Act* by s 3 and cl 3 of Sch 2 of the *Health Insurance Amendment (Professional Services Review) Act 2012* (Cth) and s 106KA was repealed. The Explanatory Statement to the Bill is not helpful in relation to the interpretation of s 82(1B): see pp 15-16 which discusses these changes. Relevantly the second reading speech on 9 May 2012 provides as follows:

The bill also includes a number of provisions that strengthen the Professional Services Review's capacity to protect the integrity of Medicare, improve the operations of the scheme, and respond to the recommendations of a review of the scheme in 2007.

…

The bill includes amendments to improve the protection of the public under the Professional Services Review.

…

The quality of patient care can be placed at risk if practitioners undertake unreasonably high numbers of services. In 1999, medical professional groups agreed that 80 or more unreferred attendances on 20 or more days in a 12-month period constituted inappropriate practice.

This bill clarifies in legislation that a practitioner who performs this number of services is automatically deemed by the legislation to have practised inappropriately, unless they can provide evidence that exceptional circumstances existed.

1. At [64] of the draft and final report, the Committee correctly identified the test in s 82(1B). At [65]-[66] the Committee also referred to the interaction of s 82(1B) and reg 11.
2. It is clear from the language of s 82(1A), and as explained in the second reading speech, that Parliament has determined that the prima facie position is that a practitioner engages in inappropriate practice if he or she renders more than 80 professional attendances on more than 20 days. Parliament relied for that view on the position taken by medical professional groups in 1999 based on the risk posed to patients by the provision of unreasonably high numbers of services. In that context, s 82(1B) poses the question of whether the Committee could reasonably conclude that, on a day on which the practitioner rendered more than 80 professional attendances, exceptional circumstances existed that affected the rendering or initiating of the services. The second reading speech recognises the practical reality that it is for the practitioner who claims it to do enough to show that exceptional circumstances existed on the relevant days so that the Committee could reasonably conclude that exceptional circumstances existed on those days.
3. In those circumstances, it is my view that the Committee was correct when it said at new [15] that “while there is no legal onus of proof in Committee proceedings, once a prescribed pattern of services has been found to exist there is a practical or evidentiary onus on Dr Nithianantha to establish that there was an absence of alternative medical services for his patients”. That is so, notwithstanding the fact that the Committee’s processes are inquisitional in nature, as submitted by Dr Lucy.

### Did the Committee focus on the issue of the availability of medical services to Dr Nithianantha’s patients?

1. In my view it did.
2. Dr Nithianantha and Mr Cracknell gave evidence of restricted services available from the Blackwater Health Care Centre which might have suggested that Dr Huda’s practice was generally limited to performing mining medical examinations and he only had one conditionally registered doctor for part of the review period. They asserted that there was limited capacity to see general patients and the Centre did not provide after-hours services so that there was an absence of other medical services for Dr Nithianantha’s patients. The Committee took that evidence into account and accepted that Dr Nithianantha and Mr Cracknell gave their evidence honestly. Notwithstanding that, in my view, the Committee did not accept their evidence because it preferred Ms Martin’s evidence which directly contradicted it.
3. The applicant submitted that the issues which must be addressed having regard to *Tisdall v Webber* at [28] were not. The applicant noted that Ms Martin was not asked about the number of patients served by the Centre and the number of services which the doctors practising there provided on any day or what they actually did if contacted on the after-hours mobile number provided on the answering machine. The applicant also submitted that Ms Martin’s evidence did not extend to whether or not both doctors were available on relevant days in light of her evidence that there were some times when one of the doctors was away for a week.
4. Bearing in mind that the applicant put his case on the basis that there was an absence of other medical services *on each and every day* in the review period and that there was an objective absence of other medical services in that period (see [67]-[68] of the draft and final reports, referring to the 23 March 2016 submissions), Ms Martin’s evidence contradicted fundamental aspects of evidence given by Dr Nithianantha and Mr Cracknell which founded the way Dr Nithianantha put his case. That was noted by the Committee at [91] of the draft and final reports. In my view, it was open to the Committee to prefer Ms Martin’s evidence based on her direct knowledge of the Centre’s staffing and willingness to accept patients from Dr Nithianantha’s practice in the review period.
5. I accept the respondents’ submissions that Ms Martin was a credible witness, with knowledge of the Blackwater Health Care Centre, she was the practice manager who had worked there for 30 years and she used her access to the practice’s records while she gave evidence. Contrary to the evidence given by the applicant and Mr Cracknell, Ms Martin gave evidence that the practice was open 8.30 am to 5.30 pm Monday to Friday and it was generally staffed by two general practitioners, albeit that one might have a week off from time to time. She answered “yes” to questions concerning whether the practice would accept new patients, patients of “the other general practice” (that is Dr Nithianantha’s patients) and urgent patients. I accept that that covers the question of whether the applicant’s patients could be seen at short notice. Ms Martin checked her files before responding that there were two doctors at the practice in the relevant period from 1 May 2013. During questioning she re-iterated her evidence that the practice would see the applicant’s patients if they called for an appointment. Ms Martin answered the question of whether there was after hours cover by stating that there was an answering machine that directed the caller to the hospital or an after-hours mobile telephone which was manned by one of the doctors. I accept that the logical inference from that answer is that a doctor was available to render services in the after-hours period. In response to a submission put by Dr Lucy, it is difficult to see why there would be the option of calling a manned mobile phone if all that a doctor manning it would do is direct patients to the hospital since the answering machine already performed that function.
6. Having regard to the authorities cited by Buchanan J referred to above I do not accept the claim that Ms Martin’s evidence was so limited that it was not open to the Committee to form the view that the Blackwater Health Care Centre’s services were reasonably available to the applicant’s patients in the review period. This case is factually very far removed from *Tisdall v Webber*. In Dr Tisdall’s case, there was a substantial body of evidence from Dr Tisdall and from many people who were well placed to know that there was a serious and long term shortage of medical services in the regional area where Dr Tisdall practiced, there was discord between Dr Tisdall and the other two medical practices in his area which affected their willingness to see his patients, the other practices would not accept patients who had drug and alcohol issues either at all or within a reasonable time and that was a characteristic of many of Dr Tisdall’s patients, the other practices’ books were closed, their hours were limited, few would bulk bill and they would not provide after-hours services to Dr Tisdall’s patients. The basis on which the committee rejected this weight of evidence was inferences from statistics and, contrary to the evidence, a finding that the other doctors were available to see Dr Tisdall’s patients. The suggested parallels between the circumstances in *Tisdall v Webber* and this case are generally not apt and must be treated with caution.
7. As the evidence stood and having regard to how Dr Nithianantha put his case, it did not require speculation, assumption or guesswork on the part of the Committee to conclude that there was not an absence of medical services for the applicant’s patients during the review period for the purposes of reg 11(b). That finding was founded on cogent evidence from a person in a better position to give it than either of Dr Nithianantha or Mr Cracknell.
8. Despite the fact that it did not say so expressly, I do not accept the submission that the Committee did not reject Mr Cracknell’s evidence that it was hard to get an appointment at the Blackwater Health Care Centre unless it was urgent and that was consistent with the fact that it was designated as an Area of Need and a District of Workforce Shortage. I accept the respondents’ submission that it was apparent from Mr Cracknell’s evidence that he does not have detailed knowledge of the availability of services at the Centre so that there was good reason for the Committee to give his evidence about the Centre little if any weight. The same might be said of Dr Nithianantha’s evidence about the Centre which proved to be ill-informed, even though the Committee found that it was honestly given.
9. It is not true that the Committee only mentioned Dr Nithianantha’s patients at new [15]. While it is true that the Committee did not spend much time analysing his patients that is because there was nothing distinctive about them from the point of view of whether they could not be equally well served by the Blackwater Health Care Centre: so much was accepted by Dr Nithianantha (see [23(4)] above). This is in contrast to the situation in *Tisdall v Webber* where the characteristics of Dr Tisdall’s patients was a significant issue. Having regard to Dr Nithianantha’s evidence and Ms Martin’s evidence, both practices served the Blackwater community without concern about whether the patients were patients of the other practice: see [85]-[86]. Further, the focus of [80]-[92] was to determine whether there was an “absence of medical services in the area” and it is clear from the context in which the phrase was used that the inquiry was directed at the availability of services for Dr Nithianantha’s patients (see, for example, [83], [84], [85], [91]). The Committee did have regard to *Tisdall v Webber* at [28] in formulating [80]-[92], even though the Committee only expressly referred to it in addressing the submissions made by the applicant on the draft report at new [8], [31]-[33].
10. At [83] of the draft and final reports, the Committee rejected Dr Nithianantha’s submission that the fact that the practitioners at the Centre were conditionally registered doctors indicated an absence of other medical services. Dr Nithianantha relied on the fact that Dr Huda (the doctors’ supervisor) had left Blackwater. The Committee pointed out that a supervisor did not have to be physically present. The applicant has not established that this was an error by the Committee. There was also no error in the Committee’s finding that the issue was not whether Dr Nithianantha’s patients had a preference against seeing a conditionally registered doctor but whether there was alternate medical services available to them.
11. The Committee had before it evidence concerning the population in Blackwater; it acknowledged Mr Cracknell’s evidence in this regard at [75]. It appears to have accepted that services from the Blackwater Hospital were limited but noted that there was no evidence of when the “on fatigue” period would be for a locum so that the focus on the after-hours period by Dr Nithianantha was “somewhat misleading” and found that it was not the only option available to his patients: new [19]-[20]. The Committee had Ms Martin’s evidence that there were two doctors generally available at the Blackwater Health Care Centre, that its books were open and it was available to take new patients (including Dr Nithianantha’s) and provided an after-hours facility.
12. There was no evidence that a doctor at the Centre would be unwilling or refuse to see the applicant’s patients either in business hours or if they called the after-hours service: to the contrary it was Ms Martin’s evidence that those services were open to the applicant’s patients and the Committee was entitled to draw the inference that the service would be provided if called upon. Indeed, in the submissions made to the Committee on 22 April 2016, Mr Davey noted Ms Martin’s evidence that the Centre *regularly* saw patients of the NBGP; he did not cavil with that evidence. Rather, he cavilled with her evidence regarding whether the NBGP saw the Centre’s patients.
13. I accept that the inferences that the Committee drew from Ms Martin’s evidence in coming to the conclusion at [92] of the draft and final reports were available, including in relation to after-hours services for the reason given at [118] above. I also accept the respondents’ submission that the factors relied on by the applicant which are set out above at [75] do not assist as they go to the merit of the Committee’s conclusion.

