10.

Submissions

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Delivery

Private & Confidential

The Secretary
David Groth
Queensland Public Hospitals
Commission of Inquiry
Level 9
Brisbane Magistrates Court
363 George Street
Brisbane Q 4000

Dear Mr Groth

Re: Doctor Terry Hanelt

Enclosed herewith please find submissions on behalf of Dr Terry Hanelt.

With Compliments

J McDougall
Chambers

encl.

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF ENQUIRY

Submissions on Behalf of Dr Terry Hanelt

1. It is easy to overlook the circumstances which gave rise to the interest of this Commission of Inquiry into the Fraser Coast District Orthopaedic Department. The North/Giblin Report did not come about as a result of any whistleblower's claims or as a result of gross mismanagement of patient care. It came about because Dr Hanelt sought the assistance of the AOA to resolve a dispute between Dr Mullen and his Director of Orthopaedics, which Dr Hanelt considered should be resolved in the interests of patient care. To now turn on Dr Hanelt based upon the scandalous content of the North/Giblin Report would be a gross injustice. The incidental exposure of faults inherent in the system of supply of hospital care in rural areas is considered healthy and it is appropriate that be dealt with by this Commission. Those faults are universal and the likes of Dr Hanelt with his long term devotion to rural medicine should be supported, not vilified.

2. In the course of this Commission there has been a tendency by witnesses, counsel assisting and the Commission itself to overlook or at least not have regard to the vastly different resources (facilities and medical staff) available to rural hospitals compared to the large tertiary hospitals. This was readily apparent in the approach adopted by the authors of the North/Giblin Report, by Dr Mullen and in the artificial distinction that has been drawn between orthopedic trauma surgery and so called elective surgery.

3. There has been no criticism of the SMOs performing trauma surgery (see para 2(b) of the list of potential adverse findings) as there can be no such criticism. That would lead to the SMOs being prevented from carrying out such surgery. That in turn would lead to a situation where most rural hospitals would simply shut down as in every discipline there are generally no specialists available to supervise and in many cases the specialist is plane journey away. If reliance was placed on specialists in obstetrics no babies would be born outside metropolitan areas.

4. The overwhelming evidence is that it is extremely difficult if not impossible to attract specialists in sufficient numbers to rural Queensland. QH is forced to rely on SMOs in all areas of need to fill the gap where required. The public demands their local hospital be open to meet community needs. The situation at the Hervey Bay was no different to most other rural or provincial communities except that it was better resourced than many.

5. The situation in Hervey Bay was vastly different from that which was revealed in Bundaberg. There have been reviews of patient's charts by independent specialists, reviews of patient complaints arising out of calls to an advertised hotline and review of a small number of patients by Dr Mullen. These reviews have revealed a very small number of adverse outcomes beyond what could reasonably be expected from orthopedic surgery - trauma or elective. Approximately 6-8 of these related to the care of the SMOs and only 3-4 of these arose out of alleged inappropriate procedural decisions by the SMOs. One of these (the so called "exploded" femur)

was explained very carefully and plausibly by Dr Krishna and his evidence has been reviewed by Dr Wilson and is left unchallenged.

6. This is an extraordinarily good outcome bearing in mind that there were about 5000 (average 1100pa.) orthopaedic admissions over the period under review. It is submitted that this is a result that would compare very favorably with the results of any tertiary hospital orthopaedic department staffed by any number of full time specialists and VMOs.

7. To single Dr Hanelt out for criticism is extremely unfair, unjust and unsupported by the evidence. The individual criticisms contained in the Notice of Possible Adverse Findings will be answered in detail below. Dr Hanelt is an extremely competent manager and a dedicated clinician who brings a wealth of experience to the management of the Fraser Coast Health District. He is a Fellow of the Australian College of Rural and Remote Medicine. He has made a career out of service in rural and remote hospitals as Medical Superintendent. He has maintained his clinical work doing shifts in Accident and Emergency and in relieving posts. He is not just a bureaucrat, as that term has been pejoratively used. He is a doctor who is clearly dedicated to his job and to the people of the Fraser Coast. He has continued to work as well as possible with the resources given to him in difficult circumstances and with difficult personalities. He is not the person to be made a scapegoat for a system that has many obvious and sometimes insurmountable shortcomings. He is exactly the sort of doctor Queensland Health and the people of Queensland desperately need.

8. The Accusers.

8.1 Dr Mullen

8.1.1 An analysis of Dr Mullen's evidence suggests his complaint was not with Dr Hanelt or indeed the hospital. It was about Dr Naidoo. There was open animosity and a history between them arising perhaps out of the period when Dr Mullen was Dr Naidoo's registrar. (Krishna- Statement para: 23)

8.1.2 Dr Mullen's criticisms of Dr Hanelt set out in his statement did not stand up to cross examination at all. He resiled from the allegation of bullying and aggression. He resiled from the suggestion that Dr Hanelt was not receptive of his complaints. (T. 5811 and following)

8.1.3 His reasons for withdrawing his services in 2002 were not supported by the contemporary documents. His reasons for allegedly refusing to sign the memorandum of the meeting of 16.01.04 (he would not sign it as it did not reflect the truth) came to nothing when it was revealed that not only had he signed it but he had amended it more than once. (T.5461,5466,5839)

8.1.4 Dr Mullen's testimony is conflicting regarding supervision of the SMOs.(T. 5836,5460 and 5454 in contrast to what he said at T.5839)

8.1.5 Dr Mullen's opinion as to what the SMOs could and couldn't do without supervision was not supported by Dr Wilson who was in a much better position to form an opinion about Dr Krishna and was not entirely

supported by Dr Crawford. Dr Naidoo was a more experienced orthopaedic surgeon than Dr Mullen and he disagreed with him. Dr Naidoo's professional ability has never been questioned in this Inquiry except by Dr Mullen and Dr Naidoo responded with a very plausible explanation of the reasons for his treatment in the Green case. Drs North and Giblin were in no position to offer any opinion at all for the reasons set out below. Dr David Morgan was complimentary of the ability of Dr Sharma in a letter tendered to the Commission.

8.1.6 Dr Mullen was critical of Drs Krishna and Sharma's performance of the so called "exploded" femur surgery. This criticism is without any foundation in fact. The "exploded" fracture was no more than the displacing of an undisplaced butterfly fracture that occurred when inserting the nail and was an anticipated risk of the surgery. The use of the retrograde nail was appropriate (T.7344). Dr Mullen was not even present for this surgery as he arrived after 5.30pm and performed the ankle surgery. This casts a degree of suspicion over all of Dr Mullen's evidence as being less than frank.

