16.

Submissions

Medical Board of Queensland

Partner: Paul McCowan

Direct Line: 07 3361 0208
Direct Fax: 07 3024 4208
Email: pmccowan@gnl.com.au

Gilshenan & Luton
LAWYERS

Our Ref: PDM:01.0690886
Your Ref:

Attention: Jarrod Cowley Grimmond
Principal Lawyer
The Queensland Public Hospitals Commission of Inquiry
PO Box 13147
GEORGE STREET QLD 4003

28 October 2005

Email: qphci@qphci.qld.gov.au

Dear Mr Cowley Grimmond

Medical Board of Queensland and Dr Jayant Patel – Commission of Inquiry No 2 of 2005

We refer to your letter dated 27 October 2005 relating to 2 further matters in respect of which you advised that there may be other potential adverse findings available to the Commission concerning our client.

Our response on these 2 matters appears hereunder. Separate letters will deal with the submissions of the Patients and the Health Rights Commissioner.

1. DR IZAK MAREE

We previously referred briefly to the matter of Dr Maree's service as Medical Superintendent of Charters Towers Hospital, at **Part "B" Submissions, paragraph 1.7.** We also annexed as Appendix "B" what we thought to be the relevant findings of the State Coroner delivered on 24 August 2005. Our submission was that the Coroner's findings exposed the difficulties facing IMG's in small regional hospitals.

As a consequence of receiving your letter dated 27 October 2005, we will deal specifically with those findings of the Coroner which may reflect in some way upon the Medical Board and its processes. Your letter does not draw attention to any particular aspect of the Coroner's findings, however, we will endeavour to extract those statements which might bear upon the potential adverse findings you have in mind.

1.1 Registration Issues

At page 26 of his findings, the Coroner said as follows:

Level 13, 259 Queen Street, Brisbane QLD 4000 I GPO Box 5276, Brisbane QLD 4001
Tel: 61 7 3361 0222 I Fax: 61 7 3361 0201 I DX 139 Brisbane I Web: www.gnl.com.au

"Because he had secured a position with Queensland Health the Medical Board granted Dr Maree conditional registration. All that it required of him was proof that he had such qualifications as would entitle him to registration and to be satisfied that he complied with the provisions of the Medical Act 1939. *The Board satisfied itself of these matters by having Dr Maree interviewed by a senior doctor from the Townsville Hospital who then wrote to the Board certifying that Dr Maree met these conditions for registration. It seems this process did not involve any assessment of Dr Maree's suitability for the position he was about to fill nor any review of his level of competence."*

Discussion

We repeat and rely upon our general submissions contained in **Part "A" Submissions dated 26 October 2005, in particular at pages Part A 1-7.**

The Commission of Inquiry has the Board's file in relation to the registration of Dr Maree.

The Board's file shows that the decision to register Dr Maree had already been made by the Board, utilising the process described by Dr Cohn and summarised in our Submissions Part **"A"** at pages **5 and 6.**

The interview was conducted by a delegate of the Board for the purposes explained by Mr Demy-Geroe at paragraph 40 of his statement, Exhibit 24, and Exhibit "MDG28".

The interview did not constitute the Board's entire process for registration pursuant to *S.18 Medical Act 1939.*

1.2 Investigation issues

At page 28 of his findings, the Coroner outlined that Dr Maree tendered his resignation effective from 17 April 2001. On 27 November 2001, the Board resolved to discontinue its investigation. The Coroner referred to the evidence of the Chair of the Medical Board, Dr Erica Mary Cohn, in which she said that:

"...the decision not to advise the home country of the doctor involved of the concerns about him was consistent with the Board's practise at the time but that now such advice would be given to any country in which it was thought the doctor in question might seek to practise".

The Coroner also referred to Dr Cohn's evidence that the Board's decision was based on the following factors:

- Dr Maree had left the country;
- The Board had a large number of investigations to deal with at the time;
- The Board was waiting for other inquiries such as *"this inquest"* to be completed before taking action, to avoid parallel inquiries.

Next, the Coroner referred to a submission put to him by the Solicitors for the Board, in which it was argued that:

"No good purpose would have been served by the Board taking further action in this case as the most the Board could have done was to de-register Dr Maree and that

*had already happened as a result of his resignation. Further, they (*the Solicitors*) suggest that no disciplinary prosecution in the Health Practitioners Tribunal would have been likely to succeed in the absence of evidence of criminal negligence and as I have found such evidence is not available in connection with the death of Ms Sabandina (sic), a disciplinary charge based on allegations of poor practise standards would not have succeeded. I shall respond to these submissions shortly."*

In the balance of his findings, the Coroner made the following observations (at page 31 of his findings):

"In my view that (the Board's decision to take no further action in relation to the report of Drs Johnson and Farlow) *was an inappropriate response to the serious allegations contained in the report. The functions of a coronial inquiry are not co-terminous with the Board's responsibility to uphold the standards of practise within the health professions and to maintain public confidence. For example, in this case, there were 11 allegations of professional misconduct raised against Dr Maree and only one of those was the subject of this inquest. Nor is it appropriate for the Board to postpone taking action until other authorities that may consider some aspects of a practitioner's performance have done so. In my view, the Board should act as quickly as possible to determine matters within its special area of responsibility. ...it is inappropriate for it to forbear from doing its duty in this regard merely because some other body may take some action or the practitioner whose conduct is in question leaves the State.*

I recommend the Medical Board of Queensland consider and determine the allegations made against Dr Maree and investigated by Drs Johnson and Farlow. Its findings in relation to those matters should be published in a form that makes them readily accessible to those who might to want to be informed of Dr Maree's past performance."

Discussion

We refer you to our previous **Submissions, Part "A", pages 35 – 36**, in which similar issues were dealt with in the context of the Board's handling of complaints in relation to Dr Malcolm Stumer.

We again submit that these issues were not canvassed to any extent in the conduct of the Commission proceedings. The Commission itself did not pursue this issue in its hearing. The matter was raised briefly with Mr Demy-Geroe in cross-examination by one of the parties[1]. Though the Coroner's findings post-dated Mr Demy-Geroe's evidence, he was not recalled for further examination on the Maree issues; nor was Dr Cohn. It is impracticable for the Board to attempt to call fresh evidence or seek any other documents in relation to the matter. Until receipt of your letter dated 27 October 2005, the Board was addressing the matter of Dr Maree as being a typical example of the difficulties confronted by overseas trained doctors when placed in areas of responsibility by QHealth.

By recourse to the Board's file on Dr Maree, it can be seen that at least the public interest of Queenslanders was protected at an early stage of the investigation by the departure of Dr Maree from Queensland. This was undoubtedly an important consideration in the Board's decision.

The unchallenged evidence of Mr O'Dempsey was that after commencing duties as Executive Officer on 4 March 2002, proactive steps to alleviate the backlog of complaints were instituted. The Board's decision in relation to Dr Maree predated the arrival of Mr O'Dempsey and predated the efforts of the Board to get its own house in order. Since 2002, the *"dysfunction"* candidly referred to

1 T481-482

by the Board in its Part "A" Submissions, pages 35- 36, have been addressed to the point where the annual rate of *"carry over"* of investigations in progress has fallen by over 40%.

If the matters of concern to the Commission of Inquiry had been addressed to Mr O'Dempsey, or Mr Demy-Geroe, or Dr Cohn when these witnesses were in the witness box, or if any one of the three witnesses had been sought for recall after the Coroner's findings and prior to the close down of the public evidence heard in the Inquiry, the Commission would have received evidence that by mid 2004 the Board had changed its general policy on such matters. Since that time, the Board has proceeded with a general policy to complete investigations and/or disciplinary action, even in circumstances where previously registered practitioners have left the jurisdiction.

In support of the above submission, we can only point to the statements made by our Counsel, Mr Devlin, on 5 July 2005[2], when at the Bundaberg Sittings of the Commission of Inquiry he announced that an investigator had been appointed by the Board to investigate matters relating to the clinical practise of Dr Patel which had been raised in the Commission evidence to that time. The then-Commissioner, Mr Morris, approved of that step being taken by the Board. Further, in a letter dated 7 September 2005[3] to the current Commission, which was primarily concerned with a construction of the second Commission's first Terms of Reference, the Solicitors for the Board clearly flagged that it was wishing to proceed to possible disciplinary action against Dr Patel in the near future.

It is regrettable that the concerns about the Board's previous decisions in relation to Drs Stumer and Maree were not raised with the Board's legal representatives at a time when further evidence could have been adduced on the topic, and the Board's witnesses had an opportunity to explain the Board's position in full. This is particularly so in light of the handing down of the decision of the Coroner on 24 August 2005 well before the closure of evidence in Commission of Inquiry No 2.

No adverse finding is warranted in these circumstances.

2. DR QURESHI

The Board has made detailed submissions about Dr Qureshi at **Submissions Part "B" dated 26 October 2005, pages 18 – 20.**

We refer in particular to **page 19** of those Submissions, in which a detailed chronology sets out the steps taken between 22 October 2003, when Dr Keating first lodged a complaint to the Medical Board, and 11 March 2004 when the Board Complaints Co-Ordinator advised Dr Keating that an investigator would be appointed. Some relevant dates upon which proper action was taken, are set out again as follows:

22.10.03 - Dr Keating advised the Medical Board Complaints Unit about a second complaint against Dr Qureshi, also referring to the first complaint, and advising that Dr Keating had already arranged for Dr Qureshi to be chaperoned during his clinical practise.

17.11.03 - Medical Board advice to Dr Keating that his complaint would be considered at the next meeting of the Board.

09.12.03 - After receiving a further complaint from staff, Dr Keating interviewed the patient and then interviewed Dr Qureshi, who denied the allegations.

11.12.03 - Dr Keating again wrote to the Medical Board Complaints Unit advising of a further incident and advising that Dr Qureshi has a chaperone and that

2 T1909
3 Exhibit "A", Commission of Inquiry No 2 of 2005

administrative action had begun under the Queensland Health Code of Conduct.

18.12.03 - facsimile Medical Board Complaints Assessment Co-Ordinator to Dr Keating requesting further information concerning the various complaints which had flowed in over the previous 2 months.

24.12.03 - Dr Keating wrote to the Medical Board Complaints Assessment Co-Ordinator supplying further information as requested.

24.02.04 - Medical Board reviewed the complaint material and noted that an investigator had been directed to investigate. (The assessment by the Board therefore took 2 months)

The Board's complaint files on Dr Qureshi, which are in the possession of the Commission, reveal that in the 4 months during which Dr Keating's complaints were under assessment by the Medical Board Complaints Unit, the following additional official activity had occurred, to the knowledge of the Board's employees, and ultimately the Board:

- On 11 December 2003, Dr Keating advised the Medical Board Complaints Unit that administrative action had begun under the Queensland Health Code of Conduct.
- On 29 January 2004, the QHealth internal auditor had referred Dr Keating's complaints to the CMC.
- In late January or early February 2004, the Crime & Misconduct Commission had referred the allegations of misconduct to the Queensland Police Service for investigation. QPS advised that prior to interviewing Dr Qureshi he fled the jurisdiction. A Warrant was issued for Qureshi's arrest and a *"passenger alert"* had been instituted with Australian Immigration and with Interpol.

It is strongly submitted that any perception of *"unreasonable and excessive"* delay is unfounded when the events between 22 October 2003 and 11 March 2004 are subjected to close scrutiny.

First, it is clear that over a period of time further complaints about Dr Qureshi flowed in through Dr Keating to the Board's Complaints Unit. Assessment of the full range of complaints occurred between 24 December 2003 and 24 February 2004.

Secondly, it is apparent that, to the Board's knowledge, Dr Qureshi was placed immediately under a requirement for a chaperone, in the conduct of any further clinical work at Bundaberg Base Hospital. The public interest was immediately served by that initiative of Dr Keating.

Thirdly, it is apparent that an internal QHealth investigation had been instituted.

Fourthly, it is apparent that the CMC became involved, which led in turn to a QPS investigation, which led in turn to advice that Qureshi had fled the country.

Fifthly, it is apparent that, to the Board's knowledge, an Arrest Warrant was brought into existence, together with an international *"passenger alert"*.

Sixthly, pursuant to S.124(1)(i) *Health Practitioners (Professional Standards) Act 1999*, a conviction for an indictable offence gives grounds for disciplinary action before the Health Practitioners Tribunal without the need for an investigation. Sexual offences are ordinarily indictable offences.

The Medical Board of Queensland would be failing in its duty if it did not prioritise the more urgent investigations within its purview.

