A CRITICAL ANALYSIS OF OVERSEAS-TRAINED DOCTOR (“OTD”) FACTORS IN THE BUNDABERG BASE HOSPITAL SURGICAL INQUIRY

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Abstract
This article explores one of the most intriguing and hitherto largely unexplored aspects of healthcare quality and safety investigations in Australia: the role of a protagonist’s status as an overseas-trained doctor (“OTD”). The topic is controversial, not the least because of the growing importance of OTDs in maintaining basic health services in some areas of Australia, but also due to the difficulty of teasing genuine quality and safety problems in this context from possible racial or xenophobic concerns. As a case study, we will explore the problems associated with Dr Jayant Patel at the Bundaberg Base Hospital (“BBH”) in Queensland. The article concludes by making recommendations for improving healthcare quality and safety in this area.

Introduction: the Australian Public Health System’s Increasing Dependence on OTDs
This article explores one of the most intriguing and hitherto largely unexplored aspects of healthcare quality and safety investigations in Australia: the role of a protagonist’s status as an overseas-trained doctor (“OTD”). It commences with an exploration of some of the regulatory problems associated with the increasing use of OTDs to provide basic health
services in some areas of Australia. As a case study, the article explores the problems associated with surgeon Dr Jayant Patel at the Bundaberg Base Hospital (“BBH”) in Queensland. The article concludes by making recommendations for improving healthcare quality and safety in this area.

In the Australian context, an OTD is a doctor who obtained their primary medical qualification in a country other than Australia or New Zealand (Sullivan et al, 2002: p614). According to the Department of Health and Ageing, there were 2447 OTDs practising in Australia in April 2005 (Australian Government Department of Health and Ageing, 2005b: p27). This figure represented an increase of 21.6 per cent over the previous 12 months (Australian Government Department of Health and Ageing, 2005b: p27). In its submission to the Productivity Commission, the Australian Medical Association (“AMA”) claimed that in 1993 - 1994, 670 OTDs were granted visas (Australian Medical Association, 2005: p11). In 2003 - 2004, that number is alleged to have increased to 2249 (Australian Medical Association, 2005: p11).

The background of OTDs migrating to Australia has changed dramatically in recent years. In 1997, the majority were from the United Kingdom (“UK”) (70 per cent), which has a comparable health system to Australia’s, however by 2002-2003, this figure had fallen to 43 per cent (Australian Medical Association, 2005: p11). OTDs practising in Australia are sometimes disadvantaged through being educated, trained and having usually practised in cultural settings where disease patterns, levels of technology, treatment options, forms of health care delivery, workplace hierarchies and etiquette differ markedly from those in Australia (Sullivan et al, 2002: p618).

Australia’s extensive reliance on OTDs stems from “faulty planning” (Noble, 16 August 2005: p11). During the late 1980s and early 1990s, the prevailing policy view was that there was an oversupply of health professionals in Australia (Noble, 16 August 2005: p11). Various “remedial” steps were taken, such as capping the number of medical school places, restricting the number of doctors entering certain sectors of the medical profession and constraining the number of OTDs entering the Australian medical workforce (Noble, 16 August 2005: 11). Noble argues that the cutting of medical student places overlooked two critical issues. First, that Australians’ views of work were changing and that employees were opting for greater work-life balance. This meant that
doctors were choosing to work less. Secondly, Noble contends that the feminisation of the medical workforce (he reports that more than half of medical graduates are female) has meant that female medical professionals work significantly less hours than their male colleagues, primarily because of their child-rearing role. These factors contribute to the shortage of medical professionals.

Australia’s extensive utilisation of OTDs has been referred to as a “shorter term policy lever” and is said to avoid the “considerable time lag involved in educating and training a doctor in Australia” (Australian Government Department of Health and Ageing, 2005a: p4). However, retention of OTDs in rural and remote areas appears to be difficult. OTDs often seek to relocate to cities and metropolitan areas after completing their initial period of service in an area of need or a district of workforce shortage (Australian Government Department of Health and Ageing, 2005a: p4). Another difficulty is the increasing global competition to recruit health professionals. The AMA Position Statement on OTDs emphasises Australia’s global responsibility to ensure that it expands its own pool of Australian-trained doctors to ensure that it has an adequate medical workforce to meet the future health needs of the population (Australian Medical Association, 2004: p1).