8.2 The North/Giblin Report

8.2.1 This document is by any measure a scandalous document and would not be admitted into evidence in any proper court. Dr North's oral evidence was equally flawed.

- The report and oral evidence reveals that no proper investigation was carried out.
- The investigators, for no valid reason, only attended at the hospitals for less than a full day.
- They conducted no audit of charts.
- They interviewed no patients.
- They only interviewed a very limited number of staff.
- They did not record interviews.
- They did not release their notes.
- They relied entirely on hearsay and innuendo and gossip.
- The alleged lack of cooperation in the production of documents proved to be entirely false.
- They made unsubstantiated scandalous allegations about Dr Naidoo's alleged relations with a prosthetics supplier which were never put to Dr Naidoo in the witness box. No attempt was made by the investigators to support this scurrilous allegation.
- They made unsubstantiated allegations about Dr Naidoo's terms of contract which were never put to him in evidence and which could have been resolved with a single phone call to the Human Resources Department
- The suggestion that they asked Dr Krishna clinical questions upon which they based their so called assessment of him was denied by Dr Krishna. Dr Krishna had no reason to deny this unless it was untrue. Dr Sharma also denies it in his statement.

- The Report suggests no one had a good word to say about the SMOs. This cannot be so. For example, Dr Mullen was full of praise for Dr Sharma and said he told the authors of this. (T.5460, 5780,5811,5812)
- The allegation that all of the nursing staff was critical of Drs Krishna and Sharma is false as they did not interview all or even a fraction of the nursing staff. Nurse Erwin-Jones was said by Dr North to be the source of this but she denies she said any such thing.
- The "sinister" innuendo about the unavailability of Nurse Winston was false and Dr North was later revealed as being quite untruthful about this witness. Nurse Winston's statement tendered on the last day puts an end to the false allegation that they did not speak to her and were prevented from doing so for "sinister" reasons. This exposes the whole of this evidence as being seriously tainted and calls into question the motives of the authors.
- The insistence by Dr North that the investigation was instigated by Dr Mullen flies in the face of the evidence that it was Dr Hanelt who sought the assistance of the AOA.
- If the investigators seriously held their views about patient safety, then why delay release of the report for 11 months? To say there were indemnity issues holding things up beggars belief. They could at any time have intimated their concerns in private.
- The Report is heavily criticised by Dr Hanelt, Drs Sharma and Krishna, by Mr Allsopp and by nurse Erwin-Jones. They are very critical of its accuracy in reporting what is recorded as their statements.

- The evidence of Dr Wilson completely contradicts the scathing assessment of Dr Krishna' skills and commitment (T.7345-7346).
- In an unresponsive answer during cross-examination by Mr Farr, Dr North, quite contumeliously it is submitted, offered up gossip about an alleged affair between a member of the nursing staff and the District Manager. This was never later put to either party to allow them to respond. This behavior by Dr North exemplifies the approach he took to this whole affair. The manner of giving evidence by Dr North seemed contemptuous of the whole process and displayed arrogance and a casual regard for the truth.
- The Report failed to address its terms of reference and was of no assistance to Dr Hanelt. It has done a great disservice to the people of the Fraser Coast. At a time when solutions were being sought it offered nothing.

8.2.2 This Report should be wholly rejected by the Commission.

Detailed Response to the Notice of Potential Adverse Findings

9. **Possible adverse findings:**

   a. **With respect to Term of Reference 2(c) that, as the Director of Medical Services at the Fraser Coast Health Service District, you:**

      (i) **failed to implement the Queensland Health policy on credentialing and clinical privileging within the Fraser Coast**

Health Service District or any alternative process to have medical practitioners in the Orthopaedic department credentialed and privileged. That failure resulted in Dr Krishna and Dr Sharma ("the Senior Medical Officers") performing orthopaedic surgery and orthopaedic clinics in circumstances where they had not been properly credentialed or privileged;

9.1 **Response**

9.1.1 The following responses are based on evidence contained in Paras 66, 67 and 109 of Dr Hanelts statement and inT.6721 and following:

9.1.2 The Queensland Health (QH) policy "Guidelines for Rural Medical Practitioners" lists hospitals for which the Credentials and Clinical Privileges process is to be determined by the Rural Committee for Clinical Privileges. This policy is still in effect to this date and the policy lists Hervey Bay and Maryborough Hospitals as included within that framework. It was last published on the Queensland Health Intranet on 14/01/2003.

9.1.3 This Policy was published at a date later than the overarching QH Policy document 15801 which sets out the principal that all medical practitioners using QH facilities require Clinical Privileges. This Policy was created on 12/09/2002.

9.1.4 Dr Krishna commenced in the District on 22/07/2002. On 10/01/2003 Dr Hanelt recommended to the District Manager that Dr Krishna be granted Interim Privileges in Trauma Orthopaedics and minor elective orthopaedic surgery whilst awaiting processing of formal privileges by the Rural

Committee. This 5½ month period was a reasonable time for assessment of Dr Krishna's skills by the Director of Orthopaedics to allow an informed recommendation in relation to Clinical Privileges. This recommendation, which was done in the form of a draft letter (correspondence is attached by way of tender.) to be signed by the District Manager, clearly articulates that at that stage Dr Hanelt was recommending Interim Clinical Privileges in accordance with QH policy and was also attempting to have the Clinical Privileges process conducted by the Rural Committee in line with QH policy in that the letter states the Privileges are Interim and in force until the Rural Committee formally grants privileges.

9.1.5 Interim privileges were also recommended to the District Manager in respect to Drs Sean Mullen, Morgan Naidoo, Veruthaslam Padayachey and Jim Khursandi in the same manner.

9.1.6 Dr Sharma commenced duties with the District on 6/03/2003. Interim privileges recommendation was not made in respect to Dr Sharma until 2/07/2004. This was an oversight that came to light when the Review of Orthopaedic Services was performed at that time. In any event the same process would appear to have been followed although not pursuant to a letter requesting same.

9.1.7 Thus four of the five doctors providing dedicated orthopaedic services within the District had Clinical Privileges recommended to the District Manager in accordance with QH policy soon after the new policy was

introduced and in the case of the fifth doctor, Dr Sharma, the requirement was overlooked.

