

## Chapter Three – The Bundaberg Base Hospital

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*‘...any healthy organisation has to welcome criticism because that is the means by which the organism changes and... grows. If you stifle criticism, you are asking for trouble.’*

Dr Brian Thiele, Bundaberg

### The history of the Hospital

- 3.1 Bundaberg is a town of approximately 46,000 people,<sup>176</sup> lying 385 kilometres north of Brisbane. The town has been involved, traditionally, with industries which support the surrounding cane and small crop farms but, in recent times, it has become home to a growing but increasingly ageing population.<sup>177</sup>
- 3.2 There are three hospitals in Bundaberg, namely the Friendly Society Private Hospital (‘the Friendlies’), the Mater Misericordiae (‘the Mater’), and the Bundaberg Base (‘the Base’). The Friendlies and the Mater are both private hospitals whilst the Base is, of course, a public facility run by Queensland Health.<sup>178</sup> There are other public hospitals located in the area, being at Gin Gin and Childers, but whereas those hospitals have 18 beds each, the Base has 136 beds<sup>179</sup> and is the primary referral centre. It has a staff of approximately 850 (including 65 medical practitioners) and an annual budget in the order of \$56 million.<sup>180</sup>
- 3.3 The Base was established in 1900.<sup>181</sup> It services the northern part of the Wide Bay region as well as the Central and North Burnett Regions. The catchment area includes the coastal towns from Burnett Heads to Woodgate, as well as Gin Gin, Childers and Mount Perry. In all, the Base services a population of about

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<sup>176</sup> See the Bundaberg City Council website at [www.bundaberg.qld.gov.au](http://www.bundaberg.qld.gov.au)

<sup>177</sup> See the Resident Orientation Handbook for Bundaberg Base Hospital at <http://www.matereducation.com.au/ssl/1/bundaberg.pdf>

<sup>178</sup> The Base falls within Queensland Health’s ‘Central Zone’ which stretches from inner city Brisbane (on the northside of the River) in a northerly direction beyond Bundaberg, and west to the State’s border.

<sup>179</sup> Exhibit 230, page 2: Clinical Audit of General Surgical Services, Bundaberg Base

<sup>180</sup> Exhibit 448, para 15

<sup>181</sup> The Bundaberg General Hospital, as it was previously known, is discussed in a 1928 Inquiry: see Exhibit 158: [Report - Royal Commission into the Medical Emergency at Bundaberg - dated 11/06/1928 by Commissioners Charles Kellaway, Pete MacCallum and A H Tebbutt](#)

85,000.<sup>182</sup> Some measure of the community's heavy reliance on the facility will be gleaned from the fact that, in the financial year ended 30 June 2005, the Base has received 18,000 admissions, 24,500 people attending the outpatients' clinic, and 28,500 people attending at the Department of Emergency.

## 1994 – 1999: Poor budget and politicisation erode the quality of service

- 3.4 From 1994 to 1999, the Director of Medical Services at the Base was a vascular surgeon called Brian Thiele.<sup>183</sup> Dr Thiele and his wife grew up in Bundaberg but he trained in Victoria and then worked as a surgeon in the USA for 18 years (where he distinguished himself within his profession.)<sup>184</sup> In 1994, as he approached retirement, he determined to leave his position as head surgeon at Pennsylvania State University Hospital and return to Bundaberg. By a happy coincidence, the position of Director of Medical Services at the Base was being advertised, and he secured it, starting at Bundaberg in June 1994.
- 3.5 The evidence made clear that Dr Thiele was a very 'hands on' leader. He would make a round of some part of the Base every Friday in the company of the Director of Nursing; he ran a clinic in the Base's outpatient's department,<sup>185</sup> and he conducted surgery from time to time,<sup>186</sup> spending about 20-30% of his time on clinical issues, and the balance in administration.<sup>187</sup> Dr Thiele explained that, in his view, one could not be sure that a hospital was running well unless 'you go around and have a look and you participate'.<sup>188</sup> He maintained an 'open door' policy but he emphasised the importance of moving amongst the staff and engaging them directly.<sup>189</sup> He testified that this was a relatively easy task at the Base because the hospital was small enough that 'you can wrap your arms around it'.<sup>190</sup>
- 3.6 Dr Thiele testified that, when he first arrived, he found the hospital staff had a low morale (so that there was 'a reluctance of staff to make eye contact ... and bid you the time of day',<sup>191</sup>) but he was convinced this was an environmental issue. He and his wife worked hard to overcome that problem. They introduced monthly

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<sup>182</sup> see the Queensland Health information at [www.health.qld.gov.au/medical/facilities/BUNDABERG](http://www.health.qld.gov.au/medical/facilities/BUNDABERG); Exhibit 230, page 2: Clinical Audit of General Surgical Services, Bundaberg Base

<sup>183</sup> See the evidence from T1818 and Exhibit 118

<sup>184</sup> See the Statement and CV for Dr Thiele, being Exhibit 118

<sup>185</sup> T1823, line 30

<sup>186</sup> T1821, line 10

<sup>187</sup> T1821, line 15

<sup>188</sup> T1821, line 40; T1862, line 50

<sup>189</sup> Exhibit 118, para 15; T1862, line 52

<sup>190</sup> Exhibit 118, para 19, T1862, line 50, T1847, line 30

<sup>191</sup> T1820, line 20

staff barbecues, an annual fete, resident dinners, a Christmas pageant and an annual staff concert, and they revived an auxiliary organisation.<sup>192</sup> Dr Thiele told, moreover, how he developed close ties to the local community<sup>193</sup> and liaised with Bundaberg business leaders about providing funding for the Base.<sup>194</sup>

- 3.7 During most of Dr Thiele's term,<sup>195</sup> the District Manager was a man called Bruce Marshall,<sup>196</sup> the Director of Medicine was a physician called Martin Strahan, and the Director of Surgery was a surgeon called Pitre Anderson.<sup>197</sup> The evidence suggests that the four men worked well together<sup>198</sup> and that the leadership at the Base maintained a constant physical presence in the wards.<sup>199</sup> It seems that, although there were problems with lack of resources from time to time, the hospital staff worked to overcome them and the District Manager and the Director of Medical Services enjoyed the support of the staff.<sup>200</sup>
- 3.8 Dr Thiele and, I infer, other leaders within the Base, had strong views about the importance of teaching to clinical standards. During the 1994 -1999 period of his administration, Dr Thiele said, the Base introduced regular weekly clinical meetings for staff, visits from Brisbane specialists, teaching ward rounds, and regular educational presentations.<sup>201</sup> He said he also introduced an ethics committee to which staff could bring concerns with an ethical dimension.<sup>202</sup> Dr Thiele explained that he was keen to create an environment which attracted quality residents on the basis that they could be assured that their educational experience would be broadened at the hospital.<sup>203</sup> He considered there was some affirmation of his strategy in the fact that half of the residents at the hospital were Australian-trained, and that overseas trained doctors were reporting favourably to their compatriots about the benefits of the Base.<sup>204</sup>
- 3.9 Dr Thiele gave evidence that the surgical department, in particular, became highly effective during his administration. He noted that the College of Surgeons awarded the Base training institution accreditation in this department and that, in consequence, the Base was able to attract registrars from Brisbane tertiary hospitals.

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<sup>192</sup> T1820

<sup>193</sup> See Dr Strahan's evidence at T3257, which I accept

<sup>194</sup> T1833-4

<sup>195</sup> Although Dr Thiele's term as Director of Medical Services finished in March 1999, he worked as a VMO at the Base until January 2004; T1853-4

<sup>196</sup> T3259

<sup>197</sup> Exhibit 118, para 9

<sup>198</sup> See T3252-3, and the evidence of Drs Strahan, Thiele, Nankivell and Anderson generally

<sup>199</sup> T3259; Exhibit 118, para 15

<sup>200</sup> T3260; T2937, line 35; T2938, line 5

<sup>201</sup> T1823, Exhibit 118, para 8

<sup>202</sup> T1836, line 10

<sup>203</sup> T1823

<sup>204</sup> T1823-4

- 3.10 I should interpolate here that many specialists<sup>205</sup> who appeared before the Commission, including Dr Thiele,<sup>206</sup> emphasised the importance of registrars being available to a hospital. Apart from the obvious long term benefit in producing specialists, there is an immediate advantage in that these trainees can be expected to function at a higher level of competence than residents. In their chosen areas, they are able to give relatively sophisticated clinical care, to provide a triaging role (so that the specialist's time is not engaged unnecessarily) and to provide something of an auditing role in relation to the competence of the teacher.<sup>207</sup> It seems that, where this middle layer of medical talent is absent, there is an increasing burden placed on the residents, the specialists, or both.<sup>208</sup>
- 3.11 Dr Thiele testified that he gradually became frustrated with a culture and a system within Queensland Health where 'an inordinate amount of energy' was required to make things happen.<sup>209</sup> He said he could see that 'the goodwill, which was the oil in the cogs of the Queensland Health system, was drying up, and ...was concerned that, as that happened, it would become increasingly difficult to be able to get people to work in the public system, and difficult to do things'.<sup>210</sup> His frustration led, in March 1999, to his resigning as the Director of Medical Services at the Base and taking up a role there as a Visiting Medical Officer two days per week until 2003. In that year, he terminated his involvement with the Base almost completely<sup>211</sup> because, he testified, there was needless inefficiency in the surgical scheduling and because, with the loss of registrars<sup>212</sup> and the decline in standards, he could not be comfortable that his patients would receive good care.<sup>213</sup>
- 3.12 There were a number of systemic problems to which Dr Thiele alluded. One of his primary concerns involved the issue of budgets. When he had first arrived, the regionalisation structure was still in place. At that time, a very detailed study had been carried out in relation to the current clinical services offered to the population and the likely need in the future. Dr Thiele considered the plan to be 'very enlightened' and viewed it as an impressive attempt to improve services.<sup>214</sup> Contemporaneously, there was a 'fairly rapid' expansion of services at the Base. The problem which emerged was that Queensland Health did not appear to allocate budgets on a needs basis but, instead, on an historical basis. There was no attempt to match budgets to clinical matters or emerging demographic trends but, instead, the central officer would fix the budget, perhaps with, say, a

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<sup>205</sup> See also Dr Anderson at T2744-5

<sup>206</sup> T1822, 1824, T1828, T1839-40

<sup>207</sup> T1836 and T2853

<sup>208</sup> T2940

<sup>209</sup> T1838

<sup>210</sup> T1838

<sup>211</sup> He still conducted an amputation clinic: see T1854, line 18

<sup>212</sup> The reasons for this are set out later.

<sup>213</sup> T1839; 1849, line 10

<sup>214</sup> T1834

four per cent increase, and the hospital was expected to work within it.<sup>215</sup> Regional hospitals were encouraged towards common resources and management, rather than responding to important needs and opportunities in their own geographic area.<sup>216</sup>

- 3.13 That position created immediate problems. Dr Thiele gave an example of a CT scan machine. He said that, when he first arrived at the Base, he found that there was no CT scanner at the Base, and he was told that this was because it was too expensive.<sup>217</sup> He considered that this was thoroughly unacceptable. The Base carried out all the trauma work in Bundaberg, and early CT scanning was crucial if the extent of patients' injuries were to be identified. Instead, major trauma patients were being taken by ambulance to the CT scanner at the Mater Hospital in Bundaberg and then brought back to the Base. Dr Thiele said that, even though the equipment was of fundamental importance to the delivery of services, it was only purchased in the course of a rebuilding project at the Base.<sup>218</sup> He said that such decisions were often affected by an attitude within Queensland Health that, if 'Rockhampton doesn't have it, neither should Bundaberg'.<sup>219</sup>
- 3.14 Dr Thiele also spoke about compromises being made in clinical care and good doctors with a public service ethos being worn down by this environment. He spoke, in particular, about waiting lists for endoscopies, a procedure used to diagnose and arrest the early development of cancer.<sup>220</sup> Large numbers of patients were being referred to the Base for such investigations but there was not sufficient staff to review the patients, nor any way of knowing which patients had the most dire need. In the event, the treating surgeons (Dr Pitre Anderson and Dr Charles Nankivell) worked their way through the list progressively but they would come across patients inevitably who had a potentially lethal problem and had been waiting an unacceptable period of time. Dr Thiele testified that this caused considerable distress to the doctors.<sup>221</sup> He said that doctors and nurses have complained about quality issues in the system and championed patients' causes, but 'for whatever reason' they were ignored, and they became disheartened.<sup>222</sup>

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<sup>215</sup> This evidence was corroborated before the Commission by the District Manager, Mr Leck. He said that there might be an increase in the budget on account of wage increases or a decrease on the basis that the Base should have been working towards more efficient practices. T7180. He said that occasionally the Base would receive 'enhancement funding for a new service: T7189

<sup>216</sup> T1831, line 35

<sup>217</sup> According to Dr Thiele, the machines cost a sum in the region of \$600,000.00 to \$700,000.00; T1830, line 29

<sup>218</sup> T1830

<sup>219</sup> T1831, line 38

<sup>220</sup> The term 'endoscopy' incorporates gastroscopies – where access is obtained orally – and colonoscopies – where access is made via the colon.

<sup>221</sup> T1829

<sup>222</sup> T1851, line 35

3.15 He testified that:

I think this [the events surrounding Dr Patel] happened because there has been a gradual shift within the health care system from the primary goal of providing quality medical services to primarily be fiscally responsible....the system gradually became structured more to as a fiscal organisation, corporation and not a healthcare system... The service delivery issue became linked to unrealistic budget allocations and service delivery was made to fit fiscal boundaries, not the need that existed. Budgets became heavily linked to activity and activity indicators, without fundamentally ensuring there was no erosion of quality.<sup>223</sup>

3.16 A further problem to which Dr Thiele alluded was that, as fiscal matters assumed primary importance, Queensland Health manifested a keen, if not obsessive, interest in exerting control from head office at the expense of local initiative and autonomy.<sup>224</sup> He gave an example of a plan he formulated to establish a foundation, governed by a board of local people, so that local people might make bequests and donations to assist the Base. It took Queensland Health almost two years to approve the plan (during which time, Dr Thiele had worked to garner support from local businesses). When approval was granted, however, it was accompanied by a list of people that Queensland Health would approve for the board, and Dr Thiele was particularly dismayed to find that they had 'political overtones'.<sup>225</sup>

3.17 Indeed, Dr Thiele linked the matter of centralised control with the lack of independent thinking<sup>226</sup>:

There's a desire to control, which to me is almost pathological, and it discourages critical commentary, it discourages thereby, progressive improvement from the bottom up, as I mentioned before, and it leads to a system which walks around with its head down, has not a great deal of self-respect because all the problems are identified from above and they're fixed from above and so people ask themselves, 'Well, what's my role here?'...And if you keep complaining about something that you fundamentally feel is wrong, and those for whom you work ignore you and ignore you and ignore you, the natural consequence is you ask yourself, 'What is my relevance here?'

3.18 Another example he gave of a failure to respect a level of autonomy or a failure to act 'opportunistically'<sup>227</sup> concerned the engagement of Visiting Medical Officers. He considered the use of such doctors vital to the proper functioning of regional hospitals (largely for the reasons identified above) but he said he had great difficulty in convincing Queensland Health to take on specialists when it seemed clearly beneficial to the hospital.<sup>228</sup> He said that the reasons for engaging Visiting Medical Officers – particularly in a regional setting - were 'just

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<sup>223</sup> T1850

<sup>224</sup> T1851

<sup>225</sup> T1833-4

<sup>226</sup> T1851

<sup>227</sup> T1831, line 40

<sup>228</sup> T1840, T1844-1845

commonsense things that I think are really no-brainers',<sup>229</sup> but there was a persistence in the view of employing full time staff, perhaps, he thought, because they were more amenable to control.<sup>230</sup> Dr Thiele maintained that Queensland Health did not adequately appreciate that there was a need to manage urban and rural environments differently and, in particular, that regional hospitals needed to be especially adaptable in the integration of proximate staff and facilities.

3.19 Dr Thiele spoke about the politicisation of the health system, as he perceived it. He testified that he had observed a very strong culture within Queensland Health of 'pleasing the boss'. He said that, particularly amongst administrators, as opposed to clinicians, he found that staff were reluctant to 'discuss real problems' and, instead, tended to downplay them.<sup>231</sup> He said that the politicisation had become intense, and it had a negative effect on the provision of services. He gave, as an example, an initiative during his term as Director of Medical Services at Bundaberg, to establish a renal dialysis service in the area. He said that the hardware for such a service was all present in Bundaberg,<sup>232</sup> as was a physician with renal dialysis experience and a surgeon (namely himself) with experience in access techniques.<sup>233</sup> Notwithstanding what seemed like a straightforward decision, Queensland Health took the view that the unit should be located in Hervey Bay, and it took a year of concerted lobbying to change the decision. Dr Thiele speculated that the only reason for considering Hervey Bay at all was that it was a marginal seat and that some people in Queensland Health were 'trying to please the political masters'.<sup>234</sup>

3.20 On the same theme, Dr Thiele spoke passionately about the powerlessness of district health councils. Whereas, he said, they should involve locally active people and should ensure that patients are represented at the highest level, he considered that, in Bundaberg, the council only received 'filtered information',<sup>235</sup> and that it was a 'toothless tiger' and a 'sop to people in the district'.<sup>236</sup> He continued:

I have a fundamental difference of opinion with Queensland Health. I do not believe this hospital belongs to Queensland Health. I believe this hospital belongs to the people of Bundaberg, and Queensland Health may have a certain responsibility for the running, but I do not believe that it should be controlled 100 per cent by Queensland Health.<sup>237</sup>

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<sup>229</sup> T1824 line 10

<sup>230</sup> T1825-6

<sup>231</sup> T1823, line 20

<sup>232</sup> Exhibit 118, para 35

<sup>233</sup> Exhibit 118, para 35; T1832

<sup>234</sup> T1831-2

<sup>235</sup> This allegation is corroborated by the evidence of the Chair of the District Health Council, Mr Chase, see T4372 to T4411

<sup>236</sup> T1832

<sup>237</sup> T1834

- 3.21 Dr Thiele expressed a concern that the form-filling and uniformity that accompanied centralisation occurred at the expense of personal relations:

I just philosophically believe that if you want to know what a patient feels, you don't send them a questionnaire of 20 questions three weeks later, you walk around the hospital and you say 'Mrs Jones, how are things going', and I firmly believe in a hands-on approach to the clinical situation. I almost became apoplectic when – and I think it was the start of the slide – when Queensland Health decided to accept the corporate model and we were going to refer to patients as clients. Now clients to me were somebody who dealt with the legal profession, occasionally accountants, and patients were something a little bit different. You know, one of the important things doctors do with patients is we lay our hands on people and there is something very realistic about that. People give us their trust in that regard...<sup>238</sup>

- 3.22 As mentioned earlier, after Dr Thiele resigned as Director of Medical Services, he continued to practise in Bundaberg and to attend the Base as a Visiting Medical Officer. He gave evidence that, by 2003, he had become uncomfortable even with this level of involvement. The training status of the Department of Surgery had been lost because there were no longer two fellows of the College present, as the College required. The registrars were lost and Dr Thiele found that there was a general erosion in the standards of the staff so that information was unreliable and communication was less sophisticated. In January 2004, Dr Thiele ceased to work as a Visiting Medical Officer at the Base and confined his role there to the supervision of an amputation clinic.<sup>239</sup> He testified that, he felt very strongly that the events surrounding Dr Jayant Patel (whom he met briefly), described below, were 'waiting to happen' in the context of all these problems.<sup>240</sup>
- 3.23 The evidence of Dr Thiele was not the subject of any significant challenge by any party, nor was it inconsistent with any of the evidence received from other witnesses. It was strongly corroborated by the evidence of a number of doctors who worked alongside Dr Thiele at various times, namely Drs Anderson, Nankivell and Strahan.<sup>241</sup> In those circumstances, I accept it. I deal with the evidence of the other doctors below.

## 1999 – 2002: an unsafe system

- 3.24 Dr Anderson gave evidence that he was a Fellow of the Royal Australasian College of Surgeons, that he commenced working as the Director of Surgery at the Base in 1994, and that he worked with another Fellow of that College, namely Dr Nankivell, until he stepped down as Director of Surgery in September

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<sup>238</sup> T1847

<sup>239</sup> T1854

<sup>240</sup> T1852; See also the evidence of Dr Baker T6393

<sup>241</sup> As will be seen below, it was also supported by evidence of a general decline in standards at the Base leading up to 2003.



2000.<sup>242</sup> He commenced to work as a Visiting Medical Officer at the Base from December 2001 and that continues to the present day.

3.25 Dr Anderson said that, with the assistance of Dr Thiele in vascular surgery matters, he and Dr Nankivell built up a strong Department of Surgery. They satisfied the College's high standards in relation to, amongst other things, case load, education programs, supervision, and audit/peer review process.<sup>243</sup> Indeed, the peer review process extended to the participation of Bundaberg surgeons in private practice, who attended for their own benefit.<sup>244</sup> He said, in consequence, junior and senior registrars of the College would do fixed periods at the Base as part of their formal training.

3.26 Dr Anderson said there was considerable frustration amongst medical staff at the Base with the process of administrative decision-making. During Dr Thiele's term, the frustration was acute when Queensland Health refused to approve Visiting Medical Officer sessions for an orthopaedic surgeon, who wanted to live and work in Bundaberg, despite a pressing need for such a surgeon.<sup>245</sup> Dr Anderson said that, after Dr Thiele's departure, he found that the workload was enormous.<sup>246</sup> He was doing a one in two roster (that is, he was on call every second day and every second weekend) with Dr Nankivell. A new administration commenced in about June 1998, with the coming of a District Manager called Peter Leck, (and, later, Dr John Wakefield as the Director of Medical Services) and Dr Anderson gave evidence that there were a series of disputes that arose between the new managers and various staff specialists, leading to the departure of the latter.<sup>247</sup> Dr Anderson asked for an additional surgeon because he considered the workload was unsafe and untenable, but this was refused. He spoke generally about the importance of Visiting Medical Officers to regional hospitals,<sup>248</sup> the refusal of Queensland Health to employ them on funding grounds despite the high workload<sup>249</sup> and the 'missed opportunities' in respect of particular practitioners, both because of funds and because of the time needed for local administration to receive a response from head office.<sup>250</sup> He also gave evidence of extremely long waiting lists for endoscopies prior to August 2000 (when Queensland Health addressed the problem by arranging gastroenterologists from Brisbane to visit the Base regularly).<sup>251</sup> He made clear

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<sup>242</sup> Dr Nankivell started at the Base in February 1995: T2742

<sup>243</sup> Exhibit 199, para 12; T2742

<sup>244</sup> Ibid; T2746

<sup>245</sup> Exhibit 199, para 14; T2750

<sup>246</sup> T2750

<sup>247</sup> T2743; Dr Marsh May, Dr Malcolm Stumer and Dr Anderson himself

<sup>248</sup> T2751-2

<sup>249</sup> T2754, T2799

<sup>250</sup> Exhibit 199, PEA14; T2770

<sup>251</sup> Following an initial endoscopy 'blitz' by the Brisbane gastroenterologists: T2801-2

that even minor pay issues for specialists could take considerable periods to resolve because of the time spent awaiting a response from head office.<sup>252</sup>

- 3.27 Dr Anderson became involved in his own dispute with management at the Base. By a letter dated 2 August 2000, the Acting District Manager outlined four complaints, namely that Dr Anderson was working in private practice when he was rostered to work at the Base, that he had lodged inaccurate timesheets, that he had removed an abdominal retractor, and that he had not provided adequate supervision to junior staff.<sup>253</sup> She also indicated that she was considering that he be suspended without pay, pending an investigation. Dr Anderson wrote back on the following day. He acknowledged there was some substance to the first complaint, but explained it had arisen in circumstances where his private practice had grown over some years, and he had been offering to become a Visiting Medical Officer with five sessions, allowing for a new staff surgeon to be appointed. He denied the other allegations and set out detailed reasons for doing so.<sup>254</sup> In particular, he indicated that the abdominal retractor was his private possession, albeit that he had allowed other surgeons to use it. He suggested that there was no reason to suspend him without pay, particularly having regard to his explanation, the disruption it would cause to patient services, and the stress it would cause to the other surgeon, Dr Nankivell.
- 3.28 On 4 August 2000, the Acting District Manager wrote again. She indicated that, notwithstanding Dr Anderson's response, it was her view that 'continuing your services during the period of investigation will prejudice the efficient and proper management of the Bundaberg Health Service District' and that accordingly, she was suspending him without pay. She indicated that he was not to 'present in the vicinity of the Bundaberg Hospital without [her] prior written permission', except to seek medical treatment for himself or his family.
- 3.29 Dr Anderson was aware that investigations conducted by Queensland Health could take months or years. He was told by the Acting District Manager that, if he resigned, the investigation would cease and he could take up private practice immediately.<sup>255</sup> In the event, Dr Anderson stepped down as Director of Surgery on 16 August 2000 (only being appointed as a Visiting Medical Officer in December 2001), and his role as Director of Surgery was assumed by Dr Nankivell.
- 3.30 Dr Nankivell gave evidence that was particularly compelling. He started work as a surgeon at the Base in February 1995, became the Director of Surgery in September 2000, and eventually resigned in January 2002. His evidence was

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<sup>252</sup> T2779

<sup>253</sup> Exhibit 199, PEA2

<sup>254</sup> Exhibit 199, PEA3 and see T2786-7; T2791

<sup>255</sup> T2796-7; Exhibit 199, para 24

that Dr Thiele was an uncomplicated, 'old style' manager,<sup>256</sup> with a high degree of optimism about the Base and the Bundaberg community,<sup>257</sup> so that during Dr Thiele's term, it was a 'very positive hospital'.<sup>258</sup> By the time of Dr Nankivell's departure in January 2002, he said, there had been a gradual deterioration so that '...morale was destroyed...everybody was distraught, basically. There was anger and bitterness. It was a destroyed hospital by the time I left'.<sup>259</sup>

- 3.31 Dr Nankivell said that he would work a one in two roster with Dr Anderson. Often the on-call work would run into the routine work so that the doctors were working very unsafe hours. The problem was exacerbated by a number of factors. First, if one doctor was to take recreational, sick or study leave, the other surgeon would find himself solely responsible for the entire catchment area of Bundaberg so that he might work 19 days in a row.<sup>260</sup> Secondly, the Base lost its surgical training accreditation,<sup>261</sup> and with that, of course, its access to registrars. Thirdly, the Emergency Department was, in Dr Nankivell's view, a 'shambles'. It tended to be staffed by junior, under-resourced, doctors who did not have the time or experience to properly assess patients or communicate with the specialist. Indeed, sometimes at night the 'surgical registrar' would be an intern.<sup>262</sup> In consequence, the surgeon would need to attend in person to assess patients.<sup>263</sup> Fourthly, in addition to ward patients, emergencies, and outpatients, the Base surgeons were required to provide access surgery in the renal unit when it was established.<sup>264</sup>
- 3.32 When Dr Anderson resigned, Dr Nankivell maintained, he had the 'shattering experience' of being virtually the only surgeon at the Base for most of three months. Queensland Health did not press surgeons from other districts into service, or even thank Dr Nankivell, or remunerate him, for the extra time he worked.<sup>265</sup>
- 3.33 Dr Nankivell also spoke passionately about the care delivered to patients. He exhibited to his statement letters dated 2 December 1997, 7 April 1998, 25 May 1999, 23 July 1999, 20 April 2000, 3 May 2000 and 24 July 2001, and mostly addressed to Base management, where he or Dr Anderson, set out concerns that patients were suffering unnecessarily poor outcomes because of the long waiting lists for endoscopies. He said that Queensland Health provided

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<sup>256</sup> T2940

<sup>257</sup> T2942

<sup>258</sup> T2938

<sup>259</sup> T2938

<sup>260</sup> T2944, line 30

<sup>261</sup> This occurred when Dr Anderson resigned and on the basis that there were no longer sufficient surgeons to meet the College's supervision requirements.

<sup>262</sup> T2940

<sup>263</sup> T2940

<sup>264</sup> T2957

<sup>265</sup> See the letter to the Director-General, attached to Exhibit 199. Mr Leck confirmed in evidence that the funding did not allow for adequate anaesthetists and surgeons so there was nothing he could do to address fatigue complaints he received: T7186-7

guidelines about waiting lists which ‘read beautifully’ in ‘beautiful manuals’, but very little was done to ensure they were followed.<sup>266</sup> Dr Nankivell spoke about how quickly cancer can spread and the importance of attending to endoscopy work quickly.<sup>267</sup> He spoke about his personal distress at seeing patients suffering because they were left to wait too long on the list.<sup>268</sup>

- 3.34 Dr Nankivell also spoke about the chaos of the Outpatients clinic at the Base. Whereas he would like to see one new patient every half hour in the clinic, he was expected to see as many as 28 in two hours. He would sometimes only see one third of the patients on his list, and he might be assisted by an intern – an unregistered doctor- who was seeing patients without close supervision.<sup>269</sup> He testified that, having worked so hard, what he really found ‘soul destroying’ was to be abused by patients, angry at waiting long periods for treatment. Dr Nankivell wrote to, and spoke with, the hospital management on a number of occasions about the ‘shambles’ that was the Outpatients clinic. By a letter dated 14 October 1999, he went so far, out of concern for staff safety, as to request a security officer and a closed circuit television for the area. He testified as follows about the circumstances surrounding that request:

We had a tiny area that people crowded in like a cattle market. There was not enough seats to sit on...if you’ve been waiting an hour, there’s no seat to sit on, naturally you’re cranky by the time you get there. Patients have often waited a year to see you anyway. [The security measures were necessary] because of the abuse that the girls at reception desk were suffering. I just got sick of seeing them in tears at the end of a clinic, because there was too many people to actually get through, and the patients would be crowding around like a shop market trying to give their personal – you know, you go to a reception and you say ...your name, your date of birth, all the usual things, with people standing around and – they get people ringing them up and they get abused, and I just got fed up with the abuse. I must say, I’m not blaming the patients. I’m not saying these are bad people. These are frustrated people at the end of their tether, and the staff are frustrated and at the end of their tether. The clerical resourcing was inadequate, and it really was a shambles.<sup>270</sup>

- 3.35 Dr Nankivell spoke about problems associated with having only one model – as a result of the centralisation of health governance – which did not allow for the major differences between the city and the country.<sup>271</sup> Like Dr Thiele, he gave the example of the orthopaedic surgeon, Michael Delaney, who might have been used as a Visiting Medical Officer. He explained that Dr Delaney was in his early 30’s, was interested in the Base, and wanted to work in Bundaberg for the rest of his life, at a time when all the orthopaedic surgeons in Bundaberg were nearing retirement.<sup>272</sup> Dr Thiele tried to ‘scrimp and scrape’ so that there was enough

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<sup>266</sup> T2949

<sup>267</sup> T2949

<sup>268</sup> T2947

<sup>269</sup> T2964

<sup>270</sup> T2963-4

<sup>271</sup> T2941

<sup>272</sup> T2942

money to keep Dr Delaney as a part time Visiting Medical Officer, but the idea 'got squashed'. Dr Delaney, instead, entered full time private practice and quickly became busy.<sup>273</sup>

- 3.36 In the end, Dr Nankivell took the view that, as a result of the centralised model, he was just talking to the wrong people. When Queensland Health would send people to the Base, they would often be bureaucrats with quite a different paradigm.<sup>274</sup> The quality assurance data which was collected and provided to him was all about finance rather than clinical care. He also noted that, where a hospital failed to work within budget, that was considered a failing by the manager in a key performance indicator, whereas he considered it might be a signal that the budget might be wrong.<sup>275</sup> In relation to endoscopies, he noted that one letter attached to his statement and dated 22 May 2000 showed the Director of Medical Services observing that, for Queensland Health's purposes, endoscopies were not '...recognised as elective surgery activity'. Against that background, he gleaned, there was little incentive to fix the problem.<sup>276</sup> He felt that administrators were interested in process (or 'ticking boxes' as he put it) rather than addressing glaring clinical issues like unsafe working hours.<sup>277</sup>
- 3.37 He was dismayed that he would deal with public servants from Brisbane, who were not medically qualified and did not know much about regional practice. He made the point that the problems that existed in Bundaberg, and their solutions, would have been immediately apparent to a clinician, and it was frustrating that he was dealing with people who did not necessarily know even elementary things such as that surgeons carried out endoscopies.<sup>278</sup>
- 3.38 The problem, as Dr Nankivell came to understand it, was that 'Charlotte Street' simply determined the budget and the Hospital was required to work within it.<sup>279</sup> He had been told, he explained, that there was no funding model. One would expect, he said, that the Department would assess the local demographics and then, perhaps, apply some formula to ascertain their likely medical needs.<sup>280</sup> He said that such an exercise was 'absolutely fundamental' to clinical and workforce planning but he was told, whilst working at the Base, that one didn't exist.<sup>281</sup> Instead, he said, he and Dr Thiele came to understand that they received money through an historical funding model 'which basically means you have been duded in the past, you are going to be duded next year'.<sup>282</sup> The funding model

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<sup>273</sup> T2942, line 50

<sup>274</sup> T2941

<sup>275</sup> T2944

<sup>276</sup> T2946

<sup>277</sup> T2989, line 40; T2990

<sup>278</sup> T2966, line 50

<sup>279</sup> T2949, line 45; T2953, line 30

<sup>280</sup> T2988-9

<sup>281</sup> T2988-9

<sup>282</sup> T2943, line 15

also led to absurdities. The staff might run out of bandages early in the year, and have to ration them or, alternatively, they might find that they had not spent their budget as 30 June approached and they would have to work out quickly how to 'get rid of' the extra money.<sup>283</sup>

- 3.39 Dr Nankivell said that it was not just that there was underfunding, but that the funding was maldistributed. There were periods when there were no waiting lists at Hervey Bay, whilst Bundaberg had huge waiting lists. But there was no one exercising the 'primary school logic' of shifting resources to where they were needed.<sup>284</sup>
- 3.40 Dr Nankivell gave evidence that he complained repeatedly about the conditions. He did not blame local management because he appreciated the problems could only be resolved at higher levels.<sup>285</sup> He said that the then Director of Medical Services worked 'very, very hard' to advance a business case for more funds but with little effect.<sup>286</sup> Dr Nankivell spoke to the District Manager, the Zonal Manager and eventually the local member of Parliament, Nita Cunningham, but there was no improvement.<sup>287</sup>
- 3.41 He said that the system did not welcome complaints and that, even though he understood that if one talked outside the Queensland Health system, 'you get sacked',<sup>288</sup> he and others went *en masse* to see Ms Cunningham in about 2000 because the conditions were so dire. He testified about concerns held by doctors, and even more so by nurses, that if they spoke out about problems publicly, they would be considered to have breached a Code of Conduct<sup>289</sup> within Queensland Health and disciplined.
- 3.42 In about November 2001, Dr Nankivell provided a letter to Dr Stable, then the Director-General of Queensland Health. The letter appears as an annexure to his statement. He wrote in the letter of a number of very serious concerns, including no effective response by Queensland Health to surgical outpatient concerns (despite it being the number one priority at the Base), the endoscopy list remaining a 'disaster despite years of begging for help', the problem of abuse from frustrated patients, the Accident & Emergency Department remaining 'a shambles', and his view that he had operated on patients when, by reason of exhaustion, he was 'totally unfit' to do so.<sup>290</sup> Despite the fact that Dr Nankivell

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<sup>283</sup> T2943

<sup>284</sup> T2945

<sup>285</sup> T2948

<sup>286</sup> T2948-9

<sup>287</sup> Exhibit 212, T3009. T2957-8; T2964

<sup>288</sup> T2957-8; and see the discussion later about Queensland Health's Code of Conduct

<sup>289</sup> T2996; This Code will be considered at length later.

<sup>290</sup> See the letter to the Director-General attached to Exhibit 212

wrote as a very senior doctor in a major regional hospital, he says he received no reply from Dr Stable whatsoever.<sup>291</sup>

- 3.43 Dr Nankivell said he had been particularly dismayed by the trite nature of one particular response to his complaints from the General Manager (Health Services) at Queensland Health, Dr Youngman. The author wrote that:

...there are no short term easy solutions. A decentralised state does have additional barriers, particularly to lifestyle as it is not possible to engage enough staff to facilitate a roster in some disciplines....

- 3.44 Dr Nankivell pointed out that there was no problem in finding good surgeons in Bundaberg: the two private hospitals were well staffed<sup>292</sup> and there were adequate doctors who might act as Visiting Medical Officers to the Base. Dr Nankivell was exasperated by the letter because he considered that the solution was, in fact, so simple:

...we needed more staff. Whether that was more full-time staff, more VMO staff...I don't really mind. We just needed more staff<sup>293</sup>.

- 3.45 Dr Nankivell said that he appreciated that the Director of Medical Services had lodged a business case for one full time surgeon and one part time surgeon with Queensland Health, and he could not understand how the logic behind that request could be refuted.

We were a busy growing area, we needed more money and it was just so obvious<sup>294</sup>...we documented unsafe working hours, we documented delayed diagnosis, we documented death. We had an expanding population, we had a bulk-billing population, we had a renal unit established, which was a great thing but a renal unit brings more surgery into town...what more did we need to prove?<sup>295</sup>

- 3.46 In the end, apparently out of frustration, Dr Nankivell gave notice in about October 2001<sup>296</sup> that he intended to leave the Base and he did so in January 2002.<sup>297</sup> Many witnesses have made clear that Dr Nankivell was a very good surgeon and that he had a strong commitment to the public health system.<sup>298</sup> He explained, for his part, that he left his position at the Base because of the problems identified above, because it seemed that nothing was being done to address his concerns, and because the end result was that it was impossible 'to have any personal life or feel like [he] was doing [his] job to the best of [his ability]'.<sup>299</sup>

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<sup>291</sup> T2964: he did learn through the District Manager that Dr Stable had received the letter.

<sup>292</sup> T2935

<sup>293</sup> T2972

<sup>294</sup> T2943

<sup>295</sup> T2972-3 The District Manager, Mr Leck, testified: 'I also thought that there weren't sufficient general surgeons on the roster. And there had been various times when we had made requests corporately for additional funding so that we could increase the number of surgeons but there was nothing I could do when we had no money to do it.' T7134

<sup>296</sup> T2937; Exhibit 212

<sup>297</sup> Exhibit 212, para 4

<sup>298</sup> See Baker, Thiele, Anderson, T5973, line 40, T6652, T3253

<sup>299</sup> Exhibit 212, page 2

- 3.47 Dr Nankivell gave evidence that he was surprised that Queensland Health did not try to talk him out of his resignation. He was aware (as the evidence before the Commission confirms)<sup>300</sup> that there has been some protests from patients and colleagues concerned by the resignation, but notwithstanding that fact, and that he had expressed his concerns at length in writing to Dr Stable, no attempt was made by Queensland Health to talk him out of the resignation.<sup>301</sup>
- 3.48 Dr Strahan gave evidence that broadly supported the proposition that there was a gradual decline at the Base from the time when Barry Marshall was the District Manager and Dr Thiele was the Director of Medical Services.<sup>302</sup> He wrote an article in the AMAQ newsletter of September 2000, expressing concerns about the loss of many clinical directors from the Base, and maintaining that 'specialist medical staff morale in the hospital [was] at a low ebb'. In December 2001, he wrote an article in the Bundaberg News-Mail complaining about the state of the Base. He subsequently attended a meeting with the Minister for Health and the District Manager but, whilst it was communicated to him that the article was 'unhelpful', he was not informed that any improvements would be made. He said that he formed the view that administration, locally and centrally, were not interested in responding to criticism.
- 3.49 There were two more witnesses who gave evidence of the period leading up to 2003 in Bundaberg. The first was a Dr Sam Baker and the second was a Dr Chris Jelliffe.
- 3.50 Dr Baker had taken up a training position at the Base for six months in 1998 under Drs Nankivell and Anderson. He observed that the Department was 'extremely well run' and, in the first half of 2001, he returned (having gained his fellowship with the College) to work with Dr Nankivell. In the event, he became the Director of Surgery himself in November 2001, following Dr Nankivell's resignation, and he stayed in that position until he resigned himself in August 2002,<sup>303</sup> ceasing employment in November 2002. Dr Baker gave evidence that he resigned because he 'had grave concerns about the management and their putting the budget in front of patient's safety'<sup>304</sup> and, in the course of his testimony, he outlined a number of concerns.
- 3.51 Dr Baker spoke about major problems in the Base's Emergency Department in that it was often staffed, especially at night, by junior doctors who were inadequately supervised.<sup>305</sup> He spoke about a concern that clinical decisions were made simply to make cost savings. In September 2001, Dr Baker

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<sup>300</sup> eg T2960, line 30

<sup>301</sup> T2960, line 10

<sup>302</sup> Exhibit 232

<sup>303</sup> T6398, line 15

<sup>304</sup> T6348, line 30

<sup>305</sup> T6349, line 10



maintained, the Base's management informed theatre staff that, in an effort to achieve 100% utilisation of the operating theatres, a new roster was to be implemented. Dr Baker could not make sense of the plan. He considered that the real goal should be to treat more cases, not to utilise the theatres for longer periods, and indeed, the latter goal seemed harmful because there is no capacity to 'absorb emergencies'.<sup>306</sup> The plan was particularly disturbing because the supporting 'business case' for head office<sup>307</sup> contemplated 'realisable savings ...with the employment of fewer nursing staff in theatres', but Dr Baker could not see how the theatre could be utilised for longer – let alone how clinical care could be improved – with fewer nurses. He found it 'bizarre but not unusual with Queensland Health' that such a plan would be developed without consultation with the theatre staff,<sup>308</sup> and he came to believe it was simply a cost-saving measure.<sup>309</sup>

- 3.52 Dr Baker gave another example of decisions that seemed to be informed by cost-savings. He said that he had noticed over his years of employment with Queensland Health<sup>310</sup> that, when somebody resigned, they were very slow to advertise for replacement staff. He had come to suspect that this was an attempt to save money at the expense of the remaining staff's workload. When he was offered the position of Director of Surgery, it appeared that, with the departure of Dr Nankivell, he would be working a 'one-in-one, 24 hours a day, seven days a week' roster at the Base until a second surgeon could be found, but Dr Baker made clear that he would not do so.
- 3.53 Dr Baker spoke about dangerous understaffing generally, especially anaesthetists, surgeons and nurses.<sup>311</sup> He said, after the re-structuring of the theatre nursing roster, cases would be cancelled for lack of staff and this created a very frustrating work environment.<sup>312</sup> He spoke about unsafe working hours and he explained that, when a surgeon is on call every second night, he or she might work up to 24 hours without sleep, and never really rest properly because of the roster.<sup>313</sup> He noted that management at the Base needed to clearly define the Department of Surgery's operations role but that had not been done.<sup>314</sup> He considered that the Base needed to develop a plan for the provision of services

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<sup>306</sup> T6360, line 20

<sup>307</sup> Dr Baker gave evidence that Queensland Health required a business plan for those changes which might have a fiscal impact: T6359, line 40

<sup>308</sup> T6359-60

<sup>309</sup> T6361

<sup>310</sup> T6367

<sup>311</sup> T6366; T6363

<sup>312</sup> T6349

<sup>313</sup> T6366. Mr Leck acknowledged that there had been fatigue concerns relating to anaesthetists and surgeons. He acknowledged this posed a threat to patient safety but he maintained that, in the absence of adequate funding, there was nothing he could do: T 7186-8

<sup>314</sup> T6365

in the district and then ascertain the resources needed to sustain it. In fact, in his view there was a similar problem with services at the Base generally.<sup>315</sup>

- 3.54 It seems that Dr Baker, like others before him, was not timid in voicing his concerns. When he was offered the position as Director of Surgery in November 2001, he made clear in correspondence that his acceptance was conditional on, amongst other things, certain systemic improvements, and, when he did not receive a prompt response, he gave three months notice of his resignation.<sup>316</sup> The development, following so closely upon Dr Nankivell's resignation and preceding a country Cabinet meeting in Bundaberg, attracted considerable local media coverage. Dr Baker said that he was called to a meeting on 30 November 2001 with Mr Leck and the then Acting Director of Medical Services,<sup>317</sup> and they discussed a number of ways in which Dr Baker might be supported by a second full-time surgeon. Dr Baker said that, at the conclusion of the meeting, Mr Leck told him that the Director-General of Queensland Health, Dr Robert Stable, was not happy with the 'media embarrassment' precipitated by his resignation, that Queensland Health was a large organisation that the Director-General would protect the organisation, and that 'we don't want to see your career affected'.<sup>318</sup> Dr Baker said that he asked Mr Leck if his words were a threat, but he received no response.
- 3.55 Dr Stable attended Bundaberg in early December 2001 at the time of the country Cabinet meeting and he arranged, through Mr Leck, to meet with Dr Baker at about the same time.<sup>319</sup> Other senior doctors from the Base – including Dr Charles Nankivell, Dr Peter Miach, and Dr Jon Joyner also attended the meeting, and concerns were expressed including about lack of resources and adequate surgical support.<sup>320</sup> Dr Stable provided a folder showing a 7% funding increase to the Base and he considered some solutions to the concerns, including that Dr Anderson be re-employed as a Visiting Medical Officer.<sup>321</sup> Dr Baker subsequently withdrew his resignation<sup>322</sup> and worked at the Base for a further 11 months. It seems, however, that some of the problems identified at the time of his appointment as Director of Surgery – particularly the matter of supervision in the Emergency Department and the provision of certain equipment<sup>323</sup> – remained when he left in November 2002.<sup>324</sup> By a letter dated 13 October 2002 and copied to a number of third parties, Dr Baker wrote to the then Acting Director of

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<sup>315</sup> T6364

<sup>316</sup> Exhibit 410, SPB 9-11

<sup>317</sup> T6385

<sup>318</sup> T6353, line 35, Exhibit 410, para 23

<sup>319</sup> Exhibit 410, paras 24 and 25

<sup>320</sup> Exhibit 410, para 25, T6394

<sup>321</sup> Exhibit 410, para 25: at the earlier meeting with Mr Leck, it was explained that Queensland Health would not contemplate re-engaging Dr Anderson at the Base; T6395, line 10

<sup>322</sup> T6395, line 1

<sup>323</sup> T6404

<sup>324</sup> T6351, line 40

Medical Services at the Base, giving details of a death that had recently occurred shortly after a patient presented at the Emergency Department, maintaining that the incident was not an isolated one, and referring to concerns expressed by Dr Baker and others 'for the last 9 months' about inadequate supervision. He gave evidence that he received no response to the correspondence, apart from a comment from the Acting Director of Medical Services that the District did not take kindly to Dr Baker going outside management.<sup>325</sup>

- 3.56 Dr Baker gave evidence that there were monthly meetings at the Base of a body called the Medical Staff Advisory Committee and many of the issues set out above were raised by him and other staff in the presence of hospital management.<sup>326</sup> He also gave evidence that, in the course of 2002,<sup>327</sup> he and the Director of Anaesthetics were required to complete a quality assurance questionnaire about their respective departments. He understood that the form was to be sent by the Base to head office. The completed questionnaires were tendered in evidence and they included assessments such as 'care is delivered on an ad hoc basis as continuum of care is impossible with current staffing levels'; 'There is little direction from management with regards to strategic direction...They appear more interested in making targets than delivery of quality health care'; and 'Management continues to ignore safe working hours practices and the fact that the anaesthetics department is grossly understaffed'.<sup>328</sup>
- 3.57 Despite the scathing nature of those comments, and the high office of the authors, Dr Baker testified that he received no inquiries or requests for amplification from Base management or Queensland Health generally.<sup>329</sup> The minutes for the Medical Advisory Committee Meeting dated 12 September 2002 record that at the previous monthly meeting, Dr Baker – in the presence of the District Manager and others – announced his resignation and 'commented that he did not wish to be told to provide a third world surgical service by the hospital management. He expressed an opinion that the Queensland Health management had no interest in providing a quality surgical service in the Bundaberg Health District'.<sup>330</sup> Dr Baker gave evidence that he was never challenged or approached about those comments. Against this background, Dr Baker left the Base in November 2002 to practise privately in Bundaberg. He continued in that role until February 2003 when he moved to Townsville.<sup>331</sup> He gave evidence that he had left because he felt that his concerns about patient safety were being ignored and that Queensland Health management 'had no

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<sup>325</sup> Exhibit 410, para 10

<sup>326</sup> T6351-2

<sup>327</sup> The best evidence suggests it was about September 2002: see SPB14 to Exhibit 410

<sup>328</sup> T6363-6366

<sup>329</sup> T6369

<sup>330</sup> Exhibit 415

<sup>331</sup> T6348, line 40

interest in providing a quality surgical service in the Bundaberg Health Service District'.<sup>332</sup>

- 3.58 Dr Jelliffe gave evidence that he worked from January 2001 until November 2002 as an anaesthetist at the Base. He had been employed on an area of need basis because, whilst he was a Fellow of the Royal College of Anaesthetists, he had not yet gained a fellowship in the Australian equivalent.<sup>333</sup> As was normal in those circumstances, he had secured a Medical Practitioner's Visa Subclass 422, which was effectively a temporary working visa which included, as conditions, that he must remain with the same employer doing the same job.<sup>334</sup>
- 3.59 He said that, although the Base was working well when he arrived, he noticed, from September 2001, that morale deteriorated and staff began leaving.<sup>335</sup> Whereas, at the outset of his employment, there were four full time anaesthetists at the Base, by March 2002 there were only two.<sup>336</sup> Matters came to a head for him around April 2002 when the other anaesthetist, Martin Carter, took study leave, and he found himself covering for 8 days straight as the sole full time anaesthetist in the Base, responsible for emergencies, obstetrics, intensive care, and elective surgery.<sup>337</sup> He testified that he became so severely fatigued that he had trouble eating, sleeping and making judgments.<sup>338</sup> He took the view that his condition could compromise patient safety and he made a unilateral decision to cancel any elective surgery that might be delayed. He testified that he notified the Director of Medical Services' secretary and, on the same day, he was called to the District Manager's office. He was taken aback when the conversation commenced with the District Manager asking for a reminder as to Dr Jelliffe's visa status. Dr Jelliffe construed this comment as a threat, and certainly it is hard to see how it had any other purpose related to elective surgery lists or the District Manager's relationship with Dr Jelliffe.<sup>339</sup> He said that he was aware of a general perception through the Base that management was not responsive to complaints and, prompted by this particular episode, he began making inquiries soon afterwards, about employment in other hospitals.<sup>340</sup>
- 3.60 The structure of the Department of Surgery in 2002 was as follows. There were two full time surgeons, and they were supplemented by a small number of Visiting Medical Officers.<sup>341</sup> The two full time surgeons had each been fellows of

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<sup>332</sup> T6392, line 10

<sup>333</sup> Exhibit 437, paras 2-4; T6648-9

<sup>334</sup> T6649-50

<sup>335</sup> T 437, paras 7-9

<sup>336</sup> T6650-1

<sup>337</sup> T6655-6

<sup>338</sup> T6655-6

<sup>339</sup> As it turned out, the threat, if it was one, could not be carried out because Dr Jelliffe had married his Australian partner, and his Subclass 422 visa had been replaced with a spouse visa.