### Did the Committee err by failing to consider whether another medical practitioner was available to see the applicant’s patients on each of the 28 days on which the applicant rendered 80 or more services?

1. Dr Lucy sought to establish, based on Lander J’s discussion in *Oreb v Williams* at [201] and [203], that it was necessary for the Committee to consider each of the “relevant days” notwithstanding that the Committee had found that the applicant had not established that “exceptional circumstances” existed during the review period.
2. Counsel argued that reg 11(b) must be interpreted so as to conform to s 82(1B) and the approach suggested by Ms Stern (see [96] above) should not be accepted. Dr Lucy agreed that *Oreb v Willcock* at [223] to [224] should be understood in the context of the case. Dr Oreb’s patients were non-English speaking refugees from the former Yugoslavia and he was uniquely suited to treating them and there was nothing to suggest that that changed day to day over the period. Counsel submitted that it was therefore immaterial in that case if the causation issue of whether there was an absence of other medical services which affected his rendering of services was considered before or after the committee considered whether the circumstances subsisted on particular days. Counsel said, however, that the stepped approach at [223]-[224] of Lander J’s judgment sat uneasily with [201], [203] of that judgment and it is unlikely that the approach was intended to apply to circumstances such as those that arise in this case where the question was whether another practice was available to provide medical services to a practitioner’s patients. Dr Lucy suggested that this approach is consistent with the statutory framework that required looking at individual days. Dr Lucy then moved on to making the arguments set out at [97] above.
3. I do not accept the applicant’s submissions and accept Ms Stern’s submission that despite the language used by the Committee at new [17], it did not misdirect itself in its reasoning.
4. It was only in the 30 November 2016 submissions responding to the draft report that the applicant placed emphasis on specific days in the review period (for example, 11 out of the 28 days on which services exceeded 80 because of the provision of after-hours services) and the force of that and like submissions was that it was up to the Committee to prove the availability of other medical services at that time on those days. In my view that submission was misconceived. For the reasons given above, although in *Oreb v Willcock* at [203], Lander J said that “Whilst those circumstances might exist over the whole period, the question for the decision-maker is still whether they operated on the particular day or days which have been reckoned as determining the pattern of services”, that question must be answered by reference to the evidence before the Committee. In this case, the applicant had put his case by reference to the whole of the period and Ms Martin’s evidence responded to and contradicted the factual basis of the applicant’s claim. The Committee did not bear the onus of establishing that the doctors at the Centre were available to provide services on the relevant 28 days for the purpose of forming its view in relation to whether there was an absence of medical services under reg 11(b) or whether the Committee could reasonably conclude that exceptional circumstances existed under s 82(1B).
5. The test in s 82(1B) is whether the Committee could reasonably conclude that exceptional circumstances existed which affected the provision of the applicant’s services on any day on which more than 80 services were provided in the “relevant period”.
6. Where a practitioner claims that there were “exceptional circumstances” on the basis set out in reg 11(b) (and only on that basis), the determination of whether reg 11(b) is satisfied is the required first step having regard to the express terms of s 82(1D). It might be doubted that it is necessary for the practitioner in such a case to show that exceptional circumstances existed *throughout* the whole of the “relevant period”; being the review period, albeit that Lander J observed that the inquiry is in relation to that period in *Oreb v Willcock* at [201]. However, it is easy to agree that it is necessary for there to be evidence that on the relevant days on which 80 or more services were rendered, exceptional circumstances existed (Lander J at [201]) having regard to reg 11(b)(i) or 11(b)(ii): (Black CJ and Wilcox J at [12]). As observed by Greenwood J in *Tisdall v Webber* at [68], it is likely that a practitioner who seeks to rely on reg 11(b) will adopt the course of attempting to show that the circumstances existed throughout the whole of the relevant period because it is likely to be forensically difficult to satisfy a committee that there was an absence of medical services for the practitioner’s patients on individual days.
7. Section 82(1D) expressly refers to the fact that circumstances that constitute “exceptional circumstances” for the purposes of s 82(1B) include but are not limited to those prescribed by the regulations. Where a practitioner relies only on reg 11(b), it is only if exceptional circumstances are made out by evidence which allows the Committee to conclude that reg 11(b) is satisfied that it is possible to move to the next step. The next step is the determination of whether the Committee could reasonably conclude that those exceptional circumstances existed on some or all of the days on which more than 80 professional attendances were rendered or initiated *and* that they affected the rendering or initiation of services by the practitioner. The force of s 82(1B) is that the days on which that intersection occurs will not be days on which the practitioner engaged in “inappropriate practice”.
8. This is an interpretation which involves no extension of the impact of reg 11 beyond the scope of s 82(1B); it is required by the express language of s 82(1D). In my view, that interpretation is wholly consistent with the approach adopted by Lander J in *Oreb v Willcock* at [221]-[223].
9. Having regard to that interpretation, where the applicant claimed that exceptional circumstances existed on all days in the review period and the Committee was not able reasonably to make that conclusion having regard to Ms Martin’s unchallenged evidence, there were no “exceptional circumstances” to fall within the definition in s 82(1B). I do not accept that s 82(1B) created an onus on the Committee to seek out evidence to displace this finding.

