

Chapter Six – Common causes and suggested remedies

'... we need to go backwards first... so that we can set the standards for what is appropriate clinical competence up-front and we can monitor that prospectively before things go wrong, so if you like, park the ambulance at the top of the cliff, not the bottom of the cliff, we don't have that at the moment.'

Dr Wakefield
Executive Director
Patient Safety Centre

Part A – Introduction

Common problems, common causes

6.1 As I think already appears from what I have said so far, this examination of the above hospitals revealed a number of common problems, which together resulted in inadequate, even unsafe health care, in some cases with disastrous results. It is, perhaps, unsurprising, that these problems, common to a number of hospitals, also had common causes. It therefore became clear that, unless all of those causes are removed, or their effects substantially diminished, a serious risk of inadequate and unsafe health care in public hospitals will remain. Those problems, their causes, and some remedies are discussed in this chapter.

Inadequate budgets; defective allocation and administration

6.2 The first of these was an inadequate budget defectively administered. In a number of cases, for example, in Bundaberg, Hervey Bay, Townsville, Charters Towers and Rockhampton, inadequate budgets resulted either in doctors being appointed to hospitals who should never have been appointed, or in doctors being put in positions beyond their level of competence. In both kinds of cases, the decisions to appoint were made because the hospital budget did not permit the hospital to make an offer generous enough to attract an appropriate applicant; and where the applicant appointed was plainly in need of supervision, the hospital budget did not permit that supervision to be provided. In some cases, Bundaberg and Charters Towers being examples, this led to disastrous consequences; in all others there was a serious risk of harm and, in some, actual harm. At Prince Charles Hospital it resulted in unacceptable delays in urgent cardiac care. There were also serious defects in the way in which budgets were allocated and controlled. The allocation of elective surgery budgets placed too much emphasis on attaining target numbers, and too little on

patient care; and the excessive control exercised by administrators, because of budget constraints, and a culture of economic rationalism, led to poor decisions about patient care. This problem, its causes and some possible solutions are discussed in Part B.

Defective Area of Need Registration

6.3 The second was a defective system of special purpose registration for areas of need. The idea of special purpose registration for areas of need was a reasonable one. But it has been abused, rather than used. In many cases, registration was granted under s135 of the *Medical Practitioners Registration Act* when neither of its pre-requisites had been satisfied. The Minister's delegate and the Medical Board were both negligent in the performance of their respective duties under that section. Their failures also contributed to harmful consequences. These defects, their consequences, and the remedy are discussed in Part C.

No credentialing or privileging

6.4 The third was an absence of credentialing and privileging. In none of the relevant cases at Bundaberg, Hervey Bay, Townsville, Charters Towers or Rockhampton were the relevant doctors credentialed or privileged. This was astonishing for two reasons. The first was that the obligation to do so, and the manner of doing so, was clear and simple. Even though Mr Berg in Townsville, and Dr Maree in Charters Towers were appointed before the Queensland Health Guidelines came into effect in 2002, there were requirements in much the same terms before then. And the second and more important reason why this failure was astonishing was that it was so obviously vital for patient safety to have a doctor's skill and competence adequately assessed before he or she commenced work. There was no excuse for not doing it. This is discussed in Part D.

Inadequate monitoring of performance and investigating complaints; better protection for complainants

6.5 The fourth problem was a failure to monitor the performance of doctors including to record and properly investigate complaints. There were no regular meetings that effectively monitored clinical performance and no adequate recording of complaints in Bundaberg. Moreover, complaints were discouraged by management. The same was true of Hervey Bay. Nor was there any adequate investigation of complaints. To take Bundaberg as an example, there were more than 20 complaints against Dr Patel, in a little under two years, yet that fact was not apparent from the complaints records. Consequently, there was no way in which an accumulation of complaints, some very serious, could be seen to require investigation. Had there been any such system, Dr Patel's conduct would have been investigated properly long before it was. Much of this also applies to Hervey Bay. When one comes to making a complaint outside the

Hospital, the array of bodies to which a complaint can be made, and the appropriate body in any case, is confusing; and the overlap in their powers leads to delay and frustration. And finally, those who do complain need greater protection against retribution than they now have. These problems and their consequences, and some general suggestions about what should be done, are discussed in Part E.

A culture of concealment

6.6 The fifth problem was a tendency of administrators to ignore or suppress criticism. Recognition of these and other problems in the public hospital system was made very much more difficult by a culture of concealment of practices or conduct which, if brought to light, might be embarrassing to Queensland Health or the Government. This culture started at the top with successive governments misusing the *Freedom of Information Act* 1992 to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate health care, there was quite a lot to conceal. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate health care. These problems and their solution are discussed in Part F.

Part B – A grossly inadequate budget and an inequitable method of allocation

Introduction

6.7 In his final submissions to this Commission, Dr Buckland said:

...it is impossible to address the circumstances of the Queensland Health workforce, and, in particular the pressures under which hospital administrators were required to operate, without addressing:

(a) the budget constraints on Queensland Health in general and on public hospitals in particular; and

(b) the entrenched culture of financial compliance which focuses on throughput and revenue rather than outcomes for the patient and the community.¹

I agree with those statements.

6.8 Consequently, while I have made findings and recommendations against Mr Leck and Dr Keating at Bundaberg, and Mr Allsopp and Dr Hanelt at Hervey Bay, I have borne these matters in mind in making them. These constraints also

¹ Final Submissions of Dr Stephen Buckland, p53

adversely affected the conduct of other administrators; Dr Scott in his dealings with Dr Aroney was an example of this. In fairness to those persons, it is necessary to say something about these dual constraints under which administrators operated; inadequate budgets and an entrenched culture which put throughput and cost cutting ahead of patient care.

- 6.9 Moreover, evidence given in this Commission proved that a root cause of unsafe operation of surgery and orthopaedic surgery units at Bundaberg and Hervey Bay, respectively, was that their budgets were grossly inadequate to enable them to provide adequate, safe, patient care and treatment, including surgery.² Lack of sufficient funds also contributed to the employment of Mr Berg in Townsville, the tragedy in Charters Towers, the dysfunctional emergency department at Rockhampton and the reduction in cardiac care at Prince Charles Hospital.³ The way in which budgets were allocated to and within hospitals also contributed to these consequences. It therefore became necessary to examine the evidence as to how that came about, which led to the identification of the following problems and a need to suggest possible solutions to those problems.
- 6.10 However, it must be emphasised that what is said in this chapter is not intended to be a comprehensive analysis of budget problems, and their solution. That is beyond my terms of reference. It is intended to identify budget problems, the solution of which is necessary, but not sufficient, to prevent the recurrence of what occurred at Bundaberg, Hervey Bay, Townsville, Charters Towers, Rockhampton and Prince Charles and, by inference, other regional and even metropolitan hospitals.

Queensland Health's budget as a whole

- 6.11 Queensland's total operating expenses for 2005–2006 are budgeted at \$25.670 billion.⁴ The amount budgeted on health is \$5.6 billion, or approximately 22 per cent of total expenditure,⁵ marginally behind education, at \$6.3 billion or approximately 25 per cent of total expenditure. By comparison, in 2004-05 the total operating expenses were budgeted at \$24.046 billion⁶ with \$5.1 billion budgeted on health or approximately 22 per cent of total expenditure,⁷ marginally behind education, at \$5.9 billion or approximately 25 per cent of total expenditure.

² Chapters 3 and 4

³ Chapter 5

⁴ *State Budget 2005-06, Budget Strategy and Outlook 2005-06*, p1

⁵ *State Budget 2005-06, Budget Highlights*, p15

⁶ *State Budget 2005-06, Budget Highlights*, p16

⁷ *State Budget 2005-06, Budget Highlights*, p15.

- 6.12 Despite successive Health Ministers announcing yearly increases in health spending,⁸ growing by an average of seven to eight per cent each year,⁹ this is based on the assumptions that the previous year's base budget was adequate and that this increased funding is keeping pace with escalating health costs and population growth, and an increasingly ageing population. These resources allocated to Queensland Health have come under increasing pressure. Demand for services across the community has increased substantially due to population growth,¹⁰ Queensland's increasingly ageing population¹¹ and changes in medical technology and techniques which have made available a wider range of health services accessible to the public.

Under-funding of Queensland Health by successive Governments

Queensland expenditure per person on health services below the national average

- 6.13 The 2005 *Queensland Health Systems Review*, Final Report, using extrapolated Australian Bureau of Statistics data, suggests that Queensland's expenditure on health services¹² per head is 14 per cent (\$200 per person) below the national average of \$1444.¹³ Dr Buckland expressed the view that the gap may be as high as \$400 per person.¹⁴ This is not a recent problem. It is of long standing, spanning successive Governments.
- 6.14 Because of the rapid growth in Queensland's population, in the years from 2000 to 2003, Queensland recorded annual reductions in health expenditure per person. Professor Stable, former Director-General of Queensland Health, gave evidence that he had had an ongoing argument with Government since 1996 about the under-funding of Queensland Health.¹⁵

Queensland expenditure per person on public hospitals below the national average

- 6.15 A more compelling analysis of comparative funding, for present purposes, is public hospital funding. The Commonwealth Productivity Commission, which seeks to compare government services across jurisdictions, highlights a growing gap between Queensland expenditure per person on public hospitals and national average expenditure. The 2003 Productivity Commission report records that in 2000-01, Queensland recorded the lowest government real recurrent expenditure per person on public hospitals (in 1999-00 dollars) at \$660 per

⁸ See for example: *State Budget 05-06: Queensland Health - Budget Highlights*, p 3 (\$250 million increase) ; *State Budget 04-05: Queensland Health - Budget Highlights*, p1 (\$500 million increase); *State Budget 03-04: Queensland Health - Budget Highlights*, p 1 (\$300 million increase)

⁹ *Queensland Health Systems Review*, Final Report, p 39

¹⁰ See para 6.20

¹¹ See para 6.20

¹² Includes public hospitals (representing approximately 64 per cent of total expenditure), mental health, public and community health and oral health

¹³ *Queensland Health Systems Review*, Final Report, pp 11 and 39

¹⁴ Exhibit 336 para 77 (Dr Buckland)

¹⁵ T5720 line 57 – T5721 line 5 (Prof Stable)

person, well below the national average of \$776 per person,¹⁶ a gap of \$116 per person. This trend has continued. For the 2004 financial year, Queensland again recorded the lowest government real recurrent expenditure per person on public hospitals (in 2001-02 dollars) at \$712 per person, well below the national average of \$895 per person,¹⁷ a gap of \$183 per person.

6.16 Further evidence of the significant under-funding of Queensland public hospitals can be found in *The state of our public hospitals*, June 2004 report, which claims, on different data,¹⁸ that Queensland's recurrent expenditure per person on public hospitals in 2001 was the lowest in Australia at \$322, 13 per cent lower than the national average of \$371 per person.¹⁹

6.17 The most recent data, in *The state of our public hospitals*, June 2005 report, suggests that the gap in under-funding of Queensland public hospitals is growing. Queensland's recurrent expenditure per person²⁰ on public hospitals in 2004 was still the lowest in Australia, at \$440, now 20 per cent (worsening from 13 per cent) below the national average of \$552 per person.²¹

Under-funding of public hospitals is exacerbated by several factors

6.18 This under-funding of public hospitals is exacerbated by several factors which suggest that to provide the same level of services as other states, funding of Queensland Health should not merely be in line with national average but should be much higher.²² These factors are:

Queensland is the most decentralised state

6.19 Queensland is the most decentralised state in mainland Australia.²³ More than 48 per cent of the population of Queensland resides outside our major cities.²⁴ The decentralised nature of Queensland's population necessitates some duplication of health services infrastructure and dilution of the medical workforce across the State.²⁵ As technology advances and the cost of providing

¹⁶ Steering Committee for the Review of Government Services, *Report on Government Services* 2003, p 9.5

¹⁷ Steering Committee for the Review of Government Services, *Report on Government Services* 2005, p 9.4

¹⁸ Commonwealth Department of Health and Ageing data

¹⁹ Australian Government, Department of Health and Ageing, *The state of our public hospitals, June 2004 report*, p17

²⁰ This data is calculated using the following 'weighted' population data – as utilised by the Commonwealth Department of Health and Ageing [NSW 7.0; VIC 5.1; QLD 3.8; WA 1.9; SA 1.7; TAS 0.5; ACT 0.3; NT 0.2] This 'weighted population' is age-weighted by modifying each age group of the population to account for the different hospital usage of that age group. This means a population with a higher than average number of older people will have a higher weighted population to take account of the higher than expected hospital usage of that older population. The weighted populations are also weighted to account for different expected hospital usage by each gender.

²¹ Australian Government, Department of Health and Ageing, *The state of our public hospitals - June 2005 report*, p 5

²² See for example: T5061-T5064 (Ms Edmond)

²³ See Department of Premier and Cabinet, *Premier's policy scan*, Issue 13 February 2004, p 4; T5721 lines 22-29 (Prof Stable).

²⁴ Exhibit 336 paras 60-65 and 78 (Dr Buckland)

²⁵ Exhibit 336 paras 60-63 (Dr Buckland)

technological infrastructure increases in investigative, diagnostic and treatment areas, there needs to be greater investment for the same outcome in a less decentralised setting, or the same investment for a lesser outcome.²⁶

Queensland has the highest level of population and of ageing population growth

6.20 Queensland has the highest level of population growth in Australia.²⁷ Moreover the mean age of the Queensland population has increased steadily and consequently health costs have increased.²⁸ The Commonwealth Productivity Commission estimates that expenditure on people aged over 65 is approximately four times more per person than on those under 65 years of age and that that increases to between six and nine times for those over 75.²⁹

6.21 As a result, the Commonwealth Department of Health and Ageing uses age-weighted population to try to standardise the population across states and territories for the purpose of making comparisons more meaningful. The age-weighted population is calculated by modifying each age group of the population to account for the different hospital usage of that age group. This means that a population with a higher than average number of old people will have a higher weighted population to take account of the higher expected hospital usage of that older population.

6.22 Queensland has recorded the largest percentage increase, 14.3 per cent, in age-weighted population³⁰ between 1999 and 2004 compared to a national average of 10.2 per cent.³¹

Queensland has a lower than average number of medical practitioners

6.23 The shortage of doctors and nurses in Australia, and indeed world-wide, is well documented.³² For a number of reasons³³ these staff shortages are more acute in Queensland than in other states.³⁴ Whilst remuneration rates for Australian doctors are low by first world standards, Queensland Health specialist rates are low by Queensland and Australian standards.³⁵

²⁶ Exhibit 336 para 60 (Dr Buckland)

²⁷ *Queensland Health Systems Review*, Final Report, p 92

²⁸ See the *Queensland Government's Submission to the Productivity Commission Study of the Health Workforce*, July 2005

²⁹ Productivity Commission, *Economic Implications of an Ageing Australia*, March 2005, p 147

³⁰ Percentage change in weighted population from 1998-99 to 2003-04: QLD 14.3 per cent; WA 11.7; ACT 11.5; NT 10.1; VIC 9.4; NSW 9.3; TAS 6.9; SA 6.8 [National average: 10.2]

³¹ Australian Government, Department of Health and Ageing, *The state of our public hospitals - June 2005 report*, p6

³² See T824 line 8 (Dr Molloy); Exhibit 209 (Dr Young - Chair of the Australian Medical Workforce Advisory Committee); T2863, and T2861 (Dr FitzGerald, Dr Woodruff, Dr Molloy and Dr Lennox); T876 and see Exhibit 28 paras 55 - 64 (Mr O'Dempsey)

³³ See Chapter 2 of this report

³⁴ T700-702 (Dr Bethnell); T899 (Dr Lennox); T2864 line 18 (Dr Young); and T2871-2 (Dr Young)

³⁵ Exhibit 34, paras 6 and 9 (Dr Molloy); Exhibit 35 (Dr Cohn); T575-6 (Dr Molloy); T846, line 40 (Dr Molloy)

- 6.24 For this and other reasons outlined earlier, the number of medical practitioners in Queensland in proportion to the population of Queensland has declined,³⁶ and the statistics for nurses are similar.³⁷ Queensland has a lower than national average proportion of doctors in the population.
- 6.25 Dr Buckland has attempted to put these medical practitioner shortages into some perspective:
- Assuming a Queensland population of 4 million people, this equates to 2480 doctors less for the same population in Victoria which does not have the rural, remote, indigenous or decentralised difficulties experienced in Queensland. In hours worked, there is 5.8 million hours less practitioner time per year in Queensland than Victoria for the same population. ...³⁸
- 6.26 The greater shortage of Australian trained doctors in Queensland, than in other states, has led to a greater reliance by Queensland Health on overseas trained doctors than by other states. By 2003, the proportion of Resident Medical Officers who were overseas trained doctors in Queensland was approaching 50 percent.³⁹ This is an unsatisfactory situation for health services in Queensland, as a growing share of overseas trained doctors are being drawn from countries with different cultures and first languages from ours, from a medical education system which is either less developed than ours or one in respect of which it is difficult to make an informed judgment, and from a medical and hospital system which is less developed than ours, or one about which it is difficult to make an informed judgment.
- 6.27 It seems likely that this shortage of Australian trained doctors, the under-funding of Queensland Health and the decreasing competitiveness of medical remuneration in Queensland⁴⁰ were significant factors leading to the need to employ overseas trained doctors in Bundaberg and Hervey Bay.

Queensland is the only state to provide substantial specialist outpatient services under the public health system

- 6.28 Queensland is the only state to provide substantial specialist outpatient services under its public health system.⁴¹ Former Minister Edmond gave evidence that Queensland was unique in providing a 'specialist outpatient service'. She indicated that in other states, this service is not provided.

If your general practitioner refers you to a specialist, you go privately, the cost of that is picked up by Medicare and what you pay is out of your own pocket.

³⁶ T2864 line 18, T2871-2, T2887; See also *Queensland Health Systems Review*, Final Report, p 13

³⁷ T2887 (Dr Young); See also *Queensland Health Systems Review*, Final Report, p 14

³⁸ Exhibit 336 para 101(iv) B (Dr Buckland)

³⁹ Exhibit 55 - DR12, p 5 (Dr Lennox); See also Birrell B, 'Australian policy on overseas trained doctors', *Medical Journal of Australia*, 2004 181, p 638 – previously published in Birrell B, Hawthorne L, 'Medicare Plus and overseas-trained medical doctors', *People and Place*, 2004; 12(2), p 91-92 - sourcing unpublished data provided by the Department of Immigration and Multicultural and Indigenous Affairs

⁴⁰ See Footnote 35

⁴¹ T5721 line 50 – T5722 (Prof Stable); T4959, line 58 – T4960, line 9 (Ms Edmond); Exhibit 336, para 180 (Dr Buckland).

Queensland is the only State that provides specialist outpatient services prior to people coming to the hospital for a particular function.⁴²

- 6.29 Dr Stable gave evidence that Queenslanders utilise specialist outpatients services 20 per cent above the national average. The provision of these services reflects the policies of successive governments.⁴³ Dr Stable has given evidence that while other states were limiting or ceasing outpatient services, Queensland was continuing to increase them.⁴⁴ Any discussion of the extent to which the Australian Health Care Agreement prevents this from being changed is beyond my terms of reference.
- 6.30 Specialist outpatients waiting lists are large and growing as are waiting lists for cardiac care.

A combination of those factors

- 6.31 A combination of those factors, greater decentralisation, a higher population growth and a higher growth in the ageing population, a lower number of medical practitioners and the provision of outpatient specialist services, appears to require greater expenditure per head of population in Queensland than the Australian average expenditure, to provide the same level of service.

Defective allocation

The allocation process; historical budgets

- 6.32 Successive governments used a 'historical funding model' to allocate health funding annually; that is, each budget was based on the budget for the previous year,⁴⁵ indexed annually for labour and non-labour cost increases and supplemented for specific government programs or election commitments.⁴⁶ However, the amounts allowed for increases in labour costs were 'discounted' and were less than the real costs of enterprise bargaining increases.⁴⁷ And the amounts allowed for increases in non-labour costs, at the rate of Consumer Price Index increases, were usually less than the actual increased costs in the health sector.⁴⁸ As a result, these increases in labour and non-labour costs allowed by Treasury never kept up with the real increases in costs.⁴⁹
- 6.33 These budgets were further eroded through an 'efficiency dividend'.⁵⁰ This was not a dividend but a reduction made each year on the assumption that increased

⁴² T4880 line 55 – T4881 line 5 (Ms Edmond)

⁴³ T5722 line 8 (Prof Stable) – sourcing Commonwealth Department of Health and Ageing data

⁴⁴ T5722 lines 15-35 (Prof Stable)

⁴⁵ For example – See T1830 line 40 (Dr Thiele)

⁴⁶ Exhibit 336, p 17 (Dr Buckland); T4978-99 (Ms Edmond); *Queensland Health Systems Review, Final Report*, p 102

⁴⁷ T4978 line 9 (Ms Edmond)

⁴⁸ T4978 line 19 (Ms Edmond)

⁴⁹ T4978 lines 15-25 (Ms Edmond)

⁵⁰ T4980 line 3 (Ms Edmond)

efficiencies would be made during the course of the year. This was invariably a reduction of one or two per cent each year.⁵¹ I shall say more about this when discussing the culture of economic rationalism.

- 6.34 In addition, budgets were affected by political promises. Dr Buckland accepted that government policy must play a significant role in determining the allocation of Queensland Health resources and that a key priority of any government was to honour election commitments, but he quite appropriately observed that 'some commitments do not necessarily deliver the best health outcomes in an environment in which public funding of health can never be enough to keep up with demand'. Dr Buckland cited as an example, that 'it may not be the best policy or the most sensible allocation of limited resources to establish a new facility in a specific location, and the significant capital and recurrent cost of doing so may be better allocated to upgrading and operating an existing facility at a nearby centre'.⁵² Although he did not say so, Dr Buckland may have been thinking of the establishment of Hervey Bay Hospital. It was opened, against the advice of Queensland Health because, according to Dr Stable, Mr Horan, then Minister for Health, directed that a hospital be opened at Hervey Bay before the 1998 election.⁵³

The problems with historical budgets

- 6.35 Historical budgets were not based on the needs of a community, linked to clinical services promised or demographic trends, but on an original budget, fixed many years ago, updated in a rather mechanical way. This gave rise to at least three problems. The first of these was that, if the original budget was not fixed fairly to provide an adequate service, it would be unlikely that this mechanical updating would change that. As Dr Nankivell put it:

Our funding was based on what I call an historical funding model ... which basically means you have been duded in the past, you are going to be duded next year.⁵⁴

- 6.36 The second problem was that, even if the original budget was based on the then needs of a community, subsequent budgets failed to take into account changes in those needs. Communities change size and demographics, sometimes quickly. Hervey Bay was an example of this. It had substantial population growth and a substantially increasing ageing population.
- 6.37 And the third problem was that, because some communities were perceived by medical practitioners to be more attractive than others, they ended up having a greater number of medical practitioners per head of population than others. No doubt that occurred also in the case of nurses. It was, therefore, and remains

⁵¹ T7180 lines 21-53 (Mr Leck)

⁵² Exhibit 336 para 89 (Dr Buckland)

⁵³ See Chapter 4.2 of this report

⁵⁴ T2943 lines 8-15 (Dr Nankivell)

necessary to provide incentives to attract doctors and nurses to those communities which are perceived to be less attractive. As I mention later, Area of Need Registration was premised on the assumption that incentives would be provided to general practitioners, both newly registered and established, to relocate to regional and rural areas of the State. But more generally, unless some incentives are provided, some areas of the State will be better served by medical practitioners than others. Historical budgets did not take into account the number of practitioners in an area who could provide support to a hospital on a part-time, or visiting sessional basis.

- 6.38 There was a further problem which, though not necessarily the result of historical budgets, was a consequence of the budget process. Public hospitals were required to carry forward any debt to the following year. The consequence was, of course, that the budget was effectively reduced in the following year. That practice was discontinued only in July 2004.

The allocation process; elective surgery targets

- 6.39 In addition to the historical budget, further funding was based on a target for elective surgery, weighted for complexity, aimed at increasing elective surgery throughput. If the target was not met, funds so allocated would not be paid or would be taken back by Queensland Health. More importantly, the elective surgery target and, consequently, the budget as a whole, would be reduced by that amount for the following year. This put pressure on hospitals to meet elective surgery targets at the expense of emergency surgery and medical services. Targets for elective surgery have now been abandoned.
- 6.40 This was in addition to the pressure placed on District Managers, like Mr Leck and Mr Allsopp, to maintain budget integrity.⁵⁵ A budget overrun was viewed very seriously, and little flexibility was permitted. District Managers had been dismissed for over-running budget. The Queensland Nurses Union summarised the practice accurately in the following submission:

Staying within budget (while at the same time having to meet unrealistic performance objectives) is the overriding imperative in Queensland Health: all else appears to take second place to this. The primacy of the budget bottom line is demonstrated again and again. In 1999 the whole District Executive at Toowoomba Health Service District (HSD) were removed for failing to come in on budget. Not long after that the District Manager in Cairns HSD was dismissed for reportedly failing to come in on budget. These dismissals were powerful symbols for the rest of the system and helped achieve better budget compliance by instilling fear of job loss on senior management across the agency, a fear that was in turn passed down to middle management and beyond.⁵⁶

As the evidence of Mr Leck and Mr Allsopp shows, this fear was ever

⁵⁵ T7179 line 30 (Mr Leck); T6048-6050 (Dr Bergin) and T7121 line 22 (Mr Leck)

⁵⁶ Queensland Nurses Union submission to the Queensland Health Systems Review, July 2005

present in their minds.⁵⁷

A culture of economic rationalism rather than patient care and safety

6.41 The plight of public hospitals funding was worsened by a philosophy of economic rationalism rather than of patient care and safety. The 'efficiency dividend' was one indication of this. Others were the concept that Queensland Health was 'purchasing' services from public hospitals, and that patients were 'consumers' of those services. Similarly, the system of elective surgery budgets focused on throughput and revenue rather than outcomes for the patient and the community.

6.42 Dr Buckland submitted:

In the mid late 1990s, Funder Purchaser/Provider Models were introduced, and the Performance Management Unit was established. This was part of the philosophy of economic rationalism that has dominated health and other government services during the last decade. Dr Buckland's evidence was that it has a major focus on linking throughput and revenue. It does not focus on outcomes for the patient or the community.⁵⁸

6.43 The philosophy that budget, including throughput and reputation, were more important than patient care is epitomised by Queensland's Risk Management Policy which grades risks in categories of seriousness from 'low risk' to 'extreme risk'. It is not surprising that, in the category of 'extreme risk' we find 'multiple deaths'. But the other matters sharing that category are 'claims greater than \$1m or multiple claims resulting from multiple similar exposures', and 'sustained national adverse publicity, Queensland Health's reputation significantly damaged'. In the 'major risk' category we find 'loss of life'. But sharing equal seriousness with that we find 'claims greater than \$500,000 or multiple claims resulting from a single response', and 'significant and sustained adverse statewide publicity'. And in the 'moderate risk' category we find 'loss of function, major harm caused' sharing equal seriousness with 'significant adverse State wide publicity', and 'experience will result in a single claim'. This approach, it seems to me, is hardly conducive to the declared purpose of the policy 'to improve the health and well being of Queenslanders'. Rather, it seems as much concerned with adverse publicity and civil damages as with death and serious injury.

6.44 The results of this philosophy and pressure can be seen in the approaches of administrators at Hervey Bay and Bundaberg. Although Mr Allsopp at Hervey Bay Hospital was concerned about Dr Naidoo's absences, his concern seemed to be more about losing throughput than about the absence of supervision of Dr Krishna and Dr Sharma. Even more concerning, is the e-mail which Dr Keating

⁵⁷ T7129 line 37 (Mr Leck); T6051 line 10; T6051 line 40 (Dr Bergin). See also Final Submissions on behalf of Mr Leck

⁵⁸ Exhibit 336 para 48 (Dr Buckland); Final Submissions on behalf of Dr Buckland, para 159

at Bundaberg sent to a member of staff on 8 February 2005, after Dr FitzGerald had been called in to investigate complaints about Dr Patel. It read in part:

...At the present time BHSD is 92 WTD separations behind target. The target is achievable. [Bundaberg Health Service District] must achieve the target – for many reasons, including financial (over \$750,000 per year), ability to undertake range of operations, new equipment for OT, repair of equipment, education and training of staff.

....Therefore, it is imperative that everyone continue to pull together, and maximise elective throughput until June 30. All cancellations should be minimal with these cases pushed through as much as possible.

- 6.45 The e-mail goes on to say that all elective surgery cancellations were to be discussed by Dr Patel and others.⁵⁹ The e-mail becomes even more disturbing when it is seen in a context in which, without Dr Patel, that target could not realistically be achieved.
- 6.46 There will always be a tension in hospitals, private as well as public, between, on the one hand, patient care and safety, and, on the other, cost. And of course there is a difference, as to what is acceptable treatment in a rural or regional area, between an emergency procedure, and an elective one. In an emergency, it may not be possible to provide specialist care in a regional, or, especially, a remote area. But where a procedure is not urgent, and a patient is able to be transferred, the position is different. Then there is no excuse for providing inadequate and consequently unsafe surgery, as occurred in Bundaberg and Hervey Bay. In both cases the perceived need to meet the elective surgery target was paramount in the minds of administrators, blinding them to the evident danger.

Some specific consequences to patient care and safety

- 6.47 There were many examples in the evidence of cost control being put ahead of patient care and safety, and of clinical decisions based on the latter being overruled by administrative decisions based on the former. Some of these examples follow.

Dr Thiele

- 6.48 Dr Thiele gave evidence, of his struggle to obtain a CT scan machine which Bundaberg did not have because it had been considered 'too expensive'.⁶⁰ This CT scanner was, according to Dr Thiele, a critical piece of equipment in modern trauma medicine used to identify the extent of patient injuries. Patients were, instead, transferred by ambulance to the Mater Hospital in Bundaberg, which had such a scanner and then brought back to Bundaberg Base Hospital. Quite understandably, Dr Thiele considered this was unacceptable. The Bundaberg

⁵⁹ Exhibit 72

⁶⁰ T1820 line 28 (Dr Theile)

Hospital did ultimately purchase a CT scanner but only in the course of a re-building project at the hospital.⁶¹

Dr Nankivell

6.49 Dr Nankivell gave evidence of an increasing demand for specialist outpatient clinics, endoscopy and colonoscopy services,⁶² and of the Bundaberg Hospital being unable to meet those demands. He attempted to have the problems he had identified in the course of his clinical practice brought to the attention of the hospital management and to Queensland Health's corporate office, but to no avail.⁶³ He became frustrated at what he saw as the serious failings in the budget allocation process. He also became disillusioned with the failure of Queensland Health to respond to what he had identified as serious failings that were affecting the health of the community that relied upon the Bundaberg Base Hospital.

Dr Jason Jenkins

6.50 Dr Jenkins is a vascular surgeon, and former Director of Vascular surgery at the Royal Brisbane Hospital.⁶⁴ He said that at the Royal Brisbane Hospital there has been a huge decrease in bed numbers;⁶⁵ that he had been directed not to use what he considered the best prosthesis due to its cost;⁶⁶ that he was required to put together a 'business case' in order to get changes made to the delivery of clinical services such as the type or prosthetics that could be used;⁶⁷ that on a daily basis he was given a message on his pager that he was not to admit any more patients as the hospital had no beds;⁶⁸ that the clinical demand for vascular surgery had increased dramatically in the previous 12 months;⁶⁹ that he had been given a direction that he was given a budget to perform 56 aortic aneurisms in a particular year and he was not to perform any more than 56 aortic aneurism procedures,⁷⁰ even though he had performed approximately 145 such procedures each year previously;⁷¹ that patients were discharged from hospital prematurely to make beds available for elective surgery,⁷² that he had to regularly cancel elective surgery due to there being an inadequate number of Intensive Care beds available to provide post operative care;⁷³ that clinicians were powerless as the system was run by administrators;⁷⁴ that the

⁶¹ T1820 lines 35-38 (Dr Thiele)

⁶² T2945 line 40; T2946 line 28; T2963 line 30 (Dr Nankivell)

⁶³ T2948 line 58 (Dr Nankivell)

⁶⁴ T3674 line 40, T3675 line 22 (Dr Jenkins)

⁶⁵ T3678 line 28 (Dr Jenkins)

⁶⁶ T3678 line 32 (Dr Jenkins)

⁶⁷ T3678 line 42 (Dr Jenkins)

⁶⁸ T3678 line 35 (Dr Jenkins)

⁶⁹ T3676 line 18 (Dr Jenkins)

⁷⁰ T3680 line 2 (Dr Jenkins)

⁷¹ T3680 line 5 (Dr Jenkins)

⁷² T3683 line 15 (Dr Jenkins)

⁷³ T3685 line 48 (Dr Jenkins)

⁷⁴ T3684 line 3 (Dr Jenkins)

funding for the Royal Brisbane Hospital was inadequate given the area that it had to cover, and the result was that the Hospital was 100 beds short of what it needed to cope with the demand placed on its services;⁷⁵ and that he, along with other vascular surgeons, had been directed to drive to the Nambour Hospital to provide vascular surgery services at that hospital rather than having patients travel to Brisbane for treatment.⁷⁶ He considered the extra travel involved a waste of the valuable time of clinicians and an inefficient use of resources. He and the other vascular surgeons were given \$400,000 in funding to provide a 'carotid artery stenting service' at the Royal Brisbane Hospital. However that funding would only be given on the condition that the vascular surgeons would travel to Nambour and provide vascular surgery services there.⁷⁷

- 6.51 Dr Jenkins, as a doctor treating patients on an almost daily basis, had a clear understanding of the increasing demands being placed on a hospital such as the Royal Brisbane Hospital. Notwithstanding this wealth of knowledge he had little or no power to influence the distribution of funds in such a way as to meet that demand. There was no consultation with him on these issues:

They need to speak to clinicians and ask them what needs to be done, not have administrators telling us what clinicians should be doing.⁷⁸

Dr Sam Baker

- 6.52 Dr Baker, the former Director of Surgery at the Bundaberg Base Hospital, gave evidence of the difficulties he experienced with the inadequate funding and lack of consultation at the Bundaberg Base Hospital when he was the Director of Surgery, including an inability to purchase replacement surgical equipment;⁷⁹ decisions made by administrators of the Hospital about increasing the efficiency of the operating theatre without consulting him,⁸⁰ and an unaddressed lack of experienced doctors working in the Emergency Department at the Bundaberg Hospital.⁸¹

Dr Sean Mullen

- 6.53 Dr Mullen was an orthopaedic surgeon and a Visiting Medical Officer at Hervey Bay Hospital. When on call on a Saturday morning he saw an elderly woman who had been admitted with a fractured hip the previous night. In his opinion it required surgery as soon as possible, a better outcome being achieved if surgery is performed within 48 hours. He booked her in for surgery that day

⁷⁵ T3689 line 21 (Dr Jenkins)

⁷⁶ T3691 line 31 (Dr Jenkins)

⁷⁷ T3691 line 50 (Dr Jenkins)

⁷⁸ T3683 line 1 (Dr Jenkins)

⁷⁹ Exhibit 410 para 14 (Dr Baker)

⁸⁰ Exhibit 410 para 20 (Dr Baker)

⁸¹ T6349 line 58 (Dr Baker)

notwithstanding a general policy that emergency surgery only be performed on the weekend. Nurse Erwin-Jones, who was at home at the time, mistakenly thinking that the fracture was two weeks old, contacted Mr Allsopp, the District Manager, who cancelled the surgery without reference to Dr Mullen. It was only after Dr Mullen and a senior anaesthetist both spoke to Mr Allsopp that the surgery was rescheduled for the following day. This was clearly a case of putting economic matters ahead of patient care.⁸²

Dr Con Aroney

6.54 Dr Aroney, a cardiologist, gave evidence of the difficulties that he faced in providing cardiology services at the Prince Charles Hospital. The cardiology unit of that hospital experienced a reduction in funding without any, or any sufficient consultation with cardiologists about the funding cuts or the reasons for them. He also spoke of a prohibition by administrators on the use of certain prosthetic devices⁸³ and administrative interference in clinical decision making to save costs.⁸⁴ He gave an example of Dr Pohlner, the most experienced paediatric cardiac surgeon in the State, being twice refused a ventricular assist device, which he considered necessary for surgery in each of the two cases. Dr Aroney believed that the refusal was based on the cost of the device, and of the consumables. The refusal was ultimately reversed but surgery was delayed.⁸⁵

Mr Whelan

6.55 Mr Whelan is the District Manager of the Townsville Health Service District. As discussed below, he, with the assistance of others, has introduced a different model of funding and administration into the Townsville Hospital. However, he also experienced overbearing central control when it came to the allocation of funding. He gave evidence of the failure of Queensland Health to consult with the community adequately or appropriately in a number of cases including a lack of consultation with the community regarding the redevelopment of the Ingham Hospital, the redevelopment being pushed along for political reasons without considering the health care needs of the community in sufficient detail;⁸⁶ a lack of consultation with the Hospital over the nature of procedures to be performed;⁸⁷ and a funding model based on funding positions rather than outcomes. One example of this was Queensland Health agreeing to fund an additional physician to provide renal services, but not providing funding for nursing and allied health staff to support that physician.⁸⁸

⁸² See Chapter 4 - paras 4.179 - 4.187

⁸³ Exhibit 263 para 10 (Dr Aroney)

⁸⁴ Exhibit 263 para 11 (Dr Aroney)

⁸⁵ Exhibit 263 para 9; T4804, line 51 – T4805 line 3 and T6282 lines 32-50 (Dr Aroney)

⁸⁶ Exhibit 236 para 7; T3531 line 15 (Dr Whelan)

⁸⁷ See Chapter 5 of this report

⁸⁸ T3338 lines 24-35 (Dr Johnson)

Some more general consequences

- 6.56 Because budgets were fixed on an historical basis, with little consultation with clinicians, the Australian Medical Association, specialist colleges, specialist associations or nursing bodies, there was no point in involving local doctors and nurses in determining changing needs. Take the example of Hervey Bay Hospital. When it opened its orthopaedic unit, it did so with one specialist orthopaedic surgeon. Had there been any consultation with the Royal Australian College of Surgeons or the Australian Orthopaedic Association, it would have become clear to Queensland Health that that was a grossly inadequate number of orthopaedic surgeons to provide an adequate and safe orthopaedic service to include elective surgery. Similarly at Bundaberg, the general surgery unit was understaffed by qualified surgeons, anaesthetists and nurses for at least three years before Dr Patel was employed and Dr Patel might never have been permitted to operate as he did, notwithstanding complaints, if it had been adequately staffed; that is, if he had had peer review.
- 6.57 Nor was there any flexibility in sharing services between districts. Dr Thiele gave the example of there being, at one time, a long surgery waiting list at Bundaberg, and almost none at Hervey Bay. Yet the system did not permit transfer of patients from Bundaberg to Hervey Bay for this purpose. Bundaberg, Maryborough and Hervey Bay seem obvious places where specialist elective services could be rationalised.

A cost-efficient system?

- 6.58 It is said that Queensland Health has, for some time been recognised as the most cost-efficient jurisdiction in Australia in delivering hospital services. The latest data records that Queensland's total recurrent cost per case-mix weighted separation⁸⁹ is \$2885 compared to the national average of \$3184,⁹⁰ more than 10 per cent lower than the national average. This lower cost at which Queensland delivers health services reflects a lower expenditure on nursing, allied health and medical services (staff numbers and average salaries) and lower relative stays in hospital than other states.⁹¹ More specifically, Queensland has a lower than average number of medical practitioners; has the lowest number of nurses per capita of any state in Australia (except Tasmania) and has a critical shortage of nurses. It employs 11 per cent fewer public hospital staff per 1000 people; and pays 5.6 per cent less in average salaries for

⁸⁹ This data is 'case-mix adjusted' to take into account the complexity of the admission

⁹⁰ Steering Committee for the Review of Commonwealth Service Provision, *Report on Government Services 2005*, Table 9A.4

⁹¹ *Queensland Health Systems Review*, Final Report, p 12

public hospital staff.⁹² Yet Queensland Health spends 82 per cent more on health administration than other states.⁹³

- 6.59 The last figure is concerning. It might be explained, in part, by the much greater decentralisation in Queensland than in other states. But whilst the limitations on my terms of reference prevent me from examining it further, it is necessary to remark that whilst it is undoubtedly the case that Queensland has too few qualified doctors and nurses, it may well be that it has too many administrators.
- 6.60 Even more concerning is that the lower cost in Queensland, in delivering health services, has come at the cost of lowering the standard of healthcare to one which is grossly inadequate and dangerous. It has been thought better to employ poorly trained foreign doctors under the area of need scheme than, for example, to make greater use of Visiting Medical Officers or to provide incentives to Australian trained doctors to relocate. And it was thought better to provide a system which was so grossly inadequately staffed as to be dangerous (as in Hervey Bay) than to provide none at all. This last appeared to be the stated views of Mr Leck and Mr Allsopp, and also of Dr FitzGerald to Ms Hoffman.

Possible solutions: The overall public hospitals budget

- 6.61 What is needed and what must be done in this respect are beyond my terms of reference. But it would be remiss of me not to point out difficulties in solutions already proposed as these difficulties have emerged from the evidence before this Commission.
- 6.62 The *Queensland Health Systems Review*, Final Report, argues that to bring the Health budget up to the national average would require an extra \$1.2 billion a year, increasing to \$1.9 billion a year by 2009 – 2010.⁹⁴ It suggests or implies that \$1.2 billion a year may not be required because, for many services, Queensland Health provides a similar level of activity but with a lower level of expenditure.⁹⁵
- 6.63 Significantly, one of the 'efficiencies' relied upon in that Report is that Queensland performs weighted separations at a lower cost than other states; that is, more efficiently.⁹⁶ But the evidence given in this Commission has shown that weighted surgical separations in public hospitals in Queensland were often provided unsafely, primarily because there were too few, too poorly qualified or supervised doctors, and too few nurses. But that lowered their cost.

⁹² *Queensland Health Systems Review*, Final Report, p 14

⁹³ *Queensland Health Systems Review*, Final Report - quoting data from *Australian Institute of Health and Welfare, Health Expenditure Australia 2002-03* (2004). See also *Australian Institute of Health and Welfare, Health Expenditure Australia 2003-04* (2005).

⁹⁴ *Queensland Health Systems Review*, Final Report, p 39

⁹⁵ *Queensland Health Systems Review*, Final Report, p 40

⁹⁶ *Queensland Health Systems Review*, Final Report, p 40

That was also true of a number of other services including psychiatry in Townsville, emergency care in Rockhampton and anaesthetics in Charters Towers. By using unqualified doctors to perform complex orthopaedic surgery (Hervey Bay), by permitting doctors to perform surgery beyond their competence or the competence of the hospital (Bundaberg and Hervey Bay), by requiring too few doctors to work unsafe hours (Bundaberg and Hervey Bay) and by 'dumping' inadequately trained doctors employed under the 'area of need' scheme, in an emergency department (Rockhampton), substantial costs were saved, but at huge cost to patient safety.