9.1.8 These recommendations which resulted in letters outlining the Clinical Privileges were signed by the District Manager and forwarded to all these doctors. Copies of the signed letters for Dr Krishna and Dr Sharma have been located and are produced.

9.1.9 The QH policy does not state the duration of Interim Clinical Privileges and as such all medical staff within the orthopaedic department who are required to hold Clinical Privileges have current Clinical Privileges.

9.1.10 At some stage after the recommendation in relation to Clinical Privileges for Dr Krishna, Dr Hanelt was advised by the Rural Clinical Privileges Committee that the Fraser Coast Health Service District Medical Staff would not be processed by that Committee.

9.1.11 After discussion with superiors within QH the Directive was given to convene a District Committee. Despite this Directive the QH policy remains that both Hervey Bay and Maryborough Hospital medical staff are to have the Clinical Privilege process performed by the Rural Committee.

9.1.12 After the Directive was received, establishing a Clinical Privileges Committee that complies with QH policy has not been possible in some specialities, due to lack of College participation.

9.1.13 An alternate process was commenced to try to overcome this situation as best as could be done. This was by combining with Bundaberg Health Service District to get a sufficient number of senior clinicians to be able to manage the process in a reasonable manner.

9.1.14 Medical staff employed in specialities in which nominees were received have had their credentials assessed and Clinical Privileges recommended by the combined District Committee.

9.1.15 The Royal Australasian College of Surgeons (RACS) and the Australian Orthopaedic Association (AOA) failed to provide nominees. The District has recently been able to obtain a RACS representative through the Queensland Branch after the request was again rejected by the Federal Branch. The Queensland Branch of the AOA has failed to respond to two letters requesting representatives since endeavours to set up a local Clinical Privileges Committee commenced. A further letter was sent to the Federal Chair of the AOA who has recently supplied three nominees. These nominees were Dr Sean Mullen, Dr John North and Dr Greg Gillett. The determining of Clinical Privileges SMO's who are not specialists, but work in a specialised clinical area remains a problem.

9.1.16 The Colleges will only be involved in the process for specialists, deemed specialists and medical practitioners who hold overseas specialist qualifications not recognised in Australia and who are undergoing a period of assessment under oversight. In relation to these two latter groups the Colleges nominate any restrictions that should be applied to these practitioners Clinical Privileges relating to their Credentials and nominate the College requirements for supervision.

9.1.17 There are Joint Consultative Committees (JCC's) set up between some of the Specialist Colleges and the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote

Medicine (ACRRM). These (JCC's) work well in relation to determination of Clinical Privileges for General Practitioners (GP's) performing operative obstetrics and Anaesthetic services. There are delineated mechanisms for determining Clinical Privileges and requirements to maintain these Privileges. This is not the case so far as orthopaedics is concerned.

9.1.18 This leaves the option (in accordance with QH Policy) of getting College representative input from the RACGP or the ACRRM for non-specialist medical staff working in a discipline specific position at an advanced procedural level.

9.1.19 Neither of these Colleges is well suited for assisting in the determination of Clinical Privileges for non-specialist SMO's working in these positions. These Colleges are suited to assisting with the determination of Clinical Privileges for General Practitioners who provide limited specific procedural services.

9.1.20 Had the Clinical Privileges for Drs Sharma and Krishna been determined under the current policy guidelines using the RACGP or the ACRRM, it is highly probable that they would have had their Clinical Privileges granted in line with the recommendation of the Scope of Practice as determined by their direct supervisor, Dr Naidoo. Apart from the concerns of Dr Mullen, there would have been no evidence not to grant such privileges. Dr Mullen's concerns were not based on the actual skills of the SMOs, but usual practice in a tertiary hospital. This is unlikely to be more persuasive than Dr Naidoo's opinion.

9.1.21 This process was too flawed to be of value and would be ignoring the issue rather than addressing the issue of appropriate determination of privileges. A Scope of Practice determination with the basing of recommendation of Interim Clinical Privileges in line with this determination was considered a better process until a more formal process could be developed.

9.1.22 The Scope of Practice was determined by the Director of Orthopaedics once clinical ability of Dr Krishna and Dr Sharma had been determined. It now appears that this process may not have been done in a reasonable manner but Dr Hanelt was unaware of this factor until evidence was presented to the Commission to that effect.

9.1.23 This Scope of Practice was requested when the SMOs commenced and was required to be reduced to a document in preparation for the formal Credentials and Privileges process. This document was only provided in writing after a formal request in writing was provided to the Director of Orthopaedics.

9.1.24 In a meeting with the two Orthopaedic Surgeons providing services at Hervey Bay Hospital on 16.01.2005, the problem of how to get an independent and unbiased assessment of the clinical ability of the SMOs was discussed. It was agreed that the AOA was asked as part of the Terms of Reference for the Orthopaedic Service Review to provide some framework for assessment of Credentials to make the process meaningful, transparent and accountable.

9.1.25 This Term of Reference was not covered by the North/Giblin report.

9.1.26 In any event the evidence of Dr Wilson is generally supportive of the opinion Dr Naidoo held of Dr Krishna's clinical skills as contained in the Scope of Practice. Dr Wilson's evidence is the best on this point. He was the specialist best able to form an opinion about Dr Krishna's skills and insight as his supervising specialist at Toowoomba. He generally agrees with Dr Naidoo. Taken at its lowest, Dr Wilson's evidence serves as an example of the differing opinions of specialists about non-specialist's skills. In addition Dr Wilson totally disagreed with the opinions expressed in the North/Giblin report about Dr Krishna. (T.) As Dr Hanelt had no reason to question Dr Naidoo's clinical judgement it was not just reasonable for him to accept Dr Naidoo's opinion on these matters, he was really obliged to. Who else could he ask? There does not appear to be any evidence based criticism of Dr Sharma's performance and very little evidence based criticism of Dr Krishna. Having regard to the fact that there were on average 1100 orthopaedic admissions to the hospital per annum (T.6794) there is very little evidence of poor outcomes beyond the what would normally be expected from a large tertiary hospital which this was not.

9.1.27 There is no criticism of the SMO's performance of orthopaedic trauma surgery. The exigencies of the situation the District found itself in left no alternative but to trust that surgery to the SMOs. It was a trust that was justified if one looks closely at the evidence of Dr Crawford and the clinical evidence of Dr Mullen as opposed to the speculation, hearsay and innuendo of the North/Giblin document.