We refer you to S.12 *Financial Management Standard 1997*, which states *inter alia:*

> ***12. Responsibilities of accountable officers and statutory bodies***
>
> *(1) Under the Act, each accountable officer and statutory body is assigned various functions.*
>
> *(2) As part of the functions, every accountable officer and statutory body must manage the agency efficiently, effectively and economically, including, for example, by developing and implementing systems to ensure the appropriate use of, accountability for and safeguarding of, public resources."*

In the context of the facts set out above, to prioritise the investigation of an absent practitioner, no longer registered in the State of Queensland, subject to possible police charges, and subject to the execution of an Arrest Warrant if found somewhere in the world in the near future, would have been a waste of resources.

It is submitted that an adverse finding of *"unreasonable and excessive"* delay in relation to the assessment period of 22 October 2003 and 11 March 2004 is unwarranted due to the unfolding and dynamic nature of the complaints to be investigated. It is apparent that the assessment phase was an active one.

It is submitted that a finding of *"unreasonable and excessive"* delay in relation to the six month possible period of delay set out in the Board's letter of 11 March 2004 is also unwarranted because:

- The period of six months was but an estimate, given as a courtesy by the Board to the complainant, Dr Keating;'
- The falling backlog of cases was an historical reality, but was proactively being dealt with; and
- The estimate of time should be understood as evidence of an appropriate allocation of resources by the Board and its employees to undoubtedly more urgent cases.

No adverse finding is warranted in the light of the circumstances raised above.

Yours faithfully
GILSHENAN & LUTON

Paul McCowan
Partner

Partner: Paul McCowan

Direct Line: 07 3361 0208
Direct Fax: 07 3024 4208
Email: pmccowan@gnl.com.au

Our Ref: PDM:01.0690886
Your Ref:

Gilshenan & Luton
LAWYERS

1 November 2005

Attention: Jarrod Cowley Grimmond
Principal Lawyer
The Queensland Public Hospitals Commission of Inquiry
PO Box 13147
GEORGE STREET QLD 4003

Email: qphci@qphci.qld.gov.au

Dear Mr Cowley Grimmond

Submissions from Wavelength Pty Ltd

We refer to paragraph 7.5 of the Submission made on behalf of Wavelength Pty Ltd wherein it was submitted:

> *"It is a function of the Medical Board of Queensland, pursuant to Section 11 of the* Medical Practitioners Registration Act 2001, *to assess applications for registration".*

If such an assertion was made in support of any submission to the effect that the Board would have had a legal obligation to "assess" Dr Patel then such assertion cannot be sustained as a matter of law.

The reference to the term *"registration"* in S 11 is in fact defined in Schedule 3 to the *Medical Practitioners Registration Act 2001* as meaning *"means registration under part 3"*. Special purpose (area of need registration) is not *"registration under part 3"*.

In any event the function as outlined in S11 is clearly applicable to assessment of *"applications"* and does not in any way import into the section any duty upon the Board to *"assess"* applicants for registration under Part 3. The Board repeats and relies upon its Submissions as contained in pages 1 – 7 of Part A of the Submissions to this Inquiry.

Yours faithfully
GILSHENAN & LUTON

Paul McCowan
Partner

Level 13, 259 Queen Street, Brisbane QLD 4000 | GPO Box 5276, Brisbane QLD 4001
Tel: 61 7 3361 0222 | Fax: 61 7 3361 0201 | DX 139 Brisbane | Web: www.gnl.com.au

Partner: Paul McCowan

Direct Line: 07 3361 0208
Direct Fax: 07 3024 4208
Email: pmccowan@gnl.com.au

Our Ref: PDM:01-0690886
Your Ref:

Gilshenan & Luton
LAWYERS

Attention: Mr Jarrod Cowley Grimmond
Principal Lawyer
The Queensland Public Hospitals Commission of Inquiry
PO Box 13147
GEORGE STREET QLD 4003

2 November 2005

Email: qphci@qphci.qld.gov.au

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Dear Mr Cowley Grimmond

Response on behalf of Medical Board of Queensland Re Submissions on behalf of Dr Hanelt

We refer to paragraph 12.1.14 of the Submissions made on behalf of Dr Hanelt wherein it has been submitted:

"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".

An examination of the files of Drs Krishna and Sahrma as well as the transcript of evidence has not revealed any evidence of correspondence to the Board which either called for any response or sought any advice or direction from the Board in this context. Further it would appear that the question of documentation which may be required by the Medical Board as to supervision was neither posited nor tested in evidence by Dr Hanelt.

In light of the above we submit that there cannot be any adverse inference against the Board in respect of paragraph 12.1.14 of the submissions on behalf of Dr Hanelt.

Yours faithfully
GILSHENAN & LUTON

Paul McCowan
Partner

Level 13, 259 Queen Street, Brisbane QLD 4000 | GPO Box 5276, Brisbane QLD 4001
Tel: 61 7 3361 0222 | Fax: 61 7 3361 0201 | DX 139 Brisbane | Web: www.gnl.com.au

Partner: Paul McCowan

Direct Line: 07 3361 0208
Direct Fax: 07 3024 4208
Email: pmccowan@gnl.com.au

Our Ref: PDM:01.0690886
Your Ref:

Gilshenan & Luton
LAWYERS

Attention: Jarrod Cowley Grimmond
Principal Lawyer
The Queensland Public Hospitals Commission of Inquiry
PO Box 13147
GEORGE STREET QLD 4003

2 November 2005

Email: qphci@qphci.qld.gov.au

Dear Mr Cowley Grimmond

Response of the Medical Board of Queensland to Submissions made on behalf of Mr Leck

At Paragraph 81 of the Submission on behalf of Mr Leck it is noted:

> *"Mr Leck acquiesced in the proposed short term re-engagement of Dr Patel from 1 April 2005 to 31 July 2005 to allow time to find a replacement. That was reasonable in the circumstance that:*
>
> .....
>
> - *Both Dr Fitzgerald and the Medical Board knew of the proposal to re-engage Dr Patel and neither had remonstrated about that."*

We submit that there is no evidence that the Medical Board of Queensland knew of the substance of the proposal to re-engage Dr Patel at the time Dr Patel was still employed at Bundaberg.

There is evidence that the Board would consider *"whether it was necessary to recommend that the Board impose conditions upon Dr Patel's registration"* in the context of an application for renewal of registration in the course of a discussion between Dr Fitzgerald and Mr O'Dempsey referred to at Paragraph 31 of the Statement of Mr O'Dempsey **(Exhibit 28)(see also T472 lines 42-60 – evidence of Mr Demy-Geroe)**.

Further the file note of the conversation between Duncan Hill (Registration Officer) and Mr Leck on 30 March 2005 reflects that there was inquiry on behalf of the Board as to *"confirmation of the conditions to be imposed by the District onto Dr Patel's employment."* **(attachment MDG-40 to Statement of Mr Demy-Geroe - Exhibit 24 and see also evidence at T7213-7214)**

Level 13, 259 Queen Street, Brisbane QLD 4000 I GPO Box 5276, Brisbane QLD 4001
Tel: 61 7 3361 0222 I Fax: 61 7 3361 0201 I DX 139 Brisbane I Web: www.gnl.com.au

The Board therefore rejects any possible inference that it supported or gave any tacit approval of any actions by Mr Leck in respect of the *"proposed short term re-engagement of Dr Patel"*.

Yours faithfully
GILSHENAN & LUTON

Paul McCowan
Partner

SUBMISSIONS OF

THE MEDICAL BOARD OF QUEENSLAND

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY NO. 2 OF 2005

Submissions from

THE MEDICAL BOARD OF QUEENSLAND

SUBMISSIONS OF THE MEDICAL BOARD OF QUEENSLAND TO INQUIRY No. 2 OF 2005

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(d) **THE APPROPRIATENESS, ADEQUACY, AND TIMELINESS OF action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above;**

(i) **within the Bundaberg Base Hospital**

Zone Manager – Dan Bergin
An overview of the evidence as to why no complaint was made to the Medical Board until February/March 2005.

THE APPROPRIATENESS, ADEQUACY, AND TIMELINESS of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above;

(ii) **outside the Bundaberg Base Hospital**

Evidence of James O'Dempsey
Evidence of Dr Gerry Fitzgerald

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DETAILS RESPONSE OF THE MEDICAL BOARD OF QUEENSLAND TO "NOTICE OF POTENTIAL ADVERSE FINDINGS AND RECOMMENDATIONS" DATED 14 OCTOBER 2005

PART A
DETAILED RESPONSE OF THE MEDICAL BOARD OF QUEENSLAND TO "NOTICE OF POTENTIAL ADVERSE FINDINGS AND RECOMMENDATIONS" DATED 14 OCTOBER 2005.

Introduction

The response of the Medical Board of Queensland ("the Board") to the "Notice of potential adverse findings and recommendations" ("the notice") is contained in this document which is "Part A" of a three part submission. "Part B" will deal with matters of interest to the Board which arise in relation to the Terms of Reference, other than clinical cases and issues of potential unsatisfactory professional conduct by registrant medical practitioners. The latter will be dealt with specifically in "Part C".

It should be noted that the changes to processes which have been adopted by the Board since the matters giving rise to Commission of Inquiry Number 1 of 2005 were always, as will be demonstrated, part of a broad range of process change which had been sought and worked toward by the Board for a long period of time. Because of the interests of key stakeholders who might be affected by any proposed changes to processes involving applications for area of need registrations of overseas trained doctors ("OTD's" or "IMG") the Board's ability to implement change was only likely to have been evolutionary. However as events have unfolded, the face of intense public interest generated in the Patel case has made and indeed enabled this process of change to be revolutionary. The recent changes thus implemented by the Board should be seen in this context.

The Commission did not itself lead any specific formal evidence of processes as adopted by other Australian medical registration boards in the handling of registration of OTD's. Thus there is no evidence that the Board was operating other than in accordance with appropriate national standards. However as will be submitted herein, there is a clear body of evidence demonstrating that the Board was in fact a leading participant in national reforms aimed at tackling the unique problems posed by the registration of OTD's in an area of need.

The Board submits with respect to each paragraph of the notice outlined as follows:

1. *With respect to Term of Reference 2(a), it is noted that the Board is charged, pursuant to Section 135 of the* Medical Practitioners' Registration Act 2001 *with the function of considering whether an applicant for special purpose registration in an area of need ("an area of need applicant") has a qualification and experience suitable for practising medicine in a given area. The Commission may find that:*

(a) The Board failed to test the clinical skills and knowledge of area of need applicants.

The Board submits that any such proposed finding could not be sustained on the evidence nor be made out as a matter of law. An examination of the scheme of the *Medical Practitioners Registration Act 2001* ("MPRA" or "Registration Act") reveals that the primary role of the Board in processing applications for registration is dedicated to the registration of those who have met the Australian Qualification Standard.[1] Such persons may then seek employment as medical practitioners wherever in this state a willing employer wishes to so appoint them if the registrant chooses not to establish his/her own private practice.

However, in the case of OTD's the process is inverted. OTD's will be attracted to a position in an area of need as a result of an employer seeking an area of need declaration, recruiting for that position then offering a position of employment. The Board is then faced with the role of considering the application for special purpose registration based upon the qualifications and experience "the board considers suitable for practising the profession in the area."[2] The Board is therefore not charged with any mandatory obligation to "test the clinical skills and knowledge" of an area of need applicant.

Thus 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 ("QHealth") during the recruitment and selection process. To effect registration the Board is then charged with the obligation to ensure that the applicant has the requisite qualifications and experience "suitable for practising the profession in the area." This obligation upon the Board requires the exercise of discretion upon facts which are subjective in each case.

But for the instance of Patel's registration which involved fraud, and Berg's application involving suspected fraud, there is otherwise no evidence of the Board failing to discharge its discretionary obligations to ensure that an applicant for Special Purpose registration had the requisite qualifications and experience "suitable for practising the profession in the area" as certified.

The assessment process for OTD's and inherent difficulties in assessing OTD's should also be understood in the context of two fundamental models of assessment whether "time based" or "competency based". Close regard should also be given to the national approach to this problem over at least the period of the last decade.

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[1] See especially Ss 43 - 45
[2] S 135(2) MPRA

The evidence of **Dr Mark Waters**[3], himself a senior staff member of QHealth, contains an argument for competency based assessment of applicants to be implemented in the future rather than "time based assessment" as currently adopted. The draft report of Dr Lennox[4] also makes reference to this issue. Clearly, this new approach to assessment requires a significant shift in the thinking of a broad range of stakeholders and appropriate funding. The Australian Health Ministers Advisory Council (AHMAC) had already rejected a package of similar initiatives proposed to them by the Australian Medical Council ("AMC") in this context to be dealt with in more detail shortly.