### The practice management issue

1. In its findings, the committee in *Oreb v Willcock* referredfrom time to time to circumstances which, in its opinion, were foreseeable. That committee argued that because circumstances were foreseeable they could not be unusual or exceptional circumstances: see *Oreb v Willcock* [228]. As found by Lander J at [229] whether circumstances are foreseeable is not a relevant consideration in a case advanced under reg 11(b) and what needs to be addressed is whether there was an absence of other medical services for the patients of the practitioner under review. That view was supported by Black CJ and Wilcox J at [14]-[17]. It must therefore be accepted that whether or not Dr Nithianantha could have better organised his practice is an irrelevant consideration for the purposes of determining whether “exceptional circumstances” had been established under reg 11(b).
2. In his submissions dated 30 November 2016 in response the draft report, Mr Davey on behalf of the applicant said:

We note that in respect of 11 of the 28 days on which Dr Nithianantha purportedly rendered in excess of 80 professional attendances, the services which in fact pushed Dr Nithianantha’s daily total up to or over 80, were all after-hours items. In our submission, that is significant for several reasons. First, if Dr Nithianantha refused to see those patients to whom he rendered an after-hours service (on the days when he rendered in excess of 80 professional attendances) and instead told them to go to the hospital, the reality is, the hospital would have been unable to deal with that number of, in effect, general practice consultations especially in circumstances where the locum was most likely on fatigue.

Secondly, the effect of the preliminary finding of PSRC No. 936 in respect of the breach of the 80/20 Rule is to suggest that it is unacceptable to the general body of general practitioners to assess a patient during the after-hours period regardless of whether or not it is urgent (or even to determine the urgency), if the practitioner may have already rendered 79 professional attendances that day and notwithstanding the fact that there may be no other medical services available and that the practitioner is familiar with the patient and their specific medical conditions. With respect, those two factors demonstrate an absence of other medical services for Dr Nithianantha's patients.

On that basis, the only possible other medical services which may have theoretically been available to see Dr Nithianantha's patients were the Conditionally Registered medical practitioners from the Blackwater Health Care Centre who would have themselves been required to attend upon the patient during that after-hours period if they were in fact minded to do so. With respect, there is absolutely no objective evidence before PSRC No. 936 which permits a factual finding that those practitioners would have been available to see the patient at the time in question.

In our submission, there was clearly an objective absence of other medical services for Dr Nithianantha's patients during the Review Period and more-specifically and clearly, on the actual days in question.

…

Moreover, we submit PSRC No. 936 has impermissibly sought to have regard to issues which on any view amount to practice management (or patient number) management strategies.

That is, on multiple occasions during the course of the Hearing and in its draft report, PSRC No. 936 advised Dr Nithianantha and made preliminary findings that he could have simply refused to see the patient or, he could have advised them to seek an alternative arrangement such as for example, to either attend the following day or to call an ambulance – or, in other words, to have better managed his patients.

In respect of that position, we note PSRC No. 936 largely directed those comments at Dr Nithianantha's after-hours practice which, as we submitted above, was primarily the reason for his having rendered in excess of 80 professional attendances on the relevant days. We submit whilst the comments were largely directed at the after-hours services, they are also directly relevant to the issue of Dr Nithianantha's having breached the 80/20 Rule for the reasons identified above.

With respect, it is [in]appropriate to suggest (in order that Dr Nithianantha might seek to avoid a possible breach of the 80/20 Rule) that a genuine option for Dr Nithianantha's patients was to either:

* 'go-without' medical services; or
* attempt to obtain medical services the following day or, the next business day; or
* hope that during the after-hours period one of the two Conditionally Registered medical practitioners from the Blackwater Health Care Centre may have been available and prepared to see them; or
* hope that during the after-hours period an ambulance would actually be available to respond to a '000' call within a reasonable period of time (and to that end we refer to our earlier submissions in respect of the general availability of an ambulance within Blackwater given the area it was required to cover - 100 km in any direction) and secondly, that it would not have to then by-pass the Blackwater hospital and proceed to Emerald, an hour's drive away.

As PSRC No. 936 would be aware, the Full Court of the Federal Court of Australia made clear in the cases of *Oreb v Willcock* [2005] FCAFC 196 ('Oreb'), *Lee v Kelly* [2005] FCAFC 197 ('Lee 1') and *Lee v Grigor* [2005] FCAFC 198 ('Lee 2') that any notions of practice management or patient number management were irrelevant to a Committee's consideration of whether or not exceptional circumstances existed if the Person Under Review pleaded his or her case as Dr Nithianantha has on the basis of the Regulations.

1. The Committee’s response to these submissions was as follows at new [27]-[30] and new [34]-[35]:

**Issue F - the effect of after-hours services on the prescribed pattern of services**

27. Dr Nithianantha claimed that for 11 of the 28 days that formed the prescribed pattern of services, the number of services were pushed over the 'applicable threshold' by after-hours items. Dr Nithianantha argued that the Hospital would not have had capacity to see those patients. Later in his submissions he stated that the rendering of after-hours services were 'primarily the reason for his having rendered in excess of 80 professional attendance on the relevant days'.

28. Dr Nithianantha also argued that it would be unacceptable to assess a patient during the after-hours period (regardless of whether or not it is urgent) if the practitioner had already rendered 79 professional services, notwithstanding that no other medical services available.

29. The Committee notes, however, that on each day where Dr Nithianantha engaged in a prescribed pattern of services, he rendered a number of health assessments (MBS items 701, 703, 705, 707 or 715) or chronic disease management items (MBS items 721, 723 and 732). In fact, on most of those days, Dr Nithianantha rendered both health assessments and chronic disease management items.

30. The Committee notes that there is no requirement that these items be completed on a particular day. Consequently, the Committee considers that it is not correct for Dr Nithianantha to claim that he rendered more than 80 services on the days in question simply because he rendered after-hours consultations on certain days.

…

**Issue H - practice management**

34. Dr Nithianantha argued that the Committee had regard to issues relating to practice or patient number management strategies in considering whether exceptional circumstances existed. Dr Nithianantha contended that, in many instances during the Hearing and in the Draft Report, the Committee made comments to the effect that Dr Nithianantha could have simply refused to see the patient or advised them to seek alternative arrangements. Dr Nithianantha did acknowledge, however, that where statements of these kind were made, they were made in the context of Dr Nithianantha's rendering of MBS item 597 services (urgent after hours services).