The temporary emigration of health service providers like OTDs from their own countries (often developing countries) to Western countries like Australia also can cause so-called “brain drain” in developing countries (World Health Organisation, 2005). The World Health Organisation is concerned that the General Agreement on Trade in Services (“GATS”), which allows nations to “liberalise” trade in services, including health-related services, may exacerbate this problem (World Health Organisation, 2005).

**General Regulatory Problems with OTDs in Australia**

Australia’s OTD registration and training processes differ significantly to those of other developed countries with comparable health systems. In Canada, the United States and the United Kingdom, an OTD’s English language, medical knowledge and clinical skills must be proven before the OTD is allowed to practice (Birrell, 2004: p635). Canada and the United States also require OTDs to initially serve in a probationary hospital residency position (Birrell, 2004: p635).
The Medical Boards of the Australian States and Territories are responsible for the registration and regulation of all health workers, including OTDs (Wallace, 2001: p417). There is no national standard for the assessment and registration of OTDs in Australia and each Medical Board prescribes its own standards (Birrell, 2004: p635). The corollary of this is that the OTD registration processes are “fragmented, inconsistent and confusing” (Australian Medical Association, 2005: p11).

There is rarely any systematic evaluation of the medical knowledge and clinical skills of OTDs before they are permitted to practise, particularly in the case of temporary resident OTDs (Birrell, 2004: p639). In fact, until recently most Medical Boards did not require OTDs to pass an English language proficiency test (Birrell, 2004: p636).

In Australia, OTDs accredited by the Australian Medical Council (“AMC”) are considered to possess qualifications equivalent to those of Australian doctors (Medical Indemnity Industry Association of Australia, 2005: p9). However, the majority OTDs practicing in the Australia are temporary resident doctors and, unlike permanent resident OTDs with unconditional practising rights, do not require AMC accreditation (McGrath, 2004: p640).

Upon arriving in Australia, OTDs do not have to undergo mandatory orientation or training programs. However, some OTD orientation programs are in operation. Sullivan et al describe a four-week, voluntary program undertaken in New South Wales, which consisted of core group teaching and a hospital clinical attachment (Sullivan et al, 2002: p614). The curriculum included communication, health and workplace skills, culture shock sessions and the role of junior doctors (Sullivan et al, 2002: p614). The program is said to have enabled the OTDs to have a more equitable entry into the public hospital system, resulting in a more integrated, confident and functional workforce (Sullivan et al, 2002: p614).

The Australian Government’s Strengthening Medicare package addresses some of the aforementioned shortcomings and includes measures designed to enhance the opportunities for OTDs to practice in Australia. These include opportunities to extend stays or obtain permanent residency, listing medical practitioners on the skilled occupations list used for the General Skilled Migration Program (consequently medical practitioners no longer require a sponsor to migrate to Australia), improving the
identification, assessment and counselling of potential OTDs, support programs for OTDs in Australia and reducing red tape (Australian Government Department of Health and Ageing, 2005b: p27).

The majority of OTDs are allocated to positions in rural or remote locations, under Area of Need (“AON”) and District of Workforce Shortage (“DOWS”) schemes (Medical Indemnity Industry Association of Australia, 2005: p9). An AON is a geographic area that has a lack of medical practitioners (Australian Government Department of Health and Ageing, 2005c: p3). Similarly, a DOWS is a geographic area in which the general population’s need for health care is not met (Australian Government Department of Health and Ageing, 2005c: p3). In such (often remote and culturally isolated) locations, the support structures, supervision and training available to doctors practising in major cities and metropolitan areas are often lacking (Australian Government Department of Health and Ageing, 2005b: p28). These categories of registration are not subject to the same, stringent requirements that apply to Australian-trained doctors (Forster, 2005: p1).

For most OTDS, AON certification is a condition of obtaining medical registration (Australian Government Department of Health and Ageing, 2005c: p3). AON requirements apply to both public and private sector positions (Australian Government Department of Health and Ageing, 2005c: p3). Furthermore, the Australian Government requires OTDs who wish to access the Medicare Benefits System to be registered with a State or Territory Medical Board and to practise in a DOWS (Australian Government Department of Health and Ageing, 2005c: p3). This practising restriction usually applies to OTDs who gain permanent residency for a minimum of 10 years, and it applies to temporary resident OTDs indefinitely (Australian Government Department of Health and Ageing, 2005c: p3).