- 6.64 If, as seems to be the case from the evidence before the Commission, weighted surgical separations have been carried out more cheaply in Queensland than in other states, at least in part because they have been provided inadequately and unsafely, it would be wrong to assume that, if they are provided at a reasonable level of competence and safety, they will still be provided more cheaply than in other states. For that reason, it may be wrong, as that Report posits, that, because of a greater level of efficiency in Queensland Hospitals, less than \$1.2 billion will be required to bring Queensland Health budget up to the national average.
- 6.65 It is also wrong, in my opinion, to assume that, to bring health funding in Queensland up to national average per head, is sufficient to provide the same level of services as the other states. There are several reasons why Queensland needs to spend more than the other states. I have mentioned these earlier. Queensland is the most decentralised state in mainland Australia; Queensland's age-weighted population is growing faster than other jurisdictions; and Queensland provides a free specialist outpatients service, much greater in its scope and cost than that provided by other states.
- 6.66 And it is also wrong, in my opinion, to assume that the other states are providing an adequate and safe system. Concerns similar to those investigated by me have been investigated in other jurisdictions; at the King Edward Memorial Hospital in Western Australia (1999),⁹⁷ the Canberra Hospital in the Australian Capital Territory (2000),⁹⁸ and Campbelltown and Camden Hospitals in New South Wales (2002).⁹⁹ The most recent example in New South Wales concerned allegations made by nurse whistleblowers of unsafe or inadequate patient care or treatment, disregard for quality and safety, and an indifferent hospital administration, following a number of patient deaths at the

⁹⁷ Douglas N, Robinson J, Fahy K, *Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital*, 2001

⁹⁸ The report was not made public. See the ACT Community and Health Services Complaints Commissioner, *Annual Report 2002-03*, Canberra, 2003 – which outlines a summary of the major findings of the Inquiry

⁹⁹ NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003

Campbelltown and Camden hospitals.¹⁰⁰ The New South Wales Health Care Complaints Commission investigated some 47 clinical incidents, including 19 deaths,¹⁰¹ at those hospitals. The Health Care Commission's investigation supported the allegations made by nurse whistleblowers, finding that there were inadequate standards of patient care and safety¹⁰² at both hospitals.

- 6.67 An associated patient care systems review of the relevant hospitals in October 2003¹⁰³ concluded, amongst other things, that the relevant health service had many fewer resident, registrar, and consultant medical staff for each occupied bed than at other facilities;¹⁰⁴ that there was a shortfall in appropriately qualified and skilled nursing and allied health workforce and extremely limited numbers of academic clinicians;¹⁰⁵ that the lack of adequate numbers in the medical workforce with adequate skill and experience levels was perceived to be the greatest weakness in the delivery of health services, most notably in the Intensive Care Unit and the Emergency Department;¹⁰⁶ that additional resources were required in the area of clinical nurse consultants in intensive care, Emergency Department and medical ward;¹⁰⁷ that the Camden Hospital had a number of limitations, including a lack of adequate numbers of skilled staff and high level facilities resulting in the need to transfer acutely ill patients;¹⁰⁸ and that the development of a supported safe reporting culture needed to be a priority.¹⁰⁹ These bear a striking similarity to inadequacies found in Queensland public hospitals by this Commission.
- 6.68 Therefore it may well be that, in order to provide safely all of the health services in Queensland, now promised at the locations at which they have been offered, a sum greater than the \$1.2 billion a year would be required. And it seems to me from what I have said so far, that the required amount can never be ascertained merely by comparing Queensland's expenditure with that of other states.
- 6.69 In October 2005, the Premier and Treasurer, in delivering a 'Special Fiscal and Economic Statement', announced net new funding for Queensland Health. It is beyond my terms of reference and, as I have already indicated, in any event impossible for me to say whether that will be adequate, or if not the extent of the inadequacy, to provide an adequate safe public hospital system. What I have

¹⁰⁰ These hospitals service the sprawling working class suburbs on Sydney's southwestern outskirts.

¹⁰¹ NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003, p 3

¹⁰² NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003, p 4

¹⁰³ Conducted by a review team led by Professor Bruce Barraclough

¹⁰⁴ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁵ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁶ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 157

¹⁰⁷ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁸ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁹ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 157

endeavoured to do in this Part is merely to point to evidence before my Commission which casts doubt on the assumption, apparently made in the Final Report of the Queensland Health Systems Review that the amount referred to there would be adequate to provide, safely and adequately, all of the services now promised to all of the people to whom it is promised, at no cost to them.

- 6.70 In order to determine what that amount would be, it would be necessary, in each public hospital in Queensland, to estimate the cost of providing, at an adequate, safe level, the services which it offers. In order to determine what would be needed to provide any health service at any specified location, Queensland Health would need the advice of the Australian Medical Council and the specialist colleges. To take the example of the provision of an orthopaedic service at Hervey Bay, it is primarily only orthopaedic surgeons who can say what are the requirements, in terms of surgeons and supporting doctors and nurses, to provide such a service. And it is now plain that, if their advice had been sought before such a service commenced at Hervey Bay, it would never have been commenced. Without such an exercise first being carried out, it seems to me that Queensland Health cannot even begin to know what it would cost to provide a reasonably safe, adequate health service.

Can the promise ever be fulfilled?

- 6.71 Dr Waters is a hospital administrator of considerable experience. He had been District Manager of the Princess Alexandra Health Service District and the Royal Brisbane and Womens Hospitals Health Service District. He had also been the General Manager of the Wesley Hospital. He put the question this way:

The primary question is an issue of scope ... Queensland Health promises to the Queensland community to do all things to all people at all times and yet, clearly, it has a defined budget.¹¹⁰

This statement gives rise to a fundamental question which requires an answer. Can Queensland, or for that matter Australia, ever provide, at no cost and at an adequate and safe level, all of the services promised to all people, at least without a substantial increase in taxation or a substantial increase in income from other sources? The evidence before this Commission shows that it is not being provided in Queensland public hospitals. And from the indications from inquiries in other states it may be that it is not being provided there either.

- 6.72 Yet, if recent reported events are any guide, this seems to be a question which national leaders, on both sides of politics, seem reluctant to face or even admit exists. When the Queensland Government raised the possibility of co-payment for some services, both the Australian Health Minister and the Leader of the Opposition stated that all Australians were entitled to a free health system -

¹¹⁰ T4662 lines 45-51 (Dr Waters)

whatever that may mean. But neither questioned what it would really cost to provide all of the free health services, now promised to all Australians, at a level which is reasonably adequate and safe; or whether indeed that is realistically possible. That is a question which is beyond the scope of this Commission.

- 6.73 If it is not possible, then it may be necessary to consider whether either the number or extent of free services should be limited, or the classes of people to whom such services are provided should be limited, or both of these. It may not be possible for Queensland alone to do this consistently with its obligations under the Australian Health Care Agreement, but that question is outside the terms of reference of this Inquiry. The question whether free hospital services may be limited in any significant way may be one which can be, and should be addressed only on a whole of Australia basis. The reality is that Australia's national real health care spending¹¹¹ has been growing faster than the Australian economy in every year since 1990.¹¹² Sooner or later this imbalance must be addressed, as must the reality that, in Australia generally, free public hospitals do not appear to be providing those services adequately.

Possible solutions: abandonment of the culture of economic rationalism

Greater involvement by clinicians

- 6.74 There are two points to be made here. The first of these is, I think, now accepted by Queensland Health. A system which included an historical budget with an efficiency dividend was wrong and should be abandoned. And elective surgery targets diminished the quality of surgery and gave priority to elective surgery over emergency surgery. It is now accepted, I think, that individual hospital budgets must be based on the changing needs of each community.
- 6.75 The second point may not yet be accepted by Queensland Health. It is that there must be much greater involvement by doctors and also nurses, and less by administrators, in the allocation of individual hospital budgets, both among and within individual hospitals. I discussed earlier how administrators have triumphed over clinicians, at the expense of patient care and safety. This is likely to continue unless clinicians are given greater control in this respect.
- 6.76 I note that the *Queensland Health Systems Review*, Final Report, recommends that administrative staff be transferred from central office to the districts.¹¹³ This

¹¹¹ Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$72.2 billion in 2002-03 (Australian Institute of Health and Welfare 2004; table EA.1). This total was estimated to account for 9.5 per cent of gross domestic product in 2002-03, up from 9.3 per cent in 2001-02 and 8.2 per cent in 1992-93 (Australian Institute of Health and Welfare 2004)

¹¹² Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Health and Welfare Expenditure Series - Number 25, September 2005, Canberra, p 7. See also Steering Committee for the Review of Commonwealth Service Provision, *Report on Government Services 2005*, E.5

¹¹³ *Queensland Health Systems Review*, Final Report, p xiv and pp 71-72.

may be a good thing if its purpose is to provide administrative support to doctors and nurses to ease their administrative burdens; for example, in the implementation of clinical governance policies, and those with respect to recording of complaints. But if it is, as I perceive it might be, so that they can determine budgets at a local level at the expense of clinician involvement, then I think that is a matter of some concern.

Townsville model

- 6.77 While the Townsville Hospital has little control over how much funding it receives from Queensland Health, the process by which that budget is allocated within that hospital has included greater clinician involvement. That process is described in Chapter Five, and while it may not be appropriate to every hospital in Queensland, the model may be capable of adaption to smaller hospitals.
- 6.78 The key features of the model are that the hospital is divided into clinical institutes. Each institute is headed by a medical director who is a doctor with both administrative and clinical responsibilities, and an operations director, who is a member of the nursing staff. The annual budget for each institute is negotiated between the executive and the directors of the Institute each year. This allows the director of each institute, who has a clinical role, to have input into the funding allocation each year. Each director is given financial delegation to enable him or her to purchase equipment and consumables; he is, to an extent, given the authority to hire nursing staff and junior medical staff; and he is accountable to the executive in the sense that he is required to meet the service standards agreed and ensure that budget integrity is maintained. The role of the executive is one of supporting the Hospital as a whole and balancing competing priorities across the Hospital.

Flexibility in the provision of services within a District and across Districts

- 6.79 Some flexibility is required in the provision of services within a District, especially in respect of specialist services. The *Queensland Health Systems Review*, Final Report, recommended a number of options to provide greater flexibility, which are worth repeating, including; greater use of Visiting Medical Officers,¹¹⁴ including on a per operation basis; and possible contracting out of surgical services to private hospitals and private specialists based on a fee for performance agreement.¹¹⁵ I mention in Chapter Six - Part C, the need to consider these matters when determining 'area of need' under s135 of the *Medical Practitioners Registration Act*. But they should be considered in all cases.

¹¹⁴ See the earlier discussion about Visiting Medical Officers in Chapter 2

¹¹⁵ *Queensland Health Systems Review*, Final Report, p129.

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

Financial incentives to experienced doctors and nurses

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

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

The defective system

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

¹¹⁶ See Chapter 3

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

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

Defects in deciding that there is an area of need

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

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

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

¹²¹ Exhibit 36 page 7

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

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

Finding against the Minister's delegate

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

¹²² Except for the rural scholarship scheme: see Chapter 2

¹²³ See Chapter 2

¹²⁴ About 50 per cent. See Chapter 2

¹²⁵ See Chapter 2

¹²⁶ See Chapter 2

Defects in Area of Need Registration of doctors other than registration in a speciality¹²⁷

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

¹²⁷ See Chapter 2

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

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

¹²⁹ See Chapter 2

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

Deemed specialist registration

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

English language assessment

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

Circumvention of the requirements for deemed specialist registration

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

¹³⁰ s143A which is reproduced in Chapter 2

¹³¹ See Chapter 2

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

¹³³ See Exhibit 36 pp 16-17

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

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

¹³⁴ See Chapter 2

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

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

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

¹³⁶ Exhibit 461, JPO 16-N JPO 16-P

¹³⁷ Exhibit 461, JPO 17 - K

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

Findings against the Medical Board with respect to registration

6.116 In the light of what I have said so far, it is convenient that I now discuss specifically the findings which I propose to make against the Medical Board in this respect.

6.117 In the first place, it was the obligation of the Medical Board to consider and determine whether an applicant for registration under s135 had the medical qualification and experience suitable for practicing in the designated area of need. In the case of registration of a person in a specialty, the Medical Board was entitled to rely on the recommendation of the relevant College which carried out an assessment of that suitability. As already mentioned, there does not appear to have been any similar process of assessment with respect to registration of persons other than as deemed specialists. The result appears to have been that no assessment by anyone qualified to do so was made of suitability of an applicant to practise the profession in the designated area before May 2004, and thereafter an assessment was made only in respect of English language skills.

6.118 The Medical Board sought to answer this apparent failure by submitting that:

the primary responsibility for matching the clinical skills of an area of need applicant with the position description of the area of need position as certified by the employer rests, in the case of Queensland Public Hospitals, with Queensland Health during the recruitment and selection process. To effect registration the Medical Board is then charged with the obligation to ensure that the applicant has the requisite qualifications and experience 'suitable for practicing the profession in the area'. This obligation upon the Medical Board requires the exercise of discretion upon facts which are subjective in each case.¹³⁹

6.119 Whatever that submission may mean and whatever the responsibilities were of Queensland Health or the relevant hospital, the Medical Board had the statutory responsibility referred to in s135(2), and that required it to make its own independent assessment of suitability.

6.120 It is plain, from what I have said so far, that the Board failed to discharge that obligation. It did not seek the assistance of the Royal Australian College of General Practitioners or of the Australian Medical Council upon whose recommendation, in either case, it perhaps could have relied. Nor did it seek the

¹³⁸ See Chapter 6

¹³⁹ Submissions of the Medical Board at p2

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

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

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

¹⁴⁰ The process is described at Chapter 2. 29.

¹⁴¹ See Chapter 2

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

6.132 I find that:

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

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

Recommendation

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

Delay

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

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

Area of Need determination

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

Registration by the Medical Board

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

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

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

application is an offence punishable with a maximum penalty of AUS\$150,000.00 or 3 years imprisonment.

- (7) Queensland Health, if it is the employer, to provide a copy of the appointment letter or offer of employment;
- (8) The employer to certify it has assessed the applicant and, based on that assessment, is satisfied the applicant has the qualifications, experience and capabilities needed for the position;
- (9) The employer to certify, utilising mandatory reference check questions, that verbal reference checks have been undertaken and that the referees verify; the experience and capabilities of the applicant; and the accuracy and completeness of any information supplied by the applicant in relation to his/her previous employment history and experience during the previous five years;
- (10) The employer to nominate a clinical supervisor who has current, general, specialist or s138 registration. For senior doctors, it is required that a Visiting Medical Officer, staff specialist or Director of the speciality department (who is Australian qualified) to be the nominated supervisor;
- (11) The clinical supervisor to agree to supervise the applicant and provide the Board any adverse reports as they are identified, and to provide an assessment form at the end of the applicant's approved period of registration;
- (12) The clinical supervisor to provide details as to how the supervision will be provided.
- (13) The applicant to organise, from 1 October 2005, provision of a certificate of primary source verification from the International Credentials Service of the US Educational Commission for Foreign Medical Graduates directly to the Board.¹⁴³

6.138 There are several matters omitted from this list which should by now have been included. These, and the apparent reliance in (8) and (9) above upon the proposed employer to perform the Board's statutory obligation to satisfy itself that the applicant has the medical qualification and experience suitable for performing the profession in the identified area of need, show, in my opinion, that the Board still does not appear to appreciate its statutory duty.

6.139 The first and most notable omission from the above list is an obligation upon the Board to check, directly with the applicant's last supervisor, the applicant's previous employment history, the circumstances in which he or she left his last employment if he or she has already done so, and his or her standing. That, it seems to me is a fundamental and necessary part of the performance by the Board of its statutory obligation. In the case of Dr Patel, it would have revealed

¹⁴³ Exhibit 420

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

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

Steps which must now be taken

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

- 6.142 It need hardly be said that there must be a genuine decision that an area is an area of need for a medical service. As mentioned earlier, it seems that, to date, there has been no genuine decision that this is so.
- 6.143 Exhibit 36 provides:
- An [Area of Need] refers to a geographic area....in which the general population need for health care is not met. It is determined by examining a range of factors, including Medicare statistics, Health Workforce data, and evidence of unsuccessful attempts to recruit an Australian doctor to a position.
- 6.144 It is necessary to consider the last of these factors, evidence of unsuccessful attempts to recruit an Australian doctor to a position, in a context in which steps have already been taken to fulfil the government's aim 'to encourage both new and existing general practitioners to relocate to rural areas through a variety of incentive programs'.¹⁴⁴
- 6.145 The only incentive offered to new general practitioners to go to rural areas, of which evidence was given in this Inquiry, is the rural scholarship system pursuant to which Queensland Health pays an allowance to medical undergraduates for a period of time during their studies, in repayment of which the young doctor, after spending a period first in a larger hospital, is required to work for a time in a rural location.¹⁴⁵ There was no evidence of any incentives provided to existing general practitioners to relocate to rural or even provincial

¹⁴⁴ Appendix 1 to Exhibit 36

¹⁴⁵ Chapter 2

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

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

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

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

¹⁴⁶ Chapter 3

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

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

¹⁴⁷ Appendix 1 to Exhibit 36

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

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

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

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

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

Imposing and enforcing necessary conditions

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

Conclusion with respect to registration under s135

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

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

Recommendation: amendment of s135

6.164 In view of the continued failure over a substantial period of the Minister's delegate to perform the duty implied by s135(3) and of the Medical Board to perform the duty implied by s135(2), the question arises whether the matters required to be taken into account in the performance of each of these duties should be stated specifically in s135. I think that they should.

6.165 However, it is not my intention to draft amendments which would achieve that. Indeed, that would be impossible because they cannot be made until certain other things are done first. Examples of these are incentives to be provided to Australian trained doctors to relocate in areas of need, in the case of the first of those duties, and determination of the appropriate body or bodies to assess the suitability of applicants, in the case of the second of those duties. Instead I propose to set out the matters which as appears from what I have said, I think need to be taken into account in making each of those decisions.

6.166 In making the decision under s135(3), the Minister's delegate should take into account, amongst other things:

- (1) Whether a service that meets the relevant need can be conveniently provided in some other way; for example, by practitioners in private practise in the same or a nearby area on a part time basis; or by doctors working in another hospital, private or public, in the same or nearby area;
- (2) What incentives have been provided to Australian trained doctors to relocate in the relevant area;
- (3) What endeavours have been made to employ Australian trained doctors to perform that service; and
- (4) The financial and safety consequences of the transfer of patients to other facilities.

6.167 In making the decision under s135(2) the Medical Board should take into account, amongst other things:

- (1) The credentials of and experience of the applicant to be assessed in accordance with the guidelines referred to earlier;

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

In both cases including:-

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

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

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

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

¹⁵⁰ Chapter 3.165 to 3.172

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

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

¹⁵¹ Chapter 2.37

¹⁵² Chapter 2.22

Queensland Health's policy and guidelines

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

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

¹⁵³ Chapter 3.173 and Exhibit 279

¹⁵⁴ Exhibit 279 para 5.3

¹⁵⁵ Exhibit 279 para 6.1

The failure to apply them

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

¹⁵⁶ Exhibit 448 para 356. See also DWK 79

¹⁵⁷ See Exhibit 448 - DWK 79

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

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

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

6.186 As to Dr Keating, even when Dr FitzGerald suggested to him in February 2005 that he should co-opt a local surgeon to serve on a credentialing and privileging committee, he declined to do so. His evidence about this, set out earlier¹⁵⁹ shows that he was more focused on the form of the process of establishing credentialing and privileging committees than on the purpose of the process; patient safety.

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

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

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

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

¹⁵⁸ T6724

¹⁵⁹ Chapter 3

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

Dr Nydam's negligence

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

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

The capacity to comply with the guidelines was there

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

¹⁶⁰ Chapter 3

¹⁶¹ Chapter 3

¹⁶² Chapter 3

¹⁶³ Chapter 3

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

Townsville

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

Charters Towers

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

Conclusions

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

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

The remedy

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

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

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

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

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

To this end, I set out a range of measures aimed at maintaining clinical standards that came to the attention of this Commission.

Maintaining Standards

6.202 There are a number of measures aimed at maintaining clinical standards in hospitals, namely:

- Credentialing and privileging;
- Clinical audit and peer review, including morbidity and mortality meetings;
- The Service Capability Framework;
- The use of College accredited training posts;
- A 'critical mass' of appropriately experienced peers;
- Safe working hours for staff;
- Continuing medical education; and
- Complaints and incident management systems.

6.203 I briefly summarise these measures below and their role in maintaining standards.

6.204 I set out in detail the role played by complaint and incident management systems and their inadequacies as they presently exist below. It suffices at this point to refer to Queensland Health's recognition of complaints and incident management systems as quality control measures, as demonstrated in its own policy:¹⁶⁵

Queensland Health recognises that consumer feedback, both positive and negative, is essential in order to provide quality health care services that meet consumer needs...

Using information gained from consumer complaints enhances organisational performance. Service improvement results from both handling complaints at the individual level and from the collation and analysis of aggregated complaint data...

The following complaints management performance standards must be met by all Queensland Health services.

- 1) Consumer feedback is actively encouraged and promoted.
- 2) Consumer and staff rights are upheld throughout the complaint management process.
- 3) Local process are implemented to support best practice in complaint handling.

¹⁶⁵ Exhibit 292

- 4) Complaints information is integrated into organisational improvement activities.

6.205 Whilst a good deal of attention has been devoted to complaints and incident management systems those systems should not be the sole focus for improvement in the future. Their success depends heavily on a human element. People have to be willing to bring their concerns forward, and people are by nature unwilling to complain. Further, complaints systems tend to be focused on eradicating inadequate treatment, rather than striving for excellence in clinical standards. Moreover, they tend to be reactive in that something has to go wrong or at least appear to go wrong before the system is invoked. Other measures for maintaining standards, such as audit, accredited training posts, and critical mass of doctors, are essential because they provide other means of checking the standard of clinical services. When they are working they provide objective indicia against which persons with concerns can confirm their concerns and overcome some of the hesitancy they may have to complaining. Further, those persons charged with responding to complaints are more likely to respond more swiftly if they have such indicia against which they can measure those complaints.

Credentialing and privileging

6.206 As I have set out elsewhere, the fact that a person holds medical qualifications does not automatically entitle them to practise medicine in Queensland public hospitals. In accordance with best practice, Queensland Health policy demands that before a doctor commences providing clinical services they must first be subject to a process of credentialing and privileging. The process involves assessment of a doctor's credentials, skills, and competence in the context of the clinical capabilities of the hospital in which they are to work with a view to determining their scope of practice at the hospital. I have outlined above the sound reasons which underlie this policy.¹⁶⁶

6.207 Under Queensland Health policy the credentialing and privileging process can be invoked in respect of its doctors in three instances, being:¹⁶⁷

- a) When a doctor is first employed by Queensland Health and before they commence performing procedures;
- b) Periodically, every three years a doctor is employed by Queensland Health; and

¹⁶⁶ See Chapter Three – Dr Patel's employment at the Bundaberg Base Hospital – Application of the credentialing and privileging process to Dr Patel

¹⁶⁷ See Chapter Three – Dr Patel's employment at the Bundaberg Base Hospital – Application of the credentialing and privileging process to Dr Patel

- c) On an ad hoc basis when matters are referred to the credentials and privileges committee by officers such as the Director of Medical Services.

6.208 Had the policy been faithfully implemented in Bundaberg, there is a good chance Dr Patel's history and shortcomings would have been identified. This is for two reasons. Firstly, if the process had been carried out rigorously, (as seems possible for reasons identified in Chapter Three) they may have had serious doubts about Dr Patel's history. Secondly, if the process had been in place, then when complaints had been received, such as the complaint from Dr Cook about the performance of oesophagectomies at the Base, they could have been referred to a credentials and privileges committee for a surgeon's opinion.

Clinical audit, peer review and morbidity and mortality meetings

6.209 A consistent theme from many witnesses was that adverse trends in Dr Patel's performance would have been identified more swiftly if he had been subject to a functioning and effective clinical audit system, including a process of peer review such as morbidity and mortality meetings.¹⁶⁸

6.210 Clinical audit involves comparison of actual clinical performance with accepted standards of what that performance should be.¹⁶⁹ The Royal Australasian College of Surgeons identifies three essential elements of clinical audit, being collection and measurement of data on clinical activities and outcomes; analysis and comparison of that data using standards, performance indicators and outcome parameters; and peer review of that data and analysis.¹⁷⁰ Clinical audit can involve collection and analysis of a range of data, including 30 day mortality and morbidity,¹⁷¹ length of hospital stay, unplanned readmission or re-operation rates, and patient satisfaction.¹⁷² It was suggested in evidence by Dr Carter that data from audits conducted by individual departments within a hospital should be reported to the hospital Executive so that, in effect, the right hand of the hospital knows what the left hand is doing.¹⁷³ Dr Woodruff said that all doctors should be periodically assessed, and he drew comparison with the measures adopted by the aviation industry.¹⁷⁴ Regular audit of such doctors' practices might form a critical part of that process. There is a great deal of benefit in documenting data from audits, or even as suggested by one witness, computerising that data so as

¹⁶⁸ See in particular evidence of Drs de Lacy, Woodruff, Young, Strahan, Nankivell, Fitzgerald - T3263, T2873, T3622-3, T4328, T4440; see also concerns expressed by Dr Risson about the abandonment of the Otago audit system in Bundaberg – Exhibit 448, DWK63

¹⁶⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷⁰ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷¹ The monthly peer review of morbidities and mortalities is discussed in more detail below

¹⁷² *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p7

¹⁷³ T3985 (Dr Carter)

¹⁷⁴ Exhibit 283 para 35 and 36

to streamline the process of accessing data for the purpose of assessing doctors' performances.

- 6.211 Audit serves the purposes of identifying ways of improving the quality of care provided to patients and assisting in the continuing education of clinicians.¹⁷⁵ The most important purpose that clinical audit serves, in the context of this Commission, is that it provides a sense of perspective and places a doctor's deaths and complications in a meaningful context.

I mean, longitudinal data. I'll give you a simple example. Supposing at our next month's meeting at my hospital someone presents a wound dehiscence, which we've been talking about in the inquiry. What does that mean? Absolutely nothing. You will only know the meaning if you analyse that doctor's data over a period of time, because over the years everybody will get every complication, if you know what I'm trying to say. I mean, we all get complications. That's part of being a surgeon. What you have to do is look for a percentage because...we know what the acceptable, if you like, benchmarks are for, say, a wound dehiscence.¹⁷⁶

- 6.212 Morbidity and mortality meetings should comprise an aspect of peer review as part of the clinical audit process. They are held monthly by each clinical department in a hospital such as surgery.¹⁷⁷ Deaths and significant illnesses are presented, usually by junior doctors, and then discussed and analysed by the attendees openly in a non-judgmental way with the aim of improving the service for the future.¹⁷⁸ Cases are selected by the Chair of the meeting or the person they delegate that responsibility to.¹⁷⁹ Ideally, they should be attended by all clinical staff, not just the doctors.¹⁸⁰ It was Dr Woodruff's view that Directors of Medical Services should attend all morbidity and mortality meetings that occur in a hospital.¹⁸¹ Anyone can attend the meetings, including doctors from outside the hospital and Visiting Medical Officers.¹⁸² If the meetings are to be part of the clinical audit process then they should be documented.¹⁸³ Dr Woodruff testified that where a death involves multiple departments then all those departments should attend the meeting.¹⁸⁴
- 6.213 In order to achieve their aim, discussions at these meetings are frank and open, and sometimes robust.¹⁸⁵ Patients' cases are brought forward and attendees suggest other approaches to the treatment of those patients than were in fact

¹⁷⁵ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷⁶ T2984 (Dr Nankivell)

¹⁷⁷ Exhibit 283 para 33

¹⁷⁸ T3620 (Dr de Lacy)

¹⁷⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p14

¹⁸⁰ Exhibit 283 para 33

¹⁸¹ Exhibit 283 para 33

¹⁸² T3620 line 1 (Dr de Lacy)

¹⁸³ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 page 11; Exhibit 283 para 33

¹⁸⁴ Exhibit 283 para 33

¹⁸⁵ T3620 (Dr de Lacy)

adopted.¹⁸⁶ Topics of discussion at the meetings might include wound infection and dehiscence rates¹⁸⁷ and rates of anastomotic leak.¹⁸⁸

- 6.214 It is essential for vibrant morbidity and mortality meetings that doctors be encouraged as much as possible to attend and actively participate. Doctors will often face difficulty in attending because they have running operating lists. Morbidity and mortality meetings should be 'quarantined' so that no other business interrupts them.¹⁸⁹ Consideration should be given to setting aside a specific part of day which is wholly devoted to morbidity and mortality.¹⁹⁰ Further, it is desirable that doctors frankly and honestly discuss their patient deaths and adverse outcomes.¹⁹¹
- 6.215 It is important that morbidity and mortality meetings and other forms of audit should not be confused with complaints and incident management systems. They are complementary and not mutually exclusive. Dr Jeannette Young, Executive Director of Medical Services of the Princess Alexandra Hospital, testified that properly functioning morbidity and mortality meetings often uncover particular issues with doctors' competence which are usually raised with her by those present.¹⁹² Further, morbidity and mortality meetings can provide a transparent forum for review of decisions about reporting incidents, such as decisions about reporting deaths to the Coroner.¹⁹³ Documented audit and peer review uncovers problems and provides people with the opportunity to test the validity of concerns they hold. Moreover, the process provides a means of communicating concerns about clinicians throughout a hospital. If the process is documented and attended by the Director of Medical Services that officer is in a better informed position to assess complaints brought to his or her attention and how to act in response.
- 6.216 Similarly, audit and peer review can potentially provide invaluable data for the process of periodic review of clinical credentials and privileges.
- 6.217 For reasons set out above, the clinical audit/morbidity and mortality system in Bundaberg failed during Dr Patel's period there. Rather than being frank and robust discussions aimed at improving the quality of service, they were subverted by Dr Patel so that they were conducted as teaching sessions where he could demonstrate his medical knowledge to the junior students.¹⁹⁴ I am

¹⁸⁶ Exhibit 283 para 33, T3620 (Dr de Lacy)

¹⁸⁷ T3840 (Dr Boyd)

¹⁸⁸ T3833 (Dr Boyd)

¹⁸⁹ Exhibit 283 para 33

¹⁹⁰ T2984 (Dr Nankivell), T3962 (Dr O'Loughlin)

¹⁹¹ Exhibit 283 para 33

¹⁹² Presumably, the issues are initially canvassed with the doctor concerned and then raised with that doctor's superiors if the problems persist - T2847 (Dr Young)

¹⁹³ T3628 (Dr de Lacy), T5164-T5165 (Dr North)

¹⁹⁴ Dr de Lacy said the only resemblance the meetings bore to morbidity and mortality meetings was they shared the same name and that was all. He commented that the complications he subsequently saw during his review were not presented at the meetings – T3620

satisfied that had there been an effective process of clinical audit operating at Bundaberg at the relevant time it is more than likely that the following would have been uncovered and verified:

- 1) That Dr Patel's rates of complications and deaths were significantly higher than is to be expected from a reasonably competent general surgeon;
- 2) That the quality of care rendered by Dr Patel in individual cases was so inadequate that it would have been reasonable to seriously doubt his competence generally,¹⁹⁵ and
- 3) That the judgment he brought to treatment was seriously impaired.

6.218 The experience of Bundaberg shows that the process of audit and morbidity and mortality meetings relies on independence and transparency for its success. As much as possible there must be independent monitoring of collection and presentation of data. Dr Jeannette Young, for example, gave evidence that the Princess Alexandra Hospital takes steps to ensure that data on deaths and complications is collected and monitored independently of the doctors involved.¹⁹⁶ Most importantly, it is the role of the Director of Medical Services to oversee the whole process and ensure it is transparent and operating as it should.¹⁹⁷

6.219 Clinical audit and peer review is not only designed to discover rogues and underperformers. The process is an invaluable clinical tool that helps identify systemic issues affecting patient care. Where patterns or trends emerge, that can provide impetus for doctors to modify their practice.¹⁹⁸ For example, audit can identify problems with the use of a particular treatment in particular patients. On that basis practice can be altered to address that and improve service.

6.220 Further, clinical audit and peer review should not be seen as a check on the quality of care of only overseas trained doctors such as Dr Patel. Dr Woodruff testified that he knew of a couple of occasions when the performances of well regarded Fellows of the College dropped below an acceptable level requiring remedial action to be taken to correct them.¹⁹⁹ Dips in a competent surgeon's performance can happen for a number of reasons, including change of environment, age related loss of motor skills or dementia, and illnesses or

¹⁹⁵ Particularly pertinent in this context are the cases that Dr O'Loughlin reviewed that led him to question Dr Patel's proficiency at performing laparoscopic surgery and therefore question his competence as a general surgeon. I particularly note the case where Dr O'Loughlin said that if one of his registrars had rendered the same level of care rendered by Dr Patel in that case, he would probably suggest to that registrar that they consider a career other than surgery.

¹⁹⁶ T2848-9 (Dr Young)

¹⁹⁷ Exhibit 283 para 33

¹⁹⁸ T3967 (Dr O'Loughlin), T5132 (Dr North)

¹⁹⁹ T4337 (Dr Woodruff)

injuries.²⁰⁰ When such dips occur clinical audit provides an essential element of the systems that identify them so that remedial action can be taken.²⁰¹

- 6.221 I am of the opinion that all hospitals should have an effective clinical audit system. As a minimum this system should include monthly audit of all mortalities and significant morbidities.

Service Capability Framework

- 6.222 Not all hospitals are created equal. Some hospitals have access to more staff, expertise, infrastructure and facilities than others. There is an obvious distinction, for example, between tertiary referral hospitals and Base hospitals. The effect of this is that some hospitals have the capability to provide certain services safely whilst others do not. In this context, Queensland Health has developed a policy framework aimed at marking out the boundaries that limit the services that its hospitals can provide.
- 6.223 Prior to July 2004, there existed separate policy regimes for defining the limitations of health services that may be provided in public and private hospitals. The *Guide to the Role Delineation of Health Services* applied to public hospitals whilst *Guidelines for Clinical Services in Private Health Facilities* applied to private hospitals. For uniformity between the public and private sector a single policy applying to both sectors was released in July 2004 known as the Service Capability Framework.²⁰²
- 6.224 The Service Capability Framework is designed to 'outline the minimum support services, staffing, safety standards and other requirements required in both public and private health facilities to ensure safe and appropriately supported clinical services'.²⁰³ The framework rates each health facility's ability to deliver a range of clinical services according to a number of factors, including service complexity, patient characteristics, and support service availability and capability. A rating of either primary, Level 1, Level 2, Level 3, or Super-Specialist is then attributed to each service.²⁰⁴ The framework serves two purposes, namely to aid in planning of health services and to provide a broad framework for setting out the minimum knowledge, skills and services that should be available to a facility in order to safely provide a service.²⁰⁵ For example, the document is designed to ensure that hospitals are not performing surgery at a level of complexity beyond their capabilities.²⁰⁶ The framework

²⁰⁰ T4337 (Dr Woodruff); *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 page 21

²⁰¹ T2847 (Dr Young)

²⁰² Exhibit 231; T3147 and T3224 (Dr FitzGerald)

²⁰³ Exhibit 231 *Service Capability Framework* p(iii)

²⁰⁴ Exhibit 231 *Service Capability Framework* p8

²⁰⁵ Exhibit 231 *Service Capability Framework* pp2 and 3, T3343-4

²⁰⁶ T3221 (Dr FitzGerald)

should form an integral part of the credentialing process so that privileges are awarded to doctors according to the facilities available to the hospitals in which they practise.²⁰⁷

- 6.225 Bundaberg is an example of a situation where the absence of clearly defined boundaries rendered the Base vulnerable to a doctor who would perform procedures clearly beyond the capabilities of that hospital (oesophagectomies and whipples procedures). So is Hervey Bay where complex elective orthopaedic surgery should never have taken place.

Critical mass of appropriately experienced peers

- 6.226 As I have set out elsewhere in this report, Dr Patel operated in ‘splendid isolation’ from his peers and thereby avoided a level of oversight which could have revealed his inadequacies as a surgeon sooner.²⁰⁸ In large measure this was the result of the fact that the Base at the relevant time had on staff only two surgeons – Drs Patel and Gaffield, that Dr Patel was the Director of Surgery, and that Dr Gaffield had significantly less experience in general surgery. The only other doctors in the surgery department were very junior and were not in a position to assess Dr Patel’s work.
- 6.227 Hospitals should aim to engage a ‘critical mass’ of doctors. By maintaining a breadth of expertise within a hospital, no one doctor can become isolated, either by choice or accidentally, and thereby arbitrarily determine what is adequate care. Moreover, it seems that staffing shortages are threatening public health services’ abilities to meet demand, particularly in rural and regional areas where for reasons discussed above public hospitals struggle to recruit a critical mass of staff specialists.
- 6.228 I deal in more detail with the challenges facing rural and regional hospitals below. However, at this point it is convenient to set out a proposal that might go some way to addressing the practical difficulties public hospitals face in trying to develop critical mass.
- 6.229 Dr Woodruff proposed a strategy he described as ‘hub and spoke’. In essence, he proposed that all regional hospitals (spokes) be attached to tertiary referral hospitals (hubs). Hubs can contribute expertise and resources to spokes’ credentialing, audit, training, assessment and other processes. The use of technology such as teleconferencing and video link can aid in this process.²⁰⁹ Drs Woodruff and O’Loughlin both noted that Dr Patel seemed to practise in isolation and, in particular, did not confer with his colleagues in the tertiary

²⁰⁷ T3244 (Dr FitzGerald)

²⁰⁸ See Chapter Three – “Splendid Isolation”

²⁰⁹ Exhibit 283 para 32

referral hospitals.²¹⁰ Dr Woodruff inferred that Dr Patel, and many other overseas trained doctors, lacked the clinical networks developed with their colleagues after years of training and practice in Australia.²¹¹

6.230 Aiding overseas trained doctors to develop those networks is essential in the Queensland Health system which increasingly relies on them; first, because, as Dr O'Loughlin said, medicine is a multidisciplinary exercise and the best care is provided when doctors can draw on as much expertise as possible; and secondly, because the Queensland public hospital system is one where the vast bulk of resources and funding is concentrated in the tertiary referral hospitals. In a sense there needs to be a symbiosis between those hospitals and the rural and regional hospitals to improve the care provided in the regions.²¹²

Accredited training posts

6.231 I have identified elsewhere in this report the benefits which College accreditation for training of registrars bring to hospitals. In summary, those benefits are:²¹³

- (a) Higher level of competence of staff;
- (b) Registrars contribute to the breadth of expertise available for the process of informal audit of staff;
- (c) Because registrars possess a higher degree of competence than more junior doctors they take some of the pressure off those doctors and the senior doctors;
- (d) Potential for retention of Fellows following completion of registrars' specialty training;
- (e) A continuing culture of professional development amongst medical staff; and
- (f) The existence of a collegiate educational culture within hospitals which is an incentive for recruitment of specialists, including Visiting Medical Officers.

6.232 Further, increasing the number of accredited training posts is necessary so that the increased numbers of graduates from medical schools in Queensland are not lost.²¹⁴ The good work in overcoming the shortage of doctors in this state by increasing the intake of medical students will effectively be undone if those graduates cannot find training positions.

²¹⁰ See Chapter Three – Competency of Dr Patel

²¹¹ T4291 and T4338 (Dr Woodruff)

²¹² I note the efforts of Townsville in this regard. See Chapter Five and in particular reference to the assistance Townsville Hospital provides for credentialing and privileging in smaller hospitals in the Northern Zone

²¹³ See Chapter Three – History of the Hospital and Chapter Five – Rockhampton Hospital; see also T1824

²¹⁴ See the discussion in Chapter Two on steps taken to increase the number of places for medical students

Safe working hours

- 6.233 A consistent theme that ran throughout the evidence before this Commission was the impact of unsafe working hours on clinical standards and patient safety.
- 6.234 Drs Nankivell, Baker, Jelliffe and others consistently gave evidence that they were required to work impossible hours at the Base.²¹⁵ Both Drs Jelliffe and Nankivell gave evidence that the effect on a doctor's ability to provide medical care who is suffering from tiredness is similar to a doctor who is under the influence of alcohol.²¹⁶ In particular, Dr Jelliffe referred to studies that have shown the ability of a doctor who has been working for ten consecutive hours is impaired to an extent equivalent to a doctor whose blood alcohol level is 0.05, and the effect gets worse as the number of hours rises.²¹⁷ Doctors at the Base were regularly required to work well over ten consecutive hours at a time.²¹⁸
- 6.235 Not only do safe working hours enhance patient safety, they are conducive to the retention of quality staff. I am satisfied that the diaspora of 'wounded soldiers' from the Bundaberg Base Hospital was in part precipitated by the work loads to which they were subject. Dr Jelliffe recalled the condition of Dr Nankivell at the time he left the Base following a period in which the only other staff surgeon there, Dr Baker, had been away on leave:²¹⁹
- He had been broken on the wheel at the hospital. He looked grey and old. He was...doing a one-in-one (on call roster). He really had no choice. I think he had to leave for his health. You can't keep up that sort of punishing roster.
- 6.236 That Bundaberg lost a Fellow of the College of the calibre of Dr Nankivell is a tragedy, given what eventually transpired there. When he turned to the Medical Board for direction on safe working hours he was informed that it was not the Board's role to define safe working hours, and that he should instead consult with the Australian Medical Association, his employer (Queensland Health) or the Department of Industrial Relations.²²⁰ I do not doubt the Board's assertion in that regard. However, unfortunately for Dr Nankivell, he is not a member of the Australian Medical Association.²²¹

Continuing medical education

- 6.237 Fellows of the relevant Colleges are subject to obligations that they must engage in continuing medical education, re-accreditation courses and other educational and quality assurance activities.²²² This process of continuing education adds to

²¹⁵ See Chapter Three

²¹⁶ T2971 (Dr Nankivell); T6656 (Dr Jelliffe)

²¹⁷ T6656 (Dr Jelliffe)

²¹⁸ See Chapter Three

²¹⁹ T6652 (Dr Jelliffe)

²²⁰ Exhibit 215

²²¹ T3003 (Dr Nankivell)

²²² See Chapter Three – The Competency of Dr Patel; T776

the quality of delivery of medical care through the ongoing maintenance of clinicians' currency of practice and competency.