<sup>340</sup> T6653 and T6659

<sup>341</sup> T6661; T4170

the Royal Australasian College of Surgeons, and one of them would act as the Director of Surgery, which attracted, it would appear additional administrative work, and additional remuneration in the order of \$3,000.00 per annum.<sup>342</sup>

- 3.61 As Dr Nankivell made to depart in January 2002, the Base employed a surgeon called Dr Lakshman ('Lucky') Kumar Jayasekera in his place.<sup>343</sup> Dr Jayasekera had obtained his primary medical degrees in Sri Lanka in 1970, and he was admitted as a Fellow of the Royal College of Surgeons in Edinburgh in 1983, practising in surgery since that time. He migrated from Sri Lanka to Australia in 1996, he became an Australian citizen in 1999 and he was admitted as a Fellow of the Royal Australasian College of Surgeons in 2000.<sup>344</sup> He gave evidence that, since his arrival in Australia, he had practised in a number of Queensland public hospitals including Redcliffe, Nambour, Caboolture, Bundaberg and Toowoomba.<sup>345</sup> Whilst employed at the Base, he was mainly engaged in general surgery.<sup>346</sup> He was, in short, a well-qualified surgeon with long and relevant experience.
- 3.62 For most of 2002, then, the two staff surgeons at the Base were Dr Baker and Dr Jayasekera. Dr Anderson had been appointed as a Visiting Medical Officer and assisted in that capacity.<sup>347</sup> Dr Jayasekera gave evidence that there was a period, before Dr Baker's departure from the Base (which, of course, occurred in November 2002), when Dr Baker took study leave for about two months.<sup>348</sup> He was replaced by a Dr Kotlovsky,<sup>349</sup> who had apparently obtained qualifications in Russia as a paediatric surgeon but whose qualifications had not been recognised in Australia.<sup>350</sup> Dr Kotlovsky had migrated to Australia in 1991 and, since 1995, he had worked predominantly as a principal house officer or a non-accredited surgical registrar.<sup>351</sup> Effectively, he was neither a fellow of the Australian college nor a trainee under an Australian surgical programme.<sup>352</sup> He had never been employed as a surgeon in Australia and, indeed, the terms of his registration required that he be supervised.<sup>353</sup>
- 3.63 There was some controversy as to how Dr Kotlovsky's time at Bundaberg unfolded and the Commission is not in a position to resolve that evidence.

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<sup>342</sup> T4171

<sup>343</sup> Exhibit 308, para 9

<sup>344</sup> Dr Jayasekera had been admitted to the Higher Surgical Training Program in 1998. Whereas a trainee would normally spend four years on the program but, given Dr Jayasekera's experience, the College admitted him to a fellowship after two years.

<sup>345</sup> Exhibit 308, paras 1 to 8 and para 12

<sup>346</sup> T5972, line 40

<sup>347</sup> Exhibit 308, para 10

<sup>348</sup> T5974, line 15; T5965, line 50, Exhibit 484

<sup>349</sup> Dr Jayasekera said that Anatoli was the doctor's first name, and that he could not recall his second name. In fact we now know – from obtaining Medical Board records – that it was Kotlovsky.

<sup>350</sup> Exhibit 484

<sup>351</sup> Exhibit 484: Dr Kotlovsky became an Australian citizen in 1994

<sup>352</sup> T5963, line 35, T5976, line 30

<sup>353</sup> Exhibit 381, para 23; T4140-4141

Suffice to say that, over the course of his stay, there were times when he was not supervised by a surgeon, and this was perhaps to be expected since he was replacing Dr Baker, and Dr Jayasekera was the only other surgeon. It appears there was some consideration given to Dr Kotlovsky taking up a permanent position at the Base but that was not pursued.<sup>354</sup>

- 3.64 I mention this period for a number of reasons. In the first place, it seems to have signalled the first time, in recent memory at the Base,<sup>355</sup> in which the role of the second staff surgeon was carried out by someone who was not a member of the Australian College. In the second place, the events that transpired should have reinforced something that Dr Nydam already knew, namely that overseas trained doctors who had not satisfied Australian formal standards were a 'mixed bag', or at least required supervision.<sup>356</sup> Finally, it brought the Base to a position where it was no longer clear that there would be two Fellows of the College employed in the Department so that it could not retain its training status.<sup>357</sup>
- 3.65 I should say that it is not necessary for the purposes of this Inquiry to determine whether each and every factual matter raised above did in fact occur. I was, however, very impressed, by the evidence of Dr Nankivell, Dr Baker and Dr Jelliffe, and by the fact that the doctors spoke, by and large, cogently and consistently, about clinical problems and difficulty in securing managerial solutions. It is clear at the very least that, by late 2002, the relationship between the Base and its medical staff had become a very unhappy one. It is also clear that, by then, the provision of surgery was grossly inadequate and that the hours which surgeons and anaesthetists were being expected to work was putting patients' safety at risk.

## Dr Jayant Patel

### 2002: The appointment of Dr Patel

- 3.66 With the departure of Dr Baker, Dr Jayasekera took over his responsibilities, and effectively became the Acting Director of Surgery.<sup>358</sup> In August 2002, Dr Nydam arranged for the position of Director of Surgery at the Base to be advertised in The Courier-Mail and the Australian.<sup>359</sup> The advertisement made clear that the closing date for applications was 16 September 2002, that the successful applicant would report directly to the Director of Medical Services, and that any

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<sup>354</sup> T4181

<sup>355</sup> It will be recalled that, at least since 1995, the two surgeons at the Base had been fellows.

<sup>356</sup> T4140, line 55

<sup>357</sup> T1839; T2749

<sup>358</sup> T5965, line 40

<sup>359</sup> See the Base's Director of Surgery file

applicant should have 'qualifications as a general surgeon acceptable for specialist registration by the Medical Board'.<sup>360</sup> Dr Jayasekera gave evidence that he was encouraged to apply for the position by Dr Nydam,<sup>361</sup> by Dr Anderson and by others.<sup>362</sup> He had some reluctance about doing so, first because he liked to 'keep a low profile' and avoid politics,<sup>363</sup> and second, because he wanted a job closer to Brisbane where his family lived.<sup>364</sup> Dr Jayasekera decided, however, after some encouragement from his friends, to apply. He spent a couple of days completing an application responding to the selection criteria and he made himself available for an interview.<sup>365</sup> There were three applicants for the position and Dr Nydam determined that two of the applicants, a Dr Strekozov and Dr Jayasekera, comfortably satisfied all selection criteria.<sup>366</sup> Each of them was interviewed by a selection panel consisting of Dr Nydam, the District Manager, namely Mr Leck, and Dr Anderson.

- 3.67 The panel decided to offer the position to Dr Strekozov but it appears that, after some weeks of consideration, Dr Strekozov rejected the offer.<sup>367</sup> One might have expected, at that point, that the position would have been offered to Dr Jayasekera. He satisfied all the criteria, he had apparently worked satisfactorily at the Base since January 2002, he had been encouraged by the two clinicians on the selection panel to make application, and the Queensland Health protocol entitled the panel to appoint him without re-advertising.<sup>368</sup> That course had the clear support of Dr Anderson but it was not adopted by Dr Nydam<sup>369</sup> who, instead, re-advertised the position.<sup>370</sup> The new advertisement gave a closing date for applications of 2 December 2002. No applications were received but, again, the position was not offered to Dr Jayasekera, apparently because he had intimated some ambivalence about the position.<sup>371</sup> Dr Jayasekera gave evidence that, if the position had been offered to him, he would have accepted it, albeit that he would have continued to look for a position closer to his family in Brisbane.<sup>372</sup> He gave evidence that he was humiliated by the failure of management to offer him a job.<sup>373</sup> On 28 December 2002, he gave the Base three month's notice of his intention to resign but he gave evidence that this was

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<sup>360</sup> T4112, line 45; Exhibit 273

<sup>361</sup> T5970

<sup>362</sup> T5981

<sup>363</sup> T5971

<sup>364</sup> T5980

<sup>365</sup> T5970, line 20

<sup>366</sup> T4113; T4115-7

<sup>367</sup> T4169; Exhibit 51, para 33

<sup>368</sup> T4188; Exhibit 280

<sup>369</sup> T4118

<sup>370</sup> The Base's Director of Surgery file discloses that the position was advertised in The Courier-Mail on 14 November 2002 and in the Australian on 16 November 2002

<sup>371</sup> T4116, line 30; T4168. This was the evidence of Dr Nydam. Mr Leck's evidence, effectively, was that Dr Nydam told him Dr Jayasekera was unsuitable and he deferred to that position: T7140

<sup>372</sup> Exhibit 381, para 2; T5980, line 40

<sup>373</sup> Exhibit 381, para 3

unrelated to the circumstances surrounding the directorship.<sup>374</sup> Whether that be the case or not, it is clear that the overlooking of Dr Jayasekera was the source of tension between senior doctors and management.<sup>375</sup> The minutes of the Medical Staff Advisory Committee for 13 February 2003 include a motion endorsed by six senior doctors, including Dr Jayasekera, in terms that:

This meeting:

Accepts the resignation of Dr Jayasekera with great regret and notes that this is one of many resignations leading to the effective demise of General Surgery at the Bundaberg Base Hospital.

Believe that this process has been largely due to the dictatorial, unresponsive, myopic and inflexible approach of management who have little regard for specialists, their needs or aspirations.<sup>376</sup>

- 3.68 Drs Jayasekera<sup>377</sup> and Dr Anderson<sup>378</sup> each gave evidence that, at the meeting, Dr Nydam and Mr Leck were asked to explain why Dr Jayasekera was not offered the position of director, but they did not respond. In the event, Dr Jayasekera left the Base on 30 March 2003 to take up a position at the Hervey Bay Hospital.
- 3.69 Dr Nydam said that he did not advertise the Director of Surgery position again, but, instead, he advertised for a 'Senior Medical Officer-Surgery'.<sup>379</sup> Dr Nydam testified that the 'usual procedure' is to advertise internally and nationally, before the hospital seeks an Area of Need declaration and looks for overseas candidates through recruitment agencies and foreign press.<sup>380</sup> He did not refer, however, to any such national advertisement in the instant case (excluding the Director of Surgery material) and there is none in evidence. The Position Description that was distributed<sup>381</sup> listed the job as 'Senior Medical Officer-surgery', noted that the 'purpose of position' included 'to provide surgical services for the Bundaberg Health Service District', indicated that the officer 'reports directly to the to the Director of Surgery, Bundaberg Base Hospital' and omitted any reference to 'qualifications as a general surgeon acceptable to the Medical Board for specialist registration'.<sup>382</sup> The only qualifications required, according to the Position Description, were that the applicant have 'experience in the provision of surgical services' and could be registered as a medical practitioner in Queensland.<sup>383</sup>

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<sup>374</sup> T5980

<sup>375</sup> See the evidence of Dr Anderson at T2779 which suggested that this position may have been an effort to put a positive spin on the situation and see 4122

<sup>376</sup> Exhibit 199, attachment 'PEA13'

<sup>377</sup> T5966, line 30

<sup>378</sup> T2760, line 10

<sup>379</sup> T4118, line 45

<sup>380</sup> Exhibit 51, paras 7 to 11

<sup>381</sup> Exhibit 40

<sup>382</sup> See Exhibit 40

<sup>383</sup> See Exhibit 40



- 3.70 It is as well to consider, at this juncture, the changes that had been wrought upon the Department of Surgery. In recent history, and much like any significant regional hospital in Australia<sup>384</sup>, the Director of the Department of Surgery at the Base had always been a fellow of the College. That director worked closely with another staff surgeon who was also a fellow of the College and, indeed, the Department (because it satisfied the College's requirements for offering a training post) had the further benefit of assistance from surgical registrars, as well as Visiting Medical Officers. By early 2003, there had been a diaspora of many good surgeons. Indeed, it was worse. Surgeons had not only left, but many had left in such unhappy circumstances that they were 'wounded soldiers',<sup>385</sup> and Queensland Health could not assume that they would necessarily assist the Base, if asked. Now, the situation had reached a point where the Base needed two new surgeons, with, presumably, one of them to act as the Director, but it was not even advertising for a specialist surgeon. It sought merely someone with 'experience in the provision of surgical services' which, as a description, applies to any number of junior and overseas trained doctors.
- 3.71 Dr Nydam's recollection is that he would have sent out a group email to several recruiting agencies in relation to the SMO position.<sup>386</sup> Wavelength Consulting Pty Ltd ('Wavelength') was one such agency. One of the Wavelength directors, Dr John Bethell, gave evidence that the company runs a medical recruitment business from offices in Sydney, that it has 14 staff (including its two directors) and that where it arranges doctors for the client employers, it receives a commission equivalent to 15% of the doctor's first year salary package.<sup>387</sup> He said that the company does not generally advertise within Australia because those doctors tend to organise themselves.<sup>388</sup> He said that more than 95% of the doctors they recruit are from overseas<sup>389</sup> and that the majority are junior doctors bound for regional areas.<sup>390</sup> He confirmed that, to his knowledge, there was a worldwide shortage of doctors and candidates from traditional source countries – such as the UK, Canada and the US - were becoming fewer.<sup>391</sup>
- 3.72 Dr Bethell gave evidence that the Base had been Wavelength's 'client' in the past, and the Terms and Conditions upon which Wavelength rely were tendered in evidence.<sup>392</sup> Clause 6 deals with the 'Responsibilities of Wavelength Consulting' and provides:

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<sup>384</sup> See the evidence of Dr de Lacy

<sup>385</sup> Dr Nankivell commented: '*...one of the problems with Queensland Health is its full of wounded soldiers. Dr Anderson is a wounded soldier, so am I... whenever you talk to people at meetings, everyone's got their bad story to tell. Everybody at some point's been done in by the system or feels that way*': T2957.

<sup>386</sup> Exhibit 51, para 14

<sup>387</sup> Exhibit 41, para 30 and see T691

<sup>388</sup> T684

<sup>389</sup> T691

<sup>390</sup> T700, line 1

<sup>391</sup> T700, line 40

<sup>392</sup> Exhibit 42

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

Wavelength Consulting will not be liable in any way for any loss or damage to property or for injury or death of a person or for any other lost cost, damage, delay, or loss of profit arising directly or indirectly from any acts or omissions of a Candidate introduced by Wavelength.

- 3.73 Dr Bethell said that he was first approached by Dr Nydam, with a verbal request to refer a surgeon for the SMO position at the Base, on 14 November 2002.<sup>393</sup> He gave evidence that some time soon afterwards, he received the position description for the job, and that his normal practice would be to record the position on Wavelength's database and then speak with known candidates.<sup>394</sup>
- 3.74 It seems that, almost immediately after Wavelength received notice of the position, Dr Patel approached the company through its website, expressing an interest in working as a general surgeon in Australia.<sup>395</sup> Dr Bethell then telephoned Dr Patel in Portland, Oregon, in the United States, and, in the course of that conversation, Dr Patel described himself as a general surgeon with some experience in paediatric, vascular and laparoscopic surgery.<sup>396</sup> On 13 December 2002, Dr Bethell sent Dr Patel generic information about Bundaberg and the Base by email, and on the same day, Dr Patel sent his curriculum vitae. Dr Bethell's evidence was that he considered Dr Patel to be very well qualified<sup>397</sup> and that he sent the curriculum vitae to Dr Nydam at the Base. He noted, in particular, that Dr Patel maintained that he had held a position as staff surgeon at the Kaiser Permanente Hospital in Oregon for some 12 years, that he had held academic positions, that he'd been the head of a surgery residency programme and that he had been widely published in well-recognised journals.<sup>398</sup>
- 3.75 Dr Nydam recalls receiving Dr Patel's curriculum vitae, and recalls also speaking by telephone to Dr Patel on two occasions between 13 and 20 December 2004. The curriculum vitae repeated the claims already made by Dr Patel. It stated, amongst other things, that Dr Patel was a US citizen, that he was a fellow of the American College of Surgeons and that he was aged 51. Dr Patel had provided six references to Dr Bethell.<sup>399</sup> They were 'open' references in that they were addressed 'to whom it may concern' and they dealt with the authors' experiences in Oregon with Dr Patel over the last ten years, rather than matching him to any

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<sup>393</sup> Exhibit 41, para 4, T683

<sup>394</sup> Exhibit 41, para 5; T672

<sup>395</sup> Exhibit 41, para 6

<sup>396</sup> T675, line 20

<sup>397</sup> T695, line 30

<sup>398</sup> T694

<sup>399</sup> T678 and see Exhibit 41, para 12

given position. Dr Bethell gave evidence that it was Wavelength's policy to carry out a minimum of two verbal reference checks.<sup>400</sup> Dr Bethell testified that he spoke to Dr Patel about this matter and that Dr Patel nominated three referees, being three of the doctors who had provided the open references.<sup>401</sup> Dr Bethell said that he spoke with a Dr Peter Feldman and a Dr Bhawar Singh and that they both spoke very favourably about the applicant.<sup>402</sup>

- 3.76 It should be said that the references were effusive in their praise for the skills, knowledge and industry of Dr Patel, even by the normal standards of such documents. A Dr Edward A Ariniello, former Chief of Surgery at the Kaiser Permanente Hospital in Portland wrote that Dr Patel had:<sup>403</sup>

...demonstrated that he is one of the most well read and well informed of all our surgeons (22), and his superior skill was also demonstrated in the operating room. He is entirely selfless in his determination to be available for call, consultations and problems...He will be difficult or impossible to replace. I can recommend Dr Patel without any reservations whatsoever.

- 3.77 A Dr Peter M Feldman, staff surgeon at Kaiser Permanente, wrote that:<sup>404</sup>

I have many good things to say about Dr Patel. He has been a wonderful colleague over the years and has been a very hard worker. He has a well above average interest in his work, and a well above average knowledge of surgery. I would judge Dr Patel to have very high moral standards...

- 3.78 An anaesthetist from the Kaiser Permanente Hospital, Dr Bhawar Singh, wrote that:<sup>405</sup>

[Dr Patel's] balanced judgment, surgical skills and decisive steps, especially in the management of high risk complex procedures, has always been appreciated by anesthesiologists and other members of the OR Team. Dr Patel's professional expertise, passion and energy for quality patient care coupled with ethical and best practice advocacy won him the vote of his colleagues for a Distinguished Physician Award.

- 3.79 There were also tributes from a Dr Wayne F. Gilbert of Portland, a Dr J T Leimert, Chief of the Department of Hematology-Medical Oncology at Kaiser Permanente, and a Dr Leonora Dantas of the Department of Internal Medicine at Kaiser Permanente.<sup>406</sup>

- 3.80 Moreover, the notes of the telephone calls to Drs Feldman and Singh appear to bear out the written references, albeit that, in retrospect, some remarks seem ominous. It is recorded that Dr Feldman explained that he had known Dr Patel for 5 to 6 years and that he was 'extremely knowledgeable, above average

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<sup>400</sup> T696, line 10

<sup>401</sup> T696, line 10

<sup>402</sup> Exhibit 41, para 12

<sup>403</sup> Exhibit 51, attachment KN4

<sup>404</sup> Exhibit 51, attachment KN4

<sup>405</sup> Exhibit 51, attachment KN4

<sup>406</sup> Exhibit 51, attachment KN4

interest in surgery, *sometimes took on complex cases handed to him by colleagues, found it hard to say no*. He is said to have continued:<sup>407</sup>

Worked together in busy surg. depart. Extremely good natured guy. Handled routine emergencies well. Well regarded by patients – like him. ‘Can do’ guy. Vast majority of colleagues liked and appreciated him. *He had a falling out with a very few of the surgeons at Kaiser*. Not aware of any problems with theatre staff. Hard working guy wonderful colleague – I missed him when he left, nothing in personal life of concern.<sup>408</sup>

[my underlining]

3.81 Dr Singh is recording as saying:

Very good, very skilful surgeon. Deliberate in decision making surgery. Asked advice appropriately. Would ask for opinions if necessary. Good general and paediatric surgical skills – some thoracic. Worked together 1- 2 times a week. Dealt with emergencies – controlled way. Actively involved in training junior surgical staff. To my knowledge patients held him in high esteem. Gets on with doctors. Generally got along well with nursing staff – a perfectionist so got upset if things not ready for him eg equipment. However was professional in manner. Very conscientious and hardworking. Nothing of concern in his personal life. Suitable for general surg job.

3.82 Dr Bethell made the telephone calls to the referees himself and he gave evidence that nothing in those conversations caused him any concern.<sup>409</sup>

3.83 Dr Bethell says that he may have spoken to Dr Nydam about the outcomes of those calls in accordance with his general practice but, certainly, it was Dr Nydam's evidence that he received the notes of those checks by facsimile on Friday 20 December 2002.<sup>410</sup> He said that he ‘took the curriculum vitae at face value’ and considered it to be comprehensive.<sup>411</sup> He had received a number of applications from overseas trained doctors, but he was impressed by the one from Dr Patel, and another application received from a Dr James Gaffield, each surgeons who had been working in America, because they had ‘first world experience’.<sup>412</sup> Dr Nydam finally settled upon Dr Patel because he had considerable experience in general surgery, whereas Dr Gaffield had developed a special interest in plastic surgery.<sup>413</sup>

3.84 By an email dated Friday 20 December 2002, Dr Nydam wrote to Dr Bethell that he had the authority of the District Manager to offer a one year contract to Dr Patel and that a letter of offer would be drafted on the Monday.<sup>414</sup> By a formal letter from the Base's Human Resources Section and dated 24 December 2002,<sup>415</sup> Dr Patel was offered the position of Senior Medical Officer, Department

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<sup>407</sup> Exhibit 51, attachment KN4

<sup>408</sup> See Exhibit 51, attachment KN4

<sup>409</sup> T680

<sup>410</sup> Exhibit 51, para 17

<sup>411</sup> Exhibit 51, attachment KN4

<sup>412</sup> Exhibit 51, para 21

<sup>413</sup> T4126, line 50

<sup>414</sup> Exhibit 43

<sup>415</sup> Exhibit 51, attachment KN9

of Surgery for twelve months, subject to Medical Board and Immigration Department approval, and by email dated 28 December 2002, that offer was accepted. On 3 January 2003, Wavelength informed Dr Nydam in correspondence that Dr Patel could commence his position on 1 April 2003.<sup>416</sup>

- 3.85 Wavelength's Terms and Conditions provided that, by way of remuneration, it would receive a sum equivalent to 15% of the successful candidate's salary. In this case, that meant that Wavelength received a sum of \$15,006.60 from Queensland Health.<sup>417</sup>
- 3.86 There were a number of matters that might well have caused Wavelength concern about Dr Patel's application. In the first place, the curriculum vitae received by the company in December 2002 stated that Dr Patel's last employment (being with the Kaiser Permanente Hospital) had ceased in September 2001, which meant that he had been unemployed for some 15 months.<sup>418</sup> In the second place, the references were somewhat unsatisfactory in that the most recent was dated June 2001 and they did not explain how Dr Patel came to be leaving Kaiser Permanente.<sup>419</sup> In the third place, when Dr Patel had cause to send a further curriculum vitae in January 2003, it contained an amendment under the title 'positions held' so that Dr Patel was said to have continued in employment with Kaiser Permanente until September 2002.<sup>420</sup> In the fourth place, it might have been considered strange that a doctor should choose to emigrate from the United States to Australia when practitioners in the former country are paid so handsomely.<sup>421</sup>
- 3.87 Dr Bethell gave evidence that he raised the first point with Dr Patel. He was told by way of response that, even though he was only 51, Dr Patel had decided to retire and did so in September 2001, before subsequently developing an interest in working overseas.<sup>422</sup> Dr Bethell said that the prospect of a doctor retiring at the age of 50 did not seem implausible because American doctors tend to make significant amounts during their careers, under some pressure, and retire at a young age.<sup>423</sup> The discrepancies between the two curricula were not noticed by Dr Bethell (and, presumably, they would have had a big impact, having regard to Dr Patel's earlier explanation) and the causes for scepticism with Americans emigrating did not strike him.

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<sup>416</sup> Exhibit 51, para 23

<sup>417</sup> Exhibit 51, KN9, Exhibit 41, para 30: note that Wavelength did not receive any additional money if the contract was extended.

<sup>418</sup> T679, line 1

<sup>419</sup> Exhibit 51, attachment KN4

<sup>420</sup> Compare Exhibit 51, KN3 with Exhibit 46

<sup>421</sup> T679

<sup>422</sup> T679, line 20; Dr Bethell specifically raised this issue in an email to Dr Nydam – Exhibit 43 – but it was not pursued.

<sup>423</sup> T679

- 3.88 Once the position had been accepted, there were, of course, a number of steps that needed to be taken so that Dr Patel could practise in Queensland. The first, of course, was that the Minister's delegate needed to determine that the position was situated within an area of need pursuant to s135(2) of the *Medical Practitioner's Registration Act 2001*. The second was that the Medical Board needed to grant registration and the third was that Dr Patel needed to secure a temporary working visa from the Department of Immigration and Ethnic Affairs. It was the practice of Wavelength to co-ordinate the various applications and, by the letter of 3 January 2003, the company indicated that it would do so in Dr Patel's case.<sup>424</sup> Under cover of that correspondence, it provided the Base with the relevant employer form for each body, and asked that Dr Nydam sign and return them.
- 3.89 Dr Bethell explained that the task of arranging the various applications was carried out by 'a staff member who looked after the administrative paperwork'.<sup>425</sup>
- 3.90 It was necessary for Dr Patel to complete separate applications for registration to the Medical Board and to the Department of Immigration. On 6 January 2003, Dr Patel provided a completed application for registration (form 2A) to Wavelength, together with supporting material, as required by the Medical Board's guidelines. That material included the prescribed fee, certified copies of all medical degrees, a detailed curriculum vitae, and a Verification of Licensure.<sup>426</sup> It seems that the Board also received Queensland Health's position description and a 'controlled substance registration certificate'.<sup>427</sup> The form required that applicants set out their personal details, qualifications, experience, and the contact details of two referees.<sup>428</sup> At about the same time, Dr Nydam completed the Hospital's application for Dr Patel to be registered (form 1A) and returned that to Wavelength. By a letter dated 17 January 2003, Wavelength forwarded those documents to the Medical Board, together with a letter from the Base formally seeking registration and the January version of the curriculum vitae.<sup>429</sup> The letter sought that Dr Patel's application for an area of need position as a Senior Medical Officer be considered at the Board's next meeting.<sup>430</sup> The correspondence noted that an Area of Need declaration and a Certificate of Good Standing (which, in Oregon, is known as the Verification of Licensure) would follow.<sup>431</sup>

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<sup>424</sup> T697; Exhibit 51 KN7

<sup>425</sup> T697, line 2

<sup>426</sup> Exhibit 51, attachment KN4

<sup>427</sup> Exhibit 41, paras 16 and 17

<sup>428</sup> Exhibit 24, MDG14

<sup>429</sup> Exhibit 24, MDG13

<sup>430</sup> Exhibit 24, MDG17

<sup>431</sup> Exhibit 24, MDG12

3.91 Dr Patel's application for registration stated that he had been employed by Kaiser Permanente until September 2002. It relevantly included the following questions:<sup>432</sup>

- Have you been registered under the Medical Practitioner's Registration Act 2001 or the Medical Act 1939 (repealed) or have you been registered under a corresponding law applying, or that applied in another State, or Territory, or a foreign country, and the registration was affected either by an undertaking, the imposition of a condition, suspension or cancellation in any other way.
- Has your registration as a health practitioner ever been cancelled or suspended or is your registration currently cancelled or suspended as a result of disciplinary action in any State or Territory or in another county.

3.92 To each of those questions Dr Patel answered 'no'.

3.93 Dr Patel faxed the Verification of Licensure to Wavelength on 19 January 2003, and then mailed the original. For its part, Wavelength sent a facsimile of the Verification of Licensure to the Board on 21 January 2003 and mailed the original on 29 January 2003.<sup>433</sup> The document carried the words 'Limitations none; Extensions none' but it also included a sentence which read: 'Standing: Public Order on File See Attached'. The attachment was not included in either version of the document provided by Dr Patel, and Wavelength did not notice that omission.<sup>434</sup> It was Dr Bethell's evidence that, in his experience with certificates of good standing, or their equivalent, comparable jurisdictions tend to either issue them, or they do not: he had not, it seems, come across qualified certificates.<sup>435</sup>

3.94 At about the same time, Dr Nydam completed the form 1 required of the Base, and Dr Patel completed the form 2 required of doctors, together with the formal request, for the Area of Need application.<sup>436</sup> The application included the January version of Dr Patel's curriculum vitae, indicated that the position for which he was sought was Senior Medical Officer, Surgery at the Bundaberg Base Hospital, and specified that the requested period was 1 April 2003 to 1 April 2004. The completed forms were provided to Wavelength and, on 8 January 2003, Wavelength sent them to Dr Michael Catchpole, then one of the Ministerial delegates (all of whom were employed within the Workforce Reform Branch of Queensland Health) and the Principal Medical Advisor.<sup>437</sup> It was approved on 17 January 2003 and apparently faxed to Wavelength's offices in Sydney, from where it was forwarded to the Medical Board.

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<sup>432</sup> Exhibit 24, MDG14

<sup>433</sup> Exhibit 24, paras 29 and 30; Exhibit 24, MDG22 and MDG23

<sup>434</sup> Exhibit 41, para 17; T705

<sup>435</sup> T697-8; T705, line 10-30. There was evidence, however, that certificates issued in the United States commonly take the form of a 'status report' requiring careful scrutiny: Exhibit 24, MDG3.

<sup>436</sup> Exhibit 24, MDG16, MDG17, MDG21

<sup>437</sup> Exhibit 58, page 8

- 3.95 When the application came to the Medical Board, it was assessed by a Registration Officer called Ainslie McMullen who was, according to the Deputy-Registrar of the Board, a very experienced and methodical member of the staff.<sup>438</sup> By a statement provided to the Commission, she has explained that she was employed as an administration officer and she would receive, collate and check applications.<sup>439</sup> She would consider the area of need applications, in particular, with the aid of a checklist developed for that purpose.<sup>440</sup> If the application was found to include all appropriate documents, she would forward it to the Registration Advisory Committee meeting for consideration, after which it was provided to the Medical Board (which, of course, also met twice a month), for confirmation of the decision.<sup>441</sup>
- 3.96 Ms McMullen has no specific recollection of considering Dr Patel's application. Unfortunately, again, it seems that the significance of the note about the attachment was not seen<sup>442</sup> or not understood. Ms McMullen has indicated that it was her experience that certificates of good standing were either granted or they were not (as Mr Demy-Geroe testified) and that she cannot recall observing anything untoward about the Verification of Licensure. She has explained that she was fortified in her 'view' by Dr Patel's answers to the questions concerning his disciplinary history.<sup>443</sup> Alongside the field in the registration checklist of 'under investigation or conditions/undertakings in place' Ms McMullen circled 'no'<sup>444</sup> and it seems that she simply overlooked the reference on the Verification to the attached 'public order'. The application was sent to the Registration Advisory Committee meeting, which appears to have met on 3 February 2003. It seems that the members agreed that he ought not be 'represented as a specialist'.<sup>445</sup> A report from that meeting records that
- Dr Patel is seeking special purpose registration under section 135 to fill an area of need as a SMO in surgery at Bundaberg Base Hospital from 1 April 2003 to 31 March 2004. Queensland Health is in support.
- Recommended that Dr Patel be approved special purpose registration under section 135 to fill an area of need as a SMO in surgery at Bundaberg Base Hospital from 1 April 2003 to 31 March 2004, subject to completion of registration requirements.<sup>446</sup>
- 3.97 The minutes for the Board of 11 February 2003 record that it made an order in precisely the terms of the recommendation.<sup>447</sup>

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<sup>438</sup> Exhibit 24, para 32; T439

<sup>439</sup> Exhibit 421, para 4

<sup>440</sup> Exhibit 421, para 8

<sup>441</sup> Exhibit 24, paras 31, 34-5, 36-7; Exhibit 421

<sup>442</sup> Ms McMullen's statement sheds little light on the issue, but having regard to the checklist answers, the better view is that Ms McMullen simply failed to notice the lack of an attachment: see also Exhibit 24, MDG 4, para 5.3

<sup>443</sup> Exhibit 421, paras 13-16

<sup>444</sup> Exhibit 24, MDG24

<sup>445</sup> Exhibit 24, para 36

<sup>446</sup> Exhibit 24, MDG25

<sup>447</sup> Exhibit 24, MDG26



- 3.98 On 12 February 2003, the Medical Board wrote to Dr Patel and indicated relevantly that:<sup>448</sup>

You have been granted special purpose registration as a Medical Practitioner in Queensland pursuant to section 135 of the Medical Practitioner's Registration Act 2001 to enable you to practise the profession in an area of need decided by Queensland Health for the period 1 April 2003 to 31 March 2004, subject to completion of registration requirements. These are as follows

Interview with a Board member

...Registration is contingent upon you practising as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent during the period of your registration. You should also note that the above approval is for a specific purpose, to be undertaken in the defined period, after which your resignation will cease. Any further period will require a fresh application for registration and further consideration by the Medical Board.'

- 3.99 It follows from what I have said that, apart from checking the documents provided to it in the way I have described, the Medical Board made no assessment of Dr Patel's skill or competence to enable it to safely conclude, as it was required to do by s135(2), that he had a medical qualification and experience suitable for practising in the position at the Base. That occurred in circumstances where the Board had not even ascertained whether some other body (Wavelength Consulting Pty Ltd or Queensland Health) had approached Dr Patel's referees. I shall say something more about this and its consequences later in this report.

- 3.100 Wavelength then sent the Area of Need determination, and the Medical Board approval for registration, to the Department of Immigration, together with a Form 55 by which the Base made application to sponsor Dr Patel for a temporary working visa, subclass 422 (known as a 'medical practitioner's visa').<sup>449</sup> Dr Patel was required to lodge his own application for the visa from the United States.

- 3.101 The Form 55, executed by Dr Nydam, indicated that the Base sought to employ Dr Patel as a Senior Medical Officer full time for one year. Where the form asked if any efforts were made to obtain suitable staff from the Australian workforce, the reply made was:<sup>450</sup>

'Position has been advertised a number of times over the past 6 months. There have been no Australian applicants. This doctor is considered to be suitable with his overseas qualifications.'

- 3.102 Dr Nydam was asked to explain this statement. He maintained that his recollection was that the position of Senior Medical Officer - Surgery at the Base had been advertised in the newspaper. He conceded, however, that having

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<sup>448</sup> Exhibit 24, attachment MDG27

<sup>449</sup> Exhibit 44, para 17

<sup>450</sup> Exhibit 44

considered the relevant files, there was no record of such an advertisement.<sup>451</sup> There was only a record of advertisements seeking candidates for the position of Director of Surgery, and even then, of course, it was not true to say that there had been 'no Australian applicants'.

3.103 Dr Nydam gave evidence that he had approached three recruitment agencies about the Senior Medical Officer – Surgery position and that he understood that the agencies would 'advertise this position as part of the recruitment process'. He did not suggest that this advertising would happen within Australia, nor did he advance any basis for the understanding, and Dr Bethell gave evidence that at least his company never submitted advertisements to the public press, apparently because Australian doctors tend to organise themselves locally rather than going through an agency.<sup>452</sup>

3.104 In the event, the temporary working visa was granted and Dr Patel arrived in Australia on 31 March 2003. He attended the Medical Board's offices in Brisbane, where he had a brief interview with an officer but, as Mr Demy-Geroe of the Board frankly conceded, that interview is more of a 'meet and greet' session, than any attempt to test the practitioner.<sup>453</sup> A certificate of registration under s135 was issued shortly afterwards and it provided relevantly that the 'special purpose activity' was 'to practise as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent on a temporary basis'.<sup>454</sup> Dr Patel then proceeded to Bundaberg and took up the position in the Department of Surgery. On the same day, 1 April 2003, the Board sent Dr Patel and the 'Medical Superintendent' at the Base, a letter which read relevantly:

You have been granted special purpose registration as a Medical Practitioner in Queensland pursuant to section 135 of the Medical Practitioners Registration Act 2001 effective from 1 April 2003 until 31 March 2004. ...Special purpose registration enables you to practise as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent on a temporary basis. It is advised that you are not registered as a specialist. Any variation to your practice would require further approval by the Board.<sup>455</sup>

3.105 It will be remembered that, on 28 December 2002, the remaining surgeon at the Base, namely Dr Jayasekera, resigned and, in those circumstances, it became necessary to employ a second surgeon. The Base offered that position to Dr Gaffield who, of course, had applied for the position awarded to Dr Patel. An agreement was reached with Dr Gaffield on similar terms to those reached with

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<sup>451</sup> See the statement of Dr Nydam dated 19 October 2005, paras 13 and 14

<sup>452</sup> T684. The assertion by Dr Nydam in January 2003 that he had advertised a number of times over the last six months, moreover, is difficult to reconcile with the evidence that he only approached Wavelength Consulting, and presumably the other agencies, in November 2002.

<sup>453</sup> Exhibit 225, para 19

<sup>454</sup> Exhibit 24, MDG31

<sup>455</sup> Exhibit 469

Dr Patel, except that Dr Gaffield was not to commence employment until 28 April 2003.

## Defects revealed in the process of appointment

3.106 In all these facts concerning the appointment of Dr Patel, there are a number of serious defects revealed. I will consider the role of the various 'gatekeepers' in turn.

### Wavelength

3.107 The process adopted by Wavelength for checking references seems seriously flawed, particularly when, as seems to be the case, they did not expect that the employer would carry out any reference checks of its own. In the first place, one would expect that recourse to referees would not be limited to those selected by the applicant and that, as a bare minimum, the doctor's last known supervisor might be contacted. In the second place, care might have been taken to ensure that referees provided current references, preferably in the context of the particular position for which the practitioner was applying.

3.108 If Wavelength had made enquiries in Oregon independent of people to whom it was directed by Dr Patel, it seems entirely possible that it would have been apprised of many of the shortcomings which became apparent in Bundaberg. This seems all the more likely given Dr Feldman's comments that Dr Patel 'sometimes took on complex cases handed to him by colleagues, found it hard to say no', and that he had a 'falling out' with 'a very few surgeons at Kaiser Permanente'.