To the present, the model for assessment of OTD's throughout Australia has been the "time-based assessment" model. Such a model (of assessing clinical skills and knowledge) involves the assessment of the applicant's CV and referees. This was performed by QHealth, a Recruitment consultant and the Medical Board, acting in combination at the relevant times under examination in this Commission of Inquiry. It accords with a national approach for uniform assessment. It is a matter for government to implement and fund significant changes to a competency-based assessment model. This will require the allocation of significant resources and is not a matter for apportioning blame to any party who has followed the current and accepted time-based model of assessment since at least 1996. See in particular the evidence of **Mr James O'Dempsey**, Executive Officer of the Board as submitted to the Bundaberg Hospital Commission of Inquiry.[5]

The Board was a party to the development of this submission to AHMAC through its membership of the AMC and the AMC's Standing Advisory Committee (The "Joint Medical Boards Advisory Committee"). The evidence of Mr O'Dempsey on these points remains uncontested. The initiatives for improvement that were supported by the Board were rejected at a national level in 1996. However they have since been gradually progressed by the Board. The Commission is urged to have particular reference to **Mr O'Dempsey's** evidence in particular **(Exhibit 28 attachment "JPO-18")** which contains a paper entitled "DEVELOPMENT OF ASSESSMENT PROCESSES FOR OVERSEAS-TRAINED DOCTORS, INCLUDING AREA OF NEED SPECIALISTS" DATED 17 MAY 2005. This paper traces the historical background of the national approach to assessment and registration of OTD's.

See also **paragraph 58** of **Mr O'Dempsey's** statement, **Exhibit 28**, wherein he stated:

"58. *The MBQ is developing the necessary changes to enhance the assessment of overseas-trained medical practitioners whilst at the same time not making revolutionary changes which would directly impact on the supply of medical practitioners to the workforce in Queensland. Broadly these initiatives are:*

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[3] T4646
[4] Exhibit 55, Statement of LENNOX
[5] See Paragraphs 58-61
Exhibits "JPO-18" paragraphs 18 & 19 and "JPO-19" to the Statement of O'Dempsey, Exhibit 28;

- *Since May 2004 the Board implemented a policy, developed in the preceding year, which required all overseas qualified medical practitioners seeking special purpose registration to sit and pass the International English Language Test. This ensures they have the necessary language skills for medical practice.*

- *Since February 2004 the Board has been developing a policy on the 'Requirements of Supervised Practice.'*

- *From July 2006 a national computer administered screening examination will be implemented for all special purpose registrants. The Board has always intended to utilise this screening examination for area of need registrants.*

- *With the introduction of the national screening examination, the online primary source verification of all qualifications will commence. Negotiations for this service are currently underway with the US Education Commission for Foreign Medical graduates".*

See also **paragraph 61** wherein **Mr O'Dempsey** stated:

"61. *A specific document demonstrating the historical background to the problems of area of need registration is evidenced in a 1996 report by the Australian Medical Council to the Australian Health Minister's Advisory Council dealing with a structured system for area of need registration. Annexed hereto and marked* ***"JPO-19"*** *is a true copy of that report. A recent forum on the assessment of temporary resident doctors for general practice hosted by Department of Health and Ageing on 20 April 2005 deals with the issues of a national approach to the assessment of temporary resident doctors. A background paper titled 'Assessment of Temporary Resident Overseas-trained General Practitioners' was published by the Department for that forum. Annexed hereto and marked* ***"JPO-20"*** *is a true copy of this document. The Registrars/CEO's sub-group of the Joint Medical Boards Advisory Committee of the Australian Medical Council produced a position paper for the forum. Annexed hereto and marked* ***"JPO-21"*** *is a true copy of that document. The report on remedial actions which I prepared for the Board's consideration, and which was subsequently presented to the Minister was based directly on the position paper produced by the Registrars/CEO's".*

Dr Gerry Fitzgerald gave evidence[6] that the AMC was currently working on a *"screening knowledge-based test"* which could be applied in an overseas country prior to the individual medical practitioner coming to Australia. It is submitted that, in light of the in-progress nationally-based initiative to introduce a knowledge based screening test for OTD's, the Board should not be

[6] T3182 lines 37-40 and T3184 lines 9-13

the subject of an adverse finding in circumstances where it has applied the current national standard and has, for some time, according to Dr Fitzgerald, been part of the AMC initiative to improve that standard.[7]

Mr O'Dempsey also referred to this national initiative in his evidence[8]. He also explained that a medical practitioner migrating to practice permanently in Australia (not on an "area of need" registration) is required to do the AMC examination for competency to the Australian Standard. He said in evidence[9] that the AMC is not resourced to provide examinations for area of need applicants, and he warned that an examination does not equal performance ability but is only an indicator of competence and safety. He said[10]:

> *"Performance is what happens when you get in clinical practise, and it is having effective supervision. I agree on having examination processes, not to the detail of having to do the AMC exam, but screening safety examination, but having that effective apprenticeship style of supervision that has generally been available in the past to those that are coming up through the system".*

This opinion evidence from **Mr O'Dempsey** remains unchallenged. He also gave comprehensive evidence of international initiatives currently in progress with the International Association of Medical Regulatory Authorities ("IAMRA") to address this issue.[11]

Dr Mary Cohn current Chair of the Board stated[12] that the Board relies upon the Registration Advisory Committee ("RAC") monthly Report in order to make the final decision about the registration of an area of need Applicant. She said:-

> *"The RAC (which is a sub-committee of the Board) relies upon a more detailed examination of the suitability of each applicant for registration. The RAC relies on the OHPRB Registration Staff Officer/s to assess the eligibility of special purpose applications for "general registration" or "area of need" by checking the submitted documentation and ticking off a checklist.*

In evidence, **Dr Cohn** described the RAC as a "very hard-working Committee".[13] Dr Cohn explained that, with the assistance of Board staff, the RAC put forward its recommendations to the Board, with only matters which were not straight forward matters for registration being given an asterisk in the Board papers. She explained that the asterixed matters were then subject to full

[7] T3181 lines 53-55
[8] T505 lines 20-25
[9] T668 lines 40-60
[10] T668 line 58
[11] T534,535
[12] Statement of Dr Mary Cohn Exhibit 33, paragraph 12
[13] T542

Board discussion. She estimated that at Board meetings, between 5 and 14 applicants would be the subject of full Board discussion and the straight forward matters approved by the RAC would be approved as a matter of course.[14] **Dr Cohn** said that, in her experience on the Board since 1998, the asterisk matters were always the subject of robust discussion at Board level. **Dr Cohn** had her attention drawn to the statistics set out in **Mr O'Dempsey's** statement, Exhibit 28, at paragraph 62, wherein refusals of registration varied from 18 in 2002/03 to 45 in 2004/March 2005. **Dr Cohn** said:-

> *"...it reflects the ability of the members of the RAC to be able to look more closely and more carefully at the – matching the job description with the relevant experience and qualifications of the applicant.*[15]

Dr Cohn explained in evidence[16] that at the end of each RAC meeting – which can take between 3 and 4 hours the members collectively discuss the applications for registration which appear to be problematical:

> *"...everybody at RAC level would have looked at the problems first before they – and that may be solved at that level, but if it is not, then it will go to the full Board."*

In **Dr Cohn's** experience, the Board's business is spread equally between the taking of the RAC recommendations, practitioner health assessment matters and practitioner complaint matters.

Dr Cohn's evidence is, in summary, that the Board's processes for assessing qualifications and experience of OTD's, through the RAC, are rigorous and thorough. The RAC and the Board did not act as a rubber stamp.

Dr Waters told the Commission[17] that in June 2004 QHealth took over the Centre for International Medical Graduates ("IMG's") from the University of Queensland and it has been subsumed into the Skills Development Centre, which opened in September 2004. Dr Waters said that there had been consultation with the Medical Board concerning the Skills Development Centre assessing IMG's as to their skill levels and their training needs. Arrangements had also been made with the Medical Board for each IMG to consent to the information arising from training and assessment to be given

[14] T543
[15] T544
[16] T546
[17] T4693, 4694

to medical superintendents and to the Board for the further assessment of IMG's. Dr Waters expanded upon these processes when questioned by Junior Counsel for the Medical Board[18].

Dr David Molloy, then President of AMAQ, also endorsed the initiatives currently under way to assess IMG's at the Skills Development Centre[19]. The only reservation Dr Molloy had was as to the funding model proposed by QHealth, i.e. as to the future funding commitment to this initiative by government.

Dr Molloy also made the following observation during his evidence, specifically in the area of assessment of clinical competence of specialists[20]:

> *"...the Medical Board is not in a position to be an arbitrator of clinical competence in terms of the nuances of standards of specialists and their fitness to practise within the range of a speciality. That would be much better decided by the College in consultation with the Medical Board".*

No finding adverse to the Board is warranted or justified on the evidence, or as a matter of law, in respect of paragraph 1 (a) of the notice. On the contrary, the Board's adherence to applicable national standards for assessing of clinical skills and knowledge of area of need applicants for special purpose registration should be acknowledged. Further the Board's proactive participation in initiatives for improvement of assessment of OTD's, involving the Skills Assessment Centre, the AMC and IAMRA, all, pre-dating this Inquiry, ought to be acknowledged.

1(b) - The Commission may find that:

> ***(b) The Board failed to determine (at least prior to May 2004) the English language proficiency of area of need applicants.***

The Board submits that any proposed adverse finding concerning the English language testing of area of need special purpose applicants for registration cannot be sustained on the evidence.

Mr Demy-Geroe gave unchallenged evidence[21] that prior to formalised English language proficiency testing in May 2004, there was an interview process in place, one of the purposes of which was to assess whether a person had an adequate command of the English language. The Medical Board discontinued the interview process in December 2004. Most importantly the Board led the nation in implementing an objective English language test for OTD's.[22]

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[18] T4695, 4696
[19] T831, 832
[20] T780 lines 49-55
[21] T420 lines 30-50
[22] T423 lines 25-50

Mr Demy-Geroe also said[23]:

> *"...we simply didn't have very many substantiated cases of doctors who couldn't communicate at all – who couldn't communicate to any acceptable level".*

It is therefore submitted that the unchallenged evidence before the Commission is that, until May 2004, the interview of OTD's was properly considered to be a sufficient means of assessing English language skills, in light of the fact that according to the unchallenged evidence of **Mr Demy-Geroe**, the number of substantiated cases of doctors who could not communicate was very low. In May 2004, well before this Inquiry, the Board significantly improved its method of English language assessment. The Board submits that this was a significant initiative because language skills testing moved from being a subjective process to being an objective one as a pro-active initiative of the Board.

In light of the matters detailed, an adverse finding such as that posited in Paragraph1(b) is not warranted and is contrary to the evidence. The Board's initiative in leading the nation in this area ought to be acknowledged.

1(c) - The Commission may find that:

> ***(c) The Board failed, as a matter of routine, to satisfy itself as to the level of supervision an applicant would receive, when such a step might be critical to a consideration of suitability.***

As submitted above it is the primary responsibility of the employer, relevantly QHealth, to satisfy itself that the OTD is selected for an *"area of need"* position which is commensurate to the OTD's skill level and seniority of position as to whether there will be an appropriate level of supervision intended within the hospital. The Board is entitled to expect that appropriate consideration was given by QHealth to the question of supervision of the OTD when a responsible and senior officer from QHealth selects a candidate and then seeks certification of the *"area of need"* position in order to appoint that particular candidate.

In the case of **Dr Patel**, the evidence demonstrates that if a suitably qualified Director of Surgery was in place at Bundaberg Base Hospital at the relevant time, **Patel** as an SMO (Surgery) would, have, *prima facie*, received appropriate supervision from that Director. On the face of the certification of *"area of need"*, the Board was entitled to expect an appropriate level of supervision was intended by the Hospital in the Board's consideration of **Patel's** suitability for *"area of need"* registration in that position. See in particular the evidence of **Dr Mark Mattiussi**[24].