Rural and regional challenges

6.238 Largely because of isolation and lack of resources, rural and regional hospitals face substantial challenges in implementing measures aimed at maintaining clinical standards, namely:

- (a) Difficulties in funding, attracting and retaining a critical mass of doctors, which means:
 - As in Bundaberg, the morbidity and mortality process is vulnerable to subversion because there are insufficient doctors involved in the process to ensure that it is independent and transparent;
 - Rural and regional hospitals do not have sufficient doctors to ensure their doctors are not overworked; and
 - Because of insufficient staff rural and regional hospitals struggle to meet the demands for services placed upon them;
- (b) Difficulties in gaining accreditation for College training posts; and
- (c) Difficulties in attracting training registrars, because of isolation and the obvious disparities between the tertiary hospitals and regional hospitals in terms of the variety of expertise that can be devoted to the educational experience.

6.239 Potentially, if the model for the delivery of public health services is not adapted to accommodate these peculiar challenges, a two-tiered health system in Queensland may perpetuate. That is, a system where the quality of care delivered in the cities is superior to the quality of care delivered in the regions.

6.240 I do not accept that the challenges facing rural and regional hospitals should inevitably lead to a two-tiered health system. Standards in rural and regional hospitals should be made a priority.

6.241 The principal step that must be taken is that rural and regional public hospitals must engage the private sector. The experience of Bundaberg provides a particularly salient illustration of the following statement:

The public and private systems may be able to run in parallel in the metropolitan areas, but in provincial areas, for health services to be optimised it has to be done jointly between the private and the public sector because that's the way in which you will have the broadest range of clinical services available.²²³

6.242 The best means of engaging the private sector is through increased use of Visiting Medical Officers. I do not suggest that either Staff Specialists or Visiting Medical Officers are necessarily superior to the other. Each serves a particular

²²³ T1826 (Dr Thiele)

purpose.²²⁴ However, it is vital that rural and regional hospitals draw on the private sector by way of Visiting Medical Officers. Bundaberg had a wealth of surgical experience in the private sector during Dr Patel's tenure as Director of Surgery at the Base. That experience could be an invaluable resource to draw on to ensure patient safety. I say this for the following reasons:

- Visiting Medical Officers with Staff Specialists could provide the necessary critical mass of expertise to ensure the effectiveness of the audit and peer review process;
- Offering more Visiting Medical Officer positions to new specialists rural and regional hospitals can increase the depth of talent available in their areas;²²⁵
- Visiting Medical Officers supplement the staff available to public hospitals so as to ensure Staff Specialists are not overworked;²²⁶
- Visiting Medical Officers increase staff available to rural and regional hospitals to meet demand for their services; and
- Visiting Medical Officers help provide the level of supervision required for College training accreditation.²²⁷

6.243 With respect to morbidity and mortality meetings more generally, rural and regional hospitals should consider the following steps so as to ensure the process is vibrant, effective, independent and transparent:

- a) Involving outsiders; outsiders chair the meetings;²²⁸ indeed, perhaps chairs can rotate on a monthly basis;²²⁹
- b) Holding multidisciplinary meetings between general practitioners and other specialist disciplines;²³⁰
- c) Holding meetings which combine doctors from a number of districts, for example Bundaberg and the Fraser Coast;²³¹ and
- d) Involving outsider doctors from metropolitan areas in morbidity and mortality meetings through regular visits and the use of teleconferencing facilities, online chat groups or discussion forums.²³²

6.244 To an extent the ability of rural and regional hospitals to secure College accreditation for training depends on the resources available to them. For

²²⁴ T2856 (Dr Young)

²²⁵ The option of becoming a Visiting Medical Officer is quite attractive to new private specialists. It provides them with a base income while they establish their private practice - T1826 (Dr Thiele)

²²⁶ Dr Nankivell testified that the presence of a few Visiting Medical Officers at the Base during his time there would have made his roster acceptable - T2935

²²⁷ Chapter Three – History of the Hospital

²²⁸ T3622-T3623 (Dr de Lacy)

²²⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

²³⁰ T4560

²³¹ T4560; *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

²³² *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

example, one of the essential requirements imposed by the Royal Australasian College of Surgeons for accreditation is that registrars be supervised by one of its fellows.²³³ However, many of the measures required for accreditation, such as safe working hours, risk management, credentialing, audit and peer review,²³⁴ represent measures aimed at maintaining standards and ensuring patient safety. Hospitals should be implementing these measures in any event, quite apart from the aim to gain accreditation.

- 6.245 In addition to accreditation, hospitals should strive to attract trainees, which as I have said elsewhere require an environment where those trainees can be assured of an attractive educational experience. Measures such as regular weekly clinical meetings, visits from Brisbane specialists, teaching ward rounds, and regular educational presentations all contribute to this experience.²³⁵

Recommendations

- 6.246 All hospitals must have effective clinical audit systems. As a minimum these systems should include monthly audit of all mortalities and significant morbidities. Hospitals must ensure that their clinical audit systems are independent and transparent. Whilst it is not my function to determine what steps they should employ to ensure this, rural and regional hospitals in particular, should consider the measures aimed at that purpose that I have outlined above and others.
- 6.247 Rural and regional hospitals must engage the private sector as much as possible, such as by the use of Visiting Medical Officers.
- 6.248 All primary referral hospitals should aim to gain accredited training status with the relevant Colleges. Adequate resources and funding should be allocated to those hospitals for this purpose. Steps should be taken to encourage trainees to fill training posts.

Complaints and incidents management

- 6.249 In the course of his evidence before the Commission, Dr Molloy, the President of the Australian Medical Association, acknowledged complaints against doctors – even if they take the form of litigious claims - can be an important tool in

²³³ *Accreditation of Hospitals and Posts for Surgical Training: Process and Criteria for Accreditation*, viewed at www.surgeons.org on 11 November 2005 p4

²³⁴ *Accreditation of Hospitals and Posts for Surgical Training: Process and Criteria for Accreditation*, viewed at www.surgeons.org on 11 November 2005

²³⁵ See Chapter Three – History of the Hospital

maintaining professional standards.²³⁶ Dr Nydam from Bundaberg Base Hospital gave evidence that, even when he was the Assistant Director of Medical Services, he would personally prepare medico-legal reports for lawyers because it presented a ‘fantastic opportunity for clinical audit...as an educator, I need to work out where things can be improved, and writing these letters, after a consideration of clinical notes, provided a very, very fertile ground...’²³⁷ The importance of recording, and acting upon, complaints was further emphasised in evidence when it was realised that, of the many complaints received during Dr Patel’s term, almost all of them were subsequently vindicated by Drs de Lacy, O’Loughlin or Woodruff.²³⁸

- 6.250 Those matters above underline what is perhaps self evident. However, many Queenslanders are reticent to make complaints. When they do, it will often be a very good indicator that they have received poor care or, at the very least, that there has been poor communication. This will be all the more so where complaints are made by medical staff because, first, there is no reason to suspect any over-readiness on their part to make complaints about colleagues²³⁹ and, secondly, they will have a technical understanding of treatment which is rarely available to patients and relatives.
- 6.251 An organisation which welcomes and addresses complaints frankly is likely to achieve more just outcomes, and it is likely in turn to minimise litigation. Furthermore, if the organisation responds properly to complaints, it is likely to function at a much higher level in the future. For those reasons, the issues addressed in this chapter are critical to confidence and clinical standards in our public hospitals.

The multiple avenues for complaints about medical treatment

- 6.252 If a patient, a patient’s relative or a member of staff wishes to complain about treatment received, or to raise an issue about conditions, in a public hospital there are various authorities to whom they might turn. The choice of the appropriate authority can be difficult and confusing, and it is perhaps complicated further by the fact that, at times, the complaint might be received by more than one body. The complaint could be made:
- a) Within the public hospital to an appropriate employee of Queensland Health;
 - b) If the complaint is to be about a medical practitioner, to the Medical Board of Queensland;

²³⁶ T770, T800 (Dr Molloy)

²³⁷ T4108 (Dr Nydam)

²³⁸ See Chapter Three

²³⁹ On the contrary it has been that doctors may tend not to make complaints about the performance of a colleague: eg Shipman Inquiry 3rd Report Chapter 11 available at www.the-shipman-inquiry.org.uk/thirdreport.asp

- c) If the complaint is to be about a nurse, to the Queensland Nursing Council;
- d) If the complaint is to be about an allied health worker, such as a physiotherapist or an occupational therapist, to the relevant registration board. Queensland has twelve other boards²⁴⁰ Each board is established under an Act with the function of registering, suspending or cancelling the registration of practitioners of any kind of health service.
- e) If the matter involves suspected official misconduct, for instance a sexual assault by a medical practitioner, a nurse or an allied health worker employed by Queensland Health, to the Crime and Misconduct Commission;
- f) If the complaint is to be about administrative action, to the Ombudsman;²⁴¹
- g) If the matter involves an unexpected death whilst in hospital, to the Coroner;²⁴²
- h) To the Health Rights Commissioner if the complaint is about the service of any provider of a health service whether the provider be a doctor, nurse or allied health worker;
- i) By litigation or the threat of it.

6.253 People wishing to choose where to take a complaint are faced with further complexity. They will find that different bodies have different investigative powers and remedial powers and that those powers may be curtailed as certain circumstances arise in the course of the investigation.²⁴³

6.254 To demonstrate deficiencies and inefficiency of the current health complaints system in Queensland and the consequential frustration for complainants, I set out some of the history from a recent case study performed by the Ombudsman²⁴⁴ which details the investigation of a complaint made to him. I will refer to it in the chapter as the 'Ombudsman's case study'.

6.255 The Ombudsman's case study is particularly apt to illustrate the complex and confusing nature of the health complaints system in Queensland. The complainants wished to complain about the tragic death of their child at a regional Queensland Hospital on 7 January 2002. The father is a Medical Practitioner, a senior official in Queensland Health and had a good understanding of the relevant systems for making complaints. Few members of

²⁴⁰ The various Registration Boards are in schedule 2 of the *Health Rights Commission Act 1991* and are Chiropractors Board of Queensland; Dental Board of Queensland; Dental Technicians and Dental Prosthetists Board of Queensland; Medical Board of Queensland; Medical Radiation Technologists Board of Queensland; Occupational Therapists Board of Queensland; Optometrists Board of Queensland; Osteopaths Board of Queensland; Pharmacists Board of Queensland; Physiotherapists Board of Queensland; Podiatrists Board of Queensland; Psychologists Board of Queensland; Queensland Nursing Council; Speech Pathologists Board of Queensland.

²⁴¹ see *Ombudsman Act 2001*

²⁴² *Coroners Act 2003* s7

²⁴³ The Health Rights Commission, for instance, cannot continue with an investigation where the complaint is the subject of litigation. Bodies such as the Queensland Nursing Council may choose to defer investigations where a coronial inquest is expected

²⁴⁴ Referred to in the Submission of Ombudsman dated August 2005 (Volume 3 Submissions No 26)

the public would have the advantages which these parents had in selecting the appropriate bodies to whom to make their complaints and in describing the issues for the complaint. Despite the advantages which they had, the fragmented health complaints system in Queensland meant that there were no less than seven separate inquiries into aspects of an adverse incident. There were inquiries by the State Coroner, the Health Rights Commissioner, the Medical Board of Queensland, the Queensland Nursing Council, the Crime and Misconduct Commission and the Queensland Ombudsman. When the Ombudsman made a submission in August this year, it seems that more than 3 years after the parents made their first complaints, some aspects of the process were still incomplete.

6.256 The Ombudsman's case study reveals:

(a) As for Queensland Health:

- On 11 January 2002, the Executive Director of Medical Services of the relevant Health Service District provided a Preliminary Investigation about the incident to Queensland Health's corporate office, concluding that the treatment provided was reasonable;
- In about March/April 2002, the doctor and his wife lodged complaints with Queensland Health, the Health Rights Commission, the Medical Board of Queensland, and the Queensland Nursing Council concerning treatment provided at the hospital;
- They also raised concerns about a 'Preliminary Investigation Report' prepared by the Executive Director of Medical Services for the relevant district;
- Indeed, they sent a 21 page letter to Queensland Health, seeking a full investigation;
- A senior executive within Queensland Health advised that, given that the Health Rights Commission, the Medical Board, the Queensland Nursing Council, and the State Coroner were likely to conduct their own investigations, Queensland Health would postpone its inquiries;
- In December 2003, after the doctor and his wife drew attention to their still unresolved concerns, another senior executive within Queensland Health commissioned a neurologist to review the circumstances the subject of the complaint;
- The neurologist's report was presented to Queensland Health in June 2004;
- The couple maintain that they have not been informed, subsequently, of the actions taken by Queensland Health in respect of the neurologist's findings and recommendations.

- (b) As for the Health Rights Commission:
- It informed the couple on 10 May 2002 that their complaint had been accepted for assessment and indicated that, in its view, the complaint raised four key issues;
 - On 8 August 2002, the Health Rights Commission indicated that it would investigate the first and fourth issues but, because the second and third concerned nurses and doctors, the Commission had a statutory obligation to consult with the Queensland Nursing Council and the Medical Board respectively to determine whether each of those bodies would accept the complaint for further action;
 - The Queensland Nursing Council and the Medical Board agreed subsequently to investigate the second and third issues;
 - The Health Rights Commission made inquiries of the relevant District Manager about the first and fourth issues, but whilst there was initially co-operation, a challenge was then made to the Commission's jurisdiction on the fourth issue. After seeking advice from Crown Law, the Health Rights Commission decided it did not have jurisdiction because, as the allegation concerned the Preliminary Investigation Report, it did not relate to an administrative service directly related to a health service. It informed the couple accordingly on 16 July 2003;
 - On 4 September 2003, the Health Rights Commission delivered a report but it did not make any recommendations;
 - The couple were unhappy about certain aspects of the report and the Commission agreed to conduct a review. That review was not published until 28 June 2004. It found that there were a number of systemic issues that needed to be addressed at the regional hospital: it made recommendations accordingly.
- (c) As for the Medical Board:
- it received a complaint on 10 April 2002 and a referral from the Health Rights Commission on 7 August 2002;
 - The Board appointed an investigator from the Office of the Health Practitioner Registration Boards on 27 August 2002;
 - After repeated complaints about delay, the Office of the Health Practitioner Registration Boards appointed an external investigator on 24 June 2003;
 - The Office of the Health Practitioner Registration Boards provided a copy of the investigator's report to the couple on 20 January 2004;

- The Office of the Health Practitioner Registration Boards referred the matter to the Health Practitioners Tribunal and, on 8 November 2004, certain disciplinary action was taken against a doctor.
- (d) As for the Queensland Nurses Council:
- It received a copy of the complaint on 11 April 2002 and it received the referral from the Health Rights Commission in August 2002;
 - The Council agreed to investigate the complaint about one nurse;
 - The investigator completed her report in July 2004;
 - Subsequently, the Queensland Nurses Council sought legal advice and as a result decided not to proceed against a nurse;
 - It is still unclear, nearly 18 months after the completion of the investigators report, whether disciplinary action is to be taken against the first nurse.

On 24 December 2003, the couple referred the matter to the Ombudsman. The Ombudsman has indicated that he is concerned that there were four separate investigations, by four different agencies, acting under different legislation, and that there were considerable delays and dissatisfaction that accompanied the process.

6.257 One can see that there is some scope for adopting a more centralised approach to managing complaints in this State. Before considering that option, I address in turn below, several of the avenues currently available for making complaints.

Complaints made within a public hospital

Overview

6.258 As already indicated, there were a range of systems through which problems and issues can be reported, detected and analysed in the hospital environment:

- 1) Complaint processes;
- 2) Incident reporting;
- 3) Risk Management;
- 4) Clinical governance committees; and
- 5) Clinical audits and peer review.

To better understand why Dr Patel was able to practise for so long, despite his incompetence, it is necessary to consider what went wrong with those systems. I have already shown how the last of these failed at Bundaberg. So also did the complaints processes, incident reporting and risk management. Their failure shows that having an adequate policy is not sufficient.

6.259 There were three Queensland Health policies applying statewide which, in various versions, applied during the period of Dr Patel's employment for the management of complaints and incidents raised by patients and staff. If properly implemented and followed at Bundaberg, they should have been useful for picking up surgical incompetence. They were:

- (a) the Complaints Management Policy.²⁴⁵ This policy was effective from 31 August 2002 and governs the management of complaints made by or on behalf of patients;
- (b) the Integrated Risk Management Policy. Two versions of this policy existed during the relevant period. It prescribes how staff should respond to risks which arise in the hospital. The earlier version effective from February 2002 was replaced by another version²⁴⁶ in June 2004; and
- (c) the Incident Management Policy²⁴⁷ which governed treatment of clinical issues raised by hospital staff and was effective from June 2004.

6.260 In addition to these Queensland Health policies, the Bundaberg Base Hospital developed local policies which also dealt with practical application of the matters the subject of the Queensland Health policies.

6.261 The following chronology details when the relevant Queensland Health and Bundaberg policies relating to patient and staff complaints and risk analysis were introduced:

Feb 2002	Queensland Health Integrated Risk Management Policy ²⁴⁸
May 2002 ²⁴⁹	Bundaberg Complaints Management System ²⁵⁰
July 2002	Queensland Health Complaints Management Policy ²⁵¹
Dec 2002	Bundaberg Risk Management Process ²⁵²
Feb 2004 ²⁵³	Bundaberg Adverse Events Management Policy ²⁵⁴
June 2004	Queensland Health Integrated Risk Management Policy (replaced policy of February 2002) ²⁵⁵
June 2004	Queensland Health Incident Management Policy ²⁵⁶

²⁴⁵ Exhibit 292

²⁴⁶ Exhibit 293

²⁴⁷ Exhibit 290A JGW6 Statement Wakefield

²⁴⁸ Exhibit 293

²⁴⁹ Exhibit 162 para 11 Statement Raven

²⁵⁰ Exhibit 162 LTR2 Statement Raven

²⁵¹ Exhibit 292

²⁵² Exhibit 162 LTR3 Statement Raven

²⁵³ Exhibit 162 para 21 Statement Raven

²⁵⁴ Exhibit 162 LTR4 Statement Raven

²⁵⁵ Exhibit 293

June 2004	Bundaberg Sentinel Events and Root Cause Analysis Policy ²⁵⁷
Nov 2004	Bundaberg Incident Management – Clinical and Non-Clinical (replaced Bundaberg Adverse Events Management Policy) ²⁵⁸
Nov 2004	Bundaberg Incident Analysis Policy ²⁵⁹
Nov 2004	Bundaberg Sentinel Events and In-depth Analysis Policy (replaced Bundaberg Sentinel Events and Root Cause Analysis Policy) ²⁶⁰
Nov 2004	Bundaberg Risk Management Process (replaced Bundaberg Risk Management Process issued in December 2002) ²⁶¹

Complaints Management Policy

6.262 The Queensland Health Complaints Management Policy²⁶² governs how Queensland Health should deal with complaints by or on behalf of patients. This policy should have been used at the Bundaberg Base Hospital for recording and analysing patient complaints. Patients are referred to by Queensland Health in the policy as ‘consumers’. The policy does not apply to staff complaints.²⁶³ When staff had clinical issues to raise they were dealt with under a different policy, namely the Incident Management Policy.

6.263 It was observed in the Queensland Health Systems Review, Final Report,²⁶⁴ that the ‘policy reflects contemporary best practice’. The Queensland Ombudsman reported to the Director-General of Queensland Health in March 2004 that the policy ‘compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management’.²⁶⁵ However, each of those compliments was based upon the policy but not upon its implementation. The Queensland Health Systems Review, Final Report observed that implementation of the policy throughout the state had been poor. The Ombudsman in March 2004 recommended that Queensland Health improve the awareness of its staff of the patient complaints management system.

6.264 The Queensland Health Complaints Management Policy relevantly provides:

- Health care consumers have the right to receive feedback and have complaints heard and acted upon;²⁶⁶

²⁵⁶ Exhibit 290A JGW6 Statement Wakefield

²⁵⁷ Exhibit 162 LTR6 Statement Raven

²⁵⁸ Exhibit 162 LTR7 Statement Raven

²⁵⁹ Exhibit 162 LTR7 Statement Raven

²⁶⁰ Exhibit 162 LTR7 Statement Raven

²⁶¹ Exhibit 162 LTR7 Statement Raven

²⁶² Exhibit 292

²⁶³ Exhibit 292: Scope and Application

²⁶⁴ Queensland Health Systems Review, Final Report p189 (www.healthreview.com.au)

²⁶⁵ Queensland Ombudsman submission to the Bundaberg Hospital Commission of Inquiry August 2005 page 43

²⁶⁶ Exhibit 292: Policy Statement

- Information from the complaints management process is used to improve quality and safety in health care;²⁶⁷
- All complaints are to be assessed in a manner that reflects the seriousness of the complaint, in categories that can be applied to the risk management framework ie. negligible, minor, moderate, major or extreme;²⁶⁸
- Complaints rated as moderate, major or extreme will be referred to the Complaints Coordinator for action, the Complaints Coordinator will inform the District Manager of major or extreme complaints and the District Manager will inform the General Manager, Health Service of extreme complaints;²⁶⁹
- Staff are encouraged to resolve minor complaints at the point of service; if this is not achieved the matter should be referred to the Complaint Coordinator who will arrange referral to the district executive. An investigator should undertake an in-depth and or root cause analysis of complaint matters;²⁷⁰
- All parties involved in a complaint are advised of the outcome of the complaint;²⁷¹
- Local processes should be put in place to support best practice in complaint handling;²⁷²
- Organisation wide improvements should result from both aggregated and individual complaint information;²⁷³ and
- A complaints management procedure and register will be in place in each District.²⁷⁴

6.265 From May 2002 a local policy also applied In the Bundaberg Health Service District. Relevantly, the Bundaberg Complaints Management System²⁷⁵ provided:

- Complaints that cannot be resolved at the point of service should be referred to the relevant Executive Director;

²⁶⁷ Exhibit 292: Policy Statement

²⁶⁸ Exhibit 292: Seriousness Categories

²⁶⁹ Exhibit 292: Reporting

²⁷⁰ Exhibit 292: Appendix 1 Complaint Handling Model

²⁷¹ Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷² Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷³ Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷⁴ Exhibit 292: Instruction, Implementation Process

²⁷⁵ Exhibit 162 LTR2 Statement Raven

- The investigation should be coordinated by the line manager or executive member and all quality improvement activities are to be registered with the Quality Management Unit and Improving Performance Committee;
- When the complaint is resolved all relevant documents are to be sent to the Complaints Coordinator for inclusion on the Complaints Register; and
- The Complaints Coordinator will provide a bimonthly report to the Leadership and Management Committee.²⁷⁶

Incident Management Policy

6.266 The Queensland Health Incident Management Policy²⁷⁷ covers all incidents, clinical and non-clinical, defined in the policy as ‘an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage’.²⁷⁸ Events with a very high and extreme risk rating and sentinel events must be reported to the District Manager, State Manager and relevant Corporate Office Branch Executive. All incidents must be reported on an incident report form and each district is to maintain a comprehensive register.²⁷⁹

The Queensland Health Incident Management policy is supplemented by three local policies In the Bundaberg Health Service District:

- Incident Management Policy;²⁸⁰
- Incident Analysis Policy;²⁸¹ and
- Sentinel Events and In-depth Analysis Policy.²⁸²

Integrated Risk Management Policy

6.267 The Queensland Health Integrated Risk Management Policy²⁸³ focuses on establishing an organisational philosophy and culture that ensures risk management is an integral part of decision making activities. This policy also applied during the period of Dr Patel’s employment. The Policy provides an ‘Integrated Risk Management Analysis Matrix’ for the risk rating of incidents. The Policy details specific requirements for reporting risks, including:

²⁷⁶ Exhibit 162 LTR2 Statement Raven

²⁷⁷ Exhibit 290A JGW6 Statement Wakefield

²⁷⁸ Exhibit 290A JGW6 Statement Wakefield: Incident Categories

²⁷⁹ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording

²⁸⁰ Exhibit 162 LTR7 Statement Raven. This policy was issued in November 2004 replacing the Adverse Events Management Policy Exhibit 162 LTR4 Statement Raven

²⁸¹ Exhibit 162 LTR7 Statement Raven

²⁸² Exhibit 162 LTR7 Statement Raven. This policy was issued in November 2004 replacing the Sentinel Events and Root Cause Analysis Policy Exhibit 162 LTR6 Statement of Raven

²⁸³ Exhibit 293

- Each district will report very high and extreme risks to their appropriate line management; and
- Each district will provide to the Risk Management Coordinator, a quarterly download of the Risk Register and details of risks that have a rating of very high or extreme.

6.268 The Queensland Health Integrated Risk Management Policy sets out principles and leaves much of the practical detail to local policy, the Bundaberg Risk Management Process.²⁸⁴ The local policy which applied throughout Dr Patel's employment requires that risks are systematically identified in each Clinical Service Forum. The Improving Performance Committee is to maintain a Central Risk Register. The Improving Performance Committee may delegate responsibility for the treatment of risks to the relevant committee. The Risk Register must be provided to the Queensland Health Integrated Risk Management Coordinator on a quarterly basis.

What went wrong in Bundaberg?

6.269 Throughout the course of the Commission it became apparent that there had been a steady stream of complaints and clinically significant incidents involving Dr Patel which commenced shortly after his arrival in Bundaberg. There were informal concerns. There were formal ones, by which I mean occasions where patients or staff filled in forms referring to clinical incidents relating to Dr Patel or formally brought issues relating to Dr Patel to the attention of the executive or a committee. If one excludes Dr Patel's holidays, his activities resulted in about one formal patient complaint or formal staff report for each month he actually worked. Despite this, the cumulative significance of the informal and the formal complaints and reports went either undetected or unaddressed for almost two years. A number of factors contributed to this:

- Many adverse incidents which occurred were not made the subject of a complaint nor of an incident report;
- Many complaints and incidents which were formalised were not dealt with as they should have been if the policies had been complied with;
- There was inadequate investigation of complaints;
- There was inadequate risk rating and referral;
- There was inadequate response and resolution;
- There was inadequate management and use of data; and

²⁸⁴ Risk Management Process (December 2002) and Risk Management Process (November 2004) Exhibit 162 LTR3 and LTR7 Statement Raven

- Implementation of systems was hindered by inadequate money, staff and time.

Many adverse incidents were not made the subject of a complaint nor of an incident report

6.270 In the two year period of Dr Patel's employment at the Bundaberg Hospital there were 22²⁸⁵ incidents or issues that were formally reported in one form or another. They can be broken down as follows:

- 7 patient complaints;
- 7 incidents reported to a member of the executive (with no formal incident report form);
- 3 incidents reported with an Incident Report only;
- 2 reported to a member of the executive and an Incident Report was completed;
- 1 incident reported to a member of the executive and a committee;
- 1 incident reported to a committee only;
- 1 incident reported by a patient complaint, Incident Report and to a member of the executive.

6.271 When the issues surrounding Dr Patel came to light, Queensland Health arranged reviews for patients who had received treatment from Dr Patel. The review conducted by Dr Peter Woodruff involved a review of charts but not of patients. It was not a random selection of charts. Dr Woodruff was confined to reviewing charts of a particular kind. The terms of reference for the cases which were to be reviewed by Dr Woodruff was relatively general. The team appointed on 18 April 2005 were to 'review the clinical cases of Dr Patel where there has been an identified adverse outcome, or where issues related to his clinical practice have been raised'.²⁸⁶

6.272 One would expect that the reviewers ought to have been able to identify those cases from the two registers that should have been established pursuant to the Queensland Health Complaints Management and Incident Management policies. They were the Complaints Register which recorded complaints made by and on behalf of patients²⁸⁷ and the Adverse Event Register which recorded incidents raised by staff.²⁸⁸

²⁸⁵ See discussion in Chapter Three: Dr Patel Works at the Base

²⁸⁶ Exhibit 102 p20

²⁸⁷ Exhibit 166

²⁸⁸ Exhibit 167

- 6.273 When one bears in mind the extraordinary findings of Dr de Lacy,²⁸⁹ Dr O'Loughlin²⁹⁰ and Dr Woodruff,²⁹¹ as to the number of procedures performed incompetently by Dr Patel with adverse results, one would expect both registers to be filled with the name Patel.
- 6.274 When the Quality Coordinator was first asked to identify complaints and incidents about Dr Patel, a review of the Complaints and Adverse Incidents registers revealed only three complaints²⁹² and five adverse events.²⁹³ There were in fact other entries on each register which related to Dr Patel that were not picked up because the medical practitioner's name was not, as a rule, put on the registers.
- 6.275 In the months after the Patel issue became public, the Quality Coordinator at the Base was able to find another five records of adverse events relating to Dr Patel's care that had been reported by staff. The extra five had not appeared on the register because they occurred before the Adverse Events Register was commenced in February 2004.²⁹⁴
- 6.276 The failure of the Base to record the names of the medical practitioners about whose treatment complaints were made or issues were raised, is explained by a desire to promote better reporting by promoting the notion of a blame free culture. It did not promote adequate reporting. Reporting was lamentable. The failure to record Dr Patel's name must have helped to conceal his dangerous incompetence.
- 6.277 Dr Woodruff did not content himself with an investigation of the three patients whose complaints identified Dr Patel on the Complaints Register and the five patients about whom entries appeared on the Adverse Events Register. Dr Woodruff was forced to look wider. He chose to look at the patients who died, those who were transferred to other institutions and at those identified as having adverse outcomes which were brought to the attention of the Review Team.²⁹⁵
- 6.278 Dr Woodruff gave evidence that, of the patients' charts he reviewed, 22²⁹⁶ showed to him that Dr Patel contributed to an adverse outcome and a further 24²⁹⁷ showed that Dr Patel may have contributed to an adverse outcome. Of the 46 adverse outcomes identified by Dr Woodruff, only seven appear on the

²⁸⁹ Para 3.416 herein

²⁹⁰ Para 3.417 herein

²⁹¹ Para 3.418 herein

²⁹² Exhibit 162 para 29

²⁹³ Exhibit 162 para 33

²⁹⁴ Exhibit 162 paras 54-60

²⁹⁵ Exhibit 102 p47

²⁹⁶ Exhibit 102, p120-125

²⁹⁷ Exhibit 102, p126-130

Adverse Events Register²⁹⁸ and only six appear on the Complaints Register^{299, 300}.

- 6.279 With respect to patient complaints, it is probably the case that many would not have been aware that their problems were the result of clinical deficiencies. Many would have assumed, or may have been informed, that any ongoing problems were normal or to be expected, hence no complaint was made.
- 6.280 The reasons why incidents were not more frequently reported by clinical staff are not so easily explained. Under the Queensland Health Incident Management Policy, which came into effect in June 2004, all incidents must be reported.³⁰¹ For the purposes of the policy, the term incident is defined as 'an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person ..., and/or a complaint, loss or damage'.³⁰² The local policies, one of which was in operation from February 2004³⁰³ had similar reporting requirements.
- 6.281 It is worth reiterating. The doctors and nurses at the Base were obliged by the policies in effect from February 2004 to report even incidents which could have led to unintended harm to a patient. It obviously was not honored by staff or sufficiently encouraged by the executive.

Unhealthy culture for staff to complain and report incidents

- 6.282 For any complaints systems to function properly it is vital that people are willing to come forward and 'speak up' about concerns that they have.
- 6.283 Whilst Toni Hoffmann campaigned (quite consistently and courageously) over quite some time to bring her concerns about Dr Patel's practices to light, many other staff at the Base were less than forthcoming in their concerns. A significant number of reportable incidents occurred in Bundaberg but were not reported.
- 6.284 In the aftermath of the Bramich incident, Dr Strahan indicated to Ms Hoffmann that there were a number of other people who had concerns about Dr Patel but were not willing to 'stick their necks out'.³⁰⁴ Whilst Dr Miach communicated his concerns about Dr Patel's incompetence in the insertion of catheters, he did not tell his line superiors, Dr Keating or Mr Leck that he had given instructions that his patients were not to be touched by Dr Patel. Indeed, he asked that Ms

²⁹⁸ Exhibit 167

²⁹⁹ Exhibit 166

³⁰⁰ These figures are with respect to the surgery or adverse outcomes referred to by Dr Woodruff. Instances where the patient appears on the register for a distinct adverse event (eg. a fall or system error) have not been included. The register was checked for complaints made prior to April 2005

³⁰¹ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording

³⁰² Exhibit 290A JGW6 Statement Wakefield: Incident categories

³⁰³ Exhibit 162 LTR4 Statement Raven

³⁰⁴ T1490 (Ms Hoffman)

Pollock not minute that direction at an ASPIC meeting.³⁰⁵ There are a number of reasons for staff reluctance to report safety issues.

- 6.285 First, some would have felt unwilling to tell of their concerns and effectively challenge Dr Patel, who was known to intimidate staff and effect some retribution upon those who challenged him. Consistent with this impression was the collective understanding propagated among the staff who worked with Dr Patel that because Dr Patel generated a large amount of revenue for the hospital by his capacity to perform elective surgery he had the unwavering support of management. Dr Strahan testified that he and others felt that if they complained against Dr Patel they would not only be challenging him, they would be challenging management.³⁰⁶
- 6.286 Secondly, Dr Strahan testified that the reason why he and others were less willing to come forward was that they did not believe that the information they had available to them was sufficient to warrant challenging Dr Patel. He effectively said that whilst, to an individual, information did not seem to justify a complaint, that information comprised a larger picture that was beyond any individual's knowledge. Had that information been combined so that the gravity of the situation was known to all those who held the separate pieces of it then he said that more people might have been willing to come forward.³⁰⁷
- 6.287 Thirdly, people who had concerns could only be confident about those things within their expertise and would be less willing to challenge Dr Patel on matters outside it. This problem is multiplied by the increased level of specialisation which characterises modern medical practice. The effect of this is that a specialist may not be willing or able to suggest incompetence in another practitioner who practises outside the specialist's scope of expertise. An eminent nephrologist, for example, may be less willing to claim that a surgeon is incompetent because surgery is not within his expertise nor within the expertise of the hospital's executive who would have to consider the claim.
- 6.288 Fourthly, because Dr Patel was the only general surgeon at the Base, (Dr Gaffield was a plastic surgeon whose general surgical experience was not so extensive as Dr Patel's), there was effectively no-one there observing Dr Patel's work, who could identify failings in Dr Patel as a surgeon with any confidence or significant credibility. Patients are often unable to identify inadequate care and for that reason are more likely to accept than challenge it by way of complaint. Further, a patient's credibility with those to whom they complain is hampered by limited or non-existent clinical knowledge.

³⁰⁵ Exhibit 70 para 21

³⁰⁶ T3282 (Dr Strahan)

³⁰⁷ T3282-3 (Dr Strahan)

- 6.289 Fifthly, the process of formally complaining is quite alien to most people, including clinicians.³⁰⁸
- 6.290 Sixthly, there were some, it seems, who were tired of complaining with no result and because of 'complaint fatigue' were unwilling to complain again.³⁰⁹
- 6.291 The Queensland Health Review team which went to Bundaberg reported³¹⁰ that numerous staff at Bundaberg reported barriers to reporting clinical incidents and summarised those barriers as follows:
- Little point reporting as nothing changed;
 - Leadership not actively encouraging reporting for 'learning';
 - Lack of feedback of outcome to reporting person/unit;
 - Culture of blame and history of punitive approach to reporter;
 - Fear of reprisal;
 - Seen as nursing business; and
 - Multiple forms.
- 6.292 By the time Dr Patel began work at the Base in 2003, the relationship between clinical staff and administrators was marked by a dysfunctional approach to complaints about clinical standards. Management was accustomed to rejecting legitimate demands because management had inadequate funds. Management was accustomed to providing an unsatisfactory service to patients about which the clinicians continued to complain. The inadequate budgets were a constant problem for the District Manager.
- 6.293 There had been some quite vehement earlier complaints about staff working unsafe hours and the need for more staff and equipment. Dr Nankivell and Dr Baker, each surgeons, had complained about their workloads. Dr Jeliffe and Dr Carter, Anaesthetists, had complained about the workloads for anaesthetic staff. When Dr Baker resigned in 2002 he said that he did not wish to continue to provide a third world surgical service. Dr Jeliffe had cancelled elective surgery during the Easter period in 2002 because he was concerned about the risks to patient safety caused by his workload. Dr Nankivell was hospitalised for exhaustion.
- 6.294 The District Manager, Mr Leck, thought that there were staff working too many hours but felt that he had to condone this because he had little practical alternative. He believed that the recommendations of Australian Colleges as to proper numbers of specialists were universally ignored in Queensland Health.³¹¹

³⁰⁸ T3268-T3269 (Dr Strahan)

³⁰⁹ T3283; T4006 (Dr Strahan)

³¹⁰ Exhibit 102 p80

³¹¹ T7187 line 49 (Mr Leck)

- 6.295 If a complaint or a suggestion required further funds, it was likely to lead to nothing but frustration. That frustration could be increased by lack of feed back. A sensible request by a clinician might have to pass through several layers of administration before a decision could be made on the request and it might take several months before the original clinician received an answer. If the request was rejected, it was possible that the clinician would be left wondering as to why it was rejected. Dr Thiele, who had been a Director of Medical Services at the Base, regarded it as 'a fundamental system failure'.³¹²
- 6.296 A general concern was expressed that a complaint about another clinician would result in reprisal or retribution.³¹³ Evidence was given of actual or perceived threats by administrators to suppress complaints. Dr Miach, Staff Physician, formed the impression that he was being threatened by the Director of Medical Services. When the Patel issue arose in the media Dr Keating came to Dr Miach's office, which was most unusual, and observed 'you know what goes around comes around'. Prior to the Patel controversy Dr Jelliffe, then a Staff Anaesthetist, was uncharacteristically summoned to the office of Mr Leck, District Manager. It was after Dr Jelliffe had cancelled elective surgery during the Easter period out of his concern for patient safety caused by the working hours for which he would be rostered. He interpreted the interview as threatening when Mr Leck asked him about the status of his visa.
- 6.297 Dr Nankivell gave evidence that 'the feeling amongst all nurses is that if you complain you'll be sacked or discriminated against', and said that nurses were terrified of the Code of Conduct.
- 6.298 It was alarming that, even after an independent internal investigation had been undertaken by Dr FitzGerald in February 2005 and it was clear to Mr Leck that legitimate concerns had been raised about Dr Patel's clinical competence, he considered taking an adversarial approach to those staff who had felt they had had no alternative but to raise their concerns with their local member. On 7 April 2005 he wrote to the Zonal Manager 'Perhaps we have the Audit Team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages?'

Lack of response to complaints:

Dr Miach's experience

- 6.299 Dr Miach, the Director of Medicine at the Bundaberg Hospital and an eminent physician and nephrologist, found management unresponsive to his serious concerns.

³¹² T1835 line 25 (Dr Thiele)

³¹³ T2251 line 25 (Ms Raven), Exhibit 102 p80

- 6.300 Shortly after Dr Keating's arrival at the hospital, he changed the system of on-call rostering without any staff consultation. Dr Miach advised Dr Keating that the rostering of the most junior staff to the Accident and Emergency Department after hours, instead of the most senior, was bad practice.³¹⁴ Dr FitzGerald whose expertise included emergency medicine confirmed in evidence that Dr Miach's concerns were appropriate.³¹⁵ The bad practice was maintained.
- 6.301 Another incident concerning Dr Miach was the creation of the catheter audit which so damned Dr Patel's competence in surgery to place peritoneal catheters and, arguably, his judgment in performing the procedure. I have referred to the efforts to bring this information forcefully to Dr Keating's attention in Chapter Three. Dr Keating's failure to question the significance of the catheter audit and his failure to become involved with the nurses' concerns about the complications must have left Dr Miach and the nurses perplexed.
- 6.302 Dr Miach also raised issues about vascular access in the hospital with Dr Keating. He wrote a letter to Dr Keating with an example of a young patient who had suffered immensely because vascular access was not performed locally and he was too ill to travel to Brisbane. He suggested that Dr Thiele, a vascular surgeon in town with a long association with the Base, be engaged as a Visiting Medical Officer to perform vascular access locally. Dr Miach received no response to that letter and had to take up the matter with the Zonal Manager.³¹⁶

Oesophagectomy complaints

- 6.303 The circumstances of the first two oesophagectomies performed by Dr Patel at the Base led to a conflict of evidence as to what notice was given to Dr Keating of concerns by Ms Hoffman, Dr Joiner and Dr Cook. Some matters remain beyond doubt. Dr Joiner advised Dr Keating that the Base was not doing sufficient oesophagectomies to maintain competency. This was correct. Dr Joiner advised that the Intensive Care Unit did not have the necessary resources for post-operative support. This, too, was correct. Ms Hoffman wrote by e-mail on 19 June 2003 that she had continuing concern over the lack of sufficient Intensive Care Unit backup to care for a patient who has undergone such extensive surgery. Dr Cook, the most senior intensivist at the Mater Hospital in Brisbane wrote to Dr Keating and spoke to him by telephone because of his concern that a surgeon at the Base would be embarking on such a complicated operation as an oesophagectomy. Dr Keating did not return to Dr Cook to inform him that he was prepared to permit such procedures to continue to be performed at the hospital nor did he respond to the email from Ms Hoffman. The decision by Dr Keating to allow the procedures to continue in the

³¹⁴ Exhibit 21 para 110

³¹⁵ T3158 (Dr FitzGerald)

³¹⁶ Exhibit 21 para 119-126

future was plainly inconsistent with the requirement to apply risk management practices.³¹⁷

- 6.304 It took two more oesophagectomies to close this chapter. It ended with the inappropriate and unnecessary oesophagectomy performed upon Mr Kemp which killed him in December 2004. The circumstances of the incident and the staff concerns raised appear in Chapter Three. The anaesthetist, Dr Berens, brought to Dr Keating his and the theatre staff's concerns about Dr Patel's conduct. Dr Berens was so concerned he expressed the view that perhaps the matter should be referred to the Coroner.
- 6.305 None of the staff involved with Dr Patel during the surgery, nor Dr Carter to whom Dr Berens first went, nor Dr Keating filled in the 'Adverse Event Report Form' consistent with the Adverse Events Management Policy requirements at Bundaberg since February 2004. It meant the event was not sent to the District Quality and Decision Support Unit for registering and risk rating. More significantly, Mr Kemp's death from elective surgery was a 'Sentinel Event' under the Sentinel Events and In-depth Analysis policy because it was an unexpected death. That policy required that the incident be given special treatment. Mr Keating was required to report it to Mr Leck immediately. Mr Leck learned of it immediately. Mr Leck was required to notify the Director-General of Queensland Health immediately. A team independent of the incident were to analyse it within 7 days. A root cause analysis investigation tool was to be used. There was no notice to the Director-General, nor an investigation. Within a month, Mr Leck and Dr Keating extracted a promise from Dr Patel that he would not carry out any further oesophagectomies at the Base.