3.109 When Wavelength was subsequently preparing the various applications for Dr Patel to work in Queensland, it could have done so with considerably more diligence. If that had occurred, it would have noticed that the curriculum vitae provided in January 2003 was inconsistent with the one provided in December 2002 (where it referred to continuing employment at Kaiser Permanente until September 2002 in place of September 2001), with the references suggesting that Dr Patel was preparing to depart in June 2001, and with the specific instructions given previously that Dr Patel did, in fact, retire in September 2001. Wavelength would also have noticed, if it conducted a thorough check that, although Dr Patel had provided two copies of the Verification of Licensure, they each omitted the attachment. If it had secured the attachment, it seems it would have learnt the information that became apparent when an internet search of the

Oregon Board of Medical Examiners site was conducted in early 2005.<sup>456</sup> A search of the name Jayant Mukundray Patel shows, alongside the field of 'standing', the words 'public order on file'. Under the heading 'Board actions taken between April 1, 2000 and December 1, 2000', there appears the following entry:

PATEL, Jayant M, MD15991, Portland, Orr: A stipulated order was entered on September 12, 2000. The order restricted licensee from performing surgeries involving the pancreas, liver resections, and ileoanal pouch constructions.

3.110 On the same page, the term 'stipulated order' is defined as:

An agreement between the Board and a licensee which concludes a disciplinary investigation. The licensee admits to a violation of the Medical Practice Act, and the order imposes actions the Board and licensee agree are appropriate. Stipulated orders are disciplinary actions.

3.111 If further enquiries had been made, the full terms of the stipulated order would have been revealed. They included that:

- (a) On 25 June, Kaiser Permanente filed a report with the National Practitioners Data Bank in the United States concerning Dr Patel;
- (b) Following extensive peer review of 79 patient charts, Kaiser restricted Dr Patel's practice to exclude surgery involving the pancreas, any resections of the liver, and construction of the ileoanal pouch;
- (c) Kaiser restricted Dr Patel's practice further by requiring that he obtain second opinions preoperatively before undertaking all complicated surgical cases (which was defined to include 'abdominoperineal recessions, oesophageal surgeries, gastric surgeries and soft tissue malignancies');<sup>457</sup>
- (d) The Board of Examiners conducted their own investigation and, before it, Dr Patel acknowledged that he had made surgical errors;
- (e) The Board's investigation of four particular patients showed violations of the Oregon legislation and, in particular, revealed wound dehiscence, a colostomy that was performed 'backwards', three deaths soon after surgery – one after an operation known as a 'Whipple's' procedure, and significant bleeding intraoperatively;
- (f) Dr Patel had agreed to sign a Stipulated Order which incorporated the restrictions imposed by Kaiser Permanente.<sup>458</sup>

3.112 The order was amended for technical reasons on 1 November 2000.

3.113 It can be expected that doctors will work between different jurisdictions and that this feature will be even more pronounced amongst incompetent doctors. In

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<sup>456</sup> See Exhibit 226, para 76 and GF21, and see Exhibit 24, para 4

<sup>457</sup> T4306

<sup>458</sup> Exhibit 24, MDG9

those circumstances, Wavelength might have insisted that doctors provide Certificates of Good Standing from each jurisdiction in which they have practised. If Wavelength had adopted that course, it may have discovered information suggesting that Dr Patel had been licensed to practise medicine in the State of New York in May 1980, and that the Board for Professional Medical Conduct ordered that he be stricken from the 'roster of physicians' in that State on 5 August 2001 after he agreed to surrender his license. The company would have learnt that a Statement of Charges, dated 5 April 2001, precipitated that development<sup>459</sup> and that it read as follows:

Jayant M Patel ... was authorised to practise medicine in New York state on May 23, 1980 ...

#### Factual Allegations

A. On or about September 7, 2000, the Board of Medical Examiners, State of Oregon ('hereinafter 'Oregon Board'), by a Stipulated Order (hereinafter 'Oregon Order'), limited Respondent's license to exclude surgeries involving the pancreas, any resection of the liver, and any constructions of ileoanal pouches, and required Respondent to obtain a second opinion on complicated surgical cases, based on gross negligence, and negligence on more than one occasion.  
B The conduct resulting in the Oregon Board disciplinary action against Respondent would constitute misconduct under the laws of New York state...

#### Specification

Respondent violated New York...Law...by having been found guilty of improper professional practise or professional misconduct by a duly authorised professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state...

3.114 An formal order of 5 August 2001 read relevantly as follows:

Upon the proposed agreement of Jayant M. Patel MD to Surrender his licence as a physician in the State of New York, which proposed agreement is made a part hereof, it is AGREED to and ORDERED, that the proposed agreement and the provisions thereof are hereby adopted; it is further ORDERED, that the name of the Respondent be stricken from the roster of physicians in the State of New York...<sup>460</sup>

3.115 Inquiries may also have revealed that it appears Dr Patel was disciplined in 1984 by the New York State Board for Professional Medical Conduct 'for entering patient histories and physicals without examining patients, failing to maintain patient records, and harassing a patient for cooperating with the New York board's investigation', receiving, amongst other things, probation and a fine.<sup>461</sup> Although the exact details of those findings are not known to the Commission, it is clear that the Statement of Charges issued by the State Board set out five cases in which Dr Patel set out a history, a physical examination, progress note

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<sup>459</sup> The notations on the New York website make clear that the license has been surrendered pursuant to disciplinary action: see Exhibit 24, MDG 3, para 4.5, and MDG9

<sup>460</sup> See the statement of Exhibit 225, GF21, and see Exhibit 24, MDG3, para 4.4

<sup>461</sup> See *Regulatory Action Against Jayant M. Patel M. D.*, Stephen Barrett, <http://www.casewatch.org/foreign/patel/patel.html>;

and or an admission order 'without personally examining the patient'; that he had practised the profession of medicine with negligence and incompetence on more than one occasion, and that he had, amongst other things, neglected a patient in need, and 'failed to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient...'.<sup>462</sup> Inquiries may also have revealed that the allegations led to Dr Patel's dismissal from the University of Rochester's surgical residency program.<sup>463</sup>

- 3.116 The orders set out above (at least those for the years 2000 and 2001) are freely and immediately available on the internet. Certainly, at the time of writing this report, it was possible to obtain them simply by using the "Google" search engine for the words 'Jayant Patel'. Moreover, several witnesses gave evidence that this was also the case in early 2004 and 2005.<sup>464</sup> One nurse, Ms Michelle Hunter, gave evidence that, by the middle of 2004, she had misgivings about Dr Patel and she did a "Google" search which revealed the restrictions in Oregon. She said that she mentioned the results to other nurses but not more widely because she understood that the job of assessing Dr Patel's competence belonged to 'whoever registers him, and management'.<sup>465</sup>
- 3.117 Whilst there may be a number of practitioners bearing the name of Jayant Patel, any serious enquiry would have noted that the applicant for the Bundaberg post, and the practitioner subject to the charges, were one and the same, having regard to the year of birth, 1951, the middle name 'Mukundray', and the address of 3739 NW Bluegrass Pl, Portland, Oregon, 97229.
- 3.118 It was Queensland Health, and in this case the Base, and the Medical Board, not Wavelength, which had assumed responsibility for patient safety in public hospitals in Queensland. They could not escape that responsibility by accepting, without further inquiry, the reliability of the information passed on to them by Wavelength, a body which stood to gain from Dr Patel's appointment, particularly in the light of the concerning matters to which I have referred.

### Queensland Health and the Base

- 3.119 As regards the Base, there were more serious failings, particularly having regard to its knowledge of the position for which Dr Patel was destined.
- 3.120 Wavelength, the Medical Board, and the Department of Immigration might have expected, if they turned their minds to such things, that as a Senior Medical Officer – Surgery, Dr Patel was to be supervised by a doctor of equal or superior

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<sup>462</sup> [http://www.oregonlive.com/pdfs/oregonian/malpractice/new\\_york\\_medical\\_board\\_records.pdf](http://www.oregonlive.com/pdfs/oregonian/malpractice/new_york_medical_board_records.pdf)

<sup>463</sup> See 'Patel's Disturbing Record at Kaiser';

[http://www.oregonlive.com/oregonian/malpractice/index.ssf?/base/front\\_page/1131093370226790.xml&coll=7](http://www.oregonlive.com/oregonian/malpractice/index.ssf?/base/front_page/1131093370226790.xml&coll=7)

<sup>464</sup> See the evidence of Dr Keating

<sup>465</sup> T2041, line 40

standing. They might have assumed that the supervisor, i.e, the Director of Surgery, would have been a fellow of the Royal Australasian College of Surgeons, as had certainly been the case at the Base at least since 1994.<sup>466</sup> Dr Nydam, however, well knew that such an assumption would be incorrect. Dr Baker had left the Base at the end of November 2002. Dr Jayasekera acted as the Director of Surgery from that time, but he announced his resignation on 28 December 2002, and he had departed on 30 March 2003, just before Dr Patel arrived. Indeed, given that Dr Gaffield was not due to commence employment until 28 April 2003, there would be a period of almost one month when Dr Patel did not even have the potential for conferring with a second staff surgeon.

- 3.121 The position descriptions provided for Dr Patel and Dr Gaffield each stipulated that that they would report to the 'Director of Surgery' but, absent some Visiting Medical Officer acting in the role (and that was not suggested by Dr Nydam), that could not be true. Moreover, Dr Gaffield was clearly considered a less appropriate candidate than Dr Patel and, as Dr Nydam eventually conceded under cross examination, he had never contemplated appointing Dr Gaffield as the Director of Surgery, so that it could not have been expected that Dr Patel would be reporting to him. In short, the Base knew, well before Dr Patel's registration or employment, that he would not be reporting to anyone. Dr Nydam effectively conceded that this was the case.<sup>467</sup>
- 3.122 Dr Strahan gave evidence that, on 1 April 2003, the day Dr Patel arrived at the Base, the latter was introduced to him as the 'Director of Surgery'. By an email dated 9 April 2003, Dr Nydam wrote to his Human Resources staff, 'Are we paying Jay Patel a Director's allowance? If not, could we do so please as he is the Director of Surgery'. Dr Nydam maintained in his evidence that, upon Dr Patel's arrival, he was only appointed the 'acting' Director of Surgery but this is difficult to reconcile with the email. More importantly, if that was his role, one might have reasonably expected that there would be plans afoot to secure a substantive Director of Surgery, but that was not the case. In fact, Dr Nydam conceded that there had been no attempt to advertise for a Director of Surgery since the closing date of 2 December 2002, and that no plans to do so were ever made after Dr Patel commenced employment. Indeed, the situation was worse. In July 2003, Dr Geoff de Lacy, a general surgeon, a fellow of the College and a former Director of Surgery of the Queen Elizabeth II Hospital, moved to Bundaberg and approached management at the Base about working there as a Visiting Medical Officer. He might have been considered for the position of Director of Surgery but his approach was rebuffed altogether. Dr Nydam gave evidence that it would have been 'fantastic' to have Dr de Lacy at the Base as a Visiting Medical Officer Director of Surgery but that did not occur.

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<sup>466</sup> See the evidence of Dr Anderson and Dr Nankivell

<sup>467</sup> T4129

- 3.123 In the end, Dr Nydam conceded that he had intended, at least from December 2002, to appoint Dr Patel to the Director's position. He said that this was on the basis that he understood he could take that step without convening an Appointments Committee because the appointment was temporary (albeit, indefinite).<sup>468</sup> He maintained that he hoped, in time, that Dr Patel would have applied for a fellowship in the Australian College and that, at that point, he could be formally appointed as the Director of Surgery. Effectively, from about December 2002, even though Dr Patel was only employed on a twelve month contract, there was no intent to look for any other permanent Director of Surgery whilst he was there.<sup>469</sup>
- 3.124 It is difficult to avoid the inference that this informed his approach to Dr Jayasekera. Although the latter was a very well qualified surgeon and a fellow of the Australian College, the Base had been able to negotiate a relatively modest wage for him. When Dr Baker's position became vacant, it became more fiscally attractive to keep Dr Jayasekera at his then remuneration, and bring in an outside surgeon to fill the other spot. Indeed, that became more attractive still when the second surgeon could be an overseas trained doctor, remunerated on the lower pay scale.
- 3.125 Whether that speculation be correct or not, it is clear that Dr Patel had been 'earmarked' for the position of the Director of Surgery<sup>470</sup> so that, upon taking up his place, he could not be reporting to that person. That had two very important consequences. First, the Base had provided the Position Description for 'Senior Medical Officer – Surgery' to the Medical Board<sup>471</sup> with the effect that, in considering Dr Patel's suitability, they were entitled to believe that he would be working in a supervised capacity, when in fact that was not the case. Secondly, and more immediately, it meant that the Base should have insisted on very rigorous inquiries in the appointment process. The Base knew that Dr Patel would be working for twelve months in circumstances where he:
- a) was in regional hospital setting;
  - b) was situated some 385 kilometres from the nearest tertiary hospital;
  - c) was responsible for some 80,000 potential patients;
  - d) was conducting emergency and elective surgery;
  - e) had, as his closest peer a more junior, overseas trained surgeon;

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<sup>468</sup> T4133, line 40

<sup>469</sup> T4129

<sup>470</sup> See T4129

<sup>471</sup> See Exhibit 421, para 12(h)



- f) was not involved, in any way, with the Royal Australasian College of Surgeons, or the policies set out in the Area of Need Assessment of Specialists guidelines;
- g) as a semi-retired Indian-educated, , American-trained doctor, could be expected to encounter significant cultural challenges;
- h) as a semi-retired Indian-educated doctor he would remain unsupervised;
- i) he was unlikely to be the subject of review by a credentialing and privileging committee in the foreseeable future.

3.126 The failure of Dr Nydam to alert the Medical Board to the absence of any Director of Surgery at any time before 12 February 2003 (when registration was to be approved) was thoroughly unacceptable. The failure of the Base and Queensland Health to inquire into Dr Patel's history was negligent.

3.127 Queensland Health should have been especially vigilant, at the very least, to see that Wavelength's recourse to referees was not limited to those selected by the applicant, and that Dr Patel's last known supervisor was contacted. Indeed, it hardly seems appropriate that this task should be delegated wholly to the recruiting agency - Dr Nydam did not suggest that he did more than peruse the notes of the calls<sup>472</sup> - when the agency has a commercial interest in 'placing' the candidate, the agency may have protected itself to some extent with terms and conditions which include a disclaimer (as was the case here),<sup>473</sup> and the recruiting officer may lack the medical, or local, knowledge to ask appropriate questions or explore answers. The Vice-President of the Royal Australasian College of Surgeons gave evidence that poorly performing practitioners may have 'different outcomes' if they are appropriately managed<sup>474</sup> and it is self evident that a doctor may have had talents which flourish in one environment but not another.<sup>475</sup> Against that background, the questioner really needed to be able to explain the conditions at Bundaberg (in terms of intensive care support, proximity to a tertiary hospital, closeness of supervision, makeup of work, etc.) if the suitability of the candidate was to be assessed meaningfully.

3.128 The evidence discloses a general lack of vigour on the part of Queensland Health in attempting to attract or retain a local surgeon at the Base. The interest from Dr Jayasekera in the position of Director was not reciprocated; the position of Senior Medical Officer - Surgery was not advertised locally; the Department of Immigration was told that the position had been advertised a number of times over the past six months without attracting Australian applicants when that was simply untrue. As to the last point, it might be said for the Base that it was

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<sup>472</sup> Exhibit 51, para 17

<sup>473</sup> T676, Exhibit 42, clause 6

<sup>474</sup> T4327-8, T4337

<sup>475</sup> See the evidence of Dr Woodruff.

inclined to treat the results of the Director of Surgery advertisements as indicative of the likely results for the Senior Medical Officer position. The difficulty with that approach is that this is not what the Department of Immigration was told and that, in any case, Dr Jayasekera made plain that there were reasons why a surgeon might be attracted to the Senior Medical Officer position but not that of Director of Surgery.<sup>476</sup>

- 3.129 Dr Nydam has indicated that he spent 'many sleepless nights worrying about how [he] was going to fill rosters' and that he was regularly in contact with the Directors of Medical Services in other districts, trying to identify locum staff.<sup>477</sup> He testified:

One of the reasons why the 18 months I spent as the Acting Director of Medical Services was probably the worst 18 months of my life was because I felt very much as though I was a member of the senior executive of a military... Except I was in the German army and when I was asking for lieutenants, I was getting sergeants, and when I was asking for 18 year olds, I was getting 14 year olds. So the military analogy is that if you have a captain who falls in the field, you trump up anybody.

- 3.130 Given the history of the Department of Surgery at the Base (including the availability of a number of fellows of the Australian College), the hospital's treatment of Dr Jayasekera, and the absence of any national advertising for the Senior Medical Officer position, it would be disingenuous to blame the appointment of Dr Patel on some general medical workforce shortage.
- 3.131 In the circumstances, I have made certain findings and recommendations against Dr Nydam and they appear later in this report.

### **The Medical Board**

- 3.132 The Medical Board was charged by statute with considering Dr Patel's suitability to practise. One would expect that, in assessing that suitability, there would be a range of factors to be taken into account, including the applicant's formal education, the circumstances of his or her experience, the level of supervision he or she could expect, and, in the light of these matters, the nature of the position in issue.
- 3.133 Any serious inquiry by the Medical Board of the Base would have alerted it to the fact that Dr Patel would be working in the circumstances set out above. Even on the information to hand, it could expect that he would be conducting surgery in a regional setting despite having never practised in Australia before.
- 3.134 In those circumstances, in considering Dr Patel's suitability for the 'practising the profession in the area', the Medical Board should have:

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<sup>476</sup> T5971, line 30

<sup>477</sup> see the statement of Dr Nydam dated 19 October 2005, para 9 and see T4119

- a) Conducted its own enquiries of Dr Patel's referees;
- b) Approached Dr Patel's last supervisor;
- c) Insisted that Certificates of Good Standing be provided from all jurisdictions in which Dr Patel had practised;
- d) Insisted that Certificates of Good Standing be provided directly by the issuing authorities so there was no opportunity for tampering;
- e) Made enquiries of the Base to ascertain the likely functions of the Senior Medical Officer post, and matched them against Dr Patel's strengths and weaknesses;
- f) Identified the name of the Director of Surgery to whom Dr Patel was to report, and confirmed that the person was a fellow of the Royal Australasian College of Surgeons;
- g) Inserted a condition requiring that there be regular reports going to Dr Patel's performance;
- h) Inserted a condition requiring that Dr Patel be subjected to an appropriate credentialing and privileging process before he commenced employment;
- i) Conducted internet searches.

3.135 Any reasonable enquiry would have revealed that Dr Patel had lied in the application about his disciplinary history. If that had been revealed, the dishonesty alone should have persuaded the Board that Dr Patel was not a suitable person for registration.<sup>478</sup> Certainly, Dr Nydam gave evidence that it was his position that 'any person who lies, who misrepresents themselves, who makes a positive effort to defraud who they really are, has got a level of morality that excludes them from any interest no matter how technically brilliant they are',<sup>479</sup> and it can be expected that the revelation of the lie might have resulted in another candidate being preferred. The Board, effectively, made no independent inquiry. Its 'checks' were limited to the perusal of material provided by the candidate and the hospital, and then largely by an administrative officer. Whereas the Base apparently perused notes of discussions between Wavelength and the referees, the Board did not even take that step. It neither contacted people in Oregon itself, nor satisfied itself that any other participant had done so thoroughly, or indeed at all.

3.136 As indicated above, I do not accept that the Board was excused from performing its statutory role because it lacked the resources. If that was the case, the Board should have informed the Minister accordingly.

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<sup>478</sup> But there is some suggestion in the Board's own material that it might simply have allowed registration in a supervised setting: Exhibit 24, MDG3, para 5.3

<sup>479</sup> T4110

- 3.137 In consequence of these findings, and of findings made in Chapter Four, it will be necessary to make recommendations with respect to the Medical Board. These are set out later.

### **A general conclusion about these defects**

- 3.138 In the end, the single most breath-taking feature of the quality control measures taken before Dr Patel's appointment was this. He was to stay at the Base for exactly two years (1 April 2003 to 1 April 2005) and in that time, he saw 1457 patients, and no doubt had an enormous impact upon the quality of life of many more Queenslanders. Notwithstanding that circumstance, the inquiries into the authenticity of his qualifications were almost entirely limited to the brief work of a private recruiting firm in Paddington, Sydney, which stood to gain by his appointment and which warned Queensland Health by its terms and conditions to make its own enquiries.

## Dr Patel's employment at the Bundaberg Base Hospital

### **Application of the credentialing and privileging process to Dr Patel**

- 3.139 In Australian hospitals, and indeed, most hospitals throughout the world,<sup>480</sup> the fact that a person holds medical qualifications is not regarded as entitling that person to carry out all procedures or activities offered by the facility. Instead, hospitals adopt a practice of imposing restrictions on the treatment that their doctors are authorised to provide by reference to a number of factors.
- 3.140 In the first place, in an increasingly specialised profession, it may be that the practitioner's qualifications or experience are confined to a particular area of medicine. Doctors are engaged in a 'craft' and, wherever possible, it is preferable that procedures be carried out by people who have the knowledge of likely complications, and recent advances, that come with regular involvement.<sup>481</sup> In the second place, it may be that there is another practitioner who is reasonably available and who has developed such a well-regarded practice in a procedure, that it makes little sense for his or her colleagues to engage in it. This will apply, even more so, if there is a facility in a particular region – such as a children's hospital or a rehabilitation centre – that is staffed by a number of people specialising in a particular field.<sup>482</sup>

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<sup>480</sup> T2851; T4139; T1843; T1859; T1864; T2846

<sup>481</sup> T6976, T6902, line 40

<sup>482</sup> T2847

- 3.141 In the third place, the scope of treatment a doctor can provide may require restriction having regard to the resources available within a hospital.<sup>483</sup> Medical practitioners may be significantly impeded performing certain procedures effectively if, for instance, they do not have a certain level of pathology or radiology services. Some surgery may require a stay in intensive care post-operatively – especially where there are complications – and it may be that the type of surgery that is to be performed at a hospital needs to be restricted because the intensive care facilities (whether by way of beds, specialists, or equipment) cannot cope.
- 3.142 The hospital's resources, of course, include staff, and a practitioner may have limitations set by his or her access to complementary experts in other fields, junior doctors, and experienced nursing staff. A practitioner in internal medicine, for instance, may be better able to advise a patient on possible treatment options if he or she can talk to surgeons, oncologists, radiologists, etc. about the likely consequences of taking different courses. Indeed, the optimal treatment path may be arrived at only after a discussion between a team of expert health providers. In that context, it may be appropriate to restrict the procedures that a doctor can provide at a particular facility because the patient would be better served by attending a larger hospital where a multi-disciplinary approach can be adopted.
- 3.143 In the fourth place, the issue of whether the treatment is elective or emergency, and how easily the patient can be transferred to another facility, will be crucial. In a remote setting, the general practitioner in the local hospital may be called upon in an urgent situation to perform neurosurgery simply because there is no one better qualified close by. If, on the other hand, a person in that same setting is suffering from the early stages of a brain tumour, it could properly be expected that he or she be transferred to a tertiary hospital and into the care of a qualified neurosurgeon. It follows, of course, from this consideration and others identified above that one doctor may have different sets of privileges at different hospitals.
- 3.144 Finally, it may be that the procedures that a doctor can provide should be restricted as a result of actual knowledge of the doctor's competence, the currency of his or her knowledge or by reference to the doctor's commitment to continuing medical education.
- 3.145 To formalise the consideration of these matters, hospitals have in place a process called 'credentialing and privileging'. The Commission heard evidence that, upon arrival at a facility, a doctor should be required, in the first place, to submit details of his or her qualifications and experience to a committee of peers, and to respond to any questions that the committee may have. The committee

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<sup>483</sup> T2847

should then make recommendations to hospital management, having regard to the applicant's credentials and the resources of the hospital (in the context of the wider matters raised above), as to those procedures which the practitioner should be authorised, or 'privileged', to carry out.

3.146 It seems that the specificity of the privileges can differ substantially. Some institutions choose to grant privileges expressed broadly by simply setting out an area of medicine (such as 'general surgery including gastroscopy/colonoscopy')<sup>484</sup> whilst others choose to express themselves narrowly and strictly so that, for instance, the privileges may be confined to particular, identified types of treatment.<sup>485</sup>

3.147 In July 2002, Queensland Health issued a document entitled 'Credentials and Clinical Privileges Guidelines for Medical Practitioners'.<sup>486</sup> It was accompanied by a Queensland Health Policy Statement on the same issue and it was expressed to replace an earlier version published in 1993. The Guidelines remain current and relevantly provide that:

1 It is recognised that rural practitioners 'need to use a more comprehensive range of skills than their urban counterparts' and the Guidelines were developed with that in mind.<sup>487</sup>

2 The principle purpose of the process is to ensure that:

only those practitioners who are appropriately qualified, trained and experienced will undertake clinical care within the constraints imposed by the available resources, including staff and equipment, and the physical facilities available within the healthcare facility concerned.<sup>488</sup>

3.148 'Credentials' represent the formal qualifications and experience of the candidate and may be evidenced by a range of documents,<sup>489</sup>

(a) 'Clinical Privileges' represent the range and scope of clinical responsibility that a practitioner may exercise within the facility,<sup>490</sup>

(b) The process of assessing credentials and recommending privileges is to be undertaken by peers, that is other medical practitioners;<sup>491</sup>

(c) The process should be conducted for new doctors, at regular intervals of three years, and as soon as possible upon request,<sup>492</sup>

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<sup>484</sup> Exhibit 410, SPB3, T6922, line 40

<sup>485</sup> See T1843, line 35

<sup>486</sup> Exhibit 279

<sup>487</sup> See the foreword to the Guidelines

<sup>488</sup> Paragraph 1 of the Guidelines

<sup>489</sup> Paragraph 2.2 of the Guidelines

<sup>490</sup> Paragraph 2.3 of the Guidelines

<sup>491</sup> Paragraph 2.4 of the Guidelines

<sup>492</sup> Paragraph 4 and 7 of the Guidelines

- (d) The recommendations should be provided to:
- the recruitment and selection/appointment committee, in the case of a new practitioner; or
  - the district manager in the case of an existing practitioner;<sup>493</sup>
- (e) The final decision as to privileges will be made by the District Manager, having regard to the committee's recommendations, as well as the 'administrative and resource implications for the facility';<sup>494</sup>
- (f) Clinical privileges should be defined before the completion of the appointment process;<sup>495</sup>
- (g) In any case, they should be defined before a doctor commences any admissions or treatment within the hospital;<sup>496</sup>
- (h) Overseas candidates for positions must be informed that any appointment is subject to the successful awarding of privileges;<sup>497</sup>
- (i) Where it cannot 'be confidently established' that a person has the necessary qualifications and experience for a given position, the person should be required to undergo a period of specialist supervision;<sup>498</sup>
- (j) The committee should be chaired by the Director of Medical Services and it should include two other medical practitioners at the hospital;<sup>499</sup>
- (k) In addition to the 'core membership' set out above, it 'should include' a representative from various named bodies (including the relevant college) 'where appropriate';<sup>500</sup>
- (l) The documentary evidence to be reviewed by the committee should go to, amongst other things, eligibility for qualifications, registration, professional good standing, satisfactory references and physical and mental fitness to practise;<sup>501</sup>
- (m) A mechanism should exist for the granting of temporary privileges for short-term appointees such as locums, without recourse to the full committee and the District Manager might delegate this power to the Director of Medical Services;<sup>502</sup>

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<sup>493</sup> Paragraph 2.4 and 6 of the Guidelines

<sup>494</sup> Paragraph 2.4 of the Guidelines

<sup>495</sup> Paragraph 6.1 of the Guidelines

<sup>496</sup> Paragraph 6.1 of the Guidelines. This is also the subject of an undertaking between the District and Queensland Health, signed by the District Manager: T7128; Exhibit 467

<sup>497</sup> Paragraph 2.3 of the Guidelines

<sup>498</sup> Paragraph 2.5 of the Guidelines

<sup>499</sup> Paragraphs 5.2 and 5.3 of the Guidelines

<sup>500</sup> Paragraph 5.3 of the Guidelines

<sup>501</sup> Paragraph 6.2 of the Guidelines

<sup>502</sup> Paragraph 7.3 of the Guidelines

- (n) Privileges may be granted for a probationary period, and subject to evaluation at the end of that time,<sup>503</sup>
- (o) The members of the committee are to be indemnified for their decisions.<sup>504</sup>

3.149 The Base had certainly engaged in the practice of privileging doctors in earlier times. Dr Thiele gave evidence that a committee dedicated to that process existed during his administration<sup>505</sup> and Dr Baker provided the Commission with a letter dated 12 June 2001 in which the Director of Medical Services at that time, Dr John Wakefield, informed Dr Baker of recommendations as to the privileges he should be granted.<sup>506</sup>

3.150 For reasons that are not clear, however, the practice seems to have fallen into disuse at the Base from about 2002, and it had not been revived by the time of Dr Patel's arrival on 1 April 2003.<sup>507</sup> The Guidelines, of course, required that the letter of offer sent to Dr Patel and dated 24 December 2002 make clear that his appointment was subject to the privileging process. That did not occur. I consider that they also required – having regard to the uncertainties as to Dr Patel's past – that any privileges awarded to him be subject, initially, to supervision or even a probationary period. That also did not occur. At the very least, the Guidelines required that Dr Patel be subject to the credentialing and privileging process prior to commencing to provide treatment but, again, that did not occur.

3.151 When Dr Patel arrived, Dr Nydam was continuing as the Acting Director of Medical Services.<sup>508</sup> He testified that he considered that Dr Patel did not require credentialing and privileging because he was a 'locum'.<sup>509</sup> I can see no foundation for that view: Dr Patel was employed on a 12 month contract with a status of 'temporary full time'<sup>510</sup> and the Guidelines clearly contemplate, in any case, that even temporary employees, including locums, were to be subjected to a form of credentialing.<sup>511</sup>

3.152 Dr Nydam gave evidence that, 'Given Dr Patel was a senior health professional, I assumed he would operate within the scope of his experience and prior practise as a General Surgeon'.<sup>512</sup> He said that, in those circumstances, any guidance given to Dr Patel was confined to the telephone conversations they had together prior to Dr Patel's appointment (which, he believes, would have concerned

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<sup>503</sup> Paragraph 7.2 of the Guidelines

<sup>504</sup> Paragraph 9.1 of the Guidelines

<sup>505</sup> T1843, line 40

<sup>506</sup> Exhibit 410, SB3

<sup>507</sup> T4136

<sup>508</sup> Dr Keating was appointed to the permanent position of Director of Medical Services on 14 April 2003: Exhibit 448, para 3

<sup>509</sup> T4142

<sup>510</sup> Exhibit 51, KN9

<sup>511</sup> Exhibit 279, para 7.3

<sup>512</sup> Exhibit 51, para 37



‘surgical workloads, the scope of clinical workload, staffing levels and a general discussion about the Bundaberg area itself’).<sup>513</sup> Given those remarks, the fact that the process had fallen into disuse, and some general comments in Dr Nydam’s initial statement to the effect that he simply had no recollection of the process being conducted,<sup>514</sup> it seems most likely that Dr Nydam never considered the issue of privileging Dr Patel or making the letter of offer subject to that process.

- 3.153 In the event, on 31 March 2003, Dr Patel was interviewed by an officer of the Medical Board in Brisbane to satisfy the only ‘condition’ of his registration. That interview, as discussed earlier, was effectively a ‘meet and greet’ session with the Board’s representative. Dr Patel then travelled to Bundaberg and reported to the Base on the following day. Notwithstanding the circumstances of Dr Patel’s registration with the Board, it is clear that he immediately assumed the position of the Director of Surgery. That conclusion is supported by the evidence of Dr Strahan that Dr Patel was introduced to him by that title on that day, by the email sent by Dr Nydam to his Human Resources staff on 9 April 2003,<sup>515</sup> instructing them to pay Dr Patel a ‘Director’s allowance...as he is the Director of Surgery’, and by the simple fact that there was no other practitioner who was acting as the Director, nor any plans afoot to recruit one.<sup>516</sup> It was not denied by any witness.
- 3.154 If the lack of any privileging made for a poor start to Dr Patel’s employment, it was compounded by other matters. There was no handover from the previous Director of Surgery or even an existing staff surgeon. Further, the Base did not offer any induction course regarding the hospital itself or the Queensland public health system generally, to overseas doctors,<sup>517</sup> so that it seems that Dr Patel was left to learn of his circumstances by a process of ‘osmosis’.<sup>518</sup>
- 3.155 It hardly needs to be said that this preparation was far from satisfactory. Dr Nydam had not communicated with Dr Patel about matters of substance for over three months, and then only in the context of long distance phone calls to a prospective employee. Dr Patel was a foreign trained doctor whose work no one had observed; he had no specialist qualifications that were recognised in Australia; indeed, he had no experience in this country; he had not worked for over a year; and he was coming to a very senior position in a relatively large regional hospital where he would not be supervised but he would supervise others. All this, moreover, was in circumstances where the Base had not carried out any checks for itself into Dr Patel’s background. Notwithstanding these matters, he was permitted to commence treating patients without the most

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<sup>513</sup> Exhibit 51, paras 18,19 and 37

<sup>514</sup> Exhibit 51, para 36

<sup>515</sup> Exhibit 58, KN12

<sup>516</sup> See the evidence of Dr Nydam discussed previously

<sup>517</sup> T4099 - There was evidence that an induction course of sorts was provided for interns.

<sup>518</sup> T4099, line 20

cursorily compliance with the practice of credentialing and privileging. Further, it seems, he was given no specific instructions as to important matters such as the availability of other institutions; when or how patients might be transferred; the extent of the support the Base could give; the protocols that the Department of Surgery might observe with the Department of Medicine or the Intensive Care Unit (amongst others); or the role of the tertiary hospitals and the assistance that might emanate from that source.

3.156 I make findings and recommendations in relation to these matters later in this report.

3.157 On 14 April 2003, that is two weeks after Dr Patel's arrival, Dr Darren Keating arrived at the Base and took up the permanent role of Director of Medical Services. The position description pursuant to which Dr Keating was appointed provided, amongst other things, that:

- (a) The Director of Medical Services reported directly to the District Manager
- (b) The Director of Medical Services was to 'facilitate the development and effective performance of clinical services in the District';
- (c) Whilst the position would operate with a 'significant degree of independence', nevertheless 'continual consultation would occur with the District Manager... and other executives within the District's facilities and agencies';
- (d) The Director of Medical Services would participate in a number of District Committees and would be the Chair of the Credentials and Privileges Committee.

3.158 Dr Keating had an impressive background. He had been awarded his primary medical degrees from the University of Melbourne in 1986; he had a Masters in Health Services Management from the Charles Sturt University in New South Wales; he had over ten years experience in clinical areas including internal medicine, emergency medicine and general practice; he had been a Commanding Officer in various units of the Australian Army between 1993 and 2000; and he had served in Somalia, East Timor, Germany and Bosnia.<sup>519</sup> Dr Keating had come directly from a position as a Senior Medical Officer in the Port Hedland Regional Hospital, Western Australia, but his induction to Bundaberg could only be described as minimal. He gave evidence that Queensland Health provided no orientation or training to the Base, no manual, and that he received only a brief handover from Dr Nydam.<sup>520</sup> It seems that, on his first day, he had a walking tour of the Base, he was introduced to some of the staff at a lunchtime

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<sup>519</sup> Exhibit 448, T6808-9

<sup>520</sup> T6932

meeting and he arranged, independently, to meet the directors of the various clinical departments.<sup>521</sup> Asked further about the guidance given to him at the outset, Dr Keating said:

I familiarised myself with the procedures as I went along. I literally was thrown in to work straight away, I was learning as I went...I came on the 9 o'clock plane [on 14 April 2003], was picked up by Mr Leck and was in a meeting at 9.30am.

- 3.159 Again, in my view, the preparation for the position was wholly inadequate. The failure to instruct Dr Keating at length about the many complex issues associated with running the Base is, in my view, inexcusable when it is considered that the Director of Medical Services was effectively the second-in-charge, and the first medical officer, of a facility which employed some 850 people, enjoyed an annual budget of \$56 million, and had enormous responsibilities for the Bundaberg District community. It is simply unthinkable that a person would be appointed to a similar position in the private sector with such little preparation, and the fact that the Director of Medical Services was responsible for *public* patients and *public* funds does not work in mitigation.
- 3.160 It will be recalled that the Director of Medical Services position had essentially remained vacant since Dr John Wakefield's departure towards the end of 2001,<sup>522</sup> and one can readily appreciate that a number of issues concerning medical administration might have required attention. Dr Keating certainly testified that he found that the credentialing and privileging process in respect of Senior Medical Officers had lapsed. He set about developing a policy that might comply with the Guidelines considered earlier, and he did so in conjunction with the Director of Medical Services at Hervey Bay, Dr Terry Hanelt.<sup>523</sup> Dr Keating gave evidence that the purpose of organising the credentialing and privileging process across the two districts was to ensure 'a critical mass of practitioners was available to undertake the process and to use scarce resources efficiently'.<sup>524</sup> I glean that the creation of a larger pool was considered attractive because there would be a greater number of 'peers' who might sit on a committee, because committees might assess a greater number of practitioners, and because those 'privileged' might move between the two facilities.<sup>525</sup>
- 3.161 The new local policy was tendered in evidence. It was expressed to have been initiated by Dr Keating and to be effective from 1 January 2003.<sup>526</sup> It provided relevantly as follows:

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<sup>521</sup> Exhibit 448, para 5

<sup>522</sup> Exhibit 437, para 8

<sup>523</sup> Exhibit 448, para 354

<sup>524</sup> Exhibit 437, para 355

<sup>525</sup> Insert the transcript references for Dr Nydam and Dr Keating T6923

<sup>526</sup> See Exhibit 276. There was no evidence as to exactly when the policy was created, but it seems to have been between April and June 2003, having regard to the commencement of Dr Keating's employment and the terms of later correspondence such as DWK82.

### **Criteria to be used in evaluating privileges**

#### **The Applicant**

Possession of (or eligibility to obtain) professional registration with the Medical Board of Queensland;

Qualifications and training appropriate to the privileges applied or;

Clinical experience and competence in the appropriate field of expertise;

Professional good standing including professional indemnity status, specialty College support, professional referee comments and peer recommendations;  
Commitment to past and continuing professional education and quality assurance activities; Physical and mental fitness to practice (sic)

#### **The Health Care Facility**

Facilities, equipment and financial resources available;

availability of necessary support services;

Role delineation of the facility

3.162 It provided that privileges were to endure for a period of three years, except that the initial appointment would be subject to a one year probationary review, and a review might be undertaken, in any case, where the Director-General, the District Manager, the Director of Medical Services or the Department Director, requested the same on clinical grounds.

3.163 Dr Keating's evidence was that, when he arrived in Bundaberg, Dr Patel was introduced to him as the Director of Surgery. He was not given to understand that Dr Patel was merely acting in that role, nor that there was any documentation that required attention, and he understood that the appointment was complete.<sup>527</sup>

3.164 Dr Keating was aware, however, that Dr Patel had not been privileged.<sup>528</sup> It might have been hoped that he would investigate the circumstances of Dr Patel's appointment and attend to that step straight away in accordance with the Guidelines, but that did not happen. It might have been hoped that, once the new local policy was developed in or about June 2003,<sup>529</sup> Dr Keating would have ensured that Dr Patel was subjected to the process described therein immediately, but that did not happen either.

3.165 By a letter dated 11 June 2003, the District Manager of the Base, Mr Leck, granted 'interim privileges' to Dr Patel. The letter read relevantly:

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

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<sup>527</sup> Exhibit 448, para 21

<sup>528</sup> T6830

<sup>529</sup> This is apparent from the correspondence subsequently sent to staff.

As per the advice of the Director of Medical Services, I hereby confer privileges in General Surgery for the hospitals within the Bundaberg Health District.<sup>530</sup>

- 3.166 Dr Keating gave evidence that, in granting – or, at least, recommending – temporary privileges, he had not carried out any investigation. He said that, since Dr Patel ‘had been employed through a specialist recruitment company’, he assumed that Dr Patel’s experience and references ‘had been checked and that he was considered qualified for the position of Director of Surgery’.<sup>531</sup> By a letter dated 26 June 2003, Dr Keating wrote to Dr Patel, underlining the importance of credentialing and asking that Dr Patel complete and return a formal application.<sup>532</sup> On the same day, Dr Patel completed the Application for Clinical Privileges (Specialists).<sup>533</sup> Under the heading of Clinical Privileges Requested, he wrote ‘General Surgery, Endoscopy’. He nominated the same referees as had appeared in his application for registration (but added Dr Leonara Dantas, also from Kaiser Permanente) and he attached his curriculum vitae. Dr Keating wrote again on 6 November 2003, seeking that Dr Patel provide copies of his ‘diplomas and board certificates’.<sup>534</sup>
- 3.167 In the event, the general process of credentialing and privileging was not implemented at the Base in respect of any medical practitioners until the last quarter of 2004.<sup>535</sup> Even then, it was not implemented in respect of any surgeons. By this time all the privileges granted by the previous Director of Medical Services had ‘completely run out’.<sup>536</sup>
- 3.168 By a letter dated 29 July 2004,<sup>537</sup> Dr Keating had written to Dr Patel, relevantly, that:

In June 2003, I wrote to you requesting completion and submission of an application for clinical privileges...Under the [combined Fraser Coast Health Service District and Bundaberg Health Service District] policy, which is primarily directed by Queensland Health policy the clinical privileges committee must include a relevant specialist nominated by the specialist college. With the introduction of this policy throughout Queensland, all colleges have been inundated with requests for nominations of suitable persons to sit on such committees. At present, the colleges have been unable to provide the appropriate nominations ...we are looking to complete the process as soon as possible pending the nomination of appropriate personnel by colleges. Thank you for your patience in this matter.

- 3.169 Dr Keating gave evidence that was consistent with the terms of the letter. He said that the Base had encountered problems garnering nominees from the various Colleges. Some Colleges were forthcoming with nominees (eg, the

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<sup>530</sup> Exhibit 448, DWK82

<sup>531</sup> Exhibit 448, para 360

<sup>532</sup> Exhibit 448, DWK82

<sup>533</sup> Exhibit 455

<sup>534</sup> Exhibit 448, DWK82; T6926

<sup>535</sup> T6927, line 30

<sup>536</sup> T6928, line 30

<sup>537</sup> Exhibit 448, DWK82

Colleges responsible for physicians and obstetricians) and the Committee met for the first time in November 2004 to consider practitioners in those areas.<sup>538</sup> Even then, however, the Royal Australasian College of Surgeons had not provided a name. It seems that enquiries were made by Dr Gopalan, the Assistant Director of Medical Services at Hervey Bay Hospital. He wrote by email on 15 July 2004 to Dr Keating and Dr Hanelt that:

I have contacted the college of surgeons in Victoria who referred me (sic) to the college branch in QLD. Following my discussions with them, they informed me that they had been swamped with applications from other area health services. Importantly they had a new chairman now and at this stage they are unable to suggest a suitable candidate as there are problems including indemnity of the college representatives for any fallout from the review. I got a call yesterday from the college informing me that they were now awaiting advice from the college headquarters in Melbourne. I will keep you posted, however I think we should get together and review our own staff applications. Can you provide me with a number of suitable dates?<sup>539</sup>

3.170 Dr Keating gave evidence that, first, he understood that the inclusion of a College representative to review a practitioner of that specialisation was mandatory; second, that he did not understand that the policy permitted him to appoint a specialist to the committee without the College's approval; and thirdly, he assumed that Queensland Health was aware of the problem (and, presumably, he assumed that it was working towards a solution).<sup>540</sup> Against the background set out above, Dr Keating did not attend to having Dr Patel credentialed at any time in the course of his employment.

3.171 It is my view that Dr Keating's failure to privilege Dr Patel demonstrated a serious dereliction of duty. Neither the Guidelines, nor the Queensland Health policy mandated that the Committee include a person nominated by the relevant College in every case. The language of the relevant provision – paragraph 5.3 – is clearly advisory rather than mandatory, as one would expect in a document entitled 'guidelines'. Section 5.1 of the Guidelines provided in part:

There should be a core membership of practitioners constant for all applications considered. Additional members *should be invited as required*, depending on the size and complexity of the facility, with representation from relevant professional and other bodies as dictated by the principle of peer representation. Representation from an 'industrial organisation' is not appropriate. The committee may be structured at a health care facility, district or cross district or zonal level. '

[my emphasis]

3.172 Section 5.3 of the Guidelines also provided:

The actual composition of the committee will vary depending on the discipline of the applicant(s) under consideration and the type of facility involved, but should

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<sup>538</sup> T6928; The minutes of the meeting were tendered as an Exhibit.

