

- 6.80 There should also be greater flexibility of services, especially specialist services, between neighbouring hospitals and districts. It may be necessary, for this purpose, to give greater discretion to those in charge of the respective Health Zones after consultation with specialists concerned and possibly also specialist colleges, to alter these priorities from time to time on a needs basis.

Financial incentives to experienced doctors and nurses

- 6.81 Queensland Health should also provide financial incentives to experienced doctors, especially specialists and nurses, to take positions, full time or on a part time, including sessional basis, in and to remain in, regional hospitals. I mention this also in Chapter Six - Part C when discussing the application of s135. The area of need scheme was premised on the assumption that such incentives would first be offered, but that has never occurred. It should be done, not just to comply with the spirit of the 'area of need' scheme, but to ensure better patient care in provincial areas.

Part C – A defective system of Area of Need Registration and its consequences; remedies

The defective system

- 6.82 This defective system has been discussed earlier in this report.¹¹⁶ It is proposed here to summarise the principal defects, to explain how they contributed to inadequate and even dangerous medical treatment and to make some consequent findings against the Minister, by her or his delegate, and against the Medical Board of Queensland.
- 6.83 There were two aspects of such registration and it is plain from the evidence before this Commission that there were defects in the administration of each. The first involved the making of decisions by the Minister's delegate, pursuant to s135(3) of the *Medical Practitioners Registration Act 2001*, that an area was an area of need; that is, that there were insufficient medical practitioners practicing in that part of the State to provide the service required at a level that met the needs of people living in that part of the State¹¹⁷. The second involved the process of registration under s135.¹¹⁸

¹¹⁶ See Chapter 3

¹¹⁷ especially in Chapter 3 – Defects in deciding that there is an area of need

¹¹⁸ especially in Chapter 3 – Defects in deciding that there is an area of need

Defects in deciding that there is an area of need

- 6.84 The scheme to which s135 of the *Medical Practitioners Registration Act* gives effect, is the result of an Australian Health Ministers Conference which on 4 August 1999 adopted a national framework to facilitate the recruitment of overseas trained doctors to work in rural areas.¹¹⁹ That provided that the State recruitment schemes, implemented in Queensland pursuant to s135, ‘aim to attract general practitioners who do not require training or supervision whilst undertaking placement in rural and remote areas’. Plainly there was no point in recruiting overseas trained doctors to positions in rural or remote areas if they required training or supervision, unless it was contemplated that there would first be some period of training and supervision for it was unlikely that either would be forthcoming in such areas. Yet, though neither Bundaberg nor Hervey Bay is remote or rural, that is precisely what occurred in Bundaberg and Hervey Bay, and no doubt in other places.¹²⁰
- 6.85 Notwithstanding the apparent aim of the scheme, the Act is not, in terms, confined in its relevant operation to rural and remote areas, and an area of need is defined, in effect in s135(3), in the way in which I have described it in Chapter Two. Indeed it appears, on its literal meaning, that the whole or any part of the State could be an area of need for the purpose of the operation of this scheme; and almost any medical position in Queensland might be the subject of an area of need decision. Moreover the determination of whether an area is an area of need, as so defined, is left to the discretion of the Minister or his or her delegate.
- 6.86 Notwithstanding its apparent breadth, there may be nothing intrinsically wrong with a provision such as s135(3) if it is properly applied. But it wasn’t. No serious attempt was made to ensure that an area in which an overseas trained doctor was sought to be appointed was an area of need; that is an area in which no Queensland registered doctors, or even Australian registered doctors would provide the relevant service. It was apparently envisaged that such a determination would be made’ by examining a range of factors, including Medicare statistics, health workforce data and evidence of unsuccessful attempts to recruit an Australian doctor to a position’.¹²¹ But that was never done.
- 6.87 Moreover another equally important aim of the scheme to which s135 was to give effect was ‘to encourage both new and existing GPs to relocate to rural areas through a variety of incentive programs.’ Yet there seems to have been little in the way of encouraging newly registered general practitioners to relocate

¹¹⁹ See Appendix A to Exhibit 36. It nevertheless continues a similar scheme which existed under the Medical Act 1939; see former ss.17 C(d), 17C(2)

¹²⁰ Dr Patel in Bundaberg should have had supervision and been subject to peer review but neither was available. Drs Krishna and Sharma should have had close supervision in Hervey Bay but that was never available.

¹²¹ Exhibit 36 page 7

to rural areas¹²² and none to encourage existing general practitioners to do so. Obvious ways of doing so would have been to offer them part time employment in public hospitals with a right of private practice, or to offer higher salaries or conditions in employment in non metropolitan hospitals than those offered in metropolitan Brisbane hospitals, or to offer opportunities for further study which might not be available to those who work in metropolitan hospitals.

- 6.88 Indeed the converse appears to have been the case. There were many more advantages in working in tertiary hospitals in metropolitan areas than there were in working in provincial cities, let alone rural or remote areas.¹²³
- 6.89 The rationale of the scheme was such that area of need would be assessed only in a context in which sufficient incentives had been offered to new or existing duly registered general practitioners to make working in non metropolitan areas attractive to at least some of the general practitioners who might otherwise choose to work in metropolitan areas. Because that was never the case, assessment of area of need, even if the Minister's delegate had turned his or her mind to it, could never properly have been made. The scheme was therefore doomed from the start.
- 6.90 The result of all of this was that applications for area of need decisions were made and granted when in fact no such need could be demonstrated. It is unsurprising then that Queensland Health has many more overseas trained doctors than any other State, or that it has a very high proportion of overseas trained doctors in its workforce.¹²⁴
- 6.91 The Minister's delegate assumed that, if an application was made for an area of need certification, that was, in itself, proof of a need because it was assumed that hospital administrators would prefer Australian trained doctors.¹²⁵ But indeed the converse may well have been the case. There is at least some cause for the suspicion of Australian trained doctors that overseas trained doctors are preferred by administrators because they are more compliant and more accepting of conditions and directions than their Australian trained counterparts, because of the control which administrators have over the visas of such doctors.¹²⁶

Finding against the Minister's delegate

- 6.92 I find that, during the relevant period, the Minister's delegate failed to perform her statutory duty under s135(3).