35. The Committee strongly rejects the assertion that it took into account issues pertaining to practice management in deciding whether there were exceptional circumstances regarding to the rendering of the prescribed pattern of services. As acknowledged by Dr Nithianantha, to the extent that any comments of this kind were made during the hearing and in the draft report, they related to the rendering of urgent after hours services. In those instances, it was directly relevant to consider whether the patient had an urgent need for treatment. Consequently, it would be appropriate to consider whether the treatment could be deferred until the after-hours period had expired.

1. The applicant’s submissions to the Court in this regard are noted at [82] above. Dr Lucy first made that submission in her written reply to the respondents’ written opening submissions. Unfortunately, because the submission was not adverted to in the applicant’s written submissions in chief, it was not addressed in the respondent’s written submissions. It was also not addressed in Ms Stern’s oral submissions, which may well be because of time constraints at the hearing through no fault of Ms Stern.
2. The Committee’s response to these submissions at new [34]-[35] was accurate having regard to those extracts from the transcript of Committee hearings which were included in the tender bundle and the contents of the draft report. The response at new [35] might equally have been made in relation to the other aspects of the 30 November 2016 submissions, rather than the somewhat confused response set out at new [27]-[30]. In my view, the premises on which the submissions on 30 November 2016 were based were generally not supported by the Committee’s factual findings based on Ms Martin’s evidence.
3. The first premise was that if the applicant refused to see a patient in the after-hours period that the patient’s only choice was to go to the hospital. The submission also assumed that the locum at the hospital would not be available after-hours because of “fatigue” unavailability. Both of those were submissions made by Dr Nithianantha but which had not accepted by the Committee.
4. The third premise was that the effect to the Committee’s preliminary finding that the 80/20 rule had been breached was to suggest that it was unacceptable to the general body of practitioners that he see a patient if it would take him over 79 attendances and “notwithstanding the fact that there may be no other medical services available”. There was no such established fact, since the Committee did not accept the applicant’s submissions in light of Ms Martin’s evidence. The 80/20 rule was established after consultation with the medical profession so it is true to say that, as a result, the legislation establishes that as an unacceptable practice in the absence of exceptional circumstances. However, what the Committee did was find that there were no exceptional circumstances in the review period – and for reasons given above, that was a finding open to the Committee. The Committee did not need to establish that the doctors from the Centre were in fact in Blackwater and available on the 11 days referred to in this submission – that was the force of Ms Martin’s uncontradicted evidence. Mr Davey had the opportunity in cross-examining of Ms Martin to ask about this and he did not, nor did he seek to address it at any time after, even when he made submissions on 22 April 2016 and when, in June 2016 he (uninvited) submitted evidence of transfer requests for patients of the Centre who sought to be patients of the NBGP.
5. The Committee’s finding at new [29] and [30] simply note that Dr Nithianantha’s submission that the provision of 80 or more services on the 11 identified days did not arise solely because of the provision of after-hours services. While it might have been better if the submission addressed each of the matters referred to above having regard to its findings, in my view the findings at new [29] and [30] are not indicative of error by the Committee on the claimed basis.

### Conclusion

1. For these reasons, the “exceptional circumstances” ground is not made out.

# Procedural fairness ground

1. In the fifth ground of the applicant’s amended application, he pleads that the Committee breached the rules of procedural fairness in that:

a. It called Ms Martin to give evidence on the last day of the hearing, with no notice to the applicant that Ms Martin would say that the Blackwater Health Care Centre had an after hours telephone line manned by doctors, or that medical services provided by the Centre were available after hours, and without providing the applicant with a statement from Ms Martin in advance.

b. The Committee informed the applicant, prior to Ms Martin giving evidence, that it was expected that Ms Martin would say that anyone requiring GP assistance out of hours would have been referred, by the Blackwater Health Care Centre, to the local hospital.

c. After the Committee took evidence from Ms Martin, it did not give the applicant an opportunity to provide evidence in response to Ms Martin’s evidence.

d. The Committee did not notify the applicant, before the evidence closed, that it was proposing to find that the Blackwater Health Care Centre provided, or was available to provide, medical services outside its operating hours of 8.30 am to 5.30 pm, Monday to Friday, to the applicant’s patients.

e. In the circumstances, the applicant was not afforded an adequate opportunity to be heard.

1. It is common ground that, the Committee had a duty to afford the applicant procedural fairness and that the fulfilment of that duty obliges it to:
2. Advise a practitioner of any adverse conclusion which would not obviously be open on the known material: see *Minister for Integration and Citizenship v SZGUR* (2011) 241 CLR 594; [2011] HCA 1 at [9], referring to *Commissioner for Australian Capital Territory Revenue v Alphaone Pty Ltd* (1994) 49 FCR 576 at 591-592;
3. Give the practitioner an opportunity to deal with adverse information that is credible, relevant and significant to the decision to be made: *Saeed v Minister for Immigration and Citizenship* (2010) 241 CLR 252; [2010] HCA 23 at [2]; and
4. Adopt a procedure that is reasonable in the circumstances to afford a person who has an interest apt to be affected an opportunity to be heard. Jurisdictional error occurs if the procedure adopted so constrains the opportunity of the person to propound his or her case for a favourable exercise of the power as to amount to “practical injustice”: see *Minister for Immigration and Border Protection v SZSSJ* (2016) 259 CLR 180; [2016] HCA 29 at [82]. See also *Assistant Commissioner Condon v Pompano Pty Ltd* (2013) 252 CLR 38; [2013] HCA 7 at [156].
5. In the submissions in reply to Ms Stern’s oral submissions, Dr Lucy clarified that this claim is as follows:

(a) The Committee was required to give Dr Nithianantha an opportunity, prior to its completion of the Draft Report, to provide it with information and/or evidence to address its proposed finding that the Blackwater Health Care Centre was available to provide medical services outside its operating hours of 8.30 am to 5.30 pm, Monday to Friday, to his patients.

(b) This is because the finding was not “an obvious and natural evaluation of the material” or, to put it another way, it was an “adverse conclusion which would not obviously be open on the known material.”