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[23] T421
[24] T 5627-5629

The Board was also generally entitled to expect a high level of supervision of OTD's within QHealth. It is not within the functions[25] of the Board to dictate to any Public Hospital as to how it was to structure its management and utilization of resources.[26] Furthermore QHealth was at the relevant time of Patel's appointment, subject to a Public Service Commissioner directive number 18/97[27] issued pursuant to S 34 of the Public Service Act 1996 which requires:

Directive:

(a) *In order to achieve continuous improvement of performance in the delivery of services as detailed in Part 3 of the Public Service Act 1996, Chief Executives shall implement a performance management system.*

(b) *To achieve the principles of work performance and personal conduct, detailed in Section 25 of the Public Service Act 1996, employees shall actively participate in departmental performance management strategies.*

(c) *Performance management systems should be linked to strategic plans and be directed toward the achievement of organisational goals and objectives.*

(d) *Performance management may be applied to the achievement of both individual and team performance objectives.*

(e) ***A performance management system shall include, at a minimum, the following strategies:***

- ***A performance appraisal and development strategy.***
- *A strategy for acknowledging high levels of performance.*
- *A strategy for the improvement of unsatisfactory performance.*
- *A strategy for managing disciplinary action".* (emphasis added)

This directive is highly relevant to the question of management and supervision within QHealth.

Good examples of close supervision can be seen in the following Board files, which have been supplied to the Commission and which are referred to in detail in Part B of the Medical Board's general submissions:

- 1.3 **Vincent Berg**

[25] See s,11 *Medical Practitioners Registration Act 2001*
[26] Affidavit of O'Dempsey, Exhibit 461, especially paragraphs 3-5

[27] The full text of the directive is annexed hereto and marked "Annexure 1"

- 1.4 **Dr Vitomir Zepinic**
- 1.5 **Dr Thamara Munasinghe**
- 1.9 **Dr Domodaran Krishna (at Toowoomba Hospital) (see statement of Dr Anthony Wilder Ex 482 and T7334)**
- 1.11 **Dr Anatole Kotlovski**

In the latter case, it is apparent from the Board's file that the OTD received close supervision at Royal Brisbane Hospital from eminent surgeons, although during his two-month locum period at Bundaberg Base Hospital ("BBH") in February 2002, there was a lack of supervision, the reason for which was not ultimately explored in evidence.

In his statement,[28] **Dr Kotlovsky**, at paragraphs 21-36, said that he did have supervision from **Drs. Nydam** and **Jayasekera**, but that the latter had expressed resentment at having to provide supervision without remuneration. Though these statements have not been able to be put to **Jayasekera**, and should not be used as a basis for any adverse finding against **Jayasekera**, the statement demonstrates two important aspects of the supervision issue:-

1. QHealth supervision can break down without the Board becoming aware of it; and
2. The excellent references provided by **Dr Kotlovsky** bear eloquent testimony to the level of supervision he received at RBH and PA Hospital.

The evidence reveals possibly unsatisfactory instances of supervision of 2 OTD's apart from **Dr Patel**, these being **Drs Sharma & Krishna**. However, in the assessment of their suitability for the position, the Board was presented with information by the employer, QHealth, that they would be supervised by the Director of Orthopaedics, **Dr Naidoo**. See in particular for example Exhibits 360 and 361, wherein the Board was advised that a prima facie appropriate person, **Dr Naidoo**, was the supervisor of the OTD. The fact that possibly unsatisfactory supervision resulted from **Dr Naidoo's** many authorised absences in the period 2003 – 2005 is not due to any act or omission by the Board, nor is it a matter of which the Board could have become aware, unless an appropriate complaint was received from some party. Although **Dr Mullen** said he had such complaints about **Drs Sharma** and **Krishna**, he chose not to address those complaints about supervision to the Board.

As **Mr Demy-Geroe**, Deputy Registrar of the Board, explained in evidence under examination from Senior Counsel Assisting[29]:

[28] Exhibit 484
[29] T492 - 493

"I think in the hospital structure generally one expects that there is supervision at all levels ...

Q: The employer didn't specify supervision available, in that respect, was that Form 1 deficient or is that how they are regularly left?

A: I think in the case of hospitals they are sometimes left like that and at that time that wouldn't have raised any concerns because, again, as I have indicated, there was an expectation that hospital's are a supervised environment..."

Mr Demy-Geroe agreed with Senior Counsel Assisting that it would be feasible for annual re-registration applications to require the applicant to obtain from the employer a certificate as to the degree of supervision that the certifier has exercised[30]. **Mr Demy-Geroe's Affidavit,**[31] demonstrates that current requirements for supervision are much improved and are evidence of the Board's ability in the circumstances to progress revolutionary change as mentioned above.

No adverse finding is warranted. The Board's recent initiatives in strengthening supervision requirements ought to be acknowledged.

1(d) - The Commission may find that:

(d) The Board failed, in particular, to require that the applicant identify the person who was to provide any supervision in order to assist in considering the applicant's suitability for practise.

With respect, the adverse finding posited in (1)(d) of the Notice misconceives the person upon whom the requirement rested at the time of the events under investigation. At the relevant time, the Board required the employer to specify the supervision available. The applicant for registration was not required to certify as to supervision available.

The employer, QHealth, by nominating the position by way of its position description and by nominating the applicant, by way of his qualifications as a medical practitioner, for special purpose (*"area of need"*) registration, in effect identified to the Board that the supervisor or supervisors would be the medical staff senior to the OTD in the particular hospital structure. For example, if the OTD was nominated for registration as an *"SMO-Surgery"*, then the Board was entitled to take the view that the staff specialists and generalists senior to the SMO would be his/her supervisor/s. Before the Commission even contemplates making an adverse finding as posited in 1(d), it is urged that the Commission examine carefully **Exhibits 360 and 361**, as well as the relevant Exhibits from the Affidavit of **Mr O'Dempsey Exhibit 461**: see in particular **Exhibit 361**, the "Form 1", where the employer, not the applicant, is required to certify as to:

[30] T493
[31] Exhibit 420

"Supervision available"

"Consultant advice available"

See **Exhibit 360**, where upon re-registration, the Assessment Form imposed obligations upon the employer as follows:

- *"assessment form must be completed by the clinical supervisor or mentor nominated on the Area of Need Certificate or training program approved by the Board.*
- *The clinical supervisor or mentor must currently hold General, Specialist or Special Purpose Section 138 registration with the Board.*
- *The assessor is to attach a brief explanation as to how the supervision or monitoring was undertaken".*

The Board's improved processes (as detailed in Ex 420 – Supplementary Affidavit of **Mr Michael Demy-Geroe**) spells out the exhaustive processes which have been adopted.

In fairness to the Board the ability to have sought timely legislative amendment, as for example the increase in penalties for false or fraudulent applications for registration, would not have realistically been available but for the high degree of public attention created by the Commissions of Inquiry. The Board's ability to affect change in registration processes when considering potential interests of all other relevant stakeholders should be seen in this light rather than as an opportunistic and reactive approach. An example of this is evidence from the Board's recommended change to the law as detailed in the Affidavit of **Mr O'Dempsey, Exhibit 28:** JPO-14, Paragraph 13. However, it took the interim report of the Bundaberg Hospital Commission of Inquiry – for legislative change to take place.

The Board submits that this issue should be considered as against practices existing at the relevant time, without the benefit of hindsight. An adverse finding would be misconceived and not based on the evidence.

1(e)- The Commission may find that:

(e) The Board failed to make inquiries of referees nominated by the applicant into the applicant's suitability for a position.

As submitted above the primary responsibility for making inquiries of referees nominated by applicants for special purpose *"area of need"* registration, lies with QHealth which has the task of matching *"area of need"* applicants to *"area of need"* position descriptions within the public hospital system. QHealth is in the best position to know the requirements of the position description.

The obligation for reference checking for the filling of a job position is clearly one which sits with an employer. Reference checking necessarily involves the job applicant giving consent either expressly or impliedly to a prospective employer or agent to contact any nominated referee and canvass confidential information about the candidate pertaining to the position.

In the case of a recruitment agency being used for the recruitment of a doctor to fill the position ultimately filled by Dr Patel it is submitted that there was an implied contractual obligation upon **Wavelength Consulting** to QHealth to diligently carry out appropriate reference checks upon Dr Patel. The express terms of the contract of agency between QHealth and Wavelength Consulting are in evidence.[32]

Whilst the contract is silent on the specific duty of **Wavelength Consulting** to carry out the reference checks it is clearly implied that **Wavelength Consulting** was under a duty to carry out those checks. First neither QHealth nor Dr Nydam carried out any reference checks on Dr Patel. Secondly they were in fact (at least in respect of 2 referees) carried out by **Wavelength Consulting** which suggests a duty on the part of **Wavelength Consulting**. Thirdly and most importantly paragraph 9.2 of the contract of agency between **Wavelength Consulting** and QHealth provides under the heading

"Warranties and Limitations of Wavelength Liability

9.2 Wavelength will refer Candidates to the client on the basis of the information provided to it by the Candidate. Wavelength will use reasonable endeavours to establish accuracy of information provided by the Candidate, however the Client must make and rely upon its own enquiries will (sic) regard to matters the Client considers relevant in determining to engage the Candidate."

The Board was as it turns out justified in having an expectation that the reference checks had been diligently carried out either by QHealth or the recruitment agency as would normally be expected to be the case.

[32] see attachment to statement of Dr Nydam Ex 51 – KN8) which is the contract of agency. These conditions post date those contained in the document in evidence - exhibit 42

Indeed, **Dr Nydam** said in evidence[33] that, because **Patel** was seen by him as a locum, a fact not known to the Board, the ordinary selection processes for permanent employees were bypassed for selection of a temporary employee. The requirements for selection processes in public service appointments (other than temporary employees) are contained in Public Service Commissioner Directive (01/04) of 5 April 2004 which is annexed hereto and marked "Annexure 2".

The Board has always relied, and is entitled to rely, on Public Sector employers, meeting their legal obligation under the *Public Service Act* and any Directives issued pursuant to that Act, in regard to the processes of recruitment and selection of candidates for a position, including appropriate reference checking. In any event, the referees were *"glowing"* according to **Dr Bethell.** In fact, **Dr Bethell** said in evidence that when he returned to the two referees, one said he did not know of the Oregon orders and the other declined to speak to him about it.[34]

Dr John Bethell[35] said in evidence that he had made contact directly with the two referees cited by **Dr Patel** in the course of seeking employment as an OTD through **Wavelength Recruiting.** The third referee did not work with **Patel**, so was not spoken to. The references were "glowing".

Mr Demy-Geroe[36] also gave evidence about the practise of contacting referees of applicants for special purpose *"area of need"* registration.

The Commission is asked to note the frank and full disclosures made by the Board to **Minister Nuttall** in a Memorandum dated 13 April 2005.[37] This Memorandum followed a detailed investigation by **Mr Demy-Geroe** of the circumstances of the registration of Patel.

There is no other evidence in relation to any other *"area of need"* applicant, to the effect that inquiries of referees nominated by the applicant were not made by the Board or by the Recruitment Agency involved, or by QHealth, in the process of assessing the applicant's suitability for a position.

The Commission has not received any evidence that there was a systemic failure by the Board to make inquiries of referees, or to see that they were made.

The Commission received evidence that **Dr Kees Nydam** and **Mr Demy-Geroe** had the belief that, from their previous experience, **Wavelength Consulting** were a superior service and reputable.[38]

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[33] T4120
[34] T705
[35] T680, 681, 696, 704, 705, 761-762
[36] T426,486
[37] Exhibit "MDG-3" to the Statement of Mr Demy-Geroe, Exhibit 24.
[38] T4137 and Statement of Mr Demy-Geroe Exhibit 24 – "MDG-3" (paragraph 2.3)

Dr Nydham, for his part, attempted to explain his own reasons for not performing referee checks, and he may be correct as a matter of law.[39]

In all of the above circumstances, it is submitted that a finding adverse to the Board is not warranted on the evidence, because the evidence is that full inquiries with referees were made by **Wavelength**, in the case of **Patel**, and no other evidence of systemic failure has been presented.

1(f) - The Commission may find that:

> ***(f) The Board failed to make inquiries of the applicant's last known employer to assist in the consideration of the applicant's suitability for a position.***

Dr Bethell of **Wavelength Consulting** gave evidence[40] that he made direct contact with **Dr Patel's** referees, at least one of whom worked at the Kaiser Permanente Hospital at Portland, Oregon with **Patel**, once or twice a week over 10 years. That is the best that can be said of the checking that was done. If the checking had included the last known employer – the administrators of Kaiser Permanente – there is a higher likelihood, though not a guarantee, that **Patel's** apparent fraud would have been discovered.