¹²² Except for the rural scholarship scheme: see Chapter 2

¹²³ See Chapter 2

¹²⁴ About 50 per cent. See Chapter 2

¹²⁵ See Chapter 2

¹²⁶ See Chapter 2

Defects in Area of Need Registration of doctors other than registration in a specialty¹²⁷

- 6.93 In the first place, the Medical Board, whose function it was to register such doctors, performed the role of checking credentials in only a cursory way. The most striking illustration of a disastrous consequence of this is the registration of Dr Patel in circumstances in which a more thorough examination of his Certificate of Licensure from Oregon would probably have led to the discovery that he had been disciplined and prevented from practising in certain surgery in Oregon and that his licence to practise surgery in New York had been suspended; and a more than cursory examination of his employment history would have led someone to have enquired why there was a discrepancy between two versions of this and why, according to one of them, he had been unemployed for about a year. But an earlier example was the registration of Mr Berg pursuant to s17C(I)(a) of the *Medical Act* in circumstances in which inquiry from the University from which he claimed to have graduated, would probably have revealed that his credentials were forgeries.
- 6.94 Secondly, the problems in the administration of the scheme were compounded, and the risk to patient safety further threatened, by the fact that no-one, the Minister's delegate, the Medical Board or Queensland Health, made any assessment of the capability of the proposed applicant for registration pursuant to s135 to perform adequately the role to which he or she was to be appointed. The decision which initiated this scheme, that of Australian Health Ministers of 4 August 1999 included the following decision:
- Assessment processes for overseas trained GPs to be consistent with processes in specialist colleges
- 6.95 As appears from what I say below, deemed specialist registration required a process of assessment by the relevant college of the applicant's suitability to practise in the speciality. It need hardly be said that, without such an assessment by some competent body, the Medical Board could not make an informed judgment that an applicant had the qualification and experience suitable for practising the profession in the designated area of need.
- 6.96 These failures to verify independently the credentials of an applicant and to assess his suitability for the position were compounded by the fact that, increasingly, applicants for these positions tended to come from countries with different cultures and first languages from ours, from a medical educational system which was either less developed than ours or one in respect of which it was difficult to make an informed judgment.

¹²⁷ See Chapter 2

- 6.97 Moreover no attempt was made by any of the persons or bodies to whom I have referred, before May 2004, to assess the language skills, or knowledge by applicants of the Queensland medical and hospital system, or to provide any instruction in respect of either. The result was that doctors were appointed under this scheme who had communication problems or who had difficulties in understanding the system in which they operated.
- 6.98 And finally, the Medical Board seemed never, or at least rarely to impose conditions upon registration, such as a condition requiring supervision, as it could have done. It did not do so in this case of Dr Patel in Bundaberg or Dr Krishna or Dr Sharma in Hervey Bay.
- 6.99 A consequence of the failure to assess suitability of applicants in the course of the registration process, but also of the absence of any adequate credentialing and privileging process, is that many area of need appointees were appointed in circumstances in which they should never have been appointed, or plainly needed supervision at least until their skills could be assessed, but were nevertheless permitted to work immediately in positions in which it was plain that no such supervision would be provided. This occurred in the case of Dr Patel at Bundaberg, in the cases of Dr Krishna and Dr Sharma at Hervey Bay,¹²⁸ and in the case of Dr Maree in Charters Towers. It is likely that it occurred elsewhere.¹²⁹ Indeed, it seems, those who were most in need of peer assessment or of supervision were appointed to positions where neither was likely to be provided. That is because, unsurprisingly, those whose skills were most demonstrably evident, those who came from educational and hospital systems which were closely comparable to our own, were appointed to the most sought after jobs, those in metropolitan tertiary hospitals.
- 6.100 As mentioned earlier, appointment as a Senior Medical Officer, or to any level below that, generally implies that the appointee would be supervised. And in the case of each of Dr Patel at Bundaberg Base Hospital, and Dr Krishna and Dr Sharma at Hervey Bay Hospital, the applications for registration indicated that each would be supervised, although that could never have occurred at either place, and Dr Nydam at Bundaberg and Dr Hanelt at Hervey Bay knew that. It would have been appropriate in the interests of patient safety, for the Board not only to impose a condition of the registration of each, that he be so supervised, but to ensure that such a condition was enforced.
- 6.101 The scheme for special purpose registration in areas of need, as so administered, had this disastrous result. Those who lived in other than metropolitan areas suffered a lower standard of medical care in public hospitals

¹²⁸ Although, as appears from the evidence of Dr Wilson, Dr Krishna had, to some extent, had his skills assessed at Toowoomba

¹²⁹ See Chapter 2

than those who lived in metropolitan areas. This remains the position today. It is plainly a morally unacceptable position.

