

- (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.<sup>150</sup> 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

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<sup>150</sup> Chapter 3.165 to 3.172

safety. Unfortunately this occurred at Bundaberg, at Hervey Bay and at Charters Towers.

- 6.170 It can also be seen that what was needed for that process of assessment was a group of persons, appropriately qualified and skilled in the area of medicine in which the applicant intended to practise in the hospital, who would make that assessment. Thus, if the applicant intended to practise surgery, as Dr Patel did, the group, or committee, would include at least some surgeons. And if the doctor intended to practise orthopaedic surgery, as Drs Krishna and Sharma did, the committee would include at least some orthopaedic surgeons. All of this seems self evident.
- 6.171 As appears from what I have said earlier,<sup>151</sup> those doctors who were appointed pursuant to the area of need scheme had not satisfied the same criteria for practise as those required of their Australian trained counterparts. Consequently, the need for such a process of assessment by credentialing and privileging, and for that to take place before a doctor commenced work in a hospital, became more acute in public hospitals as more doctors in those hospitals came to be appointed under the scheme.
- 6.172 And that dual need became even more acute as more and more doctors, appointed under that scheme, came from countries with educational, medical and hospital systems less developed than ours. As explained earlier, whereas in the late 1990s most doctors who came here on temporary visas were from the United Kingdom or Ireland, by 2002 that was no longer the case; and the proportion of those who came from developing countries had risen sharply.<sup>152</sup>
- 6.173 Consequently, by 2002 when the matters the subject of this Inquiry first arose, about half of the doctors in public hospitals in Queensland were registered under the Area of Need Registration process; and many of those were in provincial and rural hospitals. And a substantial proportion of those appointed under the area of need scheme were, by then, from less developed countries.
- 6.174 What I have said so far makes all the more surprising the failure ever to implement any such process of assessment in respect of Dr Patel in Bundaberg, Doctors Krishna or Sharma in Hervey Bay or Dr Maree in Charters Towers. Nor was any sensible explanation given by anyone for any of those failures. It is useful to examine more closely, at least what happened at Bundaberg and Hervey Bay, to see if any explanation can be found.

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<sup>151</sup> Chapter 2.37

<sup>152</sup> Chapter 2.22

## Queensland Health's policy and guidelines

- 6.175 By mid 2002, Queensland Health had issued a policy and detailed guidelines for credentialing and privileging doctors.<sup>153</sup> Unsurprisingly, both the policy and the guidelines emphasised that clinical privileges should be defined before a doctor commenced any admissions or treatment within a hospital; and that overseas candidates for positions had to be informed that any appointment was subject to the successful awarding of privileges.
- 6.176 Equally unsurprisingly, the policy and the guidelines both provided that the process of assessment should be one of review by peers. To that end, the guidelines left to the District Manager considerable discretion in the formation of a credentialing and privileging committee to ensure that it included peers from the discipline of the applicant.<sup>154</sup> And in order to ensure continuity, it was to have a core component consisting of the Director of Medical Services or his nominee, and two medical practitioners nominated by the District Manager. To that core might be added a variable membership which 'where appropriate' might include a representative of the relevant clinical college, of a university, of a body of persons experienced in rural medicine, and such other medical practitioners as would best be able to assess the clinical qualities of the specific applicant, 'as dictated by the principle of peer representation.'
- 6.177 The ultimate aim of this process was 'to ensure safe, high quality care'. And to enhance that, in some cases, the committee might grant limited privileges to an applicant until a satisfactory period of training had been completed. And an applicant from outside Australia might be required to undertake a period of supervised practice.<sup>155</sup>
- 6.178 For some time before Dr Keating commenced as Director of Medical Services at Bundaberg Base Hospital in April 2003, indeed from June in 2002, Dr Hanelt and Dr Keating's predecessor, Dr Nydam, had together been attempting to draft a document setting out a local policy for the Fraser Coast Health Service District and the Bundaberg Health Service District for credentialing and privileging doctors in those districts. That document, in what appears to be its final form in June 2003, states that:

The two hospital districts have combined in order to make the process more impartial for those being considered for credentials and clinical privileges and in anticipation of some clinicians being able to practise across the two health service districts.

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<sup>153</sup> Chapter 3.173 and Exhibit 279