9.1.28 In summary, the QH policies in relation to Clinical Privileges are in contradiction; some of the Colleges are less than co-operative in the process. There is no robust mechanism for the process in relation to non-specialists. Dr Hanelt, as is shown in the emails attached hereto by way of tender, attempted to set up an appropriate system in conjunction with Bunderberg Hospital at least as early as 12.03.03. Clinical Privileges were recommended on an Interim basis whilst attempting to develop a suitable mechanism; there was a delay in relation to Dr Sharma's Privileges due to an oversight. There was agreement between Dr Naidoo, Dr Mullen and Dr Hanelt on 16.01.2004 that the AOA would be asked to provide input on a suitable mechanism for determining the Credentials of the SMOs and subsequently formal Clinical Privileges. There are still problems in seeing how an appropriate mechanism can be developed for Clinical Privileges for doctors such as Dr Sharma and Dr Krishna without a QH wide approach to develop suitable mechanisms due to the unwillingness of the Colleges/AOA to participate to date. Dr Hanelt did everything reasonable to ensure Interim Clinical Privileges and attempt to develop an appropriate mechanism for determining formal Privileges.

9.1.29 To assist in the process for Clinical Privileges in the future Dr Hanelt suggests: –

9.1.30 QH needs to review the policies in relation to Credentials/Clinical Privileges to eliminate inconsistencies between different policies and between policies and verbal instructions provided.

9.1.31 QH needs to review the Policy in relation to Clinical Privileges for SMOs who are neither registered as specialists and are not GP's and for specialities where the Colleges fail to nominate a representative.

9.1.32 A suitable option may be for each Zone to have a senior clinician in each discipline who undertakes this responsibility for non-specialist SMOs and for specialists where there is a lack of College participation.

9.1.33 This should be combined with the establishment of supra-nummary positions (funded by the employing District) in teaching hospitals where SMOs can undergo periods of assessment to determine clinical ability independent of the employing District. This process would remove the potential for bias based on the need of the Districts Director or that service.

9.1.34 These supra-nummary positions would also be of benefit in assessment of registered specialists where there was some question raised in relation to clinical competence where the District does not have the ability to provide appropriate assessment. Ideally this is a College responsibility but the Colleges have a poor history in relation to this aspect and current mechanisms are deficient with the only exception to Dr Hanelt's knowledge being the College of Obstetricians and Gynaecologists which has a fairly well developed assessment process in place.

10. **Between July 2003 and August 2004, allowed Dr Krishna and Dr Sharma to perform elective orthopaedic procedures without providing either with an appropriate level of supervision or consultant support;**

10.1 **Response**

10.1.1 The response below is based on evidence contained in paras: 67,72-74 of Dr Hanelts statement and T.6732,6736,6745 and 6757.

10.1.2 The procedures performed by Dr Sharma and Dr Krishna were of the type that the Director of Orthopaedics had determined they were competent to perform with the assessed degree of supervision/support.

10.1.3 Contrary opinion in relation to the degree of supervision requirement was provided by Dr Mullen.

10.1.4 The assessment by Dr Naidoo is largely supported by Dr Wilson who is in a strong position to assess Dr Krishna.

10.1.5 This contrary opinion was viewed in relation to several facts –

a. Dr Naidoo was vastly more experienced than Dr Mullen.

b. Dr Naidoo had far more direct contact with both Dr Sharma and Dr Krishna and was in a better position to make judgement of clinical ability.

c. Dr Mullen continued to delegate surgical procedures to be performed by Dr Sharma and Dr Krishna without providing supervision in a situation where he knew no other supervision was being provided for the procedure

d. Dr Mullen had done his training in teaching hospitals where there were always specialists available and did not seem able to properly understand or recognise alternate models of care. Many non-specialist medical practitioners provide a range of elective surgical procedures throughout non-teaching hospitals and some teaching hospitals without

direct supervision or in many cases with no supervision. Dr Mullen did after some time agree this was widespread practice and accept this as a necessity. This is documented by his signature to the memorandum from the meeting on 16/01/2004.

10.1.5 There was no current standard that applied to the supervision requirements for non-specialists performing procedures and as such Dr Hanelt was not in a situation of being able to accurately assess or determine the level of supervision required for these two rather unique doctors within QH. It appeared reasonable to follow the model he had observed in the multiple hospitals in QH in which he had worked during his career. This model was the assessment of supervision requirements of the senior clinician to whom the non-specialist reported on a clinical basis.

10.1.6 The North/Giblin Report had as a Term of Reference to provide guidance as to appropriate supervisory requirements in a situation of difference of opinion and incongruous behaviour by Dr Mullen. This demonstrated a desire to get independent opinion to assist in determining appropriate supervision requirements.

10.1.7 The Medical Board has now developed guidelines in relation to supervision requirements for Special Purpose Registrants that will assist Directors of Medical Services in ensuring supervision in line with the expectations of the Boards and community standards and Dr Hanelt would welcome the provision of some guidance in this aspect for the future.

11. **Allowed the Senior Medical Officers to be placed 'on call' in circumstances where there was inadequate consultant support available to provide an appropriate level of supervision;**

11.1 **Response**

11.1.1 This response is based on evidence contained in paras: 46(iii), 60, 72(ii) and 74 of Dr Hanelts statement.

11.1.2 The matters raised in response to 1(b) apply to this possible finding as well as the following factors relating to provision of an on-call service.

11.1.3 It was not possible to have a specialist orthopaedic surgeon on-call at all times with the number of specialists available in the District.

11.1.4 The offer of Dr Mullen to do a 1 in 2 on-call was conditional of Dr Naidoo also doing a 1 in 2 on-call. As that condition could not be met, the offer from Dr Mullen could not be implemented.

11.1.5 Even if this condition could have been met and a 1 in 2 specialist on-call service had been implemented this would not have functioned during periods of leave for either specialist.

11.1.6 With an inability to provide a specialist on-call at all times, the only option available is to have differential levels of on-call service.

11.1.7 When a specialist is on-call then that service is provided.

11.1.8 When a specialist is unavailable someone must be on-call for patients presenting with orthopaedic conditions.

a. The Medical Officer on-call for patients presenting with orthopaedic conditions when a specialist is unavailable could be the Surgical

Department Medical Officer or an Emergency Department Medical Officer if orthopaedic non-specialist SMOs were not to be utilised.

b. Using a Surgical or Emergency Department Medical Officer would be using a Medical Officer with less Orthopaedic knowledge and skill that the Orthopaedic SMOs and would result in a service less able to meet patients needs. This was the model in place prior to employment of the Orthopaedic SMOs and was quite unsatisfactory with concerns relating to inadequate assessment and management of some orthopaedic patients.