Finally, clinical governance structures are more likely to be “top down” and focused on policy making and setting performance targets (Forster, 2005: p171) for OTDs than for Australian-trained doctors. Due to their disparate and often non-Western medical training and experience, some OTDs practising in Australia may not have previously been exposed to comparable clinical governance mechanisms.
A Case Study: OTD Aspects of the Patel Case

1) Background: A Failure of Clinical Governance

Dr Patel was born and educated in India and he later trained and practised in the United States (Morris, 2005: p3). It was, however, because of Dr Patel having received his initial medical qualifications in India that he was classed as an OTD by Australian health authorities.

It is now well known that Toni Hoffman, Nurse In Charge of the Intensive Care Unit at the Bundaberg Base Hospital (“BBH”), “blew the whistle” on Dr Patel. Before this, Dr Patel had practised as Director of Surgery at the BBH for two years, commencing in April 2003 (Morris, 2005: p3). Ms Hoffman maintained that during Dr Patel’s time at the BBH, she raised concerns about his practice and competence with at least twelve parties, including hospital staff, administration and management, Queensland Health administrators, the coroner and police, without result (ABC Television, 2005). Ms Hoffman has revealed that she and other BBH staff were so concerned about Dr Patel’s apparent incompetence that they hid patients from him (Watt, 2 August 2005: p1).

Ms Hoffman became frustrated by the inaction and apparent unwillingness to investigate Dr Patel and resorted to informing a Queensland Member of Parliament (“MP”) of her concerns (ABC Television, 2005). In March 2005, the MP used parliamentary privilege to announce that a number of patients at the BBH had suffered serious complications after being treated by Dr Patel (ABC Television, 2005). The MP’s actions were heavily criticised by BBH management, the AMA and the Queensland Government (ABC Television, 2005). Ms Hoffman also came under attack for her whistleblowing activities.

After the allegations against Dr Patel became public, a journalist from The Courier-Mail discovered, by entering Dr Patel’s name in the Internet search engine Google, that he had previously been involved in several disciplinary actions in the United States (ABC Television, 2005). He discovered that Dr Patel had been placed on probation for three years in 1984 for professional misconduct whilst practising in New York State (Anon., 2005). In 2000, the Oregon Board of Medical Examiners had restricted the scope of Dr Patel’s surgical practice (Anon., 2005) and in 2001, Dr Patel agreed to surrender his New York medical practising licence and was struck off (Morris, 2005: p9).
Following Ms Hoffman’s whistleblowing, the Bundaberg Hospital Commission of Inquiry (The Morris Inquiry) was launched in April 2005, under the guidance of Commissioner Anthony Morris QC. At the same time, and in response to public disquiet about the quality and safety of Queensland public hospital services, the Queensland Government instigated an independent review of Queensland Health’s administrative, workforce and performance management systems (The Forster Review).

The Morris Inquiry’s Interim Report called for Dr Patel to be charged with false representation, fraud, negligence, murder and manslaughter. Yet, after hearing evidence for 50 days, the inquiry was shut down in September 2005 by a Queensland Supreme Court. Justice Moynihan made findings of ostensible bias against the commissioner and his deputies in respect of two key witnesses (Ludlow, 2 September 2005: p3). The Morris Inquiry was not permitted to continue because the court believed that the evidence tainted by bias could not be disentangled from the whole body of evidence (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243). Soon after the shutting down of the Morris Inquiry, Mr Morris used parliamentary privilege to deliver a damning final report and 23 recommendations to the Commonwealth House of Representatives Standing Committee on Health and Ageing (Parnell and Hart, 9 September 2005: p5).