Directive 01/04 was issued for the Public Sector in April 2004. Therefore, as at December 2002, there was no legal requirement for QHealth to check with the former employer as part of the recruitment and selection process. It is hardly fair to criticise the Board itself for failing to make inquiries with the last known employer in circumstances where:

(a) there was no legal obligation upon QHealth or the Board to do so; and

(b) if there was a practical obligation, then it rested with QHealth in the first instance; and

(c) As **Mr Demy-Geroe** said in evidence, the sheer numbers of applications for area of need registration made it impractical for the Board staff to check with the previous employer; and

(d) There has always been the risk that, for their own purposes, employers may choose not to disclose some prior negative history; and

(e) The Board's current requirement to receive original Certificates of Good Standing direct from the issuing authority is a more reliable safeguard.

If the Government, as at December 2002 had not thought to mandate the requirement posited in paragraph 1(f) (until April 2004), the Board should not be criticised for this failure.

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[39] T4138
[40] T696

The Board submits that the Commission should note the evidence of **Dr Kees Nydam**[41] to the effect that it had crossed his mind *"quite early in the piece"* that if **Dr Patel** was as skilled and experienced as he claimed, it was unusual that he would take a position in Australia for a substantially reduced remuneration package. **Dr Nydam** conceded in evidence that this was an *"error of judgment"* and that he had made a further error when he took Patel's explanation for this decision at face value:

> *"His (Patel's) explanation was he had worked hard, he had earned a lot of money, and now it was time to give something back".*

It should also be taken into account that **Dr Bethell** was misled when a 12 month gap in **Patel's** employment was dealt with by Patel dishonestly amending his *curriculum vitae*, and forwarding a second misleading CV to QHealth.[42] This dishonesty was not exposed by **Dr Bethell** or QHealth by way of taking up inquiries directly with the previous employer. The fact that QHealth ultimately presented the "new CV" to the Board as a component of Patel's application highlights the *"inverted process"* for registration of OTD's previously referred to. It also highlights QHealth's primary practical, if not legal, obligation.

In all of the above circumstances, the Board does not accept that it had a duty to make inquiries of **Dr Patel's** last known employer. Such a duty now rests with the prospective employer, QHealth, only after April 2004, and only if the recruitment and selection process is not for a casual position such as a locum position.

1(g) - The Commission may find that:

> ***(g) The Board failed to conduct internet searches to ascertain whether any disciplinary proceedings had been brought against an applicant.***

Mr O'Dempsey outlined in his statement[43] that internet checks are by no means a reliable method for the validation of the records of overseas trained medical practitioners, or of any registrant who has practised overseas at any time in his or her career. **Mr O'Dempsey** cited a number of reasons for this inherent unreliability:

- Overseas jurisdictions do not always post registration data relating to its registrants on the internet; and
- Overseas jurisdictions do not always record on the internet whether any conditions of practice have been imposed; and

[41] T4137
[42] T717
[43] Exhibit 28 paragraphs 42 and 43

- Even if such information were to be posted, there is the possibility that it is out of date or erroneous.

Mr O'Dempsey's evidence is unchallenged, and supported by the unchallenged evidence of **Mr Demy-Geroe**, who spoke of the time-consuming and potentially inaccurate nature of such searches. He also made the valid[44] point that many internet entries are in a foreign language and also that there are inherently irrelevant pieces of information which can come back from an internet search[45].

The Commission should note the unchallenged evidence contained in **Mr O'Dempsey's** statement **Exhibit "JPO-13"** in **Exhibit 28**: Summarised herein it indicates that in April 2005, 6232 internet entries for Queensland OTD's registered at that time revealed no irregularities and numerous references to persons other than the OTD, but with identical names.

It is submitted that an adverse finding in relation to the failure to conduct internet searches should not be made in light of the unchallenged evidence as set out above, and in light of the fact that in the period 1 July 2002 to March 2005, a total of approximately 8,876 applications for *"area of need"* registration were approved by the Board[46].

1(h) & (i)Commission may find that:

(h) ***The Board adopted a practise of accepting certificates of good standing, and copies of other certificates or qualifications, from applicants rather than from the issuing bodies, being a practise which permitted fraud.***

(i) ***The Board failed to require that an applicant arrange for a certificate of good standing to be supplied from each jurisdiction in which the applicant had practised.***

At the time of the registration of **Dr Patel**, and until recently, certificates of good standing were not obtained from the issuing bodies, and certificates were not required from each jurisdiction in which the applicant had practised.

It should be noted that **Dr Bethell** of Wavelength said in his witness statement[47] that although **Dr Patel** originally faxed his Verification of Licensure, he subsequently sent the original of the document.

See also the evidence of **Mr O'Dempsey** on this issue.[48]

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[44] T456 and T458-459
[45] T459 line 40 where for example a disciplinary matter involving a polo club might be irrelevantly found
[46] Statement of O'Dempsey, Exhibit 28 Paragraph 62
[47] Exhibit 41, paragraph 17

The Board does not accept that it had a duty to accept Certificates of Good Standing directly from the issuing bodies, nor does it accept that it had a duty to arrange for a Certificate of Good Standing to be supplied from each jurisdiction in which the Applicant had practised. It does acknowledge that, in the context of **Patel**, who was acting apparently fraudulently in his dealings with **Wavelength Consulting**, his fraud would have been detected if the above procedures had been carried out.

The Board concedes that it is a better procedure to receive COG's directly from the issuing authority. It is to the Board's credit that, in the course of this Inquiry, it has instituted tighter procedures to minimise this risk of fraud. It is also to the Board's credit that, in its Memorandum dated 13 April 2005[49], it frankly identified this issue to the Minister and a full public acknowledgement and apology from the Board followed in the public media.

If an adverse finding is to be made about the Board's procedures, as a matter of fairness, the Board's swift response and handling of the problem when the issues became known should also be acknowledged.

1(j) - The Commission may find that:

> ***(j) The Board did not otherwise carry out adequate inquiries to ensure that applicants would be sufficiently competent to fill any proposed position.***

Precisely the way in which the Board failed to *"otherwise"* carry out adequate inquiries to ensure the competence of *"area of need"* applicants, is not specified, nor is the Board aware of any other evidence about any other inquiry that the Board could have made in order to determine competence of *"an area of need"* applicant in respect of the matters under inquiry.

In the absence of any further particularity, the Board is unable to make any further submissions. Therefore an adverse finding in terms of this paragraph of the notice is unsustainable.

1(k) - The Commission may find that:

> ***(k) The Board failed to implement any system for monitoring the performance of area of need applicants during the term of their registration, whether by the imposition of conditions or otherwise.***

The Board submits that it is not correct to suggest that there was no system for monitoring area of need applicants. That system consisted of the following:

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[48] T502 - L25-30, 503
[49] Exhibit "MDG-3" to statement of Demy-Geroe, Exhibit 24

- Employer notification that supervision was available[50]
- Instructions to employers in the renewal "Assessment Form"[51]
- Complaints mechanism provided pursuant to the *Health Practitioners (Professional Standards) Act 1999*[52]
- Board's periodic follow-up of OTD's efforts to seek Australian Specialist College accreditation[53].
- In addition the Board was entitled to expect an appropriate level of supervision within QHealth. In this regard QH has legal obligations pursuant to Directive 18/97 issued under S 34 of the *Public Service Act 1996*.

The proper credentialing and privileging of **Dr Patel** before or after his arrival in Bundaberg was also a matter for QHealth. The Medical Board was entitled to rely upon the proper implementation by QHealth of the Queensland Health Policy Statement on credentialing and privileging[54].

The Commission has received no evidence to suggest any further method for monitoring of OTD's with special purpose registration in an *"area of need"* , over and above the provision of the credentialing and privileging process, the provision of appropriate supervision, and the framework set out above.

The Board was also entitled to rely upon the existence, within QHealth, of a system for identifying and reporting *"sentinel events"* and *"adverse incidents"*. This provided a further internal mechanism for monitoring of IMG's by QHealth.

The Board's file on **Dr Tariq Qureshi** demonstrates the speed with which the BBH notified the Board of suspected sexual misconduct by **Dr Qureshi**. This is eloquent testimony to the monitoring system at work as for that matter are the files relating to Berg, Zepinic and Munasinghe. These are examples of usual and expected monitoring procedures at work.

Upon the substance of any adverse report of an OTD being made out, there would then be evidence upon which the Board would be able to reassess the registration of the OTD, or impose conditions upon registration. The Commission has received no evidence to suggest that the Board is guilty of a failure to implement some additional system for monitoring the performance of *"area of need"* special purpose applicants for registration during the term of their registration. The Board is unaware of any evidence upon which an adverse finding in this regard could be based.

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[50] See for example Exhibit 361
[51] See for example Exhibit 360, three "dot points" referred to above.
[52] See Board's Submissions PART A, Section 1.6 re Dr Qureshi.
[53] See evidence of Dr Younis, T3779
[54] Exhibit 279

1(l) - The Commission may find that:

(l) The Board failed to ensure that it has adequate resources to appropriately process the area of need applications that came before it

There is no evidence to suggest that the Board's handling of and processing of area of need applications was in any way systemically deficient. Thus there can be no inference that the resources as dedicated were inadequate to deal with area of need applications in any financial year. In fact in all of the evidence before the Commission the highest any suggestion comes to full utilisation of resources was with reference to the peaks of timing when area of need registrations are at their highest[55].

On a general note funding of the Board is a matter for government through the fees established in the *Medical Practitioners Registration Regulation 2001*. It is through the fees set by government that the Board receives the overwhelming majority of its funding to implement the functions under both the *MRA* and the *Health Practitioners (Professional Standards) Act 1999*.

The Board identified that further resources were necessary to implement its reforms to processing applications for special purpose registration. A recommendation in this regard was made to **Minister Nuttall**. The statement of **Mr O'Dempsey Exhibit 28: JPO-14, Attachment A, Paragraph 12**, refers.

The statement of **Mr O'Dempsey (Exhibit 28)** paragraphs 5-7 describes the legislative relationship between the Office of Health Practitioner Registration Boards (OHPRB) and the Medical Board. It annexes the annual reports of the Office of Health Practitioner Registration Boards for the period 2002 to 2004 (JPO 2- JPO 5). Of particular importance is an extract from the OHPRB report to the year ended 2004 which is publicly available and annexed hereto and marked "Annexure 3". In these reports to government issues of resourcing are shown to have been regularly addressed as detailed below:

- JPO 3 – pages 4 and 5 demonstrate that the schedule to the service agreements was reviewed and modified to ensure appropriate billing of staff time to each board; apportionment of non-salary costs was directly linked to staff usage by each board; and cross-subsidisation between the boards was minimised.

[55] At the beginning of each calendar year - evidence of Demy-Geroe T417 – Lines 1-10

- JPO 3 – page 13 reports that an investment policy developed by the office had been approved by each board and that this policy would result in increased interest revenue for all boards.
- JPO 3 – page 13 reports that recurrent costs of the office and each board had been reviewed and from this review, changes had been implemented resulting in significant recurrent cost savings.
- JPO 4 – page 6 reports that the establishment of a renewals and restorations business processing centre had resulted in a reduction in salary costs equal to the equivalent of 1.4 full time casual positions.
- JPO 4 – page 10 reports that based on a cost benefit analysis for use of external investigators the Board established a panel of contract investigators through a competitive tendering process to clear the backlog of investigations.
- JPO 4 – page 17 reports that a review of the financial management infrastructure had been undertaken and details the changes to be implemented to enhance financial management and corporate governance. In addition, the report details a further initiative of implementing Board specific merchant facilities which in part ensured that Board interest revenue would increase.
- Annexure 3 – page 6 reports that a jointly funded project for review of registration processes had been established in partnership with the integrated service delivery unit of the Department of Innovation and Information Economy.
- Annexure 3 – Page 16 reports that an objective to be achieved in the following year was *"to inform, negotiate and implement a realistic policy for fees established under the regulations of each registration act"*.
- Annexure 3 – Page 19 reports that the quality improvement in the financial management and reporting framework had been fully implemented, resulting in a more effective use of staff resources and enhanced corporate governance. A report has also provided that a model enabling 5 year financial projections had been developed and fully implemented. It was further reported that the model enhanced corporate governance and enabled each board to:

- Consider their medium to long term financial projection in both the development and approval of the annual budget;
- Incorporate a simple, cost effective and regular budget review process; and
- Model the cost of proposed initiatives to informed decision making.

- JPO 5 – Page 10 reports on progress for the development of a submission to the Minister for a change in government policy on fees established under the regulations of each registration act. It is further reported that the office has continued to progress relevant fee increases consistent with the current government policy.
- JPO 6 is a copy of a submission made to all boards which has been subsequently approved. It documents the outcomes of the registration review project and, in particular, paragraph 17 advises that a net savings of $2,382,348.00 would be generated over 10 years should the boards implement the outcomes of the project.
- Paragraph 19.2 of JPO-6 also documents that funding of $1,250,000.00 on an interest free repayable basis for the development of proprietary software was being sought from Queensland Health as the current income arrangement for the boards and the reserves available limited the possibility of boards investing such an amount in any one financial year.