Deemed specialist registration

- 6.102 Where a person registered under s135 is registered ‘to practise the profession in a specialty’, the registrant ‘is taken also to be a specialist registrant in the specialty’.¹³⁰ The purpose of this provision, it is said, is to ensure that areas of need registrants who have been assessed and approved for registration by a relevant specialist college should, in order to claim Medicare benefits, be deemed to be a specialist.¹³¹
- 6.103 This process of assessment of suitability by the specialist colleges seems to have worked reasonably well because such colleges have tended to accept as deemed specialists only those persons who are adequately qualified as such.¹³² Additionally, almost invariably the relevant specialist college will require, as a condition of the applicant’s registration, supervision and continuing medical education. However, I suggest in this Part that a period of probation in a tertiary hospital under the supervision of specialists in that speciality, may assist in making that assessment.

English language assessment

- 6.104 It was plainly assumed by the Commonwealth, from the commencement of the *Medical Practitioners Registration Act 2001* that there would be an English language assessment of all applicants for registration under s135.¹³³ By then, because of the substantial increase in the number and proportion of applicants from countries whose first language was not English that was necessary. So also was some assessment of the applicant’s knowledge of the Queensland medical and hospital system. Yet, as already mentioned, it was not until May 2004, after the events which gave rise to this Inquiry, that the Medical Board introduced any such language assessment. No system of assessment of an applicant’s knowledge of the Queensland medical and hospital system or any instruction on that subject yet exists.

Circumvention of the requirements for deemed specialist registration

- 6.105 No doubt because of the failure in practice to make the process of deemed registration consistent with the process of deemed specialist registration, which, as I have said, in practice required a process of assessment of suitability, the

¹³⁰ s143A which is reproduced in Chapter 2

¹³¹ See Chapter 2

¹³² The process is set out in Exhibit 36. See Chapter 2

¹³³ See Exhibit 36 pp 16-17

latter process has been circumvented in two ways. One of these is deliberate; the other, it appears, is inadvertent.

- 6.106 Because there was no effective system of monitoring, by the Medical Board or anyone else, the employment of a doctor registered under s135 became easy to circumvent the requirements for deemed specialist registration. What happened to Dr Patel is an example of this and of the appalling consequences which may follow.
- 6.107 Dr Patel was appointed as a Senior Medical Officer in surgery. As already mentioned, he was able to obtain registration under s135 without any independent assessment having being made of his suitability. Had an application been made for him to be appointed as a deemed specialist, the Royal Australasian College of Surgeons would, no doubt, have conducted a thorough assessment of his qualifications, experience and competence. It is, at least, very possible that that process would have revealed his suspensions, and the circumstances in which he ceased to be employed in Portland, Oregon. What occurred, however, as is now clear, is that his application did not follow the deemed specialist path notwithstanding that, at the time it was made, it was the intention of his future employer to appoint him immediately to the position of Director of Surgery at Bundaberg Base Hospital, a position in which, it was known, he would neither be supervised nor subject to peer review. This occurred again upon the renewal of his registration in March 2004. This, it seems, was a common way in which to circumvent the requirements for deemed specialist registration.¹³⁴
- 6.108 The other way in which, it seems, the requirements for deemed specialist registration were circumvented appears to have been by an inadvertent but negligent failure by the Medical Board to advert to the effect of s143A(2). This may be illustrated by the cases of Dr Krishna and Dr Sharma in respect of neither of whom was deemed specialist registration sought. Section 143A provides that a registrant is taken to be a specialist registrant in a specialty if the registrant is registered ‘to practise the profession in a specialty in an area of need’. Orthopaedics is a specialty within the meaning of s143A(2).¹³⁵ And both Drs Krishna and Sharma were thereby, on one occasion each, registered to practise their profession ‘in a specialty’ in an area of need.
- 6.109 Dr Krishna’s first registration under the *Medical Practitioner’s Registration Act*, (he had previously been registration under the *Medical Act 1939*) was in July 2002. No reference was made in that registration or in his registration certificate to any specialty. Curiously, however, in the following year he was registered for special purpose registration ‘under section 135 to fill an area of need as a Senior

¹³⁴ See Chapter 2

¹³⁵ See Chapter 3, definition of ‘specialty’; and the *Medical Practitioners Registration Regulation 2002*.

Medical Officer in Orthopaedics'.¹³⁶ Then in the following year, he was once again registered in a way which made no reference to a specialty.

- 6.110 Dr Sharma was first registered on 25 February 2003. No reference was made in that registration to any specialty. He was registered in the following year again with no reference being made to a specialty. Yet, curiously, on 17 January 2005 he was registered for the following year as 'Senior Medical Officer in Orthopaedics'.¹³⁷
- 6.111 It is accepted that, at no time, was it the Medical Board's intention to register either Dr Krishna or Dr Sharma as a deemed specialist.
- 6.112 Some other examples of the Medical Board having registered doctors pursuant to s135 'in' a designated specialty where there had plainly been no intention to register the applicant as a deemed specialist, were uncovered by this Commission. There is no evidence that any of the certificates issued to that effect had any detrimental consequences. Whilst it is true that Mr Allsopp represented to the public, through the local newspaper in January 2003 that, in effect, Drs Krishna and Sharma were both orthopaedic surgeons, there is no evidence that this was because of the terms of any certificate of any registration issued to either of them.
- 6.113 Nevertheless, this apparently random and idiosyncratic practice of registering and certifying registration in a way that sometimes did and sometimes did not describe the registrant as a deemed specialist in circumstances in which there was no intention to register the registrant as such, is alarming. So too is the fact that, before this Commission, the Board sought to maintain the untenable position that, for example, Dr Krishna's certificate of registration in 2003, and Dr Sharma's certificate of registration in 2005 did not represent that each was a deemed specialist. To be fair to the Board and its representatives before this Commission I should refer specifically to that submission.
- 6.114 At page 27 of its submission, the Board submitted as follows:
- It is submitted that it would be inconsistent with the evident scheme of ss 135, 139(2), and 143A of the Registration Act to construe the words 'to practise the profession in a specialty in an area of need' as having the effect that any reference on a special purpose registration certificate to a branch of medicine in which a junior practitioner will practise means that that practitioner is deemed to be a specialist.
- 6.115 That may be right. But if, more specifically, a certificate of registration issued pursuant to s.135 states that a registrant is registered to practise 'in X' and X is a defined specialty (as Orthopaedics was) that certificate represents that the registrant is to be taken to be a specialist registrant in that specialty. That is