1. The applicant says that the difference between the parties is whether, at the end of the hearing on 7 April 2016, the applicant was on notice that the Committee might form the conclusion that there were alternative medical services available to his patients after hours and whether this conclusion flowed from an “obvious and natural evaluation” of the material then before the Committee.
2. The applicant says that, without being alerted to the conclusion that the Committee might draw, his solicitor had no reason to apply to lead further evidence because Ms Martin’s evidence simply did not address the capacity of the Blackwater Health Care Centre to see the applicant’s patients during the review period on the relevant days. This is on the basis that, even if (contrary to the applicant’s submissions) it could be inferred from Ms Martin’s evidence that the Centre had capacity to see his patients during the hours of 8.30 am to 5.30 pm on weekdays, it was not an “obvious and natural evaluation” of her evidence that a doctor manned a mobile telephone to which the Centre’s answering machine directed a caller after-hours that the Centre was available to see the applicant’s patients. He says that the Committee should have identified the possibility that it might draw these conclusions and invite the applicant to submit evidence or call witnesses to address these matters and its failure to do so led to practical injustice.
3. The applicant says that as he only became aware that the Committee had formed that view when it saw the draft report, there was no practical prospect of the Committee allowing the applicant to lead further evidence. In these circumstances, the applicant suffered practical injustice. The proposition put by the respondents that the solicitor’s failure to make the request to be allowed to do so and that this affected whether the applicant had been afforded procedural fairness should be rejected.
4. Dr Lucy suggested that the scheme of Div 4 of Part VAA was to provide, in effect, a timetable for the conduct of the review which constrains the admission of new evidence from the point at which the draft report is provided. The applicant noted that Subdiv 4B of Part VAA contains detailed provisions concerning the holding and conduct of hearings and the rights of persons under review in that context. It was submitted that the lawyer’s role is fairly limited. Section 106H(4) requires the Committee to notify the applicant of its intention to make a finding of inappropriate practice, its reasons for that finding and provide to the practitioner an “opportunity to respond”. The provision of the draft report in accordance with s 106KD performs that function: see s 106H(5). Section 106KD(3) required the Committee to give the applicant an opportunity to provide additional submissions within a month of his receiving the draft report. In oral submissions, Dr Lucy emphasised the constrained nature of the process and submitted that the statutory scheme does not contemplate the practitioner having an opportunity to provide further evidence after the draft report has been issued.
5. Dr Lucy also noted that the Committee was under some time pressure, because s 106G requires the production of the final report within six months after the Committee receives the referral. Counsel noted that the Committee produced its draft report on 12 October 2016, more than six months after the last day of the hearing (the referral having been made on 14 October 2015. Counsel submitted that there could have been no realistic prospect of the Committee convening a hearing at that time.
6. I am not satisfied that the applicant has made out this ground.
7. The following features of the process and evidence leading up to the conclusion of the hearing on 7 April 2016 should be noted:
8. On 14 October 2015, the Director referred to the Committee an investigation into whether the applicant had engaged in inappropriate practice by, among other things, “rendering services during the review period, some or all of which constituted a prescribed pattern of services”: see [3] above. The applicant was therefore on notice from the outset that s 82(1A) of the *Health Insurance Act* was an issue.
9. When, on 9 December 2015, the Committee advised the applicant of the hearing dates in March and April 2016, it also advised that hearings may be conducted on “any other subsequent hearing dates which may be necessary to fully consider this matter”: see [17] above.
10. On 25 February 2016, the Committee sought the applicant’s submissions and response to the questions of whether he claimed that exceptional circumstances existed “on one or more of the dates listed in Table 12A” and if so, what they were and when they existed: see [18] above. The respondents submit that, from this point, there could be no doubt that this was an important issue in the review.
11. The submissions solicited on 25 February 2016 were provided by Mr Davey on 23 March 2016, after the Committee had granted an extension of time for their provision.
12. After receiving those submissions, on 1 April 2016, Mr Currie, a representative of the Committee, sent an email to Mr Davey in the terms set out at [26] above. The applicant was therefore advised that:
	1. In connection with his claim that exceptional circumstances applied in the context of his rendering of services because there were no alternate medical practitioners to see his patients, the practice manager from the Blackwater Health Care Centre had been contacted and would give evidence by telephone on 7 April 2016.
	2. Ms Martin had provided information being: the Centre’s usual business hours during the week, that there were two full-time practising doctors at the Centre, that it was accepting new patients and had not closed its books and that “anyone requiring GP assistance out of hours would have been referred to the local hospital where there was a doctor available”. It is notable that this did not mention that the Centre provided services after-hours.
	3. The issue was being flagged “so that you can consider whether you would like to pose questions to this person or make submissions to the Committee on this issue”.

Mr Davey was told “not to hesitate” to call before the meeting to discuss the issue prior to the hearing. There is no evidence that he took up that invitation.

1. At the conclusion of the hearing, the presiding member indicated that the Committee did not intend to hold a further sitting of the hearing “at this point”. There was discussion of the fact that Mr Davey would make written submissions rather than taking the opportunity to address the Committee then and he did in fact do so on 22 April 2016, including addressing some elements of Ms Martin’s evidence.
2. In the submissions which the applicant gave to the Committee on 23 March 2016, he acknowledged that it fell to him to establish that there was an absence of medical services for his patients having regard to the location of his practice and the characteristics of his patients. Dr Nithianantha’s beliefs and Mr Cracknell’s beliefs about the availability of services from the Blackwater Health Care Centre were set out in those submission: see [22] above.
3. The applicant was represented at all of the hearings by Mr Davey who was the author of all of the submissions made to the Committee. I do not accept that it is irrelevant to a consideration of the procedural fairness issue that the applicant was legally represented throughout the process. While it is true that s 103(3) describes the role of the lawyer at a hearing, none of the transcript in evidence suggests that the Committee sought to restrain Mr Davey in raising issues and he was given an opportunity to provide oral submissions on 7 April 2016 or written submissions after the close of the hearing, and he in fact provided extensive written submissions on 22 April 2016 and again in June 2016 in response to an invitation from the Committee to address some issues.
4. It must have been apparent to the applicant and Mr Davey that the evidence given by Ms Martin contradicted Dr Nithianantha’s submissions about the availability to his patients of alternate medical services at Blackwater Health Care Centre in fundamental ways. What is strange is that none of the matters raised in response to the draft report were raised in cross-examination or in either of the 22 April or June 2016 submissions. Ms Martin’s evidence was brief and powerful in light of submissions previously made by Dr Nithianantha. The topics covered were clear.
5. Ms Martin’s evidence was that there were generally two doctors at the Centre who practised on a full time basis; neither of those doctors was Dr Huda who Dr Nithianantha thought had a limited practice both in scope and time and it was not the case (as Dr Nithianantha said) that one doctor was only there for part of the review period. The practice operated from 8.30 am to 5.30 pm Monday-Friday and was randomly open on some Saturdays, the books were open, the practice would see Dr Nithianantha’s regular patients and the practice accepted urgent patients. Her evidence concerning the availability of two doctors through the review period was given by reference to her records which were therefore clearly available. In response to a question from Mr Davey about whether both doctors worked during the hours the practice was open Monday to Friday, Ms Martin said yes, but acknowledged that one might have a week off from time to time, and confirmed that “mainly – 98 per cent of the time there was two”.
6. In response to the question “Did you provide after hours cover?” Ms Martin responded “We had an answering machine directing them to the hospital or our after-hours mobile phone.” This was followed up with the question “Who manned the after-hours mobile phone” Ms Martin responded “One of the doctors”.
7. While the applicant and Mr Davey would have expected the answer that callers would be referred to the Blackwater hospital, the rest of her answer should have alerted them to an issue since it was a surprise and the issue of the provision of after-hours services by Dr Nithianantha was a prominent one in the review. As noted at [118] above, why would a doctor man a mobile phone if all the doctor was going to do was refer a patient to the hospital – the answering machine could and did do that. The obvious conclusion from Ms Martin’s evidence was that, contrary to Dr Nithianantha’s prior belief, the Centre did provide after-hours service during the review period.
8. Having regard to the fact that in the 23 March 2016 submissions the applicant submitted that there were “objectively no alternative medical practitioners available to see his patients” in the review period, in my view it was obvious from Ms Martin’s unchallenged evidence that a finding might be made that the Committee could not reasonably conclude that there was an absence of alternate medical services during the review period (the finding made at new [15]), in effect including on the days forming part of the prescribed pattern of services. The Committee’s actual conclusion at [92] - that there was no absence of alternate medical services in the review period - is not materially different for this purpose.
9. As mentioned, it is difficult to understand why Mr Davey did not, in the cross examination of Ms Martin, explore the issues which arose out of Ms Martin’s evidence during her relatively brief appearance at the hearing (for example, what a manned mobile after-hours telephone coverage meant, when the doctors took leave and the timeframe in which the doctors would see the applicant’s patients). Ms Martin had her records available to her on line while she was giving evidence so that it was open to ask these questions by reference to the days during which the prescribed pattern of services occurred. If the exercise of finding answers from the records would have been too time consuming in the context of the hearing, it was open to Mr Davey to ask the questions and for the Committee to allow time for Ms Martin to marshal answers and respond in writing after the hearing. Indeed, the available hearing date of 8 April 2016 might have been utilised to allow her to give evidence. There is no reason to think that the Committee would not have allowed this.
10. The fact that neither the applicant nor Mr Davey appears to have perceived the need to do so either in cross examination or by raising the issues in the 22 April 2016 (or June) submissions does not preclude the finding that the adverse conclusion which the Committee actually reached on the material before it was obviously and naturally open to it. Further, in June 2016, Mr Davey did provide evidence of requests to transfer information concerning six of the Centre’s patients to the NBGP, albeit that that evidence was documentary and easily obtained. I do not accept the applicant’s submission that it is “unlikely” that the Committee would have countenanced the admission of evidence from witnesses addressing Ms Martin’s evidence had Mr Davey made the request for it to do so. It was within the discretion of the Committee to determine the procedure for the conduct of the hearings and it had foreshadowed that there may be other hearing dates if need be. Given the way that the Committee conducted the proceedings, including allowing indulgence on time to make the 23 March 2016 submissions and the presiding member’s remark on 7 April 2016 that the Committee did not intend further sitting days “at this time”, in my view it would have been open to Mr Davey to seek an opportunity to address these issues by seeking to re-open the hearing to call witnesses or submit evidence before the draft report was issued. It would also have been open for him to request the Committee to seek further evidence from Ms Martin to address his concern about the perceived “gaps” in her evidence.
11. It would undoubtedly have been a better and preferable process if the Committee had obtained a thorough proof of evidence from Ms Martin by reference to the Blackwater Health Care Centre’s records and provided it to the applicant before the hearing on 7 April 2016 and, if necessary, also deferred the hearing for a time to enable it to do so.
12. Nonetheless, having regard to all of the matters identified above, in my view there was not a want of procedural fairness to the applicant in the Committee’s failure to give him express notice that it might make the finding it did in the draft report, in its failure to invite him on 7 April 2016 to call further witnesses or the fact that Ms Martin’s evidence was more extensive than the 1 April 2016 email suggested in relation to the availability after hours of a mobile telephone contact manned by a doctor.
13. Having regard to the foregoing, it is not necessary for me to make a finding as to whether the applicant could have adduced evidence or for the Committee to have convened a hearing after it issued the draft report. The fact that 106KD(3) makes express provision for the practitioner to be given an opportunity to provide written submissions would indicate that that is the approach contemplated by Parliament to be adopted in the interest of the efficient conduct of an investigation. However, there are potentially serious disciplinary consequences from an adverse finding and there is no express limitation on the Committee’s powers to hold a hearing under s 106 so it may be that it is not necessary to infer from the existence of s 106KD(3) that the Committee could not receive more evidence had it been asked to do so. It is relevant that it was not asked to do so.