Reported complaints and incidents not dealt with under the policy framework

- 6.306 Of the 22 incidents or issues that were reported, 15 of those were complaints or issues raised by staff. Of that 15, nine were reported informally, without the use of an Accident/Incident Report or as it was later known, an Adverse Event Report Form.
- 6.307 It meant that nine incidents reported to the executive in this informal way were not dealt with under the policy framework.³¹⁸ The effect of this is that:
- Incidents were not risk rated according to the severity of consequences and likelihood of reoccurrence;
 - Potential or actual incidents with a very high or extreme risk rating were not reported to the District Manager;

³¹⁷ As required at the time by the Risk Management Process Exhibit 162 LTR3 and the Queensland Health Integrated Risk Management Policy Exhibit 293

³¹⁸ Incident Management Policy, Exhibit 293; Adverse Events Management Policy, Exhibit 162 LTR4 Statement Raven; Incident Management Clinical and Non-Clinical Exhibit 162 LTR7 Statement Raven

- Incidents were not recorded on the Adverse Events Register, meaning that trends could not be picked up and this data would not be included in the quarterly trends reports provided to various committees;
- Incidents were not investigated under the comprehensive requirements of the policy,
- Corrective action plans and reports were not produced;
- Feedback about actions taken was not provided to those involved in the incident;
- Risks were not reported on the local Risk Register.

6.308 Similarly, there are examples where patient concerns became known to the executive; however, because they were not the subject of a formal complaint they were not dealt with under the policy framework.

6.309 Recall the case of Ms Lester,³¹⁹ who applied for a travel subsidy to avoid Dr Patel. The patient had seen Dr Patel on an earlier occasion to have packings from a previous procedure removed. The experience had been particularly traumatic as the procedure took place before the anaesthetic had taken effect.³²⁰ After experiencing ongoing pain, the patient sought the opinion of a different doctor. An ultrasound revealed that a foreign body was still within her.³²¹

6.310 Despite what appears to be gross carelessness on the part of Dr Patel, Dr Keating gave evidence that he did not consider it necessary to investigate the clinical aspects of this incident³²² and merely put it down to a difference of opinion between doctors.³²³ The matter was considered purely as a travel application.³²⁴

6.311 There was no record of a complaint, no record of an adverse incident, no risk assessment, no investigation of the treatment that led to the foreign body being missed. This was less than 10 days after Dr Keating counselled Dr Patel about his attitude to Mr Smith and failure to anaesthetise adequately. Ms Lester raised this same issue.

6.312 The policies support the idea that issues are addressed even if they are not raised as complaints. The Queensland Health Complaints Management Policy defines a complaint as 'any expression of dissatisfaction or concern, by or on behalf of a consumer...'. The Queensland Health Incident Management Policy

³¹⁹ Paras 3.253 - 3.255 herein

³²⁰ Exhibit 176 para 14 Statement Lester

³²¹ Exhibit 176 para 16 Statement Lester

³²² T6954 line 35 (Dr Keating)

³²³ T6955 line 17 (Dr Keating)

³²⁴ T6954 line 50 (Dr Keating)

provides that incidents can be identified in many ways, including from patient complaints.

Non-Compliance with the Complaints Management Policy

- 6.313 The Queensland Health Complaints Management Policy affirms and supports the right of patients to feedback and to have complaints heard and acted upon. The implementation of the complaints management process strives for consumer satisfaction in the way the complaint is handled, and to provide reliable and accurate information which is used to improve quality and safety in health care.³²⁵
- 6.314 A review of the Complaints Register for the period July 2002 to April 2005 paints a superficially positive picture of complaints management at the Bundaberg Hospital. During this period 675 complaints were registered, 533 were resolved within 28 days and all but four eventually resolved.
- 6.315 However, a closer analysis of individual cases paints a different picture. The Commission heard evidence that complaints were not always thoroughly investigated and resolved to the satisfaction of the patient. Further, there is evidence of disparities between the patient's recollections and perceptions and the Hospital's records of the complaint outcome.

The Fleming complaint

- 6.316 Mr Fleming's relevant medical history is more fully set out in Chapter Three. Five months after surgery by Dr Patel Mr Fleming was extremely concerned about his health because of pain and internal bleeding and was concerned about delays in having the hospital investigate it. He complained by telephone and a staff member filled in for him a Complaint Registration Form.³²⁶ The staff member chose not to classify the complaint as about 'treatment' or 'professional conduct' but as about 'access to service'. And so, when the complaint could so easily have been categorised as one raising an issue about whether the original treatment was adequate, it was categorised, instead, as a concern about delay – delay in obtaining an investigation to determine the need for remedial treatment from the hospital. When the complaint appeared on the Complaints Register³²⁷ a reader of the document would have assumed that Mr Fleming's major concern was about obtaining access to a specialist. The register gave the impression that the complaint was 'resolved' in two days by 'explanation given'. If it had been classified as a complaint about treatment it would have been more difficult to classify it as 'resolved' and to close the book on it. It would have required a consideration of the adequacy of the initial treatment and a consideration of the

³²⁵ Exhibit 292 QH Complaints Management Policy: Policy Statement

³²⁶ Exhibit 114 IGF3

³²⁷ Exhibit 166

accuracy of the patient's belief that he had internal bleeding and the need for remedial treatment. The complaint was classified as resolved two or three weeks before Mr Fleming was able to see the specialist he was so desperate to have review him.

The Smith complaint

- 6.317 On 27 February 2004 Geoff Smith made a oral complaint to Dr Keating regarding the treatment he received from Dr Patel.³²⁸ Mr Smith had a melanoma on his shoulder. Mr Smith advised Dr Patel that local anaesthetic was not effective for him and questioned him regarding alternatives. Dr Patel dismissed Mr Smith's concerns and proceeded to excise the melanoma without anaesthetising him properly.
- 6.318 Dr Keating met with Mr Smith to discuss the complaint. Dr Keating then met with Dr Patel and explained to him that the patient's complaint appeared to be legitimate and the attitude displayed to Mr Smith seemed to be inappropriate.³²⁹ After the meeting Dr Keating sent a letter to Mr Smith in which he apologised for the distress and unhappiness that had been experienced and advised that Dr Patel had given an undertaking to review his interactions with patients in such circumstances.³³⁰
- 6.319 An alert was also placed on the cover of Mr Smith's medical file stating 'local anaesthetics alone are ineffective alternative methods of pain relief are required'.³³¹
- 6.320 The complaint was registered on the Complaints Register as a 'Treatment' issue that was resolved within 12 days. The resolution is noted as 'explanation given'.³³²

P131 complaint

- 6.321 On 2 July 2004 P131 made a telephone complaint about Dr Patel which was referred to Dr Keating.³³³ P131 complained that she had attended at BreastScreen complaining of an itchy nipple. BreastScreen wrote to Dr Patel requesting that a biopsy be performed to exclude Paget's disease. When she presented for the biopsy on 1 July 2003 she was informed by Dr Patel that she only had eczema and was given cortisone cream.
- 6.322 In October 2003, she was attending the hospital for another matter and informed staff that she still had the itchy nipple and that the cream Dr Patel had given her

³²⁸ Exhibit 174 Statement Smith

³²⁹ T6953 line 20-30 (Dr Keating)

³³⁰ Exhibit 174 GS1 Statement Smith

³³¹ Exhibit 190, there is some contention as to when this alert was placed on the file see T2679-2681 (Mr Smith)

³³² Exhibit 166

³³³ Exhibit 225 GR19 Statement Fitzgerald

had not worked.³³⁴ She was referred to Dr Gaffield for review who recommended that she undergo a punch biopsy.³³⁵ P131 underwent the biopsy in March 2004, some eight months after the first scheduled biopsy that never took place. The biopsy revealed the she did in fact have Paget's disease. The patient elected to undergo a bilateral mastectomy.³³⁶

6.323 On receiving the complaint, Dr Keating took this up with Dr Patel. Dr Patel advised that he intended to review the patient after three months and if there was no improvement a biopsy would be conducted then. He explained that Paget's disease and Eczema are very hard to differentiate. Dr Patel claims that the patient did not return for her review appointment on 23 September 2003.³³⁷ It appears that the patient was not aware of a review appointment.

6.324 Dr Keating accepted Dr Patel's explanation and responded to P131 that:

Eczema and Paget's Disease (early cancer) can be very hard to differentiate and based upon your normal breast examination and mammogram, conservative treatment was begun with a review due in three months. This course of management was appropriate; unfortunately a lack of thoroughness at initial review appointment prolonged the time until definitive diagnosis and treatment in 2004.³³⁸

6.325 The complaint was registered on the Complaints Register as a 'Treatment' issue that was resolved within 31 days. The resolution is noted as 'explanation given'.³³⁹ The complaint was not given a seriousness category or risk rated.

What should have happened under the Complaints Management Policy

6.326 Under the statewide Complaints Management Policy³⁴⁰ any moderate, major, extreme and unresolved complaints are to be referred to the Complaints Coordinator. The Complaints Coordinator is to review resolved complaints and ensure comprehensive assessment or investigation of moderate, major, extreme and unresolved complaints. Under the Bundaberg policy, members of the health service executive are responsible for coordinating the investigation of a complaint in their area of authority.

6.327 In the examples above, the complaints were made directly to Dr Keating or referred to him. He attempted to resolve issues before referring them to the Complaints Coordinator.

6.328 Once the complaints were received by the Complaints Coordinator, the complaint information was put into the Complaints Register. The complaints

³³⁴ Exhibit 294 para 52 Statement Gaffield

³³⁵ Exhibit 294 para 54 Statement Gaffield

³³⁶ Exhibit 294 para 60 Statement Gaffield

³³⁷ Exhibit 225 GR19 Statement Fitzgerald

³³⁸ Exhibit 225 GR19 Statement Fitzgerald

³³⁹ Exhibit 166

³⁴⁰ Exhibit 292

were not classed according to seriousness. The complaints of Ms Lester (a foreign body left within her), Mr Fleming (continued internal bleeding and wound infection), P131 (failure to perform a biopsy to exclude Paget's disease leading to a double mastectomy) and possibly Mr Smith's (failure to give anaesthetic) should have been classed, at least, as moderate and should have been referred for investigation. None of the complaint examples received a comprehensive assessment or investigation as required by the Policy.

6.329 The Policy requires an in-depth and/or root cause analysis of complaint matter. The Policy defines investigation as:

A systematic process of collecting relevant evidence, followed by an assessment of the evidence that leads to a logical and reasonable determination or conclusion. Investigations are undertaken when a decision needs to be made and the material/evidence before the decision maker is insufficient and/or needing clarification and/or only an allegation which needs a response or collection of further evidence from another party/parties and/or conflicting and cannot be reasonably assessed without further evidence.

6.330 The Policy sets out the following responsibilities of investigators:

- Investigating complaints objectively, fairly, confidentially and in a timely manner;
- Establishing the facts associated with a complaint;
- Compiling a report on the investigation findings;
- Forwarding reports to the person who appointed them to conduct the investigation; and
- Ensuring the principles of natural justice and procedural fairness are upheld throughout the investigative process.

6.331 In each of the complaint examples, with the exception of Lester, Dr Keating discussed the incident with Dr Patel. Dr Patel's comments were accepted for the Fleming and P131 complaints and no further medical opinion was sought. With respect to the Smith complaint, Dr Keating advised Dr Patel that the complaint seemed to be legitimate and the attitude displayed to Mr Smith seemed to be inappropriate. The issues raised by Ms Lester were not investigated at all.

6.332 Dr Keating's inquiries fall significantly short of the investigation process described in the policy. At the very least, he should have sought a medical opinion from a doctor independent of the event and talked with staff who may have first hand knowledge of an incident.

6.333 With respect to the four examples, there were no investigations to establish the facts associated with the complaint. For example, Mr Fleming advised Dr Keating that there was a dispute between Dr Patel and the nurses about the treatment of his wound. It would have been a simple exercise to talk to the nurses involved.

- 6.334 Also of concern is Dr Keating's willingness to accept Dr Patel's explanations. The complaints of Mr Fleming, Mr Smith and Ms Lester occurred in relatively close succession. Dr Keating investigated Mr Fleming's complaint in October 2003. In February 2004, Dr Keating counselled Dr Patel with respect to Ms Smith's complaint. Less than one week later, Ms Lester's problems became known to Dr Keating. All three complaints involved allegations of a failure by Dr Patel to anaesthetise properly and a callous disregard for the patient. In light of the emerging pattern, one might think it essential to conduct investigations beyond obtaining Dr Patel's opinion.
- 6.335 The Policy requires that a report be compiled on the investigation findings and sent to the person who requested the investigation. In each of the four examples, no comprehensive report was produced.
- 6.336 The District Manager has a responsibility to ensure that all patient complaints with a seriousness category of Extreme are reported to the General Manager, Health Services.³⁴¹ In Bundaberg from February 2003 complaints were not categorised and, presumably, then could not be reported to the General Manager, Health Services.
- 6.337 The District Manager is also responsible for ensuring that concerns arising from complaints that relate to the health, competence or conduct of a registered professional are referred to the appropriate registration body.³⁴² This did not occur with complaints about Dr Patel.
- 6.338 Under the Bundaberg policy, following the investigation of a complaint, the line manager should identify the cause of the complaint, isolate contributing factors and identify opportunities for improvement that prevent the circumstances of the complaint recurring. All quality improvement activities should then have been referred to the Quality Management Unit and the Improving Performance Committee.³⁴³ It is not clear from the evidence or the minutes of the Improving Performance Committee whether this ever occurred.

Non-compliance with the Incident Management Policy

- 6.339 In addition to the patient complaints about Dr Patel, there was also a steady stream of concerns expressed by staff within Queensland Health. As discussed above, many were reported informally and were not dealt with under policy requirements. Of those that were reported through an Adverse Incident Form or a Sentinel Event Report Form, the policy was not strictly complied with.

³⁴¹ Exhibit 292: Compliance and Responsibilities

³⁴² Exhibit 292: Compliance and Responsibilities

³⁴³ Exhibit 162 LTR2 Statement Raven

Desmond Bramich (A Sentinel Event³⁴⁴)

6.340 Mr Bramich was admitted to the Bundaberg Hospital on 25 July 2004 suffering an injury to the chest after being trapped under a caravan. Mr Bramich appeared to stabilise but then deteriorated suddenly, he passed away on 28 July 2004. This matter is more fully discussed in Chapter Three.

6.341 Dr Keating received a number of staff complaints with respect to the care of Mr Bramich:

- Dr Carter approached Dr Keating shortly after the death of Mr Bramich suggesting that the management of the patient be audited;³⁴⁵
- Karen Fox, a registered nurse in the Intensive Care Unit lodged an Adverse Event Report Form reporting an absence of water in the underwater seal drainage unit. The unit is used to drain fluid or air from the lungs;³⁴⁶ and
- Ms Hoffman lodged a Sentinel Event Report Form. The form was accompanied by a two page letter detailing the problems the Intensive Care Unit was having with Dr Patel.³⁴⁷

Dr Keating received the Adverse Event Report Form and the Sentinel Event Report Form on 2 August 2004.³⁴⁸

6.342 Dr Keating undertook the following activities in response to the complaints:

- On 29 July 2004, he wrote to Dr Carter and Dr Patel requesting an audit of the total management of Mr Bramich within two weeks;
- On 26 August 2004, he received Dr Patel's report;³⁴⁹
- On 31 August 2004, he obtained a copy of the autopsy report from the Coroner;
- On 13 September 2004, he received Dr Carter's report;³⁵⁰
- On 14 September 2004, he received a report from Dr Gaffield;³⁵¹
- On 25 October 2004, he received a report from Dr Carter to be provided to the Coroner;³⁵²
- On 27 September 2004, he received advice from Dr Younis who was critical of Dr Patel's management;³⁵³

³⁴⁴ A sentinel event is an event that signals that something serious or sentinel has occurred and warrants in depth investigation – Exhibit 290A JGW6 Statement Wakefield

³⁴⁵ Exhibit 448 para 133 Statement Keating

³⁴⁶ Exhibit 162 LTR9 Statement Raven

³⁴⁷ Exhibit 162 LTR9 Statement Raven

³⁴⁸ Exhibit 448 para 135 Statement Keating

³⁴⁹ Dr Patel's report appears at Exhibit 448 DWK40 Statement Keating

³⁵⁰ Dr Carter's report appears at Exhibit 448 TH19 Statement Hoffman

³⁵¹ Dr Gaffield's report appears at Exhibit 448 DWK42 Statement Keating

³⁵² Dr Carter's report for the Coroner appears at Exhibit 448 DWK43 Statement Keating

³⁵³ File note of Dr Younis's advice appears at Exhibit 448 DWK44 Statement Keating

- On 19 October 2004 he discussed the case with Dr Rodd Brockett, an intensive care specialist at Logan Hospital and obtained the names of three intensive care specialists who could review the case;³⁵⁴
 - He provided Dr Patel with a copy of Ms Hoffman's Sentinel Event Report Form and statement and requested him to respond;
 - Dr Patel responded to Ms Hoffman's report and statement;³⁵⁵
 - He reviewed the medical records and various reports;³⁵⁶ and
 - He kept Ms Mulligan and Mr Leck informed of the investigation.³⁵⁷
- 6.343 On 20 October 2004, Ms Hoffman met with Ms Mulligan to raise issues of Dr Patel's clinical competence. Later that day, there was a meeting between Mr Leck, Ms Mulligan and Ms Hoffman in which these issues were discussed further. Ms Hoffman advised that a number of nursing staff had been to see Dr Keating with issues regarding Dr Patel and were not happy with the way he had investigated or managed the complaints. Mr Leck requested Dr Keating to stop investigating the Bramich case.³⁵⁸
- 6.344 After the meeting, Ms Hoffman documented her concerns in a letter to Mr Leck dated 22 October 2004.³⁵⁹ The letter was provided to Ms Mulligan and Dr Keating.³⁶⁰
- 6.345 In order to corroborate the allegations, Mr Leck and Dr Keating met with some of the doctors named by Ms Hoffman. After this Mr Leck concluded that there were some clinical issues in relation to Dr Patel that needed investigation.³⁶¹
- 6.346 On 5 November 2004, Mr Leck met with Dr Keating to discuss what action should be taken in relation to Dr Patel. Mr Leck gave evidence that Dr Keating was reluctant to agree to a review because he considered that the allegations related to a personality conflict and lacked substance.³⁶²
- 6.347 Mr Leck and Dr Keating began to make enquires at various hospitals to find a suitable person to conduct the enquiry. On 16 December 2004, Mr Leck contacted the Audit and Operational Review Branch for advice about the review.³⁶³ They advised that he should contact Dr Gerry FitzGerald, the Chief Health Officer.³⁶⁴
- 6.348 On 17 December 2004, Mr Leck contacted Dr FitzGerald's office and was advised that Dr FitzGerald was about to depart for annual leave but was aware

³⁵⁴ File note of Dr Brockett's advice appears at Exhibit 448 DWK45 Statement Keating

³⁵⁵ Dr Patel's response appears at Exhibit 448 DWK46 Statement Keating

³⁵⁶ File note of Dr Keating's investigations appears at Exhibit 448 DWK47 Statement Keating

³⁵⁷ Exhibit 448 Statement Keating

³⁵⁸ Exhibit 463 paras 42-47 Statement Leck

³⁵⁹ Exhibit 4 TH37 Statement Hoffman

³⁶⁰ Exhibit 463 para 48 Statement Leck

³⁶¹ Exhibit 463 para 51 Statement Leck

³⁶² Exhibit 463 para 52 Statement Leck

³⁶³ Exhibit 463 para 55 Statement Leck

³⁶⁴ Exhibit 463 para 56 Statement Leck

of the situation and could assist with the review. Dr FitzGerald and Mr Leck did not talk until 17 January 2005 when he returned.³⁶⁵

- 6.349 On 14 February 2005, some six months after Ms Hoffman submitted the Sentinel Event Report Form, Dr FitzGerald came to Bundaberg to interview the relevant staff.³⁶⁶
- 6.350 Having not received any feedback from Dr FitzGerald or management regarding the outcomes of investigations into Dr Patel, Ms Hoffman was somewhat comforted by the fact that Dr Patel's contract was due to expire in early 2005. When Dr Patel announced that his contract had been extended Ms Hoffman decided that she needed to do something desperate. On 18 March 2005, Ms Hoffman took her concerns to Rob Messenger, the Member for Burnett.
- 6.351 As at March 2005, Ms Hoffman had received no feedback regarding the outcomes of investigations into the sentinel event report she had lodged in August 2004.

What should have happened under the Incident Management Policy

- 6.352 The adverse and sentinel events with respect to Mr Bramich were reported in August 2004. At this time the Bundaberg Health Service District had a local Adverse Events Management Policy³⁶⁷ and a Sentinel Events and Root Cause Analysis Policy.³⁶⁸ The Queensland Health Incident Management Policy³⁶⁹ was issued on 10 June 2004. The policies of the Bundaberg Health Service District were reviewed in light of the new statewide policy and revised policies³⁷⁰ were issued in November 2004.
- 6.353 The timing of the policies is relevant because under the Queensland Health policy, sentinel events must be reported to the Director-General. This was not a requirement under the earlier policies of the Bundaberg Health Service District. The earlier Bundaberg policy requires the immediate handling of the event including, liaison and notification of the Central Zone Management Unit and Corporate Office Queensland Health.³⁷¹
- 6.354 All District Managers were informed of the new policy by memorandum from the Deputy Director-General dated 30 June 2004.³⁷² The memorandum states that all sentinel events are to be reported to the Director-General immediately.

³⁶⁵ Exhibit 463 para 57-62 Statement Leck

³⁶⁶ Exhibit 463 para 63 Statement Leck

³⁶⁷ Exhibit 162 LTR4 Statement Raven

³⁶⁸ Exhibit 162 LTR6 Statement Raven

³⁶⁹ Exhibit 290A JGW6 Statement Wakefield

³⁷⁰ Exhibit 162 LTR7 Statement Raven

³⁷¹ Exhibit 162 LTR6 Statement Raven

³⁷² Exhibit 448 DWK49 Statement Keating

- 6.355 The Queensland Health Incident Management Policy³⁷³ describes a sentinel event as an event that signals that something serious or sentinel has occurred and warrants in depth investigation. The policy provides a list of certain incidents that are deemed to be sentinel events. The list is not stated to be exhaustive. Under the policy an unexpected death of a patient is deemed to be a sentinel event.
- 6.356 The Policy sets out an Incident Management Model³⁷⁴ with nine elements:
- Prevention
 - Incident Identification
 - Classification/prioritisation
 - Reporting and recording
 - Patient and staff care/management
 - Analysis/investigation
 - Action
 - Feedback
 - Communication
- 6.357 Incidents should be prioritised according to their risk rating. The policy provides a Risk Matrix which assists in categorising the seriousness of adverse events. The event should be risk rated by the person who reports the event and again during the investigation phase. There is no evidence that the sentinel event was ever risk rated.³⁷⁵
- 6.358 The Policy requires that the line manager must report all sentinel events to the District Manager. The District Manager must report all sentinel events to the Director-General.³⁷⁶
- 6.359 One month after Ms Hoffman lodged the Sentinel Event Report Form, she heard that it had been downgraded, that it was deemed not to be a sentinel event.³⁷⁷
- 6.360 Leonie Raven, the Quality Coordinator, gave evidence that Ms Hoffman contacted her around October 2004 enquiring as to the status of the sentinel event. Ms Raven could not locate the report on the Adverse Incidents Register and contacted Dr Keating to see if he was aware of the sentinel event. Dr Keating advised that he was and that an analysis of the event had been undertaken. Ms Raven was of the understanding that Dr Keating would report back to the clinicians involved. Ms Raven stated that she believed the sentinel

³⁷³ Exhibit 290A JGW6 Statement Wakefield

³⁷⁴ Exhibit 290A JGW6 Statement Wakefield: Incident Management Model p6

³⁷⁵ Exhibit 290A JGW6 Statement Wakefield: Prevention p6

³⁷⁶ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording p8

³⁷⁷ Exhibit 4 para 89 Statement Hoffman

event was actioned appropriately and in accordance with the Hospital policy which was current at the time; it was not downgraded. The reason it did not appear on the Register was purely an administrative error.³⁷⁸

- 6.361 Dr Keating gave evidence that at no stage was Mr Bramich's death downgraded or deemed by him not to be a sentinel event.³⁷⁹ However, he did not believe the incident had to be reported to the Director-General because, although it occurred after the introduction of the Queensland Health policy, which requires that all sentinel events are reported to the Director-General, it occurred prior to the implementation of that policy in Bundaberg.³⁸⁰ I do not accept this argument.
- 6.362 Mr Leck gave evidence that he receives copies of Sentinel Event Report Forms because he is required to send a copy to corporate office within a certain timeframe. When he received Ms Hoffman's Sentinel Event Report Form, he said that he contacted the Quality Coordinator and was told that this case did not constitute a sentinel event within the terms of the specific criteria set out in the Queensland Health Incident Management Policy. On this advice, Mr Leck did not report the sentinel event to corporate office.³⁸¹
- 6.363 Each District Manager was supposed to maintain a comprehensive register of all reported incidents in their accountability area. In Bundaberg, the Adverse Incidents Register is maintained by the District Quality and Decision Support Unit.
- 6.364 Due to an administrative error, the sentinel event was never recorded on the Adverse Incidents Register. Of particular concern is that this was brought to the attention of Ms Raven, the Quality Coordinator from the District Quality and Decision Support Unit in October 2004 and the Register provided to the Commission which includes entries up to May 2005 still has no record of the sentinel event reported by Ms Hoffman.
- 6.365 Under the Queensland Health policy, the investigation of sentinel events involves the following mandatory requirements:³⁸²
- Use of a team independent of the incident;
 - Analysis, commencing seven working days after the incident;
 - The root cause analysis tool must be used;
 - Teams should be commissioned by the District Manager;
 - At least one member of the team must be trained in using the root cause analysis tool and process; and

³⁷⁸ Exhibit 162 para 37-39 Statement Raven

³⁷⁹ Exhibit 448 para 157 Statement Keating

³⁸⁰ Exhibit 448 para 159 Statement Keating

³⁸¹ Exhibit 463 paras 33-35 Statement Leck

³⁸² Exhibit 290A JGW6 Statement Wakefield: Incident Analysis/Investigation p10

- A report must be provided to the District Manager within 45 days of commencement of investigation.
- 6.366 Unfortunately, Dr Keating was still operating under the less stringent investigation requirements of the outdated Bundaberg policy³⁸³ and none of the above requirements, with the possible exception of the second requirement, were met.
- 6.367 The Bundaberg Sentinel Events and Root Cause Analysis Policy essentially requires that an investigation be undertaken by a team headed by one of the executives, a root cause analysis to be conducted and a report sent to the Leadership and Management Committee.
- 6.368 The investigation even fell short of the less stringent requirements of this Policy. In the three month period from the date of the sentinel event until the investigation was stopped to focus on wider issues, none of the requirements were met.
- 6.369 Actions are identified through investigating the underlying causes of incidents and are to be documented in a report to the District Manager. The District Manager is to nominate a person, unit or committee to receive investigation reports and authorises and resources this entity to implement actions.³⁸⁴ This did not occur.

General observations with respect to application of complaints and incident management policies

- 6.370 The policy framework for managing complaints and adverse incidents in Queensland Health and the Bundaberg Hospital appears to be adequate with one exception. The requirement of the local policy in Bundaberg that a form be filled in to raise an issue is problematic. The obligation to investigate an issue should not be made dependent upon a complaint in writing. Having an adequate policy solves only part of the problem. The downfall is in the implementation. The effectiveness of the policy framework has been seriously undermined by a number of non-compliant practices that appear to have occurred frequently.

Failure to seek independent medical opinion

- 6.371 A fundamental problem with investigations into complaints about Dr Patel was that the investigation usually consisted only of reference back to Dr Patel and acceptance of his opinion or explanation. With respect to issues of clinical competence, an independent medical opinion should always be obtained.

³⁸³ Exhibit 448 para 159 Statement Keating

³⁸⁴ Exhibit 290A JGW6 Statement Wakefield: Action p11

Failure to check accuracy and corroborate statements

6.372 Another deficiency in the investigation of complaints was a failure to check the accuracy of and corroborate statements. This occurred even in circumstances where it would have been a relatively simple exercise to check facts.

Failure to undertake root cause analysis

6.373 Where patient complaints are classed as moderate and above, they should receive a comprehensive assessment or investigation. The Investigator is required to undertake an in-depth and/or root cause analysis.³⁸⁵ This did not occur at the Bundaberg Hospital because no one was trained in this process. Dr Keating gave evidence that he was not trained in root cause analysis, nor to his knowledge was any other staff member at Bundaberg Hospital.³⁸⁶

Inadequate risk rating and referral of complaints

6.374 The Queensland Health Complaints Management Policy requires that all complaints are categorised in a manner that reflects the seriousness of the complaint. This process enables complaints data to then be applied to the risk management framework³⁸⁷ and for moderate, major, extreme and unresolved complaints to be referred for a comprehensive assessment or investigation.³⁸⁸ The Bundaberg Complaints Management System³⁸⁹ does not have a requirement that complaints be risk rated.

6.375 The Bundaberg Hospital Complaints Register³⁹⁰ includes fields for both seriousness category and level of risk. A review of the Register for the period July 2002 to May 2005 reveals that, for the 675 complaints registered, 613 were not risk rated and 610 were not given a seriousness category. After January 2003, no complaints were risk rated.

6.376 Ms Raven gave evidence that she identified the level of risk of complaints for a period, purely on speculation but stopped doing this in January 2003.³⁹¹ The fact that complaints were not being risk rated means that they may not have been referred for assessment and investigation in accordance with the policy and the complaints data could not be applied to the risk management framework.

³⁸⁵ Exhibit 292: Appendix 1 Complaint Handling Model

³⁸⁶ Exhibit 448 para 154 Statement Keating

³⁸⁷ Exhibit 292: Seriousness Categories p3

³⁸⁸ Exhibit 292: Appendix 1 Complaints Handling Model p4

³⁸⁹ Exhibit 162 LTR2 Statement Raven

³⁹⁰ Exhibit 166

³⁹¹ T2282 line 53 – T2283 line 2 (Ms Raven)

Inadequate risk rating and referral of incidents

- 6.377 It is also a requirement of the Queensland Health Incident Management Policy that incidents are assessed according to the level of risk.³⁹² Incidents identified as a very high or extreme risk should be reported to the appropriate line manager and District Manager.³⁹³
- 6.378 It appears that, for a period at the Bundaberg Hospital, incidents were not being risk rated nor subsequently referred accurately. Ms Raven gave evidence that there was some discontent surrounding the practice of risk rating ever since the system was introduced. The nurse unit manager and the clinicians who were filling out incident forms felt that they should be risk rating the incident.³⁹⁴ In an email to Mr Leck dated 14 September 2004, Ms Raven wrote that she was not rating anything above medium while there was an unresolved question over whether she should be making those sorts of judgments or decisions. The effect of this was that matters were not being referred to the relevant executive officer for investigation.

Inadequate response

- 6.379 One of the reasons why staff were hesitant to raise issues and report events was the perception that nothing would be done. The perception was reinforced when there was a lack of feedback about a complaint or report. Ms Raven gave evidence that following the implementation of the Adverse Events Management Policy in February 2004, it had been the intention of the District Quality and Decision Support Unit to provide feedback to staff who were reporting adverse events. Due to resourcing issues feedback ceased.³⁹⁵ A fundamental tenet of the policy was ignored.

Inadequate Management and use of data

- 6.380 Complaints and adverse incidents data can potentially serve as a valuable tool for quality improvement and risk management. It is apparent, however, that the data that was being captured during Dr Patel's period at the Hospital was of little value in this respect. Many of the incidents that were reported were not recorded on the registers. For those that were recorded on the registers, it was in insufficient detail to highlight that there was a problem.
- 6.381 It is a requirement under both the Complaints Management Policy³⁹⁶ and the Incident Management Policy³⁹⁷ that each District maintain a comprehensive register of complaints and incident data.

³⁹² Exhibit 290A JGW6 Statement Wakefield: Classification Prioritisation p7

³⁹³ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording p8

³⁹⁴ T2279-2280 (Ms Raven)

³⁹⁵ Exhibit 162 para 25 Statement Raven

³⁹⁶ Exhibit 292: Instruction, Implementation Process, p7

- 6.382 In Bundaberg, a Complaints Register³⁹⁸ was maintained from July 2002 and an Adverse Events Register³⁹⁹ was maintained from February 2004.
- 6.383 The Commission heard evidence from Ms Raven, the Quality Coordinator, that the data on the registers is useful to identify where complaints are coming from, how complaints are received and what complaints are about.⁴⁰⁰ Trends reports were provided to the District Manager and various quality improvement teams and committees.⁴⁰¹
- 6.384 As discussed above, an initial examination of the registers revealed only three complaints and five adverse incidents with respect to Dr Patel's treatment. We now know that 22 incidents or issues were reported in one form or another about Dr Patel. Each of these incidents or complaints should have been readily identifiable from the registers.
- 6.385 One of the reasons why it was difficult to quickly identify all of the incidents involving Dr Patel is that there is no field on either the Adverse Events Register of the Complaints Register to enter the name of the clinician or staff member involved in the incident. Ms Raven's response to this was that the Hospital was trying to introduce a blame free culture.⁴⁰² The problem with this is, that where a surgeon is consistently causing bad patient outcomes, it will not necessarily be picked up through the data registers.
- 6.386 Mr Leck gave evidence that, at the time of Ms Hoffman's complaint in October 2004, there was no information that he had received from the trend information from adverse events that indicated that there was a problem. Mr Leck agreed that if there were serious problems he would expect those sources to have alerted him.⁴⁰³
- 6.387 Another shortfall of the data is that it fails to identify clinical issues in sufficient detail. If this had occurred, it is possible that a number of trends would have been identified with respect to Dr Patel. These included:
- increase in wound infections and dehiscence;
 - inadvertent nicking of organs during surgery;
 - increased complaints about failure to anaesthetise; and
 - increased readmission and corrective surgery.

Implementation of systems was hindered by lack of resources

- 6.388 For complaints handling to operate effectively, those who are responsible must be given sufficient time to devote to it. One of the problems for Bundaberg was

³⁹⁷ Exhibit 290A JGW6 Statement Wakefield: Reporting Requirements – local p9

³⁹⁸ Exhibit 166

³⁹⁹ Exhibit 167

⁴⁰⁰ T2289 line 3-12 (Ms Raven)

⁴⁰¹ T2248 20-30 (Ms Raven)

⁴⁰² T2302 line17 – T2303 line 4 (Ms Raven)

⁴⁰³ T7288 line 20-44 (Mr Leck)

that the responsibilities created in 2002 for the hypothetical Complaints Coordinator were added to an officer's other numerous responsibilities. The role of complaints management fell to the Quality Coordinator, who already had other significant duties including preparation of the ACHS accreditation and maintaining and updating Hospital policies and procedures.⁴⁰⁴

- 6.389 In a large district like the Bundaberg Health Service District, a Complaints Coordinator who has responsibility for resolving complaints in a thorough and timely manner, should be free from other administrative tasks. It would be consistent with the recent recommendation in the Queensland Health Systems Review, Final Report.⁴⁰⁵ Queensland Health's Initial Submission to the Commission stated that the Bundaberg Health Service District has no dedicated Complaint Coordinator. The role of the Complaints Coordinator would need to be promoted in the hospital. I have not heard sufficient evidence to recommend the number of days which the Complaint Coordinator should have to attempt to resolve the complaint locally before referring the matter to the 'one stop shop' which I recommend later in this chapter. Nor have I heard sufficient evidence to recommend the exceptional cases which ought to be referred immediately by the Complaint Coordinator to the 'one stop shop'.

Other systems to capture clinical issues

Clinical governance committees

- 6.390 The Bundaberg Health Service District also had a clinical governance committee structure through which clinical safety and quality issues could be addressed.⁴⁰⁶ At the risk of over-simplifying, various committees throughout the hospital had a responsibility for discussing issues concerned with patient safety, analysing them, suggesting solutions and referring them to the appropriate person or committee to take action.
- 6.391 A review of the clinical governance committee structure in the Bundaberg Health Service District in April 2005 revealed over twenty one committees.⁴⁰⁷ The responsibility for clinical safety and quality issues was shared by a number of committees that were to report directly to the Leadership and Management Committee. A number of sub-committees were to also play a role in considering clinical safety and quality.
- 6.392 During the review of clinical services in April 2005, staff reported that there were too many committees, significant overlap in functions and potential for issues to

⁴⁰⁴ Exhibit 162 para 8 Statement Raven

⁴⁰⁵ Queensland Health Systems Review, Final Report p191 (www.healthreview.com.au)

⁴⁰⁶ Exhibit 102 para 3.4.4

⁴⁰⁷ Exhibit 102, Appendix F. The committee structure has been reviewed since this time resulting in a reduction of major committees

fall through the cracks. Staff reported that, when safety and quality issues were raised, there was rarely any feedback. It was also evident, from reviewing committee minutes, that there was little evidence of any outcomes or decisions made.⁴⁰⁸

Performance management

- 6.393 There was no formal performance management process in place for medical staff at the Base.⁴⁰⁹ Accordingly, no person with the skills to assess Dr Patel was ever called upon to manage or assess him. As I have discussed earlier, the Medical Board of Queensland required an annual assessment from the Hospital, when medical practitioners were registered under the area of need process. The Medical Board of Queensland did not monitor the registrant's performance throughout the year of their registration. However, if an application was made to renew that registration, the Medical Board of Queensland would call upon the employer to certify to a number of performance criteria based upon the registrant's service during the preceding year. Dr Keating, as the Director of Medical Services at the Base, provided such certifications towards the end of Dr Patel's first and second years of service at the Base. Dr Keating did not have qualifications to equip him to assess Dr Patel's skills as a general surgeon by watching Dr Patel's performance. Dr Keating did not watch Dr Patel perform surgery. Dr Keating did not have other general surgeons on his staff or as Visiting Medical Officers during Dr Patel's employment. It meant that he could not have the benefit of the opinion of another general surgeon about Dr Patel's skills.
- 6.394 It has been remarked earlier in this report that Dr Patel was able to practise in splendid isolation. The opportunities to observe and correct his mistakes, which would have existed in a busy metropolitan hospital with numerous general surgeons, did not exist.
- 6.395 Because of this, the importance of adequately recording and investigating complaints and clinical incidents arising as a result of general surgery was all the more acute.

The Health Rights Commission

- 6.396 Aside from complaining directly within the public hospital to Queensland Health, the most popular avenue for complaints is probably to the Health Rights Commission. The Health Rights Commission which accepts complaints about health services provided anywhere within Queensland, in both the public and private health sectors receives approximately 4,500 complaints and enquiries

⁴⁰⁸ Exhibit 102 para 3.4.4

⁴⁰⁹ Exhibit 102 para 3.4.9 (a)

each year.⁴¹⁰ In 2004 the Health Rights Commission's reception received approximately 11,500 telephone enquiries⁴¹¹ although not all became formal complaints.

6.397 The Health Rights Commission is an independent statutory body established under the *Health Rights Commission Act 1991* ('*Health Rights Commission Act*'). At present it has a staff of 26 full time equivalents, and an annual budget of \$3million.

6.398 The statutory functions of the Health Rights Commission are set out in the *Health Rights Commission Act* at s10 which provides:

10 Commissioner's functions

The functions of the commissioner are:

- (a) to identify and review issues arising out of health service complaints;
- (b) to suggest ways of improving health services and of preserving and increasing health rights; and
- (c) to provide information, education and advice in relation to;
 - (i) health rights and responsibilities; and
 - (ii) procedures for resolving health service complaints; and
- (d) to receive, assess and resolve health service complaints; and
- (e) to encourage and assist users to resolve health service complaints directly with providers; and
- (f) to assist providers to develop procedures to effectively resolve health service complaints; and
- (g) to conciliate or investigate health service complaints; and
- (h) to inquire into any matter relating to health services at the Minister's request; and
- (i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and
- (j) to provide advice to the council; and
- (k) to provide information, advice and reports to registration boards; and
- (l) to perform functions and exercise powers conferred on the commissioner under any Act.

6.399 The main roles of the Health Rights Commissioner are to impartially review and resolve complaints about health services; make suggestions for improvements to health systems and practices by utilising the feedback provided through an analysis of complaints; and to work with health service providers to help them to improve their own complaints management processes. Registration bodies are also required to forward their investigation reports to the Commissioner.

⁴¹⁰ Exhibit 354 para 26

⁴¹¹ Exhibit 354 para 26

- 6.400 Pursuant to ss31 and 32 of the *Health Rights Commission Act*, the Minister may give the Commissioner a written direction to investigate a particular matter or to conduct an Inquiry. However, this Ministerial power is rarely exercised.
- 6.401 Approximately 11,000 complaints have been received by the Health Rights Commission since its inception in 1991 concerning health services in Queensland. Just over 45 % of these complaints have resulted in outcomes that the Health Rights Commissioner has described as favourable or satisfactory to the complainant. The resolutions might include an apology or acknowledgment that a health service should have been performed better; access to treatment that had been unreasonably denied; a remedial procedure; refund of fees; an *ex gratia* payment; or financial settlement of a claim for medical negligence.
- 6.402 The Health Rights Commissioner may not take action on a complaint if the patient has commenced a civil proceeding for redress for the matter of the complaint and a court has begun to hear the matter. A patient who wishes to complain the Health Rights Commissioner is not obliged to forfeit the right to commence a civil proceeding. Presumably, if a patient complains and participates in a conciliation arranged by the Health Rights Commissioner it will be a matter considered by the patient and any other party to the conciliation whether a term of a settlement agreement will be an agreement to compromise civil proceedings.
- 6.403 The Commissioner regarded it as a significant limitation on his powers that he can only respond to complaints the Commissioner actually receives. Even if the Commissioner becomes aware of apparently serious health issues by means such as media reports, the Commissioner has no power to intervene unless the Commissioner actually receives a complaint from someone involved with the particular health service – for example, a patient or a member of staff at the health service concerned. The Commissioner has no power to investigate health care issues of the Commissioner's own initiative, even though the matter may involve important issues of public interest, significant systemic issues or serious concerns about a practitioner's competence.
- 6.404 There are two further significant practical limitations on the Commissioner's powers. Though the Commissioner may have assessed the matter about which a complaint was made, though he may understand the facts thoroughly and though the parties may be before him, the Commissioner cannot adjudicate on the complaint. He cannot determine whether a complaint is unreasonable or justified. He cannot order a restriction or a condition on the right of practice of the doctor, nurse or allied health professional whose conduct led to the complaint.
- 6.405 Section 57 of the *Health Rights Commission Act* provides the types of complaints which may be made to the Commissioner. Among the various types of complaints provided for in s57 the following would allow for complaints

relating to Dr Patel's actions and the hospital's failure to take timely action.
Complaints:

- that a provider has acted unreasonably in the way of providing a health service for a user;
- that a provider has acted unreasonably in providing a health service for a user;
- that a registered provider acted in a way that would provide a ground for disciplinary action against the provider under the Health Practitioners (Professional Standards) Act 1999;⁴¹²
- that a public body that provides a health service has acted unreasonably by:-
 - not properly investigating; or
 - not taking proper action in relation to:

a complaint made to the body by a user about a provider's action of a kind mentioned above.