¹³⁶ Exhibit 461, JPO 16-N JPO 16-P

¹³⁷ Exhibit 461, JPO 17 - K

what happened in the case of Dr Krishna in 2003, and in the case of Dr Sharma in 2005. It also appears to have happened in respect of other registrants. And there were other examples of the Board acting in ignorance of the meaning and effect of s.135.¹³⁸

Findings against the Medical Board with respect to registration

- 6.116 In the light of what I have said so far, it is convenient that I now discuss specifically the findings which I propose to make against the Medical Board in this respect.
- 6.117 In the first place, it was the obligation of the Medical Board to consider and determine whether an applicant for registration under s135 had the medical qualification and experience suitable for practicing in the designated area of need. In the case of registration of a person in a specialty, the Medical Board was entitled to rely on the recommendation of the relevant College which carried out an assessment of that suitability. As already mentioned, there does not appear to have been any similar process of assessment with respect to registration of persons other than as deemed specialists. The result appears to have been that no assessment by anyone qualified to do so was made of suitability of an applicant to practise the profession in the designated area before May 2004, and thereafter an assessment was made only in respect of English language skills.
- 6.118 The Medical Board sought to answer this apparent failure by submitting that:
- the primary responsibility for matching the clinical skills of an area of need applicant with the position description of the area of need position as certified by the employer rests, in the case of Queensland Public Hospitals, with Queensland Health during the recruitment and selection process. To effect registration the Medical Board is then charged with the obligation to ensure that the applicant has the requisite qualifications and experience 'suitable for practicing the profession in the area'. This obligation upon the Medical Board requires the exercise of discretion upon facts which are subjective in each case.¹³⁹
- 6.119 Whatever that submission may mean and whatever the responsibilities were of Queensland Health or the relevant hospital, the Medical Board had the statutory responsibility referred to in s135(2), and that required it to make its own independent assessment of suitability.
- 6.120 It is plain, from what I have said so far, that the Board failed to discharge that obligation. It did not seek the assistance of the Royal Australian College of General Practitioners or of the Australian Medical Council upon whose recommendation, in either case, it perhaps could have relied. Nor did it seek the

¹³⁸ See Chapter 6

¹³⁹ Submissions of the Medical Board at p2

assistance of any tertiary hospital in assessing the suitability of an applicant as it perhaps could have done.

- 6.121 Prior to May 2004, the Board failed in its obligation even to assess the understanding and communication skills of the applicant in the English language. There is no rational reason why, from the commencement of operation of this scheme under the *Medical Practitioners Registration Act*, the requirement, belatedly introduced in 2004, was not in force in respect of applications made under s135.
- 6.122 It also failed in its obligation to ensure that the applicant knew sufficient about the Queensland medical and hospital system to enable him to practise in the designated area. The term ‘experience’ in s135(2) plainly included the experience of all matters sufficient to make him suitable to practise in that area. That determination of this aspect of the question might result in refusal of registration, or registration subject to certain conditions.
- 6.123 I find the Medical Board failed to make any adequate assessment upon which to conclude that applicants under s135 had the medical qualifications, and experience suitable for practising the profession in the designated area of need.
- 6.124 The Medical Board has the power and the duty to impose conditions where it considers it ‘necessary or desirable for the applicant to competently and safely undertake the activity the subject of the application. Consistently with that obligation, the Medical Board should have, but failed to, impose a condition on the registration of medical practitioners registered under s135, that they not treat patients before they have been credentialed and privileged. And it should have, but failed to, impose a condition on the registration of each of Drs Patel, Sharma and Krishna that he be subject to the supervision of the Director of Surgery, in the case of Dr Patel, and the Director of Orthopaedics, in the cases of Drs Sharma and Krishna. The extent of that supervision could, of course, be refined by a credentialing and privileging committee. These should ordinarily be common conditions. But I would not be prepared to find that, in the case of Dr Patel’s first application, the Board should have enquired into whether there was, in fact, a Director of Surgery who could have provided that supervision.
- 6.125 I find the Medical Board failed to impose necessary conditions upon the registration of applicants under s135.
- 6.126 Nor am I prepared to find that the Medical Board failed to require the applicant in any of these cases, to identify the person or persons who were to provide supervision. No doubt, with hindsight, that would have been a desirable course and should now be required. But I think that the Medical Board was entitled to assume, in each of the cases of Bundaberg Base Hospital and Hervey Bay Hospital, that there was indeed a person who could provide that supervision if it were ordered.