<sup>539</sup> Exhibit 448, DWK 79

<sup>540</sup> Exhibit 448, paras 356-9

include, in addition to the core membership, a representative from the following, where appropriate:

- Relevant clinical/professional college (such as Royal Australian College of Surgeons, Royal Australian College of Physicians, Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Australian College of Emergency Medicine).
- University representative for positions at teaching hospitals or other health facilities with an academic presence.
- *Relevant clinical department (larger facilities).*
- For rural facilities a representative of the Rural Faculty, Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine or the Rural Doctors Association of Queensland.
- *Other medical practitioners co-opted as appropriate by the committee:*

The respective colleges and professional associations will nominate a representative to the committee. The district manager may refer the name to the committee for consideration as to whether the committee regards the nominee as inappropriate such as when a conflict of interest may apply.

3.173 Each of the bulleted subparagraphs in section 5.3, in my view, should be read disjunctively. The flexibility to meet local circumstance was also emphasised in the Foreword to the Guidelines.

The guidelines allow for flexibility to meet local circumstances occurring in each Queensland Health District. However, the guideline's essential principles are to be observed in establishing the appropriate mechanisms and committees to oversee the process.

3.174 Furthermore, even if the inclusion of a College representative on the committee was mandatory, that provided no reason to stop the process. What seems to have been forgotten is that the exercise of privileging is not the creation of Queensland Health and was not devised for its benefit. It is, as the Guidelines themselves make clear, a measure to enhance patient safety. It aims to ensure that doctors only provide treatment in circumstances where they can competently do so. In those circumstances, there is no reason why Dr Keating could not have asked one of the many surgeons in Bundaberg or Fraser Coast (and who were Fellows of the College) to sit on the Committee. Even if the Guidelines bore the interpretation that Dr Keating attributed to them, it was simple common sense that the Base should make ad hoc arrangements for substantive privileging until such time as the College nominated a representative. The surgeons who the Base might have approached in the Bundaberg and Fraser Coast areas alone included Brian Thiele, Geoff de Lacy, Pitre Anderson, Sean Mullen and Morgan Naidoo.

3.175 As will be described at length later, in February 2005 Queensland Health sent an investigative team, headed by its Chief Health Officer, Dr Gerry FitzGerald, to Bundaberg in response to a complaint about Dr Patel. Dr Keating concedes that, at that time, Dr FitzGerald, suggested that he co-opt a local surgeon for the

committee, in the absence of a College nominee. Dr Keating seems to have decided against that course because:

...I was focussed on making sure that the process that we began was – is transparent and as accountable as possible, and I didn't wish to run into a situation where we would be accused of mates credentialing mates and we wanted to make sure that this was an open and transparent process for all the specialties as well. And I didn't want to have one specialty saying 'Oh, you look like you have cut corners here as opposed to another specialty'. And you know specialties, the specialist in specialties can do that.<sup>541</sup>

3.176 That explanation is far from satisfactory. It would obviously be ideal that the surgeon sitting on the committee have the mandate of the College but, where that could not be achieved – especially in the circumstances in which Dr Patel was practising - the Base needed to make its own choice of an independent surgeon. If it was thought that such a surgeon could not be located in the Fraser Coast/Bundaberg districts, there was a large number of general surgeons available in Brisbane and Townsville, including of course some with experience in the Base like Dr Baker, Dr Jayasekera and Dr Nankivell. Dr Keating gave evidence that he never approached 'central zone' or Queensland Health's central office in Brisbane about the problem in obtaining College nominees and that is particularly hard to understand given the view expressed in his correspondence of 29 July 2004 that the problem was a State-wide one.

3.177 It is impossible to know whether, if the credentialing process had been carried out for Dr Patel at some point during his employment (ie, 1 April 2003 to 1 April 2005), his disciplinary history in the United States would have been revealed. In my view, there is a very real prospect that this would have occurred. In the first place, the committee might have insisted upon seeing the Verification of Licensure and noticed the reference to the 'stipulated order' and the absence of any attachment. In the second place, if an approach had been made to Dr Patel's supervisor at Kaiser Permanente, and the purpose of the approach made clear, it is difficult to see how that person would not have explained that Dr Patel's privileges had been restricted by that hospital in 1998/9, and that those restrictions were then incorporated in an order of the Oregon Board of Examiners in 2000. In the third place, there is a real prospect that Dr Thiele might have been approached since he knew the Base well, had been working there as a Visiting Medical Officer, and had very extensive experience in the United States, and he might have brought a high degree of scrutiny to the process.<sup>542</sup> Dr Patel claimed that he had carried out his surgical residency programme at the University of Rochester, New York State between 1978 and 1984.<sup>543</sup> Dr Thiele testified that he was very well acquainted with the Chairman of the program, with

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<sup>541</sup> T6929, T7067-8

<sup>542</sup> Mr Leck testified that he held Dr Thiele in high regard and he agreed that, if the process had been invoked, Dr Thiele might have been invited to sit on the committee: T7159

<sup>543</sup> See Exhibit 51, KN3 and T1844



the 'philosophy' behind the training there, and with the scope of general surgery programmes across the United States at different times.<sup>544</sup> He maintained that he could have called the hospitals where Dr Patel claimed to have worked, ascertained the extent of his privileges,<sup>545</sup> and 'fairly quickly determined whether what was on the paper was real or whether there was some problem with it'.<sup>546</sup>

- 3.178 The likelihood that the credentialing and privileging process might have involved some real scrutiny is supported by the work of the Committee to the extent that it did function. Mr Leck gave evidence that he and Dr Nydam were concerned that, in the past, the process involved little more than 'rubber stamping'. He said they were keen to change that situation with the new policy,<sup>547</sup> and it seems that they did. The minutes of a meeting of the Committee on 26 November 2004 relate to applications for credentialing from the internal medicine doctors at the Base and at Hervey Bay Hospital, almost all of whom were Fellows of the Royal Australian College of Physicians. Despite their standing, the Committee insisted that various evidence be provided before the award of privileges would become unconditional.<sup>548</sup>
- 3.179 There is a fourth reason for considering that the credentialing process might have provided some early warning as to Dr Patel's limitations if it was invoked. As Dr Keating conceded, the Committee would have been entitled to consider data going to Dr Patel's actual conduct during his time at the Base.<sup>549</sup> As will be seen below, there was a steady stream of complaints in the course of Dr Patel's employment and this might well have provoked a committee to make fuller inquiries.
- 3.180 The further issue which arises is whether, if Dr Patel had navigated the credentialing process, his privileges might have been narrower than those he requested and those he had obtained on an interim basis. Dr Keating has certainly given evidence that, at the Base, the privileges were not allocated in any detailed way.<sup>550</sup> As will be seen below, however, there were concerns early in Dr Patel's time at the Base that he was undertaking procedures too complex for its resources (particularly its intensive care facilities), and it seems possible that an independent surgeon might have at least considered whether restrictions were warranted for complex elective surgery.

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<sup>544</sup> T1843-4

<sup>545</sup> T1843

<sup>546</sup> T1844

<sup>547</sup> T7159; See also Dr Nydam's evidence at T4142

<sup>548</sup> Exhibit 277; T7160

<sup>549</sup> T7066

<sup>550</sup> T6922

## Dr Patel works at the Base

- 3.181 Soon after the commencement of Dr Patel's employment, he was joined by James Gaffield, and the two Americans became the staff 'specialists' within the Base's Department of Surgery. They were assisted by Dr Anderson who was, of course, engaged as a Visiting Medical Officer, working in urology. Dr Patel was given the more senior position of Director of Surgery and, although that might sometimes be considered an administrative role, there was no doubt that the Base considered Dr Patel to be the senior surgeon and treated him accordingly.<sup>551</sup>
- 3.182 One could understand that the people of Bundaberg might have thought that, since the two Americans were carrying out almost all of the general surgery at the Base, they were not supervised, and one of them was the Director of the Department, they must be Fellows of the Royal Australasian College of Surgeons, or recognised as having equivalent qualifications by the Medical Board. That, of course, was not the case.
- 3.183 Dr Patel's time at the Base was, on any view, a stormy one. The competency of Dr Patel was the subject of testimony from three independent surgeons, and their opinions will be considered later in this report. There were a number of complaints made about Dr Patel during his term at the Base and they are set out below, not with a view to assessing whether any complaint was well-founded but, rather, to consider whether they were harbingers of problems which the Base might have identified.

## Patient receives wrong procedure

- 3.184 The first complaint concerned an incident on 14 May 2003. A patient, identified before the Commission as P74, was admitted to the Day Surgery Unit at the Base so that Dr Kingston<sup>552</sup> could perform a right epididymectomy. Whilst the patient was waiting for that procedure, Dr Patel 'inadvertently' conducted a gastroscopy upon him, being a procedure for which he had not consented and for which he had not been scheduled.<sup>553</sup> Dr Kingston apologised on behalf of the hospital and it seems that no harm was done.<sup>554</sup> Dr Keating conducted an investigation and found that there were inadequate checks in the transfer of the patient from the Day Surgery Unit to the Operating Theatre.

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<sup>551</sup> T6824

<sup>552</sup> Dr Kingston was a Visiting Medical Officer who did minor surgery at the Base

<sup>553</sup> T6939, Exhibit 448, para 316

<sup>554</sup> Exhibit 448, DWK76

## James Phillips; the first oesophagectomy

- 3.185 The second complaint concerned a 46 year old man called James Phillips (also known as P34). He had a potentially curable lesion in the oesophagus so that an oesophagectomy (in which a portion of the oesophagus is surgically removed) was one treatment path for consideration. The circumstances were complicated, however, by his renal condition: Mr Phillips was receiving dialysis through a graft but the graft itself was suffering from stenosis (that is, it was closing over) and there was a 'very good chance' that major surgery would lead to thrombosis (the development of a blood clot), preventing dialysis.<sup>555</sup> In those circumstances, the operation was 'as difficult an oesophagectomy as one could envisage'<sup>556</sup> and a question arose as to whether the patient should be transferred to the Princess Alexandra Hospital in Brisbane. The transfer might have been attractive because the Brisbane hospital had a sophisticated renal unit, staff that included specialist oesophagectomists, and much greater facilities for post-operative intensive care.<sup>557</sup>
- 3.186 Dr Patel, however, performed an oesophagectomy on Mr Phillips at the Base on about 19 May 2003 and Mr Phillips survived that operation. The Nurse Unit Manager of the Intensive Care Unit, Ms Toni Hoffman, was involved in the post-operative care for Mr Phillips and she gave detailed evidence on the subject.<sup>558</sup> Ms Hoffman had held her position as the most senior nurse in the Intensive Care Unit for almost three years and she had been a nurse practising in Intensive Care for 22 years. She said that she was present when the Operating Theatre staff 'handed over' Mr Phillips to the Intensive Care Unit. Ms Hoffman recalled that the patient was very unstable, that his blood pressure was so low it could not be recorded and that the anaesthetist commented that 'this is an expensive way to die'.<sup>559</sup> Mr Phillips was given significant quantities of adrenalin (which, the Commission heard, is used to increase, or sustain, blood pressure)<sup>560</sup> and he was maintained on ventilator support.<sup>561</sup> The course of treatment was complicated by the fact that he required constant dialysis and there was some conflict between the doctors as to how the patient should be managed. In the event, Mr Phillips progressed to brain death.<sup>562</sup>
- 3.187 Ms Hoffman gave evidence that there were a number of aspects to the case which caused her great concern and, in consequence, she approached her 'line

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<sup>555</sup> See T4293; Dr Woodruff said that the stenosis was in the order of 70%

<sup>556</sup> T4293

<sup>557</sup> T4293

<sup>558</sup> T39; Exhibit 4, para 9

<sup>559</sup> T39-40

<sup>560</sup> T46

<sup>561</sup> Ms Hoffman gave evidence that Mr Phillips was receiving 25 milligrams of adrenalin per minute and 100% oxygen: see Exhibit 4, para 9. She also gave evidence that the patient's blood pressure had not been recordable for 45 minutes before his arrival in Intensive Care.

<sup>562</sup> Exhibit 4, para 9

manager' the Director of Nursing, Glenys Goodman who made an appointment for them to visit Dr Keating in his office.

3.188 It should be said that it was not suggested that Ms Hoffman had any history of making complaints to her line manager. She said, in effect, that if she had done so before it was 'quite uncommon', and no evidence was received to the contrary.<sup>563</sup>

3.189 Ms Hoffman recalled that in late May or early June 2003, she met with Dr Keating in his office in the company of Ms Goodman, and that she returned a couple of days later with Dr Joiner, a General Practitioner with a particular interest in anaesthetics who was a Visiting Medical Officer to the Base. Ms Hoffman's evidence was that she raised three areas of concern with Dr Keating. First, she said that Dr Patel was habitually 'rude, loud, and did not work collaboratively with the ICU medical staff'. She said that he did not seem to be on the same 'wavelength' as other staff who were working in the Intensive Care Unit, that there was a 'whole bravado about things and things didn't match up', and that his choice of drugs and treatment seemed to be '20 years behind' contemporary thinking.<sup>564</sup> Ms Hoffman gave evidence that, at the first meeting, she:

..attempted to paint an overall picture of the problems we were encountering in the Intensive Care Unit with Dr Patel including our observations as to the way Dr Patel interacted and spoke which indicated that something was not right. I also recall advising that Dr Patel appeared to be very old fashioned in his treatments...I recall Dr Keating saying that we had to allow that Dr Patel was from another country. I specifically recall advising Dr Keating that it was more like we were coming from two different planets.<sup>565</sup>

3.190 The second issue Ms Hoffman raised was that whilst, in the course of his stay in Intensive Care, Mr Phillips was obviously extremely unwell and the nursing staff were providing this information to the family (which was known to them from Mr Phillips' dialysis sessions), Dr Patel was telling the family, and writing in the chart, that the patient was 'stable'.<sup>566</sup> Ms Hoffman was concerned that this statement was inaccurate and that it caused unnecessary tension.<sup>567</sup>

3.191 The third issue she raised was to question whether oesophagectomies should be carried out at the Base when it lacked appropriate Intensive Care facilities for patients undergoing major surgery. Ms Hoffman gave evidence that the Base's Intensive Care Unit lacked an intensivist, had only three ventilators, generally did not have adequate nursing staff to cope with more than two ventilated patients,

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<sup>563</sup> T43

<sup>564</sup> T42, line 30

<sup>565</sup> Exhibit 4, para 9

<sup>566</sup> This caused considerable tension with the nursing staff because they were very familiar with the patient from his time on renal dialysis and they were telling his relatives that the patient was unstable T40, line 1.

<sup>567</sup> T6944; T47; T40, line 1

and should really transfer patients after 48 hours of care.<sup>568</sup> Against that background, she suggested a patient receiving an elective oesophagectomy (and a complex one at that) should have been transferred to a tertiary hospital.

3.192 Ms Hoffman's recollection was that, at the first meeting, she spoke predominantly (but not exclusively) about the overall behaviour of Dr Patel, rather than the decision to perform oesophagectomies.<sup>569</sup> Ms Hoffman's recollection is that the specific issue of oesophagectomies was addressed more squarely during the second meeting.<sup>570</sup> She said that when the issue did arise, Dr Keating told her that Dr Patel was a 'very experienced surgeon, very used to doing these sorts of surgery, and that no, it was important we keep him in the hospital so it was important we worked with him and did what he wanted, basically'.<sup>571</sup>

3.193 Dr Keating has a somewhat different recollection of events. He recalls a meeting with Ms Hoffman and Ms Goodman. His recollection, however, was that, at this meeting, Ms Hoffman voiced concerns which primarily concerned Dr Patel's tendency to make disparaging comments about the Intensive Care Unit nursing staff. His memory was that, in response, he told Ms Hoffman to make an appointment with Dr Patel so that she could explain the limitations of the Intensive Care Unit, and the need for all concerned to work as a team. He said he followed up this advice in discussions with Dr Patel.<sup>572</sup>

3.194 Dr Keating's recollection was that he did have a meeting with Dr Joiner in which Dr Joiner expressed concerns that the Base was not doing sufficient oesophagectomies to maintain competency, and that the ICU did not have the necessary resources for the post-operative support required by the operation. Dr Keating did not recall Ms Hoffman being present at this meeting and his recollection was that the meeting with Dr Joiner did not occur until after the events set out in the paragraphs that follow immediately below.

### **Claim that wrong part of ear removed**

3.195 The third complaint about Dr Patel was received on 2 June 2003, and concerned a patient known before the Commission as P151. He said that he had a consultation with Dr Patel in April 2003 to discuss the removal of cancer to his ear. They discussed the location of the cancer (which was clearly visible, he maintained, from his general practitioner's previous attempts at excision) and he then attended the Base for an operation on 20 May 2003. He complained that,

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<sup>568</sup> This was in accordance with the Guidelines of the Joint Faculty of Intensive Care Medicine – Exhibit 6 – according to which the Base had a Level One ICU. See also Exhibit 9

<sup>569</sup> T43

<sup>570</sup> T43

<sup>571</sup> T46

<sup>572</sup> Exhibit 448, para 48

when he was discharged from the Base and looked in a mirror, he found that the operation had been carried out to a very different part of his ear.<sup>573</sup> Dr Keating spoke with Dr Patel about the complaint and it was agreed that Dr Patel would review the patient. In the event, the review was apparently carried out by a different doctor, who apparently agreed, on the basis of an examination and the biopsy results, that the procedure had been conducted in the wrong place.<sup>574</sup> A further operation was carried out to the ear on 22 July 2003 and the complaint progressed no further.<sup>575</sup>

## The second oesophagectomy

3.196 In June 2003, a fourth complaint was made. It concerned a 63 year old male patient known before the Commission as P18 who, despite the controversy attending the operation to Mr Phillips, was the subject of an oesophagectomy performed by Dr Patel in early June 2003. This second oesophagectomy was accompanied by serious complications. There were two incidents of wound dehiscence,<sup>576</sup> three returns to the Operating Theatre, and the patient had an extended stay in Intensive Care, commencing 6 June 2003. Ms Hoffman gave evidence that, whilst a patient would normally spend 2 to 3 days in intensive care post-operatively if this surgery went well, P18 was in the Intensive Care Unit at the Base for 14 days.<sup>577</sup> She also gave evidence that there was an arrangement made to transfer the patient to a Brisbane hospital but that hospital required confirmation from Dr Patel, as the treating surgeon, that the transfer was warranted, and he declined, at least initially, to give that consent. By the time Dr Patel was amenable to that course, according to Ms Hoffman, the bed in Brisbane had been lost.<sup>578</sup>

3.197 By an email dated 19 June 2003,<sup>579</sup> Ms Hoffman outlined her concerns to Dr Keating. The email relevantly read as follows:

I am writing to inform you of the situation that currently exists in ICU with the post-op patient, P18. As you are aware, P18 underwent an oesophagectomy on the 6<sup>th</sup> of June. He subsequently returned to theatre twice for wound dehiscence. He again returned to theatre last evening for repair to leaking jejunostomy. He remains ventilated on .55% Fio2 and 5 peep. He is becoming more haemodynamically unstable and has been commenced on inotropic support which is currently being increased. *I am writing due to my continuing concern over the lack of sufficient ICU backup to care for a patient who has undergone such extensive surgery.* Both the RBH and the PAH have expressed concern

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<sup>573</sup> Exhibit 226, GF19

<sup>574</sup> Exhibit 226, GF19, letter of 11 June 2003

<sup>575</sup> Exhibit 448, paras 318 and 319.

<sup>576</sup> More will be said of wound dehiscence later. The word comes from the latin 'dehiscere' meaning 'to gape', and describes a post-operative wound opening up – either superficially or completely – and usually because of infection or poor closure technique. It is a relatively rare complication and Ms Hoffman gave evidence that she had only come across an incidence of dehiscence 'probably about once' in her career

<sup>577</sup> It will be seen that the patient also had an extended stay in a Brisbane hospital

<sup>578</sup> Exhibit 4, para 21

<sup>579</sup> Exhibit 4, TH3

about this surgery being done in our facility without this backup. *There remains unresolved issues with the behaviour of the surgeon which is confusing for the nursing staff. At present,, whilst there is consensus regarding transferring the patient to Brisbane, there are no beds to be found anywhere in the state. I am very worried that this patients care has been compromised by not sending him to Brisbane on Tuesday, and whilst I realise it is easy to be wise in hindsight, and I do not wish to make an issue of this, I would like this to be noted.* I believe we are working outside our scope of practice, for a level one Intensive Care Unit.

The reality of the situation which currently exists in ICU is we now have an extremely ill patient who may or may not deteriorate further and the bulk of the responsibility for trying to liaise with the two teams has been left to a very junior (but excellent) JHO. The ongoing issues regarding the transfer of patients and the designated level of this ICU may need to be discussed at a later date. *The behaviour of the surgeon in the ICU needs also to be discussed, as certain very disturbing scenarios have occurred.* The current status is that we are awaiting a bed in a tertiary ICU.

[my emphasis]

- 3.198 Ms Hoffman was not alone in her concerns. Dr Keating's recollection is that it was at this stage that he was approached by Dr Joiner. His records suggest that the meeting occurred on the morning of 17 June 2003 and he recalls that Dr Joiner raised three issues. In the first place, he suggested that the Base's Intensive Care Unit could not give the intense, long term support that was needed for oesophagectomies. In the second place, he suggested – on the basis of medical literature – that a hospital could not maintain its competency with the procedures unless they were doing at least 30 each year. In the third place, he considered that the patient required transfer to Brisbane but he noted that Dr Patel was resisting that course.
- 3.199 As mentioned, Dr Patel eventually resiled from his position in relation to a transfer, and the patient was in fact transferred to the Mater Hospital in Brisbane on 20 June 2003. Soon afterwards, Dr Keating was also approached by the most senior intensivist there, Dr Peter Cook.<sup>580</sup> Dr Cook gave evidence that, when his Hospital received P18, he became very concerned that a surgeon at the Base would be embarking on such a complicated operation, and he expressed that concern in a letter to the Executive Director of the Mater Public Hospital.<sup>581</sup> He also telephoned Dr Keating and his recollection was that he talked about the same issues raised in the letter.<sup>582</sup> He was concerned as to whether the Base had 'sufficient ancillary services' to give the post-operative care needed for such a complex operation. He also raised a query as to the 'accreditation of the surgeon'.
- 3.200 Dr Cook said that the operation report showed that the staff had identified palpable lymph nodes and this made him wonder whether surgery was ever an

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<sup>580</sup> T3013-5

<sup>581</sup> Exhibit 218, Appendix A2: the letter also makes clear that P18 remained in Intensive Care at the Mater in Brisbane until 30 June 2003. Ms Hoffman gave evidence that he died on 8 January 2004: T51

<sup>582</sup> T3015

appropriate option. Against that background, he queried with Dr Keating whether the treating surgeon was appropriately trained, and had adequate currency of experience, to perform the operation.<sup>583</sup> Dr Cook said that he does not believe that he raised the issue of the lymph nodes specifically with Dr Keating. He recalled that he did tell Dr Keating that the very fact that a surgeon would consider the Base an appropriate place for this operation made him wonder about the surgeon's competence.<sup>584</sup> Dr Cook gave evidence that, after the telephone conversation, he decided to document his concerns to Queensland Health because he was not convinced that the procedure would be proscribed.<sup>585</sup>

3.201 Dr Keating gave evidence that he spoke to Dr Cook on 1 July 2003 after Dr Cook had telephoned the District Manager in Bundaberg, Mr Leck.<sup>586</sup> He conceded that Dr Cook raised concerns about oesophagectomies being carried out at the Base. Dr Keating said, by way of response, that he would raise the issue with the Director of Surgery (Dr Patel), the Director of Anaesthetics (Dr Carter)<sup>587</sup> and the Credentials and Privileging Committee (which, of course, had not yet met, and would not meet for more than one year). Dr Keating says that he spoke to Dr Patel and Dr Carter and he took away from those conversations that oesophagectomies might proceed at the Base.

3.202 I accept that Dr Keating might quite properly have understood that Drs Patel and Carter considered that oesophagectomies might proceed at the Base. It seems unlikely that Dr Patel would have questioned his own judgment in proceeding with the operations for Mr Phillips and P18. Further, Dr Carter gave evidence that, at that time, he believed the surgery could be carried out at the Base by a competent surgeon and he had no reason to doubt Dr Patel's competence and confidence.<sup>588</sup>

3.203 It is, however, concerning that Dr Keating appears not to have responded to Ms Hoffman's email (even to identify the 'very disturbing scenarios' to which she referred)<sup>589</sup> or returned to Dr Cook. It is also concerning that, since Dr Keating could not refer the matter to a Credentials and Privileging Committee,<sup>590</sup> and did not otherwise seek the advice of an independent surgeon,<sup>591</sup> he had no way of knowing whether Dr Patel's decision to retain the patient for surgery was an appropriate one. There was, in my opinion, a distinct lack of vigour in his inquiries.

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<sup>583</sup> T3013; T3138

<sup>584</sup> T3139

<sup>585</sup> T3139

<sup>586</sup> Exhibit 448, para 52

<sup>587</sup> It should be noted that Dr Carter was not present at the Base when either of these oesophagectomies was performed: T3997

<sup>588</sup> Exhibit 265, para 39

<sup>589</sup> T6980; T53

<sup>590</sup> T6980-81

<sup>591</sup> T6980



- 3.204 The oesophagectomies continued. Two more would be performed by Dr Patel at the Base (each with a terrible outcome) before the issue was re-visited.

### Wound dehiscence

- 3.205 The next complaint about Dr Patel concerned his attention to cleanliness and emanated from the Base's Infection Control Co-ordinator, a registered nurse called Gail Aylmer<sup>592</sup>. Ms Aylmer gave evidence that she was the Nurse Practice Co-ordinator for the Surgical Ward at the Base from 14 April 2003 to 11 May 2003. She said that, during this period, she would accompany Dr Patel on rounds but she observed that he would not wash his hands between examining patients, even if he was handling their dressings and touching their wounds.<sup>593</sup> She said that she spoke to Dr Patel about the importance of adopting basic infection control techniques but his behaviour did not change.

- 3.206 Ms Aylmer became the Infection Control Co-ordinator on 2 June 2003 and, later that month, several nurses in the Department of Surgery commented that the incidence of wound dehiscence had been unusually high in the last couple of months. The word 'dehiscence', I should interpolate, comes from the latin verb *dehiscere*, 'to gape'. In medicine, it describes a phenomenon where a surgical wound comes undone. It may be a complete dehiscence, where the wound opens up all the way through the abdominal wall. It may be a superficial dehiscence where the fascia or skin comes undone. It may even be an inside out dehiscence, where the abdominal wall comes undone (so that the organs move through the breach) but the fascia remain intact. The Commission received evidence that the phenomenon is usually related to one of two causes, namely infection or poor wound closure technique.

- 3.207 Ms Aylmer testified that, when she made inquiries into the level of wound dehiscence in the Department of Surgery, she found that, whereas one might expect a 'run' of up to 2 or 3 incidents in a two month period, there were in fact 13 reported incidents.<sup>594</sup> She addressed the issue in her report to the Leadership and Management Committee dated 7 July 2003, which read relevantly as follows:

Concern re high number of abdominal wound dehiscence since early May – currently investigating 13 patient charts at the moment ? technique ? fault with closure product used...would like to implement that all wound dehiscence in the future are automatically swabbed for culture (and sensitivity).

- 3.208 Ms Aylmer recalled that, shortly after the meeting, she compiled a report (which showed that the majority of wound dehiscence incidents were suffered by Dr

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<sup>592</sup> Exhibit 59, para 1

<sup>593</sup> Exhibit 59, para 6; T970

<sup>594</sup> T975

Patel's patients) and provided the same to Dr Keating.<sup>595</sup> Later that day, Dr Patel visited her with the report in hand.<sup>596</sup> 'Ms Aylmer gave evidence that she was surprised and taken aback by the visit because she had expected that any communication would be between Dr Keating and her. She said that, although Dr Patel did not bring any patient records with him, he went through her report and offered explanations for each patient there recorded. Ms Aylmer gave evidence that she was in no position to argue with Dr Patel about the causes of particular cases, and she accepted his explanations.<sup>597</sup> 'On the following day, she sent Dr Keating an email saying that, upon investigating the 13 reported incidents, she had been able to exclude all but 4, and she had now discussed those remaining 4 with Dr Patel. 'She wrote in the email that Dr Patel had admitted to technique problems with two patients, and he gave 'very reasonable' explanations for the other two, so that she had 'no further concerns'.<sup>598</sup> Her testimony, however, was that she was uncomfortable that she was put in the position of discussing this issue with Dr Patel when it could only really have been reviewed by another surgeon.<sup>599</sup> It should be said that this discomfort was not manifest in the email.

## Ian Fleming

3.209 The sixth complaint concerned a patient called Ian Fleming or P126, and was received on 28 October 2003. Mr Fleming gave evidence before the Commission that he had suffered from diverticulitis and diverticular disease since about 2001, and that he experienced symptoms of increasing severity. He met with Dr Patel in April 2003 and he conducted an operation known as a sigmoid colectomy on 19 May 2003. Mr Fleming gave evidence that he noted bright red bleeding with bowel movements after the operation, and told Dr Patel but he was discharged, in any case, on 22 May 2003. He returned to the Hospital on 28 May 2003, for the removal of the staples around the operative wound on his stomach. By that time, he said, there was swelling and a dark red discoloration around the wound, and he was in agony. Mr Fleming said that he showed and described his condition to Dr Patel, but Dr Patel told him he was fine. He removed the staples and told Mr Fleming, in effect, that he should get on with his life.<sup>600</sup>

3.210 Mr Fleming testified that, on the evening of 29 May 2003, the wound 'blew out', and he was immediately admitted to the Hospital. By that stage, the staff were recording that he was suffering from a wound infection and he noted that, whilst

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<sup>595</sup> Exhibit 59, para 12

<sup>596</sup> T975

<sup>597</sup> T976-7; T979

<sup>598</sup> Exhibit 60

<sup>599</sup> T1025; Exhibit 59, para 13

<sup>600</sup> Exhibit 114, para 10

the nurses were keen to use a suction pump and wound dressings to drain the site, Dr Patel denied their requests. The wound did not heal, despite the use of antibiotics. Mr Fleming's evidence was that Dr Patel visited his bedside with an entourage of young doctors, and became agitated with the lack of healing to the wound. Mr Fleming testified that, shortly afterwards, one of three young doctors appeared at his bedside and said he had been sent by Dr Patel to 'fix this up'. He proceeded, said Mr Fleming, to separate the wound without anaesthetic.

3.211 Mr Fleming testified that he was discharged on 4 June 2003 but that his wound did not heal until August 2003 (and his abdominal pain did not stop at all). He said that he called the executive offices of the Base on 28 October 2003 to ask about how he might make a complaint in writing. The person receiving the call, 'Joan', said that complaints could be made over the telephone and she took a detailed message. Mr Fleming said that he made four complaints, namely that:

- (a) Dr Patel failed to diagnose the wound infection when the staples were removed;
- (b) Dr Patel failed to accede to the nurses' requests that a suction pump and special dressings be used;
- (c) No anaesthetic or pain relief was used when the wound was re-opened; and
- (d) He was still bleeding internally.<sup>601</sup>

3.212 Mr Fleming said that he was called by Dr Keating two days later and the conversation commenced with Dr Keating introducing himself and saying, 'I hear you have lodged a complaint against Dr Patel. I must tell you that he is a fine surgeon and we are lucky to have him here in Bundaberg'. Mr Fleming said they spoke for 30 to 40 minutes, during which time Mr Fleming spoke to his four complaint headings but that Dr Keating was belittling and condescending.<sup>602</sup> Dr Keating testified that, from reading his notes of the conversation with Mr Fleming, he believes that they spoke primarily about the continued bleeding. A handwritten note of the first call, taken by the receptionist, reads in part 'Dr Patel performed operation. As a result of the operation, open wound, discharge, Dr Patel removed staple. Excruciating agony. Couldn't stand up. Nurse up there told him opinion incision blew open thurs. Fri nite. No anaesthetic. Open incision up...passing blood'. I find it extremely unlikely that Mr Fleming canvassed those issues with the receptionist but failed to discuss them with Dr Keating, and I note that Dr Keating does not put his position so highly. On balance, I accept that Mr Fleming did raise all four matters with Dr Keating on 30 October 2003.

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<sup>601</sup> Exhibit 114, para 22

<sup>602</sup> Exhibit 114, para 29. Mr Fleming said that Dr Keating did arrange for him to attend a follow up consultation at the Base in relation to the bleeding problem.

## Patient P198

3.213 The seventh complaint disclosed by the records was received on 21 November 2003. It concerned a patient identified as P198. He complained to Dr Keating that he had suffered swelling and bruising to his scrotum after Dr Patel performed an operation to repair an inguinal hernia. Dr Keating gave evidence to the effect that he considered this to be an accepted complication of the procedure and he did not seek Dr Patel's input in responding to the patient. Against that background, he said, he provided an explanation, reassurance, and a plan for review.

## Dr Smalberger

3.214 The eighth complaint<sup>603</sup> appears to be one that emanated from a young doctor at the Base called Dawid Smalberger. Dr Smalberger was registered as a specialist physician in his country of origin, South Africa, and moved to the Base in May 2003, to work in the Department of Medicine. He gave evidence that, late in that year, whilst he was working in the Department of Medicine at the Base, he had an altercation with Dr Patel which led to him making a complaint to Dr Keating. There was a patient (known before the Commission as P51) who was admitted to the Department with a heart attack. His haemoglobin was very low and, given that he had been involved in a truck accident in the previous weeks, Dr Smalberger considered that it was important to rule out trauma to the chest or stomach. He sent the patient for a chest x-ray and a CT scan and it seems that, whilst the patient was there, Dr Patel came across him. He called Dr Smalberger to say that he had studied the CT scan (although he was not invited to do so), believed that the spleen was in two pieces, and had determined to carry out a splenectomy.

3.215 Dr Smalberger was concerned that the patient would be at grave risk in any operation given that he had just suffered a heart attack, and he told Dr Patel so. He arranged to meet Dr Patel in the Intensive Care Unit and they studied the CT scan films there together but Dr Smalberger could see no evidence that the patient needed a splenectomy (and he considered that the patient's condition was entirely inconsistent with the diagnosis).<sup>604</sup> He said that the patient did not need an operation but needed to be transferred to Brisbane for a coronary angiogram. He became very concerned when, as the discussion was continuing, an anaesthetist arrived and Dr Smalberger realised that Dr Patel had already made arrangements to operate. The patient had been admitted under Dr Smalberger's care and he refused to allow the surgery. He was considerably junior to Dr Patel and the refusal was not well received. At the foot of the

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<sup>603</sup> It seems that this complaint was made 'close to Christmas 2003': T1971

<sup>604</sup> T1969-70

patient's bed, in the patient's hearing, and with nursing staff nearby, Dr Patel told Dr Smalberger that his opinion was the 'most stupid thing' he had ever heard.<sup>605</sup>

- 3.216 Dr Smalberger did not discuss the case further with Dr Patel. He arranged the transfer to Brisbane and the staff there subsequently confirmed that the patient's spleen was intact and that the angiogram showed severe stenosis of one artery, requiring the insertion of a stent.
- 3.217 Dr Smalberger said that he had never made a complaint about another doctor in his career but he was so concerned about Dr Patel's lack of clinical competence and his unprofessional conduct<sup>606</sup> that he visited Dr Keating in his office and asked how he might lay a formal complaint. He gave evidence that he explained in detail to Dr Keating the clinical circumstances of his conflict with Dr Patel.<sup>607</sup> In particular, he mentioned his concerns about Dr Patel intervening in the patient's case without invitation, and his apparent commitment to operating upon a patient with a heart problem.<sup>608</sup> He said that Dr Keating listened and said he would raise the matter with Dr Patel. He did not ever tell him how to lodge a written complaint, nor did he ever return to Dr Smalberger with the results of the discussion but, Dr Smalberger said, he was approached by Dr Miach (who supported his position) and his relationship with Dr Patel improved.
- 3.218 Dr Keating gave evidence about this matter. He said that Dr Smalberger approached him with a concern that he had been treated poorly by Dr Patel and that he sought advice about how to re-establish a working relationship. He said that he told Dr Smalberger that the problem could be handled in one of three ways, and Dr Smalberger asked that the third course be adopted, namely Dr Keating approach Dr Patel on Dr Smalberger's behalf. Dr Keating said that he reminded Dr Patel of the need to treat colleagues fairly, and that he received no further complaints from Dr Smalberger. Dr Keating recalled that Dr Smalberger also complained about Dr Patel's interpretation of a CT scan but Dr Keating put this down to a 'professional difference of opinion'.<sup>609</sup>
- 3.219 The two versions of the conversation are not dramatically different, and it is unnecessary to state a preference. On any view, Dr Keating was informed of Dr Patel's dogmatic and unprofessional manner, and of the dispute as to the diagnosis disclosed by the CT scan. It is difficult to believe that Dr Keating was not also informed of Dr Patel's conduct in approaching the patient without solicitation, and in preparing for surgery in circumstances where it put the patient at risk and the diagnosis was not supported by any external signs. In my view, it

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<sup>605</sup> Exhibit 133, para 11; T1997

<sup>606</sup> T1971

<sup>607</sup> T1972; It should be noted that Dr Smalberger was not sure if, at the time of the meeting with Dr Keating, the results had come back from Brisbane, vindicating his position: T1988

<sup>608</sup> T1997

<sup>609</sup> Exhibit 448, para 181.

is clear at the very least that those things could have been ascertained by any level of inquiry.

### **‘Doctors don’t have germs’**

- 3.220 The ninth complaint emanated from the Base’s Renal Unit. That Unit, it will be recalled, had been established during Dr Thiele’s administration. It was headed by an eminent nephrologist, Dr Peter Miach, and it seems to have been relatively stable in the sense that it had retained Dr Miach, and many of the nursing staff, for well over 5 years. The Nurse Unit Manager for the Renal Unit, Ms Robyn Pollock, gave evidence that she had occupied that position since 1998.<sup>610</sup>
- 3.221 The Unit employed 7.3 full time nursing staff and they were mostly engaged in caring for patients receiving haemodialysis or peritoneal dialysis, as well as providing follow up for transplant victims.<sup>611</sup> Wherever possible, it is understood, the Base would try to provide patients with the option of dialysis by catheter – that is, where fluids are introduced into the patient through a catheter surgically inserted in the peritoneum – because this dialysis could be managed by patients at home, and increased their independence.
- 3.222 Ms Pollock testified that, not long after Dr Patel arrived at the Base, he approached the Renal Unit offering his services in placing catheters, and he then began to visit the Unit regularly. There had been concerns for some time that Dr Patel did not observe proper standards of sterility when dealing with patients.<sup>612</sup> This was an issue of particular sensitivity to the staff of the Renal Unit because, the Commission was told, chronic renal disease tends to suppress the body’s immune system. The issue came to a head on the morning of 25 November 2003. Two patients in the Renal Unit, known before the Commission as P52 and P53, who were having blood flow problems with the central line used for haemodialysis. The line was attached to each patient by means of a catheter which entered the neck, and led to the internal jugular vein. Dr Patel attended the Unit so that he might undertake the task of placing a guide wire into the catheters to dislodge any blockages. Three of the core nursing staff were working that morning, and they subsequently reported a number of concerns to Ms Pollock.
- 3.223 The nurses arranged the two patients on beds adjacent to each other, and they set up two trays of equipment between the beds. They had a number of issues with Dr Patel’s conduct. It seems he did not wash his hands before commencing the procedures, and ignored a request to do so. Indeed, he responded to the

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<sup>610</sup> The formal title since March 2002 for the head nurse was Nurse Unit Manager: see Exhibit 70

<sup>611</sup> Exhibit 70, para 4.

<sup>612</sup> See, in particular, the evidence of Ms Aylmer set out above

nurse making the request that 'Doctors don't have germs'. He did agree to a request, however, to wear gloves.<sup>613</sup>

3.224 When Dr Patel started the physical examination of the patients, he did not wash his hands, nor change gloves, between patients, nor did he observe the normal practice of replacing the bungs covering the catheters as soon as the procedures were completed to reduce the risk of infection. Further, having used a syringe on one patient and returned it to the patient's tray, he made to use the syringe on the other patient, until he was stopped by the nurses. Even then, the nurses subsequently related to Ms Pollock, Dr Patel seemed put out and said words to the effect of, 'I'm doing you a favour'.

3.225 The nurses completed an incident form, and Ms Pollock contacted the Base's Infection Control Nurse, Ms Aylmer, to discuss their concerns. The result was that Ms Pollock and Ms Aylmer made an appointment to see Dr Keating and met with him on 27 November 2003.<sup>614</sup> Ms Pollock related the matters set out above and Ms Aylmer, for her part, related other complaints she had received from staff concerning Dr Patel's attention to sterility. Ms Pollock gave evidence that Dr Keating said he would speak to Dr Patel about the incident in the renal unit but that it was difficult to do more in the absence of clear data that Dr Patel's patients were suffering, disproportionately, from infection. It seems that Dr Keating did speak to Dr Patel<sup>615</sup> but Dr Patel denied the nurses' version of events and subsequently ceased acknowledging Ms Pollock.<sup>616</sup>

3.226 It is to be noted that the issue of Dr Patel's attention to sterility issues did not cease at this point. Ms Aylmer became aware that, contrary to what seemed to be accepted good practice, Dr Patel would leave the hospital buildings in his theatre attire so that he might smoke in the car park.<sup>617</sup> She also became aware that the theatre staff generally were wearing their theatre attire freely outside the theatre complex. She wrote emails to Dr Patel and Dr Carter on 5 and 15 November 2004 about a protocol, but she came to the view that, whilst Dr Patel was feigning support, he was undermining the process. By an email dated 3 February 2005, and copied to Dr Keating, Ms Aylmer wrote that she was concerned that staff were still wearing their theatre attire outside and then walking straight back into theatre, that she had received reliable reports that Dr Patel was disparaging about the new protocol (which was agreed in December 2004), and that she intended to post signs in theatre advising of the new requirements. Dr Patel did not respond.<sup>618</sup>

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<sup>613</sup> Exhibit 70, para 10

<sup>614</sup> Exhibit 70, para 13

<sup>615</sup> Exhibit 59, GA7

<sup>616</sup> Exhibit 70, para 16

<sup>617</sup> T998

<sup>618</sup> T997

## Confrontation in the Intensive Care Unit

- 3.227 There was a further dispute or complaint concerning Dr Patel on about 8 March 2004.<sup>619</sup> One of the anaesthetists, was a doctor of South African origin called Dieter Berens. He testified that he moved to Bundaberg in January 2004 and had worked regularly from that time with Dr Patel. He said that he had some general misgivings about Dr Patel. He said that, whilst he was quite efficient with some procedures, his medical knowledge was not up to date, he could be aggressive with staff when operations were attended by complications, and he was not always entirely honest about problems.<sup>620</sup>
- 3.228 Dr Berens testified that there was a particular incident in which he was concerned by a decision made by Dr Patel to give blood to a certain patient in intensive care.<sup>621</sup> He testified that he confronted Dr Patel and asked him to explain the grounds for his decision, but Dr Patel declined to do so and said that the only person to whom he would be explaining himself was Dr Keating. The altercation became heated and Dr Berens walked out of the Intensive Care Unit, saying that Dr Patel could look after his own patients.<sup>622</sup> Dr Berens testified that, soon after this conversation, a Nurse McClure asked Dr Berens to return to treating patients in the Intensive Care Unit and he explained that, whilst he was upset with Dr Patel's continual interference, he was prepared to do that. Nurse McClure (who was apparently supportive of Dr Berens' position) said she would be informing Dr Keating of the situation. Dr Berens said that he was called to Dr Keating's office and he gave Dr Keating a 'rundown' of what had occurred.<sup>623</sup> He said that he told Dr Keating about the subject of the dispute but was not asked to go into any detail.<sup>624</sup> Dr Keating told him that he and Dr Patel should sort it out between themselves.<sup>625</sup>

## Insertion of Peritoneal Catheters

- 3.229 As mentioned earlier, the Renal Unit at the Base offered haemodialysis and peritoneal dialysis. Evidence was received from the nurse in charge of peritoneal dialysis, Lindsay Druce. She testified that there would be 8 to 10 of these patients at any one time. She said that she was on maternity leave between November 2002 and November 2003 so that she did not meet Dr Patel when he first arrived at the Base. When she returned from leave and received a handover, however, she noted a number of problems with peritoneal catheters. She set about performing an exhaustive study of all patients who received

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<sup>619</sup> Exhibit 448, para 79

<sup>620</sup> Exhibit 128, para 6

<sup>621</sup> T1946

<sup>622</sup> T1946

<sup>623</sup> T1915

<sup>624</sup> T1954

<sup>625</sup> Exhibit 128, para 9



catheters in 2003. She testified that what she discovered was that, for every single patient who had a catheter placed by Dr Patel in that year, there had been a complication.<sup>626</sup>

3.230 Ms Druce gave evidence that she approached Dr Miach to explain the problem and, in consequence, she commenced compiling a report on what she had found. She also spoke to Dr Patel, hoping to deal with the issue informally, but she said that he responded to her concerns by stating that he was the surgeon and walking out of the unit. In those circumstances, she continued working on the report.<sup>627</sup>

3.231 In the meantime, there was a tragic event. There was a patient known before the Commission as P30 who had received a catheter inserted by Dr Patel. The catheter had migrated and Dr Patel then conducted an operation to address the migration and insert a permacath. In the course of that operation, Dr Patel perforated the thoracic vein and the patient died.<sup>628</sup> Ms Druce gave evidence that she was distressed by this development. No other patient had died at the Base from the insertion of a permacath, and in her opinion, the need for an operation and the poor outcome of the operation were both consequences of a lack of competence on Dr Patel's part.