# Wrong question ground

1. This ground revolves around the correct interpretation of MBS item 597 and reg 2.15.1 which are set out in Part 2 of Sch 1 to the *GMST Regulations*. MBS item 597 appears under the heading “Group A11 – Urgent attendances after hours” and provides as follows:

Professional attendance by a general practitioner on not more than one patient on one occasion – each attendance (other than an attendance in unsociable hours) in an after-hours period if:

(a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient’s medical condition requires urgent treatment; and

(b) if the attendance is performed at consulting rooms-it must be necessary for the practitioner to return to, and specifically open, the consulting rooms for the attendance.

1. Regulation 2.15.1 of the *GMST Regulations* provides as follows:

**2.15.1 Meaning of patient’s medical condition requires urgent treatment**

(1) For items 597 to 600, a patient’s medical condition requires urgent treatment if:

(a) medical opinion is to the effect that the patient’s medical condition requires treatment within the unbroken after‑hours period in, or before, which the attendance mentioned in the item was requested; and

(b) treatment could not be delayed until the start of the next in‑hours period.

(2) For subclause (1), medical opinion is to a particular effect if:

(a) the attending practitioner is of that opinion; and

(b) in the circumstances that existed and on the information available when the opinion was formed, that opinion would be acceptable to the general body of medical practitioners.

1. In its draft and final reports, the Committee found as follows:

**MBS item 597**

…

48 Dr Nithianantha contended that, in considering the 'urgency' requirement, the Committee has misunderstood the operation of the item descriptor for MBS item 597 by working backwards from the clinical records, knowing what the outcome of the consultation was to demonstrate whether there was an urgent need for medical treatment. [The Committee does not consider this argument to have merit and considers that Dr Nithianantha has misconstrued this aspect of the MBS item descriptor.\*] In particular, the Committee notes that Dr Nithianantha is not required, nor is he able, to bill an MBS item 597 in advance of rendering the consultation. The Committee also notes that a practitioner has the option of rendering an after-hours consultation and claiming the appropriate MBS item in accordance with Group A22 in Division 2.23 of Schedule 1 of the Regulations if it subsequently transpires that the consultation does not meet the requirements of MBS item 597.

49. In his submissions, Dr Nithianantha refers to the case of a patient presenting with a rash (randomly sampled service number 3). The Committee's reasoning with respect to this argument is set down in Table 4.3.3 of Part 4.3 of Appendix 3. In short, however, the Committee applied the test set out in the statutory scheme for MBS item 597, that is, the Committee considered whether the patient required urgent treatment. The Committee made a finding of fact that the patient did not, in this instance, require urgent treatment (despite the anxiety of the parent).

50. On this basis, the Committee rejects Dr Nithianantha's submissions that the Committee misunderstood the operation of the item descriptor.

51. Dr Nithianantha also contended in the April Submissions that there were many circumstances where he declined to render an MBS item 597 service to patients. The Committee does not find this contention particularly relevant to the issues at hand, other than it possibly indicates that he knew that the item to be billed was a matter to determine after the service was rendered.

52. Dr Nithianantha also argues that he was not in a position to refer patients elsewhere and there was limited after-hours services available in Blackwater during the Review Period. Dr Nithianantha made a similar point in his submissions to the Committee of 17 June 2016 (the June Submissions), noting that he '*determined to accede to patient requests for urgent after-hours consultations if he formed the view, based on the telephonic history provided at the time the requires was made, that to do so was appropriate'*.

53. The Committee reiterates its comments above that it does not consider that Dr Nithianantha should necessarily have declined to see the patient in the after-hours period. Rather, the Committee has made findings that the consultation did not meet the requirements of MBS item 597. It would have been open for Dr Nithianantha to render after-hours consultations using the other MBS items outlined in Group A11 if he considered it appropriate to do so in the circumstances.

54. In respect of each of the services referred to in Table 3 of Appendix 1, the Committee’s [preliminary\*\*] finding is that Dr Nithianantha engaged in inappropriate practice for one or more of the following reasons:

* failure to meet the requirements of the MBS item descriptor;
* failure to provide adequate clinical input in relation to the presenting complaint; and
* failure to keep an adequate and contemporaneous record.

The sentence marked \* was including in [54] of the final report but not the draft report.