Funding of the Board is ultimately a matter for Government. In the Reports to Government of the OHPRB from the years 2002 – 2004 (Publicly available on the OHPRB website), issues of funding of the functions of the Office can be shown to have been regularly addressed.

It is also noted that a specific grant was sought in respect of funding research into the issue of safe working hours for doctors.[56] Thus the Board was, particularly from the year 2002 onwards, acutely aware of its funding and resourcing needs and pro-active in addressing those needs. The Board submits therefore that there is a clear body of evidence to suggest that any such proposed adverse finding is not sustainable nor justified on the evidence.

1 (m) **The Commission may find that "the Board failed to comply with good practise, the National Policy document entitled Assessment Process for Area of Need Applicants (see Exhibit 36), or the legislative intent of Section 135 and 143A of the Act, in that:**

[56] Exhibit 229 (a request for funding is made in respect of this important study)

(i) Where an application would result in the applicant becoming a deemed specialist, it should only be approved following consultation with the relevant College and pursuant to such conditions as the College might recommend;

(ii) Section 135 and 143A, when read together, provided that, where the Board registered an applicant "to practise the profession in a specialty in an area of need", the applicant was deemed to be a specialist;

(iii) The Board regularly registered applicants to practise in positions such as a "Senior Medical Officer in Orthopaedics" or a "Principal House Officer in Obstetrics and Gynaecology";

(iv) The effect of such registration was that the applicant, by operation of Section 143A, became a deemed specialist.

(v) Where it so acted, the Board failed to consult with the relevant College either adequately or at all.

The Board rejects the suggestion that any registrant, through area of need special purpose registration, in any circumstance was improperly processed such that he/she became a "deemed specialist" under S 143A of the MPRA.

There can be no doubt that the conduct of the Board in considering registration of in an area of need under special purpose S135 registration per se in circumstances where the registration certificate will read such as *"Senior Medical Officer in Orthopaedics"* or *"Principal House Officer in Obstetrics and Gynaecology"* does not have the effect by operation of Section 143A of deeming that applicant to be a specialist.

Neither Sections 135 nor 143A of the Registration Act have yet been the subject of judicial construction.

It is submitted that an analysis of the operation of each of Sections 135 and 143A will demonstrate that the Board's processes as evidenced in the Affidavit of **Mr O'Dempsey - Exhibit 461** result in the proper registration of registrants as intended and provided under the relevant law.

(a) Ministerial decision as to *"area of need"* is a condition precedent to special purpose registration.

For S135 to be invoked requires a ministerial decision as to there being an "area of need for a medical service in a particular area of the State."

S143A of the Registration Act did not have an equivalent provision in the former *Medical Act* nor in the Registration Act as it was originally enacted. The provision of Section 143A was inserted into the Registration Act prior to the commencement of the operative provisions of that Act in 2002[57]. It is submitted that the amendments made to the Registration Act prior to commencement were primarily driven by a need to enable Queensland to conform to a proposed national scheme for the assessment of overseas trained specialists seeking registration to practise in an area of need. The Minister advised the House in the second reading speech:

(b) The amendment to insert Section 143A

"The Bill contains amendments to the Medical Practitioners Registration Act 2001. *The amendments are necessary to facilitate a proposed national scheme for the assessment of overseas trained specialists seeking registration to practise in an area of need. Under the scheme, overseas trained specialists who are granted special purpose registration by the Medical Board of Queensland to practise in an area of need would be subject to periodic assessment by the relevant specialist college. The scheme envisages that the Board will change the conditions of registration if the results of a college's assessment indicate this action is necessary. However, the current provisions of the Act only allow the Board to change the conditions of registration on renewal of registration, which could be up to one year after a College's assessment. The Bill overcomes this difficulty by enabling the conditions on special purpose registration to be changed during the term of registration if this is necessary for the registrant to practise safely and competently. The Bill also provides that area of – need – specialists, who have special purpose registration, are deemed to also have specialist registration. Deemed specialist registration will be necessary for appointment to public sector specialist positions and for specialist recognition under the* Health Insurance Act 1973"

It can thus be seen that the amendment by adding Section 143A facilitated the appointment of area of need special purpose registrants to public sector specialist positions and the securing of specialist recognition of these persons for the purposes of the *Commonwealths Health Insurance Act 1973*. That Commonwealth Act provides for the payment of specified benefits for the provision of medical including specialty services by approved providers.

(c) The scope of Section 135 – *"Medical Service*

[57] *Medical Practitioners Registration Act 2001*, Act No. 7 of 2001, date of assent 11 May 2001 Sections 1-2 commenced on date of assent. Sch.2, AMDT 1 of the *Health Practitioners (Professional Standards) Act 1999* commenced 12 May 2002 (automatic commencement under the *Acts Interpretation Act 1954*, Section 15DA(2)(AMDT could not be given effect) (remaining provisions commenced 1 March 2002)(2002 SLNo.30)

"It is submitted that Section 135 of the Registration Act is not directed just to the registration of those people who will provide specialist services in an area of need. The language employed in ss.135(1), 135(3) and 135(4) is *"area of need for a medical service"*. The term *"medical service"* is not expressly defined in the Registration Act and neither is the term *"specialist medical service"*. The term *"professional service"* is expressly defined – "***professional service*** *means a medical service, including a specialist medical service"*[58]

It is submitted that a *"specialist medical service"* is a subset of a *"medical service"*. This is implied in the definition of *"professional service"*. It is also explicit in the Act's definition of *"speciality"* – speciality means a branch of medicine prescribed under a regulation to be a specialty[59]

(d) The effect of s.139(2)

A conclusion that special purpose registration, including special purpose registration under s135 is not confined to the practise of a specialty is consistent with the use of the conditional tense in s139(2) of the Registration Act with respect to the details for the inclusion of which a special purpose registration certificate must provide:

"(2) The approved form for a certificate of special purpose registration or certificate of provisional special purpose registration must also provide for the inclusion of –

(a) details of the special purpose and activity for which the registrant is registered; and

(b) ***if the special purpose involves the practise of a specialty, details of the specialty" (emphasis added)"***

It is submitted that there is nothing in the Minister's second reading speech to suggest that all practitioners registered under s.135 were to be deemed specialists under 143A. Neither the second reading speech, nor the construction of the scheme of the legislation, can justify this conclusion.

It therefore follows that it is not legitimate to construe the statement in s143A(1) as to the application of s143A as an indication that s135 is confined in its operation to the special purpose registration of a person *"to practise the profession in a specialty"*. It sits equally comfortably with the language of s.143A(1) to construe it as applicable only to those

[58] Definition, S8 and Schedule 3 *"dictionary"*, Registration Act
[59] Ibid. As to what a *"specialty"*, Section 6 of the *Medical Practitioners Registration Regulation 2002* provides 6 specialties – Act, Sh.3, Definition "**specialty**"
For the definition *"specialty"* in Schedule 3 of the Act, a branch of medicine mentioned in Schedule 1, Column is a specialty.

particular s135 special purpose registrants whom the Board has registered to practise the profession in a specialty in an area of need. Those whom it has registered under s135 just to practise the profession and without reference to so doing in a specialty fall outside the deeming regime for which s143A makes provision.

Thus, special purpose registration under s135 does not, on the true construction of the Registration Act, automatically engage the deemed specialist registration for which s143A makes provision. It will be necessary to consider further what is meant by the words *"to practise the profession in a specialty"* in s143A when considering whether the Registration Act may have the consequence that those special purpose registrants whose position is in a specialty area of medicine are nonetheless deemed to be specialist registrants by that section.

(e) The need for a *"medical service"* is the core of the ministerial decision.

What informs the making of a ministerial *"area of need"* decision is not geography per se but rather a need for a medical service in a particular locality. That service, for the reasons given, may or may not be a specialist medical service. In notifying his decision to the Board in conformity with s135(4), the Minister must notify both the area and the associated medical service need in that area. The notification of all that information is necessary for the Board to be able to conform to the requirements imposed on it by s139(2) of the Registration Act in relation to the details that must appear on a special purpose registration certificate.

It is submitted that as a matter of language, the words *"in orthopaedics"* and *"in obstetrics and gynaecology"*, each read in isolation, refer just to a branch of medicine. As used by the Board, these words form part of a position description (which is developed and approved by Queensland Health) and are descriptive of the branches of medicine in which the special purpose registrant is to practise in one or other of the nominated offices – eg. JHO, PHO or SMO etc.

(f) The descriptors of the *"area of need"* position

The nominated offices have a long standing meaning in the medical profession and, through the usage of those descriptors, in the broader community.[60] *"Medical"*, when employed adjectivally with *"officer"* to create the term *"medical officer"* yields nothing more than a term meaning *"a doctor appointed by a company or public authority to attend to matters relating to health"*. The term has never carried the connotation that the holder of such an office, so described, is a medical specialist. As a matter of ordinary language, the

[60] Refer to Affidavit of James Patrick O'Dempsey paragraph 3

adding of a reference to a specialty field to each of these nominated officers does nothing more than indicate the branch of medicine in which the medical officer or, as the case may be, the house officer is to be employed.

(g) Further observations upon the scheme of the Act – the effect of ss.143A(4) and (5)

S143A clearly is intended to have the consequence that a person registered for that particular special purpose will be deemed to be a specialist registrant. The occasion for the insertion of that section prior to the commencement of the amendment act, as revealed in the secondary materials referred to above, makes it abundantly clear that this was Parliament's intention. The section bears the explicit stamp of that intention in the exemptions found in ss.143A(4) and 143A(5) from the ordinary specialist resident registration pathways in the Registration Act. These subsections deal with exemption from formal requirements for specialist registration and other formal requirements of registration. These are designed to engage with the national scheme for overseas recruitment and specialist college advice to which the Minister referred in her second reading speech.

(h) Conclusion

It is submitted that it would be inconsistent with the evident scheme of ss135, 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.

It is therefore submitted that the Commission will upon a careful analysis of the provisions and the detailed submissions above, determine that there can be no criticism of the Board's conduct in relation to its processing of the special purpose (area of need) applications for registration and the basis upon which the Board processes applications for deemed specialist registration where it is clearly appropriate to do so pursuant to s.143A of the *Medical Practitioners Registration Act*.

The Board rejects any suggestion that it failed to comply with its obligations. The process of consultation with the relevant College is well known and accepted by the Board (see paragraphs 31-37 and 39) in the Affidavit of **Mr O'Dempsey – Exhibit 461** wherein the Board has followed a rigorous and patently distinct procedure in dealing with an application for *"deemed"* specialist registration. Clearly the process followed to affect a *"deemed"* specialist registration in an area of need was in accord with the national pathway and in reliance upon College assessment.

It is submitted that a registrant who is registered pursuant to Section 135 does not attract *"deemed"* specialist registration where he/she is simply being placed in a position within a particular

department of a hospital. (See description of positions within various departments of hospitals – Paragraph 3 Affidavit of **Mr O'Dempsey - Exhibit 461**).

The Board in its correspondence confirming the fact of registration to any special purpose (area of need) registrant reiterated in the correspondence to the registrant that he/she was *"not registered as a specialist"*.

The Board, whenever dealing with an application for *"deemed"* specialist registration would consult the relevant College (Paragraph 33 Affidavit **Mr O'Dempsey**). It must be pointed out that this process is initiated through the College by the relevant employer in accordance with the nationally agreed protocol.

The Board had no reason or obligation to consult with any of the relevant Colleges in respect of any of the special purpose (area of need) applications for registration other than bona fide applications for *"deemed"* specialist registration.

2 - With respect to Term of Reference 2 (a) and with respect to the Board's assessment, registration and monitoring of Dr Jayant Patel, the Commission may find that:

(a) **Dr Patel acted fraudulently in completing his application for registration in that he falsely maintained that his registration in other jurisdictions had not been cancelled, suspended, or subject to an undertaking of a condition when the same was not true;**

(b) **Dr Patel's application for registration included a document entitled Verification of Licensure from the State of Oregon Board of Medical Examiners which containing a notation:**

"Standing: Public Order on File See Attached."

The Public Order was not attached but the Board, by its staff, failed to note that omission or to make enquiries into the terms of the said Public Order. If the Public Order had been obtained and perused, it would have revealed that Dr Patel had been restricted from performing surgeries involving the pancreas, liver resections, and ileoanal reconstructions, and it may have led to the application being rejected or approved subject to stringent conditions.