3.232 In January 2004, Ms Druce told Dr Miach about the results of the death of P30. She also provided him with a copy of her completed report, entitled 'Peritoneal Dialysis Catheter Placements – 2003' ('the catheter report').<sup>629</sup> The report took the form of a simple table, setting out the name of each patient, the name of the surgeon, the date the catheter was placed, the catheter problem; the ultimate outcome, the catheter position, and the nature of the infection. It showed that:

- (a) There were six peritoneal catheters placed at the Base in 2003 and they were all placed by Dr Patel;
- (b) Every patient had experienced problems in that the catheter had migrated (3), or become infected (2) or there was impaired outflow drainage (1);
- (c) Each of the catheters was placed sideways or upwards (whereas good practice is that the catheters are inserted facing downwards to increase drainage and reduce the chance of infection);
- (d) Three of the patients had required further surgical intervention, two had died and one required an intravenous drip for infection.

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<sup>626</sup> Exhibit 67, para 4

<sup>627</sup> Exhibit 67, para 5

<sup>628</sup> Exhibit 67, para 6

<sup>629</sup> The report appears on the record as Exhibit 67, attachment LD1 and Exhibit 18

- 3.233 As mentioned above, the Director of Medicine at the Base was a physician called Peter Miach. Dr Miach was, on any view, an eminently qualified doctor. He had been a Fellow of the Royal Australian College of Physicians and a Fellow of the Royal Australasian College of Physicians since the early 1970's. He had spent some years carrying out research in the field of nephrology in both the Austin Hospital, Victoria, and a large nephrological hospital in Paris. He also had a Doctorate in Philosophy from the University of Melbourne. He had been a senior lecturer at the University of Melbourne and the University of Queensland and he had been an examiner and censor for the Royal College of Physicians (of which he was awarded a fellowship).
- 3.234 Dr Miach gave evidence that he had worked as the Director of Medicine at the Base since August 2000. He said that he had observed Dr Patel from the start of his employment in April 2003 and was alarmed by a number of matters. He related a number of incidents which caused him to doubt Dr Patel's competence. The matter concerning Dr Smalberger set out above was one such incident. It came to his attention because Dr Smalberger was one of his staff. The matter concerning P34 was another. Dr Miach gave evidence that it was generally not considered viable to perform major surgery such as an oesophagectomy on a patient with significant 'co-morbidities' – that is, unrelated medical problems. P34 had been Dr Miach's patient because of his renal problems. When he developed cancer in the throat, Dr Miach decided to seek a surgical opinion as to whether surgery was a realistic option so that he could advise the patient fully. He said he was extremely disturbed when Dr Patel proceeded to conduct an oesophagectomy, without returning to Dr Miach, much less providing an opinion.
- 3.235 There were a number of other incidents related by Dr Miach in his evidence. One concerned a patient called P33, an elderly man who was admitted with a heart attack. In the course of treatment for a renal problem, the staff had perforated his jugular vein, and Dr Patel then arrived in the ward, insisting that he should operate. The nursing staff then called Dr Miach to dissuade Dr Patel. He said he arrived at the patient's side, Dr Patel was still insistent. In Dr Miach's view, the patient was very unlikely to survive surgery with his heart condition. He told Dr Patel that he would not permit him to operate, and he told the staff to arrange a transfer to Brisbane after they had stemmed the bleeding non-surgically.
- 3.236 Dr Miach also related a disturbing incident in which he went to theatre to watch Dr Patel do a 'pericardial window'.<sup>630</sup> When he arrived, he found that – contrary to usual practice – Dr Patel had not anaesthetised the patient, who was screaming in apparent pain.<sup>631</sup>

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<sup>630</sup> This is an operation where the surgeon puts a hole into the pericardial space and drains that area

<sup>631</sup> Exhibit 21, para 86

- 3.237 Dr Patel had claimed, when he initially came to the Base, that he 'did everything'. As can be imagined, Dr Miach became increasingly sceptical of that claim. When he received the Catheter audit in January 2004, he acted quickly. In the first place, before he went on sabbatical leave that month, Dr Miach informed one of the locum doctors, a Dr Knapp, that if any renal patients needed surgery, he should 'stay clear' of Dr Patel. Dr Miach said that he had also informed Dr Strahan, Dr Smalberger, the Clinical Forum Meeting, and the nursing staff, at least by early 2004, that Dr Patel was not to operate on his patients. This was no idle comment. Dr Miach gave evidence that, as far as he was aware, Dr Patel did not operate on any of his patients whilst he was on leave. He said that he never referred another patient to Dr Patel even when he returned from leave.
- 3.238 In the second place, Dr Miach testified, he took the catheter report to the executive. He could not be sure whether he took this step before he left on leave, or after his return in April 2004, but he had a very specific memory of the event.<sup>632</sup> In any case, his evidence was that certainly by the later date he had delivered the report to Dr Keating. He said that he received no response and, when he raised the issue with him on 21 October 2004, Dr Keating questioned ever having received the report. Dr Miach said he provided it to Dr Keating again but that again he received no response.
- 3.239 Dr Keating gave evidence that he was not aware, at any time during Dr Patel's employment at the Base, that Dr Miach had declined to allow his patients to be operated upon by Dr Patel.<sup>633</sup> I find that statement implausible for a number of reasons. In the first place, the matter was the subject of some conversation around the Base. Certainly, Dr Strahan, Dr Smalberger, Dr Gaffield, Ms Hoffman,<sup>634</sup> Ms Pollock,<sup>635</sup> Ms Druce,<sup>636</sup> Dr Athanasiov and others, each gave evidence that they were aware of Dr Miach's directive. Ms Pollock also gave evidence that Dr Miach had reiterated his position on other occasions. She said that she was the minute taker at a Medical Clinical Services meeting held in June 2004 and attended by Level 3 nurses when Dr Miach informed the group that 'Dr Patel is not to operate on my patients'.<sup>637</sup> It is extremely hard to believe that, in a 140 bed regional hospital, the fact that the Director of Medicine had prohibited the Director of Surgery from operating on his patients on the grounds of competence, had escaped the notice of management. This is all the more so given that the situation persisted from January 2004 until Dr Patel's departure in

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<sup>632</sup> T292

<sup>633</sup> Exhibit 448, para 119

<sup>634</sup> Exhibit 4, para 48

<sup>635</sup> Exhibit 70, para 20

<sup>636</sup> Exhibit 67, para 17

<sup>637</sup> It should be noted, however, that Dr Miach then told Ms Pollock, 'Don't minute that': Exhibit 70, para 21

April 2005. Certainly, a number of doctors gave evidence that they were aware at least of this: that Dr Miach would not send any of his patients to Dr Patel.<sup>638</sup>

3.240 In the second place, Ms Druce gave evidence that the renal unit nurses communicated the Miach directive to the Acting Director of Nursing, Patrick Martin, during a meeting on 10 February 2004. Mr Martin met on the same day with Dr Keating and, although it was denied by Mr Martin and Dr Keating, one suspects that Dr Miach's directive might have been discussed at the second meeting.

3.241 There was a third point. Dr Miach's stance necessitated a major administrative adjustment. It will be recalled that Dr Patel had been placing the peritoneal catheters for the Renal Unit. Dr Miach's refusal to allow Dr Patel to operate on his patients put the whole peritoneal dialysis programme in jeopardy. The position became even more dire when, whilst Dr Miach was on leave, 'Brisbane' declined to place the catheters, apparently on the basis that there was adequate surgical assistance for the task at the Base.<sup>639</sup> Against that background, Ms Pollock and Ms Druce showed disarming ingenuity. Queensland Health has a contract with a company called Baxter Healthcare Pty Ltd, according to which the company supplies almost all the fluids that are used in peritoneal dialysis. I infer that the contract is quite a lucrative one.<sup>640</sup> Ms Druce approached the Baxter representative and suggested that he take some action to ensure the proper placement of catheters in the future. Initially, the Baxter representative thought that Dr Patel might be sent to Brisbane for training but the idea was not pursued when it seemed that Dr Patel had little interest in the medical aspect of that excursion.<sup>641</sup>

3.242 In March 2004, the Baxter representative suggested a solution based on a Western Australian model. In essence, Baxter would pay for the patients' out-of-pocket expenses in having the catheters inserted at a private hospital, but the patients would then return to the Base to participate in the peritoneal dialysis program. There would be no charge to the Base, and it effectively meant that patients at the Base were receiving private health care funding from Baxter.<sup>642</sup>

3.243 On 15 June 2004, there was a meeting attended by, amongst others, Dr Miach, Dr Keating, Dr Thiele, and the Baxter representatives, at which it was agreed that the patients would be sent to the Friendlies Hospital in Bundaberg and the procedure would be carried out, at Baxter's expense, by Dr Thiele. None of those who attended could recall Dr Keating being told that the reason for the

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<sup>638</sup> T2051, and see the evidence of Dr Carter

<sup>639</sup> Exhibit 70, para 33

<sup>640</sup> Ms Druce gave evidence that, to her knowledge, the 'consumables' per patient costs between \$2,000.00 and \$3,000.00 per month: Exhibit 67, para 24

<sup>641</sup> Exhibit 67, para 20

<sup>642</sup> Exhibit 67, para 27

arrangement was Dr Patel's incompetence but, as Dr Thiele noted, there had never been any other reason.<sup>643</sup>

- 3.244 Dr Keating also gave evidence (consistent with his comment to Dr Miach set out above) that he had never received the catheter report prior to 21 October 2004. He said further that, when he did receive it, the implications were not clear: although it set out 6 patients with complications, the size of the sample group was not entirely clear. In other words, the report did not inform Dr Keating whether the complications represented a 100% failure rate, or something less.
- 3.245 I must say, again, that I found Dr Keating's evidence implausible. The renal unit nurses gave evidence that they communicated their concerns about the peritoneal catheters independently of Dr Miach. Ms Druce had, of course, completed her report by January 2004<sup>644</sup> and she then sent an email to Ms Pollock on 4 February 2004 requesting an appointment to discuss, amongst other things, the 'cessation of peritoneal dialysis catheter placement at Bundaberg Base Hospital'. It was as a result of that email that the two nurses met with the Acting Director of Nursing, Patrick Martin, on 10 February 2004.
- 3.246 Both nurses said that they discussed the catheter report with Mr Martin in some detail, and also informed him about Dr Miach's directive that Dr Patel not operate on the renal patients.<sup>645</sup> Ms Druce said that she took the report with her to the meeting and they discussed its contents. She said the meeting ended with Mr Martin saying he would take the report and the other concerns to Dr Keating and Mr Leck. Mr Martin gave evidence that he did not recall the provision of a report at the meeting but he did recall general information being provided about the failure of tenckhoff catheters, that he communicated that information to Dr Keating, and that Dr Keating then said that the nurses would need to provide evidence to support their complaints.<sup>646</sup> Ms Pollock said that she did receive an email from Mr Martin saying that Dr Keating needed more data but she asked Mr Martin what further information could possibly be provided about the six cases, and he did not answer.<sup>647</sup>
- 3.247 In short, not only was Dr Miach adamant that he gave Dr Keating a copy of the report in April 2004, but the two nurses were adamant that they had given the report to Mr Martin and provided him with a summary of its contents. That evidence was supported by Mr Leck who gave evidence that the catheter report appeared on his desk in or before June 2004 and he promptly discussed it with Dr Keating, who said it was not a concern.<sup>648</sup> I do not accept Dr Keating's claim

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<sup>643</sup> I should mention that Ms Druce gave evidence that, with the introduction of the 'Friendlies' arrangement, there have been no migrations and there was reduced infection.

<sup>644</sup> See Exhibit 67, para 16

<sup>645</sup> Exhibit 67, Exhibit 70

<sup>646</sup> Exhibit 139

<sup>647</sup> Exhibit 70, para 32

<sup>648</sup> T7223

that the meaning of the report was ambiguous. It did not suggest anywhere that the cases were randomly chosen. On the contrary, the report's title, 'Peritoneal Catheter Placements – 2003' suggests that it constituted an exhaustive list of placements and that view was confirmed by the notation below the six entries, being 'x6 Peritoneal Dialysis Catheter Placed 2003'.

- 3.248 In the end, it seems enough to say this, with respect to the catheter report: even if one accepts that the executive had not been given notice of the precise problem, it was certainly put on enquiry. Dr Keating acknowledged that Dr Miach informed him in late April or early May 2004 of his concerns about the peritoneal catheter placements by Dr Patel to support the Baxter proposal described above.<sup>649</sup> Dr Keating maintained that he asked for more data and that, in fact, the catheter audit (which Dr Miach had himself received) was not forthcoming.
- 3.249 The matter came to a head on 21 October 2004 when Dr Miach and Dr Keating argued vigorously as to whether Dr Miach had provided Dr Keating with a copy of the catheter report.<sup>650</sup> Dr Miach provided Dr Keating with a copy of the report on the following day. Dr Keating testified that the import of the document was not clear to him but that he did not return to Dr Miach for clarification. Instead, he informed Mr Leck that the 'data ...provided by Dr Miach in support of his concerns about Dr Patel's surgical expertise in the insertion of Tenckhoff catheters' was 'poor quality'.<sup>651</sup>
- 3.250 Dr Keating also acknowledged that Mr Martin told him in February 2004 that the Renal Unit nurses were raising concerns about complications associated with peritoneal dialysis. He said that he asked for data 'to back up the concerns' and chose not to raise the matter with Dr Patel until that data was forthcoming.<sup>652</sup> Dr Keating acknowledged that, when Mr Martin communicated the nurses' concerns, he responded with a comment to the effect that, 'If they want to play with the big boys – bring it on'.<sup>653</sup> Perhaps unsurprisingly, when Mr Martin relayed that comment to the nurses, they interpreted it as being less than supportive of their position.<sup>654</sup> In any case, on any view, Dr Keating was notified by the Nurse Unit Manager of the Renal Unit, Ms Pollock, and the Director of Medicine, Dr Miach, that they were each concerned with Dr Patel's performance in relation to catheter placement.

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<sup>649</sup> Exhibit 448, para 204: It should be noted that Dr Keating maintains that the impact of this information was reduced by Dr Miach explaining that he had had problems with other surgeons in the past.

<sup>650</sup> Exhibit 448, para 218

<sup>651</sup> Exhibit 448, DWK66

<sup>652</sup> T6951

<sup>653</sup> Exhibit 448, para 202

<sup>654</sup> Ms Pollock gave evidence that her recollection was that she had already provided Mr Martin with the six documented cases and she could not see what additional data could be presented: Exhibit 70, para 32

## Geoffrey Smith

- 3.251 On 27 February 2004, a complaint was received from a Geoff Smith. Mr Smith was concerned, in particular, that Dr Patel had carried out a procedure to remove a large melanoma on Mr Smith's shoulder with local anaesthetic, knowing that local anaesthetic had little effect on Mr Smith. When Mr Smith made protestations of pain, Dr Patel declined to stop the procedure.
- 3.252 Dr Keating sent a letter of apology to Mr Smith and also, he said, counselled Dr Patel about his manner with patients.<sup>655</sup>

## Vicki Lester

- 3.253 Ms Lester had certain procedures carried out by Dr Patel between September and December 2003 in circumstances where the treatment seemed clearly unsatisfactory. In particular, Dr Patel told her that certain pain was a result of a 'negative attitude' when there was, in fact, a physiological basis. Dr Patel had conducted an investigation and decided that there was no packing in a wound, but a subsequent x-ray ordered by the general practitioner showed that he was wrong.<sup>656</sup> Further, when he operated on Ms Lester subsequently, he declined to use anaesthetic, and she experienced, she said, severe pain.
- 3.254 In March 2004, it was necessary for Ms Lester to undergo further surgery and she applied to Dr Keating for a patient travel subsidy so that she might have the procedure performed at the Rockhampton Base. He refused the application on the basis that the surgery was available locally, and Ms Lester paid for the trip herself. He made no attempt, he said, to ascertain whether Ms Lester's complaint regarding the wound packing was well-founded.<sup>657</sup>
- 3.255 In March 2005, Ms Lester had persisting problems and she complained to Dr Keating formally about Dr Patel. She never received a substantive response to that letter.

## Patient P131

- 3.256 This patient made a complaint to Dr Keating on 2 July 2004. She was a 66 year old lady who had presented at the Base with an itchy breast. On her first visit, she was seen by Dr Gaffield who recommended a biopsy. When she returned for the biopsy, however, she was seen by Dr Patel who said it was unnecessary. He said she was suffering from eczema and prescribed steroid cream. Apparently when she came to the Base on an unrelated complaint, the doctor insisted on a biopsy and cancer was diagnosed in the breast. The patient

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<sup>655</sup> Exhibit 174, attachment GS1

<sup>656</sup> T6954

<sup>657</sup> T6955

complained that Dr Patel had failed to properly identify the problem but Dr Keating sent a letter saying that he thought the treatment was appropriate.<sup>658</sup>

### **The return of wound dehiscence**

3.257 The Nurse Unit Manager of the Surgical Ward, Dianne Jenkin, gave evidence that, in April 2004, she became concerned that there was a high incidence of complete wound dehiscence in her ward. At a committee meeting held on 9 June 2004 (and attended by, amongst others, Dr Keating and Mr Leck), she provided a report on the topic. It suggested that all surgeons at the Base between January 2003 and January 2004 had at least one patient with wound dehiscence, but that there were many more for Dr Patel's patients.<sup>659</sup> Dr Patel presented his own report to a committee meeting of 18 August 2004 (attended by Mr Leck). It showed that 9 of his patients had developed wound dehiscences and one patient had a major complication of a fistula near a colostomy, necessitating a 70 day stay at the Base. Ms Jenkin gave evidence that, at the meeting, Dr Patel contended that this incidence was 'within range' for a two year period. She stated that he did not produce any scientific data as to expected ranges. Moreover, the use of a two year period seemed dubious since he had only been employed 17 months earlier, and he had taken extended leave between April and August 2004.<sup>660</sup> It was agreed that wound dehiscence would be recorded in the future through the adverse incident system, but otherwise, Ms Jenkin said, the matter was closed.<sup>661</sup>

### **Linda Parsons**

3.258 On about 4 September 2004, a patient called Linda Parsons sent a letter of complaint to the Base following an operation performed by Dr Patel on 15 March 2004. In that correspondence, Ms Parsons complained that the surgical staples were removed prematurely causing the wound to dehisce, that Dr Patel's junior had then packed the wound when it clearly required sutures, that Dr Patel's junior had failed to properly anaesthetise her when he subsequently administered stitches and that, when she later returned to the Base with an infection, she was not given adequate care or information.<sup>662</sup>

3.259 In response to her written complaint, Ms Parsons was called by a clerical person at the Base and asked to attend a meeting in the Executive section of the Base. She attended with a friend called Vicki Hall and they were met by Dr Nydam, the Acting Director of Medical Services at that time. Dr Nydam said that the junior

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<sup>658</sup> See Exhibit 448, para 338; Exhibit 225, GF19

<sup>659</sup> Exhibit 494, DJJ7

<sup>660</sup> Exhibit 494, para 53

<sup>661</sup> Exhibit 494, paras 54 and 55

<sup>662</sup> T 1733 – T1734.



doctor who had treated Ms Parsons may not have administered anaesthetic appropriately but he no longer worked at the hospital, and as such could not be counselled.<sup>663</sup> Ms Parsons suggested that Dr Patel should be held responsible as the consultant in charge but Dr Nydam did not respond.<sup>664</sup> Instead, Dr Nydam introduced Ms Parsons to the Infection Control Nurse, Ms Aylmer, who had not been briefed on Ms Parsons' circumstances, nor provided with her file. Ms Parsons gave evidence that Dr Nydam's manner at the meeting was condescending and dismissive.<sup>665</sup> She did, however, receive a letter from Dr Nydam, apologising for what he described as 'sub-optimal care'.<sup>666</sup>

## P127 and P15

3.260 These patients were the subject of adverse incident forms on 20 August 2004 and 29 October 2004, respectively. Dr Keating said he understood the matters were to be reviewed at an Errormed meeting and that satisfied him.<sup>667</sup> The first incident concerned a wound dehiscence. The second incident was remarkable in that the adverse incident form was completed by Di Jenkin, the Nurse Unit Manager of the Department of Surgery, and she put the risk rating as 'high'. The patient underwent a routine operation for removal of gallstones by keyhole surgery (a laparoscopic cholecystectomy) but then experienced a number of complications requiring a return to the Operating Theatre and a prolonged stay in the Intensive Care Unit. Ms Jenkin wrote in the adverse incident form 'surgical technique?' Dr Keating said that it did not require investigation by him in the first instance because that could be done by the Errormed Committee but, as he was aware, Dr Patel sat on the Committee.<sup>668</sup>

## Marilyn Daisy

3.261 The next complaint was received in November 2004 from a senior vascular surgeon in Brisbane, Jason Jenkins. Dr Jenkins gave evidence that he had a confrontation with Dr Patel in the course of 2004. He became aware (from the transfer of patients from the Base to Brisbane) that Dr Patel was doing a measure of vascular surgery, and he came to the view, from observing and treating some of those patients, that Dr Patel was working beyond his level of competence. He said that he was particularly concerned for renal access patients because if the surgery is managed badly, they have reduced options for dialysis in the future. Dr Jenkins said that he approached Dr Miach to voice his

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<sup>663</sup> Exhibit 106 para 25. In fact, the junior doctor was merely on leave but it seems Dr Nydam made no inquiries into that issue.

<sup>664</sup> Exhibit 106 para 25

<sup>665</sup> In this evidence, Ms Parsons was supported by Ms Hall: T1730, T1787

<sup>666</sup> Exhibit 106 para 27

<sup>667</sup> Exhibit 448, paras 339 and 340.

<sup>668</sup> T6961

concerns but was told – to his amazement - that Dr Patel was difficult to stop because he tended to ‘find’ patients in wards and operate without consulting Dr Miach.<sup>669</sup> Dr Jenkins said that this amazed him because the practice of operating on a patient without first gaining the permission of the primary carer breached a clear protocol within hospitals.<sup>670</sup>

- 3.262 A particular incident caused Dr Jenkins to write a formal letter to Dr Miach on 2 November 2004, and copy the same to Dr Patel.<sup>671</sup> There was a patient who was a 43 year old lady with severe diabetes with renal problems. She was referred to Dr Jenkins for dialysis but he noticed that one of her legs had been amputated and the stump was still bandaged. The patient told Dr Jenkins that the operation had been performed 6 weeks earlier. On examination, he noticed that the stump was still healing. He was deeply concerned by a number of aspects of the lady’s treatment. His letter read in part:

I was astounded when I discussed with Marilyn about when did she have her left below knee amputation and I understand she was quite unwell and this was a life saving procedure...but she still has sutures in her amputation stump six weeks following the procedure. I find it mind boggling that someone could leave sutures in for this long. ...I think if procedures can’t be performed appropriately within the Bundaberg Hospital then they should not be performed at all of if they are performed, then they should be followed up appropriately.

- 3.263 Dr Keating said that, on 8 November 2004, Dr Miach provided him with the letter without comment. He said that the patient had been reviewed once by the surgical team whilst she was in the Renal Dialysis Unit but he could not explain why she had not been reviewed again. It appears that Dr Keating did not take the matter any further.<sup>672</sup>

## Desmond Bramich

- 3.264 Mr Bramich was admitted to the Base on 25 July 2004, suffering a crush injury after a caravan fell upon him. His condition stabilised and then improved so that he was talking freely and walking around. There was a sudden deterioration, however, at about 1pm on 27 July 2004, and Drs Gaffield and Patel provided treatment until Mr Bramich died ten minutes after midnight.
- 3.265 The death of Mr Bramich caused major controversy within the Base, and was the subject of considerable evidence before the Commission. In summary, there was a view that Mr Bramich should have been transferred to Brisbane early on the day of 27 July 2004, and that Dr Patel inappropriately declined to allow that transfer. There was also a view that Dr Patel had carried out a particular

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<sup>669</sup> Exhibit 254, para 9

<sup>670</sup> It should be said that this complaint about Dr Patel was raised by Dr Miach, Dr Smalberger and Dr de Lacy and Dr Strahan.

<sup>671</sup> Exhibit 17

<sup>672</sup> Exhibit 448, para 199

procedure, known as a pericardiocentesis inappropriately and unnecessarily. Finally, there was a view that Dr Patel behaved unprofessionally towards Ms Bramich.

3.266 Dr Keating was apprised of the staff's concerns through a number of routes. He acknowledged that Dr Carter, the Director of Anaesthetics, approached him shortly after the death, and suggested that the patient's management be audited. He acknowledged that he also received, on about 2 August 2004, an Adverse Event form from a nurse called Karen Fox<sup>673</sup> and a Sentinel Event form from Ms Hoffman. The latter included a very detailed two-page letter explaining problems the Intensive Care Unit was experiencing with Dr Patel. In particular, she wrote that:

- (a) Dr Patel had created a culture of fear and intimidation in the Unit;
- (b) On several occasions, Dr Patel has blocked the transfer of patients to Brisbane, even when they have stayed in the Base's Intensive Care Unit for more than 48 hours and a bed has been made available in Brisbane;
- (c) Dr Patel was doing operations which needed more post-operative support than the Unit was able to give;
- (d) All these problems had affected the care for Mr Bramich.<sup>674</sup>

3.267 Dr Keating testified that he carried out some preliminary investigations into the incident and decided there were clinical management problems as well as personality conflicts. He said he planned to meet with the relevant staff to discuss how the problems might be prevented. Those meetings had not occurred by 22 October 2004 (when a more wide ranging complaint was made by Ms Hoffman about Dr Patel), and Dr Keating said he was directed by Mr Leck not to take any further action on the Bramich review. He took that course.<sup>675</sup>

### Gerardus Kempes

3.268 Mr Kempes was a 77 year old man who presented to the Base in December 2004 with a lump in his throat which was impeding him from eating. The evidence, in short, was that Dr Smalberger saw him in the Department of Medicine and took the view that he had a large cancerous mass in his oesophagus and that the cancer had spread to other parts of his body. He considered that the patient needed to be transferred to Brisbane where the staff might consider palliative care such as chemotherapy, and the laparoscopic introduction of a stent to assist with swallowing. Dr Smalberger understood that 'Brisbane' would not accept the transfer without the approval of the Bundaberg surgeons and he sent Mr Kempes

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<sup>673</sup> Exhibit 448, para 135, Exhibit 162, annexure LTR9

<sup>674</sup> Exhibit 4, annexure TH16

<sup>675</sup> Exhibit 448, paras 132 to 160

to the Department of Surgery for that purpose. Unfortunately, Dr Patel simply proceeded to carry out an oesophagectomy and by the time Dr Smalberger was aware of the development, Mr Kemps was dead.

3.269 Dr Keating says that he first heard about the operation when he received an email from Mr Leck on 21 December 2004<sup>676</sup> which read:

Hi Darren,

The Oesophagectomy concerns me somewhat. Have any of these patients survived?

Peter

Mr Leck could not recall ever receiving any response to that email, nor pressing Dr Keating for such a response.<sup>677</sup>

3.270 The anaesthetist involved in the operation was Dieter Berens and, soon afterwards, he spoke to Dr Carter to say that he and others involved in the operation had some concerns about how it was conducted.<sup>678</sup> The pair then met with Dr Keating and Dr Berens outlined the concerns of the theatre staff as to Dr Patel's conduct, and his own view that perhaps the matter should be referred to the Coroner. Dr Berens said that Dr Keating effectively said it was a matter for Dr Berens whether he chose to report the matter. Dr Keating, he said, showed no interest in investigating himself. Dr Berens and Dr Carter, for their part, learnt that Mr Kemps had already been buried and they decided against a referral to the Coroner on the basis that it would cause the family too much distress. In the event, they did not take the matter further.

3.271 On 14 January 2005, three nurses involved in Mr Kemps' care, namely Katrina Zwolak, Damien Gaddes, and Jenelle Law, lodged individual complaints with the Director of Nursing about the care that Dr Patel had provided to Mr Kemps. The Director of Nursing provided those complaints to Mr Leck but it seems no action was taken other than to provide them, in turn, to those who subsequently conducted a general clinical audit of the Department of Surgery at the Base.<sup>679</sup>

## Patient P26

3.272 On 23 December 2004, that is two days after the death of Mr Kemps, a 15 year old boy, known before the Commission as P26, was flown to the Base. He had fallen from a motorbike and suffered an injury to his femoral vein, from which blood was being lost very rapidly. Dr Patel operated immediately to ligate the femoral vein. The blood loss was stemmed and the boy's life was saved. An

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<sup>676</sup> Exhibit 448, annexure DWK75; Exhibit 470

<sup>677</sup> T7172

<sup>678</sup> There were really two separate, but related, issues concerning Mr Kemps. In the first place, as Dr Smalberger and other testified (Exhibit 133), he seemed to be an entirely unsuitable candidate for an oesophagectomy. In the second place, the operation itself seemed to have been managed very badly.

<sup>679</sup> Exhibit 448, para 300. Exhibit 281, attachment 4. The audit is discussed below.

issue arose, however, about the subsequent treatment given the boy. In the course of the next 12 hours, it was noted that he continued to suffer from ischaemia (that is, a lack of blood) to his left leg, and Dr Patel conducted two further operations. Further, it seems, when Dr Patel went on holidays on 26 December 2004, the boy remained at the Base and, indeed, was not transferred to Brisbane, and the care of a vascular surgeon, until 1 January 2005. When he was transferred, he was suffering an acute fever and a very bad infection. The vascular surgeons at the Royal Brisbane determined that the boy's life was at risk anew, and they amputated his left leg through the knee.<sup>680</sup>

- 3.273 The transfer of the patient from the Base to Bundaberg had been overseen by an experienced Emergency Medicine specialist in Brisbane, Stephen Rashford. He gave evidence that he was shocked that such a young patient with such a major vascular condition would remain at the Base, after three operations, for nine days. Dr Rashford testified that he went in person to see the boy upon his arrival in Brisbane and he was aghast at his condition. Dr Rashford said he slept on the issue for a night, but still found himself upset on the next day at the care the boy had received.
- 3.274 On 4 January 2005, Dr Rashford sent Dr Keating an email. He also sent the email to Mr Leck and to the zonal manager, Dan Bergin. The email ran for two pages. It gave the history of the case and explained that, on arrival in Brisbane, the boy had 'an ischaemic left leg – blue, cold and blistered. All the wounds were purulent. He had spiked fevers to 40C and had a HR of 140/min in flight'. Dr Rashford suggested that the 'role of earlier transfer needs to be assessed' and asked that his chart and management be examined.
- 3.275 Dr Keating gave evidence that the zonal manager requested a report on the incident and that Dr Keating provided one on the following day, 5 January 2005, concluding that 'ideally, patient should have been transferred to RBWH when stable on or about 25-26 December 2004' and that 'BHSD will institute a policy of transfer to tertiary facilities of patients with emergency vascular conditions when condition is stable (ie, life and limb are safe)'. Curiously, the report was prepared without speaking to Dr Patel (who was still on holidays) or the Brisbane vascular surgeons, and there was no evidence that Dr Keating ever formalised a new policy.<sup>681</sup>
- 3.276 When Mr Leck provided the report to the zonal manager on 5 January 2005, he wrote that Dr Keating was 'not sure in the circumstances that an external review is warranted'. Mr Bergin responded on 7 January 2005:

Could there please be discussions between relevant staff of Bundaberg and RBWH HSD's to ensure in future the timely transfer of patients who require

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<sup>680</sup> Exhibit 254, Exhibit 208

<sup>681</sup> Exhibit 448, para 173

specialist vascular and other care not available in Bundaberg so as to improve patient outcomes. Please let me know of any unresolved difficulties in this regard.<sup>682</sup>

- 3.277 A complaint was also made about P26's care by one of the surgical ward nurses, Michelle Hunter,<sup>683</sup> to the then Director of Nursing, Linda Mulligan. Her correspondence, also dated 4 January 2005 was directed more squarely to Dr Patel's role. It read in part:

My concerns are with the surgeon that performed his initial 3 operations whilst in the care of the Bundaberg Health Service. I am concerned that if the patient had been transferred to Brisbane initially he may not have lost his leg or be in such a grave condition (sic). I would like his treatment at this hospital investigated as I fear his health and well being has been compromised by inadequate, sub standard treatment by the medical team.

- 3.278 Ms Mulligan wrote back that she had referred the matter to Mr Leck, but Ms Hunter never heard anything further.<sup>684</sup> It seems that no further action was taken on that complaint other than to provide it later to those conducting the clinical audit.<sup>685</sup>

## Conclusion

- 3.279 It follows that staff or patients made over 20 complaints about Dr Patel in the course of his 24 month term at the Base.<sup>686</sup> They vary, of course, with respect to the seriousness of the circumstances and the formality with which they were made. It was clearly unacceptable, however, that by January 2005 there had been no audit or inquiry into Dr Patel's skills by a doctor, let alone an independent general surgeon. One is struck by the sheer consistency of the complaints. They begin, as set out above, with an incident six weeks after Dr Patel commenced at the Base, when he performed a procedure on a patient for which he was not admitted, and they end with a failure to transfer the young patient, P26, in circumstances where his condition had required major vascular surgery.
- 3.280 The gravity of some of the complaints is immediately apparent. There was an approach by the most senior intensivist at a tertiary hospital in Brisbane; there was strident criticism from the Nurse Unit Manager of the Intensive Care Unit; there was a Director of Medicine who, on any view, was making novel arrangements to accommodate perceived incompetence by the Director of Surgery; there were approaches from doctors providing the anaesthetic services, namely Dr Joiner, Dr Carter and Dr Berens; and there were issues raised by a

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<sup>682</sup> Exhibit 210, SJR4

<sup>683</sup> Exhibit 141

<sup>684</sup> Exhibit 141

<sup>685</sup> Exhibit 281

<sup>686</sup> In fact, the situation is slightly worse because Dr Patel took extended leave from April to August 2004: see the evidence of Ms Jenkin in Exhibit 494, para 53

senior vascular surgeon in Brisbane, a senior patient retrieval expert, and the Nurse Unit Manager of the Department of Surgery.

- 3.281 One is struck by two other matters when considering this history. The first is that the evidence of Dr Keating, and the evidence of the other witnesses, strongly supports a conclusion that management persistently downplayed complaints about Dr Patel. Where clinical problems were raised, the Base's Executive was quick to classify them as 'personality conflicts'. It was very reluctant to initiate any investigation into clinical decisions and, in some cases (eg, the challenge to the Renal Unit nurses to 'bring it on'), seems to have been quite obstructive.
- 3.282 The second feature is that the Commission heard much evidence from witnesses that problems that were not communicated to management because it was perceived as being unresponsive.<sup>687</sup> That view is hardly surprising. Against that background, one can speculate with some confidence that, if the Executive at the Base had set out to ascertain the level of satisfaction with Dr Patel, they would have identified significantly more complaints.

### The virtues of Dr Patel

- 3.283 It should not be thought that Dr Patel's time at the Base attracted only criticism. There were, as one might expect of a doctor who held a senior office for two years, many positive qualities that witnesses attributed to him.
- 3.284 In the first place, he was a prodigious worker. During his term, he saw over 1,450 patients in the course of 1,824 admissions.<sup>688</sup> He operated on approximately 1,000 patients and he conducted some 400 endoscopic procedures.<sup>689</sup> Staff attested to the fact that Dr Patel worked tirelessly.<sup>690</sup> One principal house officer, Dr Kariyawasam, told how Dr Patel would book five patients per day for surgery and, if the surgical team fell behind schedule, they would work late rather than cancel operations.<sup>691</sup> He said that, from time to time, Dr Patel would organise 'blitzes' on particular procedures so that for instance, in one week, he performed 15 gallbladder operations.<sup>692</sup> He said that Dr Patel prided himself on the speed and the volume of his surgery,<sup>693</sup> and on his ability to reduce surgical waiting lists.<sup>694</sup> Dr Patel would actively liaise with theatre staff to ensure his patients received treatment as quickly as possible. Dr

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<sup>687</sup> See for example, Exhibit 59, para 42

<sup>688</sup> Exhibit 102, page 26

<sup>689</sup> Exhibit 102, page 26

<sup>690</sup> See, for instance, the evidence of Dr Kariyawasam

<sup>691</sup> Exhibit 221, paras 12 to 18

<sup>692</sup> Exhibit 221, para 16

<sup>693</sup> Insert references including the Gaffield stuff and the Berens stuff. See Exhibit 221, para 13

<sup>694</sup> Exhibit 221, para 14

Kariyawasam said his time at the Base was the busiest of his surgical experience.<sup>695</sup>

3.285 Dr Patel implemented protocols to ensure that the Day Surgery Unit was operating at maximum capacity.<sup>696</sup> He sat on a number of committees and he accepted an appointment as the accountable officer of Operating Theatres, which carries certain administrative responsibilities (and no extra remuneration).<sup>697</sup> He would attend the Base each morning at 7.00 a.m. and he would conduct ward rounds well before most rostered staff had arrived.<sup>698</sup> He arranged the theatre roster so that maximum operations could be conducted and he was happy to assume responsibility for operating lists where another surgeon was called away.

3.286 Further, it seems that Dr Patel was keenly aware of the means by which the Base was funded and he worked to maximise that funding. More will be said of the funding arrangements later in the Report, but it suffices to say a couple of things here. In the first place, Queensland Health sets down elective surgery targets for public hospitals and adopts a policy of reducing funding for those hospitals who do not reach their target. In the second place, where a hospital has treated a patient, the remuneration or credit allowed by Queensland Health for that treatment is determined by a system based on 'weighted separations'. That is, there are people who work out, by reference to a code, the complexity and expense involved in a given procedure and the hospital is given acknowledgment accordingly. Dr Berens gave evidence that Dr Patel could indicate the 'weighted separation' of a particular procedure, and numerous witnesses gave evidence that he constantly expressed to staff how valuable he was to the Executive in terms of reaching elective surgery targets. That view seems to be confirmed by a number of things. In the first place, even when the Executive were expressly informed of Dr Patel's comments about his value, it did not disabuse staff of their veracity.<sup>699</sup> In the second place, when the District Manager eventually spoke to the Audit and Operational Review Branch of Queensland Health about involvement in an investigation, the Branch officer recorded that Mr Leck 'stated that the District needed to handle this carefully as Dr Partell (sic) was of great benefit to the District and they would hate to lose his services as a result of this complaint'.<sup>700</sup> Thirdly, the contribution of Dr Patel to the Base was made clear by the statement tendered of Dr Keating:

When Dr Patel arrived at the hospital it was struggling to achieve its elective target. In the past, the Hospital had failed to achieve the elective surgery target resulting in a reduced funding allocation for the next financial year. There was

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<sup>695</sup> Exhibit 221, para 13

<sup>696</sup> Exhibit 230

<sup>697</sup> Exhibit 448, para 22

<sup>698</sup> See the evidence of Dr Carter

<sup>699</sup> See the cross-examination of Dr Keating about the letter of 22 October 2004, and see Exhibit 4, TH10

<sup>700</sup> Exhibit 225, GF10



also significant pressure to reduce the size of elective surgery waiting lists. This pressure arose in the form of increasing overall time spent by patients on the waiting lists, increasing numbers of people on the waiting lists and numerous complaints by patients' relatives and local Members of Parliament.

Elective surgery encompasses virtually all surgery other than emergency surgery for acute surgical conditions (such as injuries sustained in motor vehicle accidents) or severe immediately life threatening conditions...

Dr Patel appeared to have an understanding of these multiple pressures and worked hard to reduce elective surgery waiting lists. In conjunction with ...Dr James Gaffield, he also assisted in the reduction of the outpatient waiting lists, being those patients waiting to be seen by a surgeon for an opinion as to future treatment. Many of these patients had been on the waiting list for 2 to 3 years. There was no financial benefit to the hospital in reducing these waiting lists...<sup>701</sup>

- 3.287 The extent to which the matter of elective surgery targets influenced decision-making within the Base - and made Dr Patel particularly important - can perhaps best be gleaned by an email from Dr Keating to some of the theatre staff on 8 February 2005.<sup>702</sup> It read relevantly:

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

Should the target not be achieved, BHSD will not get another chance to upgrade the target and hence lose flexibility and significant dollars (with increased scrutiny of all dollars spent in OT). Therefore it is imperative that everyone continue to pull together and maximise elective surgery thruptut until Jun 30. All cancellations should be minimal with these cases pushed thru as much as possible.

To this end, as per draft policy, all elective surgery cancellations are to be discussed by Dr Patel, Dr Carter, Muddy and A/NUM OT. Should there be a problem, the final decision will be made by me...

- 3.288 Whilst, as will be seen later, those independent surgeons who evaluated Dr Patel's work considered he fell well below the standard of a reasonable surgeon, it will be seen also that he was not without skill, intelligence, and an aptitude for learning, and might well have thrived in a larger hospital where he was closely supervised.<sup>703</sup> Dr Carter, the Director of Anaesthetics at the Base throughout Dr Patel's term, thought that Dr Patel was a reasonable surgeon.<sup>704</sup> He said that when Dr Patel was doing routine work, his standard of surgery was 'as good as anybody who had been there previously'.<sup>705</sup> Dr Carter indicated that it was not

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<sup>701</sup> Exhibit 448, paras 24 to 26

<sup>702</sup> Exhibit 72. Dr Keating denied that the Base was wholly dependent on Dr Patel's surgery, and in particular, upon his complex surgery. 'I think he only did 20% of the elective surgery work and that in fact I think we did four oesophagectomies and a couple of Whipples and I think the number, the weighting for those is very small and we are talking about a large [elective surgery] target. ..If you are talking about weighting, joint replacements are far better value and in fact that's where we were concentrating our efforts.' T6869

<sup>703</sup> See the summary of Dr Woodruff's evidence

<sup>704</sup> T4004

<sup>705</sup> T 3980

until December 2004 - when the fourth oesophagectomy resulted in Mr Kemps' death - that he lost confidence in Dr Patel.

- 3.289 There was also evidence from patients that Dr Patel could be an engaging force. One patient, Ian Fleming, testified that at their first meeting, Dr Patel was 'charming' and 'very confident' and that he was a 'powerful personality'.<sup>706</sup> Mr Kemps widow testified to like effect. She said that the family had already been advised that Mr Kemps would be transferred to Brisbane when Dr Patel arrived in the ward, introduced himself as the 'Chief of Surgery', and indicated he would be performing keyhole surgery. Mrs Kemps said that they did not question Dr Patel because he seemed to know what he was talking about.<sup>707</sup>
- 3.290 Evidence of Dr Patel's ability to exude confidence and charm was also received from the nurses. Certainly, it seems, he could be impressive. It is noted that, in September 2003, the position of Academic Co-ordinator – Surgery at the University of Queensland's Central Queensland campus was advertised. There were two applicants for the position, Dr Patel and Dr de Lacy, and even though the latter was a fellow of the College with relevant Australian academic and surgical experience, the members of the selection panel apparently chose Dr Patel unanimously after the candidates gave addresses and answered questions.<sup>708</sup>
- 3.291 Perhaps the greatest of Dr Patel's attributes was his energy in working with younger doctors. A Dr Athanasiov, who was a Junior House Officer at the Base in 2004 gave evidence that, whereas the Base executive showed little interest in ensuring the professional development of junior doctors or listening to their concerns, Dr Patel was one of the doctors who was very supportive. He said that Dr Patel could be abrupt and abrasive but he would consider alternative viewpoints: it was just that 'you had to phrase your suggestion or your viewpoint in a certain way for Dr Patel to consider it'. Dr Athanasiov said he felt comfortable to ask questions and seek guidance from him.<sup>709</sup> He testified:

[Dr Patel] put in a lot of effort with teaching, both informal teaching and formal teaching, and he always made himself available to provide assistance and advice. When he was on-call, you could call him at any time of day or night and he was always prepared to come in and help if you were out of your depth. And even if he wasn't on call and the other consultants felt like they needed help, then he would come in and help. So in that sense he was a good assistance to the junior staff just by being constantly present and providing us with assistance. ..He did informal teaching on ward rounds and on a case to case sort of basis where he would talk about what the problem with the patient was and management of the patient. He also took tutorials where he taught general surgical principles and he also had formal tutorials with the medical students as I understand.