The word marked \*\* was deleted from [54] in the final report

1. With reference to the example given at [49] of the draft and final reports, the material in Table 4.3.3 of Part 4.3 of Appendix 4 relevantly provides:

The Committee is of the opinion that the general body of general practitioners would find that Dr Nithianantha's conduct in connection with the rendering of this service would be unacceptable for each of the following reasons:

* failure to meet the requirements of the MBS item descriptor; and
* failure to keep an adequate and contemporaneous record.

**MBS Item Descriptor**

On consideration of the clinical record for this service, as well as the relevant Medicare data for the date of service, the Committee is of the opinion that Dr Nithianantha did not meet the requirements of the item descriptor for MBS item 597.

A requirement of MBS item 597 is that the patient's medical condition requires urgent treatment.\* This means that there are two requirements to be met:

(a) medical opinion is to the effect that the patient's medical condition requires treatment within the unbroken after-hours period; and

(b) treatment could not be delayed until the start of the next in-hours period.\*

Having regard to the clinical record and Dr Nithianantha's oral evidence, the Committee is of the view that the patient's condition did not require urgent medical treatment. In this particular instance, the clinical records indicate that the patient was suffering from a *'rash with mild fever*'. The diagnosis was *'measles* *possibility'* and treatment appeared to only require *'homestay'*.

The Committee notes that Dr Nithianantha indicated in the April Submissions that the patient's mother was in *'a* *very* *anxious* *state'* and requested an urgent consultation. The parent's anxiety, however, is not of itself determinative of the patient's need for urgent treatment. The Committee considers that Dr Nithianantha could have chosen to render an after-hours service (such as an MBS item 5020) to the patient in the circumstances.

In light of this, the Committee is of the view that the information in the clinical record does not indicate that the patient required urgent treatment and, consequently, this consultation does not meet the requirements of MBS item 597.

[\* indicates that a footnote was deleted which referred to MBS Item 597 and reg 2.15.1 of the *GMST Regulations*]

1. The applicant’s claim is, in summary, that the Committee misdirected itself when making its finding at [48]. The applicant says that:
2. The scheme of the *Health Insurance Act* does not require MBS item 597 to be interpreted so that the practitioner’s opinion that treatment is required must be formed after a consultation. A consideration of the text of reg 2.15.1 of the *GMST Regulations* indicates that the time of forming the opinion may be before the consultation.
3. In the alternative, a Committee could not “reasonably conclude” that claiming for item 597 as the applicant did would be unacceptable to the general body of the members of the profession on the basis that there was general debate about the interpretation of that item and the applicant’s position was strongly arguable.
4. The applicant says that the Committee asked itself the wrong question: whether having regard to the circumstances known after the consultation, the treatment was required urgently and it thereby misconceived its jurisdiction.
5. The respondents accept that the Committee acted on the basis that the time at which urgency is to be assessed was at the conclusion of the attendance the subject of the MBS item 597 claim. The respondents say that the ground must fail because that is the correct position.
6. Before taking the analysis further, I do not accept that the Committee failed to take into account Dr Nithianantha’s opinion. By claiming under MBS item 597 and having regard to the cited oral evidence, he had made the content of his opinion and the time at which he formed it clear. I find that the shorthand use of “medical opinion” in the example given above at [170] did not overlook this element but rather referenced the “rolled up” concept of “medical opinion” which is contained in reg 2.15.1(2). It is plain that the Committee formed its opinion by reference to MBS item 597 and reg 2.15.1(2).
7. The applicant accepts that, by operation of s 10 of the *Health Insurance Act*, a “professional service” must have been rendered before a claim may be made and that this must be a “clinically relevant service” (see [59] and [60] above). The applicant therefore accepts that the service must be generally accepted in the profession as being necessary for the appropriate treatment of the patient.
8. However, the applicant says that that is not determinative of, or relevant to, the time at which urgency has to be assessed for the purposes of item 597. He identifies the point of departure between him and the respondent as being that he says that treatment actually provided when claiming under MBS item 597 need not be the “urgent treatment” which the practitioner initially thought was required. He says it is enough if, when he formed his opinion that urgent treatment was required, that opinion would have been acceptable to his peers “in the circumstances that existed and on the information available when the opinion was formed”, even if it turns out that the patient requires treatment for a different, non-urgent condition which is diagnosed during the consultation.
9. The respondents did not make extensive oral submissions in relation to this ground, but they did make extensive written submissions. As noted above, the respondents’ position is that it is not possible to determine prospectively whether a service rendered by a practitioner is a “clinically relevant service”. They say that the focus of MBS item 597 and reg 2.15.1 is the need for treatment and the timing of that need, not on the need for assessment, which logically suggests that the opinion should be formed at the conclusion of the attendance. The respondents point out that MBS item 597 forms part of a group (Group A11) that relates to urgent attendances after hours and that the fees of those services are generally high, ranging between $104.75 for item 598 and $150 for item 599.
10. Further, Group A11 is not the only group of MBS items which deal with after-hours attendances; Group A22 specifies a range of after-hours attendances (that is, on public holidays or Sunday, before 8 am and after 1 pm on Saturday and before 8 am and after 8 pm on any other day – reg 2.23.1(1)). Those fees are higher than applicable “in hours” attendances ranging from $28.45 for a basic attendance through $48.05 for an attendance of less than 20 minutes involving at least one basic step (eg a patient history) and $115.45 for an attendance lasting at least 40 minutes and involving at least one basic step.
11. The respondents submit that Groups A11 and A22 pursue a common policy of compensating practitioners for the additional burden of providing services out of hours. They have a common basic component: a professional attendance which is relevantly defined in reg 1.2.3(2) as follows:

A professional attendance includes the provision, for a patient, of any of the following services:

(a) evaluating the patient’s condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19(5) of the Act;

(b) formulating a plan for the management and, if applicable, for the treatment of the patient’s condition or conditions;

(c) giving advice to the patient about the patient’s condition or conditions and, if applicable, about treatment;

(d) if authorised by the patient - giving advice to another person, or other persons, about the patient’s condition or conditions and, if applicable, about treatment;

(e) providing appropriate preventive health care;

(f) recording the clinical details of the service or services provided to the patient.