6.406 It follows that a complaint about Dr Patel's decision to perform complex surgery or his manner of performing surgery would each be appropriate for referral to the Health Rights Commission. A complaint that he was unfit for registration would not.

6.407 The Health Rights Commission is not responsible for matters relating to the registration of individual health providers. Decisions as to whether a medical practitioner is entitled to be or to remain registered in Queensland are for the Medical Board of Queensland. The *Health Rights Commission Act* recognises this fact by requiring the Commissioner, in specified circumstances, to refer certain health services complaints to the appropriate registered provider's registration board.⁴¹³ In relation to the issue of registration and monitoring of overseas trained medical practitioners, the Health Rights Commission has no role, nor any powers, and absent a complaint, no responsibility in respect of their ongoing assessment and monitoring.

6.408 Section 71 of the *Health Rights Commission Act* provides that, before accepting a health service complaint for action, the Commissioner must first be satisfied that the complainant has made a reasonable attempt to resolve the matter with the health service provider⁴¹⁴, unless it is clearly impracticable to do so.⁴¹⁵ Three telephone enquiries were received by the Health Rights Commission from patients of Dr Patel. In each case the patients were referred to the Bundaberg

⁴¹² The Commission's interaction with registration boards is discussed in more detail below. While there are some synergies between the respective bodies, there are also areas where the statutory responsibilities of the Health Rights Commission and registration boards are quite distinct.

⁴¹³ See s68 of the *Health Rights Commission Act 1991*

⁴¹⁴ This is discussed in s71(2)(a) of the *Health Rights Commission Act 1991*

⁴¹⁵ Instances where the Commissioner would generally regard it as impracticable include where allegations are made of serious breaches of professional conduct (such as sexual misconduct), or where there is a clear evidence of a threat to public safety. The Commission's policy is also to accept complaints in the first instance where the complainant may, for language or cultural reasons, find it difficult to take up their concerns with the provider on their own behalf.

Base Hospital and advised of their right to come back to the Health Rights Commission if they wanted to take the matter further. Presumably these three referrals were to satisfy s71(1)(a) of the *Health Rights Commission Act*.

- 6.409 Before accepting a complaint for statutory action, the Commissioner is required to consult the provider's registration board about the complaint.⁴¹⁶ The Health Rights Commission must not take any action with respect to the complaint until the relevant registration board provides comments, advises that it does not intend to comment, or a specified period of time has passed.⁴¹⁷
- 6.410 Section 77 of the *Health Rights Commission Act* provides that if the Commissioner receives a health service complaint about a registered provider, believes that the provider poses an imminent threat to public safety and therefore, considers that immediate suspension of the provider's registration may be necessary, the Commissioner must then immediately refer the complaint to the provider's registration board.
- 6.411 Some clinical staff at Bundaberg Base Hospital had become concerned about Dr Patel well before issues relating to his competence became public. No complaints were received by the Health Rights Commission directly from clinical staff. It would have been open to the Health Rights Commissioner to accept such complaints had they been made. Section 59 of the *Health Rights Commission Act* provides that a 'health service complaint' may be made to the 'Commissioner' by a person other than the *user* of the health service or the user's representative, if it is considered by the Commissioner to be in the public interest to do so. The effect of s59(1)(d) is that a staff member of a public hospital wishing to make a complaint to the Health Rights Commissioner has no right to do so. However, if the Commissioner considers that the public interest requires that the staff member make the complaint then the Commissioner will accept it. Accordingly, if Ms Hoffman in her capacity as a Nurse Unit Manager had chosen in October 2004 to report her concerns to the Health Rights Commission she would have had no certainty that the Health Rights Commission would have acted on the complaint. The first hurdle for her would have been to persuade the Commissioner that the public interest required that she be permitted to make her complaint. If Ms Hoffman had tried to do so, it is reasonable to conclude that her complaint would have been rejected and that she would have been referred to the Medical Board of Queensland as this is in effect what happened to Mr Messenger MP.
- 6.412 When Mr Messenger MP contacted the Health Rights Commission on 23 March 2004 raising Ms Hoffman's concerns about Dr Patel, the Health Rights

⁴¹⁶ s71(3) *Health Rights Commission Act 1991*

⁴¹⁷ s71(6) *Health Rights Commission Act 1991*

Commissioner's recommendation to Mr Messenger was that the Medical Board was the most appropriate body to investigate the concerns.⁴¹⁸

- 6.413 If a staff member of the Bundaberg Base Hospital had persuaded the Commissioner that there was a public interest requirement that the complaint be accepted, the end result may well have been a time consuming assessment process and conciliation with little or no benefit for the staff member or the public.
- 6.414 The *Health Rights Commission Act* essentially follows the so-called conciliation approach to complaints resolution that has been adopted by all States and Territories other than in New South Wales. The Health Rights Commission strives to work cooperatively with all parties to a complaint and wherever possible to help preserve the relationship between them. This contrasts with the more prosecutorial approach to complaints resolution that is reflected in the NSW complaints system, whereby the Health Care Complaints Commission, in addition to its other functions, retains a prosecutorial role.
- 6.415 It should be noted that the Commissioner has no power to compel parties to respond to a complaint or to provide information during assessment. The Commissioner may invite a response or may request information from the provider against whom the complaint was made, or request advice from a practitioner who subsequently treated (or provided a second opinion to) the complainant.⁴¹⁹
- 6.416 Where the information obtained in assessment supports a claim for compensation or some other significant remedy, the matter would quite likely be moved into conciliation, enabling the complaint to be explored further in a privileged and confidential setting. Under the *Health Rights Commission Act*, the parties can reach a legally binding settlement. Of the complaints conciliated, 21 per cent resulted in an agreement that compensation be paid to the complainant.
- 6.417 For a complaint against a registered provider such as Dr Patel, the only further action that is open to the Commissioner following assessment is to try to resolve the complaint by conciliation, if the Commissioner considers that it can be resolved in that way,⁴²⁰ or to refer the matter to the provider's registration board. The Commissioner's power to conduct investigations of individual registrants, was removed by the *Health Practitioners (Professional Standards) Act 1999*.

⁴¹⁸ Exhibit 354 para 48, Statement Kerslake

⁴¹⁹ A 'third party'

⁴²⁰ *Health Rights Commission Act 1991* s71(4)

Only a registration board has the power to formally investigate issues relating to a registered provider.⁴²¹

- 6.418 For a complaint against an individual such as Dr Patel, the actions available to the Commissioner are limited to assessing the complaint, conciliating it or referring it to the provider's registration board.⁴²² The Health Rights Commissioner, Mr Kerslake, explained that, as Commissioner he had no power to punish or sanction.⁴²³ While the Commissioner had power to assess all complaints, he did not have power to investigate a complaint about Dr Patel but did have power to investigate a complaint about Bundaberg Base Hospital.⁴²⁴
- 6.419 Where the Commissioner and a registration board agree that a matter should be referred to the registration board, the Commissioner must generally defer conciliating the complaint until the registration board completes its own investigation.⁴²⁵
- 6.420 The Health Rights Commissioner may not take action on a health service complaint if the matter of complaint arose more than a year before the complaint was made to the Commissioner.⁴²⁶ Such a limitation could affect the treatment by the Health Rights Commissioner of a complaint by a concerned person such as Ms Hoffman if the complaint were based upon a series of clinical misadventures which commenced more than a year before the complaint was made. This is noteworthy because it is similar to the situation which arose in respect of Dr Patel. Ms Hoffman wrote to the District Manager on 22 October 2004⁴²⁷ listing a number of matters of concern to her extending back as far as June 2003.
- 6.421 In summary, while the Health Rights Commissioner performs many useful functions, he was not empowered to provide a practical solution in a case like Patel's where a member of hospital staff held the opinion that several patients had been harmed by a medical practitioner who was likely to harm further patients. No single patient was likely to be aware of the numerous complaints relating to Dr Patel. No patient was likely to complain to the Commissioner of more than an isolated event. A patient's complaint may have led to a conciliation about the patient's individual concern. A member of staff was in a better position to perceive that Dr Patel had harmed several patients and was likely to continue to do so. But a member of staff had no right to force the

⁴²¹ The Commissioner's sole power to require the provision of information falls within the category of 'non-registered' providers (such as a hospital), when undertaking a formal investigation under Part 7 of the Act

⁴²² This can result in quite convoluted with overlapping processes and enquiries in certain circumstances, such as where a complaint is made about a health service performed by an individual doctor in a hospital setting

⁴²³ T5633 line 15 (Kerslake)

⁴²⁴ T5634 line 13 (Kerslake)

⁴²⁵ *Health Rights Commission Act 1991* s75

⁴²⁶ *Health Rights Commission Act 1991* s79(5)

⁴²⁷ Exhibit 4 TH37

Health Rights Commissioner to accept the complaint unless the Commissioner could be persuaded that it was in the public interest. If the Commissioner accepted the complaint, the Commissioner had no power to investigate Dr Patel, no power to sanction Dr Patel and no power to terminate his registration. The Commissioner's power was to conciliate. The most practical thing the Health Rights Commissioner could do if a staff member raised allegations that a medical practitioner had caused harm to numerous patients was to refer the matter to the Medical Board of Queensland. If the Health Rights Commissioner heard of the issue in the media or from a person who was not making a complaint, the Commissioner had no power to act.

Health Rights Commission's response to Bundaberg complaints

- 6.422 As at March 2005 the name of Dr Patel had attracted no significance, nor any level of recognition within Health Rights Commission. A review of the Health Rights Commission's complaints and enquiries database indicated to the Health Rights Commissioner that during the two year period from 1 April 2003 to 31 March 2005, the Health Rights Commission had received six written complaints concerning the provision of health services at Bundaberg Base Hospital. This was not a high level of complaints for that period of time from a provider of the size of Bundaberg Base Hospital. None of these complaints concerned services provided by Dr Patel. There were three telephone enquiries about Bundaberg Base Hospital received over the same period where Dr Patel was named as the treating doctor. In each instance the callers were happy to take their concerns up directly with Bundaberg Base Hospital. The Health Rights Commission advised them of their right to come back to the Health Rights Commission if they wished to take the matter further but none did so prior to April 2005.
- 6.423 On 23 March 2005 the Health Rights Commission received a copy of Mr Rob Messenger MP's letter to the Minister for Health dated 22 March 2005 raising concerns about Dr Patel. Following receipt of this letter the Commissioner spoke with Mr Messenger's office to advise that as the letter primarily raised competency issues concerning a registrant, the Medical Board was the most appropriate body to investigate the concerns, and the Commissioner would confirm with the Medical Board that it would be addressing the matter.
- 6.424 On 8 April 2005 *The Courier-Mail* newspaper reported that the Chief Health Officer of Queensland Health had carried out an investigation into the competency of a surgeon at the Bundaberg Base Hospital who had been linked to the death of at least 14 patients and that the surgeon in question had since 'fled the country'. Upon it becoming apparent that there would be a larger number of complaints and a broader range of issues to be addressed, the Commissioner contacted Mr Messenger and advised that the Health Rights Commission would clearly need to be involved in the assessment and investigation of the complaints, and asked that he refer any additional matters of

which he became aware to the Health Rights Commission. Mr Messenger continued to do this.

- 6.425 The Health Rights Commission sent a senior officer to Bundaberg to liaise with potential complainants and the Health Rights Commission Complaints Manager attended Bundaberg for this purpose for the week of 18 April - 22 April 2005. Over 70 formal complaints or enquiries were received in the course of that week. A priority in this initial period was to ensure that patients in need of medical treatment could receive it. The Commissioner engaged in liaison with Queensland Health. The Health Rights Commission agreed a protocol with Queensland Health that it would advise patients seen by its liaison officers in Bundaberg of their right to complain to the Health Rights Commission, and that the Health Rights Commission would inform complainants who were potentially in need of treatment of the opportunity to make contact with a Queensland Health liaison officer. While in Bundaberg the Health Rights Commission's Complaints Manager arranged for the urgent review of some complainants' immediate health needs. The Health Rights Commission did not initially refer its complaints about Dr Patel to the Medical Board as the Medical Board advised that Dr Patel's registration had expired and they had declined to renew his registration.
- 6.426 As at 5 August 2005, the number of formal complaints received by Health Rights Commission concerning health services provided by Bundaberg Base Hospital had grown to 97 and the Health Rights Commission had notified the Medical Board of Queensland of these complaints and was keeping the Medical Board informed of developments.
- 6.427 Although no formal findings had been reached by the time the Commissioner gave evidence, assessment of these complaints by the Health Rights Commission was well advanced. The Commissioner advised in oral evidence on 20 September 2005 that he had appointed an independent expert to assist with this process being a surgeon from Melbourne, Dr Allsop. A considerable number of cases had already been reviewed, which reviews had identified a range of significant inadequacies in the standard of care provided to patients of Dr Patel. It was then impractical to call Dr Allsop. The results of the reviews were to be made available to the Medical Board of Queensland to assist in its deliberations. The Health Rights Commission had put in place arrangements with Queensland Health to facilitate the prompt assessment, and where appropriate, resolution of these complaints, including the payment of compensation.

6.428 The Health Rights Commission also has an investigative function,⁴²⁸ although that function is limited.⁴²⁹ Mr Kerslake described the Health Rights Commission's investigative functions as invoked:

where a complaint raises serious systemic issues that might warrant detailed examination or result in formal recommendations for change.⁴³⁰

In this ability to investigate systemic issues the Health Rights Commission has the advantage over the Medical Board which has no equivalent investigative power. Yet, if there emerged an obvious need to investigate a doctor, the Health Rights Commissioner would be unable to investigate but the Medical Board could. The Health Rights Commission may use its powers to investigate only:

- A complaint about a health service provider such as a hospital or nursing home;
- An unsuccessful conciliation; or
- A complaint where the Commissioner has elected to end a conciliation.⁴³¹

It could not investigate an individual practitioner such as Dr Patel.

6.429 Through the Australian Health Care Agreements ('the Agreements') the provision of health funding by the Commonwealth is conditional in part on all States and Territories maintaining independent health complaints commissions. Under the Agreements, each of these bodies must:

- be independent of the State's Hospitals and the State's Department of Health;
- be given powers that would enable it to investigate, conciliate and/or adjudicate upon complaints received by it; and
- be given the power to recommend improvements in the delivery of public hospital services.

In the agreements between the Commonwealth and Queensland and the Commonwealth and New South Wales, it is agreed that the:

Powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary boards...and that the exercise of powers by the complaints body will not affect the rights that a person may have under common law or statute law.⁴³²

6.430 The Health Rights Commissioner, Mr Kerslake perceived benefits in keeping the conciliation function of the Health Rights Commission separate from the professional standards and disciplinary function of the Medical Board of Queensland. Mr Kerslake's opinion was that the disciplinary function of the

⁴²⁸ *Health Rights Commission Act 1991 Part 7*

⁴²⁹ *Health Rights Commission Act 1991 s95*

⁴³⁰ Exhibit 354 para 21

⁴³¹ *Health Rights Commission Act 1991 s95*

⁴³² See schedule D clause 6 of the Australian Health Care Agreement between the Commonwealth of Australia and the State of Queensland 2003-2008 and of the Australian Health Care Agreement between the Commonwealth of Australia and New South Wales 2003-2008

Medical Board did not 'fit readily together' with the Health Rights Commissions functions of resolution of complaints and recommending systemic improvement of the health sector.⁴³³ Mr Kerlake considered that the New South Wales Health Care Complaints Commission, which performs all three functions, receives significantly less cooperation from the health service providers than is received by the Queensland Health Rights Commission.

The Medical Board of Queensland

6.431 The Medical Board of Queensland is established by the *Medical Practitioners Registration Act 2001*. The objects of that Act are:

- To protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way; and
- To uphold the standards of practice in the profession; and
- To maintain public confidence in the profession.⁴³⁴

6.432 In the year 2003/2004 the Medical Board received 232 complaints,⁴³⁵ including 128 complaints from patients or persons acting on behalf of patients. In that year the Health Rights Commission referred 21 complaints to the Medical Board.⁴³⁶ Of those 232 complaints the Medical Board referred 74 complaints to the Health Rights Commission.⁴³⁷ A further 34 complaints were investigated by the Medical Board, some of which resulted in disciplinary action.⁴³⁸

6.433 The Medical Board may investigate complaints it receives,⁴³⁹ or a complaint referred to it by the Minister⁴⁴⁰ or the Health Rights Commission.⁴⁴¹ The Medical Board may also conduct an investigation on its own motion.⁴⁴² This is an advantage that the Health Rights Commission does not have for it must wait to receive a complaint and then its power is generally limited to assessment but not investigation.

6.434 When the Medical Board of Queensland determines to investigate a complaint it appoints an investigator from the Office of the Health Practitioner Registration Boards to carry out the investigation. On occasion the Medical Board uses a panel of external investigators to conduct investigations.⁴⁴³

⁴³³ T5645 line 4- line 45 (Dr Kerlake)

⁴³⁴ *Medical Practitioners Registration Act 2001* s7

⁴³⁵ See Medical Board Annual Report available at:

<http://www.medicalboard.qld.gov.au/Publications/Publications.htm>

⁴³⁶ Medical Board Annual Report 2003/04 p11

⁴³⁷ Medical Board Annual Report 2003/04 p12

⁴³⁸ Medical Board Annual Report 2003/04 p12

⁴³⁹ *Health Practitioners (Professional Standards) Act 1999* s62(d)

⁴⁴⁰ *Health Practitioners (Professional Standards) Act 1999* s62(a) & (b)

⁴⁴¹ *Health Practitioners (Professional Standards) Act 1999* s62(c)

⁴⁴² *Health Practitioners (Professional Standards) Act 1999* s62(f)

⁴⁴³ Medical Board Annual Report 2003/04 p12

6.435 The Medical Board has broad powers when conducting its investigation into a doctor including:

- the power to require a person to provide information, attend before the investigator and answer questions, and to produce documents;⁴⁴⁴
- the power to enter and search premises and seize evidence;⁴⁴⁵
- the power to require a medical practitioner to attend a health assessment.⁴⁴⁶

6.436 If the investigation is related to a complaint, then during the investigation the Medical Board must also keep the Health Rights Commission informed about the progress of that investigation.⁴⁴⁷ It must also send a copy of its report to the Health Rights Commission.⁴⁴⁸ The Health Rights Commission may, within 14 days or such further times as may be agreed by the Medical Board, comment on the report.⁴⁴⁹

6.437 The *Health Practitioners (Professional Standards) Act 1999* sets out the functions of various boards established under Health Practitioners Registration Acts. It applies to the Medical Board of Queensland. The *Health Practitioners (Professional Standards) Act 1999* provides at Section 11:

11 Boards' functions under this Act

A board's functions under this Act are the following:

- (a) to receive complaints about its registrants and, if appropriate, refer the complaints to the commissioner;
- (b) to consult and cooperate with the commissioner in investigating and disciplining its registrants and in relation to complaints about impaired registrants;
- (c) to immediately suspend, or impose conditions on, the registration of its registrants if the registrants pose an imminent threat to the wellbeing of vulnerable persons;
- (d) to conduct investigations, whether because of complaints or on its own initiative, about the conduct and practice of its registrants;
- (e) to deal with disciplinary matters relating to its registrants that can be satisfactorily addressed through advising, cautioning and reprimanding;
- (f) to bring disciplinary proceedings relating to its registrants before panels or the tribunal;
- (g) to implement orders of panels or the tribunal relating to the board's registrants;
- (h) to establish health assessment committees to assess the health of registrants who may be impaired and make decisions about impaired registrants;

⁴⁴⁴ *Health Practitioners (Professional Standards) Act 1999* s78

⁴⁴⁵ *Health Practitioners (Professional Standards) Act 1999* Pt 5 div 5 subdiv 2,3 & 4

⁴⁴⁶ *Health Practitioners (Professional Standards) Act 1999* div 5 subdiv 7

⁴⁴⁷ *Health Practitioners (Professional Standards) Act 1999* s116(2)

⁴⁴⁸ *Health Practitioners (Professional Standards) Act 1999* s116(3) & (4)

⁴⁴⁹ *Health Practitioners (Professional Standards) Act 1999* s116(5)

- (i) to monitor its registrants' compliance with conditions imposed or other disciplinary action taken, or undertakings entered into, under this Act;
- (j) to cancel or suspend, or impose conditions on, its registrants' registration as a result of action taken under a foreign law;
- (k) to consult and cooperate with other boards, foreign regulatory authorities and other relevant entities about the investigation and disciplining of its registrants and the management of its registrants who are impaired;
- (l) to exercise other functions given to the board under this Act.

6.438 The *Health Practitioners (Professional Standards) Act 1999* establishes the Health Practitioners Tribunal.⁴⁵⁰ That tribunal may hear disciplinary matters relating to medical practitioners and other health service providers.⁴⁵¹

6.439 Complaints to the Medical Board must be in writing,⁴⁵² and may be made by a patient, an entity acting on behalf of a patient, another registrant, which includes registered medical practitioners, nurses and allied health workers, the Director-General of Queensland Health, the Minister for Health, or a foreign regulatory authority.⁴⁵³

6.440 The way the Medical Board may deal with a complaint about a doctor depends on the person who makes the complaint. Complaints by and on behalf of a patient are dealt with differently from complaints from any other entity. If a doctor or nurse complains to the Medical Board of Queensland about a registered doctor and the complainant is not representing a patient then the Medical Board would deal with the complaint under the protocol in Section 53 of the *Health Practitioners (Professional Standards) Act 1999*. It provides so far as is relevant:

53 Action by board on receipt of complaint made or referred by another entity, or complaint commissioner not authorised to receive

(1) This section applies if:

- (a) a registrant's board receives a complaint about the registrant from an entity, other than a user of a service provided by the registrant or an entity acting on behalf of the user; or
- (b) a complaint about a registrant is referred to the registrant's board by the commissioner under the *Health Rights Commission Act 1991*; or
- (c) a registrant's board receives a complaint about the registrant and
 - (i) the complaint is about a matter that happened before 1 July 1991; and
 - (ii) the complainant was aware of the matter before 1 July 1991.⁴⁵⁴

⁴⁵⁰ *Health Practitioners (Professional Standards) Act 1999* Pt2 div4

⁴⁵¹ *Health Practitioners (Professional Standards) Act 1999* s30

⁴⁵² *Health Practitioners (Professional Standards) Act 1999* s49

⁴⁵³ *Health Practitioners (Professional Standards) Act 1999* s47

⁴⁵⁴ See the *Health Rights Commission Act 1991*, s149

- (2) After considering the complaint, the board must decide to do 1 of the following:
- (a) under the immediate suspension part, to suspend, or impose conditions on, the registrant's registration;
 - (b) investigate the complaint under the investigation part;
 - (c) start disciplinary proceedings under the disciplinary proceedings part;
 - (d) deal with it under the impairment part; 14 See the *Health Rights Commission Act 1991*, section 149 (Transitional for *Health Rights Commission Act 1991* (Act No. 88 of 1991)).
 - (e) deal with the complaint under the inspection part or the health practitioner registration Act under which the board is established and, if appropriate, start proceedings to prosecute the registrant under this Act or the health practitioner registration Act;
 - (f) refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter;
 - (g) reject the complaint under section 54.

6.441 But if instead, a complaint is from or on behalf of a patient about a medical practitioner, the Medical Board is obliged to refer that complaint to the Health Rights Commission⁴⁵⁵ unless, certain conditions exist. They are set out in sub-section 51(2) of the *Health Practitioners (Professional Standards) Act 1999*. This is seen from sub section 51(1) and (2):

51 Action by board on receipt of complaint

(1) This section applies if a registrant's board receives a complaint about the registrant from a user of a service provided by the registrant or an entity acting on behalf of the user.

(2) The board must refer it to the commissioner unless:

- (a) following consultation between the board and the commissioner, the board and the commissioner agree it is in the public interest for the board to do 1 of the following:
 - (i). *keep the complaint for investigation under the investigation part;*
 - (ii). *keep the complaint and start disciplinary proceedings under the disciplinary proceedings part;*
 - (iii). *keep the complaint and deal with it under the impairment part;*
 - (iv). *keep the complaint and deal with it under the inspection part or the health practitioner registration Act under which the board is established and, if appropriate, start proceedings to prosecute the registrant under this Act or the health practitioner registration Act;*
 - (v). *refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter; or*
- (b) the board keeps the complaint under a standing arrangement entered into between the board and the commissioner and deals with it in a way mentioned in paragraph (a); or
- (c) the board, under the immediate suspension part, suspends, or imposes conditions on, the registrant's registration; or

⁴⁵⁵ *Health Practitioners (Professional Standards) Act 1999* s51(2)

- (d) the complaint is about a matter that happened before 1 July 1991 and the complainant was aware of the matter before 1 July 1991.⁴⁵⁶

6.442 Once the Medical Board has referred a complaint to the Health Rights Commission, then the Medical Board may take no further action with respect to the complaint, unless the Health Rights Commission chooses to refer it back to the Medical Board.⁴⁵⁷

6.443 Unlike the Health Rights Commission, the Medical Board also has the power to immediately suspend a registrant, or to impose conditions on the doctor's registration.⁴⁵⁸ This power is given to the Medical Board to effectively respond to threats posed by medical practitioners to the well being of vulnerable persons. In theory, the Medical Board was empowered in October 2004 to receive Ms Hoffman's complaints about Dr Patel and to take action if Ms Hoffman had chosen to complain to the Medical Board.

6.444 If Ms Hoffman had complained about Dr Patel and had done so on her own behalf and not on behalf of a patient, the Medical Board would have had power to suspend Dr Patel immediately or to impose conditions on his registration. But before doing so the Medical Board would have been obliged to form a reasonable belief about two matters. These appear in s59 of the *Health Practitioners (Professional Standards) Act 1999* which provides, so far as is relevant:

59 Immediate suspension or imposition of conditions on registration

- (1) This section applies if a registrant's board reasonably believes at any time, whether on the basis of a complaint or otherwise, that—
 - (a) the registrant poses an imminent threat to the wellbeing of vulnerable persons; and
 - (b) immediate action to suspend, or impose conditions on, the registrant's registration is necessary to protect the vulnerable persons.
- (2) The board may decide to suspend, or impose conditions on, the registrant's registration.
- (3) However, in making its decision under subsection (2), the board must take the action the board considers is the least onerous necessary to protect the vulnerable persons.

6.445 Where a nurse or a doctor complains to the Medical Board of Queensland about a doctor in a way that suggests that patients may be in danger, the Medical Board is faced with two practical choices. Suspend immediately⁴⁵⁹ and then

⁴⁵⁶ The *Health Rights Commission Act 1991*, section 149, provides that the Act does not authorise a complaint to be made to the commissioner about a health service provided before the commencement of the section, if the complaint relates to a matter arising more than 1 year before the commencement and the complainant was aware of the matter of the complaint more than 1 year before the commencement. Section 149 commenced on 1 July 1992.

⁴⁵⁷ *Health Practitioners (Professional Standards) Act 1999* s52

⁴⁵⁸ *Health Practitioners (Professional Standards) Act 1999* Pt 4

⁴⁵⁹ *Health Practitioners (Professional Standards) Act 1999* s53(2)(a)

investigate the doctor⁴⁶⁰ or postpone the decision about suspension and investigate first.⁴⁶¹

- 6.446 The Medical Board can make the choice to immediately suspend a doctor on condition that it has first reasonably formed the belief that the doctor poses an imminent threat to the well being of patients and secondly that immediate action to suspend is necessary to protect them. Dr FitzGerald was a member of the Medical Board at the time he investigated, for Queensland Health, the complaints relating to Dr Patel. Dr FitzGerald did not choose to recommend to Queensland Health either suspension or the imposition of conditions upon Dr Patel's employment. Dr FitzGerald did write to the Medical Board.⁴⁶²

I wish to formally bring to your attention and seek assessment of the performance of Dr Jayant Patel...My investigations to date have not been able to determine if Dr Patel's surgical expertise is deficient, however, I am concerned that the judgment exercised by Dr Patel may have fallen significantly below the standard expected...I would be grateful for the Board's consideration in this matter.

This was not a recommendation from Dr FitzGerald to suspend Dr Patel. It is probable the Medical Board would not have formed the beliefs necessary to suspend Dr Patel if its members had acted on the basis of that letter to the Medical Board 24 March 2005. If Ms Hoffman had made her complaints to the Medical Board by providing it with a copy of her letter to Mr Leck of 22 October 2004⁴⁶³ would the material in it have permitted the Medical Board to reasonably believe that Dr Patel posed an imminent threat to patients? Possibly, at the very least, the letter would have justified the Medical Board in arranging an urgent and prompt investigation to determine the imminence and extent of any threat to patients and whether suspension of Dr Patel or a less onerous⁴⁶⁴ condition was required to protect patients.

- 6.447 Would a complaint to the Medical Board in October 2004 have led to any practical result? In practice it would have been dependent upon the Medical Board's investigators' case backlog and priorities as to whether the Medical Board would have taken any practical action in a timely way. Mr O'Dempsey on behalf of the Medical Board referred to Section 59 of the *Health Practitioners (Professional Standards) Act 1999* and the way it has been interpreted⁴⁶⁵ writing that:⁴⁶⁶

The threshold was a high one for applying section 59 *Health Practitioners (Professional Standards) Act* for a suspension in terms of evidence of 'immediacy of the threat' ... I believe this provision in its current form is inconsistent with one of the

⁴⁶⁰ *Health Practitioners (Professional Standards) Act 1999* s59(4)(a)

⁴⁶¹ *Health Practitioners (Professional Standards) Act 1999* s53(2)(b)

⁴⁶² Exhibit 225 GF13 Letter Dr FitzGerald to Mr Jim O'Dempsey of 24 March 2005

⁴⁶³ Exhibit 4 TH37

⁴⁶⁴ The Health Practitioners Tribunal in *Thurling v the Medical Board of Queensland* [2002] QHPT 004 held that the Medical Board when applying its power under section 59 of the *Health Practitioners (Professional Standards) Act 1999* should determine the least onerous action necessary to protect vulnerable persons from the imminent threat.

⁴⁶⁵ *Thurling OP.CIT.*

⁴⁶⁶ Exhibit 28 para 41

overall objects of the legislation which is the protection of the public by ensuring health care is delivered by registrants in a professional, safe and competent way...

It seems clear from that evidence that the approach from the Medical Board, since the Health Practitioners Tribunal's decision of 2002, has been to require more evidence of danger to the patients before acting to suspend than Mr O'Dempsey regards as appropriate for protection of the public.

- 6.448 It is appropriate that there should be concern for the rights of a doctor or an allied health professional who is accused of endangering patients. This is especially so if the accusation cannot be tested until there has been a thorough investigation of the facts. However, it is undesirable if the concern for the doctor or allied health professional causes the relevant authority to allow a real risk to patients to continue until a thorough investigation has taken place, or worse, until the evidence is tested in a contested hearing. Under the *Nursing Act 1992* there is a provision to allow for the immediate suspension of a nurse's registration or enrolment prior to an investigation. It creates a lower threshold for suspension than the one which appears in Section 59 of the *Health Practitioners (Professional Standards) Act 1999*. The *Nursing Act* relevantly provides:

67 Immediate suspension of registration or enrolment by council

(1) If the council is satisfied that the ability of a nurse to continue to practise nursing is seriously impaired to such an extent that a patient's health or safety could be at risk, whether because of the state of the nurse's condition or the nurse's conduct or practice, the council may by written notice given to the nurse suspend the nurse's registration or enrolment.

- 6.449 The Medical Board of Queensland had determined to investigate the complaint in the Ombudsman's case study on the 27 August 2002. At that time the Medical Board had a backlog of 295 investigations being about 50 for each of its 6 investigators. Eventually, the Medical Board referred the investigation to an external investigator 10 months after the Medical Board first determined to appoint an investigator. The investigation then took 6 months. The Medical Board found evidence to conclude that the doctors' management constituted unsatisfactory professional conduct. The Medical Board then referred the matter to the Health Practitioners Tribunal. Ten months later the Tribunal accepted a guilty plea from the doctor concerned and imposed sanctions upon his registration. So much emerges from the Ombudsman's case study. It reveals also that the period between complaint to the Medical Board and discipline of the doctor by the Tribunal was two years and seven months. It seems unlikely that a complaint made to the Medical Board in October 2004 would have led to limitations being placed upon Dr Patel's clinical practice before his departure in April 2005. Indeed, the facts of the Ombudsman's case study tend to suggest it is reasonable to expect to wait six months for investigation and a further ten

months for a Tribunal hearing. If the case study can be relied upon as a rough guide, even acting upon the assumption that the investigation would be complete in six months after the complaint⁴⁶⁷ and assuming that it then takes a further ten months for a tribunal hearing as it did in the case study, Dr Patel may well have been practising until April 2005 before the investigation was complete and the investigator informed the Medical Board. If the Medical Board failed to suspend Dr Patel until the evidence was tested in the Tribunal then Dr Patel may have practised until February 2006 before the Tribunal made a finding and determination as to whether conditions should have been imposed upon his registration.

Disciplinary action by the Medical Board

6.450 The Medical Board may start disciplinary action against a medical practitioner in four ways. It may take disciplinary proceedings itself⁴⁶⁸ or establish a disciplinary committee to conduct the proceeding.⁴⁶⁹ It may refer the matter for hearing by a professional conduct review panel.⁴⁷⁰ The role of professional conduct review panels is to conduct hearings of routine disciplinary matters in an informal and collaborative manner.⁴⁷¹ Under Part 6, division 5 of the *Health Practitioners (Professional Standards) Act 1999*, a professional conduct review panel has substantial powers and may refer appropriate matters to the Health Practitioners Tribunal if the matter may provide ground for suspending or cancelling a doctor's registration. Fourthly it may refer the matter for hearing before the Health Practitioners Tribunal.⁴⁷²

6.451 There are a number of grounds for disciplinary action against a medical practitioner including:

- Unsatisfactory professional conduct;⁴⁷³
- Failure to comply with a condition of registration.⁴⁷⁴

6.452 Once proceedings have commenced the Medical Board has extensive powers including the power to:

- Conduct hearings;⁴⁷⁵
- Summon witnesses to provide evidence or produce documents;⁴⁷⁶
- Inspect documents or other things;⁴⁷⁷
- Hold persons in contempt of the Medical Board.⁴⁷⁸

⁴⁶⁷ Instead of the 21 months in the Ombudsman's case study

⁴⁶⁸ *Health Practitioners (Professional Standards) Act 1999* s126(1)(a)

⁴⁶⁹ *Health Practitioners (Professional Standards) Act 1999* s126(1)(a)

⁴⁷⁰ *Health Practitioners (Professional Standards) Act 1999* s126(1)(b)

⁴⁷¹ See the Explanatory Notes, *Health Practitioners (Professional Standards) Bill 1999*

⁴⁷² *Health Practitioners (Professional Standards) Act 1999* s126(1)(b)

⁴⁷³ *Health Practitioners (Professional Standards) Act 1999* s124(1)(a)

⁴⁷⁴ *Health Practitioner (Professional Standards) Act 1999* s124(1)(b)

⁴⁷⁵ *Health Practitioners (Professional Standards) Act 1999* s137

⁴⁷⁶ *Health Practitioners (Professional Standards) Act 1999* s143

⁴⁷⁷ *Health Practitioners (Professional Standards) Act 1999* s148

- 6.453 The Health Rights Commission may intervene in proceedings before the Medical Board if it so chooses.⁴⁷⁹
- 6.454 The Health Practitioners Tribunal, established by s.26 of the *Health Practitioners (Professional Standards) Act* 1999, is comprised of the judges of the District Court. The Tribunal's functions include:
- The hearing of disciplinary matters referred to it by health practitioner boards;⁴⁸⁰
 - The hearing of appeals from decisions of health practitioner boards.⁴⁸¹
- 6.455 The Health Rights Commission may choose to intervene in any disciplinary proceedings before the Tribunal.⁴⁸²
- 6.456 The tribunal has broad powers to hear disciplinary matters including power to:
- Conduct public hearings;⁴⁸³
 - Suppress the name of the registrant to whom the disciplinary proceeding relates;⁴⁸⁴
 - Summon witnesses to give evidence or produce documents;⁴⁸⁵
 - Punish for contempt of the tribunal.⁴⁸⁶
- 6.457 The Tribunal has broad powers if it decides to discipline. They vary from a caution to imposing conditions upon registration to cancelling registration and declaring that the doctor must never be registered by the Medical Board of Queensland.⁴⁸⁷
- 6.458 The Medical Board first learned of concerns relating to the clinical practice of Dr Patel at the Bundaberg Base Hospital on 15 February 2005. Mr O'Dempsey met with two representatives of the Queensland Nurses' Union who indicated that their members were concerned about Dr Patel and had been interviewed by Dr FitzGerald. The Medical Board of Queensland did not receive a formal complaint about Dr Patel. Mr O'Dempsey spoke with Dr FitzGerald, ascertained that Dr FitzGerald was finalising a report and that there may have been recommendations or information about Dr Patel to be included in that report and asked Dr FitzGerald to inform the Medical Board's Registration Advisory Committee before the end of May 2005 so that it could consider whether to recommend conditions upon Dr Patel's registration. This was practical in the opinion of Mr O'Dempsey because conditions upon registration would be more easily imposed under the *Medical Practitioner's Registration Act* than under the *Health Practitioners (Professional Standards) Act*.⁴⁸⁸ This is consistent with the

⁴⁷⁸ *Health Practitioners (Professional Standards) Act* 1999 s163

⁴⁷⁹ *Health Practitioners (Professional Standards) Act* 1999 s153(1)

⁴⁸⁰ *Health Practitioners (Professional Standards) Act* 1999 s30

⁴⁸¹ *Health Practitioner (Professional Standards) Act* 1999 s30(2)

⁴⁸² *Health Rights Commission Act* 1991 s130

⁴⁸³ *Health Practitioners (Professional Standards) Act* 1999 s220

⁴⁸⁴ *Health Practitioners (Professional Standards) Act* 1999 s223

⁴⁸⁵ *Health Practitioners (Professional Standards) Act* 1999 s229

⁴⁸⁶ *Health Practitioners (Professional Standards) Act* 1999 s239

⁴⁸⁷ *Health Practitioners (Professional Standards) Act* 1999 s241

⁴⁸⁸ Exhibit 28 para 31

effect of the interpretation of s59 of the *Health Practitioners (Professional Standards) Act 1999*⁴⁸⁹ which has led the Medical Board to the view that before suspending or imposing conditions upon a doctor it was obliged to find evidence to meet a high threshold of proof of 'immediacy of the threat' and that it should determine the least onerous action to protect the patient.⁴⁹⁰

- 6.459 A consequence of the Medical Board's concern for the quality of evidence required to satisfy s59 of the *Health Practitioners (Professional Standards) Act 1999* is that it is more attractive to the Medical Board to allow an Area of Need registrant such as Dr Patel to continue practicing without conditions or suspension until the expiration of the doctor's year of registration and to consider imposing conditions when the doctor applies for a further year's registration. This cannot be in the best interests of patients.

The Queensland Nursing Council

- 6.460 Complaints against the nursing profession are referred to the Queensland Nursing Council.⁴⁹¹ The Queensland Nursing Council has, as one of its functions, the investigation of complaints against members of the nursing profession⁴⁹². In 2003/04 the Queensland Nursing Council received a total of 177 complaints against nurses.⁴⁹³
- 6.461 The Queensland Nursing Council may accept⁴⁹⁴ complaints about a nurse or midwife from any entity.⁴⁹⁵
- 6.462 If the complaint is from a patient, then before the Queensland Nursing Council can investigate a complaint it must first refer the complaint to the Health Rights Commission.⁴⁹⁶ If the complaint is from someone other than a patient then the Queensland Nursing Council may retain and investigate the complaint.⁴⁹⁷
- 6.463 The Queensland Nursing Council has broad powers to investigate complaints and may also immediately suspend a nurse if satisfied that there is a risk to patient safety.⁴⁹⁸
- 6.464 During the investigation, the Queensland Nursing Council is obliged to keep the Health Rights Commissioner informed on the progress of the investigation,⁴⁹⁹

⁴⁸⁹ See *Thurling v the Medical Board of Queensland* [2002] QHPT 004

⁴⁹⁰ Exhibit 28 para 41

⁴⁹¹ Established by the *Nursing Act 1992* s6

⁴⁹² *Nursing Act 1992* s7(g)

⁴⁹³ Queensland Nursing Council, Annual Report 2003 – 2004

⁴⁹⁴ regarding the acceptance of complaints see *Nursing Act 1992* s102A

⁴⁹⁵ *Nursing Act 1992* s102

⁴⁹⁶ *Nursing Act 1992* s102A, although in some circumstances, following consultation with the Health Rights Commissioner, the Queensland Nursing Council may retain the complaint for investigation if that is in the public interest, or in other case: see *Nursing Act 1992* s102A(2)

⁴⁹⁷ *Nursing Act 1992* s102A

⁴⁹⁸ *Nursing Act 1992* s67

⁴⁹⁹ However the council is only obliged to keep the Commissioner informed of the progress of the investigation if the Health Rights Commissioner asks to be kept informed

and is also required to provide to the Health Rights Commission the final report about the investigation.⁵⁰⁰

- 6.465 If satisfied that there are grounds for disciplinary action,⁵⁰¹ then the Queensland Nursing Council may refer the charge to the Nursing Tribunal.⁵⁰²
- 6.466 The Nursing Tribunal is an independent tribunal⁵⁰³ established under the *Nursing Act* 1992. It has no relationship with the Health Practitioners Tribunal established under the *Health Practitioners (Professional Standards) Act* 1999.⁵⁰⁴ It has broad powers and its function is to hear disciplinary charges with respect to nurses, make findings, and take appropriate action in response to disciplinary charges.⁵⁰⁵
- 6.467 The Ombudsman's case study reveals that the complaint about a registered nurse which was made to the Queensland Nursing Council was not immediately investigated by the Council. The investigation was delayed for three and a half months while the Health Rights Commission assessed the complaints, sought submissions and consulted with the Council. The Council accepted the complaint for investigation after that delay. The Council's investigation into the complaint against that registered nurse took a further fourteen months. Despite finding that there were concerns regarding the nurse's competence, the Queensland Nursing Council resolved to await an inquiry by the Coroner to determine what action should be taken. Three years and three months after complaining to the Queensland Nursing Council the complainants were still waiting to learn what disciplinary action, if any, would be taken against the nurse.

Queensland Ombudsman⁵⁰⁶

- 6.468 The Ombudsman can investigate administrative actions of an agency,⁵⁰⁷ including Queensland agencies that provide health services, deal with complaints about the provision of health services, and regulate the health service professions. The Ombudsman can investigate the administrative actions of the Health Rights Commissioner, the Medical Board of Queensland, Queensland Health and the Queensland Nursing Council.