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<sup>706</sup> Exhibit 114

<sup>707</sup> Exhibit 126, para 7

<sup>708</sup> See the evidence of Dr Keating in Exhibit 448, para 29, who was one of the three members of the selection panel:

<sup>709</sup> Exhibit 142, paras 13 to 16

3.292 Dr Athanasiov's comments above were endorsed by Dr Kariyawasam. He said that Dr Patel would be available to junior staff whether it be on week days or weekends, working hours or the middle of the night.<sup>710</sup> Further, when Dr Patel's position came under some challenge in January 2005, Dr Kariyawasam signed an open letter prepared by Dr Athanasiov, drawing attention to the support and assistance' and the 'direction and advice' that Dr Patel had freely given.<sup>711</sup> Dr Athanasiov and three other junior doctors also signed the letter.

### **'Splendid Isolation'**

3.293 The expert evidence received by the Commission (and discussed later) showed that, in a number of respects, there were some serious shortcomings in Dr Patel's work. That begs the question, of course, as to how Dr Patel managed to maintain his position for so long. Part of the answer may lie in the fact that, whether by design or careful management, Dr Patel adopted a number of practices which reduced any scrutiny of his work.

3.294 In the first place, he dealt very severely with those around him who directly challenged his level of care. This was a constant theme in the evidence. Dr Berens, the anaesthetist, gave evidence, of course, about a vigorous discussion over a clinical issue, which ended with Dr Patel refusing to acknowledge Dr Berens. Dr Smalberger gave evidence, as canvassed earlier, about Dr Patel commenting, in front of nurses and the patient, that Dr Smalberger's opinion (which was later vindicated) was the 'stupidest thing he had ever heard'. A junior doctor, David Risson, gave evidence about sending a patient to Brisbane for treatment when unbeknownst to him, Dr Patel had intended that the patient be transferred for purely diagnostic purposes only. He said that when Dr Patel discovered what he had done, he became abusive and told Dr Risson to report to Dr Keating so that he could be re-assigned. Dr Joyner gave evidence that Dr Patel refused to speak with him after a difference of opinion and Dr Martin Strahan gave evidence that he arranged the transfer of a surgical patient to Brisbane in circumstances where he thought it might attract Dr Patel's ire and had some concern for his own safety.<sup>712</sup> Nurses Hoffman, Aylmer, Druce and Pollock all described events in which they had raised issues with Dr Patel and he had subsequently refused to speak with them (sometimes for months and in the face of compelling clinical reasons for communication).

3.295 Dr Keating conceded that he was aware of a perception amongst staff that Dr Patel was 'arrogant, abrasive, rude and potentially abusive'.<sup>713</sup> He expressed that opinion on 4 January 2005 in a formal record but, of course, it was hardly

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<sup>710</sup> Exhibit 221, para 29

<sup>711</sup> Exhibit 142, ARA4

<sup>712</sup> Exhibit 232

<sup>713</sup> T6874, T 6884

fresh. Ms Hoffman had complained as early as June 2003 not only that the Intensive Care Unit could not cope with the complexity and the complications that accompanied Dr Patel's surgery, but that he was regularly disparaging about the Unit and its staff. One of the theatre nurses, Jennifer White, gave evidence that Dr Patel was habitually rude to nursing staff and junior medical staff. She said that Dr Patel would talk constantly about himself, loudly and in self serving terms.<sup>714</sup> When Dr Gaffield was asked in cross examination to explain how he responded to a particular approach from Dr Patel, he testified:

Like I normally did to him, which was to try to get away from him as soon as I could because he just – he had – he was somebody who had lots of bad things to say about everybody around, including people standing right next to him, so I really didn't want to be any part in that sort of behaviour<sup>715</sup>

3.296 There was also heard from a number of witnesses that Dr Patel would inform other staff that he was highly valued by the management. He would explain how vital he was in terms of reaching elective surgery targets, he would suggest that the Base was really a third world hospital and lucky to have him, and he would, on occasion, threaten to resign if his views on patient management were not adopted.<sup>716</sup> In short, it seems that Dr Patel communicated to people that, if they were to challenge him, he would visit retribution upon them and, in any case, the challenge was unlikely to receive serious consideration by management.

3.297 The second way by which Dr Patel avoided scrutiny was that he dismantled the surgical audit process, known as the Otago system. The Commission heard evidence that health care professionals might reasonably differ on the best auditing system to use, and the Otago system might properly have been replaced with an alternative. That, however, did not occur.

3.298 The third way was that Dr Patel tended to work with very junior staff. As will be remembered, there were no surgical registrars at the Base by the time Dr Patel came to work there. But, also, Dr Patel tended to work with doctors who did not have any consistent experience in surgery so that they would not have realised that the level of complications amongst Dr Patel's patients was abnormal. As Dr de Lacy later speculated in evidence:

There must have been somebody dying on the surgical ward all of the time and there must have been horrendous complications physically being managed on the surgical ward all of the time. If that's your first experience in surgery, then your conclusion that you draw is that that's what happens in surgery, in general surgery, and that is not true.<sup>717</sup>

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<sup>714</sup> Exhibit 71 para 9

<sup>715</sup> T 4593; Dr Carter said that Dr Patel was always 'brash and in your face' and it seems he was not inclined to seek him out.

<sup>716</sup> See, for example, the evidence of Ms Hoffman

<sup>717</sup> T4483

3.299 Fourthly, Dr Patel avoided the ‘general community of surgeons’<sup>718</sup> and any substantial contact with other specialists. He was not a fellow of the Royal Australasian College of Surgeons and, in consequence, he was not subject to the requirements the College places on fellows to maintain currency and transparency. Further, it meant that he was not drawn into contact with other surgeons who might ask questions about his work. That isolation was enhanced by Dr Patel’s conduct at the Base. Whereas, it seems, it is common for surgeons in regional centres to work and socialise closely,<sup>719</sup> and there were five or six surgeons in Bundaberg, Dr Patel did not seem to mix with them. Dr Thiele said he only passed him in the corridors; Dr de Lacy said that he seemed to keep to himself; and Dr Gaffield said that he was naturally inclined to avoid contact with Dr Patel in any case. There was no evidence of any close association between Dr Patel and any other surgeon.

3.300 As concerns other specialists, it is clear that, notwithstanding evidence that the practice of modern medicine unequivocally embraces a multi-disciplinary approach to many conditions (so that, for instance, oncologists and surgeons might confer about the best way to treat a cancer), Dr Patel rarely – if ever – sought the opinions of other specialists or referred patients or problems to them for opinions.<sup>720</sup> Within the Base too, Dr Patel resisted any collaborative approach to treatment. Dr Carter gave evidence that there was frequent conflict between anaesthetists, on the one hand, and Dr Patel on the other.<sup>721</sup> It seems that, notwithstanding that Dr Patel’s medical knowledge was in some cases outdated, he would feel at liberty to countermand the orders of the anaesthetists.<sup>722</sup> He declined to adhere to the Australian principle that the anaesthetists and intensivists are the primary carers for a patient whilst that person is in the intensive care unit. Indeed, Dr Patel was aggressive in his bid for control.<sup>723</sup> When Dr Carter was asked whether the Australian protocol was brought to Dr Patel’s attention, he responded:

Yes, and I brought it regularly to the attention of Dr Patel. We tried to make him sort of comply with the joint ward rounds but if we were there at half past seven, he would be there at seven. If we came in at seven, he would have been there at half past six. I think starting your ward rounds at midnight and laying in wait for the man would be a little stupid<sup>724</sup>

Dr Carter also made a comment that was entirely consonant with the evidence from a number of the nurses, namely that he was ‘not sure that Dr Patel had any

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<sup>718</sup> T4428

<sup>719</sup> T3628

<sup>720</sup> See the evidence below of Dr Woodruff and Dr O’Loughlin

<sup>721</sup> T 3989

<sup>722</sup> Refer to the transcripts for Carter and Berens

<sup>723</sup> T 3989

<sup>724</sup> T 3991

respect for nursing staff in general' and that Dr Patel was not keen to listen to anybody's advice.<sup>725</sup>

- 3.301 Fifthly, Dr Patel was much more reluctant than other doctors to transfer patients to tertiary hospitals.<sup>726</sup> Perhaps this was because he had an over-inflated idea of his own capabilities but one of its consequences was the lessening of any scrutiny. Where a person is transferred, the tertiary hospital will have occasion not only to examine the patient and, perhaps, consider the quality of the surgical work, but it will study the patient records and be in a position to assess the decision-making. That opportunity was often not available for Dr Patel's patients.
- 3.302 Sixthly, he subverted Mortality and Morbidity meetings. More will be said of this aspect of hospitals later. Suffice it to say here that there is a practice in many surgical and other departments, of referring those cases the subject of a death or an adverse outcome to 'mortality and morbidity meetings'. The meeting will be attended by doctors within the department and often doctors from other departments, and doctors from outside the hospital.<sup>727</sup> The referred cases will often be 'presented' by a junior doctor who was involved in the treatment and those present will be invited to comment on how the care might have been improved, with a view to ensuring a high standard of treatment is maintained. There was evidence that the meetings can sometimes be rather 'fraught', in that the discussion can be robust. All those who commented, however, said that the 'm & m' meetings are an important tool in maintaining clinical competence.<sup>728</sup> That is borne out, in any case, by the fact that the Royal Australasian College of Surgeons requires its fellows to participate regularly in such meetings.<sup>729</sup>
- 3.303 In Bundaberg, Mortality and Morbidity meetings had been held effectively during Dr Thiele's administration.<sup>730</sup> During Dr Patel's time, the meetings were held but, on several accounts, they were not true to their purpose. They appear to have been rarely attended by senior staff<sup>731</sup> so that any consultant-to-consultant interaction was absent. Instead, they tended to take the form of Dr Patel teaching younger staff about a given topic, rather than any open discussion.<sup>732</sup> The consequence was that the many complications that attended Dr Patel's surgery were not the subject of concerted attention from senior staff.
- 3.304 Seventhly, there was at least a repeated suggestion that Dr Patel wrote falsified and self serving notes. Ms Hoffman maintained that, when patients were handed

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<sup>725</sup> T 3991-2

<sup>726</sup> See the evidence of Dr de Lacy Ms Hoffman and Ms Hunter

<sup>727</sup> See the evidence of Dr Young and Dr Woodruff; The doctors will consultants, registrars and house officers

<sup>728</sup> See the evidence of Dr Young, Dr Woodruff, Dr de Lacy

<sup>729</sup> See Chapter 6

<sup>730</sup> Indeed, so much so, as discussed earlier, that doctors from other hospitals would attend with their own cases to discuss

<sup>731</sup> Dr Gaffield was often in surgery and Dr de Lacy ceased attending because he considered that they were a farce: insert references

<sup>732</sup> See the evidence of Drs Nydam, de Lacy, and Kariyawasam, but note the contrasting evidence of Dr Boyd

over from the theatre staff to the Intensive Care staff, the latter would often be informed of some matter that did not appear in the notes.<sup>733</sup> As will be seen later, this was given some support by the evidence gathered by the expert surgeons on review.

- 3.305 Eighthly, of course, Dr Patel was assisted by the circumstances in which he found himself. No inquiries of consequence had been made into his American history; he was not only the Director of the Department of Surgery, but clearly the more experienced surgeon; and he had not been the subject of any credentialing process. Moreover, as a doctor practising surgery in a public hospital, he was not subject to the 'market review' which affects a surgeon working privately.<sup>734</sup> He was able to practise, as one counsel put it, in splendid isolation.<sup>735</sup>

### Complicity in the Executive

- 3.306 As will be seen in due course, Dr Patel wreaked extensive havoc in Bundaberg. It was suggested by Dr de Lacy that two things needed to come together for that situation to arise. The first was that there was a surgeon who was prepared to actively mislead people and to shield himself from any scrutiny. The second factor - which in Dr de Lacy's view was no less important - was that there was 'complacency at best by the supervising body'.<sup>736</sup> In my view, there is considerable force in that opinion. Despite what appear now to be concerted efforts by Dr Patel to shield himself from any real scrutiny, there were at least 20 complaints to management over the 24 months of his term. The failure to act on those complaints can, in part, be attributed to a lack of adequate systems. There was no adverse events policy at the Base until September 2004; there was no risk policy until June 2003; there was no integrated complaints policy that required that all complaints concerning any given practitioner (whether they emanated from staff, patients, adverse event forms, risk incident forms etc.) be centrally available; there were no functional mortality and morbidity meetings, and there was no Credentialing and Privileging Committee (let alone one with a surgeon amongst its members) that could assess Dr Patel initially and on an ad hoc basis as significant complaints emerged. Dr Gaffield, in the course of his testimony, gave some insight into the particular problem that Dr Patel presented:

He definitely craved professional acknowledgment of his good work. He wanted people to think he was really, you know, better than average whether that be through the complexity of the operations he could do, the volume of them, the speed at which he could do them. He wanted – he was not content with being average, he wanted to stand out. Bundaberg Hospital wasn't a place that that was appropriate – for that kind of person, I mean, there's lots of surgeons like

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<sup>733</sup> Exhibit 4, para 44

<sup>734</sup> T3622

<sup>735</sup> Counsel for the Medical Board: T4336

<sup>736</sup> T4471

that but I don't think they'd seen one like him there for a long time, if ever, and the place wasn't set up to keep pace with him or to police him either way.

- 3.307 In my view, however, a lack of good systems can not account for the failure to act on complaints of the type described. It was a small hospital, the complaints were emanating from a number of senior people, and one is left to wonder at the fact that it was not until April 2005 that Queensland Health or Base staff ever asked an independent surgeon to review the work or the decision-making processes of Dr Patel. At the very best, Dr Keating and Mr Leck demonstrated a woeful ignorance of clinical outcomes in the Base, and a disconnection from staff. That may have come about because Dr Patel was such an intimidating and impressive figure. Perhaps it was because he held himself out as an accomplished general surgeon and those in management did not feel qualified to challenge him. Maybe it was because the Base was much more fiscally driven under the Leck/Keating administration and Dr Patel seemed much more adept at meeting surgery targets. Perhaps it was because management had come to realise how difficult it was to recruit surgeons prepared to work in the conditions operating at the Base. I think it was a little of each of these factors. The conduct is, nevertheless, inexcusable.

### Renewal of registration

- 3.308 It will be recalled that Dr Nydam had offered Dr Patel the position of Senior Medical Officer, Department of Surgery at the Base on a 'temporary full time' basis. The appointment was expressed to run from February/March 2003 for a period of twelve months. By January 2003, Dr Nydam and Wavelength seem to have agreed that Dr Patel would commence his employment on 1 April 2003<sup>737</sup> and, in the event, the Board granted registration for that period. The letter notifying Dr Patel of his registration read in part:

Registration is contingent upon you practicing as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent during the period of your registration. You should also note that the approval is for a specific purpose, to be undertaken in the defined period after which your registration will cease. Any further period will require a fresh application for registration and further consideration by the Medical Board.

- 3.309 On 25 November 2003, Dr Keating wrote to Dr Patel offering him an 'extension of [his] current contract' from 1 April 2004 to 31 March 2005, with an option of renewal for a further twelve months. Although the offer was phrased in terms of an extension, it provided that the appointment was as the Director of the Department of Surgery, rather than the Senior Medical Officer position envisaged by the initial contract.

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<sup>737</sup> Exhibit 51 KN10



- 3.310 Dr Keating gave evidence that the reason the offer was made some four months before the expiry of the initial contract was that there were the three administrative hurdles – namely the area of need declaration, Medical Board registration and issue of temporary working visa - which needed to be surmounted.<sup>738</sup> On 21 November 2003, Dr Huxley at the Workforce Reform Branch of Queensland Health (and in her capacity as the Minister's delegate) considered the application for an area of need certification.<sup>739</sup> Dr Huxley's evidence was that, to her knowledge, 'assuming the documentation has been completed correctly, no Area of Need application for a position within the public health system has ever been refused'.<sup>740</sup> This application was not refused.
- 3.311 Dr Nydam wrote to Department of Immigration with a view to extending the sub class 422 temporary working visa. On 27 January 2004, the Department of Immigration wrote to Dr Keating to indicate that the Base's sponsorship of Dr Patel had been approved.<sup>741</sup>
- 3.312 Dr Nydam also approached the Medical Board. By a letter dated 1 December 2003, Dr Keating advised the Medical Board that the Base had extended Dr Patel's contract to 31 March 2005 and enclosed an application for further registration.<sup>742</sup> Dr Keating was required to provide the Medical Board with the area of need position description (Form 1). He did so by explaining that Dr Patel was to be the Director of Surgery and would provide surgical services to outpatients and inpatients at the Base, amongst other things.<sup>743</sup> He was also required to provide the Board with a completed Assessment Form (this form being peculiar to area of need registrants), setting out Dr Patel's skills by marking boxes across eleven categories. He did so by indicating that Dr Patel's performance was 'better than expected' across nine categories and 'consistent with level of experience' for the balance. Where Dr Keating was required to list Dr Patel's strengths, he wrote that he 'effectively utilises his broad knowledge, skills and experience in general surgery to provide high quality patient care. He is a willing and enthusiastic leader. He also brings understanding and clinical management subjects to appropriate forums'. Where Dr Keating was asked to list Dr Patel's areas for improvement, he wrote that he 'should continue to develop his understanding of the Australian/Queensland health care systems and work towards implementing a formal approach to evaluation of the quality of surgical services provided at BHSD'. Dr Keating left blank the section where employers were invited to comment on those areas 'requiring substantial

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<sup>738</sup> Exhibit 448 para 36

<sup>739</sup> Exhibit 58 para 10(xvi)

<sup>740</sup> Exhibit 58, para 10(xvi)

<sup>741</sup> Exhibit 448 DWK10

<sup>742</sup> Exhibit 448 attachment DWK4

<sup>743</sup> Exhibit 448 DWK 5

assistance' or 'further development' and setting out an 'improving performance action plan'.

3.313 On 9 March 2004, the Medical Board wrote to Dr Patel, indicating that he had been granted special purpose registration and that no conditions were imposed. The letter read in part:

Special purpose registration enables you to fill an area of need at Bundaberg Base Hospital, or any other public hospital authorised by the Medical Superintendent on a temporary basis. It is advised that you are **not registered as a specialist**. Any variation to your practice would require further approval by the Board. You should also note that the above approval is for a specific purpose to be undertaken in the defined period of time.

3.314 I have already made comments about the process of Dr Patel's initial registration. Many of them apply with more force to the renewal of his registration. In particular, I am disturbed by the following features:

- (a) Whilst the Minister was empowered by s135(3) to declare an area of need where there was a scarcity of medical practitioners, his delegate made no inquiry to ascertain whether such a situation existed in relation to the Director of Surgery position at the Base;
- (b) Such an inquiry in my view was clearly warranted given that a practitioner with general registration was being proposed for a position as a Director of Surgery;
- (c) If inquiries had been made, the Minister or his delegate would have ascertained, at the very least, that there was a fellow of the Royal Australasian College of Surgeons who had extensive rural experience, had worked as the Director of Surgery in a major tertiary hospital and, had extensive experience in general surgery who had already approached the Base in July 2003 seeking a Visiting Medical Officer position, being of course Dr de Lacy.<sup>744</sup> It may well be that there were other people who might have accepted the position;
- (d) Dr Nydam indicated that, in his view, Dr Patel was only the acting Director of Surgery. He envisaged, it seems, not so much that a more suitable candidate might be found but that Dr Patel might take steps towards gaining a fellowship in the College. Some small steps had been taken along this path. Dr Keating and Dr Patel had completed in January 2005 a Queensland Health form entitled 'performance appraisal and development agreement',<sup>745</sup> and the agreement envisaged that Dr Patel will lodge an application for recognition as a specialist with the College.<sup>746</sup> There is no evidence, however, that either Dr Patel or the Base ever

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<sup>744</sup> See the evidence of Dr de Lacy

<sup>745</sup> Exhibit 448, para 45, DWK12

<sup>746</sup> Exhibit 448, DWK13

approached the College with a view to ascertaining what program Dr Patel might meet in order to gain fellowship;

- (e) Further, the application to the Medical Board did not seek deemed specialist registration so that the Board was not strictly required to invoke the national guidelines<sup>747</sup> and take counsel from the AMC and the College as to the appropriate path for Dr Patel;
- (f) The Board was now squarely apprised of the fact that Dr Patel was to work as the Director of Surgery. It granted registration for that position whilst explicitly noting that Dr Patel was 'not registered as a specialist'. That conduct was entirely unacceptable. The Board was required to refrain from registering applicants unless they had a 'medical qualification and experience ... suitable for practicing the profession in the area'. It is difficult to see how a person who the Board has declined to register as a specialist could nevertheless be considered suitable for heading the Department of Surgery in a major regional hospital;
- (g) One can well understand there will be situations where, for reasons of timing, for example, an overseas trained doctor filling a legitimate area of need, cannot gain a fellowship. The national guidelines, however, allow for that possibility. They provide that the State Boards might register overseas trained doctors as 'deemed specialists' on the proviso that they introduce appropriate safeguards in consultation with the Australian Medical Council and/or the relevant College. There was no such consultation here. There were no conditions attached. There was absolutely no scrutiny of Dr Patel's performance and suitability, and this occurred in circumstances where he had no real reporting mechanisms in his first year;
- (h) Given that the application referred to Dr Patel's contract being 'extended', the Medical Board might have asked itself when Dr Patel had become the Director of Surgery and how it came about that he was no longer a Senior Medical Officer reporting to the Director of Surgery (as the first application envisaged). It seems that the issue was never considered;
- (i) The Board continued its practice of giving a generic approval. The comment from the Medical Board in its correspondence that 'special purpose registration enables you to fill an area of need at Bundaberg Hospital, or any other public hospital authorised by the Medical Superintendent on a temporary basis' has no legislative basis. If it was intended to indicate that special purpose registrants are entitled to work at any public hospital ex officio, that is simply unsupported in the Act. If it

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<sup>747</sup> See Exhibit 36

was suggested that the terms of Dr Patel's particular registration meant that he could work wherever directed by Dr Keating, that is also unsupported. The registration envisages that the registrant will practise in an area of need. Such an area exists where the Minister has certified it to be so. Dr Huxley expressly disavowed the suggestion that all of Queensland is an area of need<sup>748</sup> and Dr Keating could not direct Dr Patel to work at a public hospital other than the Base because the mere direction would not make that other hospital an area of need.

- 3.315 In all the circumstances set out above, it was especially important for the Board to enquire as to whether or not there had been any complaints about the applicant or at the very least, whether there had been any assessment of Dr Patel by a surgeon. That simply did not happen.
- 3.316 In the absence of invoking the College process, it was particularly incumbent upon the Board to impose conditions requiring supervision for Dr Patel but it failed to take even this rudimentary step.
- 3.317 The Medical Board specifically advised Dr Patel that he need not re-submit the documents which accompanied his original application<sup>749</sup> and this included the verification of licensure. That omission not only denied the Board an opportunity to revisit documents apparently perused hurriedly in the past; it also meant that the Board was not making any enquiries to ascertain whether the Board of Examiners in Oregon had heard disciplinary proceedings against Dr Patel in the year just past.

## The demise of Dr Patel

- 3.318 It will be recalled that the Nurse Unit Manager of Intensive Care, Ms Hoffman, raised concerns in June 2003 that Dr Patel was performing operations so complex that her Unit could not provide adequate support. It will also be recalled that Dr Keating spoke with a number of doctors and decided that the operations might proceed, but he did not return to Ms Hoffman. Her concerns did not abate. Ms Hoffman gave evidence that, in the months that followed, her apprehension was heightened by her awareness of further events, set out below, concerning Dr Patel.
- 3.319 On 3 July 2003, there was notice given by Ms Aylmer of an increasing incidence of wound dehiscence.

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<sup>748</sup> Exhibit 58 para 11

<sup>749</sup> Statement of Demy-Geroe, para 48

- 3.320 In September 2003, there was a patient who had been in the intensive care unit for some twelve days, and was likely to require further lengthy ventilation. Ms Hoffman understood that Dr Patel was resisting any move to transfer the patient and she approached Dr Keating and the Director of Nursing, Linda Mulligan about her concerns.<sup>750</sup>
- 3.321 By the end of 2003, Ms Hoffman testified, she had personally witnessed, or otherwise been informed by Intensive Care staff, of occasions where theatre staff would tell her staff, at the point of handover, of errors which had occurred during the operation and were not set out in Dr Patel's notes.<sup>751</sup>
- 3.322 On 25 February 2004 she was concerned about a patient known as P49 who was the subject of an operation on a Friday, leading to there being three ventilated patients in the ICU on a Sunday morning.<sup>752</sup> (There was evidence that there were usually only three nurses on duty in ICU and three ventilated patients would occupy the entire time of those nurses when there were ten beds in the ward).
- 3.323 By early 2004, Ms Hoffman had become aware that Dr Miach had directed that Dr Patel not operate on his patients.<sup>753</sup>
- 3.324 In early February 2004 and whilst Ms Hoffman was the Acting Director of Nursing, she met with Mr Leck, the District Manager, and set out in some detail her concerns with the increased use of Intensive Care for ventilated patients and, in particular, for Dr Patel's patients. Ms Hoffman gave evidence that, in the course of that meeting, she provided Mr Leck with a document entitled 'ICU Issues with Ventilated Patients' which summarised those concerns. That document is in evidence<sup>754</sup> and was very direct. Ms Hoffman maintains there that:
- (a) The Intensive Care Unit was only capable of ventilating patients for short periods of 24 to 48 hours;
  - (b) The Intensive Care Unit was constantly exceeding this timeframe and whilst that could be done for short periods it could not be sustained;
  - (c) The staff had explained the situation to the surgeons, particularly Dr Patel, but he has not heeded that advice and had said he would 'not practise medicine like this';
  - (d) In response to Intensive Care's claims that the level of surgery was too complex for their resources, Dr Patel had repeatedly threatened to

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<sup>750</sup> Exhibit 4 para 34

<sup>751</sup> Exhibit 4 para 44

<sup>752</sup> Exhibit 4 para 45

<sup>753</sup> Exhibit 4 para 48

<sup>754</sup> Exhibit 4 para 50, TH10, Mr Leck gave evidence that he then made inquiries of Dr Keating and Ms Mulligan about the issues raised by Ms Hoffman: T7217

resign, to withdraw elective surgery patients from the Intensive Care Unit, to complain to the Medical Director or go 'straight to Peter Leck' as 'I have earned him half a million dollars this year';

(e) Dr Patel had in fact refused to transfer his patients on several occasions despite them having deteriorated;

(f) There was a feeling of 'disunity' amongst Intensive Care staff and the nurses were refusing to care for Dr Patel's patients.

3.325 Ms Hoffman says that she indicated to Mr Leck that she did not wish him to act upon her complaints at that time because she would attempt to broach them directly with Dr Patel. Ms Hoffman testified, however, that the complications and the complex operations continued. She mentioned four such patients, in particular, in the months following this conversation (mostly concerned with serious complications following Patel operations).<sup>755</sup> She made reference to a number of patients for whom the clinical conditions appeared to mandate transfer to Brisbane, but Dr Patel declined.<sup>756</sup> She also testified that she had been reliably informed that Dr Patel had instructed his junior doctors to avoid certain words such as 'wound dehiscence' in the medical charts.<sup>757</sup>

3.326 In or about February 2004, a new Director of Nursing was appointed, namely Linda Mulligan. Ms Hoffman said that, at this time, she was speaking widely and freely within the Hospital with a view to preventing more of the larger operations.<sup>758</sup> She said that she met with Ms Mulligan, on several occasions to discuss her concerns but Ms Mulligan took the position that the problems were borne of some 'personality conflict'.<sup>759</sup>

3.327 On 27 July 2004, the patient called Desmond Bramich, referred to earlier in this report, died. He was the man who was admitted to the Base after suffering crush injuries when a caravan fell upon him. He was treated by Dr Gaffield and whilst, initially, he seemed to have recovered well he became seriously ill on the afternoon of 26 July 2004 and died three hours later. His death caused enormous distress amongst the nursing staff involved in his care. They were concerned, in particular, that Dr Patel had obstructed a transfer of the patient, that he had performed, very crudely, a procedure known as a pericardiocentesis, and that he had treated Mr Bramich's wife abruptly.

3.328 Ms Hoffman consulted the Queensland Nurses Union about what she should do. A Union representative raised the concern with Ms Mulligan but, on the representative returning to Ms Hoffman, the latter became concerned that the

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<sup>755</sup> Exhibit 4 paras 58 - 61

<sup>756</sup> Exhibit 4 paras 67 - 70

<sup>757</sup> Exhibit 4 para 64

<sup>758</sup> Exhibit 4 para 117

<sup>759</sup> Exhibit 4 para 84

matter was still being portrayed as some kind of personality conflict.<sup>760</sup> In the event, she received, and provided to Ms Mulligan, statements from some six nurses who all expressed in various ways their concerns about the care received by Mr Bramich.<sup>761</sup> On 28 September 2004, she emailed Ms Mulligan in relation to her concerns about the over use of the Intensive Care Unit. She received a reply but she was not convinced that it squarely addressed her concerns.<sup>762</sup> Ms Hoffman said that she then made an appointment to see Ms Mulligan. This would have been on about 20 October 2004. She said that she was more forceful in that meeting than she had been previously. She said that she raised squarely six concerns, namely that:

- (a) There was a high level of complications coming to the Intensive Care Unit from people who had been the subject of Dr Patel's surgery;
- (b) There was a high number of deaths;
- (c) Dr Patel's behaviour in the Intensive Care Unit was inappropriate;
- (d) The Bramich incident had caused considerable distress amongst the staff;
- (e) The Hospital was not providing support to the staff;
- (f) Dr Patel had suggested to the nurses that he was untouchable because he made so much money for the Base.

3.329 Ms Hoffman testified that Ms Mulligan told her to put her concerns in writing. She did so and she returned to meet with Ms Mulligan and Mr Leck on the same day. Ms Hoffman said that, when she was ushered into Mr Leck's office, she repeated all of her concerns. She explained that her Union had advised that she should make a complaint to the Crime and Misconduct Commission or write to the Director-General but she was eager first to attempt an internal resolution of the matter. She told Mr Leck, she said, that unless there was an independent chart audit of Dr Patel's patients, she would be forced to take some other action.

3.330 Ms Hoffman said that Mr Leck listened carefully to her, took notes, and asked that she make a formal written complaint.<sup>763</sup> In the event, she sent Mr Leck a copy of her document 'ICU Issues with Ventilated Patients' (with annotations to include the Bramich case). Soon after the meeting, she also sent Mr Leck a formal letter setting out information she had collected which formed the basis for her concerns about Dr Patel's fitness. A file note ran for two pages and recorded that Ms Hoffman had made the following points:

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<sup>760</sup> Exhibit 4 para 111

<sup>761</sup> Exhibit 4 para 114

<sup>762</sup> Exhibit 4, attachment TH35

<sup>763</sup> Exhibit 4 para 125

- (a) Dr Patel seemed to be operating outside his scope of practice when looking at the transfer of a patient;
- (b) Staff would book hospital beds in Brisbane but the patient would not be transferred;
- (c) Dr Patel was wont to use funding as a threat – he would say that he made \$500,000.00 for the hospital and if the staff couldn't guarantee to provide care, he would resign;
- (d) Dr Patel was very old-fashioned in the type of drugs he used and, when arguments erupted between him and the anaesthetists, the nurses were caught in the middle;
- (e) Ms Hoffman had raised her concerns with Dr Strahan who said that the local doctors had concerns but did not 'have enough to stick their necks out with';
- (f) Dr Miach would not let Dr Patel operate on his patients;
- (g) Ms Hoffman had already raised her concerns, in the company of Dr Joiner, with Dr Keating. People were refraining from making complaints because they could not see any point to doing so;
- (h) Dr Patel was pushing the intensive care unit so hard that it was working outside its scope of practice;
- (i) Dr Miach was openly questioning Dr Patel's qualification.

3.331 That letter was dated 22 October 2004 and, as will be seen, it marked a significant development in the unrest about Dr Patel.<sup>764</sup> Here was a complaint that could not be dismissed as some personality clash or a passing clinical difference. Ms Hoffman set out a history dating back to the Phillips oesophagectomy on 19 May 2003 and ending with the Bramich case. She identified the poor care which had allegedly been given to certain patients and she provided the Universal Record numbers for those patients. She recorded that Dr Miach refused to allow Dr Patel to operate on his patients; she attached statements from five other nurses, and she named doctors who might corroborate her concerns. The letter (to which I shall refer as 'the Hoffman letter') is set out in full below.

Dear Peter,

I am writing to officially inform you, of the concerns I have for the patients in ICU in relation to the behaviour and clinical competence of one of the surgeons, Dr Patel.

Dr Patel first voiced his displeasure with the ICU around the 19<sup>TH</sup> May 2003. A patient UR number 034546 came to the ICU post oesophagectomy. This patient

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<sup>764</sup> The letter is Exhibit 4, TH37





UR 880266 issue with transferring patient to Brisbane

UR 083866 Bowel Obstruction Resection and Anastomosis on 7/2/04 T/F to Brisbane on 11/2/04 on the 12/2/04 laparotomy showed perforation and peritoneal soiling

UR 134442 Wound Dehiscence and complete evisceration 8/4/04. Booked for sigmoid colectomy and found to have ovarian ca.

UR 020609 27/4 Wound dehiscence

UR 29/6 Insertion of Vascath perforated @ IJ

UR 086644 Delay in Transfer to Brisbane, See attached report, Pt died.

UR 017794 10/7 laparotomy for Ventral Hernia, developed haematoma in ward and attempted evacuation done without any analgesia. Drs notes consistently say patient well when Pt was experiencing large amounts of pain and wound ooze.

UR 057809 pt had Whipples, death cert stated he died of Klebsiella pneumonia and inactivity

UR 063164 death cert state pt died of malnutrition. Had been operated on 31/7/04

Several conversations were had with other doctors, Acting Directors of Nursing and NUMs. Dr Miach refused to allow Dr Patel to care for his patients as he stated he had 100% complication rate with Peritoneal Dialysis insertion. This was stated in a Medical Services forum as well as in a private conversation with myself. This data was shown to the Acting Director of Nursing Mr Patrick Martin.

On the 27<sup>th</sup> July 2004, Pt UR number 086644 returned to ICU in Extremis with a chest injury. The events of these 13 hours is well documented. Dr Patel interfered in the arranged transfer of this patient to Brisbane and the patient died after it was thought the retrieval team were on their way to retrieve this patient. The subsequent events of this intervention and the traumatic pericardial tap (described by the nurse caring for the patient as repeated stabbing motions) resulted in the ICU staff requesting advice from the nurses union. The staff involved in this situation described it as the worst they had ever seen. They were acutely distressed. An attempt was made to seek EAS support, but they were unable to assist due to their workload. One staff member accessed Psychological support privately. I was requested to fill in a sentinel event form, by the then QI Manager Dr Jane Truscott. The events of this incident were discussed at length with the union, who offered support to the staff. They also offered me several ways I could report the long standing concerns I had with the current situation in ICU. The day after the patients death, when I thought he had safely been transferred to Brisbane, Dr Strahan came to talk to me in the office and found me very distressed. He offered to talk to some of the other doctors and get back to me as the representative of the AMA in Bundaberg. He did this state 'here is widespread concern, but at the moment no one is willing to stick their neck out'. He urged me to keep stats on my concerns. I spoke with Dr Dieter Berens and informed him the nursing staff were going to report their concerns with Dr Patel to an official source. He stated he would support us, by telling the truth, but he was concerned he would lose his job and Dr Patel would be the one left behind. It is widely believed amongst the medical and nursing staff that Dr Patel was very powerful, that he was wholeheartedly supported by Peter Leck and Darren Keating and was untouchable. Anyone who tried to alert the authorities about their concerns would lose their jobs. This perception was indeed perpetrated by Dr Patel on a daily basis. Many of the residents and PHO's have expressed their concerns, Dr Alex Davis and Dr David Risson, But

were unsure of what to do because of the widespread belief Dr Patel was protected by executive.

The Nurses union have offered advice in that there are several ways these concerns can be reported if not dealt with internally, after my conversation with Peter Leck and Linda Mulligan on Wed, I believe they were not in receipt of the full concerns, but now that they are they will deal with them.

Dr Miach has reiterated he has dealt with the issue by not letting Dr Patel near his patients. These concerns were openly discussed at the medical services forum.

A peripheral concern is the reports the junior doctors have voiced about forms not being filled out correctly, of being told not to use certain words in discharge summaries, and various other chart irregularities.

Toni Hoffman.

Documentation from Karen Stumer, Karen Fox, Kay Boisen x 2, Karen Jenner, Vivienne Tapiolas included.

- 3.332 In spite the meeting with the District Manager and the Director of Nursing, and despite the level of detail contained within the letter, Ms Hoffman heard nothing by way of response for many months. In the meantime, her concerns only escalated. On 20 December 2004, there was an incident concerning a patient known before the Commission at P44. In essence, that patient was being maintained by a ventilator in Intensive Care. There was a perception amongst the nursing staff in the Unit that Dr Patel placed pressure on staff for the ventilator to be switched off so that the bed was made available for another operation (in fact, the oesophagectomy for Mr Kemps). They were concerned because it is the practice in hospitals to have two independent doctors conduct brain death tests before such a drastic step is taken (notwithstanding that, it seems, there are other reliable indicators of brain death) and Dr Patel was apparently eager to avoid the formalities of that step.<sup>765</sup> The staff were concerned both at the lack of formality and the intimidatory approach adopted by Dr Patel.
- 3.333 Ms Hoffman said that, at some point early in 2005, she made a list of all those operations which had gone badly since the Bramich incident. She sets out that list in her statement and they number eight.<sup>766</sup> They include people with complications such as a wound dehiscence or a haematoma, Mr Kemps who died, and the boy, P26, whose leg was ultimately amputated.

### **Action taken by Dr Keating and Mr Leck**

- 3.334 In the meantime, there were developments in the Executive Office. By a coincidence, Dr Miach had also attended those offices on 22 October 2004. He

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<sup>765</sup> Exhibit 4 para 139 TH42

<sup>766</sup> Exhibit 4, para 142

had a heated exchange with Dr Keating on 21 October 2004 in which Dr Miach maintained that he had previously provided Dr Keating with the data concerning the catheter report and Dr Keating denied that this was so.<sup>767</sup> After the meeting, Dr Keating emailed Dr Miach and requested that he forward the document they had discussed. On 22 October 2004, Dr Miach provided the report (which measured two sheets). It seems that Dr Keating had difficulty understanding the ramifications of the report but, nevertheless, he refrained from approaching Dr Miach.<sup>768</sup>

3.335 On 22 October 2004, Mr Leck provided Dr Keating with a copy of the Hoffman letter. He said he asked Dr Keating to arrange meetings with some of the doctors mentioned in the letter, because Dr Keating maintained that it was 'all personality-based conflict' and Mr Leck wanted him to hear what other doctors had to say.<sup>769</sup> In consequence, Dr Keating approached Dieter Berens, David Risson and Martin Strahan. Meetings with those doctors were held on 29 October 2004, 2 November 2004 and 5 November 2004 respectively. The doctor, in each case, was interviewed by Mr Leck and Dr Keating and the latter made notes of the meetings.<sup>770</sup> The note concerning Dr Berens read that:

- (a) Dr Beren said that he could only talk about those areas where he 'crossed over' with Dr Patel and that was, primarily, the intensive care unit;
- (b) His critical care knowledge was not up to date in relation to the 'choice of some drugs and fluids plus application of some physiology principles to care of critically ill patients;'
- (c) He could remember two cases of concern and he was also aware that Dr Patel had a difficult working relationship with the intensive care unit nurses;
- (d) Dr Berens said that Dr Patel's manual skills were very good and that the patients being admitted to the base were, as a group, older and sicker than several years ago;
- (e) He questioned Dr Patel's judgment in undertaking some procedures in relation to his currency and made particular mention of vascular surgery and the Whipple's operation;
- (f) Dr Berens said that Dr Patel's attitude to other professionals made him hard to work with on occasions and that he 'made categorical statements, didn't appear flexible and wouldn't discuss alternative clinical options';

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<sup>767</sup> Exhibit 448, para 218-9

<sup>768</sup> Exhibit 448, para 219 and attachments DWK62-4, T7001

<sup>769</sup> T7195, T7223

<sup>770</sup> Exhibit 448, DWK 61.

- (g) Dr Berens said that Dr Patel was reluctant to admit his own mistakes and 'didn't appear to be completely accountable and honest about his surgical actions';
- (h) He did acknowledge, however, that he could continue to work with Dr Patel.

3.336 The notes of the meeting with Dr Risson record that:

- (a) Dr Risson had concerns as to the transparency of the current surgical audit process which, in his view, lacked structure. He was concerned that no reasons were given for the termination of the Otago database nor was it replaced adequately;
- (b) He had a concern which was shared by nursing staff about the apparent number of post-operative complications including infection;
- (c) He said that his relationship with Dr Patel was amicable but he appreciated that he could be flighty and unpredictable and that resident staff considered that he could be severe in his reprimands;
- (d) Dr Risson had never been told to refrain from writing or mentioning anything on a discharge summary.

3.337 The notes of the meeting with Dr Strahan record that:

- (a) Dr Strahan was concerned by a case in which he was performing a gastroscopy but he could not advance the scope further after multiple attempts;
- (b) The woman experienced ongoing pain and she was referred to the Base;
- (c) Dr Patel operated and found a carcinoma of the pancreas;
- (d) She was sent home and later re-admitted for a Whipple's operation but she died;<sup>771</sup>
- (e) Dr Strahan questioned whether Dr Patel should be conducting Whipple's operations in Bundaberg. He also said that he believed Dr Patel could be rigid in his thinking and inflexible when new evidence came to hand;
- (f) Dr Strahan said that Dr Patel appeared to operate without some form of peer review.

3.338 It seems that Mr Leck had assumed responsibility for dealing with the letter. He did not, however, deal with it quickly. He and Dr Keating had interviewed the three doctors named above within two weeks but they did not make any enquiries of Dr Miach, despite the unambiguous assertion that the Director of

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<sup>771</sup> In fact, subsequent evidence revealed that Dr Patel had refrained from carrying out the Whipple's operation. He performed a palliative procedure instead but the patient died some weeks later.

Medicine was 'not letting Dr Patel near his patients', nor of Dr Joiner, Dr Patel, or Doctor Carter.<sup>772</sup> Notwithstanding the very specific information contained in the Hoffman letter, they did not call for the files, nor arrange for an independent surgeon to assess the allegations and, indeed, it seems that Dr Keating continued to maintain that the complaints were 'personality based'.<sup>773</sup>

- 3.339 On 16 November 2004, the tilt train disaster occurred in Bundaberg and it can be appreciated that this would have consumed management to some extent. It is notable, however, that no formal steps were taken towards an independent review until 16 December 2004, being some six weeks after the provision of the letter of 22 October 2004. In the meantime, and notwithstanding the very serious allegations being made by Ms Hoffman and the real corroboration provided by the three doctors, Dr Patel continued to operate without restriction or supervision.
- 3.340 On 16 December 2004, Mr Leck made a telephone call to the Audit and Operational Review Unit of Queensland Health. The call was taken by an officer called Rebecca McMahon and a copy of her file note, dated 17 December 2004, has been the subject of comment earlier in this report. According to the note, Mr Leck indicated he had received a formal written complaint from the Nurse Unit Manager of the Intensive Care Unit. Ms McMahon records that Mr Leck said that the complaint concerned the Director of Surgery, "Dr Partell" (sic). He indicated that the doctor had poor outcomes from surgery, including deaths, and was keeping patients in the Intensive Care Unit when they should be transferred. Mr Leck, moreover, had made preliminary enquiries and 'staff had supported this complaint with vague statements and concerns'. He noted, however that there was no clear evidence at this stage of inappropriate surgical practices. He said that there was some personality conflict between the Director of Surgery and the Nurse Unit Manager, and that the complaint needed to be handled carefully because 'Dr Partell was of great benefit to the district'.<sup>774</sup> He said he was proposing to deal with the complaint by 'doing a clinical review of the procedure in the ICU generally' and he proposed to use Mark Mattiussi or a certain intensivist from Redcliffe-Caboolture. He was contacting Audit to see if they had an interest.
- 3.341 The note records that the officer advised Mr Leck that the matter appeared to concern clinical practices rather than official misconduct and that it should be reviewed by a clinician. The officer said that, in the past, such reviews had been conducted by the Chief Health Officer. The note records that the officer made

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<sup>772</sup> Nor had Mr Leck done so when Ms Hoffman made detailed complaints about Dr Patel in March 2004: T7218

<sup>773</sup> T7227

<sup>774</sup> Mr Leck said in evidence that he was conscious that, whilst Dr Patel was at the Base, the elective surgery targets had been met. He conceded this was part of the reason for underlining the importance of Dr Patel: T7190

further enquiries which confirmed her view that the Chief Health Officer, Dr Gerry FitzGerald, might be the appropriate person to conduct the review.