<sup>154</sup> Exhibit 279 para 5.3

<sup>155</sup> Exhibit 279 para 6.1

## The failure to apply them

- 6.179 Whilst it was no doubt of advantage to both districts to combine their resources in one credentialing and privileging committee, it remains baffling why it was thought necessary to formulate a new local policy with respect to the evaluation of credentials and privileges. The Queensland Health guidelines already conferred considerable discretion on the District Managers to decide whether a credentialing and privileging committee should be confined to one hospital or apply across a district, or apply at across district or even zonal level. Any further policy to give effect to the desire to combine resources or to enable clinicians to practise across the two health districts, was therefore plainly unnecessary.
- 6.180 Even more baffling is the view, expressed by Dr Keating, but apparently shared by Dr Hanelt, that:
- A credentialing and privileging committee is required by Queensland Health guidelines to have a representative of the relevant specialist college attend the meetings where a practitioner of that specialisation is seeking privileges.<sup>156</sup>
- 6.181 Under the Queensland Health guidelines, a representative of a relevant college was only one of a number of categories of persons who might be added to such a committee 'where appropriate', 'as dictated by the principle of peer representation.'
- 6.182 It was because both Dr Keating and Dr Hanelt thought that it was necessary to obtain representation from all relevant specialist colleges on credentialing and privileging committees that they spent most of 2003 and 2004, drafting such a policy and then seeking representation on various committees from the relevant specialist colleges.
- 6.183 Astonishingly, at no stage in 2003 or 2004, or in the case of Dr Hanelt, 2002, did it appear to occur to either Dr Hanelt or Dr Keating that, in the interest of the safety of patients, any doctor to be appointed to his hospital should have his clinical competence assessed by some peer body, however constituted, before he was permitted to commence service at that hospital, or, in the case of Dr Keating, that any doctor at his hospital, who had not been credentialed and privileged before April 2003, should be assessed in that way immediately. On the contrary, when Dr Hanelt emailed Dr Keating on 7 May 2003 his concern at the absence of the formalisation of clinical privileges was not about patient safety but that, if clinicians had not been appropriately credentialed and privileged, they might be denied indemnity by Queensland Health.<sup>157</sup>

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<sup>156</sup> Exhibit 448 para 356. See also DWK 79

<sup>157</sup> See Exhibit 448 - DWK 79

6.184 Dr Hanelt acknowledged in his evidence to this Commission that, in hindsight, when he could not get a college representative on a credentialing and privileging committee:

We should have said, 'Yes, I won't worry about the policy. We will simply do it contrary to the policy.'<sup>158</sup>

6.185 He agreed that that did not occur to him at the time. And even then he appeared to maintain the untenable view that he could not comply with Queensland Health's Policy and Guidelines without having a college representative on a credentialing and privileging committee.

6.186 As to Dr Keating, even when Dr FitzGerald suggested to him in February 2005 that he should co-opt a local surgeon to serve on a credentialing and privileging committee, he declined to do so. His evidence about this, set out earlier<sup>159</sup> shows that he was more focused on the form of the process of establishing credentialing and privileging committees than on the purpose of the process; patient safety.

6.187 In summary therefore, there seemed to have been three reasons why, in 2003 and thereafter, neither Dr Patel in Bundaberg, nor Dr Krishna nor Dr Sharma in Hervey Bay was credentialed and privileged. The first of these was a misconception, apparently shared by Dr Hanelt and Dr Keating, that, in order to pool resources of Bundaberg and the Fraser Coast Health Service District for the purpose of credentialing and privileging it was necessary to formulate a joint policy.

6.188 The second was a misconception, also apparently shared by Dr Hanelt and Dr Keating, that it was necessary to have a representative of the relevant specialist college upon any credentialing and privileging committee which was assessing the credentials and privileges of a person who might be performing work which came within the speciality of that college.

6.189 And the third reason was an astonishing shared failure of Dr Hanelt and Dr Keating to grasp that, in order to protect patient safety, any doctor, before commencing practise in a hospital, must have his competence to perform the work which it is proposed that he will perform in that hospital, assessed by a group of peers.

6.190 The first two misconceptions arose simply from a misreading of the Queensland Health policy and guidelines which are not difficult to read. On the contrary they seem quite clear. Yet both Dr Hanelt and Dr Keating appeared to misconstrue them in each of the ways I have discussed; or perhaps neither read them, but made assumptions about what they said.

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<sup>158</sup> T6724

<sup>159</sup> Chapter 3

6.191 The only explanation which I am able to advance for their failure to see why patient safety demanded such an assessment is that both had become so entrenched in a bureaucratic system that they never directed their minds to the importance of such an assessment in ensuring patient safety. As already mentioned, Dr Hanelt was concerned at the absence of credentialing and privileging, but apparently only because of the risk which that absence might have for indemnity of the doctors concerned. And as I have shown elsewhere both were concerned primarily with maintaining budgets. Whatever the explanation, neither appeared to advert to the critical underlying purpose of credentialing and privileging.

### **Dr Nydam's negligence**

6.192 There was, however, an additional and perhaps overriding reason why Dr Patel was not credentialed and privileged before he commenced work at Bundaberg Base Hospital. Dr Nydam, who was then the acting Director of Medical Services concluded, plainly wrongly, that Dr Patel did not require credentialing and privileging because he was a 'locum'.<sup>160</sup> It was not only plainly wrong of Dr Nydam to reach that conclusion; it was grossly negligent of him to do so. Dr Patel was not a locum. He was appointed for a period of twelve months. And, in any event, the guidelines, as might be expected, contemplated some form of credentialing and privileging for locums.