Premier Beattie did not appeal the court’s finding, but eventually bowed to public pressure and appointed the Hon. Geoffrey Davies AO to complete the work commenced by the Morris Inquiry (Odgers and Watt, 7 September 2005: p1). Dr Patel declined Commissioner Davies’ invitation to defend himself by either appearing before the inquiry or filing a written submission (Parnell, 6 October 2005: p3). The Davies Inquiry’s final report, findings and recommendations were released late in 2005. Commissioner Davies has recommended that Dr Patel, who has been linked to at least 13 patient deaths and the harm of at least 31 others during his time at the BBH, be charged with various offences under the Queensland Criminal Code: fraud, attempts to procure unauthorised status, assault, assault occasioning bodily harm, grievous bodily harm, negligent acts causing harm and manslaughter (Davies, 2005: p191).

Commissioner Davies also recommended that the Medical Board of Queensland investigate Dr Patel’s conduct in holding himself out as a general surgeon (Davies, 2005: p191). The Medical Board has since changed Dr Patel with unsatisfactory professional
conduct and will argue before the Health Practitioners Tribunal that he fact the maximum 
penalty: deregistration and a $100 000 fine (Parnell, 13 December 2005: p3). Dr Patel is 
not required to appear before the tribunal; it can make findings in his absence. If Dr Patel 
is found guilty, it is likely that the Medical Board will seek to notify medical authorities 
worldwide of his deregistration in Queensland (Parnell, 13 December 2005: p3).

In obtaining his registration in Queensland, Dr Patel did not disclose prior 
incidents reflecting incompetence, even though the application documentation 
specifically sought such information (Morris, 2005: p8). Dr Patel submitted a verification 
of licensure certificate issued by the Oregon Board of Medical Examiners with his 
application to the Queensland Medical Board, however he omitted to attach a document 
that detailed the restrictions that had been placed on his practising license (Morris, 2005: 
p8). The Queensland authorities failed to uncover Dr Patel’s suspect practising history 
and did not detect the absence of the attachment.

It is possible that Dr Patel’s tainted registration history was not discovered by the 
Queensland Medical Board’s registration processes because they were lax per se, or 
because the Board was intentionally less-thorough in order to fast-track his AON 
appointment. However, it is also possible that the Board, upon seeing Dr Patel’s training 
and practising experience in the United States, presumed he was competent. It is arguable 
that Dr Patel’s application for registration would have been assessed differently had he 
not trained and practised in the United States. Furthermore, had Dr Patel’s significant 
disciplinary history been exposed “it would probably have prevented his practising as a 
surgeon in Queensland, and most certainly would have prevented his being appointed as 
Director of Surgery at BBH and practising largely without supervision or restriction” 
(Morris, 2005: p7). Dr Patel’s appointment was contingent on him being supervised by 
the Hospital’s Director of Surgery. Instead, Dr Patel himself was immediately appointed 
to that position (Morris, 2005: p14).

2) Specific OTD Regulatory Factors in the Patel Case

Dr Patel was appointed to the BBH on the basis that the Hospital was located in 
an AON, as defined under the Medical Practitioners Registration Act 2001 (Qld) (Morris, 
2005: p5). In his Submission to the Standing Committee on Health and Ageing, Mr 
Morris was highly critical of Bundaberg’s AON classification (Morris, 2005: p6). He
identified various shortcomings in the AON classification process.

Morris alleged that Queensland Health blindly accepted all applications from public hospitals for AON positions and did not assess the clinical competence of AON position applicants and did not undertake any ongoing monitoring or assessment of special purpose registrants like Dr Patel (Morris, 2005: p6). The Morris Inquiry received evidence that an Australian-qualified surgeon had previously applied for Dr Patel’s position, but was not offered the position when the selection panel’s preferred candidate declined the offer of employment (Morris, 2005: p6). Morris noted that even though several Australian-qualified surgeons were practising privately in Bundaberg, no attempts were made to establish whether they were prepared to provide surgical services at the BBH as visiting medical officers (“VMOs”) (Morris, 2005: p6).

Mr Morris’ comments suggest that proper processes were not employed in relation to determining Bundaberg an AON. This conclusion is most important, as AON status was a necessary precondition to the appointment of an OTD, and thus of Dr Patel, to the Hospital.

It should be said, however, that Dr Patel’s position at the Hospital, seems to be the exception, rather than the norm. Most OTDs are deployed to General Practitioner positions, or junior doctor positions, in remote practices and hospitals. Even though Dr Patel was registered on the basis he be employed as a Staff Medical Officer (“SMO”) under the supervision of the Director of Surgery, he was immediately appointed to the commanding and unsupervised position of Director of Surgery (Morris, 2005: p14). Dr Patel had not applied for the position, did not hold specialist registration as a surgeon and his appointment was clearly inconsistent with the terms of his registration.