1. The respondents submitted that it can be seen from this that treatment is something which characteristically may follow from an attendance, but treatment is not itself within the definition of an attendance. The result of an evaluation which forms the attendance may be the formulation of a plan for treatment and giving advice about treatment. The further result may be that the patient seeks and is given treatment for his or her condition. They say that that treatment would not be claimed as part of a Group A11 or Group A22 attendance. This demonstrates the difference between Group A11 items and Group A22 items. Group A11 items are concerned with cases where, during an after-hours attendance (which may include an examination) the practitioner forms the opinion that the patient’s medical condition requires urgent treatment possibly resulting in giving advice to facilitate that urgent treatment. Group A22 items are concerned with cases where there is no need for urgent treatment. Either way, the respondents say that the time at which the opinion is to be formed is at the conclusion of the attendance.
2. The respondents say that the policy rationale for the higher fee in Group A11 items can be seen as the Government’s assessment that an attendance which yields an acceptable opinion that urgent treatment is required is likely to be more labour-intensive and complex than an attendance (such as a Group A22 attendance) which does not yield that opinion.
3. The respondents observe that this construction of reg 2.15.1 and MBS item 597 “serves the salutary purpose of helping avoid abuse of the medicare claims scheme”, and it would be a cogent indicator of whether a Group A11 item has been properly claimed if urgent treatment followed the attendance, but if it does not, it cuts the other way.
4. The applicant submitted in reply that the definition of “clinically relevant service” has nothing to say about the time at which the necessity for treatment is to be assessed because in most cases a practitioner would need to make a judgment about whether the service is necessary for appropriately treating the patient before providing the treatment.
5. As to the respondents’ argument that the focus of MBS item 597 and reg 2.15.1 is treatment, not assessment, the applicant says that the focus is on “medical opinion” not treatment – that is, the medical opinion must be that the patient’s medical condition *requires* treatment. If the legislature wanted to convey that the opinion was to be formed at the end of the consultation, it would have said so by using the past tense – required, not requires, treatment. The applicant says that that makes sense because it would only be if the practitioner formed that opinion that they would go to the consulting rooms to open them (as envisaged by MBS item 597(b)). He says it is also consistent with the language of reg 2.15.1(2)(b) “in the circumstances that existed and on the information available when the opinion was formed” – that phrase would be redundant if the opinion was to be formed in retrospect. A determination having regard to “circumstances that existed” at the time the opinion was formed does not require that the opinion be formed only with hindsight.
6. He says that the submissions concerning the various fees which might be claimed for different MBS items and the object of Part VAA (being the object of protecting the integrity of the Commonwealth medicare benefits program) are not relevant to the appropriate interpretation of MBS item 597. The applicant submits that the “policy rationale” suggested by the respondents for the difference between Group A11 items and Group A22 items is speculative. The difference need not relate to complexity or the labour intensity of the service. It makes sense that a practitioner who operates on a Saturday afternoon can expect to receive a higher fee than “in hours”, and Group A22 items cater to that. Group A11 items reward both the “after hours” feature and the unscheduled and urgent nature of the requirement to open consulting rooms. The applicant also says that serving the “salutary purpose” of helping to avoid abuse is not a good reason to displace legislative intention evinced in reg 2.15.1. Abuse is avoided by the requirement that the practitioner’s opinion be one which would be acceptable to the general body of medical practitioners.
7. The applicant submitted that, even if the interpretation of MBS item 597 is found to be wrong, his interpretation is strongly arguable. The interpretation is not straightforward, even for lawyers. The applicant is a busy practitioner and could reasonably have interpreted the provision incorrectly. Having regard to “much debate” about the whether the requirements of the descriptor are satisfied when a service is requested or after it is provided, the applicant’s conduct in making a claim is not such that a Committee could reasonably conclude that it was “unacceptable to the general body of the members of the profession” within s 82(1)(a) of the *Health Insurance Act*.
8. In my view, the Committee did not ask itself the wrong question. While there is some initial attraction to the applicant’s argument, in my view it is not correct.
9. In what follows, I note the interaction of s 10 and the definitions of “clinically relevant service” and “professional service” described at [175] above. This is common ground between the parties that the entitlement to a medicare benefit hinges on the rendering of a service which is generally accepted as being necessary for the appropriate treatment of a patient. However, I do not accept that the interpretation contended for by the applicant at [176] is correct or supported by the decision of the Full Court in *Sevdalis v Director of Professional Services Review* [2017] FCAFC 9 (***Sevdalis FCAFC***). I note that the Full Court dismissed with costs an appeal from the decision of Mortimer J in *Sevdalis v Director of Professional Services Review (No 2)* [2016] FCA 433 (***Sevdalis******first instance***). The applicant relied on *Sevdalis first instance* at [123] and [125]. Paragraph [123] is to the same effect as the common position of the parties. Paragraph [125] is addressing a different item, albeit by reference to the definitions of “clinically relevant service” and “professional service”.
10. I accept the applicant’s submission that the focus of MBS item 597and reg 2.15.1 is on the “medical opinion” as to whether the patient’s condition requires treatment. However, I do not accept the argument referred to at [184] above. In my view the term “requires” where used in MSB item 597(a) and in reg 2.15.1(1)(a) is not susceptible of the meaning “might require”, which would be necessary to adopt the interpretation contended for by the applicant.
11. It might be that there are many occasions on which a practitioner could, at the time of receiving a request for services in the unbroken after hours period, form an opinion with a high degree of certainty that the patient’s condition requires urgent treatment. However, that cannot be determined definitively – as the term “requires” implies – until a consultation has taken place. I do not accept the applicant’s argument that the language of reg 2.15.1(2)(b) “in the circumstances that existed and on the information available when the opinion was formed” would be redundant if the opinion was to be formed after consultation. The circumstances in which an urgent after hours consultation takes place may well be far from ideal and the practitioner may well only have limited information available to him or her (for example, because the patient has limited capacity to communicate effectively). Accordingly the language referring to circumstances in reg 2.15.1(2)(b) is required on both interpretations proposed by the parties. Before the consultation, the practitioner can only form a view, having regard to the circumstances which have been conveyed to him or her by someone who may not be the patient. The best the practitioner can do at that point is form a view of what might be required at that time, not what is required. What is required can only be determined following consultation which can, if necessary, include examination.
12. It is true that the doctor must, at the time he or she receives a call requesting an attendance, make the decision whether to provide the attendance. While there would be plain unfairness if the practitioner were not to be remunerated at all for after-hours effort, that is not the effect of the scheme of the regulations. I am persuaded by the respondents’ arguments for the application of the different after-hours period rates reflected in Group A11 and Group A22 and that that scheme tends towards an interpretation of MBS item 597 and reg 2.15.1 for which the respondents contend.
13. Further, although the objects set out in s 79A apply to Part VAA, in my view they are objects which inform much of the regime; to avoid risk to patients and the community which may result from inappropriate practice and to protect the Commonwealth from costs associated with that. Those objects support the rationale suggested by the respondents for the interpretation of MBS item 597 and reg 2.15.1 in a way that promotes payment at the higher rates only where the medical opinion (that is the practitioner’s opinion supported by the opinion of the general body of medical practitioners) is that the patient’s medical condition requires treatment in the unbroken after hours period. The interpretation contended for by the applicant does not promote those objects.
14. I also reject the applicant’s argument that, having regard to the existence of debate about the time at which entitlement to MBS item 597 arises, it was not open to the Committee to make the finding it did concerning the applicant’s conduct in making the claims he did under MBS item 597. While Dr Nithianantha put into evidence an opinion that had been obtained by someone (it is not clear that it was the applicant) from the Provider Services Branch of the Department of Human Services which supported his reading of MBS item 597 (see [38(6)] above), the Committee rejected that advice on the basis that it was not correct. Dr Nithianantha could not have relied on that advice because it was obtained after the review period (at [60]-[62] of the final report). There was no other evidence of the debate. In any event, as noted in *Sevdalis FCAFC* at[21], the Committee is a peer review body. Under s 95(5) of the *Health Insurance Act*, where the person under review is a general practitioner, the members of the Committee must also be general practitioners. The Committee was in a position to form a view of whether the claims made by the applicant under MBS item 597 would be unacceptable to the general body of members of that profession having regard to their (in my view correct) interpretation of that item and reg 2.15.1, notwithstanding that some practitioners may have had a different view.

# Conclusion

1. For the reasons given above, the applicant has not made out any of the grounds on which he relied. Accordingly, the application should be dismissed. I will hear the parties on the issue of costs.

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| I certify that the preceding one hundred and ninety-four (194) numbered paragraphs are a true copy of the Reasons for Judgment herein of the Honourable Justice Farrell. |

Associate

Dated: 18 December 2018