- 6.127 When one comes to the inquiries which the Board made with respect to Dr Patel before accepting on their face what appeared, from a cursory examination, to be adequate evidence of qualifications and experience, I think that its conduct fell short of what would reasonably have been expected. The problem for the Medical Board, and also for Queensland Health, is that each appears to have delegated its responsibilities to check Dr Patel's credentials to a commercial entity, Wavelength, which had a financial interest in securing Dr Patel's appointment.
- 6.128 An additional problem for the Board in any assessment of the adequacy of its scrutiny of applications for Area of Need Registration is that, by the time of Dr Patel's appointment there had been, for many years, a steady increase in applications for Area of Need Registration by applicants from countries with less developed educational and hospital systems than ours, and from countries of whose educational and hospital systems little was known. As the demand in Queensland for overseas trained doctors continued to outstrip supply, the risks of insufficiently competent and even fraudulent applicants were steadily increasing. Yet the Medical Board did not consider the need for any increased scrutiny.
- 6.129 The Board now acknowledges that if it had sought a certificate of good standing from the issuing authority, Dr Patel's suspension would have been revealed. And it was, in my opinion, plain that if the Board had checked with Dr Patel's former employer, that would also have revealed that he left employment a year before, in his amended CV, he said he had, and, probably also, that he had been disciplined in his practice as a surgeon. In my opinion, the Board should have taken both of these courses.
- 6.130 In its submission, the Board points to Queensland Health's 'primary responsibility' for making these checks and to the apparent reliability of Wavelength. But it is plain that the Board had a statutory duty to ensure that an applicant had the medical qualification and experience to practise the profession in the area. The Board could not avoid that responsibility by referring to the responsibility of Queensland Health or the apparent reliability of Wavelength.
- 6.131 So far as the Board made any checks of an applicant's credentials, that was only of documents supplied by the applicant.¹⁴⁰ That process was plainly inadequate. Moreover it was performed by low level clerks who should not have been asked to assume that responsibility.¹⁴¹ It is one thing to employ clerks to check on formal completion of documents and to ensure that they came directly from the maker. But it is quite another to require them to assess the completeness of certificates of good standing, given that they may be in different forms from the

¹⁴⁰ The process is described at Chapter 2. 29.

¹⁴¹ See Chapter 2

different countries. It is unclear whether the deficiency referred to in this paragraph was because of inadequate resources or of poor administration or a combination of both.

6.132 I find that:

- (1) The Medical Board failed, before registering Dr Patel, to obtain directly from the registering authority in all jurisdictions in which he had practised, a certificate of good standing.
- (2) The Medical Board failed, before registering Dr Patel, to obtain from his last employer a certificate of good standing, and an explanation of the circumstances in which he left that employment.
- (3) The Medical Board failed, before registering Dr Patel, to adequately check the documents supplied by him on the basis of which he sought registration.

6.133 Finally, the certificates of registration issued to Dr Krishna in 2003, and to Dr Sharma in 2005 shows, worryingly, that the Medical Board failed to understand the effect of those certificates. There are other examples of the failure of the Medical Board to understand the effect of s135, for example, the letter from the Medical Board to Dr Patel, upon the renewal of his registration in 2004 that '*special purpose registration enables you to fill an area of need at Bundaberg Hospital, or at any other public hospital authorised by the Medical Superintendent on a temporary basis*'. As I pointed out earlier, this had no legislative basis. Special purpose registration under s135 enabled a registrant to practise in and only in an area of need, not in any other public hospital authorised by a medical superintendent.

Recommendation

6.134 That the Medical Board obtain legal advice upon the meaning and effect of the Act under which it operates, so that it does not issue misleading certificates, or give misleading advice.

Delay

6.135 There was also criticism before this Commission of the delay in the time taken to obtain Area of Need Registration. The causes of this were not explored before this Commission though they appear to be an insufficiency of resources and consequently of qualified staff. They should be investigated and this delay reduced. It has caused substantial problems. No doubt the additional requirements referred to in paragraphs 6.136 to 6.167 will add to that delay in the absence of further adequate resources. On the other hand, if the recommendation in Chapter Six - Part E is adopted the removal of the Board's power to investigate and adjudicate against doctors will permit the resources presently deployed in performing those functions to be deployed elsewhere.

What is needed to make Area of Need Registration effective and safe: steps taken since 2003

Area of Need determination

6.136 There do not appear to have been any material changes relevant to the matters to be considered for area of need certification. Those deposed to by Dr Huxley relate to the adequacy of the credentials of the applicant.¹⁴² However, it is apparently proposed that the task of such certification will be delegated to the Executive Officer of the Office of the Health Practitioners Registration Board. I shall discuss that later.

Registration by the Medical Board

6.137 Since 2003 the following changes have been made by the Medical Board of Queensland to its system for determining, pursuant to s135(2) of the *Medical Practitioners Registration Act*, whether a person has a medical qualification and experience suitable for practising the profession in a designated area of need:

- (1) Certificates of Good Standing to be provided directly by the registering authority in all jurisdictions in which the applicant has practised and from his/her jurisdiction of training. In addition, a software driven process for searching the Internet about an applicant's disciplinary history is now being used;
- (2) The applicant to provide a full practise history, in the form of a standard curriculum vitae, from the time of qualification to the time of application, and to explain any gaps in the practise history to the Board's satisfaction;
- (3) The applicant to advise whether he/she has attempted any medical qualifying examination(s) and, if so, the results of that examination(s);
- (4) The applicant to advise of any skills assessment, bridging program or periods of observer-ship undertaken in any Australian or New Zealand health care or skills assessment facility (and specifically at the Skills Development Centre, Royal Brisbane and Women's Hospital);
- (5) The applicant to consent to the Board seeking assessment reports relating to any practise of medicine, periods of observer-ship, bridging programs or assessment of skills undertaken in any Australian or New Zealand health care facility;
- (6) The applicant to acknowledge that making a materially false or misleading representation or declaration in the application is a ground for cancellation of registration and that the giving of materially false information or a document to the Board in connection with the