It is unclear whether the Director of Surgery position was an AON position. In any event, it appears from the facts that no earnest effort was made to fill the position using formal channels. It seems inappropriate, and perhaps bordering on negligent, to have appointed a doctor whose qualifications had not been verified and who would be practising unsupervised, to such an important position within the hospital. In this regard, Dr Patel’s OTD status, notably his respected surgical training and supposedly unblemished practising experience in the United States, arguably facilitated his appointment to such a senior position without the occurrence of appropriate, preliminary
The particular registration processes applied to Dr Patel, and his subsequent appointment to the BBH, were significantly affected, if not determined, by Dr Patel’s OTD status. Although Dr Patel’s personal dishonesty facilitated his registration in part, the fact that Dr Patel was overseas-trained resulted in his registration being special purpose and arguably led to his qualifications being less-stringently assessed than they otherwise may have been in order to fast-track his deployment to Bundaberg. Further, it is possible that Dr Patel’s training and practising experience in the United States contributed to the lax approach adopted in relation to his registration, and also to his informal and seemingly inappropriate appointment to the unsupervised position of Director of Surgery at the BBH. The following section examines whether Dr Patel’s OTD status had any impact on the failure of traditional quality assurance mechanisms to identify his incompetence and frequent adverse clinical outcomes.

3) General Impact of Patel’s OTD Status on Clinical Governance Mechanisms

Clinical governance is a framework through which health services are “accountable for continuously improving the quality of services and safeguarding standardised care by creating an environment in which excellence in clinical care can flourish” (Irvine, 2004: p28). Most health care organisations in developed countries like Australia have an array of clinical governance systems, including incident reporting and analysis, clinical audit, mortality and morbidity review, credentialing and clinical privileging. Additionally, all Australian jurisdictions have processes for the inspection, registration and accreditation of healthcare institutions and healthcare consumer complaints mechanisms (Kerridge et al, 2005: p129).

One of the most perturbing aspects of the Dr Patel case is that none of the numerous incidents of compromised patient care and poor clinical outcomes at the BBH was detected by the hospital’s internal clinical governance systems. The Forster Review notes that the Hospital’s systems of clinical governance to manage a range of clinical risks were “either not in place or were not working effectively” (Forster, 2005: p169). Furthermore, the events at the hospital were not exposed by external quality control mechanisms, such as the Australian Incident Monitoring System (“AIMS”) or hospital accreditation processes. The lack of external detection is not unusual; most of the high-
profile Australian health system failures have occurred at fully-accredited facilities. The failure of both internal and external quality assurance mechanisms at the BBH has led to a questioning of whether “the Australian medical system is competent to carry out even the most basic monitoring, reporting and management of medical errors” (Price, 10 September 2005: p63).

4) OTD Status and Whistleblowing in the Patel Case

Whistleblowing has become one of the most successful quality and safety features of contemporary Australian healthcare (Faunce, 2004: p44). Despite this, the BBH responded negatively to nurse Toni Hoffman’s whistleblowing about Dr Patel’s poor surgical performance. A likely explanation for this is that the administrators may have sensed that it arose from possible racial or xenophobic motives related to Patel’s OTD status. The current President of the AMA, himself an OTD, is greatly disturbed by the “medical racism” towards OTDs practising in Australia and its seeming exacerbation by the Patel case (Haikerwal, 2005). He claims that “[b]ecause of the Patel case, doctors with funny names, accents, coloured skin and different backgrounds are getting a hard time. They are under scrutiny for getting a medical degree from overseas… Overseas-trained doctors do not practise inferior medicine. Nor are they less committed to patient care… But we still have to fix the checks and balances so we do not have another Doctor Death situation in Australia” (Haikerwal, 2005).

Medical racism is particularly concerning given the extent of Australia’s current dependence on OTDs to supplement the Australian medical workforce. The Department of Health and Ageing believes that the future recruitment of OTDs to Australia is contingent upon Australia “remaining an attractive destination for health professionals from other countries, and on their acceptance by the Australian community” (Australian Government Department of Health and Ageing, August 2005b: p29).