11.1.9 The alternative option of having no Medical Officer providing orthopaedic advice/assistance to a junior doctor from the Emergency Department and that junior doctor contacting a hospital such as the RBH or PAH would also be less suitable due to the limited ability in orthopaedic patient assessment of the junior doctor in the Emergency Department.

11.1.10 Throughout QH provincial and rural hospitals, having SMOs being on-call without local consultant supervision is common practice and is accepted as the norm. Acting in a manner widely accepted within QH as the normal practice should not be deemed inappropriate practice by an individual. If the practice is inappropriate then it must be applied to all Queensland Health facilities, both public and private.

12. **In the 'area of need' application for Dr Krishna and Dr Sharma, provided information that suggested that both doctors would have consultant supervision "24 hours per day/ 7 days per week" in circumstances where, due**

to consultants being on leave or unavailable or off duty, the level of supervision was likely to be significantly lower;

12.1 **Response**

12.1.1 The response below is based on evidence at T.6715-6721 and para:104 of Dr Hanelts statement.

12.1.2 The Area of Need forms completed for the Medical Board were filled in with the intent to portray the supervision in an accurate manner.

12.1.3 Further details of other Forms 1 produced by the Medical Board provide a more complete picture. In addition, prior to requiring a proforma "Performance Report" for application of renewal of registration under the "Area of Need" category a free form report was required. The required forms were completed in what was Dr Hanelt's belief to be the Medical Board requirements and it clearly articulated the specialist support level in terminology that is understood by other practitioners and Dr Hanelt believes, by practitioners on the Medical Board

12.1.4 The guidelines for registration in the Area of Need lack specificity in the requirements for provision of information. More explicit details of the supervision requirements would have been met, as has been done since the application forms were altered to make it more clear what information the Medical Board required.

12.1.5 In relation to information supplied to the Medical Board about supervision for Dr Krishna the information varied with the annual applications. Phrases used included –

- "Orthopaedics – Provide management of wide range of conditions with minimal supervision. Supervision available – Director of Orthopaedics (full-time) 2 x VMO's. Consultant advice available – Normal working hours + weekday nights. Not all weekends on site but remotely always."
- "Orthopaedics – Experience and procedural ability in the area of orthopaedics and ortho trauma operative skills. Supervision available – 3 x consultants. Consultant advice available – Available 24 hrs a day."
- "Supervision available – Supervision by a Staff Specialist "business hours" and as necessary after hours."

12.1.6 The forms submitted showed to varying degrees that the position required orthopaedic operative skills; the ability to manage a wide variety of orthopaedic conditions; that this work was required with minimal supervision; and that consultant advice was only available remotely at times.

12.1.7 Supervision available as necessary after hours is considered as accurate as the scope of practice was limited to that in which Dr Krishna had been assessed by the Director of Orthopaedics to be competent to perform independently. It was intended that no procedures be performed if supervision had been deemed necessary and that supervision was not available.

12.1.8 The supervision during business hours may, in hindsight, have been worded more explicitly to reflect that during times of leave by the Director

of Orthopaedics supervision was limited to times when a VMO was available. It is submitted that this would not have changed the registration granted by the Medical Board as the Board was aware from the same documentation that after hours Dr Krishna worked without direct supervision being available and did not impose any restriction in relation to this activity.

12.1.9 In a report to the Medical Board on 17.04.2003 Dr Hanelt stated "Dr Krishna has very good insight into his ability and limitations and does not attempt to independently manage any patients that would better be managed by a specialist Orthopaedic Surgeon." This clearly demonstrates that the Board was advised Dr Krishna was independently managing some orthopaedic patients and certainly did not indicate supervision at all times.

12.1.10 The registration category approved special purpose activity and conditions imposed by the Medical Board for Dr Krishna did not vary in response to these applications that indicated Dr Krishna was performing a range of operative orthopaedics and that this was not done with constant supervision. There were no restrictions imposed by the Medical Board in relation to limitation of practice or supervision requirements.

12.1.11 The documentation completed in relation to Dr Sharma was very similar to that of Dr Krishna and the same registration categories and requirements were applied by the Board.

12.1.12 It was usual for the Medical Board to impose supervision requirements irrespective of the information provided if supervision was felt necessary.

12.1.13 SMOs are employed in that capacity due to their ability to work as basically independent practitioners. If this ability was not present employment was at the level of Principal House Officer or lower. Employment and registration as a SMO inherently indicates that the Registrant would be performing at a high level of responsibility.

12.1.14 It is unreasonable to expect a Director of Medical Services to know the exact information required by the Medical Board when there was limited documentation in relation to the requirements and correspondence to the Board received no responses.

13. **Failed to take steps to ensure that either Dr Naidoo or another registered orthopaedic surgeon was able to supervise or be contacted to assist the Senior Medical Officers in circumstances where you were aware:**

a. Dr Naidoo was difficult to contact on occasions when he should have been able to be contacted;

b. The Senior Medical Officers had on occasions, called Dr Naidoo for assistance, and he had not been available;

***c.* Dr Naidoo was absent from the hospital for extended periods.**

13.1 Response

13.1.1 The response below is based on paras: 62-63 of Dr Hanelts affidavit.

13.1.2 Dr Hanelt relied on Dr Naidoo. He was aware of the need to provide supervision for the SMOs having regard to their assessed scope of practice, clinical privileges and the availability of supervisors. He was also

aware of Dr Mullen's view. However, he accepted the assessment of his Director of Orthpaedics as he was obliged to do until he had good reason not to. It is grossly unfair to judge Dr Hanelt's actions with the benefit of hindsight. The relationship between Dr Hanelt and his Director of Orthopaedics would have been quite untenable if he was to overrule the Director without apparent good reason. As things turned out Dr Hanelt took the very serious step of seeking to have the dispute between Drs Mullen and Naidoo resolved by inviting the AOA to nominate investigators.

13.1.3 Supervision was required if the SMOs were to perform a procedure for which their assessment required that they must only perform that procedure with supervision. Dr Wilson gives strong evidence of Dr Krishna's insight as to his capabilities.