(c) **As a result of the Board's failure as described in above, Dr Patel's fraudulent conduct was not revealed.**

Exhibit 421 is the duly certified Police statement of the original assessor of Patel's application, **Ms Ainslee McMullen.** She was at that time an employee of the Board, and the Board's most *"experienced and reliable registrations officer at that time".*[61]

In her Police statement dated 27 June 2005[62], Ms McMullen said:-

> *"On the original checklist, there is a section which asks, "under investigation or conditions/undertakings in place" with the options of either circling "yes", "no", or "N/A". To this question I have circled "No". This response is based to (sic) the fact that I did not observe any reference to any investigation, condition, undertaking or disciplinary action on any of the documents supplied by PATEL.*
>
> *From my experience, a Certificate of Good Standing ("CoGS") is either granted or not. The "Verification of Licensure" as supplied by PATEL was taken by me to be the equivalent of a CoGS. I can't recall observing anything untoward on PATEL's "Verification of Licensure" that warranted me performing further inquiries. In PATEL's application form, there are also questions concerning his "Fitness to Practice". In this area, the applicant makes declarations including the status of their registration overseas and whether it has been the subject to (sic) any undertaking or the imposition of a condition, suspension or cancellation or in any other way. There is also a declaration concerning whether their registration as a Medical Practitioner had been cancelled or suspended. To both these questions, PATEL has crossed the boxes marked "No".*
>
> *These factors made me believe that Patel's application and "Verification of Licensure" were legitimate. If PATEL had ticked any of the boxes "yes", I would have made the appropriate enquiries and passed on the information to the RAC for their consideration. Had I been aware of the previous disciplinary history of PATEL, I would have bought (sic) it to the attention of the RAC for their further investigation and consideration."*

In his Memorandum dated 13 April 2005[63], a Memorandum which was forwarded to **Minister Nuttall** upon the instruction of the Board, the Deputy Registrar of the Board frankly stated[64]:-

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[61] Memorandum of Michael Demy-Geroe, Exhibit "MSD-3", paragraph 5.3 – part of Exhibit 24
[62] paragraphs 13-16 of Exhibit 421
[63] Demy-Geroe's Exhibit "MSD-3"
[64] paragraphs 5.1-5.7

"5.1 *Patel clearly set out to deceive the Board in the response he gave in his initial application for registration regarding his past disciplinary history, and also in his subsequent renewal applications. The conclusion is also inescapable that the attachment to the verification certificate from Oregon, which detailed Dr Patel's disciplinary history, had purposely been removed and withheld by him when the document was given to the recruitment agency for submission to the Board.*

5.2 *Dr Patel's omission to disclose his past to the recruitment agency and his employer reveals similar deceptive conduct.*

5.3 ***It is undeniable however that had a thorough check been made of the verification of licensure document, and the notation queried, Dr Patel's registration is unlikely to have been approved, at least in an unsupervised setting.*** *The oversight, while inexcusable, nonetheless might be regarded within the context of its occurrence. The officer who processed Dr Patel's application is not currently employed by the Office and was in fact the Medical Team's most experienced and reliable registrations officer at that time. All officers engaged in processing are routinely reminded of the importance of checking documentation for authenticity and any irregularities, as the Registration Advisory Committee could not be expected to undertake this responsibility. The Committee concentrates its efforts on the suitability of an applicant to engage in the special purpose activity the subject of the application, and does this through considering the particular skills and experiences disclosed in the curriculum vitae and the Forms 1 and 2 compared to the specification of the area of need vacancy. Certificates of Good Standing and copies of other certificates of qualification are expected to have been passed as acceptable by the Office in accordance with the Board's policies and guidelines, in the preliminary processing stage, and are generally not revisited at the decision making stage.*

5.4 *Some issues surrounding the Oregon certificate are also worthy of comment. Certificates of Good Standing are a traditional assurance tool used by registration authorities to assist in considering the fitness to practise of an applicant for registration. They follow a similar format in most jurisdictions internationally and contain a clear statement that the registrant is in good standing and not subject to disciplinary action or investigation. Conventional certificates of good standing are most commonly still passed directly between registration authorities. It is sufficient therefore to give such documents only a cursory review as the heading "good standing" and the certification provide the information required.*

5.5 *United States medical registration authorities however generally do not issue certificates of good standing in the customary format. The verification certificate more commonly issued by US registration boards is a status report or statement of details from the register usually with no specific comment or certification. They often are given directly to the registrant and require more careful scrutiny as details can more easily be overlooked. Comments on the registrant's standing such as "Public Order on file – see attached" may not be as meaningful or conspicuous to processing officers as the absence of a certificate of good standing would be in other cases,* ***although as already mentioned, the absence of an attachment should have, at the least, prompted some questions.***

5.6 *Another factor which might explain, as much as is possible, how such an oversight could occur is the sheer volume of registration activities with which registration officers must deal during the December-February peak period. Dr Patel's application was initiated in mid January with the receipt of an area of need certification, on 17 January 2003, and the form of application with supporting documents three days later. During January 2003 a total of 233 area of need special purpose applications were approved, and 104 were approved during February 2003. At that time area of need applications were prepared for the decision making stage by 1.4 FTE A03 level officers. Registration officers must deal with constant pressure from agencies, applicants and employers seeking to expedite applications, and this adds to the substantial workload in peak periods. Constant interruption and distraction from the task at hand obviously is conducive to errors occurring.*

5.7 ***It is my view that a combination of circumstances coincided in this case with unfortunate consequences. These were firstly, the intention of the applicant to mount a deception; secondly the nature of the American certificate which tended to obscure the vital information within the document's format and through use of unfamiliar terminology; thirdly, the oversight by the processing officer; and lastly, the workload pressures under which registration staff were functioning at the material time."*** (emphasis added)

In his evidence before the Commission of Inquiry, **Mr Demy-Geroe** said that the words *"see attached"* ought to have prompted some concerns and ought to have been pursued.[65] **Mr Demy-Geroe** did point out however, that the abovementioned endorsement is potentially at odds with two other endorsements on the face of the *"Verification of Licensure"* namely:-

"Limitations – none"; and
"Extensions – none".

[65] T437

Mr Demy-Geroe said:-

> *"...the description* 'standing – public order on file *without the further comment* "see attached – public order on file" *is really quite meaningless, in our experience. Could mean any number of things. If it does relate to a persons disciplinary situation in that jurisdiction, then the limitation, as you have observed, would appear to be conflicting with that."*

Mr Demy-Geroe said as a result of the Patel incident, Certificates of Good Standing emanating from the United States were re-examined and it was discovered that these entires were *"fairly typical"*. He therefore frankly acknowledged that the assessor ought to have picked up the words *"see attached"* and enquired further.

Mr Demy-Geroe doubted that QHealth would have seen the *"Verification of Licensure"* but said that the recruiting company also should have noted it and seemed to have missed it.

The Board has always acknowledged its error and the public apology made is a matter of record.[66] **Dr Bethell** from **Wavelength** similarly acknowledged that the endorsement on the *"Verification of Licensure"* should have been followed up. It is a relevant circumstance, however, that Patel made two false answers on his Application in order to deflect further inquiry. Further, having been encouraged by both **Dr Kees Nydam** and **Dr Darren Keating** to seek specialist registration through the AMC – where closer scrutiny of his qualifications may well have revealed the fraud – **Patel** did no more than enter into the earliest phases of that process, even though he was employed at Bundaberg for a continuous period of approximately 23 months.[67] **Patel** did not want to be discovered and succeed in this endeavour, partly as a result of the Board's employee being duped by his, fraudulent behaviour.

In over 8,000 approvals since Patel's, only the approval of Berg in 1999 – predating Patel's – has emerged as having been potentially induced by fraud.

Any adverse finding pursuant to paragraph 2 of the Commission's Notice should acknowledge the combination of factors which led to the error, as set out by **Mr Demy-Geroe** in his Memorandum.

3 - The Commission may find that "with respect to Term of Reference 2(a) and the Medical Board's role in monitoring and managing complaints about medical practitioners generally, the Commission may find that:

[66] T 540 L 8 - 20
[67] see Exhibit 274 – Nydam's email to Patel dated 25 February 2003/see Keating's evidence, T6831

(a) The Medical Board failed to publicised (sic) and promote its investigatory and disciplinary role with respect to medical practitioners;

No evidence has been adduced to the effect that the Medical Board failed to promote its investigatory and disciplinary role. On the contrary, there is clear, compelling and unchallenged evidence that the Board had widely publicised and promoted its investigatory and disciplinary role with respect to medical practitioners.

The Board has its own dedicated website which complies with the obligations of public publication of matters it is required to published pursuant to its governing legislation. See in particular T521 line 30 evidence of **Mr O'Dempsey**. See also paragraph 21 of the Statement of **Mr O'Dempsey (Exhibit 28)** as well as **Exhibit 32** wherein a number of newspaper articles concerning the Board in its disciplinary role are identified. **Mr O'Dempsey's** contribution to public discussion in the media is evidenced in the articles referred to in Exhibit 32. It should also be borne in mind that the Health Rights Commission has a leading role in publicising its complaint handling process in respect of users of health services and that also the administration of QHealth has its own responsibility to develop and implement its own complaint handling processes.

In addition, it is a common theme throughout the evidence of witnesses at the Inquiry particularly within the medical profession that the Board is the appropriate complaints handling body in relation to complaints against medical practitioners. To this extent see evidence of **Dr Anderson** T2771 - line 58.

Evidence of **Ms Aylmer** T1027-T1028 – line 10. In this reference Ms Aylmer refers to an apparent long standing knowledge of complainants being able to refer complaint to the Medical Board and/or Health Rights Commission.

Dr Cleary at T4851 – line 35-48.

Nurse Gaddes was familiar with the Board's handling of impaired medical practitioners and was obviously aware of the Board's regulatory role T2117- line 50-55.

Nurse Jenkins' discussion as to referral of matter to the Medical Board T3717 – Lines 25-35.

Dr Johnson at T3368 - line 30-35 indicated it was *"when there are issues of clinical concern my normal practise to contact the Medical Board"*.

See **Dr Johnson** further at T3403 – line 20 and further at T3421 – lines 45-55, and T3422 – lines 15-25.

Dr Keating clearly knew of the role of the Medical Board in investigating and disciplining medical practitioners T6886 – line 50.

See also the evidence of **Dr Molloy** T598 at lines 10-20 where he stated:

> *"so for example, if they knew a colleague – and, you know. I have personally experienced this and seen it at closer hand – was taking – was drug addicted, I think they would almost always take that problem to the Medical Board because I think the Medical Board has a very good track record of handling that".*
>
> *Q: And further question or perhaps sexual misconduct or things of that kind?*
>
> *A: Exactly, that's right".*

Dr Nankivell wrote a complaint to the Board about an issue he had T2974 – lines 10-20.

Dr North in respect of concerns over orthopaedic care offered in the Fraser Coast region was aware that those matters might be referred to the Medical Board for investigation: see T5156 – lines 1-10.

Ms Raven was aware of the availability of the Medical Board to receive complaints: see T2362 – lines 30-40.

Mr Smith, a patient of the hospital was aware of the process of complaining to the Medical Board of Queensland – see Statement of Mr G L Smith paragraph 20 and evidence of Mr Smith T2438 – lines 40-55 (albeit it would appear this complaint had been made to the Health Rights Commission).

Dr Strahan gave evidence of intimate knowledge of the Board's processes in a particular case T3311 – lines 22-42.

Dr Young gave unequivocal evidence as to the types of matters where a complaint could be taken to the Board: see T2849 – T2850 and T2888 – lines 18-33.

Also it should be noted that the **Queensland Nurses Union** knew of the processes involved (Paragraph 30 - Affidavit of **Mr O'Dempsey Exhibit 28**) in particular where the Queensland Nurses Union representatives came to meet Mr O'Dempsey in relation to a Gold Coast based doctor who was subject of a written complaint by the Union on behalf of a number of its members. It is submitted that the body responsible for representing most of the nurses within Queensland Health clearly knew the processes for a complaint to the Board.

The Health Rights Commission also is an integral part of the complaints awareness process and has a legislative obligation to fulfil in notifying the Board of any formal complaint before referring the complainant back to the hospital.

It would be unfair to the Board, and contrary to the evidence, for the Commission to find that the Board failed to publicise and promote its investigatory and disciplinary role. The Commission could well find that the prevailing culture within the QHealth hospital system was to deal with complaints of a clinical nature as an internal matter. Such findings, if made, do not and cannot convert into a finding adverse to the Board and would be in the teeth of a substantial body of evidence to the contrary.