Such criticisms appear to have been ameliorated here, however, because Dr Patel was well known to be a “money spinner” for the BBH (Morris, 2005: p12). His teaching for the University of Queensland resulted in direct financial rewards for the BBH (Morris, 2005, p12). Furthermore, he was a highly active surgeon, which boosted BBH’s statistical results and entitled the Hospital to extra funding from Queensland Health (Morris, 2005: p12). The Hospital’s additional entitlements were contingent on the
quantity and complexity of the surgery undertaken by Dr Patel, regardless of the clinical outcomes of the surgery (Morris, 2005: p12).

5) OTD Status in the Morris and Davies Inquiries and the Forster Review

The hypothesis explored here is that Patel’s OTD status may have been a factor in the any bias exhibited towards him by these inquiries. Under the Commissions of Inquiry Act 1950 (Qld), the Morris Inquiry was not bound by the procedural or evidential rules or practice of any court or tribunal (Commissions of Inquiry Act 1950 (Qld) s 17). The inquiry was free to conduct its proceedings and inform itself as it sought fit (Commissions of Inquiry Act 1950 (Qld) s 17), however its activities were subject to natural justice rules, including procedural fairness requirements (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 33).

In July 2005, the BBH’s Director of Medical Services (Dr Keating) and the District Manager (Mr Leck) claimed that Mr Morris and his deputies should be disqualified from further proceeding with the inquiry, or alternatively from making findings or recommendations in respect of Dr Keating and Mr Leck, on the common law ground of apprehended bias (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 18). Their claim was based on “the combined weight of the circumstances in which they were called to give evidence [short notice], the nature of their examination by the commissioner, the way in which they were treated by comparison to other witnesses [differential treatment] and other factors” (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 49).

Justice Moynihan of the Supreme Court of Queensland held that the circumstances gave rise to a reasonable apprehension of a lack of impartiality on the commissioner’s part. Both witnesses had been subjected to aggressive, hostile, sarcastic, belittling, accusatory and unfair behaviour by Mr Morris (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 89). Mr Morris’ approach has subsequently been likened to “counsel assisting the inquiry rather than the Chair of the inquiry” (ABC Radio National, 2005). Mr Morris’ “effusive endorsement” of the untested evidence of Ms Hoffman and others early in the proceedings also concerned Justice Moynihan (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 99).
Justice Moynihan does not refer to Dr Patel’s OTD status in his judgment. This suggests that his decision was not influenced by Dr Patel being an OTD and that Mr Morris’ bias was therefore not attributable to Patel’s OTD status. Justice Moynihan’s decision is instead founded on procedural fairness considerations, particularly the impartiality of decision-makers and the need for the strict enforcement of procedural fairness rules given the intense public and media interest in the Morris Inquiry (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 161).

Although Justice Moynihan does not link Mr Morris’ bias to Dr Patel being an OTD, he does conclude that Mr Morris displayed “a pervasive disdain for or contempt towards “bureaucrats” and doctors who administer but do not treat patients” (Keating v Morris & Ors [2005] QSC 243; Leck v Morris & Ors [2005] QSC 243, para 90). Mr Morris’ firm views towards “bureaucrats” are overtly expressed throughout his Submission to the Standing Committee. His contempt of Dr Patel is also apparent, however this appears to be directed towards Dr Patel’s dishonesty, clinical incompetence, self-importance and lack of self-restraint, rather than his OTD status. Whilst this may be indicative of Mr Morris’ dislike of Dr Patel, it arguably does not point to him being prejudiced towards OTDs.

Mr Morris has been widely discredited following the bias finding made against him and his controversial Submission to the Standing Committee. There is concern that the bias finding and the general controversy surrounding the Patel case may jeopardise both the Davies Inquiry and the possible extradition and criminal prosecution of Dr Patel.