¹⁴² Exhibit 58 par 17; T939/55 to 940/10

- application is an offence punishable with a maximum penalty of AUS\$150,000.00 or 3 years imprisonment.
- (7) Queensland Health, if it is the employer, to provide a copy of the appointment letter or offer of employment;
 - (8) The employer to certify it has assessed the applicant and, based on that assessment, is satisfied the applicant has the qualifications, experience and capabilities needed for the position;
 - (9) The employer to certify, utilising mandatory reference check questions, that verbal reference checks have been undertaken and that the referees verify; the experience and capabilities of the applicant; and the accuracy and completeness of any information supplied by the applicant in relation to his/her previous employment history and experience during the previous five years;
 - (10) The employer to nominate a clinical supervisor who has current, general, specialist or s138 registration. For senior doctors, it is required that a Visiting Medical Officer, staff specialist or Director of the speciality department (who is Australian qualified) to be the nominated supervisor;
 - (11) The clinical supervisor to agree to supervise the applicant and provide the Board any adverse reports as they are identified, and to provide an assessment form at the end of the applicant's approved period of registration;
 - (12) The clinical supervisor to provide details as to how the supervision will be provided.
 - (13) The applicant to organise, from 1 October 2005, provision of a certificate of primary source verification from the International Credentials Service of the US Educational Commission for Foreign Medical Graduates directly to the Board.¹⁴³
- 6.138 There are several matters omitted from this list which should by now have been included. These, and the apparent reliance in (8) and (9) above upon the proposed employer to perform the Board's statutory obligation to satisfy itself that the applicant has the medical qualification and experience suitable for performing the profession in the identified area of need, show, in my opinion, that the Board still does not appear to appreciate its statutory duty.
- 6.139 The first and most notable omission from the above list is an obligation upon the Board to check, directly with the applicant's last supervisor, the applicant's previous employment history, the circumstances in which he or she left his last employment if he or she has already done so, and his or her standing. That, it seems to me is a fundamental and necessary part of the performance by the Board of its statutory obligation. In the case of Dr Patel, it would have revealed

¹⁴³ Exhibit 420

that, in fact, he had been unemployed for a year, and probably also, the limitations placed upon his practise by disciplinary proceedings against him.

- 6.140 The second omission, even in (9) above, is of an obligation to check directly with referees, including some not nominated by the applicant for such an approach. Again, in the case of Dr Patel, such an approach ought to have put the Board on inquiry as to Dr Patel's true standing.
- 6.141 The Board cannot discharge its obligation under s135 (2) by, in effect, leaving it to the employer to perform that obligation and relying on it as it appears to have done in (8) and (9) above. There is nothing wrong with requiring the employee to perform those tasks. But that does not relieve the Board from performance of its stated obligation. It must, itself or by a competent independent delegate, assess the clinical skills and competence of the applicant as being suitable for practicing the profession in the designated area of need. I shall discuss later what that should involve. It must also check directly with at least some referees.

Steps which must now be taken

A decision that an area is an area of need for a medical service

- 6.142 It need hardly be said that there must be a genuine decision that an area is an area of need for a medical service. As mentioned earlier, it seems that, to date, there has been no genuine decision that this is so.
- 6.143 Exhibit 36 provides:

An [Area of Need] refers to a geographic area.....in which the general population need for health care is not met. It is determined by examining a range of factors, including Medicare statistics, Health Workforce data, and evidence of unsuccessful attempts to recruit an Australian doctor to a position.
- 6.144 It is necessary to consider the last of these factors, evidence of unsuccessful attempts to recruit an Australian doctor to a position, in a context in which steps have already been taken to fulfil the government's aim 'to encourage both new and existing general practitioners to relocate to rural areas through a variety of incentive programs'.¹⁴⁴
- 6.145 The only incentive offered to new general practitioners to go to rural areas, of which evidence was given in this Inquiry, is the rural scholarship system pursuant to which Queensland Health pays an allowance to medical undergraduates for a period of time during their studies, in repayment of which the young doctor, after spending a period first in a larger hospital, is required to work for a time in a rural location.¹⁴⁵ There was no evidence of any incentives provided to existing general practitioners to relocate to rural or even provincial

¹⁴⁴ Appendix 1 to Exhibit 36

¹⁴⁵ Chapter 2

centres to work in public hospitals. Given that it was in the context of such incentives having been provided that it was anticipated that areas of need would be determined, in my opinion there can be no genuine area of need decision made unless such incentives are provided, and, notwithstanding those incentives, an Australian trained doctor cannot be persuaded to accept the position.

- 6.146 It is therefore essential that, without delay, incentives be provided to Australian trained doctors to work in hospitals outside metropolitan areas. I have already suggested a number of ways in which those incentives could be provided.¹⁴⁶
- 6.147 Only after those incentives are in place can a realistic area of need decision be made. If, notwithstanding the provision of appropriate incentives, attempts to recruit an Australian doctor to a position have been unsuccessful, the question which should then be considered is whether that medical service can be provided in that area in some other way; that is other than by engaging a person who needs special purpose registration. It may, for example, be capable of being provided by specialists or general practitioners in the area serving on a part-time basis in the hospital. Or it may be capable of provision by outsourcing the service to another nearby public hospital or to a private hospital. These avenues should be explored before a decision can be made that there are insufficient medical practitioners practising in the State, or part of the State, to provide the service at a level that meets the needs of people living in that part of the State.
- 6.148 There was evidence that the task of certifying that an area was an area of need for a medical service would be delegated to the Executive Officer of the Office of the Health Practitioners Registration Board. That is a good thing in one sense, namely that it has been delegated to a body independent of the public hospitals and of Queensland Health. But it is plain from what I have said that two further steps need to be taken urgently. They are:
- (i) Incentives must be provided to Australian trained doctors, established as well as recently graduated, to relocate to provincial areas where further medical staff are required in public hospitals.
 - (ii) Guidelines must be provided to the Board as to how to determine whether an area is an area of need for a medical service.