⁵⁰⁰ *Nursing Act* 1992 s103A(2)

⁵⁰¹ *Nursing Act* 1992 s104A

⁵⁰² *Nursing Act* 1992 s104

⁵⁰³ The Nursing Tribunal is established under the *Nursing Act* 1992 Pt 5 Div 1

⁵⁰⁴ The Health Practitioners Tribunal hears matters concerning health practitioners other than nurses

⁵⁰⁵ The actions that the Tribunal can take are contained in the *Nursing Act* 1992 s116

⁵⁰⁶ The Queensland Ombudsman helpfully provided to me a copy of his submission of August 2005 to the Bundaberg Hospital Commission of Inquiry. I have relied upon the submission to describe the role of the Queensland Ombudsman so far as it relates to dealing with complaints about the Health Service and particularly for a case study done by the Queensland Ombudsman of a health related complaint. The case study illustrates well some unsatisfactory consequences which arise from Queensland's system which allots to different authorities different responsibilities for dealing with health complaints.

⁵⁰⁷ As defined in ss8 and 9 of the *Ombudsman Act* 2001

- 6.469 The Ombudsman is expected to liaise with other complaints entities to avoid inappropriate duplication of investigative activity⁵⁰⁸ and would not ordinarily accept an initial complaint about the provision of a health service if the complaint more appropriately fell within the jurisdiction of the Health Rights Commission, the Medical Board of Queensland (or another registration board), or the Queensland Nursing Council.
- 6.470 In most cases, the Ombudsman will not accept a complaint unless the complainant has tried to resolve it with the agency which is the subject of the complaint.
- 6.471 In the 2004/2005 financial year, the Ombudsman's Office received 339 health related complaints. Of those:.
- 156 related to Queensland Health;
 - 50 related to the Health Rights Commission;
 - 33 related to a registration board or the Queensland Nursing Council.
- 6.472 In accordance with the Ombudsman's normal practice in relation to Queensland Health complaints, many of the 256 complaints received (126) were referred to Queensland Health for internal review, while an additional 37 complaints were referred to the Health Rights Commission or to the relevant registration board.
- 6.473 The Ombudsman received no complaints about medical services at Bundaberg Base Hospital or about maladministration by health agencies in dealing with complaints about medical services at Bundaberg Base Hospital.

Recommendations for complaints management

Health Systems Review recommendation for complaints management

- 6.474 The final report of the Queensland Health Systems Review⁵⁰⁹ (the Forster Report) recommends changes to the current system of complaints management within Queensland Health.⁵¹⁰
- 6.475 Some key features of the Forster Report's proposed complaints model are:
- A complaints model be adopted that provides for local resolutions first whilst requiring escalation to an independent complaints body, a Health Commission if the complaint is not resolved in 30 days;⁵¹¹
 - the proposed Health Commission would have powers to investigate

⁵⁰⁸ *Ombudsman Act 2001* s15

⁵⁰⁹ *Queensland Health Systems Review, Final Report, September 2005*

⁵¹⁰ *Queensland Health Systems Review, Final Report, September 2005* p190-192

⁵¹¹ *Queensland Health Systems Review, Final Report, recommendation 9.16 at p196*

the complaints;⁵¹²

- There should be better coordination of the work of the Health Rights Commission, the Medical Board of Queensland and the other Health Practitioner registration boards, the Crime and Misconduct Commission, the State Coroner and the Queensland Ombudsman;⁵¹³
- A separate and short review needs to be undertaken of the legislation and working arrangements between those external bodies to determine how their work can be better coordinated;⁵¹⁴
- The proposed Health Commission could assume within its functions the role of the current Health Rights Commission;⁵¹⁵
- The proposed Health Commission would adjudicate complaints in a timely way.⁵¹⁶

6.476 The Forster Report did not explain what powers should be given to the proposed Health Commission as part of its role as an adjudicator of complaints. It was not obvious from the report whether the Health Commission would be 'one stop shop' with power to discipline or power to impose conditions upon the right to practice of doctors, nurses or allied health professionals.

Ombudsman's proposals for a new health complaints system

6.477 The submission of the Queensland Ombudsman⁵¹⁷ set out a comprehensive outline of features for a proposed new health complaints system.⁵¹⁸ The Queensland Ombudsman's office initiated a project in March 2003 called the Complaints Management Project and provided a report to the Director-General of Queensland Health on 8 March 2004 concluding that the Queensland Health system of complaint management 'compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management.' However, the Ombudsman's office had recommendations for improvement then. That office has considered the matter since and in particular in light of the experience of the Bundaberg Base Hospital and has set out a comprehensive outline of the health complaints system which the Ombudsman proposes.

6.478 Some features of the Ombudsman's submission relating to a new health complaints system differ from the features I have extracted from the Forster

⁵¹² *Queensland Health Systems Review*, Final Report, p190

⁵¹³ *Queensland Health Systems Review*, Final Report, p198

⁵¹⁴ *Queensland Health Systems Review*, Final Report, recommendation 9.22 p198

⁵¹⁵ *Queensland Health Systems Review*, Final Report, p199

⁵¹⁶ *Queensland Health Systems Review*, Final Report, p191

⁵¹⁷ Submission to Bundaberg Hospital Commission of Inquiry, August 2005, which was resubmitted to this Inquiry

⁵¹⁸ Ombudsman's submission at Section 5.4

Report. The Ombudsman's recommendations included the following features not apparent among the Forster Report's recommendations:

- A new and independent body which could provide complainants with a 'one stop shop' in that it would have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers of health services in both public and private sectors with power to assess and coercive powers to investigate.⁵¹⁹ The Medical Board and the other registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the new body;
- Generally before the new body would accept a complaint the complainant would be required to demonstrate that the complainant had attempted to resolve the matter with the health service provider. In this respect the recommendation of the Ombudsman is somewhat similar to the recommendation of the Forster Report. However, the Ombudsman adds significant practical exceptions:

There should be exceptions to this, for example where there is an immediate risk to the health or safety of a user or consumers, or where a complaint is made by a staff member of the relevant HSP who is fearful of reprisal.⁵²⁰

6.479 On the basis of the evidence and submissions received I am not in a position to recommend, in any detailed way the indicia of a better system. Some deficiencies are obvious. By dividing the jurisdiction to deal with complaints between numerous bodies there is a confusion for the complainants as to which is the best authority or the appropriate one for a practical resolution. Complaints often pass from one body to another and back again with consequential delays. The transfer of matters from one authority to another is dispiriting for complainants. From the Ombudsman's case study, it emerged that the Medical Board and the Nursing Council had no statutory power to investigate the matter for the first few months after receiving the complaints while the Health Rights Commissioner was assessing them. During the same months, while the Health Rights Commissioner was empowered to assess, he lacked the Medical Board's and Nursing Council's powers to investigate and had no power to adjudicate. The same case study reveals that for the next ten months, the backlog of Medical Board investigations prevented an investigation. When the investigation was assigned by the Medical Board to an external investigator it took six months to complete. In total, the time between complaint to the Medical Board and the

⁵¹⁹ Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry August 2005 p74

⁵²⁰ Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry August 2005 p77

disciplining of the doctor about whom the complaint was made was two years and eight months. When, in August of this year, the Ombudsman submitted the case study three years and four months had elapsed since the complaint to the Queensland Nursing Council. The complainants then were still waiting to learn what disciplinary action, if any, would be taken against the registered nurse about whom they first complained.

- 6.480 There are obvious advantages in having one independent body which could act upon complaints from patients and health practitioners or on its own initiative with the powers to assess and to investigate doctors, nurses, allied health professionals, private hospitals and public hospitals and which had the power to conciliate but also to adjudicate, discipline and suspend in cases where there exists a real risk to patients.
- 6.481 On the basis of the complaints made by Ms Hoffman in October 2004 some authority independent of Queensland Health ought to have existed with sufficient investigators to verify in no more than thirty days whether there existed a real risk that patients were in imminent danger and with the willingness and the power to suspend Dr Patel. If necessary, the suspension could be followed by a subsequent, more thorough, prompt investigation into whether the suspension was justified and whether it should continue. Fairness to a doctor or nurse suspended could be offered with a right to appeal and provisions such as those appearing in s92 of the *Public Service Act* 1996. That section provides so far as relevant:

92 Effect of suspension from duty

- (1) An officer suspended from duty under this part is entitled to full remuneration for the period for which the officer is suspended, unless the employing authority otherwise decides.
- (2) If the officer is suspended without full remuneration, the authority cancels the officer's suspension and the officer resumes duty, then, unless the authority otherwise decides, the officer is entitled to be paid the prescribed remuneration to which the officer would have been entitled apart from the suspension, less any amount earned by the officer from additional employment undertaken during the suspension period.

Complaint by litigation

- 6.482 Some significant claims against doctors, nurses and allied health professionals are made without notice to the Health Rights Commissioner or to the relevant registration board. This commission received a copy of an extract from a foreign newspaper that asserted that Dr Patel had been made the subject of several medical malpractice suits in the United States and that those suits had been settled without trial and without public record.

- 6.483 It is common for insurers to require of their insured that the insurer be notified by their insured if a claim for professional negligence is made against them. It would be useful if the insurer of a doctor, nurse or allied health professional gave notice of receipt of claims for professional negligence against its client and, upon resolution of the claim, details of the resolution. Legislation to compel this should be considered. The appropriate body to whom such notice should be given by the insurer is the body which has power to suspend or impose conditions upon the practise of the doctor, nurse or allied health professional, whether that body be the relevant registration board or the proposed 'one stop shop'.
- 6.484 In summary, it seems to me that serious consideration should be given to legislation to oblige insurers to report notice of claims for negligence against health practitioners and to creating a body which:
- Is a 'one stop shop' independent of Queensland Health and the registration boards having sole power to act upon complaints from or on behalf of patients or issues raised by health practitioners or upon notice of claims notified to insurers of health practitioners;
 - Has power to investigate, conciliate and adjudicate;
 - Has the power, where there is a real risk to a patient's health or safety from acts or omissions of a doctor, nurse or allied health professional, to immediately suspend or impose conditions on the doctor, nurse or allied health professional. Patient safety should have a higher priority than fairness to the practitioner. A sensible compromise for the practitioner would be a preliminary assessment of the reality of the risk to patients and, if a suspension or the imposition of a condition upon practise were to be ordered, it would be followed by a prompt investigation into whether the suspension or condition was justified and whether it should continue, a right of appeal, and a fair approach to remuneration for the practitioner for the period of suspension.

Whistleblower protection and reform

- 6.485 The people of Queensland owe a great deal to Ms Toni Hoffman, whose decision to speak to her local member of Parliament about her concerns regarding the activities of Dr Patel and the apparent threat he represented, led to his exposure and this Inquiry. Without her taking that step, the extent of Dr Patel's actions may yet remain unknown. As shown in Chapter Three above, that was not the first time that she had complained about Dr Patel.

6.486 Whether Ms Hoffman realised it or not, her disclosure to Mr Messenger MP was not protected by the *Whistleblowers Protection Act* 1994.⁵²¹ The fact that Ms Hoffman had to reveal her concerns to Mr Messenger MP, to have those concerns dealt with, and that her disclosure was not protected, reveals the failure of the current system of protecting whistleblowers.

The present system of Whistleblower protection

6.487 When introduced in 1994, Queensland's *Whistleblowers Protection Act* was the first of its kind in Australia and indeed one of the first in the common law world.⁵²² Whistleblower protection is an attempt to encourage people to speak out against corruption and poor practices without fear of reprisal as a result of speaking out. The *Whistleblowers Protection Act* recognises and attempt to achieve a balance of competing interests such as:

- The public interest in the exposure, investigation and correction of illegal, improper or dangerous conduct;
- The interests of the whistleblower in being protected from retaliation or reprisal and in ensuring that appropriate action is taken regarding the disclosure;
- The interests of persons against whom false allegations are made, particularly the damage to reputations and the expense and stress of investigations;
- The interests in the organisation affected by the disclosure in ensuring its operations are not disrupted and also in preventing disruptive behavior in the workplace; and
- The need to ensure that whistleblower protection has appropriate safeguards to protect against abuse.⁵²³

6.488 In attempting to strike a balance between these competing considerations the *Whistleblowers Protection Act* permits specified persons to make disclosures to particular entities about specified conduct. As the system presently stands, public officers are entitled to make public interest disclosures afforded the protections in the *Whistleblowers Protection Act* provided that disclosure is to a public sector entity about conduct that amounts to:⁵²⁴

⁵²¹ Under Part 4 Division 2 of the *Whistleblowers Protection Act* 1994, in order to attract the protections of the Act public interest disclosures must be made to a public sector entity. A public sector entity is defined in Schedule 5, section 2 of the Act. That definition does not include disclosures to a member of the legislative assembly.

⁵²² See: 'Three Whistleblower Protection Models: A comparative analysis of Whistleblower Legislation in Australia, the United States and the United Kingdom' a report of the Public Service Commission of Canada available at: www.psc-cfp.gc.ca/research

⁵²³ These points are drawn from the Ombudsman's submissions

⁵²⁴ For the source of this information see the Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry, see also: Sections 15, 16, 17, 18, 19, and 26 *Whistleblowers Protection Act* 1994

- Official Misconduct;
- Maladministration that adversely affects anybody's interests in a substantial and specific way;
- Negligent or improper management involving a substantial waste of public funds; or
- A substantial and specific danger to public health or safety or to the environment.⁵²⁵

6.489 Apart from public officers⁵²⁶ any person⁵²⁷ may make a public interest disclosure about:

- A substantial and specific danger to the health or safety of a person with a disability
- An offence under certain legislation that is or would be a substantial and specific danger to the environment
- A reprisal taken against anybody for making a public interest disclosure

6.490 There are two significant limitations to this system. Firstly, disclosures must be made to an 'appropriate entity'. Secondly, only public officers are permitted to make disclosures about official misconduct, maladministration, waste of public funds, or threats to public health.

Disclosures to an 'appropriate entity'

6.491 Section 26 of the *Whistleblowers Protection Act* provides:

26 Every public sector entity is an appropriate entity for certain things

- (1) Any public sector entity is an appropriate entity to receive a public interest disclosure—
 - (a) *about its own conduct or the conduct of any of its officers; or*
 - (b) *made to it about anything it has a power to investigate or remedy; or*
 - (c) *made to it by anybody who is entitled to make the public interest disclosure and honestly believes it is an appropriate entity to receive the disclosure under paragraph (a) or (b); or*
 - (d) *referred to it by another public sector entity under section 28.4.*
- (2) Subsection (1)(c) does not permit a public sector entity to receive a public interest disclosure if, apart from this section, it would not be able to receive the disclosure because of division 4, 5 or 6.5.

⁵²⁵ Clearly Ms Hoffman's complaint would fall into this category, however her disclosure to Mr Messenger MP was not a disclosure to a 'public sector entity' as defined by the Act.

⁵²⁶ A public officer is an officer of a public sector entity see Schedule 6, *Whistleblowers Protection Act 1994*

⁵²⁷ as opposed to a public officer

- (3) If a person makes a public interest disclosure to an appropriate entity, the person may also make a public interest disclosure to the entity about a reprisal taken against the person for making the disclosure

6.492 The term ‘appropriate entity’ is defined in the *Whistleblowers Protections Act* 1994 as including bodies such as:

- a committee of the Legislative Assembly;
- the Parliamentary Service;
- a court or tribunal;
- the administrative office of a court or tribunal;
- the Executive Council;
- *a department*;
- a commission, authority, office, corporation or instrumentality established under an Act or under State or local government authorisation for a public, State or local government purpose.

6.493 Section 26 of the *Whistleblowers Protection Act* has the effect that, as far as Queensland Health is concerned, under that section an appropriate entity to receive a public interest disclosure about Queensland Health is itself.⁵²⁸

6.494 There was considerable evidence before this Commission about staff of Queensland Health having little or no faith in Queensland Health in dealing with complaints. In an organisation that actively conceals information and uses Cabinet confidentiality provisions to avoid Freedom of Information laws, it seems unlikely that public interest disclosures by employees would be dealt with any differently.

6.495 In any event, Ms Hoffman’s complaint to Mr Leck would amount to a public interest disclosure⁵²⁹ to an appropriate entity under the *Whistleblowers Protection Act*.⁵³⁰ However, Ms Hoffman did not consider that the actions taken by Queensland Health were appropriate to her complaint.

Limitations of persons and entities to whom a protected disclosure can be made

6.496 Noticeably a member of Parliament is not an ‘authorised entity’ to whom a public interest disclosure can be made under the *Whistleblowers Protection Act*.

⁵²⁸ s26(1) of the *Whistleblowers Protection Act* 1994 states that a public sector entity is the appropriate entity to receive a public interest disclosure about its own conduct or the conduct of any of its officers

⁵²⁹ concerning a threat to the health and safety of patients at the Bundaberg Hospital

⁵³⁰ Queensland health is an appropriate entity to receive a disclosure about the conduct of one of its own officers.

- 6.497 Furthermore, a disclosure to a journalist or a member of the media attracts no protection under the *Whistleblowers Protection Act*. During the course of this Commission of Inquiry, there was at least one instance of a report being provided to *The Courier-Mail* newspaper.⁵³¹ How that document came into the possession of the *The Courier-Mail* before being disclosed to the Commission was not investigated. However, needless to say that disclosure was afforded no protection under the *Whistleblowers Protection Act*.
- 6.498 The findings made in respect of Bundaberg, Rockhampton, and Queensland Health show that Ms Hoffman had no choice but to complain to her local member of Parliament, and that another person felt the need to disclose a confidential report regarding the Rockhampton Emergency Department should be provided to *The Courier-Mail*, in my opinion demonstrates that the protection to whistleblowers in the Queensland public sector needs reform.

Limitations on who can make a protected complaint

- 6.499 As set out in paragraph 6.488 and 6.489 above, it is not just any person who can make a public interest disclosure about maladministration or a threat to public safety. Patients, or their family members, are unable to gain the protections of the *Whistleblowers Protections Act* should they wish to make a public interest disclosure. The categories of persons permitted to make protected disclosures needs expansion.

Lack of central oversight of public interest disclosures

- 6.500 As submitted by the Ombudsman, another failure of the current system is the lack of a central body charged with overseeing and managing public interest disclosures. Under the present system, the Office of Public Service, Merit and Equity is responsible for administering the *Whistleblowers Protection Act*.⁵³² That office has no role in overseeing public interest disclosures, each department being required to develop its own policy and procedures for managing public interest disclosures.⁵³³
- 6.501 Queensland Health has developed a document titled 'Policy and Procedures for the Management of Public Interest Disclosures' that sets out the processes to be used in managing public interest disclosures under the *Whistleblowers Protections Act*.
- 6.502 Broadly, the procedures in place at Queensland Health are as follows:

⁵³¹ Exhibit 129: Rockhampton Emergency Department Review, which was 'leaked' to *The Courier-Mail* prior to being disclosed to the Commission of Inquiry

⁵³² See Administrative Arrangements Order (No 2) of 2005 available at:
http://www.premiers.qld.gov.au/library/pdf/admin_arrangements2_05.pdf

⁵³³ See Ombudsman's submission August 2005

- Public interest disclosures must be brought to the attention of the Director-General to determine appropriate management and investigation of the disclosure.
- The Director-General is also charged with considering the risk of reprisals and with taking steps to ensure that an employee who makes a public interest disclosure is not disadvantaged as a result of making the disclosure.
- The Audit and Operational Review Branch of Queensland Health is obliged to record the public interest disclosure and also record the action taken. This information is collected for publication in the department's annual report.

6.503 At present there is no single body charged with overseeing public interest disclosures within the Queensland Public Sector (save where that public interest disclosure involves official misconduct⁵³⁴). In my opinion this is a serious shortcoming. As the facts revealed in this Inquiry show, it was futile to expect Queensland Health to manage public interest disclosures about itself with no external oversight.⁵³⁵

6.504 The Queensland Ombudsman has provided a helpful submission to the Commission, in which he recommends changes to enhance the protection of whistleblowers in the public sector. The Ombudsman makes the following recommendations regarding changes to the current whistleblowers protection system.

6.505 Firstly the Ombudsman recommends that his office be given a supervisory role over public interest disclosures made under the *Whistleblowers Protection Act* 1994⁵³⁶. That role would be similar to the role which the Crime and Misconduct Commission has in overseeing and investigating complaints about official misconduct. The Ombudsman recommends a model where:

agencies would have an obligation to refer to the ombudsman all public interest disclosures that involve serious maladministration but do not amount to official misconduct.⁵³⁷

6.506 The Ombudsman takes the view that the phrase 'serious maladministration' includes such things as conduct that would amount to a danger to the health and safety of the public or the environment and also negligent or improper management affecting public funds.⁵³⁸

6.507 The Ombudsman recommends that public interest disclosure regarding official misconduct should remain subject to the present arrangements of referral to, and oversight by, the Crime and Misconduct Commission.

⁵³⁴ in that case the complaint must be dealt with in accordance with the *Crime and Misconduct Act* 2001 which obliges notification of the Crime and Misconduct Commission

⁵³⁵ the same can be said for any public sector body

⁵³⁷ See Ombudsmans Submission to the Bundaberg Hospital Commission of Inquiry, August 2004

⁵³⁸ See the *Queensland Ombudsman, Annual Report 2004/2005*

6.508 I adopt those recommendations.

Proposals for reform

6.509 I recommend the following changes to the *Whistleblowers Protection Act* 1994:

Central oversight of public interest disclosures

6.510 Firstly I recommend that the Queensland Ombudsman be given an oversight role with respect to all public interest disclosures save those involving official misconduct. I recommend a system similar to that involving Official Misconduct where all public interest disclosures must be referred to the Ombudsman who may then either investigate the disclosure itself, or refer it back to the relevant department for investigation, subject to monitoring by the Ombudsman.

Increase the class of persons who may make a public interest disclosure

6.511 Secondly, I recommend that the categories of persons who may make a public interest disclosure protected by the *Whistleblowers Protection Act* be expanded in cases involving danger to public health and safety, and negligent or improper management of public funds, to include any person or body.

Expansion of bodies to whom a complaint may be made

6.512 Finally, I recommend a scale of persons or bodies to whom a complaint may be made. Effectively a whistleblower ought to be able to escalate his or her complaint in the event that there is no satisfactory action taken with respect to it. The scale should be as follows:

- (a) A whistleblower should first complain to the relevant department – or public sector entity under Schedule 5 of the *Whistleblowers Protection Act* – subject to the Ombudsman’s monitoring role discussed above. The *Whistleblowers Protection Act* must also provide strict time limits to investigate and resolve the disclosure. A time of 30 days would be appropriate.
- (b) If the matter is not then resolved within the time, to the satisfaction of the Ombudsman, the whistleblower ought to be able to make a public interest disclosure to a member of Parliament.⁵³⁹
- (c) If disclosure to a member of Parliament does not result in resolution, to the satisfaction of the ombudsman, within a further 30 days, then the whistleblower should be entitled to make a further public interest disclosure to a member of the media.

⁵³⁹ It should not be restricted to a local member of Parliament, but should be any member of Parliament, for example an Opposition spokesperson on the relevant matter.

Part F - A culture of concealment and its consequences

The issue

- 6.513 The evidence before this Commission of Inquiry yielded, among other things, examples of persons in stewardship roles in Queensland Health engaging in conduct pertaining to clinical practice and procedure which diminished the prospect of facts being open to proper scrutiny. An occasional concomitant of concealment is reprisal; there was also some evidence of this.
- 6.514 It is one thing to identify isolated instances of concealment. It is quite another if the disposition to conceal existed at a high level throughout the relevant period and was pervasive, encouraging others in leadership positions within hospitals to themselves conceal facts.
- 6.515 Was concealment (and its occasional bedfellow reprisal) endemic within Queensland Health? If it was then that evidenced a culture of concealment within Queensland Health. What I propose to do is discuss this issue by reference to the various levels of Queensland Health management, commencing with the overarching stewardship of that government department by Cabinet. Only then can the practices at hospital level be seen in proper focus.

Cabinet

- 6.516 There are two spheres of relevant conduct to be addressed with reference to Cabinet. First, there is the issue of publication of elective surgery waiting lists. Secondly, there is the issue of the Measured Quality Reports. I will deal with them in turn.

Elective surgery waiting lists

- 6.517 From no later than 1996 there have existed two lists relating to elective surgery at Queensland public hospitals. First, a list of patients who have attended an appointment with a resident or Visiting Medical Officer specialist and placed on a list of persons awaiting surgery. I shall call that 'the surgery list'.
- 6.518 Secondly, there is a list of persons who have been referred by a general practitioner for specialist appointment at a cohort hospital but not yet seen and assessed. I shall call that 'the anterior list'.
- 6.519 The anterior list itself consists of two sub-categories. First, there are patients who have not yet been allocated such an appointment. Secondly, there are patients who have been allocated such an appointment but have not yet been seen.

- 6.520 From about November 1998 to about June 2003 Queensland Health collected and collated data from the 31 reporting hospitals in relation to their surgery and anterior lists.⁵⁴⁰ This data was provided monthly by the hospitals to the Surgical Access Team.⁵⁴¹ From April 1999, this data was in turn provided by the Surgical Access Team on a monthly basis to the General Manager Health Services, the Director-General and the Minister for Health⁵⁴² and on a quarterly basis to Cabinet.⁵⁴³ Unlike the collated surgery list which was published quarterly on its Internet site to the public,⁵⁴⁴ the collated anterior list was never published.⁵⁴⁵
- 6.521 In late 2000, the reporting of the anterior list data was scaled back to a summary on a zonal basis.⁵⁴⁶ In 2003, the Office of the General Manager Health Services instructed the Surgical Access Team to cease the monthly reporting of such data to the General Manager Health Services, the Director-General and the Minister for Health.⁵⁴⁷ Such information remained available and able to be provided if it had been requested. Until January 2005, the outpatients' waiting list data continued to be reported by the hospitals to the Team.⁵⁴⁸ In January 2005, the Team was disbanded. The management of such information devolved back to the zones.⁵⁴⁹
- 6.522 As to the number of patients on the anterior list, a table prepared from the specialist outpatients' waiting list data base⁵⁵⁰ shows, as at 1 July 2001, 1 July 2002, and 1 July 2003, it was 51,876, 54,725 and 55,684, respectively, of which 33,929, 35,945 and 36,165 had been offered an appointment.
- 6.523 An analysis of 1 July 2004 data⁵⁵¹ undertaken by the Commission staff,⁵⁵² solely with respect to surgical disciplines, computed 67,052 persons on the anterior list. Of whom 46,637 were without an appointment. I think this to be correct as at 1 July 2004. Clearly such anterior list was growing.
- 6.524 The Surgical Access Team, however, thought the anterior list data, collected over time, unreliable.⁵⁵³

⁵⁴⁰ Exhibit 326 paras 23-26 (Zanco)

⁵⁴¹ Exhibit 328 para 62 (Walker)

⁵⁴² Exhibit 328 para 70; Edmond T4998

⁵⁴³ Exhibit 326 para 22

⁵⁴⁴ Exhibit 326 para 44; Exhibit 328, para 29

⁵⁴⁵ Exhibit 317 (Scott) para 10.2

⁵⁴⁶ Exhibit 328 para 70

⁵⁴⁷ Exhibit 328 para 72, 74

⁵⁴⁸ Exhibit 328 para 76

⁵⁴⁹ Exhibit 328 para 8

⁵⁵⁰ Exhibit 326 attachment 'MCZ8'

⁵⁵¹ Exhibit 267

⁵⁵² Exhibit 318, T5251, 5252

⁵⁵³ Exhibit 326 para 24; T6183, 6203

6.525 As was rightly conceded by most witnesses;⁵⁵⁴ it would be much more meaningful for the public generally, and certainly patients, to know not just the total number of persons awaiting surgery but also how long it takes to receive appropriate treatment from the time of referral from their general practitioners. Not only would this statistic more accurately represent true waiting times of patients awaiting surgery, but it would allow patients and their general practitioners to better evaluate and plan their care, affairs and priorities. It may be that during earlier stages, the collection of anterior list data was not as standardised or accurate as the surgery list data.⁵⁵⁵ But, as Mr Walker conceded, some information is better than no information.⁵⁵⁶

6.526 The evidence of Dr Stable was instructive in this regard.⁵⁵⁷

You say in paragraph 74 of your statement that you have ... no difficulty '(w)ith transparency of outpatient lists broken down into specialty

which include surgical and non-surgical specialties.'... -- That's correct. I would have preferred it to be the case. It would have supported my

ongoing argument since January 1996 about the underfunding of health in Queensland. In March 1996 the Australian Institute of Health and Welfare reported 16 per cent underfunding in Queensland. To have actually had all that transparent would have been very good for the people of Queensland, but also for the Department.

Your opinion is that if outpatient specialist waiting lists had have been publicised as early as possible, that that would have enhanced the argument to obtain greater funding for Queensland Health?-- Absolutely. This has been an issue since the eighties, I might add, but absolutely.

...

Having regard to your comments earlier about the publication of outpatient specialist waiting lists and the enhancement to the argument for better funding that would ensue from their publication, why is it that the politicians of the day haven't disclosed them?-- In discussions I've had both at state level and nationally, as Chair of the Australian Health Ministers Advisory Council, I don't think politicians have wanted to admit - I'll call it political honesty. Either the funding has to be there or there's a limit on services, or maybe even both, and I think there needs to be quite a serious debate in this country to actually bring that to the fore about what actually can be afforded, or are governments going to put in the necessary funding. That's the issue.

The Queensland system presently, and throughout the entirety of your tenure, was contrasted with interstate analogues in terms of dealing with specialist outpatient patients. Is that not so?-- That's correct, yes.

Just explain to the Commission how that was different? Well, other states were limiting, or in fact stopping outpatient services. We in fact continue to increase them. In fact during the term that I was Director-General, according to the annual reports of Queensland Health, there was a 37 per cent increase in non-inpatient occasions of service, which includes outpatients, all those sort of things. But Queensland, when I discussed it with Ministers over the years, have

⁵⁵⁴ T4885 line50 T5307 line 20; T5254 line 20, 5255, 5257 line 40 T6183 line 30

⁵⁵⁵ T6181

⁵⁵⁶ T6183 line 20

⁵⁵⁷ T5720 line 50 -T5723 line 10

always said, 'We've got a free hospital system. We intend to keep it.' The Commonwealth Department of Health reported in June last year in its annual report of public hospitals that Queenslanders utilise outpatients 20 per cent above the national average, and that reflects the policy of consecutive governments. But I might add, at the same time we're significantly underfunded, but we have this extra demand on our hospitals.

...Quite apart from the funding - the important funding issue that you've raised, you would agree that there would be other advantages in the publication of specialist outpatient surgical waiting lists?-- Oh, I think there are clear indications. It means, doctors out there in practice can look and say, 'Well, there's a wait at this hospital. I'll refer you to another hospital', or can say to the patient, 'Look, there's a significant wait, a 12 month wait for this procedure in the public system. I can arrange for you to go privately, but of course you're going to have to pay.' But then there can be an informed decision, and of course the public, at each election, can decide whether they want to elect someone who is going to put more money into - and significant and honest more money, not this stuff where it's to cover the labour costs, which just enables us to stand still.

Perhaps if not put more money, perhaps even less money, but restructure the system, and say so?-- Or be honest about, 'We can't provide certain procedure in the public system because we can't afford it.'

What sort of pressure does the non-publication of lists place on the individual hospital?-- Well, because they have to continue to present the public face that they can do everything - and of course there's been periods where hospital superintendents have done a letter to say, 'We can't take this booking', it gets in the media and the politician of the day gets all upset about it. But that's the pressure that hospitals are under.

- 6.527 I accept this evidence.
- 6.528 Evidence as to the disposition of Cabinet to surgical waiting lists, in successive governments, was given by Mr Michael Clare.⁵⁵⁸ Mr Clare was an impressive witness and I have no hesitation in accepting his evidence (with one exception, concerning Dr Stable, to which I will come). He worked for Queensland Health for 27 years. From January 1997 to January 2002 he was the Manager, Parliamentary and Ministerial Services and Cabinet Legislation Liaison Officer.
- 6.529 Part of his duties included the preparation, scheduling and lodgement of Cabinet submissions generated within the department. In July 2002 he was appointed by the then Beattie Government as a member of the Medical Board of Queensland.
- 6.530 Mr Clare gave evidence that governments of both political persuasions in the period of his tenure from 1997 (initially the Borbidge Coalition Government and then the successive Beattie Labor Governments) abused the Cabinet process in order to avoid information deemed sensitive or politically embarrassing falling into the public arena. This was because s36 of the *Freedom of Information Act* 1992 provided for an exemption from Freedom of Information disclosure of documents which, in effect, were submitted to Cabinet.

⁵⁵⁸ Exhibit 387; T6075-T6088

- 6.531 Mr Clare gave evidence that, during the period of the Borbidge Coalition Government he procured a 'fridge trolley' in order to deliver and retrieve documents associated with Cabinet submissions which collected surgery waiting lists in Queensland public hospitals. In response to a Freedom of Information application which had been lodged seeking hospital waiting list documents.⁵⁵⁹ In this way that Government concealed from the public the surgery list.
- 6.532 Following the election of the Beattie Labor Government in 1998, Mr Clare said the remitting of such waiting lists to Cabinet was continued and formalised by the inclusion of the same on Queensland Health's 'Cabinet Forward Timetable'.
- 6.533 Mr Clare said that, on a number of occasions, his instructions were received, in relation to this issue, from Dr Stable. It was plain that Mr Clare inferred that Dr Stable was responsible for submitting waiting list information to Cabinet.
- 6.534 Dr Stable gave evidence that the decision was a political one made by the Minister and Cabinet of the day in a conscious endeavour to engage the Freedom of Information exemption.⁵⁶⁰ I accept Dr Stable's evidence in this regard.
- 6.535 Below when dealing separately with the conduct of former Minister Edmond, I again address this issue of waiting lists. Her conduct, consisting of a campaign by press release, was plainly undertaken with the full knowledge of Cabinet.
- 6.536 All this reflects poorly on the politicians involved in the stewardship of Queensland Health. There was a bipartisan (in the pejorative sense) approach to concealing from public gaze the full waiting list information. Only the (shorter) surgery list was published from 1998.

Measured quality reports

- 6.537 I turn to the issue of the 'measured quality reports' and Cabinet's disposition of the same. Mr Justin Collins gave evidence to the Commission.⁵⁶¹ I accept the evidence of Mr Collins. He was an impressive witness.
- 6.538 From September 2001 Mr Collins was manager of Measured Quality Service at Queensland Health. Although not involved with the development of Measured Quality Service from its inception he was very knowledgeable about it.
- 6.539 Measured Quality was (and is) a system which routinely measured the quality of services provided at selected Queensland Health hospitals. Data collected through the Measured Quality process was designed to be used to identify variation in performance between comparable hospitals across the State, and areas for potential improvement as well as areas of good practice in the

⁵⁵⁹ T6077

⁵⁶⁰ T5720 lines 40-50

⁵⁶¹ Exhibits 377, 378, Transcript for 26 and 28 September 2005

particular hospital. In turn this information was used by the hospitals to focus their attention on identified areas for detailed analysis.

6.540 It is plain from any fair reading of the medical literature referred to by Mr Collins⁵⁶² that concealment of medical and hospital data (excluding individual patient information) is inconsistent with maintenance of high medical standards. One of the articles, published in 2002 in the *Medical Journal of Australia*,⁵⁶³ said:

We believe that a negative response to public disclosure in Australia would be counterproductive. Greater openness in healthcare is inevitable. Information is freely available about most areas of modern life and many believe that healthcare is one of the last bastions of protectionism. When millions of dollars are spent on healthcare, those who pay have a right to know that the money is being spent effectively, and the publication of comparative data sends a strong message about the willingness of health professionals and organisations to be accountable.

In addition, public disclosure appears to be an effective way of improving quality. There is a growing body of evidence that the current level of quality of care is unacceptable and that quality-improvement initiatives using confidential data have been largely ineffective at changing the behaviour of health professionals. When comparative data are released to the public it appears to remind providers of the issues and refocuses them towards taking action.

Arguments in support of the status quo – that the data are inadequate, the public won't understand them and the media will misuse them – are not sustainable if public disclosure is introduced properly. There are lessons that can be learnt from other countries to guide the process of disclosure in Australia. The United States has nearly 15 years' experience at publishing data in the form of 'single report cards' or 'provider profiles'. The initiative was launched by the Federal Government and the momentum has been maintained by a variety of public, private, commercial and not-for-profit organisations. Consumers and purchasers of healthcare were expected to play a key role by selecting high-performing providers, but recent experience suggests that the providers themselves make greater use of the data than the service uses.

There are some notable examples of improvements in both processes and outcomes of care associated with the publication of performance data. Public reporting in Europe is less well established than in the United States, but hospital 'league tables' have been published in the Netherlands for several years, and the UK Government plans to introduce incentives linked to a range of publicly reported performance criteria.

What can we learn from the initiatives that have been introduced?

- First, a backlash from some doctors, professional groups and institutions (particularly those seen to be performing badly) is predictable. Some criticisms were justified in the early days of report cards but lessons are being learnt. For example, we know that forcing initiatives on reluctant professionals is not the most effective way of changing attitudes, and the introduction of report cards is more likely to be successful if doctors are encouraged to take a lead, particularly in selecting the performance measures. Bringing the media on board at an early stage to ensure fair and balanced coverage also helps. In addition, delaying publication for a short

⁵⁶² Exhibit 378, annexure 'JEC-27'

⁵⁶³ Marshall & Brook MJA 2005-2006 *Public Reporting of Comparative Information About Quality of Health Care*

period to allow providers time to look at and act upon the data is a useful strategy.

- Second, it is important that those who publish the data show a commitment to investing in the process and progressively improving the quality of the data and the validity of comparisons arising from the data. However, it makes little sense to 'wait for better data' – data will always be imperfect and, as one commentator stated, it is important not to let 'perfect be the enemy of good'. Experience suggests that the process of publication can in itself act as a catalyst for data improvement.
- Third, the utility of comparative data comes less from making absolute judgments about performance than from the discussion arising from using the data to benchmark performance. There is therefore a strong educational component to the effect of use of comparative data, and resources are required to facilitate this process.
- Finally, it is important to be cognisant of the risks of publishing comparative data. The danger of institutions refusing to treat certain disadvantaged groups in order to improve their apparent performance is well recognised, although probably overstated, and can be reduced by careful adjustment of risk and casemix. A tendency to focus on what is being measured at the expense of other areas of practice can be minimised by publishing a wide range of quality indicators. The risk of 'short-termism' – an inappropriate focus on annual reporting cycles – can be reduced by ensuring a balance between short-term targets and long-term strategic aims.

A greater degree of public reporting and information about healthcare quality is an inevitable and desirable way forward. Practitioners and policy makers in Australia have an opportunity to ensure that the policy is implemented in the manner that is most likely to produce positive change.

[footnotes omitted]

6.541 I accept this view.

6.542 The Measured Quality Service process was in two parts. First, there was a hospital report prepared for each hospital. I shall call these 'the hospital reports'. Secondly, there was an annual public report. Mr Collins gave evidence that the Measured Quality Service policy, in mid 2002, was never to 'hide' any document.⁵⁶⁴ He explained that the Measured Quality Service was concerned to contribute towards a 'blame free' environment within hospitals.⁵⁶⁵ There was concern⁵⁶⁶ that the hospital reports, if made public, could be 'misleading' because they were based on data collected before the hospitals had an opportunity to investigate the results and analyse them.

6.543 Mr Collins emphasised,⁵⁶⁷ however, that, in his view, clinicians and hospital managers needed to be provided with data which indicated the hospital's performance, together with information about successful strategies which had been adopted within other health service districts.

⁵⁶⁴ Exhibit 378 para 9

⁵⁶⁵ Exhibit 378 para 6

⁵⁶⁶ Exhibit 378 para 7

⁵⁶⁷ Exhibit 378 para 8

- 6.544 Engaging the hospital clinicians, Mr Collins said, was an important aim of the Measured Quality process. He also emphasised that the public needed to be provided with a thorough explanation of what the data meant. Achieving this balance was part of the process.
- 6.545 As Mr Collins explained,⁵⁶⁸ the public report provided ‘analysed data comparing the relative quality and safety performance between peer groups at a statewide level and also comparing Queensland Health with the rest of Australia’. The hospital reports identified problems and resources in individual hospitals. But in relation to publication ‘it would be left to the relevant Health Service District to determine whether or not to release the hospital reports for their Health Service District publicly’, it being ‘recognised ... that the hospital reports may have to be released to the media or to the general public through a Freedom of Information ... application and as a result it was decided to develop a strategy to assist Health Services Districts if that occurred’.
- 6.546 This process altered once the politicians’ hands came upon it. I canvass below, when dealing with former Minister Edmond, what occurred at and following the presentation by Mr Collins to Minister Edmond and Director-General Stable on 13 August 2002. Shortly prior to that meeting Dr Glenn Cuffe, the Manager of the Procurement Strategy Unit of Queensland Health, and Mr Collins’ superior, told Mr Collins⁵⁶⁹ that ‘Ms Edmond and/or Dr Stable may ask that the measured quality phase 1 public hospital reports be sent to Cabinet and this would restrict our ability to disseminate the reports to Health Services Districts and effectively kill the measured quality program’. Mr Collins said⁵⁷⁰ that he and Dr Cuffe agreed that ‘this was not desirable from the perspective of safety and quality as well as overall improvement within Queensland Health’. The concern was that open discussion of the hospital reports by clinicians and administrators would be prevented.
- 6.547 This comment by Dr Cuffe proved prophetic.
- 6.548 Neither Mr Collins nor any other Queensland Health employee advised nor suggested that the then phase one Measured Quality Service hospital reports (the hospital reports) be sent to Cabinet. He said that this course was raised by Minister Edmond at the 13 August 2002 presentation. I accept the evidence of Mr Collins as being accurate in this (and in all other) respects.
- 6.549 Mr Collins was involved in drafting the Cabinet submission. The submission was considered by Cabinet on 11 November 2002 and went under Minister Edmond’s hand. It is worth noting that the submission in question was for the ‘information’ of Cabinet accompanied by a large wad of documents consisting of

⁵⁶⁸ Exhibit 378, para 9

⁵⁶⁹ Exhibit 378, para 12

⁵⁷⁰ Exhibit 378 para 12

public and hospital reports.⁵⁷¹ This could not sensibly have been done to inform Cabinet but rather to engage the Freedom of Information Cabinet exemption.

6.550 The drafting of the Cabinet submission was a tortuous process. Mr Collins was obliged to consult with representatives of the office of the Department of Premier and Cabinet, Treasury and the Minister's office. By the time the Cabinet submission was drafted the communicated policy therein was that the hospital reports were no longer to be released publicly. Rather, there was to be⁵⁷² confidential distribution of each hospital report to the relevant District Manager and Zonal Manager.