13.1.4 There was an arrangement that the SMOs were to contact alternate sites on occasion when neither the Director of Orthopaedics nor a VMO was available. In cases where the patient's condition required management beyond the scope of the SMO then transfer for care or admission with care provision when a specialist was available were the normal options available. They were capable of making this decision. T.6798, 6734, 6748 refers to recruitment of additional orthopaedic staff. Steps were taken to try to obtain additional specialist services in orthopaedics within the District to cover periods of leave. This was done by attempting to recruit additional specialist staff, both on a permanent basis and on a locum basis.

13.1.5 The attempt to recruit these additional staff was to allow for the provision of a specialist level service during absence of the Director rather than a non-specialist SMO level service during these absences.

13.1.6 Recruitment efforts were significant including advertising, contact with recruitment companies and direct mail outs to every registered orthopaedic specialist in Australia and New Zealand.

13.1.7 Recruitment was unsuccessful except for the period from January 2005 when a locum was recruited.

13.1.8 When additional specialist supervision was not available the service level was reduced to the best that could be provided with the available staff. Patient care was not compromised. To remove Dr Sharma and Dr Krishna from orthopaedics during periods of unavailability of the Director would have resulted in staff with less expertise being obliged to provide an orthopaedic service.

14. **With respect to general findings that the Inquiry intends to make with respect to the Hervey Bay Hospital:**

(ii) Dr Naidoo was unable to be contacted when he was on call, and on duty within the Fraser Coast Health Service District;

14.1 **Response**

14.1.1 The response below is based on paras: 61-62 of Dr Hanelts statement and paras: 1(a), 1(b-c) of the supplementary statement and T.6730.

14.1.2 Dr Hanelt was aware of such claims from time to time, but was unable to confirm this as on the occasions this was brought to his attention at the time, he was able to establish contact.

14.1.3 On several of these occasions Dr Hanelt confirmed Dr Naidoo's physical location (eg scrubbed in the operating theatre or in transit between hospitals and seeing him after his arrival).

14.1.4 There were obviously occasions about which Dr Hanelt was unaware. This was not surprising as Dr Hanelt was responsible for a large medical staff between the two hospitals.

15. **Dr Naidoo was, on occasion, in Brisbane when he should have been on duty at the Hervey Bay Hospital;**

15.1 **Response**

15.1.1 The response below is based on evidence at T. 6730, 6739 and 6740.

15.1.2 Dr Hanelt was aware of some times when Dr Naidoo reported sick from Brisbane when he was rostered for duty.

15.1.3 He was also aware of some times when Dr Naidoo would depart early to travel to Brisbane. This flexibility was allowed for all staff in return for overtime that had been worked but not claimed and is normal practice within QH. (Time off in lieu.)

15.1.4 Dr Hanelt is now aware from the telephone call audits and fuel docket audits that there are occasions when calls were made from locations and fuel was obtained at locations not consistent with Dr Naidoo's work roster and leave claims, assuming he had possession of his car and phone at such

times as was a requirement. There has been no opportunity to seek an explanation of these apparent discrepancies since they became known, as Dr Naidoo has been absent on sick leave since these apparent discrepancies were noted. In any event Dr Hanelt did not have access to these documents prior to this inquiry because of privacy issues. This information was within the province of Human Resources.

15.1.5 The QH payroll system is counterproductive to monitoring staff attendance as reporting is by exception. That is to say if one works normal rostered hours or fails to notify the pay office of any variation one is paid for normal rostered hours. No regular time sheets are submitted through Medical Administration so policing attendance is difficult. This does not create difficulties where staff are in the same location as their supervisor. This is dysfunctional for medical staff as all are rostered to work over multiple locations over two hospital campuses and staff are often not seen by Medical Administration for significant periods.

15.1.6 The problem with the monitoring of attendance has been discussed with various levels within QH without any provision of advice as to suitable mechanism. Dr Hanelt has been unable to find or formulate a mechanism to date that would not be onerous to Medical Administration and staff and produce a feeling of apparent mistrust of staff.

15. **Dr Naidoo authorised Drs Krishna and Sharma to perform certain orthopaedic procedures without:**

a. an appropriate level of supervision or consultant support;

b. observing either Dr Naidoo or Dr Krishna performing those procedures;

c. reviewing patient outcomes following procedures performed by Drs Krishna and Sharma;

d. otherwise satisfying himself of Drs Krishna and Sharma's competence to perform those procedures instead relying on Dr Krishna and Dr Sharma to advise him of their respective levels of competence with respect to orthopaedic surgeries;

16.1 **Response**

16.1.1 The response below is based on evidence contained in paras: 22, 96-97 of Dr Hanelts statement and at T.6716, 6728, 6733, 6736 and 6745.

16.1.2 The supervision requirements should depend on clinical competence. Lack of an Australian specialist qualification does not preclude competence.

16.1.3 The available evidence to date indicates this may be correct in relation to some of the procedures in so much that the process of assessment of operative skills appears to have been deficient. Dr Hanelt was not aware of this until the Commission evidence was heard.

16.1.4 The second point is recognised and acknowledged. It occurs with all medical staff in relation to their Director and certain procedures. It is submitted that it is not always necessary to observe each and every procedure performed by a staff member as the same skills and abilities applying to some procedures are identical or to a lesser degree, applicable to other procedures. (T.) However Dr Hanelt concedes that the level of observation performed by Dr Naidoo in determining the clinical skills of Dr Sharma and Dr Krishna, as revealed in evidence, is not what Dr Hanelt expected to be the case when he relied on Dr Naidoo's assessment.

16.1.5 Reviewing patient outcomes is referred to at T.6729 to 6730 and 6802.

16.1.6 Dr Hanelt concedes there was a deficiency in that longer term clinical audits were not performed regularly. This problem was related primarily

to lack of suitable tools for data entry and analysis and lack of staff to perform this function had the tools been available. Data was collected but was not collated or analysed. This was a system fault rather than an individual fault. The District and QH failed to provide the resources. This has since been rectified.

16.1.7 The assessment process to determine competencies for Dr Krishna and Dr Sharma as revealed is less than what Dr Hanelt expected from Dr Naidoo.

17. Dr Krishna and Dr Sharma performed procedures that may have been beyond their competence;

17.1 **Response**

17.1.1 The response below is based on evidence at T.6726-6727 and 6735.

17.1.2 There is evidence of some adverse outcomes. However these outcomes are recognised complications of the surgery that was performed.

17.1.3 At T.6726 and 6727 the issue of the e-mail stating the SMOs could book cases that they were happy to do during the absence of Dr Naidoo is raised. Dr Hanelt concedes this was worded poorly and open to misinterpretation. The intent was that they would book cases within their level of competence and not anything except joint replacements as was suggest in the Commission.