Determining medical qualification and experience suitable for practising the profession in an area

- 6.149 The implementation of s135(2) must be seen in the light of an aim of the scheme to which it gives effect; ‘to attract general practitioners who do not

¹⁴⁶ Chapter 3

require training or supervision whilst undertaking placements in rural and remote areas'.¹⁴⁷ It can be seen from what has been said so far that the scheme, as presently administered, is no longer achieving that aim. A very high proportion of applicants for positions in areas of need are from developing countries with educational facilities and hospital systems less developed than ours. These are doctors who are most in need of training and supervision. Yet they are being placed in positions where it is likely that they will receive neither. As already mentioned, this has been a major cause of the inadequacies in patient care and safety revealed at public hospitals, especially those in non-metropolitan areas.

- 6.150 In order to ensure adequate patient care and safety, it is essential that those persons who are placed in areas of need where adequate supervision may not be readily available are those who can function adequately and safely without further training or supervision. This requires two pre-conditions. The first is a process of adequate assessment of the suitability of an applicant to practise in the designated area of need. And the second is, as a result of that assessment a determination of the extent to which the applicant may need further training and supervision, and consequently whether, and if so, where that person may be placed for employment.
- 6.151 A comprehensive assessment process was advanced by Dr Lennox in Exhibit 55 but never adopted. There is no point now in considering whose fault that was. But it is likely that, at bottom, the problem was an insufficiency of funds to establish an adequate training and assessment facility.
- 6.152 Dr Lennox suggested that assessment of an applicant would need to be made in four areas:
- (1) English language competence and capability in the Australian context;
 - (2) Cultural safety – Australian culture generally, rural and indigenous cultures specifically;
 - (3) Clinical competence and capability – in diagnosis and management of illness and injury, preventive health and public health management;
 - (4) Understanding of the Australian and Queensland health care settings.¹⁴⁸
- I agree with that.
- 6.153 It may be that the assessment of clinical competence and capability may need to be more specific depending upon the area of need sought. In the case of Dr Krishna and Dr Sharma, for example, the asserted area of need was in the orthopaedic unit at Hervey Bay. Consequently, assessment would need to have been made specifically of orthopaedic skills.

¹⁴⁷ Appendix 1 to Exhibit 36

¹⁴⁸ Exhibit 55, 'management of international medical graduates' at page 9.

- 6.154 Dr Lennox also expressed the view that the assessment should be accredited by a tertiary institution and he suggested perhaps the Skills Development Centre. There was some other evidence before the Commission about the Skills Development Centre¹⁴⁹ but I do not have sufficient information about it to assess its capability to make an adequate assessment of applicants in the above respects. I can say only that such an assessment is necessary and that it should be made by an appropriately qualified and independent body. The Royal Australian College of General Practitioners and the Australian Medical Council would no doubt, be such bodies in most cases. But in cases in which it is intended that the service be within some speciality, it may be more appropriate for it to be a specialist college. But those bodies may not have the means to perform that task; and the cost of that assessment must be borne by Government.
- 6.155 Unless the appropriate body certifies that the applicant is capable of operating independently in the proposed position with no or minimal supervision, he or she should not be appointed to an area of need where adequate supervision cannot be guaranteed. Where an applicant is assessed as being capable of performing adequately in a public hospital only subject to supervision, he or she should be appointed only to a hospital where that supervision can be assured. That will generally be only a hospital in a major metropolitan area. As the evidence has shown, that assured supervision did not exist in either Bundaberg or Hervey Bay.
- 6.156 The experiment at Townsville Hospital with respect to Dr Myers might, with appropriate safeguards, provide a useful analogy to assist in any such assessment. And it might also be appropriate, where deemed specialist registration is sought, to assist the specialist college in assessing the specialist suitability of the applicant. The problem with the process in Townsville in that case was that there were insufficient neuro-surgeons to enable Dr Myers to be properly supervised and assessed during his 'locum' period. But the practice of requiring overseas trained doctors to spend a period of probation under the supervision of doctors in a tertiary hospital may assist in making an assessment of the suitability of an applicant in either case.
- 6.157 For registration under s135, except as a deemed specialist, it may be sufficient to require an applicant, as a pre-requisite of registration, to spend a probationary period of, say, six months in a tertiary hospital where his skill and competence to perform in the position for which he has applied may be assessed. To take an example, Dr Krishna and Dr Sharma could have been assessed over such a period by working with specialists in the orthopaedic unit at Royal Brisbane Hospital or Princess Alexandra Hospital, not for the purpose of deemed

¹⁴⁹ See for example, Dr Buckland, Exhibit 336 par 132 and following.

specialist registration, but for the purpose of assessing what, if any orthopaedic surgery they could perform in the orthopaedic surgery unit at Hervey Bay Hospital department and the extent to which that performance would need to be supervised, and consequently conditions imposed on registration under s135. Such a process would not be a substitute for credentialing and privileging which would still be required at a local level. It might, however make the task of credentialing and privileging easier.