6.551 When asked about when the original promulgated policy about hospital report disclosure (canvassed above) altered, Mr Collins could only say that this alteration occurred 'at some point between the presentation of the Minister and the Director-General and the actual Cabinet submission being finalised' and that 'more than likely' the change occurred at the behest of someone either within the office of the Premier, Cabinet or Treasury because they had 'the most input'.⁵⁷³

6.552 The influence of these other persons or bodies upon the content of the Cabinet submission is underscored by the email exchange between Mr Collins and Mr Smith, Queensland Health's Manager of Parliamentary and Ministerial Services,⁵⁷⁴ who was liaising with Cabinet on behalf of Queensland Health. When speaking of suggestions raised by officers of the Department of Premier and Cabinet Mr Smith observed:⁵⁷⁵

Please incorporate the issues raised This helps ensure that the Premier is happy when the matter is considered in Cabinet in relation to the concerns about retention rates, etc. ...

6.553 On 11 November 2002, Mr Collins received an email from Mr Smith indicating Cabinet's approach to the disposition of the Measured Quality Service reports⁵⁷⁶:

Cabinet will be approving a public release of the report 'Qld hospitals and the 21st century', accordingly the report will be a public document and the copies distributed will have no security attached to them.

The 60 individual hospital reports on the other hand should remain confidential and to help maintain any protection afforded by the FOI document to Cabinet material, any distribution of these reports to District Managers etc should be on a confidential/restricted basis.

6.554 On 12 November 2002, there was distributed, to each of Mr Collins, Director-General Stable, General Manager Health Services Buckland and Dr Cuffe, an

⁵⁷¹ Exhibit 377 attachment 'JEC9'

⁵⁷² Exhibit 377 attachment 'JEC9A' para 16 of submission

⁵⁷³ T5921 lines 10 to 30

⁵⁷⁴ T5949 line 40

⁵⁷⁵ Exhibit 378 attachment 'JEC35'

⁵⁷⁶ Exhibit 378 attachment 'JEC38'

email from Mr Smith communicating Cabinet's view of what was required of the Measured Quality Service in respect of the hospital reports and public reports⁵⁷⁷:

Further to my conversation with you on Monday, 12 November 2002, additional advice has been received from the Department of the Premier and Cabinet that the Premier has given the following directive this morning to the Director-General, Department of the Premier and Cabinet in relation to this matter,

neither the proposed public report which was attached to the Cabinet Submission nor any of the 60 individual Hospital Reports are to be distributed to *anyone*;

Senior Management can be briefed on the outcomes of the quality measurements and the contents of the documents, but they are *not* to be given copies of any of this material.

The Department of the Premier and Cabinet advised that the Premier has emphasised that Cabinet does not want this material released or circulated in any way....

- 6.555 Mr Collins gave evidence that this directive caused considerable delay and difficulty in the implementation of the Measured Quality Service process.⁵⁷⁸ It delayed publication of the public report. Most relevantly, it made it extremely difficult if not impossible to enable clinicians to discuss the hospital reports freely, or even to obtain access to them. I canvass that in more detail below, in particular by reference to the ministerial briefing of 10 March 2003, when dealing with former Minister Edmond.
- 6.556 Notwithstanding his explanation of these difficulties, Mr Collins was directed by Minister Edmond to submit the phase 2 reports (further hospital reports) to Cabinet. That occurred on 10 June 2003.⁵⁷⁹ The Cabinet submission,⁵⁸⁰ like that of 11 November 2002, was for the 'information' of Cabinet and had as attachments a vast wad of public and hospital material.
- 6.557 The result was the same secrecy and concealment as had occurred with the waiting list information canvassed above.
- 6.558 The Measured Quality Service process, fortunately, survived. I find that that was largely due to the involvement of Dr John Scott in his role as General Manager Health Service, in 2004.⁵⁸¹ Whilst I deal with Dr Scott elsewhere in this report concerning Dr Aroney and the North Giblin report, I think it remains correct to say that the termination of Dr Scott's employment by the present Beattie Government was a considerable loss to Queensland Health.

⁵⁷⁷ Exhibit 340

⁵⁷⁸ Exhibit 378, attachment 34; T5942, 5943; T6542 lines 1-10 (Cuffe)

⁵⁷⁹ Exhibit 377, attachment 'JEC15'

⁵⁸⁰ Exhibit 377, attachment 'JEC15'

⁵⁸¹ Exhibit 377 para 37; Exhibit 377; T5247, 5248; T5946 line 30

Conclusions with respect to Cabinet

6.559 The conduct of Cabinet, in successive governments, in the above respect, was inexcusable and an abuse of the *Freedom of Information Act*. It involved a blatant exercise of secreting information from public gaze for no reason other than that the disclosure of the information might be embarrassing to Government. In the case of the Measured Quality Service policy, Cabinet's decision was undertaken in the teeth of a contrary view expressed by Queensland Health and, had any one outside the ranks of Queensland Health bothered to enquire, contemporaneous literature.

6.560 On 28 September 2005⁵⁸² I gave an intimation in respect of findings in relation to elective surgery waiting lists and Measured Quality Service reports. On that occasion I indicated in open hearing the following:

I have given this intimation at this stage to give to any person the opportunity to consider whether to give or tender further evidence upon either of these issues and to permit that consideration to be given before the close of evidence which will possibility occur at the end of next week.

6.561 Apart from the submissions received from relevant participating parties, namely former Minister Nuttall and former Minister Edmond, no politician (past or present) took up this opportunity.

6.562 I received a letter from Premier Beattie on 30 September 2005.⁵⁸³ That spoke prospectively of the current Government's intentions in respect to waiting lists and Measured Quality reports. It said:

I am prepared to act to continue my Government's record of openness and accountability. Therefore, my Government now commits to legislating to ensure that all relevant data about waiting lists and all Measured Quality Reports about individual hospitals will be reported in an annual State of Health Report. That information will be available to be accessed by all Queenslanders.

6.563 The opening sentence of this extract is inconsistent with the facts as I have related them pertaining to elective surgery waiting lists and Measured Quality hospital reports.

Findings against Cabinet

6.564 I make the following findings with respect to elective surgery waiting lists:

(a) In 1997 and 1998, Cabinet under a Coalition Government decided not to disclose to the public statistics which showed the number of persons on elective surgery waiting lists.

(b) That decision was contrary to the public interest.

⁵⁸² T6088-6090

⁵⁸³ Exhibit 388

- (c) In 1998 and thereafter until 2005, Cabinet under an Australian Labor Party Government decided to disclose to the public the surgery lists but not the anterior lists and only that disclosure was made.
- (d) To disclose the surgery lists but not the anterior lists was misleading and was contrary to the public interest.

6.565 With respect to Measured Quality Reports I make the following findings:

- (a) These were of two kinds: the first, the public reports, were reports intended for publication to the public about the performance of Queensland hospitals. The second, the hospital reports, which were reports specific to each of the hospitals which were part of the measured quality program, were intended by Queensland Health for publication only to managers and clinicians at those hospitals.
- (b) In late 2002, Cabinet under an Australian Labor Party Government decided to limit publication of the hospital reports to an extent which was contrary to the public interest.
- (c) That decision was made contrary to the advice of officers of Queensland Health.

6.566 Any findings which I make below against current and former employees of Queensland Health, with respect to secrecy and concealment, must be seen in the light of what I have said and found above in this section of this Chapter of my report.

Former Minister Edmond

6.567 The Honourable Wendy Edmond was a member of successive Labor Governments from 1998. She was Minister for Health from June 1998 to February 2004. She retired from Parliament in early 2004.

6.568 In the case of Ms Edmond, there are two matters which I ought to canvass in the context of concealment as I introduced above in this portion of this Chapter. The first is elective surgery waiting lists. The second is the Measured Quality Service issue. Each of these matters I have treated in the preceding section concerning Cabinet.

6.569 A submission is made on behalf of Ms Edmond to the effect that treatment of these matters is outside my terms of reference. I disagree. Ms Edmond, when Minister, was at the pinnacle of leadership of Queensland Health. She undertook a stewardship role in respect of policy and conduct of staff at hospital level in their adoption of clinical practices and procedures. If the conduct of any member of staff of Queensland Health is to be the focus of criticism, then it must be considered in the light of the policy adopted by, and statements made by those in senior leadership positions, including Minister Edmond. It is therefore necessary to make findings about the conduct of Ms Edmond.

Waiting lists

6.570 I deal first with waiting lists. In this regard I adopt what appears in the preceding section of this chapter concerning Cabinet and those lists.

6.571 Ms Edmond's written statement⁵⁸⁴ deals with the issue of waiting lists. Upon assuming office, to her great credit, she immediately caused the publication of the elective surgery waiting lists. However she did not, then or at any time during her approximately six year stewardship as Minister, cause publication of the anterior lists. There can be no doubt, from her early press releases about the issue,⁵⁸⁵ that Minister Edmond knew of the anterior lists and, importantly, by making press releases, was publicly acknowledging her and the Government's knowledge of and intention to deal with them.

6.572 In her 30 July 1998 press release⁵⁸⁶ Minister Edmond expressed:

'However, Ms Edmond said her major concern was that the figures did not represent the whole picture.

'I believe there is an untold story out there about patients who have been given appointments to see out-patient specialists and therefore can't get on a waiting list ...', she said

'I have asked Queensland Health for standardised and improved procedures on this issue and on the collection of data.

'I expect a flurry of appointments and, as a result, the next quarterly elective surgery report may show some politically unattractive jumps in waiting times.

'I am prepared to wear this in the interests of honesty, openness and a better public health service.'

6.573 Apparently there was an investigation conducted within Queensland Health, at the request of Minister Edmond, between 30 July and 16 October 1998 because, on the latter date, a further press release was issued⁵⁸⁷ which contained the following:

'Health Minister Wendy Edmond's investigation into hospital waiting lists has revealed a massive 'unofficial' list of would-be patients who haven't even made the official list.

Ms Edmond said the investigation confirmed her long-held fears but represented a major step towards tackling the issue.

...Ms Edmond said in July that she was concerned about the untold story of the waiting list to get an appointment.

...Ms Edmond said Queensland Health had made some progress on her instruction to develop standardised and improved procedures for allocating appointments and collecting information.

'The downside is that I now know that the waiting list to get into the waiting list for surgery is almost as long as the waiting list for surgery', she said.

⁵⁸⁴ Exhibit 302

⁵⁸⁵ Exhibit 303; Exhibit 302 sole attachment

⁵⁸⁶ Exhibit 303

⁵⁸⁷ Exhibit 302; sole attachment

The upside is that we can now tackle the problem systematically.

Ms Edmond said Queensland Health was collecting appointment waiting list data manually because no computer systems currently were doing this....'

6.574 Just over 12 months later, on 11 November 1999,⁵⁸⁸ Minister Edmond issued a press release in response to Opposition criticism of waiting list data:-

Health Minister Wendy Edmond said today that the Opposition's campaign to discredit the waiting list data was desperate and dishonest.

...'There has been no manipulation of waiting list figures. Waiting list data is available to all. The level of transparency is unprecedented.

'The Opposition collected the same data in exactly the same way, the only difference is this Government publishes the data openly and honestly as part of its elective surgery strategy and as part of its commitment to open an accountable Government.

'The pathetic attempts of the Opposition to claim that specialist out-patient appointment waiting times would provide the 'real picture' of elective surgery waiting times shows a complete misunderstanding of the hospital system.

'People waiting for specialist out-patient appointments do not necessarily need surgery.

'Elective surgery coordinators from Queensland Health have developed processes to ensure that once a surgeon completes a surgery booking form for a patient, that patient's name is immediately placed on the Elective Surgery Waiting List.

That is the 'real picture', that is the truth.

'All hospitals have processes in place to ensure that there are no 'hidden' waiting lists at any stage of the process at any facility across the state', Ms Edmond said.

6.575 I am left in no doubt that this press release was misleading and, particularly in light of the press releases of approximately a year earlier, which are extracted above, knowingly so on the part of Minister Edmond. Earlier she referred to her investigation revealing a 'waiting list for the waiting list' but, in the last mentioned press release, she told the people of Queensland who might read the press release in the media, and staff, that the data has been published 'openly and honestly', 'waiting list data is available to all' and that 'there are no 'hidden' waiting lists at any stage of the process at any facility across the State.

6.576 This was clearly a significant issue for Minister Edmond. The publication of the surgery list, she clearly thought, was a major achievement of her Government. Having accurately identified the anterior list in October 1998, just over a year later she knowingly misrepresented that the published surgery list comprised all of the 'waiting list data'.

6.577 Ms Edmond's approach to the matter did not improve with the passage of time after the abovementioned press release of Remembrance Day 1999. From

⁵⁸⁸ Exhibit 304

September 1998 to January 2003 the Minister received monthly reports which dealt with, among other things, the (growing) anterior lists.⁵⁸⁹ It must also have been plain from those documents, as was the fact, that Queensland Health was encountering real difficulty in developing an electronic data base to marshall that anterior list data. Yet press releases were issued from 2000 to 2003 in her name, and one infers with her approval, speaking of the improving surgery lists without hint of a mention of the anterior lists or their growing size.⁵⁹⁰

6.578 As to the marshalling of this anterior list information, I accept that the Surgical Access Team was concerned about the reliability of the information about the anterior lists. Mr Walker of that Team was of the view that he had difficulty with the notion that the anterior list data ought be released, and that if it was to be released he 'would put a rider on it that we need to actually make sure that the data was actually accurate'.⁵⁹¹ Mr Walker also indicated that a lack of funding was stymieing the improvement of this data collection.

6.579 I reject the submission, that to publish the surgery waiting lists, without the anterior lists, was not a misleading course. Whilst general practitioners may have some ability to obtain some information about these matters, such general practitioners and the public, making decisions about personal health funding, ought at least have had the benefit of periodical (say quarterly) information about the state of anterior lists. For Minister Edmond to make statements, as she did, from 1999, which had the effect of misrepresenting the existence, nature and extent of anterior lists, was to mislead and, in my view, was against the public interest.

6.580 Moreover, it set a very poor example for Queensland Health staff in relation to the openness with which they should deal with matters which might be embarrassing to the Government or Queensland Health.

Measured quality reports

6.581 By mid 2003 Minister Edmond had five years experience in her portfolio. There could be no doubt that she knew of the provisions of the *Freedom of Information Act* 1992.

6.582 On 13 August 2002, Mr Justin Collins (to whom I referred earlier) and other Measured Quality Service staff made a presentation⁵⁹² to the Minister and the Director-General in relation to the Measured Quality process.⁵⁹³ One of the matters identified at the presentation (dealt with under a heading 'Communication Objectives', in one of the presentation documents) was

⁵⁸⁹ Exhibit 311

⁵⁹⁰ Exhibit 305

⁵⁹¹ T6181 to T6183

⁵⁹² T5916

⁵⁹³ Exhibit 377, attachment 'JEC8'; Exhibit 378, attachment 'JEC30'

Queensland Health's policy of 'delivering on its commitment to be open and transparent'. Another issue identified was about the likelihood, in relation to hospital reports, that 'journalists will request individual facility reports on local hospitals once they are aware of their existence' and that 'a decision needs to be made on whether access would be granted administratively or only through a Freedom of Information request'.

- 6.583 Mr Collins said that what he was identifying (and this would have been plain to any listener) was whether, in pursuit of Queensland Health policy developed to that point in relation to the Measured Quality process, an individual hospital report ought be the subject of provision by the District Manager of the Hospital upon request, or if not then provision to an applicant under a Freedom of Information application.
- 6.584 Mr Collins said it was Minister Edmond who raised the proposal to take the Measured Quality reports to Cabinet.⁵⁹⁴
- 6.585 Mr Collins sent an email to a former Queensland Health associate, Mr Filby, after the 13 August presentation, namely on 28 August 2002.⁵⁹⁵ Therein one sees a contemporaneous recollection by Mr Collins to the effect that a person or persons in attendance at the presentation expressed that he, she or they were 'very concerned about the media consequences' of the process and that 'as a result it has been decided that the reports should go to Cabinet'.
- 6.586 I accept that Minister Edmond, in part, was motivated to take the Measured Quality process documents to Cabinet with a view to properly informing Cabinet as to those matters. However, in my view, the clear import of the above evidence, and Minister Edmond's experience at that point, meant that she knew, and intended, that in doing so the Freedom of Information Cabinet exemption would be triggered. Nothing seems to have been done by her to address any disadvantages of that course.
- 6.587 Following the directive from Cabinet of 12 November 2002⁵⁹⁶ referred to in the last section of this Chapter, a dissemination strategy was developed within the Measured Quality Service. On 10 March 2003, from within Minister Edmond's office, a request was made for a briefing for the Minister as to the Measured Quality Phase 1 and Phase 2 Hospital reports. That briefing was drafted by Mr Collins.⁵⁹⁷ It described the dissemination strategy development, which essentially involved restricted dissemination to the District Manager, with elimination of all options for printing and distribution, and with documents marked 'Cabinet in Confidence'.

⁵⁹⁴ T5917 line 10

⁵⁹⁵ Exhibit 378, attachment 'JEC31'

⁵⁹⁶ Exhibit 340

⁵⁹⁷ Exhibit 377, attachment 'JEC13'

6.588 The briefing went on to recite, under a heading 'KEY ISSUES', the following:

Due to the restricted distribution of the Measured Quality Hospital reports (District Managers Only), difficulty may be encountered in the dissemination of the results within the Hospital environment. This may impact on the usefulness of the Hospital reports and limit the engagement of clinicians and managers to whom change is to be delivered.

The Phase 1 Hospital reports and Public report were considered by Cabinet on 11 November 2002. It is recommended that the Phase 2 Hospital reports also be considered by Cabinet, as an information submission, to afford it the same consideration for FOI exemption.

6.589 The evidence of Mr Collins was that, in the drafting the document, the second paragraph extracted above was added at the suggestion of Dr Cuffe.⁵⁹⁸ That followed what had transpired from the previous presentation and the eventual submission to Cabinet of the Phase one reports, together with the Cabinet directive extracted in the last section.

6.590 This, in my view, shows the understandable response of Mr Collins and Dr Cuffe to the directive which came from Cabinet and the Ministers, on 12 November 2002, that the hospital reports should be concealed. Employees of Queensland Health, in response, were likely to remind their political masters that Freedom of Information exemption and like practices for concealing documents ought be routinely adopted. Concealment practices of this kind, encouraged by politicians, filtered down to Queensland Health staff and, through them, to administrators in public hospitals.

6.591 Minister Edmond, reading this 10 March briefing at the time, could have been under no illusion, from the first of the paragraphs last extracted above, that Measured Quality Service staff were of the view that, due to the restricted distribution, difficulty would be encountered with the dissemination of the results in the hospital environment, detracting from the usefulness of the report and limiting discussion with and among clinicians.

6.592 In submissions on behalf of Ms Edmond it was contended that the use of the linguistic 'may' in this paragraph represented a softening of the likely impact which ought not have given concern to Minister Edmond. I do not accept that. An experienced Minister (as Minister Edmond was), having sought such a briefing, ought to have immediately seen that the Measured Quality process was being diminished by the restrictions on distribution, and attempted to ameliorate that outcome. Staff within Queensland Health, having made this 'cry for help' in relation to the Measured Quality process, it is plain, were ignored.

6.593 To the credit of Mr Collins, and his fellow staff, the identification of the difficulties presented by the dissemination strategy, particularly in the process caused by the implementation strategy, were the subject of reiteration. Mr Collins made a

⁵⁹⁸ T5934 line 50

further presentation to Minister Edmond and the Director-General, Dr Stable, on 6 May 2003.⁵⁹⁹ He made his presentation from notes in the form of a powerpoint display, which he exhibited to the first of his statements.⁶⁰⁰ From those he was able to say⁶⁰¹ he canvassed the following matters with those present at the presentation:

- In utilising the hospital reports, to obtain the serious attention of clinicians and managers without physically distributing the reports the Measured Quality Service personnel would need to undertake a presentation of approximately two hours.
- To ensure the security of the reports but to still engage clinicians and managers there had to be addressed the uncontrollable nature of the hard copy report.
- Negativity had been expressed, in the interviews undertaken thus far, about the restriction of distribution as staff had shown a great eagerness to discuss ways to improve or identify reasons for good performance.
- Importantly, hospital clinicians were reacting negatively to responding to Mr Collins because they couldn't see the individual hospital report and such clinicians were not satisfied with a response from Mr Collins to the effect that the reason that was done was because Queensland Health wanted to avoid misinterpretation.

6.594 Notwithstanding these matters, no instruction came from any person present to alter the dissemination strategy.⁶⁰² To the contrary, on 10 June 2003 the Phase two Hospital reports and Public Reports were submitted to Cabinet, as an information submission.⁶⁰³

6.595 In the Cabinet submission, which went under the hand of Minister Edmond, the sensitive nature of the hospital reports is identified, and the dissemination strategy outlined, but none of the abovementioned concerns about the disadvantages of that dissemination strategy upon the Measured Quality process is identified. The issue of necessary engagement of clinicians is identified⁶⁰⁴ but unembroidered by the negativity being experienced by Mr Collins in the field.

6.596 Minister Edmond would have known of the impact of the Freedom of Information exemption obtained by taking the Phase two Hospital reports to Cabinet. Indeed, in my view, the Phase two reports were taken to Cabinet for that purpose because that was part of the dissemination strategy developed

⁵⁹⁹ T5940

⁶⁰⁰ Exhibit 377, attachment 'JEC14'

⁶⁰¹ T5942-5944

⁶⁰² T5944 line 10

⁶⁰³ Exhibit 377, attachment 'JEC15'

⁶⁰⁴ Exhibit 377, attachment 'JEC15', paras 14 to 18 of 'Body of Submission'

following restriction imposed by Cabinet on 12 November 2002 (eg, documents marked 'Cabinet-in-confidence').

- 6.597 In my view this conduct was contrary to the public interest. Again, it was only due to the endeavours of Mr Collins and Dr John Scott, in 2004, that the measured quality process managed to survive in an effective way.

Findings against former Minister Edmond

- 6.598 It may be accepted that Minister Edmond was acting under the usual political constraints associated with Government. Nevertheless, the response of Minister Edmond to those matters constituted, at the very least, a poor example to staff of Queensland Health with respect to concealment of facts in dealing with matters at all levels, and principally at the level of hospitals.

- 6.599 I make the following findings in respect of the conduct of Minister Edmond:

- (a) During the period 19 June 1998 to February 2004 when the surgery lists were published at Ms Edmond's behest as Minister, Ms Edmond took no steps to publish the anterior lists, the outcome being misleading and not reflecting the true nature of surgical waiting time in Queensland public hospitals.
- (b) Ms Edmond's press release of 11 November 1999 headed 'Health Minister says Opposition campaign to discredit the waiting lists data is desperate and dishonest, in light of the previous press release of 3 July 1998 entitled 'Health Minister lifts the lid on waiting lists' and a further previous press release of 16 October 1998 entitled 'Labor Plan reveals hidden waiting lists' was misleading in not reflecting the true nature of surgical waiting time in Queensland Public Hospitals.
- (c) With respect to the Measured Quality Program developed by Queensland Health directed to improvement of patient safety and medical standards, following a presentation by Mr Justin Collins of Queensland Health on 13 August 2002, in which Minister Edmond was informed that use and dissemination of hospital reports was proposed to be left to District Managers, Ms Edmond directed that the measured quality program hospital reports be taken to Cabinet for noting;
- (d) Further, with respect to the Measured Quality program, following a ministerial briefing to Ms Edmond dated 10 March 2003, and a presentation to Ms Edmond by Mr Collins on 10 May 2003, in each of which Ms Edmond was informed of the deleterious effect which the Cabinet restriction of 12 November 2002 had on the use of the measured quality hospital reports, Ms Edmond directed the phase two reports be taken to Cabinet for noting and failed to include the aforesaid deleterious effect in the Cabinet Submission;

- (e) As a result of the directions or decisions in (c) and (d) above, Ms Edmond knew or believed that the Measured Quality Reports would not or may not be available to the public, and further that access by hospital staff thereto would be delayed, and use thereof restricted in a manner deleterious to the effective implementation of the policy;
- (f) The directions or decisions in each of paragraph (c) and (d) above and the outcome in paragraph (e) above, were contrary to the public interest.

Former Health Minister Nuttall MP

6.600 The Honourable Gordon Nuttall MP was Minister for Health in the Government from February 2004 to July 2005. The only matter I need canvass in this section concerning Minister Nuttall are those about his emerging knowledge of Dr Patel and the investigation of his conduct at Bundaberg Hospital. I have already canvassed these matters, in part, in Chapter Three.

6.601 On 22 March 2005, the Member for Burnett, Mr Messenger MP, raised issues about the clinical practices and procedures of Dr Patel at Bundaberg Hospital. This led to Minister Nuttall requesting a briefing from Dr FitzGerald, the Chief Health Officer for Queensland Health. Dr FitzGerald sent the Senior Departmental Liaison Officer in Minister Nuttall's office an email at 1.25pm, attaching a suggested response to Parliamentary questions,⁶⁰⁵ which included the following:

The significant issue regarding the competency of Dr Patel appears to relate to his preparedness to take on cases which are beyond the capacity of the Bundaberg Hospital and possibly beyond his personal capacity. There is no evidence that his general surgical skills are inappropriate or incompetent.

However, the fact that he has taken on those cases may reflect significantly poor judgment to a level which may be grounds for disciplinary action by the Medical Board. Thus, the Chief Health Officer has recommended that this matter be referred to the Medical Board for attention.

6.602 It seems that, later in the day, Dr FitzGerald met with the Minister and informed him, in substance, that:⁶⁰⁶

- Dr FitzGerald had conducted an investigation concerning allegations about Dr Patel.
- Such report of the investigation was near completion and would be finalised in the near future because he was awaiting benchmarking data from similar hospitals.
- Dr Patel had performed surgery outside his scope of practice.
- Dr FitzGerald had advised Bundaberg Hospital that Dr Patel was to cease performing surgery outside his scope of practice.

⁶⁰⁵ Exhibit 391

⁶⁰⁶ Exhibit 319 para 27; T5311.30-5312.12; T6134

- 6.603 Dr FitzGerald in fact finalised and produced his audit report on 24 March 2005. I accept the evidence of Mr Nuttall that a copy of that report was not given or shown to him (by any person, even his ministerial staff if they had received it) until some time after 9 April 2005. On this lastmentioned date Minister Nuttall appointed a full inquiry in respect of Bundaberg Hospital and in particular Dr Patel.
- 6.604 Minister Nuttall attended Bundaberg Hospital with Dr Buckland on 7 April 2005. He travelled there by plane via Springsure where he opened a Queensland Health facility. On arriving in Bundaberg, he participated with Dr Buckland in a meeting of staff.
- 6.605 The evidence is unclear as to precisely what Minister Nuttall and Dr Buckland discussed about Bundaberg Hospital issues, on or shortly prior to 7 April between themselves, or with others, prior to commencement of the staff meeting. But I accept that the existence of, and thereby content of, Dr FitzGerald's audit report of 24 March 2005 was not discussed.
- 6.606 I infer there must have been some discussion about the Patel issue because of what was said by Minister Nuttall to the Bundaberg meeting.
- 6.607 I find Minister Nuttall's recollection of the events of the meeting to be quite vague. That is perhaps understandable for a busy minister.
- 6.608 Evidence was given from witnesses Margaret Mears, and Karen Jenner Doherty⁶⁰⁷ of what was said by Minister Nuttall, and also Dr Buckland at the meeting. I have set out in Chapter three some pertinent parts of their recollections of the meeting and I accept that evidence.
- 6.609 An example of conflict between the evidence of these witnesses and Minister Nuttall is of what Ms Mears attributed to Minister Nuttall concerning Mr Messenger:⁶⁰⁸
- During the meeting, Mr Nuttall said that the only way we could stop the rubbish that was going on at Bundaberg Base and in Bundaberg was if we were to vote Mr Messenger out.
- 6.610 Mr Nuttall vehemently denied making such a statement.⁶⁰⁹ I do not accept his evidence in this respect.
- 6.611 Minister Nuttall also informed the meeting that the report contained (or more properly, given his state of knowledge, would contain) confidential patient information. That was untrue. It may be that Minister Nuttall was informed of this by Dr Buckland or a member of his staff. If that is so, I consider it was

⁶⁰⁷ Exhibits 507, 508 and 509, T7374-7404

⁶⁰⁸ T7375 line 35

⁶⁰⁹ T5321 line 40

reasonable for Minister Nuttall, given his state of knowledge, to accept and say that.

- 6.612 I accept that Minister Nuttall told the meeting that Dr FitzGerald's report was incomplete, and that was his true belief. That was also untrue. It is quite unacceptable, however, that he would not have taken the trouble to make a specific enquiry of Dr FitzGerald or Dr Buckland as to whether, in truth, it had been completed or what lead time was involved in such completion.
- 6.613 It will be remembered, in this regard, that Minister Nuttall had been told on 22 March, 15 days earlier, that the report was near completion. In expressing his belief as to report non-completion, Minister Nuttall was not corrected, either publicly or privately, by Dr Buckland. I return to this issue below when dealing with Dr Buckland.
- 6.614 Minister Nuttall also informed the meeting that Dr Patel could not give his version of events to the Chief Health Officer and thereby Dr Patel could not be afforded natural justice. In speaking of matters canvassed at the meeting Minister Nuttall said:⁶¹⁰
- I indicated to them that the report wouldn't be able to be released because Dr Patel wouldn't have a chance to respond to the report.
- 6.615 Minister Nuttall said that what was in his mind was that the audit report was a type of document which ordinarily would not be released, being a clinical audit.⁶¹¹ But that, in my view, was not what was communicated by Minister Nuttall at the meeting (nor by Dr Buckland).
- 6.616 From what was said by Dr Buckland at the meeting there could have been no doubt in Minister Nuttall's mind that Dr Patel had by then left Australia, probably never to return and most likely unco-operative at a distance.
- 6.617 Minister Nuttall's choice of language at the meeting was poor. I find it reprehensible that he was prepared to say at the meeting, in effect, that Dr FitzGerald report would remain incomplete because Dr Patel would not have a chance to put his side of the story. If that is what he was told by Dr Buckland, or his staff, then he was at best naive and at worst disingenuous in his asserted acceptance of that advice. To a politician of Minister Nuttall's obvious experience, any such advice would obviously be nonsense.
- 6.618 Minister Nuttall commissioned a wide ranging review on 9 April 2005. He did so on the advice of Dr Buckland. Minister Nuttall's evidence was to the effect that it was not until some days after 9 April that he came to know of reports of Dr Patel's adverse clinical history in the United States. Dr Buckland says that he

⁶¹⁰ T5319 line 55

⁶¹¹ T5319 line 50

informed Minister Nuttall to this effect on 8 April. I accept Dr Buckland's evidence in this respect.

6.619 The statements made by Minister Nuttall at the meeting show a disposition to conceal adverse information. Concealment of Dr FitzGerald's report was not in the public interest.

Findings against former Health Minister Nuttall

6.620 My findings in respect of Mr Nuttall are:

- (a) In circumstances where Mr Nuttall had no knowledge, nor made any inquiry whether Dr FitzGerald's investigation or report was complete or could be completed, and Mr Nuttall had not read any report by him in complete or incomplete form, Mr Nuttall attended a meeting at the Bundaberg Base Hospital on 7 April 2005 during which Mr Nuttall advised hospital staff present that:
 - (i) The report being prepared by the Chief Health Officer was incomplete, when Mr Nuttall had made no enquiry as to whether this was true;
 - (ii) Dr Patel had not given his version of events to the Chief Health Officer and, therefore, had not been afforded natural justice; the report, therefore, could not be completed or publicised in incomplete or completed form.
- (b) Such conduct was misleading, unreasonable and careless.

Dr Buckland

6.621 There are a number of matters to be canvassed with respect to Dr Buckland:-

- The events on or about and following 24 March 2003 with respect to Dr Patel.
- The meeting in Bundaberg attended by Dr Buckland, with Minister Nuttall, on 7 April 2005.
- The events concerning Mr Berg at Townsville Hospital in 2002.
- The events concerning the North-Giblin report in or about May 2005.
- Earlier events in 2003 concerning an alleged instruction to destroy Queensland Health documents.

6.622 As I have already canvassed the North-Giblin report and Berg issues in Chapters Four and Five respectively, I do not propose to repeat those here. I dealt with the 7 April 2005 meeting issues in Chapter Three and earlier in this Part. I need to expand upon that.

Dr Buckland's background

- 6.623 Dr Steve Buckland is a very experienced medical bureaucrat.⁶¹² He has a medical background, graduating from the University of Queensland with a Bachelor of Medicine and a Bachelor of Surgery in 1976. He was registered as a medical practitioner in 1977. He became a Fellow of the Australian College of Occupational Medicine (now the Australasian Faculty of Occupational Medicine of the Royal Australian College of Physicians) in 1985. He obtained specialist registration in the specialty of occupational medicine in 1991.
- 6.624 Dr Buckland obtained a Masters Degree in Health Administration from the University of New South Wales in 1990. He became an Associate Fellow of the College of Health Service Executives in 1990. He became a Member of the Royal Australian College of Medical Administrators in 1999.
- 6.625 Dr Buckland worked⁶¹³ as a medical professional from 1977 until 1999. He was Medical Superintendent of Redcliffe Hospital from December 1989 and District Manager and Medical Superintendent in the Redcliffe-Caboolture Health Service District from 1996.
- 6.626 From August 1999 to July 2002 Dr Buckland was Queensland Health's Southern Zone Manager. From 29 July 2002 to 1 November 2003 he was General Manager Health Services (having acted in that capacity at various times previously). He was Acting Director-General of Queensland Health from 1 November 2003 to 29 April 2004, being appointed permanently to that position on the latter date. He remained in that position until 26 July 2005 upon which date his employment was terminated by the Queensland Government.
- 6.627 From the above recitation of background, and the evidence given by Dr Buckland, it is clear that he is a man of experience and intelligence. He was also far from naïve in matters of medical administration. These comments, however, prove a double-edged sword for Dr Buckland in an endeavour to explain away his conduct by reason of, for example, deference to Minister Nuttall or delegation of responsibility to Chief Health Officer Dr FitzGerald.

Dr Patel

- 6.628 It is convenient to deal first with issues pertaining to Dr Patel. It was on 22 March 2005 that Dr Buckland was first informed of Dr Patel, together with the fact that Dr FitzGerald had been undertaking an investigation into general surgery services at the Bundaberg Hospital.⁶¹⁴ On that day Dr Buckland received an oral briefing from Dr FitzGerald. He was aware that Dr FitzGerald had briefed the Minister orally and in writing the same day. When briefing Dr

⁶¹² Exhibit 335 para 5

⁶¹³ Exhibit 335 para 6

⁶¹⁴ Exhibit 335 para 17

Buckland on 22 March, Dr FitzGerald did not advise Dr Buckland to suspend Dr Patel or to take any action against him, at least at that point.⁶¹⁵

- 6.629 Dr FitzGerald completed his audit report on 24 March 2005 and on that day supplied a copy to Dr Buckland.⁶¹⁶ The same day Dr FitzGerald provided to Dr Buckland what was in effect a covering memorandum to the audit report.⁶¹⁷ He also met with Dr Buckland.
- 6.630 The effect of the evidence of Dr Buckland was that by the conclusion of the briefing of 24 March 2005, he considered that no immediate action was required with respect to Dr Patel,⁶¹⁸ and there was no advice by Dr FitzGerald that any such action was required.⁶¹⁹ Dr Buckland said that he was not informed nor had any sense that there was any major issue with respect to Dr Patel's competence and was satisfied that the matter was being dealt with (adequately) by referral of Dr Patel to the Medical Board of Queensland.⁶²⁰
- 6.631 Dr FitzGerald had advised Dr Buckland that action had been taken to limit the scope of the surgery being performed by Dr Patel and to ensure that critically ill patients were being referred to higher level hospitals.
- 6.632 Dr Buckland gave evidence that Dr FitzGerald informed him, on 24 March 2005, that 'Dr Patel was fundamentally an average surgeon ... he's not as good as some but he's not as bad as others'.⁶²¹
- 6.633 Dr Buckland agreed with Mr Douglas SC, Counsel Assisting the Commission of Inquiry, that the reference of Dr Patel to the Medical Board of Queensland might entail investigation which could take 'possibly months' and that Dr Patel might continue to work at Bundaberg Hospital in the meantime.⁶²² Further, he knew that it was within his power to suspend Dr Patel forthwith from providing clinical (but not other) services at Bundaberg Hospital, and on full pay.⁶²³
- 6.634 Mr Douglas asked this of Dr Buckland in respect of his stewardship of surgeons within Queensland Health as Director-General:⁶²⁴

I am seeking to elicit from you...in the conduct of Queensland Health during your time as Director-General, how bad a surgeon has he to be, working within Queensland Health in order to move the Director-General to cross the Rubicon and suspend that person?-- I would have to be concerned to the point where I felt that the individual was dangerous, that patients were dying unnecessarily, or that there was some other major event in terms of a surgeon's either mental or surgical capacity.

⁶¹⁵ T6138

⁶¹⁶ Exhibit 230

⁶¹⁷ Exhibit 335 attachment SMB3

⁶¹⁸ T5490

⁶¹⁹ T5490 line 10

⁶²⁰ Exhibit 335 paras 20, 22 and 24

⁶²¹ T5489 line 15

⁶²² T5496 line 35

⁶²³ T5496 line 25

⁶²⁴ T5497 lines 40-55

COMMISSIONER: You would have to have proof that they were dying or being injured, would you?—Commissioner, you would need to have significantly more evidence than I had available to me at that time.

- 6.635 The audit report,⁶²⁵ even though (as I have discussed in Chapter Three and further below) it is more muted in its terms than properly reflects the facts, remains a disturbing document. Although it did not specifically refer to Dr Patel, in the mind of Dr Buckland, it was clearly referable, principally, to the conduct of Dr Patel. I refer to the ‘summary’ of the document. The judgment of Dr Patel was clearly placed in question. Moreover, reference is made to what appears to be a disturbingly high complication rate in respect of standard procedures (28 times the national average for one common procedure) in Dr Patel’s surgical sphere.
- 6.636 To the extent that the audit report may have been, to some extent muted, the accompanying memorandum certainly was not.⁶²⁶ It is addressed to Dr Buckland from Dr FitzGerald and the subject matter was ‘Clinical Audit – General Surgical Services at Bundaberg Hospital’. The document is dated 24 March 2005. The document provides:

In February this year I was asked to undertake a clinical audit of general surgical services at Bundaberg Hospital. As you are aware, the events which triggered this audit have now been the subject of questions in Parliament.

The report of the clinical audit is now complete and I have attached a copy of this memorandum. There are issues which I need to bring to your attention. There is evidence that the Director of Surgery at Bundaberg Hospital has a significantly higher surgical complication rate than the peer group rate (Appendix 1). In addition, he appears to have undertaken types of surgery which, in my view, are beyond the capability of Bundaberg Hospital and possibly beyond his own skills and experience, although his surgical competence has not been examined in detail. I believe his judgement, both in undertaking these procedures and also delaying the transfer of patients to a higher level facility, is below that which is expected by Queensland Health. I would recommend that these matters should be examined by the Medical Board and have written to the Executive Officer – Mr Jim O’Dempsey, bringing the matter to his attention.

The audit report also identifies that there has been a failure of systems at the hospital which has led to a delay in the resolution of these matters. The credentials and clinical privileges committee has not appropriately considered or credentialled the doctor concerned. The executive management team at the hospital does not appear to have responded in a timely or effective manner to the concerns raised by staff, some of which were raised over 12-months ago. While the report makes a number of recommendations for system improvements, I would recommend that some discussion should occur with the hospital management, reminding them of their responsibilities to put such systems in place and ensure they respond appropriately to reasonable clinical quality concerns.

- 6.637 A number of disturbing features, concerning the competence, judgment and character of Dr Patel, are identified in this document:-

⁶²⁵ Exhibit 230

⁶²⁶ Exhibit 335, Attachment SMB3

- He had undertaken (and thereby, implicitly had a penchant for undertaking) types of surgery which, in Dr FitzGerald's view were beyond the capability of the Bundaberg Hospital and possibly beyond his own skills and experience.
- He had delayed (and implicitly had a penchant for delaying) the transfer of patients to a higher level facility, at a standard below that expected by Queensland Health.
- The matters in question were sufficiently serious to be examined by the Medical Board of Queensland.
- Dr Patel (a surgeon operating on patients by then for almost two years at Bundaberg) had not been credentialed or privileged in accordance with Queensland Health policy.
- There had been a failure of systems at Bundaberg Hospital which led to a delay in investigating these matters, concerns about these matters first being raised 12 months earlier.

6.638 Dr Buckland agreed that the audit report and the 24 March memorandum, to some extent, contradicted each other,⁶²⁷ the latter being more critical of Dr Patel. He agreed that he did not attempt to elicit from Dr FitzGerald the reason for such contradiction.⁶²⁸

6.639 Dr Buckland agreed⁶²⁹ that, knowing what he then knew about Dr Patel, he would not have let that doctor perform elective surgery upon him (Dr Buckland), although Dr Buckland did indicate that he had not previously considered that as an issue.

6.640 Following the briefing on 24 March 2005, Dr Buckland had a telephone conversation and an email exchange with Mr Peter Leck, the District Manager of Bundaberg.⁶³⁰ Dr Buckland said in evidence that he did not take up with Mr Leck the issues upon which he had been briefed that day.⁶³¹ Rather he had a conversation with him in an attempt to arrange for Dr Patel to work over the Easter break which would conclude in early April 2005. By that exchange Dr Buckland's clear endeavour was an attempt to maintain the provision of Dr Patel's services at Bundaberg Hospital.

6.641 In my view, the conduct of Dr Buckland (and Dr FitzGerald, as I discuss below) in their disposition of the Dr Patel issue, at the latest by the end of 24 March 2005, was wholly unsatisfactory. On any fair or intelligent reading of it, the material canvassed in the audit report, as augmented by the memorandum of that date, was such as to move any person in a senior stewardship role, having

⁶²⁷ T5562 line 20

⁶²⁸ T5562 lines 22-60

⁶²⁹ T549p line 10

⁶³⁰ Exhibit 335 attachment SMB4

⁶³¹ T5500 line 20

regard to the safety and interests of patients, to suspend Dr Patel from providing any further surgical services. At the very least Dr Patel remained uncredentialed and unprivileged. As noted above, he could have been suspended on full pay, permitting him to provide other non-surgical services. Any decision other than suspension, in my view, was negligent. This is so even if, in truth, Dr Patel was soon to depart Bundaberg in any event.