6.193 Dr Nydam also negligently assumed that Dr Patel 'would operate within the scope of his experience and previous practise as a general surgeon'.<sup>161</sup> Both this and the negligent assumption referred to in the previous paragraph were the main reasons why Dr Patel was not credentialed and privileged before he commenced operating at Bundaberg Base Hospital. If he had been, there is a strong possibility that his fraudulent statements to the Medical Board would have been uncovered,<sup>162</sup> or at least his privileges narrowed.<sup>163</sup>

### **The capacity to comply with the guidelines was there**

6.194 At all relevant times, in my opinion, it would have been possible to constitute a credentialing and privileging committee in Hervey Bay, in accordance with Queensland Health guidelines, to credential and privilege Dr Krishna and Dr Sharma. There were at all those times three registered orthopaedic surgeons in the area; Dr Mullen and Dr Naidoo at Hervey Bay and Dr Khursandri at Maryborough. Any two of those three, together with Dr Hanelt, would have constituted such a committee in accordance with the guidelines.

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<sup>160</sup> Chapter 3

<sup>161</sup> Chapter 3

<sup>162</sup> Chapter 3

<sup>163</sup> Chapter 3

- 6.195 At all relevant times it would have been possible to constitute a credentialing and privileging committee in Bundaberg, in accordance with Queensland Health guidelines, to credential and privilege Dr Patel. At all those times there were three general surgeons practising in Bundaberg; Dr Thiele, Dr Anderson and Dr de Lacy. Any two of those, together with Dr Keating, would have constituted a credentialing and privileging committee in accordance with Queensland Health guidelines.
- 6.196 Moreover, as already indicated, it would have been possible, in either Hervey Bay or Bundaberg, at any time to invite a doctor from the other centre to sit on a credentialing and privileging committee. Nor would that have been likely to impose any major, inconvenience on the doctor concerned. After all, one was only an hour or so drive from the other.

### **Townsville**

- 6.197 Neither Dr Myers nor Mr Berg was credentialed and privileged, notwithstanding the apparent existence of committees appropriate for that purpose. It seems that Dr Myers' appointment has nevertheless been successful despite that absence. As mentioned earlier, he was closely supervised and granted no independent privileges during his probationary period.

### **Charters Towers**

- 6.198 No explanation could be found, in the limited examination by this Commission of Charters Towers, for the failure to credential and privilege Dr Maree. In one serious respect, his appointment as Director of Medical Services paralleled that of Dr Patel as Director of Surgery in Bundaberg. Dr Maree was appointed to a position in which there would be no supervision and little opportunity for peer assessment of his work, in circumstances in which he had not been credentialed and privileged. His appointment also had a disastrous consequence. It seems likely also in this case that if his skill and competence as an anaesthetist had been assessed by registered anaesthetists, his lack of competence would have been revealed.

### **Conclusions**

- 6.199 The clarity of the Queensland Health Guidelines, the ease with which they could have been complied with, in each of the cases discussed, and the importance, in the interest of patient safety, of complying with them, together make it astonishing and alarming that they were not complied with in Bundaberg with respect to Dr Patel, in Hervey Bay with respect to either Dr Krishna or Dr Sharma, or in Charters Towers with respect to Dr Maree. The responsibility for complying with them in each case was upon the District Manager, but in each case he had, understandably, delegated that responsibility to the Director of

Medical Services, who, it might have been thought, because of his medical qualifications, would have understood the need for peer assessment of medical practitioners before they commenced work in a hospital. In each of the cases of Dr Nydam and Dr Keating in Bundaberg, and Dr Hanelt in Hervey Bay, his failure to implement that process was a gross dereliction of duty.

### The remedy

6.200 As appears from what I have already said, it is and was at all times simple to apply Queensland Health guidelines which are clear and comprehensive. In applying them four matters should be borne in mind. They are:

- (1) That the process is one of independent peer assessment; consequently an assessment by a group of independent peers is more important than compliance with the letter of the policy or guidelines;
- (2) That whilst college participation in the process is of advantage, it is not essential;
- (3) That it must be applied before the applicant commences to work in hospital;
- (4) That privileges may be limited by the committee, and that, for an area of need applicant, a period of supervised practice may be first required.

## Part E – Inadequate monitoring of performance and investigating complaints: inadequate protection for complainants

6.201 Every year in Australia there are a huge number of adverse outcomes which are 'iatrogenic' in origin: that is, the poor outcome for the patient is caused by the health care provider rather than the underlying condition. It is conservatively estimated that around 4,500 preventable deaths occur in hospitals each year as a result of mistakes and inappropriate procedures.<sup>164</sup> Against that background, it is, of course, vitally important that any health care organisation implement early warning systems to identify, and remedy, poor care. Moreover, it is important to acknowledge that the ultimate aim of any health system should be the creation of an environment predisposed to preventing, rather than reacting to, poor care.

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<sup>164</sup> Australian Government Productivity Commissioner Annual Report 2003-2004 page 14. I say conservatively because there have been other studies to suggest that the figure may be more than three times higher than this: David Ranson, *How Efficient? How Effective? The Coroners Role in Medical Treatment related Deaths* (1998) 23 *Alternative Law Journal* 284 at 285