In spite of Justice Moynihan’s finding that the tainted evidence received by the Morris Inquiry could not be disentangled from the whole body of evidence, Commissioner Davies admitted all of the evidence previously admitted in the Morris Inquiry, with the exception of the evidence of Mr Peter Leck and Dr Darren Keating (http://www.qphci.qld.gov.au at 15 October 2005). In Mr Davies’ opinion, the Morris Inquiry was contaminated by Mr Morris’ own actions and dialogue, rather than by the evidence obtained during the course of the failed inquiry (Odgers and Watt, 7 September 2005: p1). Dr Patel’s lawyers allege that the evidence relied upon in the Davies Inquiry is contaminated by Commissioner Morris’ bias and that the Davies Inquiry is “drinking from the same polluted waters” (McKenna and Hart, 8 October 2005: p9). It appears that
the bias finding may undermine the credibility and force of the Davies Inquiry’s findings and recommendations.

The Patel case also gives rise to the hypothesis that OTD status can jeopardise the ability of Australian authorities to hold OTDs accountable for their actions. When the Patel case broke, Dr Patel immediately fled to America. There are now grave fears that any extradition attempts made by Australian authorities’ will be unsuccessful.

This concern is premised on Dr Patel’s lawyers arguing that any charges that may be laid against him are politicized (Parnell and Hart, 6 September 2005: p7). The extradition treaty between Australia and the United States precludes extradition in relation to offences of a political character (Parnell and Hart, 6 September 2005: p7). It is believed that this prohibition extends to offences, such as those alleged against Dr Patel, which have become politicised by circumstance (Parnell and Hart, 6 September 2005, p7). In this regard, it is incontestable that there has been intense political and media hype in Australia surrounding the Dr Death scandal. The perceived political importance of the case is evidenced by the Queensland Labor Party’s attribution of its August 2005 double by-election loss of former safe seats to the Dr Death fiasco (Fels and Brenchley, 20 September 2005: p62). Dr Patel’s lawyers assert that “[t]he scandalous handling of this entire affair has made it impossible for Dr Patel to ever be fairly tried in Australia were charges to be laid” (Bonner, 2005).

On the one hand, it is arguable that Dr Patel’s OTD status and training in America facilitated his initial flight from Australia and that an Australian doctor would not have been able to escape prosecution by fleeing overseas. Alternatively, however, it can be argued that the accountability issues in the Patel case have arisen merely because of the particular circumstances of the case, rather than as a direct result of Dr Patel’s OTD status. For instance, the bias finding against Anthony Morris and the subsequent allegation of contamination of the Davies Inquiry’s evidence has provided Dr Patel’s lawyers with an additional avenue of argument to support their assertion that he should not be extradited. Similarly, it is possible that the foreseeable extradition difficulties have arisen because Dr Patel fled to America. The Australian-American extradition treaty happens to contain a prohibition of extradition on political grounds. Furthermore, America is renowned for its strong stance on due process and individual rights issues,
particularly in regards to the rights of those accused of crime, and it is highly likely that Dr Patel’s lawyers will draw on such concepts.

**Regulatory Reforms and OTD Status**

To address workforce shortages that have lead to reliance on OTDs in some sectors, the Australian Government has introduced initiatives to increase the number of Australian-trained doctors, such as expanding medical training places (Birrell, 2004: p635) and increasing the number of bonded medical places (Van Der Weyden and Chew, 2004: p633). However, these policies are not expected to be beneficial for another eight to ten years and will be still be hindered by demographic trends, such as parents choosing to work part-time. This has led some experts to call for more radical responses to workforce shortages, such as the use of independent nurse practitioners.

Given the likely continued importance of OTDs to the Australian medical workforce, a national, coordinated system of OTD recruitment, assessment, registration, orientation, training and monitoring should be established. This suggestion is backed by a number of prominent medical organisations, include the AMA and the Medical Indemnity Industry Association of Australia (“MIIAA”). Some commentators also call for the establishment of a national OTD body to oversee this process (McGrath, 2004: p642).