- 3.342 Soon after the telephone call, it seems. Mr Leck sent Ms McMahon a copy of the Hoffman letter by facsimile.<sup>775</sup> On the same day Ms McMahon sent an email to Mr Leck and to Dr FitzGerald confirming her view that the complaint involved 'issues of clinical practice and competence rather than allegations of official misconduct' and would thus be the subject of review by 'a suitably qualified team of medical practitioners.' The officer said that Dr FitzGerald would be 'able to provide advice as to the manner in which this review should be conducted.'<sup>776</sup> Dr FitzGerald has confirmed that he received this email. He notes, however, that he did not receive a copy of the Hoffman letter at this time. It seems that he did nothing other than to print out the email and await an approach from Mr Leck.<sup>777</sup> For his part, Mr Leck telephoned Dr FitzGerald's office on 17 December 2004 and, although he did not speak to Dr FitzGerald himself, he was told that the doctor was going on leave and any attention to the issue would need be delayed.<sup>778</sup>
- 3.343 Dr FitzGerald was scheduled to take leave over the Christmas-New Year period. On 26 December 2004, however, the tsunami struck in the Indian Ocean. He was involved in the Queensland Health response<sup>779</sup> and this delayed his holiday. In the event, he did not return to his position until 17 January 2005.<sup>780</sup>
- 3.344 In the meantime, Mr Leck made some efforts to further the matter. He had already been corresponding with the Deputy Director-General of Queensland Health, Dr John Scott, in relation to concerns about the care given to P26. He wrote to him by email on 13 January 2005,<sup>781</sup> and the correspondence read as follows:

Sorry we have missed each other over the last week.

I was really trying to catch up about Dr Patel, our Director of Surgery, who undertook the procedure on the 15yo male who had initial surgery in Bundaberg and subsequently transferred to Brisbane where he had a leg amputation. You will recall that Steve Rashford raised some concerns.

I was just wanting to flag that I actually do have some concerns about the outcomes of some of Dr Patel's surgery. Late last year I received some correspondence from a member of the nursing staff outlining a number of concerns about outcomes for patients (including some deaths). This is coloured by interpersonal conflict between Dr Patel and nursing staff – particularly in ICU.

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<sup>775</sup> T4251, Exhibit 225, GF8

<sup>776</sup> Exhibit 225, GF8

<sup>777</sup> T3200

<sup>778</sup> T4252

<sup>779</sup> Exhibit 225 para. 56

<sup>780</sup> Exhibit 225, para 54

<sup>781</sup> Exhibit 225, GF9

Until the last week, my medical superintendent did not believe the complaints were justified and were completely driven by the personality conflict – however, he has now expressed some concern although he still believes most of the issues are personality driven.

Late last year I made contact with Mark Mattiussi for advice about who could conduct a review of the concerns – and particularly of elective surgical ICU cases. My med super is keen not to have a professional ‘boffin’ from a tertiary hospital undertake such a review for fear that they might not relate to ‘real’ world demands of surgery in regional areas.

Mark suggested Alan Mahoney from Redcliffe. I flagged this also with Audit and Operational Review seeking some assistance for the review. They have referred me to Gerry FitzGerald.

Unfortunately, Gerry has been away (back next week) – I was really ringing to flag this with you as I am becoming increasingly anxious about the need for a swift review process and wasn’t sure I could wait until next week to get something going (now I think that this is OK – sorry!).

A few of the nursing staff have advised that they reported the matter to the QNU before coming to management (thankfully the QNU advised them to report to us).

3.345 Dr Scott responded on 20 January 2005 by suggesting that Mr Leck contact Mark Waters or John Wakefield (both of Queensland Health) if Dr FitzGerald could not be contacted. It seems, however, that Mr Leck telephoned Dr FitzGerald on 17 January 2005. He explained that the issue was becoming increasingly important to him and that, against the background of conflicting opinions within the Base on Dr Patel, he needed to know whether there was a clinical issue at the heart of the complaints.<sup>782</sup> On 19 January 2005, Mr Leck provided Dr FitzGerald with certain material going to concerns about Dr Patel,<sup>783</sup> under cover of a memorandum of the same date. The memorandum explained that Ms Hoffman had raised concerns about ‘the outcomes of surgery for some patients’ being treated by Dr Patel, that Ms Hoffman suggested there was conflict between Dr Patel and a number of staff including herself, and that she had put her concerns in writing, giving some detail about patients, their treatment and outcomes. The memorandum explained that interviews had been held with some staff (ie Drs Risson, Strahan, and Berens), that the concerns had been raised with Dr Patel following his return from leave on 13 January 2005, and that he had indicated that he did not intend to renew his contract when it expired on 31 March 2005.<sup>784</sup> There were several attachments to the memorandum, namely:

- (a) The Hoffman letter;
- (b) The notes of the interviews with Drs Berens, Risson, and Strahan, and Ms Hoffman;

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<sup>782</sup> T3202, T4253, T4204

<sup>783</sup> The material is set out in Exhibit 281

<sup>784</sup> Exhibit 281, T3203



- (c) An Adverse Event Report form signed by Ms Hoffman going to the Bramich incident (in which the assessor rated the risk as 'very high');
- (d) A copy of the email from Ms McMahon dated 17 December 2004;
- (e) A letter of complaint from a registered nurse on the surgical ward, Michelle Hunter, dated 4 January 2005 about the care given by Dr Patel to P26;
- (f) Letters of complaint from three registered nurses, Jenelle Law, Damien Gaddes, and Katrina Zwolak, all dated 14 January 2005, concerning Dr Patel's conduct in relation to the P44 incident, and the care given to Mr Kemps;
- (g) Ms Hoffman's revised version of 'ICU Issues with Ventilated Patients';
- (h) Letters of complaint from a registered nurses, Karen Stumer, dated 22 October 2004, concerning allegedly poor care provided to patients by Dr Patel;
- (i) Two statements from a registered nurse, Karen Fox, concerning poor care allegedly given by Dr Patel to Mr Bramich and another;
- (j) Letters of complaint from other nurses, namely Vivian Tapiolas, Kay Boisen (two), Karen Jenner concerning various poor care allegedly provided by Dr Patel;
- (k) A Sentinel Event form concerning Mr Bramich signed by Ms Hoffman; and
- (l) The catheter report.

3.346 There was various email correspondence between the Dr FitzGerald's office (mostly from Susan Jenkins, the Manager of Clinical Quality Unit for the Chief Health Officer) and the Base in the course of February 2005.<sup>785</sup> The result was that Mrs Jenkins arranged that she would attend the Base on 14 February 2005 with Dr FitzGerald and the Base would make available certain medical records for perusal, together with certain people (numbering over 20) for interviews. Further, Dr FitzGerald indicated to Mr Leck that his visit would not take the form of an investigation into Dr Patel concerning particular charges. Instead, it would be a general clinical audit of the Base. He wrote that:

I have reviewed all the material to date and while it is appropriate to proceed with the clinical audit, it is too early to be able to document any particular concerns regarding any individual...it would be too early and inappropriate to raise any particular concerns with Dr Patel which he may feel he has to respond to in particular...<sup>786</sup>

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<sup>785</sup> Exhibit 225, GF11

<sup>786</sup> Email of 8 February 2005, Exhibit 225, GF12

Dr FitzGerald says that prior to his visit, he met with officials of the Queensland Nurses Union and reassured them that those who attended meetings with him would be treated with respect, dignity and confidentially.<sup>787</sup>

3.347 I should say that there was evidence from Dr Keating that, during the meeting with Dr Patel on 13 January 2005, he was told that he was not to conduct any more oesophagectomies at the Base.<sup>788</sup> It is startling to note, at this stage, how little had otherwise occurred. The Nurse Unit Manager had made a formal complaint on 22 October 2004 containing extremely serious allegations about the Director of Surgery. The complaint named particular files which might be studied and named particular doctors who might corroborate the concerns. The preliminary enquiries by management had, in fact, corroborated the concerns. They had also been supported by a barrage of complaints from a number of nurses, concerning a number of patients, some of them involving the deaths of patients. Further, some of the most serious complaints concerned incidents that had occurred after the Hoffman letter was delivered (notably the Kemp's death and the P26 amputation). Notwithstanding those circumstances, it was the case by February 2005, that Dr Patel had been operating for some four months, without any investigation, since the delivery of the Hoffman letter. Further, now that some enquiry was being made, it was not being conducted by a surgeon but, rather, by the Chief Health Officer who, whilst he had qualifications as an emergency medicine specialist, had not practised clinically for some fifteen years.<sup>789</sup> The investigation, if it can be called that, moreover, was not focused on considering the veracity of the charges against Dr Patel. Instead, it was to take the form of a clinical audit which, by definition, is 'non-judgmental or non-threatening,' which does not adopt 'processes which would seek guilt' and which, instead, seeks to 'identify issues of concerns so that those issues can be addressed in the interests of quality improvement.'<sup>790</sup> One can well imagine circumstances where such a tool is useful, but this situation – where so many questions had been raised about a very senior, un-credentialed doctor conducting surgery in a regional hospital – is not one of them.

### **Dr Patel's contract is extended**

3.348 Dr Keating maintained that, in December 2004, when Dr Patel was due to take leave (and was aware, of course, that his contract ended on 31 March 2005) he

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<sup>787</sup> Exhibit 225, para.62, T4205

<sup>788</sup> T6822, T6828: Dr Keating says that this restriction was followed up later with another: that Dr Patel would not perform elective surgery requiring the support of the Base's Intensive Care Unit.

<sup>789</sup> T6094. Some inquiries were apparently made in the course of November 2004 but the person identified was not considered suitable to perform the audit: T7229 Mr Leck testified that he spoke with Dr Mark Mattiussi in the course of his search for a suitable person to conduct an audit, and that conversation gave him some comfort that perhaps oesophagectomies were appropriate for the Base: T7238

<sup>790</sup> T3214, Exhibit 225, para 63, T6113

put pressure on Dr Keating, to agree in writing on the terms of any extension.<sup>791</sup> The result was that Dr Keating wrote to Dr Patel by a letter dated 24 December 2004, offering an extension of his contract from 1 April 2005 to 31 March 2009.<sup>792</sup>

- 3.349 Dr Patel never accepted the four year contract proposal from Dr Keating. He went on holidays, and whilst he was away, there were further complaints about him, particularly from Dr Berens, Dr Carter and the registered nurses Ms Jenner, Ms Zwolak and Mr Gaddes, about the Kemps matter, and from Dr Rashford and the registered nurse, Ms Hunter, about the P26 matter. By the time Dr Patel had returned from holidays, Dr Keating had prepared two detailed briefing papers for Mr Leck. The papers spoke of Dr Patel's enthusiasm, his commitment to teaching and his efficiency innovations in the operating theatres. They also, however, acknowledged that Dr Patel had a number of serious flaws. They spoke of 'poor patient selection', a refusal to make appropriate transfers, carrying out operations when appropriate post-operative support was not available, unprofessional conduct with junior staff, poor judgment at times, outdated medical knowledge, and a lack of support from much of the staff. They also made reference to a number of allegations, including those of poor personal infection control measures, Dr Miach's concerns about the peritoneal catheters, Dr Jenkins concerns about P52, the increased wound dehiscence, the complaints surrounding the Bramich matter, and Dr Cook's approach.
- 3.350 Those notes were the subject of discussion between Dr Keating and Mr Leck.<sup>793</sup>
- 3.351 On 13 January 2005 and soon after Dr Patel's return, he and Mr Leck met with Dr Patel to discuss complaints that had arisen. At that meeting, they secured an undertaking that Dr Patel would not carry out any further oesophagectomies at the Base. Dr Patel then indicated he would not be renewing his contract.<sup>794</sup> He wrote a letter to Dr Keating (with a copy going to Mr Leck) on 14 January 2005, indicating that he considered his decision was in everyone's best interest.
- 3.352 As might be expected, by this time, the issue of Dr Patel's competence, and the pending investigation were pressing on Mr Leck's mind. When he received an email from one of the Intensive Care nursing staff, Karen Smith, on 13 January 2005, reading simply, 'Dear All, Treacherous Day, regards, 'Muddy' [Ms Smith's nickname],<sup>795</sup> he responded by emailing Ms Mulligan, 'Linda, please explore

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<sup>791</sup> Exhibit 448, para 258, T6868

<sup>792</sup> Exhibit 448, para 259, DWK65; T6867 the offer was made notwithstanding Queensland Health guidelines requiring that appointments for more than one year be the subject of a formal appointment process. Dr Keating said he reasoned that, if the investigation into Dr Patel found that the complaints were well founded, the Base could escape the contract

<sup>793</sup> Exhibit 448, para 261

<sup>794</sup> Exhibit 448, DWK68

<sup>795</sup> Exhibit 471

what is meant by 'treacherous day' – I assume it relates to Jay - so we need to quieten this down.<sup>796</sup>

- 3.353 The employment situation changed quickly. By a letter dated 2 February 2005, Dr Keating offered Dr Patel a three month locum to 31 July 2005 (at a rate of \$1,150.00 per day) and Dr Patel accepted that locum position on 7 February 2005.<sup>797</sup> At the same time, Dr Keating began navigating, for a third time on Dr Patel's behalf, the three obstacles for overseas doctors practising in Queensland, namely area of need certification, Medical Board registration, and obtaining a visa.
- 3.354 Dr Keating sought area of need certification for Dr Patel. That application recorded that registration was sought for the period from 1 April 2005 to 31 March 2006, and that a visa was sought from 1 April 2005 to 31 March 2009. The application was approved by Dr Huxley on 1 February 2005.<sup>798</sup>
- 3.355 On 31 January 2005, Dr Keating sent an application for registration to the Medical Board in respect of Dr Patel.<sup>799</sup> Oddly, notwithstanding the correspondence that had already passed between Dr Keating and Dr Patel, the covering letter for the application (signed by Dr Keating) maintained that Dr Patel's contract had been extended to 31 March 2009.
- 3.356 There are a number of aspects of the application which warrant mention, namely:
- (a) Renewal was sought for a period of 12 months;
  - (b) No explanation was offered for how – given the terms of s141 of the *Medical Practitioners Registration Act*, an area of need doctor could be offered a contract for four years;
  - (c) Dr Patel for the third time maintained, falsely, that his registration in another country had not been affected by a condition;
  - (d) In the assessment form, Dr Keating again gave a glowing reference. Of the eleven categories, he marked Dr Patel's performance as 'exceptional' in two; 'better than expected' in six; and 'consistent with level of experience' in three. When asked to list Dr Patel's strengths, he recorded that 'Dr Patel is a very committed and enthusiastic clinician who has continued to be a very effective member of staff and Director of Surgery. He has a very strong work ethic which is a model for others. Dr Patel is a willing and effective teacher who has continued to make strong contributions.' When asked to list areas for improvement in Dr Patel, Dr Keating wrote simply 'nil significant'.

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<sup>796</sup> Exhibit 479. In fact, the initial email related to an entirely separate issue.

<sup>797</sup> T6826, T6873-7, Exhibit 448, DWK 69, DWK70

<sup>798</sup> Exhibit 448, DWK71

<sup>799</sup> Exhibit 448, DWK70

(e) In the area of need position description, Dr Keating wrote, amongst other things, 'Dr Patel has been in this role for the past 12 months and his performance ...rates as excellent'.

3.357 Also, on 1 February 2005, Dr Keating wrote to the Department of Immigration<sup>800</sup> seeking an extension of Dr Patel's visa for four years. On behalf of the sponsor, the Bundaberg Health Service District, Dr Keating recorded that the proposed period of employment was four years.

3.358 Given the environment of complaint and pending investigation, one is driven to wonder, of course, how management at the Base could possibly contemplate engaging Dr Patel for another three months, let alone another four years. Dr Keating answered these queries in his testimony, albeit to my mind unsatisfactorily. He said that Dr Patel had been keen to secure a four year working visa in Australia, that he was very insistent and that the four year contract had been proposed to assist with the visa. He said that he was always conscious that any contract could be terminated if the investigation found against Dr Patel. He said that he was more effusive about Dr Patel than was warranted because he was concerned that Dr Patel would read the documents.<sup>801</sup> He said that he wanted to allow for the possibility that Dr Patel might leave the Base but agree to work there again at some later time.<sup>802</sup> He said he had overlooked the fact that some aspects of the documentation had not been altered after the parties began to look at a three month, rather than four year, extension.<sup>803</sup> He inferred that the three month extension was necessary to allow the Base time to recruit a new surgeon.

3.359 I will deal with these matters more fully in my findings. Suffice to say, here, that I find it completely unacceptable that, faced with many staff complaints, and accepting as they did, that many of the complaints were well founded or warranted investigation, the executive should proceed to extend Dr Patel's contract.

### **Dr FitzGerald visits the Base**

3.360 Dr FitzGerald and Mrs Jenkins visited the Base on 14 and 15 February 2005. Dr FitzGerald testified as to his involvement that:

Ordinarily I would arrange for somebody else to undertake these sorts of investigations and reviews and reports through me, but in this case, because I think, of the concerns raised by Peter Leck in our discussions over phone, and also the information presented, I thought this was probably a complex situation that may need perhaps – not so much technical judgment, but perhaps more – if I say political, the policy and interaction of people, and judgment about those

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<sup>800</sup> Exhibit 448DWK71

<sup>801</sup> T6886

<sup>802</sup> T6911

<sup>803</sup> T6913

issues as well as the management of evidence, shall we call it, but certainly data about outcomes et cetera...

He also testified, however, that the visit effectively lasted only one day because on 15 February 2005, he and Mrs Jenkins visited Hervey Bay Hospital on unrelated business.<sup>804</sup> He said that, when they first arrived at the Base, they met with Mr Leck and Dr Keating, and were informed that the Base had received no patient complaints or adverse events about Dr Patel (but a folder of complaints was located by the Central Zone Manager on 15 April 2005).<sup>805</sup> Dr Keating gave evidence that, to his recollection, Dr FitzGerald's question was restricted to complaints that were the subject of litigation (of which there was only one relating to Mr Bramich).<sup>806</sup> I prefer the evidence of Dr FitzGerald and, in any case, I can see no good reason for Dr Keating refraining from volunteering those complaints which had not, as yet, resulted in litigation.

- 3.361 Dr Keating did not communicate the issues set out in the briefing papers to Dr FitzGerald when he visited (let alone provide him with a copy). He took the attitude, he said, that he would answer such questions as were asked, and he said (as Dr FitzGerald acknowledged) that their discussions were very general.<sup>807</sup>
- 3.362 Dr FitzGerald testified that he did not seek to gain evidence on any particular matters during the Bundaberg interviews but, rather, he sought to 'collect [the] personal impressions of issues of concern' to those who chose to meet with him. He said that the principal issues of concern raised with him were that Dr Patel was conducting operations outside his scope of practice and that patients were not being transferred promptly.<sup>808</sup> He conceded, however, that he gathered a wide range of information. He accepted, for instance, that Dr Miach spoke to him about the catheter placement issue and indicated, after consistent failures by Dr Patel, Dr Miach refused to send more patients to him.<sup>809</sup> Dr FitzGerald said that, although he did not raise the issue with Dr Keating, he understood that the procedure of inserting the catheters should not have been complicated and, in any case, he questioned Dr Patel's judgment in doing six when he was incompetent.<sup>810</sup> He met a number of nurses and, presumably, they spoke to the wide ranging issues the subject of their complaints. He also gave evidence that most of the surgery was carried out by Dr Patel because Dr Gaffield reported to him. He said that he was surprised that oesophagectomies would be carried out, and concerned about the judgment of a surgeon who would do them.<sup>811</sup> He was

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<sup>804</sup> T3226

<sup>805</sup> Exhibit 225, para 75, T4239

<sup>806</sup> T6966, Exhibit 448, paras 349 and 350

<sup>807</sup> T6820

<sup>808</sup> Exhibit 225, para. 65.

<sup>809</sup> T3226

<sup>810</sup> T3226, T4249-50

<sup>811</sup> T4230

also concerned by the judgment of a surgeon who would conduct the six peritoneal catheter placements.

- 3.363 Dr FitzGerald said he discovered a strange thing about Dr Patel's notes, either in the course of the visit or soon afterwards. He said it is not uncommon to come across medical records that are incomplete or inadequate. With Dr Patel, however, something quite different was evident. The notes were very well written: they just did not seem to reflect the information being received from other people.<sup>812</sup> He gave the example of consents to operations and said that, if the notes were correct, then Dr Patel followed 'an exquisite process' in obtaining consent.
- 3.364 Ms Hoffman was one of the nurses who met with Dr FitzGerald. She said that the meeting lasted for 1½ to 2 hours. Dr FitzGerald explained that he was not conducting an investigation but rather a fact finding mission to decide whether an investigation should ensue. Ms Hoffman recalled that she spoke of all her general concerns about Dr Patel. She gave Dr FitzGerald specific examples of allegedly poor care and, where asked, she elaborated upon them.
- 3.365 The meeting did not fill Ms Hoffman with confidence. In the first place, she noted that Dr FitzGerald had not obtained a copy of her letter dated 22 October 2004 setting out in detail her concerns, let alone the various statements attached to that letter. (Dr FitzGerald testified, and I accept, that he had received the letter but did not take it to the meeting – or even, perhaps, to Bundaberg – because he was not there to test allegations.<sup>813</sup>) Further, she recalls that, when Dr FitzGerald asked Ms Hoffman what she thought should happen and she said that she thought Dr Patel should be stood down pending an investigation,<sup>814</sup> he responded that it was 'better to have a surgeon rather than no surgeon at all.'<sup>815</sup> Counsel for the Nurses Union put this contention to Dr FitzGerald, and I note that he did not dispute it.<sup>816</sup> Dr FitzGerald said that he found Ms Hoffman to be very impressive, and so too a number of other staff members articulating similar views. He said, however, that there were some staff who believed that – whilst Dr Patel was doing operations which were inappropriate, and delaying transfers too long – his 'basic surgery was probably all right'.<sup>817</sup>
- 3.366 Dr FitzGerald said that, at the conclusion of the interviews at the Base, he met with Dr Keating. He testified that he explained the outcome of the interviews generally and said that he would provide a draft report to the executive at the Base in due course (so that they could check it for factual accuracy) with a view

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<sup>812</sup> T4206

<sup>813</sup> T4209

<sup>814</sup> Dr FitzGerald himself agreed that Ms Hoffman specifically raised concerns about Dr Patel continuing to perform surgery: T4209

<sup>815</sup> T4208

<sup>816</sup> T4208-9

<sup>817</sup> T4213

to providing the final report in four to six weeks.<sup>818</sup> He said that, by the time he left, he had received undertakings from Dr Keating and Dr Patel that the latter would cease performing complicated operations at the Base and that he would ensure that patients were transferred appropriately. When Dr FitzGerald returned to Brisbane, he set about preparing a report but its completion was delayed by the need to obtain benchmarking data as to what was normal in comparable surgical practices.

- 3.367 Both Dr Keating and Mr Leck gave evidence<sup>819</sup> – consistent with Dr FitzGerald's evidence<sup>820</sup> – that at the time of Dr FitzGerald's departure from the Base, he had reached no firm view on Dr Patel's competence.

### The end game

- 3.368 Whilst Dr FitzGerald was drafting his report in Brisbane, Ms Hoffman was becoming increasingly concerned in Bundaberg that no action was being taken upon her letter of 22 October 2004. Dr FitzGerald did not return to her (or, for that matter, to the Base management) to indicate how the draft was developing. She was aware that, since delivery of her letter on 22 October 2004, a number of very serious incidents had occurred (attracting complaints about Dr Patel), including the death of Mr Kemps and the amputation of P26's leg. She was aware that, notwithstanding her letter, the Executive had named Dr Patel in November 2004 as the Employee of the Month.<sup>821</sup> She was aware, of course, that Dr Patel continued to operate. Further, whereas she had sought a chart audit, she was disappointed to be informed by Dr FitzGerald that he was undertaking something much more general, and to find him imbued with an attitude that 'a bad surgeon is better than no surgeon'. Ms Hoffman was particularly dismayed when Dr Patel came to the intensive care unit in about February 2005 to tell everybody 'the good news' that his contract was to be extended to July 2005 to help the Base achieve its elective surgery target.<sup>822</sup> She testified that, given the nature and number of the complaints against Dr Patel, this apparent development felt like a 'big huge slap in the face'.<sup>823</sup>

- 3.369 Ms Hoffman decided that she must take further action and she determined to approach the local member of Parliament, Mr Messenger MP.

- 3.370 Something should be said of Mr Messenger. He gave evidence before the Commission. He had been a member of the Royal Australian Air Force for some twenty years and an ABC radio journalist in 2002 and 2003. He said that in the

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<sup>818</sup> T4237

<sup>819</sup> T6900, T7204

<sup>820</sup> T4234-7

<sup>821</sup> T184

<sup>822</sup> Exhibit 4 para 154

<sup>823</sup> T184



course of his work with the ABC, especially, he became keenly aware that health was a pressing issue in the Bundaberg area. State elections were held in Queensland on 7 February 2004. Mr Messenger gained pre-selection for the National Party and he campaigned very heavily around a theme of Bundaberg needing better health services, and of a halt being brought to bullying of health providers. In the event, Mr Messenger was elected as the Member of the Legislative Assembly for the seat of Burnett. It seems that, from that time, he became something of a lightning rod for health complaints. This may be because, whereas Mr Messenger was a member of the Opposition, the other seats in the area, Bundaberg and Hervey Bay, were held by members of the Government so that people were uncertain as to whether complaints would be fully explored. Alternatively, or additionally, it may be because of the terms of his campaign. In any case, in the course of his evidence, Mr Messenger was able to set out a busy history of receiving complaints from various constituents about problems with the Base Hospital. In particular, he related concerns communicated to him about the Mental Health Unit within the hospital.

- 3.371 On 18 March 2005, Ms Hoffman visited the offices of Mr Messenger and provided him with a copy of her letter dated 22 October 2004. She also spoke for some two hours to Mr Messenger about her concerns and Mr Messenger recorded that conversation.
- 3.372 In the days that followed, Mr Messenger sought advice from his political colleagues and on that basis decided that, before progressing Ms Hoffman's complaints, he should seek some corroboration. He made a telephone call to Dr Strahan who was, of course, named in the letter as somebody who was a leader in the local medical community. Mr Messenger's evidence was that Dr Strahan told him that the local medical community was well aware of concerns about Dr Patel but they were hoping that he would go away at the end of his contract.
- 3.373 Mr Messenger considered this to be sufficient corroboration for Ms Hoffman's complaints which, one can readily see, would have been cogent and compelling in themselves. On 22 March 2005, Mr Messenger tabled the Hoffman letter in Parliament, and the Shadow Health Minister, Stuart Copeland, MP, asked a question without notice of the Minister for Health, Gordon Nuttall MP.<sup>824</sup> He referred to 'the fact finding process conducted by Dr FitzGerald' and the serious allegations raised about Dr Patel's competence, and asked if the Dr FitzGerald's findings would be released. Mr Nuttall responded that he was not aware of the issue but would make enquiries.
- 3.374 On the same day, Dr FitzGerald was asked to provide notes to, and orally brief, the Minister about Dr Patel. Dr FitzGerald emailed the Minister's office with

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<sup>824</sup> Hansard, 22 March 2005, page 611

background information and suggested answers to Parliamentary questions. He met with the Director-General and, later in the day, he met with the Minister (when, it seems, he spoke to the emailed material).<sup>825</sup> He indicated to the Minister – as was the case – that his draft report was nearly complete but he was awaiting benchmarking data from similar hospitals. He also indicated that Dr Patel had been performing surgery outside his scope of practice but that Dr FitzGerald had advised the Base that he should cease doing so.<sup>826</sup> On 23 March 2005, Mr Nuttall made a statement to Parliament, explaining amongst other things that Dr FitzGerald's clinical audit was incomplete but it would be provided, when finalised, to the Director-General.<sup>827</sup>

3.375 Still, it seems, nothing was done to stop Dr Patel practising surgery on the people of Bundaberg. On the contrary, a number of nurses gave very consistent evidence that they were reprimanded *en masse*.<sup>828</sup> Ms Hoffman said that, on the day after Mr Messenger spoke in Parliament, the Acting Director of Nursing called a meeting of ICU staff. She said that, when all the nurses were assembled, Mr Leck arrived. He was visibly furious, lectured those present about the Code of Conduct, that the conduct in naming Dr Patel was appalling and that it would erode confidence in the Base. Then he left.<sup>829</sup>

3.376 On the same day, and with the apparent approval of head office,<sup>830</sup> Mr Leck responded to urgings from Dr Patel by writing a letter of support in the Bundaberg News-Mail which read:

I refer to the article of March 23 concerning allegations made against surgeon Dr Jay Patel. The fact that a number of allegations have been made public without completion of a review process designed to ensure that the application of natural justice, is reprehensible. At this time, I have received no advice indicating that the allegations have been substantiated. A range of systems are in place to monitor patient safety and the community can be assured that we constantly work to improve our service delivery. Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go.<sup>831</sup>

3.377 On the following day, Dr Patel resigned.<sup>832</sup> He wavered, subsequently, it seems in his position, and Mr Leck testified that, as far as he was concerned, the three month contract to July 2005 was still available to Dr Patel.<sup>833</sup> In the event, of course, he resigned.

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<sup>825</sup> Exhibit 391, T6134, T6154

<sup>826</sup> T5311-2: Dr FitzGerald gave evidence that he gave advice in the terms of his subsequent report, which was effectively complete but for the benchmarking detail: T6134

<sup>827</sup> Hansard, 23 March 2005, page 691

<sup>828</sup> Nurses Hoffman, Aylmer, Jenner

<sup>829</sup> Exhibit 4, paras 167-9

<sup>830</sup> T7207, Exhibit 474

<sup>831</sup> Exhibit 473

<sup>832</sup> Exhibit 475, T7245

<sup>833</sup> T7246. Mr Leck said that this was because any immediate departure would cause problems in maintaining a service: T7244

3.378 Also on 24 March 2005, Dr FitzGerald finalised his report and provided it to the Director-General (but not the Minister).<sup>834</sup> The report, which was tendered in evidence:<sup>835</sup>

- (a) was entitled 'Clinical Audit of General Surgical Services, Bundaberg Base Hospital, Confidential Audit Report';
- (b) explained that a clinical audit is a 'systematic review and critical analysis of recognised measures of the quality of clinical care, which enables benchmarking and identified areas for improvement...';
- (c) says that the catalyst for the audit was a 'level of concern raised by a number of staff at the hospital in regard to some patient outcomes [and] ...a number of staff interactions';
- (d) summarises staff opinion under the 'nine quality dimensions of the National Health Performance Framework';
- (e) suggested a number of systemic changes including the implementation of a credentialing system and an audit system;
- (f) compared some rates of complications for Bundaberg with those recorded nationally;
- (g) maintained that staff concerns fell into two main groups, namely procedures being conducted beyond the scope of the Base and the lack of good working relationships between staff;
- (h) noted that there was also concern about increased rates of unplanned admission, complication and wound dehiscence;
- (i) suggested a number of systemic changes.

3.379 I should say that there are a number of aspects of the report that concern me. First, notwithstanding the events which precipitated the report, it makes no reference to Dr Patel by name, and infrequent reference to him by office, i.e., 'the Director of Surgery'.<sup>836</sup> Second, no comment is made on startling statistics contained within the report. A table contained in Appendix A-1 suggested that the rate of surgical complications in Bundaberg was, in a number of categories, more than double that for the peer group.<sup>837</sup> Further, a table at page 9 of the report shows that, whereas the national rate of bile duct injury had been steadily decreasing so that it was at .29% in 2003, the Bundaberg rate had steadily increased from July 2003 so that, for the semester ended December 2004, it was at 8.06% some 28 times higher than the national figure. Dr FitzGerald gave

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<sup>834</sup> T6096

<sup>835</sup> One version appears as Exhibit 230 (T3214) and the final version appears as Exhibit 225, GF30

<sup>836</sup> Exhibit 225, T4221

<sup>837</sup> T3216

evidence that most of those injuries would be associated with the procedure known as a laparoscopic cholecystectomy, and that this was a relatively routine operation for a general surgeon. Those factors, in my view, would rather excite one to question the competence of the operating surgeon, Dr Patel. I note that I asked Dr FitzGerald, in the course of his evidence, to explain why he did not mention in the report that there was a prima facie case that Dr Patel was incompetently performing routine surgery. He said he could not answer that question.<sup>838</sup>

- 3.380 In the third place, where references are made to the Director of Surgery, they are almost all positive<sup>839</sup>. It is noted that the Director was ‘accessible...and easy to contact’, had ‘a good work ethic and a heavy workload,’ and had ‘created efficiencies in OT by changing some outmoded work practices’. Further, where negative comments are made, they are juxtaposed with positive comments or downplayed. The report speaks very generally about concerns being raised and then continues: ‘However, as well as raising concerns, some staff made complimentary comments about the divisional director’s commitment to teaching and mentoring of junior medical staff. In addition, there has been significant improvement in efficiency, especially in the operating theatre and in meeting elective surgery targets’. Where the report talks of a lack of good working relationships between staff, it acknowledged that the director had a confronting personality, but it also read ‘the director of surgery has high standards and this has led to some degree of conflict with staff.’ Dr FitzGerald said that it is part of the philosophy behind clinical audits that, whilst they might include positive comments about an individual, they omit negative ones. As he was forced to agree, that necessarily gives the reader a skewed picture of the individual.<sup>840</sup>
- 3.381 Fourthly, where changes were recommended, it was suggested that the problems were generic rather than confined to Dr Patel.<sup>841</sup> The report spoke of the need for ‘team building’ but Dr FitzGerald could not identify problems in communication independent of Dr Patel; it spoke of the need to complete the implementation of credentialing but Dr FitzGerald was not aware of anyone who had not been credentialed other than Dr Patel (and, by inference, perhaps, Dr Gaffield).<sup>842</sup> He did not highlight, moreover, the very disturbing fact that Dr Patel had not been the subject of this process in a term lasting almost two years.<sup>843</sup>
- 3.382 Fifthly, there was no attempt to address the very serious allegations raised by a number of senior doctors and nurses, and no suggestion that those allegations might be dealt with by a more detailed enquiry.

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<sup>838</sup> T6111

<sup>839</sup> T4221-4

<sup>840</sup> T6121

<sup>841</sup> T6123

<sup>842</sup> T4221-4

<sup>843</sup> T6125

- 3.383 Sixthly, there was no critique of important systemic failings such as the failure to credential and privilege Dr Patel, to have a strong audit system in place, or to conduct frank mortality and morbidity meetings.
- 3.384 Seventhly, the report contained many recommendations but none of them proposed that Dr Patel should be directed to cease operating<sup>844</sup> or that his contract should not be renewed.<sup>845</sup>
- 3.385 Dr FitzGerald has responded to these points. He said that the practice in clinical audits is to praise individuals, where appropriate, but to confine criticisms to systems rather than people. He said that he was not performing a management audit and that was why he did not look at managerial failings. He said that he did not address concerns about Dr Patel's registration because, even though clinical audits are confidential, they often reach the public domain. He also points out that he did take steps to confine any damage from Dr Patel. In the first place, he obtained an undertaking from Dr Keating that Dr Patel would not carry out oesophagectomies or complex surgery.<sup>846</sup> In the second place, he contacted the Medical Board on 16 February 2005 and arranged that the determination of Dr Patel's pending application for renewal would be deferred.<sup>847</sup> In the third place, he wrote to the Medical Board when he completed his report on 24 March 2005, suggesting that they consider investigating the competency of Dr Patel.<sup>848</sup> In the fourth place, he notes, he sent a memorandum to the Director-General on 24 March 2005, dealing more directly with concerns about Dr Patel.
- 3.386 The latter memorandum (which was not sent to anyone other than the Director-General) was certainly in dramatically different terms to the report. It read relevantly:<sup>849</sup>

The report of the clinical audit is now complete and I have attached a copy to this memorandum...

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 judgment, 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

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<sup>844</sup> Dr FitzGerald acknowledged that this was an option available to Queensland Health (as, of course, is clear from the credentialing policy): T6097

<sup>845</sup> T4226, T42328

<sup>846</sup> T4234

<sup>847</sup> T3228, T6146

<sup>848</sup> T3248

<sup>849</sup> Exhibit 225, GF14

Credentials and Clinical Privileges Committee has not appropriately considered or credentialed 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 twelve months ago. While the report makes a number of recommendations for system improvements, I would recommend that some discussions should occur with hospital management, reminding them of their responsibilities to put such systems in place and ensure they respond appropriately for reasonable clinical quality concerns.

3.387 In the end, I remain critical of Dr FitzGerald's conduct. The reason for his involvement was that Mr Leck was anxious to ascertain whether there was any substance to the serious allegations he was receiving. He should have received an answer in the affirmative. Instead, and despite the very serious allegations with which he was briefed before he even visited Bundaberg, Dr FitzGerald chose to adopt a style of investigation which, necessarily, would 'accent the positives.' That point, in any case was, for a long time, academic because Dr FitzGerald testified that, although he sent the completed report to the Director-General on 24 March 2005, he did not send it (or a draft) to the executive at the Base until 7 April 2005 (and only then because the Director-General asked him to do so).<sup>850</sup> Dr FitzGerald could not explain why this was so.<sup>851</sup> The political considerations in Brisbane seem to have taken priority over the clinical interests of patients in Bundaberg. In that regard, it is little comfort that Dr Patel should give an undertaking not to conduct complex operations. Given that he had no effective supervisor and there was no written protocol, he was to be the arbiter of complexity - and that in circumstances where his judgment was extremely questionable.<sup>852</sup> Further, the statistics (both in the report's tables and in the catheter results) demonstrated that Dr Patel could show incompetence even in routine procedures.

3.388 The issue of supervision leads me to a further failing in Dr FitzGerald's work. He was not only the Chief Health Officer but, by virtue of that position, a member of the Medical Board. He was informed, of course, during his visit to Bundaberg that Dr Patel had not been credentialed at the Base. He said that he was told that this was because the College's co-operation could not be secured so he recommended that the Base nominate its own surgeon.<sup>853</sup> Given the failings he had noted in management and the complaints he had heard in relation to Dr Patel, he should have taken steps to see that happened immediately but he did not do so.<sup>854</sup> There is a bigger issue. Dr FitzGerald commenced his review on

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<sup>850</sup> T6015-6, T6819. The fact that the Base did not learn of the audit findings until 7 April 2005 is all the more remarkable because the Director-General was in telephone and email contact with Mr Leck on 24 March 2005: T5500

<sup>851</sup> T6133. The delay is hard to reconcile with Dr FitzGerald's knowledge that Mr Leck was relying upon the report: T6145

<sup>852</sup> T4236, T6108

<sup>853</sup> T4236, T3222, T3224, T3225, T6929

<sup>854</sup> T6112

about 20 January 2005, when he received Mr Leck's memorandum with a bundle of attachments.<sup>855</sup> Dr FitzGerald should have checked the circumstances of Dr Patel's registration (and he could have done so very quickly as a member of the Medical Board). He would have noted a striking anomaly, namely that Dr Patel was not recognised as a specialist in Queensland, and yet he was practising in an unsupervised position, without any peer review, as the Director of Surgery. That, and the bundle of complaints, should have prompted him to see that there was urgent assessment of Dr Patel's work by a surgeon and to seek a review by the Medical Board. He never took the first step. The second was only taken on 24 March 2005 - seven days before Dr Patel's registration was due to expire - when Dr FitzGerald asked the Medical Board for an 'assessment of [his] performance'.<sup>856</sup>

- 3.389 Dr FitzGerald gave evidence that his understanding in February 2005 was that the Base and Dr Patel were negotiating about a possible extension to the contract for three months.<sup>857</sup> That fact should have made action on Dr FitzGerald's part particularly urgent – both to ensure that any incompetency be curtailed over that three month period and because the Base would have wished to know of any such issues before negotiations concluded.
- 3.390 The necessary result of Dr FitzGerald's approach was that Dr Patel was able to continue to practise, and that any investigation would, at best, be substantially impaired because he had departed. Dr FitzGerald said that Mr Leck's memorandum of 19 January 2005 made him turn his mind to finishing the investigation before Dr Patel left because 'it worries me at times where we don't progress investigations because people depart, that there is unfinished business, and as a result, when these people come back there is no evidence to avoid or manage the issues that were of concern before'.<sup>858</sup> I share that concern and would add that there should be some sense of responsibility within Queensland to ensure that incompetent and dangerous doctors are not able to simply move to a different state or country and set up practice anew with a clean record because Queensland has failed to respond promptly to complaints.
- 3.391 On 29 March 2005, Mr Leck informed Dr FitzGerald that Dr Patel was on 'stress leave' and was intending to depart the country.<sup>859</sup> In fact, two days later, Dr Patel departed Australia for America, with a ticket paid for by Queensland Health.

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<sup>855</sup> T6110

<sup>856</sup> Exhibit 225, GF13; Dr FitzGerald acknowledged that he was aware any investigation by the Medical Board could take weeks or months: T6117

<sup>857</sup> T6159, and see T6145-6 and Exhibit 392, Copy 1

<sup>858</sup> T3203

<sup>859</sup> T6107

- 3.392 On 7 April 2005, the Minister, Gordon Nuttall MP, and the Director-General of Queensland Health, Dr Stephen Buckland, visited the Base. Staff were notified by email that there was to be a 'staff forum' concerning the Patel matter<sup>860</sup> and, in the event, about 100 to 150 staff attended the forum. One of those attending was Margaret Mears and she said that, from the outset, she 'felt under attack.' She said the Minister noted that he had just been to Springsure, which was a 'wonderful town' and 'now here we are in Bundaberg'.<sup>861</sup> She recalls that Mr Nuttall and Dr Buckland told the staff that the outcome of the clinical audit would not be published because of the release of the Hoffman letter, and Dr Patel's departure. Dr Buckland said that, in the circumstances, no decent doctor would want to work in Bundaberg.<sup>862</sup> Her recollection was that Mr Nuttall said that the only way they could stop the 'rubbish' was by voting out Mr Messenger.<sup>863</sup>
- 3.393 Another nurse who attended the meeting, Karen Jenner, gave evidence that the meeting was told that the report compiled by Dr FitzGerald would not be made public now because Dr Patel had been denied natural justice and had returned to America.<sup>864</sup> She said Dr Buckland said that he 'supported his staff one hundred per cent and would not tolerate them being denied natural justice'.<sup>865</sup>
- 3.394 Ms Aylmer also attended the forum. She said that the speakers took an aggressive tone, particularly Dr Buckland, and that the staff were told that, 'due to the leak to the media' the clinical audit could not be released.<sup>866</sup> She recalled Ms Jenner querying the contention that the audit results could not be published because Dr Patel was overseas, and Dr Buckland responding with words to the effect, 'The report will not be released: what part of that don't you understand'.<sup>867</sup>
- 3.395 Dr Buckland addressed this issue in evidence and in his statement. He said that he and the Minister were visiting Springsure and they decided to divert the plane back because of the negative media coverage concerning the Base. He said that neither he nor the Minister said there would be no further action taken on the clinical audit: rather, Dr Buckland maintained, he said that it would be hard to take any action against Dr Patel in view of his departure but the review process would otherwise continue.<sup>868</sup> He acknowledged that he did say that, now that Dr Patel had left the country, the 'audit process would be difficult to finalise'.<sup>869</sup> Dr Buckland accepted that the tone and effect of his comments at the meeting were probably critical of the way that matters had been ventilated in the media.<sup>870</sup> He

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<sup>860</sup> Exhibit 507, para 12

<sup>861</sup> Exhibit 507

<sup>862</sup> Exhibit 507

<sup>863</sup> T7375

<sup>864</sup> Exhibit 508

<sup>865</sup> Exhibit 508

<sup>866</sup> Exhibit 59, para 47

<sup>867</sup> T1009-1010

<sup>868</sup> Exhibit 335, para 34

<sup>869</sup> Exhibit 335, para 33, T5505

<sup>870</sup> T5567



also conceded that he may have said words to the effect that ‘no decent doctor would want to come to Bundaberg to work in such circumstances’.<sup>871</sup> Dr Buckland testified that the intent of the visit was not to ‘engage in a major confrontation’ but rather to ‘reassure the staff that they had our support’.<sup>872</sup> One can understand how that might not have been readily apparent to the staff.