- 6.642 Dr Buckland's attempt to sheet home responsibility to Dr FitzGerald by, in effect, delegating to him the need to advise Dr Buckland that Dr Patel ought to be prevented from providing surgical services until further notice, evidences lack of candour on his part. It may be accepted that Dr FitzGerald was closer to the issues, having undertaken the audit. However the information placed before Dr Buckland by Dr FitzGerald, including the memorandum of 24 March, ought to have left Dr Buckland in no doubt that he was obliged to suspend Dr Patel immediately. He was derelict in his duty in not doing that.
- 6.643 Moreover, when seen in the light of his conduct on 7 April, his conduct on this occasion, in my opinion, was affected, at least in part, by a desire to put an end to any inquiry into Dr Patel's conduct, thereby limiting further public discussion and criticism. The issue of Dr Patel had been raised at a political level, by Mr Messenger in Parliament. Dr Buckland knew that Dr Patel might soon leave Bundaberg.

The 7 April meeting

- 6.644 The events at the 7 April 2005 meeting are canvassed in Chapter Three of this report, and also in the above subsection of this section of the report concerning Minister Nuttall.
- 6.645 Dr Buckland and Minister Nuttall attended a staff meeting in Bundaberg on 7 April 2005. At no time between 24 March and 9 April 2005 did Dr Buckland ask Minister Nuttall whether he had received or read the audit report.⁶³² Nor did he at any time discuss the content of it with him. In evidence he said that:⁶³³

I made an assumption, and maybe that's an incorrect assumption, that because the Minister was dealing directly with Dr FitzGerald on this case and because of the nature of the case, that in fact a report may well have been made available to him or his staff.

- 6.646 Dr Buckland said that he did not even take a copy of the report with him to Bundaberg for the meeting.⁶³⁴ Some briefing of Minister Nuttall by Dr Buckland must have taken place but it is difficult to know precisely what that was. What was said by each at the meeting in the presence of the other was, in the above circumstances, surprising and inexplicable.

⁶³² T5503 line 5

⁶³³ T5503 line 20

⁶³⁴ T5503 line 55

6.647 Minister Nuttall told the meeting the FitzGerald Report was incomplete. Dr Buckland did not correct the Minister. Dr Buckland acknowledged that he told the staff meeting that:

As Dr Patel had left the country, the audit process being conducted by Dr FitzGerald in relation to Dr Patel would be difficult to finalise as natural justice had not been afforded to him (Dr Patel).⁶³⁵

6.648 Yet, as already mentioned, he had a copy of Dr FitzGerald's completed report.

6.649 Ms Mears, a staff member present at the 7 April meeting said Dr Buckland also said at the meeting (necessarily referring to Dr Patel and any replacement).⁶³⁶

How are we going to get him back from America now?

...

No decent doctor would want to come to Bundaberg to work in these circumstances.

6.650 Dr Buckland agreed it was 'probable' he made each of these remarks.⁶³⁷

6.651 Dr Buckland acknowledged that he had conducted matters at the meeting rather poorly in implying that the audit process had not been completed.⁶³⁸ To explain his abovementioned statement, he said that he intended to communicate the true position, namely that Dr FitzGerald's audit report was only the start of the process.⁶³⁹

The whole process is not a process of accusation, the process is a process of improvement, and trying to do that in a no-blame situation, so there may well have been, as I said earlier, plausible or understandable, or even clinically correct explanations for certain sets of outcomes. So, these sorts of things have to be fully investigated ... that was my belief at the time, that it would be very difficult because Dr Patel was not there to be able to inform the whole process. I mean, sure we have grabbed the data, we could have looked at that, and Dr FitzGerald had done some of that in relation to infection, but not to the whole patient cohort

6.652 I put the following to Dr Buckland:⁶⁴⁰

If Dr Patel had left the country and wasn't coming back, you would never be able to accord natural justice to him in the way you have described it? .. That's probably – that is probably true, Commissioner, yes.

You would have known that at the time and, therefore, you were going to close the whole inquiry down? -- No, that's not true. That wasn't the intention at all. We gave a very clear indication, both the Minister and myself, that Dr FitzGerald would be returning to Bundaberg to meet with staff to talk about his findings and to meet with the District Executive to be able to follow through with what he had.

⁶³⁵ T5505 line 30

⁶³⁶ Exhibit 507 para 15

⁶³⁷ T5567 line 5-25

⁶³⁸ T5507 line 5

⁶³⁹ T5505-5506

⁶⁴⁰ T5506 lines 40 to 60

- 6.653 This, in my view, comprised Dr Buckland's stance in respect of Dr Patel. That is, the audit report was the end of the investigation by Queensland Health of Dr Patel and the complaints made about him. It would not be released. Dr FitzGerald would return to Bundaberg only for the purposes of placating staff who had complained about Dr Patel and to follow through with the District Executive, presumably in terms of future management. Dr Patel was gone. That dispensed with the trouble of further investigation. Yet Dr Buckland must have known that Dr Patel's absence did not prevent, nor impede, a full investigation of his conduct, as subsequently occurred.
- 6.654 As is recorded in Chapter Three of this report, shortly following the 7 April meeting, Dr Keating took Dr Buckland aside and told him of the outcome of his (Keating's) 'Google' search in respect of Dr Patel's disturbing US history. Dr Buckland did not inform the Minister of that because he wished to undertake his own search that evening. He did so, and advised Minister Nuttall the following day. Only then did he recommend to the Minister the undertaking of a detailed inquiry.
- 6.655 What stymied Dr Buckland's intention was this 'Google' search. Once he found that information was on the net Dr Buckland must have known that it would be discovered by others. That is why, in my opinion, he recommended a detailed Queensland Health inquiry. This was announced on 9 April 2005.

The surgical access team's 30 July 2003 submission

- 6.656 The Surgical Access Team of Queensland Health made an unsolicited submission to Dr Buckland, who was then General Manager of Health Services, in a document dated 30 July 2003. The concern of the submission was that a number of hospitals were engaged in reclassification of patients from emergency patients to elective surgery patients and thereby illicitly gaining additional funding.
- 6.657 There was a clear disagreement about this issue between the Team and Health Service Districts which it is not necessary for me to resolve. I should indicate, however, that Dr Buckland's view is probably the preferred one, namely that whilst one or two hospitals may have been illicitly reclassifying patients, the then surgical funding rules were vague. In stating this I imply no criticism of Mr Walker and his fellow Team members. They were diligent staff members seeking to ensure proper expenditure of departmental funds.
- 6.658 Of greater importance, in the context of any culture of concealment within Queensland Health, is the evidence that there was a direction that the 30 July submission be destroyed.
- 6.659 Whilst, as noted below, there is no question that ultimately a direction was communicated to the Surgical Access Team that original and electronic copies of the document be destroyed, a hard copy of the document was retained within

the office of the General Manager Health Services, and, in addition, information technology analysis also revealed that an electronic copy had not been ultimately deleted from the Queensland Health network.⁶⁴¹

- 6.660 There is no direct evidence to the effect that Dr Buckland gave any person an instruction that the 30 July submission be destroyed.
- 6.661 Dr Glenn Cuffe was Manager, Procurement Strategy Unit, of Queensland Health, from 1999 to 2004. He is now the Director, Analysis & Evaluation Unit, Innovation Branch, Innovation and Workforce Reform Directorate in Queensland Health. Dr Cuffe was an impressive witness. I accept him as a truthful and reliable witness. However that acceptance does not necessarily resolve this issue against Dr Buckland.
- 6.662 Dr Cuffe gave evidence⁶⁴² that shortly after a meeting of 15 August 2003, attended by representatives of the Surgical Access Team, Dr Buckland, Dr Cuffe and Ms Deborah Miller, he received a telephone call from Ms Cheryl Brennan, the Executive Secretary to Dr Buckland.
- 6.663 Dr Cuffe knew Ms Brennan very well. He said that he did not recall exactly what Ms Brennan said; however 'she communicated a direction that hard copies of the 30 July 2003 submission held in the SAS were to be destroyed and that the copies on the network were to be deleted'.⁶⁴³
- 6.664 Dr Cuffe said⁶⁴⁴ that Ms Brennan, to his recollection, did not mention Dr Buckland or any other persons name as the person who gave the direction but he assumed it came with Dr Buckland's knowledge. Upon receiving the direction he spoke to Mr Walker and Mr Roberts of the Surgical Access Team and passed on the direction.
- 6.665 Dr Buckland⁶⁴⁵ and Ms Miller⁶⁴⁶ deny having given or knowing of any such instruction given to Ms Brennan. Ms Brennan has no recollection one way or the other of having received or given such direction.⁶⁴⁷ Ms Brennan was quite distressed and did not give oral evidence but gave a written statement to that effect.
- 6.666 In early 2004 Dr Buckland had a conversation with Dr Cuffe. One of the issues raised was to the effect that Dr Buckland had been informed by one of his staff members that such staff member had seen a copy of the 3 July submission in the Surgical Access Service work area team. It seems clear that Dr Cuffe could not recall the exact words used. He expanded upon this in examination.

⁶⁴¹ Exhibit 495 paras 21, 22; T6197, T6222

⁶⁴² Exhibit 426

⁶⁴³ Exhibit 426 para 11

⁶⁴⁴ T6554 line 55

⁶⁴⁵ Exhibit 459 para 20

⁶⁴⁶ Exhibit 416 para 31

⁶⁴⁷ Exhibit 425 paras 15 to 17

To Mr Douglas SC⁶⁴⁸ and to Mr Applegarth SC,⁶⁴⁹ Dr Cuffe related the following:-

How certain are you that in this conversation you had with Dr Buckland that he was in fact referring to the 30 July submission, ... as opposed to any other submission that may have preceded it or followed it? -- Well, he – his words were, if I can recall to the best of my ability, the document that was asked to be destroyed had been seen on the officer's desk, which was a 30 July submission.

...Dr Buckland wasn't specific about the document? -- No, he – my recollection is that he said that the document that he had asked – or that had asked to be destroyed was – had been seen on the desk in the Surgical Access Service.

- 6.667 Dr Cuffe, and the witnesses from the Surgical Access Team, say that they remember the events because it was the first time in the history of their long employment with Queensland Health that any had been asked to destroy a document. I accept that Dr Cuffe received such a direction. But the apparent uncertainty of Dr Cuffe's exact recollection of the conversation, the substance of which he relates in the previous paragraph, has caused me to have some doubt that the direction came from or was ratified by Dr Buckland. Whilst I reiterate that I found Dr Cuffe a thoroughly reliable, and indeed engaging witness, to make a finding of such seriousness against Dr Buckland on the basis of the above evidence, in my view, would be improper.
- 6.668 Before leaving this issue I should advert to the evidence of Ms Miller in respect of the discrete issue of the removal of the 30 July submission from RecFind, a document management system maintained by Queensland Health. RecFind is an index, not a data storage system, upon which the document itself is contained.⁶⁵⁰ The removal of the reference to the document on RecFind is not to delete the document from the computer server upon which it is stored.
- 6.669 Ms Miller⁶⁵¹ was a Principal Project Officer attached to Dr Buckland's office. She was, in effect a senior liaison officer. She possessed tertiary qualification in nursing and business administration. She had worked for Dr Buckland's predecessor, Dr Youngman, in the same capacity, for two years.
- 6.670 Ms Miller gave evidence to the effect that, as she had done on other occasions with different documents, she instructed that the 30 July submission be removed from RecFind because, in effect, her understanding was that until a submission to the General Manager Health Services was approved, it remained a draft.⁶⁵²
- 6.671 This approach to the disposition of documents, in my opinion, is fanciful. A submission, even if misconceived in content, remains just that. The approach

⁶⁴⁸ T6557 line 25

⁶⁴⁹ T6579 line 55

⁶⁵⁰ see T6548 (Cuffe); T6407 (Miller)

⁶⁵¹ Exhibit 416

⁶⁵² Exhibit 416 paras 20,21; T6413

certainly did not accord with the Executive Services Guidelines.⁶⁵³ Such a practice would involve a submission to the Minister or Senior Service being more difficult to locate, for example upon a *Freedom of Information Act* search in that if one was looking for a submission, then (as Dr Cuffe agreed)⁶⁵⁴ the first place one would go looking is in RecFind. To look elsewhere would only make the task harder.

6.672 Dr Buckland eschewed any knowledge of such practice being routinely adopted or the so-called 'draft' characterisation of submissions.⁶⁵⁵ I accept his evidence in this respect.

Findings against Dr Buckland

6.673 I make the following findings with respect to Dr Buckland in addition to those findings I have made in Chapter Four:

- (a) On and after 24 March 2005, being in possession of information that provided reasonable grounds for Dr Buckland to believe or suspect that:
 - (i) Dr Jayant Patel, the Director of Surgery at the Bundaberg Base Hospital ('the Hospital') had a significantly higher complication rate than his peers;
 - (ii) Dr Patel undertook surgery beyond the capacity of the Hospital and possibly beyond his own skill and experience;
 - (iii) Dr Patel had delayed the transfer of patients to tertiary hospitals in circumstances where those patients should have been so transferred;
 - (iv) The Chief Health Officer Dr FitzGerald had serious concerns about Dr Patel's clinical judgment;
 - (v) Dr Patel had never been credentialed or privileged by the Hospital, under Queensland Health's Policy requiring as much;
 - (vi) Staff complaints about Dr Patel had not been appropriately acted upon by the Hospital executive over a period of at least 12 months;
 - (vii) The data presented in the Chief Health Officer's audit report of 24 March 2005 showed that the complication rates for laparoscopic cholecystectomy procedures at the Hospital were 28 times the national average over the previous 18 months.

⁶⁵³ Exhibit 460

⁶⁵⁴ T6549-6550

⁶⁵⁵ T7109 line 10-20

- (viii) The Hospital had increased rates of wound infection and wound dehiscence probably associated with Dr Patel's surgery; and
- (ix) Issues with respect to Dr Patel had been raised in Parliament, and
- (x) Dr Patel would be continuing to perform procedures at the Hospital at least until 1 April 2005 and possibly until 31 July 2005

Dr Buckland (A) failed to take any, or any appropriate action, to suspend him from duty, or providing surgical services, or further restrict his scope of practice, and (B) failed to take any step to further investigate, or cause any further investigation of Dr Patel's conduct until 9 April 2005, after Dr Patel had left the country. Each failure, in the circumstances, was deliberate or careless and incompetent and unreasonable.

- (b) Being in possession of the information referred to in paragraph (a) above, Dr Buckland deliberately or carelessly and incompetently and unreasonably:
 - (i) Failed, at any time, to provide Minister Nuttall, but in particular prior to the meeting at the Bundaberg Hospital, a copy of the audit report;
 - (ii) Further, failed, at any time, to provide Minister Nuttall with a copy of the audit report or the memorandum of Dr FitzGerald to Dr Buckland dated 24 May 2005, which accompanied delivery of the report to Dr Buckland;
 - (iii) Failed to enquire of the Minister, at any time, but in particular prior to the meeting at Bundaberg Hospital on 7 April 2005, whether he had read or knew of the contents of the said audit report or the said memorandum;
 - (iv) Failed, at any time, but in particular prior to the meeting at Bundaberg Hospital on 7 April 2005, to inform and accurately brief the Minister on the content of the audit report or the memorandum;
 - (v) Advised the Minister, on or shortly prior to 7 April 2005, that the audit report could not be completed because of the absence of Dr Patel from Australia; and
 - (vi) Formed the view and determined, on or shortly prior to 7 April 2005 (and prior to Dr Buckland undertaking an internet search revealing the disciplinary record of Dr Patel in the United States) that any further investigation of Dr Patel's conduct at Bundaberg Hospital would not be pursued because of his absence from Australia, the lastmentioned fact being a convenient excuse for such view and determination because it

afforded a means of avoiding further embarrassment to Queensland Health arising from Parliamentary and media publicity.

- (c) On 7 April 2005 at Bundaberg, in circumstances where Dr Buckland knew that the Chief Health Officer's audit report had been completed on 24 March 2005:
- (i) Dr Buckland advised a meeting of staff that the report could not be completed because Dr Patel had left Australia, and
 - (ii) Dr Buckland advised Minister Nuttall to that effect.

Dr FitzGerald

Dr FitzGerald's background

- 6.674 Dr Gerrard Joseph FitzGerald, from the end of January 2003 until quite recently, held the position of Chief Health Officer in Queensland Health. That is a statutory position created in accordance with the *Health Act* 1937. It entails membership of a number of statutory bodies, including the Medical Board of Queensland. In addition the Chief Health Officer provides advice to the Minister and the Director-General on the quality and standards of health care.
- 6.675 Under Part 6 of the *Health Services Act* 1991, Dr FitzGerald was appointed, from 21 April 2001 as an investigator. This entailed him having standing approval to undertake investigations as may be required from time to time within Queensland Health.⁶⁵⁶
- 6.676 Dr FitzGerald possesses an impressive curriculum vitae.⁶⁵⁷ He obtained a Degree of Bachelor of Medicine and Bachelor of Surgery from the University of Queensland in 1976. In 1993 he became a Foundation Fellow of the Australasian College for Emergency Medicine. He obtained a Bachelor of Health Administration from the University of New South Wales in 1998. He became a Fellow of the Royal Australian College of Medical Administrators in 1990. Also in 1990 he obtained his Doctorate in Medicine from the University of Queensland.
- 6.677 Dr FitzGerald has held a number of statutory and teaching positions. He was Medical Director of the Queensland Ambulance Service from 1990 to 1993 and Commissioner of that service from January 1994 to January 2003, when he took up his present position.

⁶⁵⁶ Exhibit 225 paras 9, 10

⁶⁵⁷ Exhibit 225 attachment GF1

6.678 I might add that, from my impression of him in the witness box, and from the evidence of others, Dr FitzGerald seems to be, and to be regarded as an affable and decent person.

Clinical audit

6.679 The history of matters leading to the canvassing and pursuit of the clinical audit undertaken by Dr FitzGerald appear in Chapter Three of this report.

6.680 It was on 17 January 2005 that Dr FitzGerald first became involved in a prospective clinical audit concerning Dr Patel. It was then that Dr FitzGerald first became aware that the clinical standards of Dr Patel had been called into question. Dr FitzGerald was also advised by Mr Leck, in Mr Leck's memorandum of 19 January 2005⁶⁵⁸ that Dr Patel did not intend to renew his (Dr Patel's) contract when it expired on 31 March 2005.

6.681 Dr FitzGerald decided that further enquiries would be necessary before he could offer any opinion about standards. He advised Mr Leck that his review would take the form of a clinical audit and would not be an investigation into any individual.⁶⁵⁹ That was, to say the least, curious, given that the material forwarded by Mr Leck, which included the letter of Ms Toni Hoffman of 22 October 2004 and the interviews with the three practitioners undertaken by Mr Leck and Dr Keating in the fortnight following that, was focused upon Dr Patel and his practices.⁶⁶⁰

6.682 On 14 and 15 February 2005 Dr FitzGerald, and his assistant Ms Jenkins, attended the Bundaberg Hospital to interview staff and collect further information. He said in evidence that the nature of his audit process, while at Bundaberg, was expressed to be, and intended to be 'non-judgmental or non-threatening to ensure that people do participate in the clinical audit'.⁶⁶¹ Again, that was curious, given the nature of the material and the potential seriousness of the criticism of Dr Patel which it contained.

6.683 The principal issue of concern for Dr FitzGerald during his visit, it seems, was that Dr Patel was conducting surgical procedures beyond the scope of practice of the hospital and that there was delay in transfer to a larger hospital where appropriate.⁶⁶²

6.684 Prior to leaving Bundaberg Dr FitzGerald obtained assurances from Dr Patel and Dr Keating that these practices would cease.⁶⁶³ Unfortunately, and in my view inappropriately, he did not give any definition of this protocol to ensure Dr Patel's

⁶⁵⁸ Exhibit 225 attachment GF10

⁶⁵⁹ Exhibit 225 para GF61

⁶⁶⁰ Exhibit 225 attachment 10

⁶⁶¹ T3214 line 25

⁶⁶² Exhibit 225 para 65

⁶⁶³ T3210 line 25

evidently poor judgment prevented him from falling into his previous harmful habits.⁶⁶⁴

You would expect, in respect of either aspect of the undertaking, that Dr Patel was the person who would be obliged to exercise the principal judgment in respect of either matter?-- Yes, the principal judgment of whether the patient needed that procedure, and that was the procedure to be performed. The judgment of whether that procedure would be performed at Bundaberg could be determined by the Medical Superintendent, by a number of people.

In either case it would be left to his judgment, as a surgeon still undertaking work from the time the undertaking was given in February 2005 in the course of day-to-day practice at Bundaberg Hospital?-- Yes.

Was there any written protocol which was entered into in that respect?-- No.

Such as to particularise the types of matters - or exemplify the types of matters to assist Dr Keating and Dr Patel in exercising that judgment?-- Not to my - not that I was aware of, no.

Do you think it should have been, in retrospect?-- Probably. In retrospect I think the Medical Superintendent should have made it clear with the doctor concerned about what should or shouldn't be done.

I suggest you should have made it clear to Dr Patel that you, as the person eliciting the undertaking, required a very strict and exemplified adherence to what was required in that respect?-- Yes.

But it didn't happen?-- It didn't happen, no.

The fact that it didn't happen, I suggest, exemplifies a very poor approach to your undertaking of this audit. ... -- Well, I don't believe it was a poor approach. I believe, obviously in retrospect, there are things we could have done better.

- 6.685 Upon returning to Brisbane, Dr FitzGerald, on 16 February 2005, spoke to Mr O'Dempsey, from the Medical Board of Queensland, the result of which was that it was agreed that the Registration Advisory Committee of the Medical Board would defer consideration of Dr Patel's current application for renewal of registration until finalisation of his clinical report and further investigation.⁶⁶⁵ Thereafter Dr FitzGerald began to compile his report.
- 6.686 It was Dr FitzGerald's stance in evidence that there was insufficient evidence to take any particular action against any individual and to suspend anyone would be unjust and inappropriate.⁶⁶⁶
- 6.687 Dr FitzGerald's approach to conduct of the audit, and his interpretation of his results, in my view, were quite inexplicable.
- 6.688 Dr FitzGerald chose the clinical audit path as a means of responding to Mr Leck's request which concerned complaints about the competence and conduct of Dr Patel. But his position in respect of clinical audits, at the time, was.⁶⁶⁷

⁶⁶⁴ T6108 line 45, T6108 line 30 to T6109 line 10

⁶⁶⁵ Exhibit 225 para 27, T6146-T6417

⁶⁶⁶ T6138 line 40-50

⁶⁶⁷ T6121 lines 10-30

... the clinical audit should avoid adverse comments about individuals but it doesn't necessarily exclude positive comments ... the intent behind a clinical audit is to try and avoid adverse comments about individuals ... every bit of information that I have from experts in the field and from the literature regarding clinical audit, that a non-judgmental or non-adversarial approach is the way to exact systems improvements and improve the quality of health care.

- 6.689 After acknowledging that this was his approach he agreed in evidence that suspending a surgeon was something he could have done but he preferred referral to the Medical Board of Queensland. In response to a question from me in relation to the adequacy of mere reference to the Medical Board, the following answers were given by FitzGerald:⁶⁶⁸

Well, that's a grossly inadequate response though isn't it ...? -- -Yes sir

You did a grossly inadequate response just to refer it to the Medical Board?--
Well, the Medical Board were in a position to take action.

So were you? -- Yes, or the administration of the hospital, yes.

- 6.690 Dr FitzGerald went on to describe his approach, and a critique thereof, in the following fashion in answer to Mr Allen, counsel for the Nurses' Union⁶⁶⁹:-

Doctor, if you follow that approach of only including positive comments about an individual and deliberately omitting any negative comments, that must necessarily present to any reader of the report a skewed picture of the individual, surely?—I'm sure you're correct, yes.

And that's what your report did?—yes.

By only including positive comments about Dr Patel and deliberately omitting any negative ones, it presented a false picture regarding Dr Patel to any reader of the report?-- I accept your point, that was not the intent, the intent was to identify the issues, the structural and organisation issues that needed to be improved to address the issue – address the concerns.

You say that it was not your intent, but that is the obvious inevitable consequence of such an approach? – I accept that.

- 6.691 Dr FitzGerald finalised his report on 24 March 2005 and provided a copy to Director-General Buckland under cover of a memorandum of the same date.⁶⁷⁰

Dr FitzGerald did not provide a copy of the audit report to any other person until 7 April 2005. The 24 March memorandum was not supplied to anyone else.

- 6.692 Dr FitzGerald wrote to the Medical Board of Queensland also by letter dated 24 March 2005. That letter provided (in part):

My investigations to date have not been able to determine if Dr Patel's surgical expertise is deficient, however, I am concerned that the judgment exercised by Dr Patel may have fallen significantly below the standard expected. This judgment may be reflective of his decision to undertake such complex procedures in a hospital that does not have the necessary support, and in his apparent preparedness to retain patients at the hospital when their clinical condition may warrant transfer to a higher level facility.

⁶⁶⁸ T6121 lines 40-60

⁶⁶⁹ T6121 line 50 – T6122 line 12

⁶⁷⁰ Exhibit 225 – Attachment 'GF14'

- 6.693 It is plain that Dr FitzGerald was leaving it to the Medical Board to undertake a thorough assessment or investigation of Dr Patel.
- 6.694 The audit report, to the extent that it adverts to the conduct of Dr Patel, and the memorandum of 24 March to Dr Buckland contrast in content and emphasis. Dr FitzGerald's evidence was that they 'were intended to be complementary and for a different purpose'.⁶⁷¹ He said that the memorandum was intended to raise issues 'about the standard and quality of medical services ... concerning Dr Patel'.⁶⁷²
- 6.695 The content of the memorandum, in my view, was self evidently alarming. I have already canvassed this above in respect of Dr Buckland. At its base lies a non-compliance in the credentialling and privileging policy required by Queensland Health particularly in circumstances in which, as in the case of Dr Patel, the employee was a foreign trained surgeon who had not previously worked in Australia prior to appointment to Bundaberg where he was Director of Surgery.
- 6.696 On any view of the content of the memorandum, Dr FitzGerald was satisfied that Dr Patel had poor clinical judgment. The undertaking given with respect to undertaking particular surgery, and effecting early transfers, undefined as it was, did not address these defects. He also expressed at least strong suspicions about the clinical competence of Dr Patel.
- 6.697 The statistics about Dr Patel's complication rate for a routine procedure, set out in the report, were equally alarming. This showed a complication rate that was 28 times the national average.
- 6.698 In evidence Dr FitzGerald said:⁶⁷³

As to the conduct of clinical audits, do you consider that Queensland Health have learnt any lessons from this particular audit procedure in respect of Bundaberg?-- Well, I'm sure I have in terms of process, but certainly what we've learnt, of course, is that we do need to be - to try and get experts in initially. I felt that at the time I was being called upon to

try and judge surgical procedures where I didn't have the expert - personal expertise. The subsequent establishment of the Mattiussi Review et cetera brought that expertise to bear.

There is some other evidence before this Commission to the effect that you remarked to Dr Buckland on or about the 24th of March 2005, if not two days earlier, the 22nd of March (t)hat Dr Patel was not the best of surgeons but he also wasn't the worst?-- Yes.

Do you recall saying something like?-- That - yes, I do because that was the information we obtained from people in Bundaberg at the time, comments to that effect were made to us.

⁶⁷¹ T6115 line 45

⁶⁷² T6132 line 25

⁶⁷³ T6118-6119

I suggest to you on the information that you knew on or about the 24th of March 2005, you couldn't bring to mind a worse surgeon, that is, a more incompetent surgeon apparently than Dr Patel working within Queensland Health?-- I wouldn't - there was certainly none that I was aware of but I would - could I just comment on the fact that comment that was – he wasn't the best, he wasn't the worst, that came from the people who knew him and observed his surgery, but it also came from the data which we retrieved which we commented on at some length because one of the things that did concern us then when we drew that data from various hospitals, various hospitals are up and down across the parameters and some of them were much more.

The patients (sh)ould have been given the benefit of the doubt in relation to Dr Patel pending an investigation, shouldn't they?-- Yes, I'd accept that.

And they weren't Dr FitzGerald? -- That's true.

- 6.699 In my view, any sensible administrator in Dr FitzGerald's position, having formed the views contained not just in the audit report but in the memorandum, would have moved to immediately suspend Dr Patel from providing clinical services (on full pay). To leave matters, as Dr FitzGerald did, for investigation by the Medical Board of Queensland, with whatever delay that may entail, and in the knowledge that Dr Patel probably wouldn't, but may seek interim registration in the meantime or may leave Australia, was a wholly unsatisfactory response.
- 6.700 The audit report was an inadequate document. I canvass this in Chapter Three of this report. Dr FitzGerald conceded that, in drafting the report, he believed that the persons to whom the report was disseminated, and in turn those to whom it might be passed for action, would be relying upon him candidly to express the opinions he held and evidence for them.⁶⁷⁴
- 6.701 As to the audit report:
- Dr FitzGerald knew that serious allegations had been made about Dr Patel's clinical practices.
 - he knew that serious allegations had been made as to Dr Patel having a high infection rate.
 - he accepted that he had discerned from his investigation that Dr Patel apparently had a high complication rate (in the case of the common procedure, cholecystectomies, 28 times the national average)⁶⁷⁵ and infection rate but he didn't identify this as a freestanding category of complaint in his summary.
- 6.702 On 22 March 2005 Dr FitzGerald provided to Minister Nuttall a document dealing with the Patel issues.⁶⁷⁶ Dr FitzGerald accepted that he should have been far more specific and direct in conveying the information he did in that document, particularly in relation to infection rate.⁶⁷⁷

⁶⁷⁴ T6098 line 45

⁶⁷⁵ T6109 line 30

⁶⁷⁶ Exhibit 391

⁶⁷⁷ T6162 line 50

6.703 In my view Dr FitzGerald:

- adopted a wholly inappropriate approach to the investigation in response to the request of Mr Leck. If a 'no blame' neutral clinical audit, of the type he described, was a generally acceptable method of investigation (which I do not accept) it was a wholly inappropriate response to the complaints about Dr Patel given the content of the allegations and the materials provided to Dr FitzGerald by Mr Leck.
- at the lowest, the approach of Dr FitzGerald in the views expressed and advice he gave in his audit report and the memorandum was inappropriate and incompetent. Any sensible person in his position ought to have immediately advised suspension of Dr Patel.
- permitting Dr Patel to continue to practise (including during the term of the audit once Dr FitzGerald had formed his views) and then leaving it to the Medical Board of Queensland to take whatever steps they thought necessary, was a course designed to minimise publicity and in effect conceal the truth.

6.704 In my view, Dr FitzGerald had it in his mind from the outset that it was likely that Dr Patel would not remain in practice in Australia beyond 31 March 2005. This was likely to put an end to the issue. He did this against the background of knowing that from 22 March 2005 the issue had become a political one, it being raised in Parliament by Mr Messenger MP, with the consequence of him having to provide information to the Minister that same day.

6.705 Importantly, Dr FitzGerald knew that Dr Patel, a foreign trained surgeon, who was not credentialled and privileged under longstanding Queensland Health policy, and was the subject of serious (albeit not yet wholly substantiated) complaints, had been undertaking surgery in Bundaberg on many patients for two years and would continue to do so, unless stopped, until he left, whenever that was. The interests of the patients were ignored.

Findings against Dr FitzGerald

6.706 My findings in respect of Dr FitzGerald are these in addition to those findings I have made in Chapter Four:

- (a) On 24 March 2005 Dr FitzGerald, believing that there were reasonable grounds to believe or suspect that, following completion of his audit investigation prior to 22 March 2005, and his audit report of the Bundaberg Base Hospital:
 - (i) Dr Patel had a significantly higher complication rate than his peer group;
 - (ii) Dr Patel undertook surgery beyond the capacity of the Hospital and possibly beyond his own skill and experience;

- (iii) Dr Patel delayed transferring patients who should have been transferred;
 - (iv) Dr Patel had not been appropriately credentialed or privileged;
 - (v) There was reason to hold serious concerns about Dr Patel's clinical judgment;
 - (vi) Staff complaints about Dr Patel had not been appropriately acted upon by the Bundaberg Base Hospital Executive
- (A) deliberately or carelessly and incompetently failed to include this information in his report of 24 March 2004; (B) deliberately or carelessly and incompetently failed to inform the Minister for Health of any of the above information when it would have been reasonable to inform the Minister because on 22 March 2004 he advised him that there was 'insufficient evidence to take action against any individual' as at the time he had no comparative data or complication rates; (C) in addition to the above matters knowing that the completion rate at Bunderburg for a common surgical procedure was 28 times the national average, deliberately or carelessly and incompetently failed to take steps to suspend Dr Patel, or advise the Director-General, Dr Buckland that Dr Patel be suspended from surgical practice until further notice.
- (b) Each omission, or at least some of them, were for the purpose of limiting the publication of these matters to the general public.
 - (c) Dr FitzGerald's response to the complaints and concerns raised by Mr Peter Leck, in light of his investigations leading to his audit report, was inadequate in the following respects:
 - (i) Dr FitzGerald failed to take any steps to review, or have reviewed, Dr Patel's credentials or clinical privileges;
 - (ii) Dr FitzGerald failed to take any step to restrict Dr Patel's surgical practices through suspension, limitation of practice, or restriction of duties at the Hospital, whether temporarily or otherwise, when such action was reasonably appropriate and warranted;
 - (iii) Dr FitzGerald failed to provide a copy of his report to the Minister for Health instead of relying on the Director-General to do so.
 - (iv) Dr FitzGerald failed to provide a copy of his report to the District Manager until 7 April 2005, some 2 weeks after the matter had entered the public domain notwithstanding that Mr Leck commissioned him to perform the audit;
 - (v) In circumstances where Dr FitzGerald had doubts about Dr Patel's clinical judgement, he failed to clearly identify with Dr Patel and the Director of Medical Services, Dr Darren Keating, the scope of practice with which Dr Patel was to comply;
 - (vi) Dr FitzGerald failed to obtain a specific undertaking from Dr Patel with respect to paragraph (v) above.

I recommend that the Director-General give consideration to taking disciplinary action against Dr FitzGerald pursuant to s87(1)(a) of the *Public Service Act* 1996 on the basis that he may have performed his duties carelessly and incompetently.

Dr Keating

- 6.707 I have canvassed in Chapter Three the conduct of Dr Keating at Bundaberg.
- 6.708 Dr Keating's conduct, in my view, evinces an intention to shield affairs in his domain from any real scrutiny. There was a very steady stream of complaints about Dr Patel, containing very serious allegations and emanating from well qualified people. Those complaints were not well received and, in my view, the circumstances (which are set out in detail in Chapter Three) demonstrated more than a mere failure to comply with the Queensland Health policy on complaints handling. They demonstrated a propensity to downplay or 'fob off' any attempts to scrutinise Dr Patel's conduct.
- 6.709 Specific instances were these:
- (a) When Ms Hoffman raised concerns about oesophagectomies in June 2003, Dr Keating told her that she should raise the matter with Dr Patel herself and that, on Ms Hoffman's version (which I accept), Dr Patel was a very experienced surgeon who should not be lost to the hospital.
 - (b) When Mr Fleming complained to the Base about Dr Patel in October 2003, he testified (and I accept) that the conversation with Dr Keating began with the latter saying that Dr Patel was 'a fine surgeon and we are lucky to have him';
 - (c) When Dr Cook raised concerns about the same issue in July 2003, Dr Keating told him that they would be considered by the Credentialing and Privileging Committee, even though there was never such a committee for surgeons. Dr Keating did not return to Dr Cook after he discussed the matter with Dr Patel, nor otherwise seek the advice of an independent surgeon.
 - (d) Whereas Dr Smalberger gave cogent evidence (which I accept) that he sought to make a formal complaint about two issues concerning the care given to P51, namely Dr Patel's poor clinical decisions and his unprofessional conduct, Dr Keating did not document the matter, and treated the approach simply as a request for advice in dealing with Dr Patel.
 - (e) When the Renal Unit nurses approached Dr Keating through their line manager about the 100% peritoneal catheter complications, Dr Keating told line manager that if the nurses 'want to play with the big boys, bring it on'. When Dr Miach raised the same issue, Dr Keating maintained that

he did not receive the report until October 2004, which I do not accept. Even then, he took the view that the report was ambiguous, but did not return to Dr Miach and, instead, informed Mr Leck that the report was based on 'poor data'.

- (f) When Dr Keating received the Hoffman letter of 22 October 2004, he took no steps to confirm or deny the extraordinary allegation that the Director of Medicine at his hospital refused to allow his patients to be treated by the Director of Surgery, or to ensure that, at the very least, a chart audit was performed by an independent surgeon.
- (g) Indeed, even after three doctors had provided some corroboration of Ms Hoffman's concerns, Dr Keating continued to advise Mr Leck that the complaint was largely personality-based.
- (h) Dr Berens said that when he and Dr Carter raised concerns about the Kemps' oesophagectomy (against the background of the earlier complaints), Dr Keating showed little interest in investigating and that it was a matter for them whether they reported it to the Coroner, which evidence I also accept.
- (i) When Dr Rashford raised serious 'sentinel' concerns about the care of P26, Dr Keating completed a report immediately, and without speaking to the treating surgeon in Bundaberg, i.e. Dr Patel, or Brisbane. The only conclusion was that transfers should happen more promptly but even this view was not articulated in any formal policy.
- (j) There was a general trend in the evidence of Dr Keating failing to inform staff whether their complaints were being progressed.
- (k) Dr Keating's assessments of Dr Patel's performance to the Medical Board were glowing and knowingly exaggerated, even as late as February 2005.
- (l) Dr Patel was not credentialed even on an ad hoc basis, when that would have been a simple matter to arrange.
- (m) Dr Keating did not seek 'deemed specialist' status for Dr Patel with the Medical Board, even though that was the obvious way to ensure that he complied with Australian surgical standards.
- (n) When Dr FitzGerald visited the Base on 14 February 2005, and notwithstanding the serious concerns raised in Dr Keating's briefing note of early January 2005, Dr Keating did not volunteer any significant information about the perceived shortcomings of Dr Patel.

6.710 These events occurred in circumstances where Dr Patel was giving significant assistance to the Base in reaching its elective surgery targets, where there would be real difficulties in recruiting a new staff surgeon and where any

disruption of surgical services at the Base was likely to attract the kind of media attention to which Queensland Health was so averse.

- 6.711 When the matters are considered together, they lead to the view that there was a strong element of orchestrated incompetence, or wilful blindness, in Dr Keating's response to complaints about his Director of Surgery.
- 6.712 I find that Dr Keating deliberately diminished or downplayed complaints about Dr Patel. He declined to initiate inquiries into Dr Patel where, at the very least, serious concerns had been raised, and he promoted or acquiesced in a perception amongst staff that Dr Patel was 'protected' by management because he was valuable. I make no separate recommendations in that regard.

Mr Leck

- 6.713 Like Dr Keating, Mr Leck's conduct, in my view, evinces, if not a policy of calculated concealment, an attitude that discouraged any frank discussion of clinical issues within the Base.

The circumstances are discussed in Chapter Three, but I note the following in this regard:

- (a) Dr Baker gave evidence (which I accept) that when he resigned in November 2001, Mr Leck told him that the Director-General was not happy with the media embarrassment and that 'we don't want to see your career affected'.
- (b) Dr Jelffe gave evidence (which I accept) that, when he declined to provide anaesthetic services for certain surgery on the basis that his fatigue made it unsafe, he was asked to attend Mr Leck's office and the conversation commenced with what was clearly a veiled threat, namely Mr Leck asking Dr Jelffe to remind him of his visa status.
- (c) Mr Leck was provided with the peritoneal catheter audit in the first half of 2004 but took no steps to talk with Dr Miach.
- (d) When Ms Hoffman personally set out her serious concerns about Dr Patel to Mr Leck in March 2004 and then in October 2004, Mr Leck did not approach any independent surgeon for a review. He took no steps to disabuse staff of the perception, of which he was informed, that Dr Patel was protected, and he did not approach Dr Miach despite the extraordinary allegation that Dr Miach would not let his patients be operated upon by Dr Patel.
- (e) When an external investigation was instigated on 17 December 2004, Mr Leck is recorded as telling the Audit and Operational Review Branch that the District 'needed to be handled carefully as Dr Partell (sic) was of great benefit ...and they would hate to lose his services'.

- (f) Mr Leck emailed Dr Keating on 21 December 2004, immediately after learning of the Kemps' oesophagectomy, to ask if 'any of these patients have survived' what was, of course, elective surgery, but he did not follow up the email.
 - (g) Mr Leck's address to certain nurses on 23 March 2005 appears to have been calculated to give all those present a sense of fear as to what could happen if they raised issues outside Queensland Health. That is rather confirmed by his subsequent suggestion to the zone manager that 'perhaps we have the Audit team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages'.
 - (h) Mr Leck's letter to the Bundaberg News-Mail of 23 March 2005, saying that he 'had received no advice... that the allegations had been substantiated' and that there was a 'range of systems in place to monitor patient safety', at best created a false impression.
 - (i) Mr Leck was present at, and acquiesced in, the comments made by Mr Nuttall and Dr Buckland which, I am satisfied, were generally critical of the disclosure of information. This occurred in circumstances where Mr Leck should have appreciated the frustration of staff that they had been raising concerns for a long period and no serious attempt had been made to test them.
 - (j) When Mr Leck received an email on 13 January 2005 from one of the nursing staff saying simply 'Dear All, Treacherous Day', he asked the Director of Nursing to find out what was meant and continued, 'I assume it relates to Jay – so we need to quieten this down'.
 - (k) Mr Leck's email to the Zonal Manager on 7 April 2005 said 'perhaps we have the Audit Team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages'.
- 6.714 One needs to bear in mind that the Bundaberg Base Hospital was only 140 beds. It was a relatively small institution.
- 6.715 It beggars belief that Mr Leck could have no knowledge of the personal and professional concerns about Dr Patel, and the many complications that were arising, unless he took some steps to quarantine himself.
- 6.716 As with Dr Keating, I am satisfied that, against a background of elective surgery targets, a dearth of doctors wishing to work under the poorly resourced conditions at the Base, and Queensland Health's sensitivity to media exposure, Mr Leck discouraged criticism and complaint within the hospital generally and of Dr Patel in particular. I make no separate recommendations in that regard.

Conclusion with regard to concealment

- 6.717 Successive governments followed a practice of concealment and suppression of relevant information with respect to elective surgery waiting lists and measured quality reports. This, in turn, encouraged a similar practice by Queensland Health staff.
- 6.718 Queensland Health itself, by its principal officers Dr Buckland and Dr FitzGerald, implemented a policy of concealment and suppression of events, the exposure of which were potentially harmful to the reputation of Queensland Health and the government.
- 6.719 The conduct of officers of Queensland Health, together with its strict approach to surgical budget targets enforced by penalties, led to similar practices in hospitals, especially with respect to complaints about quality of service and it also led to threats of reprisal in some cases. These caused suppression of complaints which ought to have been exposed earlier.
- 6.720 In my view it is an irresistible conclusion that there is a history of a culture of concealment within and pertaining to Queensland Health.