17.1.4 Use of the term "happily manage" is in the context of meaning-'within their scope of competence' and again does not mean they are doing things that they are not competent to perform.

17.1.5 Dr Sharma or Dr Krishna may have performed procedures which they were confident to perform but in which they required further training to increase their skill levels.

17.1.6 Without a proper audit of the incidences of adverse outcomes or an independent assessment of their clinical competence, Dr Hanelt no longer accepts the assessment of Dr Naidoo, especially in light of the manner in which this assessment was performed as revealed by the evidence before the Commission. Nevertheless there was significant evidence that the work of Drs Krishna and Sharma was in the main reasonable and within their level of competence.

18. **The lack of supervision in the orthopaedic department at the Hervey Bay Hospital resulted in patient safety being placed at risk;**

18.1 **Response**

18.1.1 The response set out below is based on paras: 57, 58, 98, and 105 of the statement and in evidence at T. 6736

18.1.2 To the extent that adverse outcomes occurred in a small number of cases, this may be correct, although some of the evidence is unclear as to whether the adverse outcomes were due to lack of supervision or were simply complications which could occur in the best of hands. This statement also has to be balanced against the competing risks to patient safety of no service being provided at all, or simply by junior doctors in an Emergency Department.

18.1.3 The lack of adequate skill assessment of the SMOs by Dr Naidoo means that there was the potential for safety to be compromised. There is very little evidence that it was.

18.1.4 This proposition ignores the fact that the SMOs were capable of determining the safe level their own abilities and that they could and did seek advice elsewhere within the system and could and did in fact refer patients on. This meant the level of service available at Fraser Coast was compromised but not patient safety.

19. **The Senior Medical Officers were routinely placed on duty after hours in circumstances where they had inadequate consultant supervision.**

19.1 **Response**

19.1.1 See 1(c) above, as well as below.

19.1.2 This is only accurate if the scope of practice/Clinical Privileges were assessed inaccurately.

19.1.3 A system whereby practitioners act within their level of competence and arrange alternate care for patients who have conditions beyond their level of skill is congruous with the available level of supervision.

19.1.4 Since the withdrawal of services by specialist orthopaedic surgeons at Hervey Bay Hospital, patients still present with orthopaedic conditions. These patients must still receive treatment. This treatment is at a GP type level now with less expertise than was previously available from the SMOs. This has necessitated increased referrals to other centres. Lack of available beds at alternate facilities has caused treatment delays that in some cases are associated with increased risk of adverse patient outcomes.

20. **And you are invited to make written submissions regarding the following possible adverse recommendation:**

With respect to term of reference 2(e) that as a result of any or all of the potential findings in paragraph 1 and 2 above, the Director-General of Queensland Health consider whether you should be disciplined under s.87 (1) (a) and (b) of the Public Service Act 1996 on the grounds that you may have

performed your duties carelessly, incompetently, inefficiently, or are guilty of misconduct.

20.1 Response

20.1.1 Dr Hanelt has performed his duties to the best of his ability and at a high standard.

20.1.2 Failure to complete some components of his duties results from difficulties resulting from inconsistent policy, lack of co-operation by other necessary participants and the magnitude of his workload.

20.1.3 The QH policies having conflicting requirements hindered compliance with of the Clinical Privileges policy – one policy states they must go through the Rural Clinical Privileges group which was unable to provide that service.

20.1.4 The lack of co-operation by certain Colleges/Associations hindered the performance of the Clinical Privileges process.

20.1.5 Attempts were made to comply with the Policy as closely as possible with the recommendation of Interim Clinical Privileges whilst determining a suitable model that would be functional.

20.1.6 Reliance and trust was placed in certain individuals to perform their duties in a reasonable manner. Without delegation and reliance on others there would be serious limitations on what could be achieved by Dr Hanelt personally performing every task.

20.1.7 Dr Hanelt works significant amounts of unpaid overtime in an attempt to fulfil the range of duties assigned to his position. Even with this dedication it is not possible to achieve all that is required of the position.

20.1.8 Dr Hanelt's workload during the period of interest included responsibility for the following -

- All Medical Staff issues.
- Processing Registration and Immigration.
- All Allied Health Staff except Community Health Staff.
- Pharmacy.
- Medical Imaging.

- Rostering of Medical Staff for the Emergency Department.
- Allocation of junior staff to clinical placements.
- Organising coverage for emergent leave.
- Medico-legal matters.
- Clinical Complaints.
- Resolution of staff complaints.
- Recruitment of staff – medical and allied health.
- Head of Surgical Services Management Advisory Group.
- Strategic management of Elective Surgery target achievement.
- Liaison with private practitioners, Emergency Services and the media.
- Executive functions including: Weekly Executive Meetings, Monthly Surgical MAG meetings, District Health Council meetings (monthly), Monthly MSAC, District Quality meetings (fortnightly), Heads of Departments meetings (monthly), Division of General Practitioners Meetings (as required).
- Instituting relevant new policy and legislative requirements including necessary staff education.
- Provision of direct Clinical care.
- Medical Education.
- Orientation of new medical staff.
- Patient Travel Subsidy Scheme.
- Monitoring budgets.
- Performance appraisal of 65 staff.

20.1.9 During the period of his employment within the District Dr Hanelt's responsibilities have had a huge increase with no additional support until January 2004 other than one support officer. The District went from one secondary level facility and one primary care facility to two secondary service level hospitals. In 1994 the District employed 24 full-time doctors. The District now employs just over 60 full-time doctors. The Allied Health staff also doubled from about 20 to about 40 full-time staff. This is a massive workload increase and was impossible to manage adequately.

Since the start of 2004 and especially during 2005 several changes have occurred that have diminished this workload. These include –

- Appointment of a Deputy (January 2004).
- Allied Health staff transferred to Community Health (Early 2005).
- Temporary appointment of HRM support for medical recruitment (August 2005).
- Temporary appointment of a Clinical Governance assistant (July 2005).
- Temporary appointment of a Morbidity & Mortality administrative assistant (Mid 2004).
- Temporary appointment of an A/Director of Emergency Medicine (June 2005).
- Devolution of medical officer clinical attachment determinations to the Director of Clinical Training (June 2005).

20.1.10 These changes have the potential to reduce the workload to the degree that it is possible to perform the required duties for the position.