- 6.158 The extent to which training facilities should also be provided to equip overseas trained doctors to pass an assessment sufficient to enable them to practise in an area of need is a matter beyond the scope of this report. It could only be determined after balancing the cost of incentives to Australian trained doctors to provide those services and the high desirability that those services should, wherever possible, be provided by Australian trained doctors, against the costs of training overseas trained doctors to provide them.

Imposing and enforcing necessary conditions

- 6.159 Doctors registered under s135 should ordinarily be registered subject to some condition with respect to supervision: see chapter 6.37.
- 6.160 It is essential that overseas trained doctors registered under s135 should, as soon as reasonably practicable, proceed to obtain Australian registration by qualifying either through an Australian College, including the College of General Practitioners or through the Australian Medical Council. A condition has apparently long been imposed, but rarely, if ever, enforced, that this occur within 4 years of special purpose registration. Dr Huxley said that this was now being enforced but there was no evidence of how this was being achieved.
- 6.161 I would question whether a person registered under s.135 should be permitted as long as four years within which to qualify for Australian registration. But there is insufficient evidence upon which to reach a conclusion on this question. What is clear is that, in deciding whether registration, at the end of the first or any subsequent term thereof, should be renewed, consideration should be given to the progress made by the applicant in this respect.

Conclusion with respect to registration under s135

- 6.162 Unless both the letter and the spirit of s135 (3) in respect of area of need certification, and of s135 (2) in respect of the qualification and experience sufficient to show suitability to practise the profession in an area of need, are complied with – and it is plain that they have not been in the past – the serious risk of inadequate care and the consequent risk to patient safety will remain. There is no doubt that the failure to adequately comply with the letter and spirit of these provisions contributed to the tragic circumstances in Bundaberg and to the dangerous situation which developed in Hervey Bay. Until they can be complied with, there should be no further appointments made pursuant to s135.

6.163 There has been no evidence before this Commission of applicants for special purpose registration pursuant to s135 being appointed provisionally pursuant to s143. Except possibly for the purpose of permitting probationary registration, only for the purpose of permitting assessment of an applicant's skills and competence by experienced practitioners in a tertiary hospital, pursuant to the proposal canvassed above, in my opinion, s143 should not apply to applicants for special purpose registration pursuant to s135. To be permitted to be so registered is conducive to the dangers to which I have already referred.

Recommendation: amendment of s135

- 6.164 In view of the continued failure over a substantial period of the Minister's delegate to perform the duty implied by s135(3) and of the Medical Board to perform the duty implied by s135(2), the question arises whether the matters required to be taken into account in the performance of each of these duties should be stated specifically in s135. I think that they should.
- 6.165 However, it is not my intention to draft amendments which would achieve that. Indeed, that would be impossible because they cannot be made until certain other things are done first. Examples of these are incentives to be provided to Australian trained doctors to relocate in areas of need, in the case of the first of those duties, and determination of the appropriate body or bodies to assess the suitability of applicants, in the case of the second of those duties. Instead I propose to set out the matters which as appears from what I have said, I think need to be taken into account in making each of those decisions.
- 6.166 In making the decision under s135(3), the Minister's delegate should take into account, amongst other things:
- (1) Whether a service that meets the relevant need can be conveniently provided in some other way; for example, by practitioners in private practise in the same or a nearby area on a part time basis; or by doctors working in another hospital, private or public, in the same or nearby area;
 - (2) What incentives have been provided to Australian trained doctors to relocate in the relevant area;
 - (3) What endeavours have been made to employ Australian trained doctors to perform that service; and
 - (4) The financial and safety consequences of the transfer of patients to other facilities.
- 6.167 In making the decision under s135(2) the Medical Board should take into account, amongst other things:
- (1) The credentials of and experience of the applicant to be assessed in accordance with the guidelines referred to earlier;

- (2) In the case of an application for deemed specialist registration, the suitability of the applicant to perform the service in the designated area as a deemed specialist, after taking into account the assessment in that respect of the relevant specialist college;
- (3) In the case of other applications, the suitability of the applicant, to perform the specified service in the designated area, after taking into account the assessment of an appropriately qualified and independent body capable of assessing that suitability;

In both cases including:-

- the level of competence of the applicant in understanding and communicating in oral and written English, after taking into account the assessment of an independent body appropriately qualified to make such assessment.
- the level of knowledge and understanding of the applicant of the Queensland hospital and medical system

Part D – The absence of any adequate credentialing and privileging and its consequences; the remedy

The critical purpose of credentialing and privileging: the consequent need to fulfil it.

- 6.168 As explained earlier, the process of credentialing and privileging is a formalised process of assessing a doctor's credentials, and his skill and competence to perform the job to which it is proposed he will be appointed; and of assessing the hospital to which he will, if appropriately assessed, be appointed so that any limitations on the capacity of the hospital are reflected in the work which he is permitted to do.¹⁵⁰ What must never be lost sight of and, unfortunately, was lost sight of at Bundaberg and at Hervey Bay, is that the process of credentialing and privileging is no more than that; a means of assessing the clinical capacity of a doctor in the hospital in which it is intended he will work.
- 6.169 Once that is seen, it can also be seen immediately that it is necessary for that assessment to take place before the doctor commences to work in that hospital. To find out, after a doctor has been working in a hospital for some time, that he has been working beyond his capacity or beyond the capacity of the hospital, would be plainly negligent and causative of serious risk to patients' lives and

¹⁵⁰ Chapter 3.165 to 3.172