Not one witness criticised a lack of resolve in the Board to investigate and prosecute medical practitioners where appropriate, nor did one witness criticise the Board's lack of profile in the community as a regulatory body acting in the public interest.

(b) The Medical Board did not manage the investigation into the clinical practise of Dr [redacted] in a timely and efficient manner;

The Board submits that the Commission has not afforded the Board an appropriate opportunity in the conduct of the Commission proceedings to address the issues concerning Dr [redacted] as it did not feature in any of the Commission evidence apart from a brief reference to it after initially having been brought to the attention of the Bundaberg Hospital Commission of Inquiry in Paragraph 49 of the Statement of **Mr O'Dempsey (Exhibit 28)**. There was no proper opportunity to cross-examine any relevant witnesses in relation to the matter. It is now impracticable for the Board to attempt to call evidence or seek the issuance of subpoenas as to production of certain records from QHealth. Those records would evidence the fact that Dr [redacted] had been the subject of certain conditions of clinical practice as imposed by QHealth as a result of clinical issues coming to light, including the one subject of the complaint.

The Board's file clearly shows that the public interest was protected at an early stage of the investigation by clinical matters being addressed by QHealth, whilst an admittedly protracted and complex investigation proceeded.

There is also a non publication order in relation to the name of Dr [redacted] and the Board was led to believe in the conduct of the proceeding, in the Bundaberg Hospital Commission of Inquiry, that the Commission did not intend pursuing the issue of Dr [redacted]

There is clear unchallenged evidence of the enormous backlog of investigations which existed when **Mr O'Dempsey** commenced duties as Executive Officer on 4 March 2002. Pro-active management has alleviated the backlog of Complaints (T519 – line 40.) This clearance of the backlog has been verified by Mr Kerslake, Health Rights Commissioner at T5668 – lines 5-10. Further reference to Exhibits **"JPO-3" to "JPO-5"** to O'Dempsey's statement, **Exhibit 28** reveals that the Stumer investigation was being conducted at a time when the Board's investigation

processes were dysfunctional. Since 2002, that dysfunction has been fully addressed. In the period 2002 to 2005 the *"carry over"* of investigations in progress has fallen over 40%.

4 - The Commission may find "With respect to the registration and monitoring of Vincent Berg in circumstances where:

(a) the Medical Board had information that the Royal Australian and New Zealand College of Psychiatrists ("the College") had been unable to verify the authenticity of Vincent Berg's claimed qualifications from the Voronezh State University;

(b) the Medical Board had in its possession copies of correspondence from the Voronezh State University to the College in which it advised that:

(i) having reviewed the qualifications provided by Vincent Berg they appeared to be "crude forgeries"; and

(ii) at the relevant time it did not offer the course that Vincent Berg claimed to have completed;

(c) Vincent Berg had been employed by the Townsville Mental Health Service for 12 months and had administered psychiatric treatment to numerous patients during that time;

the Medical Board took no step to advise Queensland Health that there was real reason to suspect that Vincent Berg held no psychiatric qualifications.

The Board first became aware of the forgery allegation relating to Berg's claimed Russian medical qualifications on 19 October 2001. On that date, the Board received a letter from the Royal Australian and New Zealand College of Psychiatrists ('RANZCP') to the AMC in which Berg's qualifications from a Russian University were said to be false.

At this time Berg had already ceased as a registrant in Queensland or any other State of Australia.

Berg, however, chose to vigorously defend himself in letters to the AMC dated 30 October 2001 and 11 November 2001. The Board considered that it was not in a position to verify or disprove Berg's claimed qualifications. The Board's dilemma was compounded in that another government agency, the Commonwealth Department of Immigration, had accepted Berg's status as a Refugee. It appears that Berg's claimed status of a Russian Medical Practitioner had been a factor in his successful application to the Department of Immigration.

It is important to note that at the time the Board received the advice of the possible forgery, Berg was not a registrant in Queensland. He was not known to be a registrant in any other Australian jurisdiction.

It is submitted that the Board cannot be criticised for taking its initial view that Berg's qualifications were unable to be verified, rather than taking the more stringent view that they were false. Undoubtedly several factors influenced the Board's position as at late 2001:

- Berg had taken the step of seeking specialist registration through the AMC. A person who held demonstrably false qualifications may well not have taken such a step; and
- In two spirited and detailed defences, in direct response to the allegation of forgery, Berg claimed Refugee status and claimed that the assertion by the Russian University was yet another attempt to persecute him; and
- The Board's file showed that Berg had the support of a number of psychiatrists, both in Sydney and in Townsville, who spoke well of his clinical skills. This at least indicated the likelihood that he was duly qualified.

It should be kept in mind that if Berg is shown to be a skilful fraudster, then he has also managed to hoodwink the Department of Immigration, which conferred Refugee status upon him, at least partly, it seems, upon the strength of his claimed qualification as a specialist medical practitioner.

The Board has frankly acknowledged its regret that the Townsville Health Service District was not notified of the difficulties with Berg's registration until Dr Toft's letter dated 28 February 2003. The failure to notify occurred against the background that the Board, during 2002, held the view that the qualifications could not be verified one way or the other, and that he had departed Queensland, to the Board's knowledge.

In all of the circumstances, the Berg incident should be seen as unique. See in particular the evidence of **Dr John Allan.**[68]

> *"Q: To sum up then, would it be fair to say that in Berg's case you confronted a somewhat unusual set of circumstances?*
>
> *A: Correct*
>
> *Q: You had a fellow that showed some medical knowledge, is that right?*

[68] p3500 l.17 to p3501 l.10

A: Yes

Q: Some psychology based knowledge?

A: Yes

COMMISSIONER: Or psychiatry?

A: Something or other. Yes.

Q: Quite personable at times?

A: Yes

Q: Claiming to have been persecuted by nefarious unknown people in his country of origin?

A: Yes

Q: Even claiming to have been a clergyman at some point?

A: Yep

Q: Is that right? And another one that – where you aware of this – that on coming to Australia he changed his name?

A: Yes, I was aware of that. That was part of the persecution story

Q: Yes. So he volunteered that to you?

A: Well, his documents were in a different name. He had various documents from the Department of Immigration showing this claim and he said that that was their advice.

Q: Yes. He, it appears, did get refugee status with Australian authorities?

A: Yes, that's true

Q: Did he speak to you about claims based on international law that as a refugee he was entitled to have his qualifications looked at afresh rather than the authorities going back to the country of origin because of alleged persecution? Did he ever raise that with you?

A: That's what he told me about contact with Russia.

Q: So it was an incredible grab bag of issues that this man presented with?

A: Yes

Q: And unique in your experience, one would hope?

A: I would hope not to meet it again.

Q: But unique in your experience?

A: Yes

Q: And, therefore, even as an experienced clinician, very difficult to unravel?

A: Yes, it was. It was very difficult to unravel."

The Board's failure to notify Townsville in October 2001 is regrettable. Berg had left the jurisdiction. He had been employed in a training position but had never practised psychiatry in Townsville without supervision. The status of his qualifications, for some time, were viewed by the Board as "unverifiable" rather than "false". These factors undoubtedly obscured the immediate need to advise Townsville Hospital of the October 2001 correspondence.

Therefore any adverse finding in relation to the Board's handling of the Berg matter should be made against the context of all relevant facts.

5 – "With respect to terms of reference 2(a) and (3) the Commission may make recommendations as to the future legislative and administrative structures for the registration of medical practitioners and the investigation and determination of complaints against medical practitioners, other health practitioners, and nurses including but not limited to amendment or repeal of provisions of the *Medical Practitioners Registration Act*,

the *Health Practitioners (Professional Standards) Act*; the *Health Rights Commission Act*, and the *Nursing Act*.

It is submitted that the legislative framework with which the Medical Board of Queensland is constituted and by which it operates does not need substantive amendment on account of the matters dealt with in the Terms of Reference of this Commission of Inquiry 2(a) and (3).

The evidence of Mr O'Dempsey clearly sets out the pro-active conduct of the Office of Health Practitioner Registration Boards in its administrative and support functions for the Medical Board. His evidence also provides an informed observation as to the effectiveness of the operation of the legislation to date which has been subject thus far to one external review.[69] Such an observation which was unchallenged would indicate that there is no basis for repeal of any of the governing legislation. However the Board submits that there are some amendments which, if recommended and adopted would assist the Board in carrying out its functions more effectively in the public interest. These amendments should be proposed to the Minister as one set of amendments.[70]

Mr O'Dempsey referred to the benefits in delegating the role of decision making in relation to registration decisions. The Board does not have the discretion to delegate such decisions. If a delegation is made then that would engender a "*more definitive approach in defining policy and procedure which applies for the accountable officers or the delegate to actually make the decision*".[71]

Mr O'Dempsey also noted the limitations of Sections 47[72] and 59 (**Exhibit 28 paragraph 31**) of the *Health Practitioners (Professional Standards) Act 1999*. These provisions relate to who may make a complaint against a medical practitioner and the limited power of the Board to suspend or impose conditions on registration in the public interest.

The issue of mandatory reporting was also canvassed.[73] The Board submits that mandatory reporting to a responsible authority of a complaint made and received within QHealth should be the subject of favourable recommendation.

Also where someone complains to the Board and is referred to the Health Rights Commission and the file is subsequently closed by the Health Rights Commission because it does not meet the threshold for investigation, then the Board should be the appropriate authority to finalise the

[69] Statement of O'Dempsey 19-20 and 66
[70] T533 L1-20
[71] T499-500 L50
[72] T522 L20
[73] T662 L1

complaint if necessary. See the discussion of this and related issues by Mr O'Dempsey in evidence.[74]

It is submitted that area of need registrations should be able to be influenced by the imposition of standard conditions (which are not subject to an appeal) at the time of registration. The issues are canvassed in further detail in the evidence of Mr O'Dempsey.[75]

It is submitted that the role of the Board as prosecutor should not be altered since the Health Practitioners Tribunal is an independent body appropriate to deal with the more serious disciplinary matters. See the evidence of Mr O'Dempsey dealing with the matters.[76]

It is submitted that the *Health Practitioners (Professional Standards) Act 1999* be amended to include a non-adversarial process for competence assessment modelled on Part 7 of that Act.[77]

The Commission should consider recommending that directive 1/04 issued pursuant to Section 34 of the *Public Service Act 1996* be applied to all special purpose registrants being employed by QHealth notwithstanding their status as locums or temporary employees.

The legislation should be tightened in relation to practitioners describing areas of practice they undertake when they could be mistaken as holding themselves out as specialists.[78]

The Commission may wish to consider recommending the mandating of clinical assessment by the Skills Development Centre of QHealth and that the assessment be available to the Board in its registration determination. Should such a recommendation be made the issue of appropriate funding of the assessment must be concomitant to such process.

It is submitted that there is certainly no evidence of any systemic failure or neglect which would warrant any substantial change to the Board. In fact it is submitted that the Board has carried out its functions in an appropriate manner. However in order for the Board to be seen to be totally independent of government it is submitted that some recommended change could be made to its appointment processes.

Rather than have all positions made by Governor in Council[79] it is submitted that the Board should be enabled to set position descriptions and actively recruit and appoint persons to those positions.

The Board should also be enabled to set appropriate levels of remuneration to ensure retention of membership of the highest calibre. The issues involved in this regard were the subject of evidence

[74] T529 L1-15
[75] T532 L25-39
[76] T655 L10-60; T656; T657 L1-25
[77] T632 L1-40; T634 L1-25
[78] T627 L1-20
[79] See Ss 15 – 19 MPRA as to provisions for appointment of Board members

from Dr Cohn and Mr O'Dempsey.[80] It is submitted that such changes would need to be made through legislative amendment.

On the matter of funding the Medical Board, the Commission may consider recommending upon two key issues. First, to assist in funding the Board in its reforms introduced for the processing of applications for special purpose registration, that it recommend the amendment of the MPRA to increase the application fee and to introduce an appropriate application fee for renewal of registration.[81] Second, that the Government review its current policy for setting statutory fees which are the primary source of funding the functions of the Board.[82]

It is submitted that any amendments to the legislation should be directed to improvements in process where there is an identified need based upon reliable evidence in support thereof.

[80] T 546 L 50-60; T547 L 1- 50; T533 L 1 - 20
[81] Exhibit 28: "JPO-14", Attachment A, Paragraph 12
[82] Exhibit 28: "JPO-5", Page 10