20.1.11 Dr Hanelt's history of continuous service to QH since 1983 demonstrates commitment to that organisation.

20.1.12 During that period there have been no concerns raised about Dr Hanelt in relation to having performed his duties carelessly, incompetently, inefficiently, or being guilty of misconduct.

J A McDOUGALL

Counsel for Dr T Hanelt

From: Terry Hanelt
To: Nydam, Kees
Date: 12/03/2003 4:39 pm
Subject: Clinical Privileges

Kees,
I have made a couple of changes (highlighted). See what you think. I went through the latest guidelines (July 2002)
I have also attached a list of our staff that need clinical privileges (a couple yet to start) I have also marked the ones that I think would be good as college reps Can you compile a similar list with recommendations and I will write to the Colleges with our suggestions and seeking their input Please also let me know of any other specialities you have that we do not have such as Dermatology so these do not get overlooked
Once we are happy with the Policy, we can meet with Dr Paddy and finalicy the actual procedure for the process.
Terry H

From: Terry Hanelt
To: Keating, Darren
Date: 7/05/2003 3 25 pm
Subject: Fwd: Clinical Privileges.

Darren,
This has some priority.
If the clinicians do not have clinical privileges formalised, they could be denied indemnity by QH
Could you please have a look at the attached and give me a ring if you wish to discuss any aspects
Maybe next Thursday when we meet about the Renal stuff we could touch on this issue as well.
Terry H

Dr Terry Hanelt
Director of Medical Services
Fraser Coast Health Service District
PO Box 592,
Hervey Bay Qld. 4655.
Ph 07 41206859
Fax 07 41206799
e-mail Terry_Hanelt@health.qld gov.au

From: Vinod Gopalan
To: Hanelt, Terry; Keating, Darren
Date: 15/07/2004 2:25pm
Subject: credentialling

Dear All

Just an update into whats happening. I have contacted the college of surgeons in Victoria who refereed me to the college branch in QLD. following my discussuions with them, they informed me that they had been swamped with applications from other area health services. Importantly they had a new chairman now and at this stage they are unable to suggest a suitable candidate as there are problemsd including indemnity of the college representative for any fallout from the review. I got a call yesterday from the college informing me that they were now awaiting advice from the college headquaters in Melbourne. I will keep you posted, however I think we should get together and review our own staff applications Can you provide me with a number of suitable dates?

Regards

vinod gopalan

From: Terry Hanelt
To: Gopalan, Vinod, Keating, Darren
Date: 6/09/2004 4.35 pm
Subject: Re: credentailling

Vin,
You have access to my calender so you can check as needed Also need both Districts Directors of O&G involved.
Terry H

>>> Vinod Gopalan 09/06/04 02.22pm >>>

Dear All

The RANZCOG have got back to me They have informed me that Dr Adam Bush from Gladstone is available to credential our o+g specialists. Can you provide me with some dates when you are free so I can organise a formal reveiw?

Regards

vinod gopalan

From: Darren Keating
To: Vinod Gopalan
Date: 7/09/2004 8 53 am
Subject: Re credentailling

Hi Vin

Do you want to do this via teleconf or in person ? I'm on leave 23/9 - 9/10 inc.

R/Darren

>>> Terry Hanelt Monday, 6 September 2004 16 35 49 >>>

Vin,
You have access to my calender so you can check as needed Also need both Districts Directors of O&G involved.
Terry H

>>> Vinod Gopalan 09/06/04 02:22pm >>>

Dear All

The RANZCOG have got back to me They have informed me that Dr Adam Bush from Gladstone is available to credential our o+g specialists Can you provide me with some dates when you are free so I can organise a formal review?

Regards

vinod gopalan

CC: Terry Hanelt

From: Vinod Gopalan
To: Darren Keating
Date: 9/09/2004 9:27 am
Subject: Re. credentailling

Dear Darren

I'm not sure. Does Dr. Bush need to come down from Gladstone? Also can you tell me the name of the director of o+g in Bundaberg Terry tells me we need to have the directors of both sites involved also. I will then sned out an email requesting suitable dates and tee that up with Dr. Bush.

Regards

vin

>>> Darren Keating 09/07/04 08 53am >>>

Hi Vin

Do you want to do this via teleconf or in person ? I'm on leave 23/9 - 9/10 inc

R/Darren

>>> Terry Hanelt Monday, 6 September 2004 16:35 49 >>>

Vin,
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Terry H

>>> Vinod Gopalan 09/06/04 02 22pm >>>

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Regards

vinod gopalan

Queensland Government
Queensland Health

Fraser Coast Health Service District.

Enquiries to: Mr Mike Allsopp
District Manager
Telephone: (07) 41206666
Facsimile: (07) 41206799
Email: Mike_Allsopp@health.qld.gov.au
File Number:
Our Ref.:
Your Ref.:

Dr. D. Krishna
Hervey Bay Hospital
Hervey Bay. Qld. 4655.

Dear Dr Krishna,

The formal process of obtaining Credentials and the granting of Clinical Privileges will be undertaken in the Fraser Coast Health Service District in the near future. Until this process is completed, interim privileges have been granted on the recommendation of the Director of Medical Services. These privileges will lapse when the formal process is completed.

As per the advice of the Director of Medical Services, I hereby confer privileges in Trauma Orthopaedics and minor elective Orthopaedics for the hospitals within the Fraser Coast Health Service District.

The Clinical Privileges are valid until the formal Clinical Privileging process is completed and you are notified of the outcome of that process, unless terminated or suspended prior to that time.

Should you wish to appeal this decision, the process is outlined in Section 9 of the document "Credentials and Clinical Privileges Guidelines for Rural Medical Practitioners — July 2002".

Yours sincerely,

..... / /
Mr Mike Allsopp
District Manager
Fraser Coast Health Service District

Hervey Bay Office
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HERVEY BAY Q 4655
Phone 07 41206666 Fax 07 41206799
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MARYBOROUGH. Q. 4650.
Phone 07 41238425. Fax 07 41231606.
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Queensland Government

Queensland Health

FRASER COAST HEALTH SERVICE DISTRICT

Enquiries to: Mike Allsopp
Telephone: (07) 4123 8425
Facsimile: (07) 4123 8447
Our Ref:

Dr D Krishna
Hervey Bay Hospital
Hervey Bay Qld 4655

Dear Dr Krishna

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Yours sincerely

Mike Allsopp
District Manager
Fraser Coast Health Service District
13 January 2003