In recent times, some Australian jurisdictions, such as the Australian Capital Territory and New South Wales, have enacted or are considering enacting, legal mandatory reporting obligations. These are intended to increase the instances of reporting by medical professionals and thereby assist to either prevent, or detect at an early stage, incidents of compromised care such as those involving Dr Patel. Under the *Health Professionals Act* 2004 (ACT), each health professional registered in the ACT is under a legal obligation to report the suspected contravention, by another health professional, of a required standard of practice or a suitability to practice requirement (*Health Professionals Regulation* 2004 (ACT) s 145). The New South Wales *Health Services Act* 1997 (NSW) requires the chief executive officer of a public health organisation to report to a registration authority any conduct that they suspect on reasonable grounds may constitute professional misconduct or unsatisfactory professional conduct.
Following the Patel scandal, some Australian Medical Boards have made their approval and credential checking procedures for OTDs more stringent. In New South Wales and Queensland, OTDs must now provide the Medical Board of those States with statements of good standing for each country in which they have practiced (Sommerfield, 13 January 2006: p2 and Pollard, 17 August 2005: p3). Copies of the statements are not permitted; they must be provided directly to the boards by the overseas regulatory authorities (Sommerfield, 13 January 2006: p2). Australian Medical Boards have also acknowledged the need to work towards a nationally consistent approach to OTDs (Australian Department of Health and Ageing, 2005b: p28). Some progress has been made in this regard, notably the introduction of a standardised national English language requirement (Australian Government Department of Health and Ageing, 2005b: p28).

Australian legislation prescribes that a doctor must possess indemnity insurance in order to gain registration. Following the revelation of the Patel case, there were claims that the scandal would gravely affect the availability of medical indemnity insurance for OTDs. The MIIAA has maintained that Australia’s universal coverage provisions provide easy access to indemnity insurance for all registered doctors, whether Australian-trained or overseas-trained (Medical Indemnity Industry Association of Australia, 2005: p8).

Whilst members of the MIIAA are prepared to indemnify OTDs, a condition of indemnity is that each doctor’s alleged qualifications have been thoroughly verified by the relevant Medical Board (Medical Indemnity Industry Association of Australia, 2005: p8). The MIIAA is concerned that without verification, patients and insurers risk exposure to doctors who do not meet the expected levels of quality and safety (Medical Indemnity Industry Association of Australia, 2005: p8). Medical indemnity insurers have risk management tools at their disposal, such as premium loadings, practise restrictions and supervisory and training requirements, which could be applied to OTDs whose skill levels are unverified and thus uncertain (Medical Indemnity Industry Association of Australia, 2005: p9).

The use of personal digital assistants ("PDAs"), which has already been introduced in some Australian hospitals with promising results, has the prima facie potential to increase the rate of reporting and thereby improve health care quality and safety in Australia (Bolsin, Faunce and Colson, 2005: p303). PDAs enable even small
deviations in performance to be revealed at an early stage, which permits timely intervention to prevent negative outcomes (Bent et al, 2002: p496). PDAs also reveal patterns of error or poor performance. A threshold issue, however, is that PDA technology is yet to be widely adopted in rural and remote areas, where most OTDs practise. Another foreseeable problem of PDA use by OTDs is that these doctors may not be familiar with such technology. Whilst this difficulty is not necessarily OTD-specific, it is arguably exacerbated by OTDs’ lack of training and professional-development opportunities in Australia.

Australian clinical governance structures should now fully acknowledge OTD-specific regulatory problems, including monitoring and assessment of, and potential institutional legal liability for, minimum level of competence (Robertson v Nottingham Health Authority [1997] 8 Med LR 1) (McGrath, 2004: p641).

Conclusion
We conclude Dr Patel’s OTD status appears to have directly affected his registration and appointment processes. Whilst it arguably did not influence Ms Hoffman’s decision to “blow the whistle” on Dr Patel, clinical governance structures in operation at the BBH did not acknowledge, or provide for, OTD status and the particular regulatory challenges it gives rise to. This arguably contributed to the lack of detection of Dr Patel’s poor practise through formal, clinical governance pathways.

OTD status seems to have affected the institutional response to Ms Hoffman’s whistleblowing. Examination of Justice Moynihan’s judgment revealed that OTD status was not the basis of Commissioner Morris’ bias. However, Dr Patel’s OTD status, in combination with the particular circumstances of the case, has significantly diminished the chances of securing his extradition and accountability.

The Patel case highlights that healthcare policy makers and regulators need to be aware of the distinct quality and safety problems raised by OTD status. Just as the major failure in paediatric cardiac surgery at the Bristol Royal Infirmary was “a powerful political lever for change” in the United Kingdom (Walshe and Shortell, 2004: p103), the events at Bundaberg must be the catalyst for long-overdue reform to the way that OTDs are dealt with in the Australian healthcare system.
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