3.396 The comment that the audit process would be difficult to finalise, is particularly hard to understand given that Dr FitzGerald had specifically indicated by his memorandum of 24 March 2005, that his attached audit was complete. Dr Buckland testified that the audit process is much more than the report, that after the report is written there is a period of consultation with those considered therein, and this was the part that would be difficult to complete. He denied that what he was really communicating was that, since Dr Patel was not coming back and could not be afforded natural justice, the audit would not be completed, but he conceded that his language was poorly chosen.<sup>873</sup>

3.397 In the end, I accept the evidence of the nurses. It is corroborated, in any case, by much of the other testimony, including the evidence of Dr Keating who was present at the meeting. He said that the Minister and the Director-General announced that there would be no further investigation, and that the investigation had been stopped. He said that Dr Buckland told the meeting that this was because Dr Patel ‘could not put his side of the story’ from America.<sup>874</sup> He said that some recommendations going to systemic matters would be provided to the executive. He said that Mr Nuttall had said he was there to support the staff and that it was going to take a lot of work to regain the trust of the local community. He recalls the Minister saying that he had just come from Springsure where he opened a multipurpose health service, and that there was a contrast in what he had done that day.<sup>875</sup>

3.398 The evidence from the nurses spoke consistently about aggression or belittling or angry tone on the part of the speakers. I do not believe that the Minister and the Director-General would have allowed this impression to be communicated inadvertently. Dr Buckland agreed that there was clearly a ‘level of frustration and anger’ on the part of staff regarding the issue, and he could hardly have thought that his comments would be construed as supportive. I am strongly inclined to the view that the main purpose of the meeting for the Minister and Dr Buckland was to tell staff that the audit report would not be released and to admonish them to ‘move on.’ I do not accept Dr Buckland’s explanation of his comments. In particular, I believe he was less than honest in telling staff that the

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<sup>871</sup> T5567

<sup>872</sup> T5567

<sup>873</sup> T5506, Exhibit 335, para 34

<sup>874</sup> T6817

<sup>875</sup> T6818

audit process had not been finalised, that it could not be released in Dr Patel's absence, and that - somehow - natural justice could only be afforded to people who are present in the country. The position taken by Dr Buckland was particularly unsavoury because, as he well knew, Dr FitzGerald – by his memorandum of 24 March 2005 - had reached firm views on Dr Patel's competence, had recommended that the matter be referred to the Medical Board, and had not suggested that Queensland Health needed to take up any issues with the practitioner.

3.399 The effect of the comments made by Mr Nuttall, and especially Dr Buckland, at the forum was to discourage staff from raising complaints about clinical issues,<sup>876</sup> and I find that the two men were well aware that the comments would have that effect.

3.400 Some time later on 7 April 2005, Mr Leck was communicating with the zonal manager, Mr Bergin, about the leak of information.<sup>877</sup> Where Mr Bergin had asked whether Internal Audit had been 'involved' to investigate the matter, Mr Leck responded relevantly:

No, not at present...In the meeting today the DG advised that we would not have a witch hunt and that we needed to move on from this incident. The Minister said that leaking confidential information including patient details such as UR numbers was unacceptable and that whilst he supports freedom of speech in terms of raising matters with MP's, he would not tolerate the leaking of such information...Perhaps we have the Audit team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary message?

...

3.401 Dr Keating gave evidence that, immediately following the meeting at the Base attended by the Minister and the Director-General, he spoke privately with Dr Buckland. He explained, as was the case,<sup>878</sup> that he had conducted a "Google" search on the previous evening and it had revealed Dr Patel's disciplinary history in the United States.<sup>879</sup> Dr Buckland recalls receiving that information and gave evidence that, as they returned by aeroplane to Brisbane, he said to the Minister words to the effect of 'There is more to this guy than we know. I will have a look at it', but no more<sup>880</sup>. The Minister, for his part, could not remember such a conversation. Dr FitzGerald gave evidence that, within a day or so of Dr Buckland's visit to Bundaberg, Dr Buckland told him that he had been informed by Dr Keating that a "Google" search revealed problems with Dr Patel's registration.<sup>881</sup>

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<sup>876</sup> T6821

<sup>877</sup> Exhibit 477; T7211

<sup>878</sup> T6812

<sup>879</sup> T6815

<sup>880</sup> T5507, Exhibit 391, para 36

<sup>881</sup> T4211

- 3.402 Certainly, it is the case, that although Queensland Health and the Medical Board were alerted to the possibility of registration anomalies by about 8 April 2005,<sup>882</sup> the existence of those anomalies was only made known to the public through an article in *the Courier-Mail* on Wednesday 13 April 2005.<sup>883</sup> There appear to have been no plans at that time to disclose the registration anomaly with the public.<sup>884</sup> The article by Mr Thomas created huge interest because it revealed that Dr Patel had been restricted from certain types of surgery in Oregon and that he had been required to surrender his licence in New York.
- 3.403 It remained the case that still a surgeon had not reviewed Dr Patel's work.
- 3.404 On 9 April 2005, however, the Minister announced that a Queensland Health team, headed by Dr Mark Mattiussi, the District Manager for the Logan and Beaudesert District Health Service), and including Dr John Wakefield (Executive Director Patient Safety Centre) and Associate Professor, Leonie Hobbs (Acting Executive Director Women's & Newborn Services, Royal Brisbane and Women's Hospital) and Dr Peter Woodruff (vascular surgeon) would conduct a review.
- 3.405 On 26 April 2005, the Government announced a Commission of Inquiry.

## Conclusion

- 3.406 It is impossible to consider the history of complaints against Dr Patel without one matter impressing itself forcefully. Within eight weeks of the commencement of Dr Patel's employment, there was a very serious complaint, relating to an oesophagectomy for Mr Phillips and another for Mr Grave. From that time, there was a long, long history of patients who received terrible outcomes, and people, whether they be patients, relatives or for that matter medical staff, who were deeply affected by experiences. Notwithstanding that first complaint in May 2003, Queensland Health did not obtain a surgeon's review of Dr Patel's work until June 2005, when Dr Wooduff provided his section of the review team's report. It was painfully obvious to Dr Woodruff and indeed the other two surgeons who subsequently reviewed Dr Patel's work, that he was not a competent surgeon. One must ask then how the system failed Bundaberg so badly.

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<sup>882</sup> T4261

<sup>883</sup> T4229-4230: The story of Dr Patel and Mr Messenger's speech had been reported by the *Bundaberg News-Mail* and *The Courier-Mail* but it received fresh impetus with the publication of Mr Thomas' article about Dr Patel's disciplinary history.

<sup>884</sup> T4264

## THE COMPETENCE OF DR PATEL

3.407 Dr Patel held himself out as a general surgeon - both by his initial approach to Wavelength Consulting Pty Ltd<sup>885</sup> and by the subsequent provision of his *curriculum vitae* - and he engaged in the practice of a general surgeon whilst employed at the Base. Accordingly, when I consider his competence below, I do so by reference to the standard expected of a general surgeon in Australia.

### What is a General Surgeon?

3.408 The *Medical Practitioners Registration Act 2001* provides, in effect, that a person may only use the title of 'surgeon' in Queensland if he or she is a fellow of the Royal Australasian College of Surgeons, and is registered by the Medical Board in one of nine subspecialties.<sup>886</sup> The College, for its part, recognises the same nine subspecialties of surgery, namely general, cardiothoracic, orthopedic, pediatric, vascular, urology, plastic and reconstructive, otolaryngology head and neck, and neurosurgery.<sup>887</sup> In practice, a trainee surgeon must choose from those nine areas and, if the trainee gains a fellowship, it will be specific to that sub-specialty. It follows, of course, that a surgeon may gain a fellowship in an area such as orthopaedics or neurosurgery, without ever understanding those issues peculiar to general surgery.

3.409 The subspecialty of general surgery is predominantly concerned with the abdominal organs, including the liver, the pancreas, the bowel, and the gallbladder. It is also concerned with breast, extracranial and endocrine surgery (particularly where the latter concerns the thyroid).<sup>888</sup> The surgery to be conducted will include hernia repair (where a hole in the abdominal wall is patched or stitched), appendectomies, colorectal procedures, splenectomies breast reconstruction, mastectomies, and procedures to the liver, gallbladder, pancreas, bowel and the thyroid.<sup>889</sup> The College points out that the scope of general surgery is difficult to define<sup>890</sup> and I infer that general surgeons may also practise in those areas not covered more specifically by one of the other subspecialties.

3.410 As might be expected, the training required to become a Fellow in General Surgery is rigorous. The usual path is as follows. Candidates complete a primary medical degree and they then work for one year as interns in hospitals;<sup>891</sup> they

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<sup>885</sup> T675

<sup>886</sup> see section 161, and Schedule 3 to the Regulations

<sup>887</sup> [www.surgeons.org](http://www.surgeons.org)

<sup>888</sup> T4421

<sup>889</sup> T3598, T 4421; Wilson RE, 'Multispecialty Surgical Conditions in General Practice', *MJA* 2005; 182 (7): 337-339; and see 'Logbook, General Surgery' at [www.surgeons.org](http://www.surgeons.org)

<sup>890</sup> [www.surgeons.org](http://www.surgeons.org)

<sup>891</sup> T555, [www.surgeons.org](http://www.surgeons.org)

will work for a further one to three years as a house officer as they wait to gain selection for an accredited training position,<sup>892</sup> then they will complete two to four years of basic surgical training.<sup>893</sup> At the end of that training, the doctor – now a registrar - may compete for a position on an advanced surgical training program in general surgery (or such other subspecialty as the doctor chooses).<sup>894</sup> This program will be completed over four years<sup>895</sup> and the College stipulates, amongst other things, that the registrar must perform a certain number of procedures unassisted in the course of the program.<sup>896</sup> Throughout the basic and specialist surgical programs, the trainees are subject to checks by the College in terms of logbooks, reports and examinations.<sup>897</sup> There are also minimum requirements for training posts to ensure quality, including a minimum number of specialists to supervise trainees and a minimum amount of work flowing through those posts.<sup>898</sup>

- 3.411 Following successful completion of these requirements, the doctor is awarded a fellowship in general surgery from the Royal Australasian College of Surgeons. By that time, the doctor is likely to be aged in his or her mid 30's and will have considerable experience as a junior doctor, as a registrar, and in performing various operations both supervised and unassisted. Even after gaining fellowship, surgeons are required to meet certain standards set by the College. They must engage in continuing medical education programs, reaccreditation courses (usually on a three to five year basis), and other educational and quality assurance activities.<sup>899</sup> The College runs panels of review for its members and, where necessary, requires them to attend certain courses, have their work mentored, or cease certain activities pending skills assessment.<sup>900</sup>
- 3.412 One of the key quality assurance activities the College requires of its members is regular participation in morbidity and mortality meetings. In essence these meetings are attended by surgeons and junior doctors. Recent cases which have involved a death or an adverse outcome are presented, usually by junior doctors, and then discussed by all present, with a view to considering how similar outcomes might be avoided in the future and improving generally the level of clinical care.<sup>901</sup>

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<sup>892</sup> T555, Exhibit 34 para [4]

<sup>893</sup> RACS: *Review of the Assessment of Overseas Trained Doctors*, April 2005, page 9 viewed 2 November 2005, <http://www.surgeons.org> Selection into basic surgical training is a two part process, requiring selection into the College program and appointment to an accredited hospital.

<sup>894</sup> RACS: *Review of the Assessment of Overseas Trained Doctors*, April 2005, page 9 viewed 2 November 2005, <<http://www.surgeons.org>>

<sup>895</sup> T555, [www.surgeons.org](http://www.surgeons.org)

<sup>896</sup> [www.surgeons.org](http://www.surgeons.org)

<sup>897</sup> T770 and T771

<sup>898</sup> T776

<sup>899</sup> T771

<sup>900</sup> T771

<sup>901</sup> T3620

- 3.413 Doctors who have been trained overseas may, of course, gain a fellowship in the College. Indeed, the changes to the *Medical Practitioner's Registration Act 2001* made by s143A, if implemented appropriately, should ensure that doctors who are registered as 'deemed specialists' are moving towards full fellowship if they stay for any length of time. For each overseas trained applicant, the College will usually assess the doctor's qualifications and experience, and then determine the further training required to gain fellowship. It will usually require that the applicant undergo a period of at least twelve months supervision before being considered for fellowship.<sup>902</sup> Where overseas trained doctors have been awarded a fellowship they have met precisely the same standards as are required of an Australian-trained surgeon.<sup>903</sup>
- 3.414 In short, a person will only attain the position of general surgeon in Australia if he or she has demonstrated discipline, aptitude, experience and knowledge, and complied with the professional obligations set by the College. Citizens are entitled to expect (as, in my experience, they do) that doctors who hold this standing will act in a learned and professional way.
- 3.415 Evidence going to the competency of Dr Patel was received from three surgeons, namely Geoffrey de Lacy, Barry O'Loughlin, and Peter Woodruff. Each of those doctors considered a sample of Dr Patel's patients, and whilst the range of patients differed markedly, the doctors' conclusions did not. Each of them found, amongst other things, that the care given by Dr Patel fell well below the standard expected of a reasonably competent surgeon.

### Dr de Lacy

- 3.416 Dr de Lacy gave evidence that:
- (a) He was awarded a fellowship of the Royal Australasian College of Surgeons in 1997 and has practised since that time as a general surgeon. During 1998 and 1999, he was the Director of Surgery at the QEII Hospital in Brisbane, and he has also held appointments as a senior lecturer in surgery at the University of Queensland, and as an examiner for the Australian Medical Council;<sup>904</sup>
  - (b) He has worked previously in regional hospitals at Maryborough, Hervey Bay, Broken Hill, Gosford and Griffith;
  - (c) He moved to Bundaberg in July 2003 and has maintained a private practice from the Mater in Bundaberg as a general surgeon since that

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<sup>902</sup> RACS: *Review of the Assessment of Overseas Trained Doctors*, April 2005, page 28 viewed 2 November 2005, <http://www.surgeons.org>; see T1985 and 1986 for an explanation of the rigorous process applied by one of the Australian Colleges.

<sup>903</sup> eg, Dr Jayasakera in surgery, and Dr Smalberger and Dr Berens in the Royal Australian College of Physicians

<sup>904</sup> T 3594

time. He has also worked for approximately two years as a Visiting Medical Officer at the Base;<sup>905</sup>

- (d) Queensland Health had implemented an arrangement whereby former Patel patients might see one of a panel of surgeons at Queensland Health's expense, for a second opinion or follow up surgery. Dr de Lacy participated in that arrangement. In consequence, he saw over 150 patients and he has carried out more than 100 procedures, whether they be diagnostic or remedial.<sup>906</sup> For all the patients, Dr de Lacy prepared individual reports and provided the same (which go into considerable technical detail and have been tendered in evidence) to the relevant general practitioners;<sup>907</sup>
- (e) In providing information and opinions in those reports, Dr de Lacy availed himself of the following sources, namely the history taken from the patient, the x-rays and pathology reports (all of which were made available by the Base)<sup>908</sup>, and the data gleaned through an examination of the patient and, in some case, subsequent surgery;<sup>909</sup>
- (f) Dr de Lacy had his reports to hand when giving evidence;
- (g) In his opinion, Dr Patel fell well below the standard of a competent surgeon in the vast majority of cases.<sup>910</sup> Although he had not compiled a list, Dr de Lacy believed that the number of patients who received appropriate care may have been as few as ten;<sup>911</sup>
- (h) Dr de Lacy said there were four main areas in which Dr Patel performed poorly namely:
- Inadequate assessment of the presenting patient;
  - Defective surgical techniques;
  - Poor post operative management;
  - Inadequate follow up.

In the course of his testimony, he gave details of care provided to particular patients to illustrate these shortcomings;

- (i) In relation to the *assessment of presenting patients*, Dr de Lacy said Dr Patel failed to make use of all appropriate tests and, perhaps in

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<sup>905</sup> Exhibit 252, para 3

<sup>906</sup> Exhibit 252, para 5 T3598, T3639

<sup>907</sup> Exhibit 252A T3598

<sup>908</sup> T 3599, T3596

<sup>909</sup> Exhibit 252 paras 5 and 6, T 3597

<sup>910</sup> T 3605, T3639

<sup>911</sup> T 3639. Dr de Lacy made the point, it should be noted, that poor care would not necessarily result in a poor outcome: T3607

consequence, he regularly misdiagnosed patients. The pre-operative investigations (going to such matters as the patient's suitability for anaesthetic<sup>912</sup>) were regularly omitted and this led to more frequent incidents of post operative heart attack and post operative respiratory compromise.<sup>913</sup> Further, whereas good surgeons tend to be reticent to operate (because, surgery, by its nature, is an intrusive procedure), Dr Patel seemed reluctant to consider other treatment paths;<sup>914</sup>

- (j) Dr de Lacy said that the *poor surgical techniques* were evidenced by high infection and leak rate, poor wound closure technique, injuries to contiguous anatomical structures, removing the wrong organ, missing cancers on diagnostic procedures, and failing to remove cancers at the time of operation.<sup>915</sup> He said that Dr Patel seemed to be out of date in his techniques and gave the example of Dr Patel's failure to make use of a procedure called a cholangiogram in the course of a procedure to remove the gallbladder called a laparoscopic cholecystectomy;
- (k) Dr de Lacy spoke about anastomotic leaks. He said that when a surgeon joins two ends of a hollow tube, the procedure is called 'anastomosis.' It commonly occurs when a general surgeon removes a cancerous segment of bowel and then re-unites what remains. Dr de Lacy said that an anastomotic leak is a recognised indicator of poor care and that the number of leaks suffered by Dr Patel's patients was 'grossly excessive';<sup>916</sup>
- (l) Dr de Lacy spoke at some length about incisional hernias and their relationship with wound dehiscence. He explained that the abdominal wall may be damaged inadvertently in the course of surgery. Where it fails to repair itself, an incisional hernia develops. In consequence, the intestines can make their way through the abdominal wall and, sometimes, through the outer layer of the skin. Either of those phenomena is called a wound dehiscence (or, more colloquially, a 'burst abdomen');<sup>917</sup>
- (m) Dr de Lacy said that incisional hernias can be caused by poor wound closure technique, by infection, or by poor suturing material. Some patients will suffer problems because, by reason of medication or other illnesses, they do not heal swiftly.<sup>918</sup> He said that good surgeons could

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<sup>912</sup> T 3655

<sup>913</sup> T 3636, Exhibit 252, para 7

<sup>914</sup> T 3635 – T3636

<sup>915</sup> Exhibit 252 para 7(b)

<sup>916</sup> T 3616, line 50

<sup>917</sup> T 3611. Dr de Lacy said that there are also cases where the abdominal wall remains intact but the superficial skin opens up. This is a relatively common and unremarkable phenomenon.

<sup>918</sup> T 3608



expect that the incidence of wound dehiscence and incisional hernias would be rare. On the other hand, in the course of treating the former Dr Patel patients, Dr de Lacy had already carried out more than twenty incisional hernia repairs;<sup>919</sup>

- (n) Dr de Lacy said that it was possible to infer from these findings, with confidence, that Dr Patel had poor wound closure technique and that he would often select inappropriate people for surgery;<sup>920</sup>
- (o) Dr de Lacy said he could also infer that Dr Patel must have been rough in his technique because Dr de Lacy had observed injuries to the liver, the spleen, the rectum, the bladder, the ureter and other abdominal organs;<sup>921</sup>
- (p) Dr de Lacy said that he had looked after complications in the last four months that he had never seen before.<sup>922</sup> Dr de Lacy recalled his first former Patel patient. She had presented to Dr Patel for repair of an incisional hernia. She presented to Dr de Lacy with a bowel obstruction and he discovered, upon operating, that the stitches for the hernia repair had passed through twenty loops of the small bowel.<sup>923</sup> He said that it was very hard to envisage how a surgeon could make such a mistake but that he has subsequently seen in Dr Patel's former patients many other errors of a similar magnitude;<sup>924</sup>
- (q) As to the issue of *post operative management*, Dr de Lacy said that Dr Patel would fail to recognise, or treat, major post operative complications such as a haemorrhage following bowel resection, bile leak following cholecystectomy, dehiscence after abdominal incision, and cardio respiratory failure;
- (r) In relation to *inadequate follow up*, Dr de Lacy said there was a notable failure by Dr Patel to refer patients to appropriate specialists or to recognise failings in his own operations. He would also fail to follow up on inadequate resection margins;<sup>925</sup>
- (s) One of the major problems in Dr de Lacy's view was that Dr Patel seemed to consider operations an end in themselves rather than a means of improving the patient's condition. He did not appear concerned to ensure that procedures reduced patients' suffering. He

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<sup>919</sup> T 3611

<sup>920</sup> T 3608

<sup>921</sup> T 3601

<sup>922</sup> T 3605, line 30

<sup>923</sup> T 3597

<sup>924</sup> T 3601.

<sup>925</sup> This refers to the practice amongst good surgeons of marking out a cancer and providing some margin on either side to ensure that the entire cancer is excised: Exhibit 252 para 7(d)

gave as an example a man known to the Commission as P16. Dr Patel performed an oesophagectomy on P16 and he survived.<sup>926</sup> Dr de Lacy noted that the primary purpose of the procedure is to lessen the patient's discomfort by allowing them to swallow.<sup>927</sup> When Dr Patel performed the oesophagectomy however, he omitted that part of the operation which prevents reflux. The result was that the man still could not swallow, received little benefit from the operation, and was very unhappy with his quality of life;<sup>928</sup>

- (t) Dr de Lacy said that the magnitude of Dr Patel's errors can only properly be understood when you compare his results to those you would expect of a normal general surgeon. He said that Dr Patel's results were not 'ten times what you might expect. They're more like 100 times what you might expect',<sup>929</sup> He said that one should bear in mind, in particular, that most of Dr Patel's surgery was elective (as opposed to being an emergency situation) so that there was ample time to assess the patient, arrive at a treatment path, and decide whether the local hospital had adequate supporting structures for the path envisaged.<sup>930</sup> Dr de Lacy said that a death in those circumstances is a disaster and should be very rare. Although, by the nature of his involvement, Dr de Lacy had not studied those cases where patients had died, he believed that the results of Dr Woodruff's audit (which showed 13 deaths over the two years, mostly concerned with elective patients) was very telling,<sup>931</sup>
- (u) In Dr de Lacy's opinion, Dr Patel failed to appreciate his own limitations or those of the Base. Dr de Lacy made the point that the regional setting has different ramifications for emergency and elective surgery. Where an emergency situation develops in a rural area, a general surgeon may, of necessity, move beyond his or her normal scope of practice. On the other hand, in relation to elective surgery, the regional setting will tend to restrict that scope. The surgeon will be keenly aware that there are better places for certain procedures.<sup>932</sup> Oesophagectomies were a good case in point. Dr Patel should not have attempted them at the Base. They are always complicated because they interfere with lung function, there is a danger of leaks,

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<sup>926</sup> He, in fact, performed 4 oesophagectomies during his time at the Base: two patients died within hours of surgery, one died within months, and P16 was a survivor.

<sup>927</sup> He said that the procedure does not extend the patient's life expectancy.

<sup>928</sup> T 3605

<sup>929</sup> T3602, line 15

<sup>930</sup> T 3602

<sup>931</sup> T 3602

<sup>932</sup> T 3613

and they are always elective because the cancer moves slowly.<sup>933</sup> Good surgeons understand that you do them regularly to maintain competence or you do not do them at all.<sup>934</sup> They also understand that, even if you have maintained competence, you do not do them at a hospital with insufficient support facilities;<sup>935</sup>

- (v) What Dr de Lacy found particularly striking when he compared Dr Patel's notes with the objective evidence and the patients' histories was that, in his view, Dr Patel clearly set out to mislead the reader. There would be instances of wound dehiscence, incisional hernias or anastomotic leaks, but no reference to the same in the notes. Dr de Lacy said that, on the other hand, the notes would be sprinkled with stock phrases such as 'risks and complications of the operation explained'<sup>936</sup> but patients regularly told Dr de Lacy that Dr Patel had only seen them for one minute in the pre-operative consultation<sup>937</sup> and that he had not examined them.<sup>938</sup> The notes would often contain text book descriptions of operations but when Dr de Lacy subsequently operated on the same patients, he found that the descriptions were wholly inaccurate.<sup>939</sup> Dr de Lacy reached the view that the notes were dishonest rather than merely slipshod, and that they showed a surgeon trying to cover himself.<sup>940</sup>

## Dr O'Loughlin

3.417 O'Loughlin testified that:

- (a) He has been a fellow of the Royal Australian College of Surgeons since 1984 and the Director of Surgery at the Royal Brisbane Hospital since about 1995. He was a senior lecturer in surgery at the University of Queensland between 1985 and 1987;
- (b) In the course of 2005, he has seen approximately 42 former Patel patients. As for Dr de Lacy, this occurred pursuant to an arrangement made by Queensland Health. Dr O'Loughlin said that he saw the patients at the Base and that there were two other surgeons from the Royal Brisbane, namely Michael Rudd and George Hopkins, who also saw patients there;<sup>941</sup>

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<sup>933</sup> T 4423

<sup>934</sup> T 4423

<sup>935</sup> T3603, T 4423

<sup>936</sup> T4428, line 40

<sup>937</sup> T4428

<sup>938</sup> T 4425

<sup>939</sup> T 4426

<sup>940</sup> T 4428

<sup>941</sup> Dr O'Loughlin said that Dr Rudd and Dr Hopkins saw about 25 to 30 former Patel patients between them.

- (c) The 42 patients fell into three categories. There were 14 patients who had received reasonable care and who simply required re-assurance,<sup>942</sup> there were seven patients who required remedial surgery,<sup>943</sup> and there was the balance - some 20 patients - who had a range of symptoms and complaints, and required further investigation such as an endoscopy or an ultrasound;<sup>944</sup>
- (d) Dr O'Loughlin emphasised that one needed to be careful in drawing conclusions from his findings because he saw a small number of patients whereas Dr Patel operated on a very large number of people.<sup>945</sup> He also wished to emphasise that surgery is not a benign undertaking so that, even in the best hands, there will be complications. Dr O'Loughlin said that good surgical practice involves seeking to minimise the risk of complications and dealing with them well by availing oneself of the best techniques, being trained well, keeping up to date, and enlisting the support of more competent and experienced people;<sup>946</sup>
- (e) In reaching opinions, Dr O'Loughlin, like Dr de Lacy, had recourse to the clinical records, together with his own observations from examining patients, taking a history and performing surgery;
- (f) In Dr O'Loughlin's view, about half the patients he saw received a standard of care which was less than he would expect from a competent surgeon.<sup>947</sup> In general, he observed shortcomings in judgment, knowledge and technical abilities. Asked whether he would have allowed Dr Patel to operate on him, Dr O'Loughlin said simply 'no;'
- (g) Dr O'Loughlin said he had formed the view from examining records and talking with patients that Dr Patel did not perform satisfactory examinations of the patients. Where, for instance, a patient presented with rectal bleeding, Dr Patel would send the patient for a colonoscopy without first carrying out a rectal examination, and Dr O'Loughlin regarded this as a serious omission;<sup>948</sup>
- (h) Further, whereas good practice required that Dr Patel consider non-invasive treatment, there was little evidence that that happened. Instead, Dr Patel generally recommended an operation. Dr Patel did not seem to

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<sup>942</sup> T 3956

<sup>943</sup> Exhibit 173A para 5 – T 3958

<sup>944</sup> T 3958

<sup>945</sup> T 3957, line 45

<sup>946</sup> Exhibit 173A para 11

<sup>947</sup> T 3966 line 30

<sup>948</sup> T 3959

exercise appropriate clinical judgment in terms of recognising that, on occasions it is better to refrain from operating;<sup>949</sup>

- (i) The practice of medicine is a multi disciplinary exercise and it is mandatory that surgeons consult with other specialist groups such as gastroenterologists, gynaecologists and urologists. Dr Patel, on the other hand, seemed to practise in isolation.<sup>950</sup> Consistent with this multi-disciplinary view of medicine, Dr O'Loughlin, as the Director of Surgery at the RBH, was regularly contacted by his previous counterparts at the Base (Doctors Nankivill and Anderson) who consulted with him on a range of matters. Not once during his tenure as Director of Surgery at the Base did Dr Patel ever make contact with Dr O'Loughlin;<sup>951</sup>
- (j) Dr O'Loughlin said that complications are not uncommon in emergency surgery, particularly when the patients, as was common in Bundaberg, had a range of 'co-morbidities', but he was concerned that particular Patel patients had several complications even though they were treated in an elective context;<sup>952</sup>
- (k) Dr O'Loughlin discussed five patients to illustrate his point. The first patient was a man with a polyp in his bowel.<sup>953</sup> Dr Patel conducted a biopsy and it did not show any malignancy. In those circumstances, Dr Patel should have recommended that the entire polyp be removed by an experienced colonoscopist<sup>954</sup> and analysed comprehensively. Instead, he proceeded to remove the entire bowel. There is no evidence that Dr Patel ever advised the patient of the biopsy results, and this raised questions about Dr Patel's professional integrity.<sup>955</sup> Further, when Dr Patel attempted to replace the bowel with an ileostomy<sup>956</sup> and a stoma collection bag, the attempt was made poorly, unsuccessfully and over the course of two operations;
- (l) There was another patient who presented to Dr Patel with a painful gallstone condition. Dr Patel recommended that the gall bladder be removed by a laparoscopic (that is, keyhole) procedure known as a cholecystectomy, mentioned earlier. A number of complications followed. Whereas the procedure is normally straight forward (if technically demanding) and the patient is discharged within 24 hours, this patient was the subject of four operations. The gall bladder was inadvertently

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<sup>949</sup> T 3959

<sup>950</sup> Exhibit 173A para 8

<sup>951</sup> Exhibit 173A para 8

<sup>952</sup> T3962

<sup>953</sup> A polyp is a fleshy growth that arises in the lining of the bowel and will, in some cases, develop into cancer – See Exhibit 173, para 7

<sup>954</sup> Exhibit 173, para 8

<sup>955</sup> Exhibit 173A, para 10

<sup>956</sup> Being the section which protrudes from the skin

opened causing gallstones and bile to spill; a haematoma developed where an instrument had been used; there was a collection of fluid under the liver; and the patient commenced bleeding internally and draining bile, but Dr Patel neither identified the sources of those fluids nor investigated them further. Moreover, the patient developed a hernia at the site of the wound from the third operation, and the alignment of the hernia suggested it was caused by a technical failure in sewing the wound together.<sup>957</sup> Dr O'Loughlin agreed that if a registrar showed him such a history, Dr O'Loughlin would be questioning whether the registrar was suited to a career in surgery,<sup>958</sup>

- (m) The third case study concerned a lady who had a laparoscopic cholecystectomy for painful gallstones. Again, however there were a number of complications. The small bowel was inadvertently opened, causing a leak of bowel contents; a second operation was conducted to repair the laceration but this resulted in a further inadvertent laceration to a different part of the bowel. Following the second operation, moreover, the patient developed a complete wound dehiscence which required packing for some months, and there was an incisional hernia which eventually required further repair. Dr O'Loughlin said that the main problem was a failure to access the abdominal cavity in an optimal way. He said that it is possible that this complication could occur in a competent surgeon. He tended to suspect, however, that Dr Patel was not proficient in laparoscopic surgery. Dr O'Loughlin said that, whilst they were only two cases, they demonstrated significant and serious complications and, further, he was aware of a further laparoscopic cholecystectomy patient who suffered complications and was transferred to the Royal Brisbane. Dr O'Loughlin said that this is no small failing because cholecystectomies are a routine part of a general surgeon's work. He said that they are a good litmus test of a surgeon's competence.<sup>959</sup> He said, further, that laparoscopic surgery is a very important part of a general surgeon's practice,<sup>960</sup>
- (n) The next example was a patient who had a mass which might have emanated from the bowel or an ovary. Dr O'Loughlin said that the appropriate course to take was further investigation. Dr Patel, however, removed part of the bowel as well as the left ovary. The patient suffered a complete wound dehiscence and this required a return to the operating theatre. Moreover, she suffered a post operative heart attack so that her

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<sup>957</sup> Exhibit 173A para 23, T3965

<sup>958</sup> T3963, line 10

<sup>959</sup> T 3964

<sup>960</sup> T 3964

recovery was 'stormy and prolonged.' The patient eventually saw a gynaecologist at the RBH. It emerged then that the cancer had been emanating from the ovary. The optimal treatment was to provide clearance surgically around the ovarian area and then provide chemotherapy. Surgery was not, however, an option because of the heart attack following the first operation. Dr O'Loughlin believed that the patient was not given appropriate care in that she was inadequately assessed pre-operatively, the wound closure technique may have been defective and the conduct of the first operation effectively denied the patient the opportunity for a better directed operation;<sup>961</sup>

- (o) Dr O'Loughlin gave a further example. It concerned a man who had a perianal fistula. He had a worrying cardiac history but Dr Patel appears not to have reviewed him pre-operatively and he proceeded to surgery. The operation proceeded badly in that a good part of the anal sphincter was divided (which is not a mistake that an experienced surgeon would make). Given the dual complexities of the presenting problem and the cardiac history, the patient should have been referred to a tertiary hospital.<sup>962</sup>

## Dr Woodruff

3.418 Dr Woodruff testified that:

- (a) He was admitted as a Fellow of the Royal College of Surgeons in 1971 and as a Fellow of the Royal Australasian College of Surgeons in 1984. He is a former Vice-President of the Royal Australasian College of Surgeons and the President elect of the Australian and New Zealand Society of Vascular Surgeons;<sup>963</sup>
- (b) Dr Woodruff has qualifications in general surgery and vascular surgery but he has practised as a vascular surgeon since at least 1977. He has worked in several rural locations including Mr Isa, Orkney, Shetland and Bougainville;<sup>964</sup>
- (c) Dr Woodruff was one of a team of four medical professionals ('the Review Team') appointed by the Director-General of Queensland Health on 18 April 2005 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,<sup>965</sup> amongst other things;

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<sup>961</sup> T3965-3966, Ex 173A paras 31-39

<sup>962</sup> Exhibit 173A paras 40 - 46

<sup>963</sup> Exhibit 283 paras 1-9

<sup>964</sup> Exhibit 283 paras 1-9

<sup>965</sup> Exhibit 102 page 20

- (d) The Review Team's work was completed on 30 June 2005<sup>966</sup> and Dr Woodruff was primarily responsible for reviewing Dr Patel's surgical performance.<sup>967</sup> The Team ascertained that Dr Patel saw some 1,450 patients during his time at Bundaberg and the Team made a decision to carry out the task described in the subparagraph immediately above by confining its investigations to those patients who had died, who were the subject of a complaint or who had been transferred to another institution;<sup>968</sup>
- (e) Dr Woodruff and the Review Team identified 221 cases (including 88 deaths) which met the criteria set out above.<sup>969</sup> Dr Woodruff accepted, however, that there would undoubtedly be patients who suffered adverse outcomes but were not caught by the Review Team's methodology;<sup>970</sup>
- (f) In considering the treatment provided to those patients, Dr Woodruff had the benefit of all the files relevant to the 221 patients. He said that those documents ran to some 47,500 pages and that he was able to organise them with the benefit of scanning and a specialised computer software.<sup>971</sup> Dr Woodruff did not have the benefit enjoyed by Dr de Lacy and Dr O'Loughlin of speaking to the patients, much less examining them or performing surgery;<sup>972</sup>
- (g) Dr Woodruff said that there were 16 patients who were considered by both Dr de Lacy and himself. He said that of those patients, in relation to 14, he and Dr de Lacy had reached the same conclusion, and in relation to the balance, their conclusions were similar;
- (h) Dr Woodruff noted that:
- There were thirteen deaths in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome;<sup>973</sup>
  - There were a further four deaths in which an unacceptable level of care on the part of Dr Patel may have contributed to the outcome;<sup>974</sup>

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<sup>966</sup> Exhibit 102

<sup>967</sup> T 4270 It should be noted that there were no other surgeons or indeed treating doctors, on the team

<sup>968</sup> T 4270

<sup>969</sup> T 4270; Exhibit 283, para 12

<sup>970</sup> T 4271

<sup>971</sup> Exhibit 283 para 16

<sup>972</sup> T 4361

<sup>973</sup> Exhibit 283, table D3

<sup>974</sup> Exhibit 203, table F



- There were, in addition, 31 surviving patients where Dr Patel's poor level of care contributed to, or may have contributed, to an adverse outcome;<sup>975</sup>
  - Of the 31 patients identified, there were 23 patients who suffered major technical complications;<sup>976</sup>
  - In all, there were 48 patients where Dr Patel contributed, or may have contributed, to an adverse outcome;<sup>977</sup>
- (i) Dr Woodruff concluded:
- I have no hesitation in saying that [Dr Patel's] performance was incompetent and that his performance is far worse than average or what one might expect by chance.<sup>978</sup>
- (j) Dr Woodruff spoke in detail about particular cases, starting with the deaths. He said that, although he had identified some 88 deaths (34 occurring within one month of surgery) with which Dr Patel was associated, in many cases his association was incidental;<sup>979</sup>
- (k) When the figures are considered carefully, however, it leads to a harsher judgment of Dr Patel. Many patients were *in extremis*<sup>980</sup> or suffering terminal pathology. Those deaths (which are not attributable to Dr Patel) 'spuriously' show Dr Patel in a better light. Dr Woodruff believed that they should not be considered when arriving at a 'denominator.'<sup>981</sup> When one reduces the sample accordingly, one finds there is a high proportion of operations that went wrong. Dr Woodruff said, in particular, that of the 13 deaths, there were seven or eight where the treatment was just 'outlandish' and involved 'absolutely non defensible processes';<sup>982</sup>
- (l) Dr Woodruff referred to a patient known before the Commission as P238 as an example of incomprehensible treatment. In December 2002, she required partial removal of the pancreas and stomach and she presented to the Base. Dr Baker (who, Dr Woodruff opined, was a very competent surgeon)<sup>983</sup> referred the patient to the experts at the Royal Brisbane Hospital for treatment. She nevertheless had a 'very stormy' admission and almost died. She presented with a recurrence

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<sup>975</sup> Exhibit 283, table G

<sup>976</sup> Exhibit 283, table H – 1 patient appeared under two headings

<sup>977</sup> Exhibit 283, Table E

<sup>978</sup> T 4327

<sup>979</sup> T 4282

<sup>980</sup> T 4273

<sup>981</sup> T 4283

<sup>982</sup> T 4282

<sup>983</sup> T 4281

of the problem at the Base during Dr Patel's time and, despite the history, Dr Patel elected to operate. The patient died;

- (m) There was a patient known as P161 who died after Doctor Patel carried out a very complicated operation known as a 'Whipple's procedure.' Whipples procedures are outside the scope of the Base's practice.<sup>984</sup> Dr Patel attempted a number of these operations at the Base and that showed an error of judgment.<sup>985</sup> Dr Woodruff said that there was a lack of judgment in even putting this patient forward for the operation because a CT scan disclosed 'more than a suspicion of metastatic disease.'<sup>986</sup>
- (n) Similarly there was a patient known to the Commission as P224. A CT scan showed that he was suffering from a non-resectable tumour but Dr Patel attempted a thyroidectomy. The patient died. Dr Woodruff could not understand why Dr Patel would recommend surgery, let alone attempt that surgery at the Base,<sup>987</sup>
- (o) Another example was a patient known before the Commission as P98. Dr Patel elected to proceed with surgery notwithstanding that the patient was suffering from obstructed jaundice on that day, which is a clear error of judgment. Dr Woodruff said that the patient appears to have died from fatal hepatorenal syndrome which is a risk of taking that course;
- (p) Dr Woodruff considered, of course, the three oesophagectomies (out of a total of four conducted by Dr Patel), for which the patient died, namely Kemps, Phillips and Grave. He said that, given the history of Mr Kemps, you could 'almost guarantee' that the tumour was not curable<sup>988</sup> and that the procedure would lead to aortic bleeding. He said he could not understand how anybody could even contemplate surgery.<sup>989</sup> In relation to Mr Phillips, he said that surgery was a legitimate consideration but, given the renal problems, the procedure was going to be very difficult and the patient should have been transferred to a tertiary hospital.<sup>990</sup> In relation to Mr Grave, he said that there was evidence of metastases. He said that the operation demonstrated 'a litany of surgical ineptitude,'<sup>991</sup> including vocal chord

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<sup>984</sup> T 4289

<sup>985</sup> T 4290

<sup>986</sup> T 4286

<sup>987</sup> T 4287

<sup>988</sup> It was the evidence of Dr Smalberger, who had referred Mr Kemps to the Department of Surgery at the Base for transfer to Brisbane, that the pathology strongly suggested, at that time, that Mr Kemps cancer was widespread or 'metastatic' (so that the removal of the oesophagus would not halt the progress of the disease).

<sup>989</sup> T 4291

<sup>990</sup> T 4293

<sup>991</sup> T 4295

paralysis, myocardial infarction, peritonitis, two wound dehiscences and a leak from the jejunostomy site. He said that, although Mr Grave eventually died from the underlying cancer, the complications would have reduced his ability to resist the disease;

- (q) Dr Woodruff said that it had occurred to him that, of the 13 deaths, eight related to procedures from which Dr Patel had been prohibited in Oregon. He speculated:

And I wonder whether this is not the missing piece of the mosaic... I wonder if his motivation for doing these quite outlandish operations is not to try and re-assert in his own mind that what he's been precluded from doing in Oregon he is in fact capable of doing, and that he is, in effect re-credentialing himself if only in his own mind.<sup>992</sup>

- (r) Dr Woodruff turned to the other adverse outcomes. He said Dr Patel had a frightening complication rate.<sup>993</sup> His audit revealed, amongst those patients of the 221 who survived, 7 cases of major wound dehiscence, 12 cases of infection or haematoma, and 5 cases of anastomotic leaks, and that these are all recognised indicators of poor care,<sup>994</sup>
- (s) Dr Woodruff said that his review showed instances to support the thesis that Dr Patel engaged in rough handling in the course of his surgery;<sup>995</sup>
- (t) He said that, although he had distinguished between those patients where Dr Patel's poor care had contributed and 'maybe' contributed to an adverse outcome, the large number of technical problems which he had encountered suggested that one could be more confident about the latter category;<sup>996</sup>
- (u) Dr Woodruff said that certain forms of surgery necessitated that the surgeon has recourse to other colleagues. This would be a little more difficult in Bundaberg but Dr Woodruff said that it was remarkable that having considered over 47,000 pages of case notes for Dr Patel's patients 'there is not one letter from Patel to any other doctor, not one,<sup>997</sup>
- (v) Dr Woodruff considered, despite the foregoing, that Dr Patel was an intelligent and extremely industrious man<sup>998</sup> who had a potential in a different environment to be a 'productive contributor.' Dr Woodruff said

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<sup>992</sup> T 4307

<sup>993</sup> T 4328

<sup>994</sup> Exhibit 283, Table H; He agreed, further, that incisional hernias were another good indicator. Since they usually develop some time after surgery, information on the same was available to Dr de Lacy but not Dr Woodruff

<sup>995</sup> T 4361

<sup>996</sup> T 4310

<sup>997</sup> T 4290

<sup>998</sup> T 4336

that Dr Patel's surgical performances were not the worst that Dr Woodruff had seen.<sup>999</sup> He said that if Dr Patel had spent time in a skills laboratory (such as the one run by Queensland Health) and had been supervised appropriately (as envisaged by the Medical Board of Oregon), the outcomes of his surgery might well have been different;

- (w) He said that the situation in Bundaberg was not unique and there had been aberrant surgical practices in other parts of Queensland. They have often been picked up, however, by credentialing, or through morbidity and mortality meetings.<sup>1000</sup> He said that, if Dr Patel had been working in a major tertiary hospital, any sub-standard performance would have been 'very evident'.<sup>1001</sup> He said he was aware of practitioners who are now well regarded Fellows of the College whose performance had improved remarkably when their environment was changed, particularly from one of isolation;<sup>1002</sup>
- (x) Dr Woodruff said there were some notes that seemed to have been made retrospectively but otherwise they seemed to demonstrate Dr Patel's 'rose-tinted view' of his own care, rather than any dishonesty;<sup>1003</sup>
- (y) Dr Woodruff said that there are nine characteristics<sup>1004</sup> that the College considers necessary in a competent surgeon. Dr Patel clearly lacked judgment. Dr Woodruff said it was also clear from the records that Dr Patel did not always work well with other staff and did not always have the support of the nurses. Dr Woodruff concluded that Dr Patel also lacked collaboration, management and leadership attributes.<sup>1005</sup>

## Conclusion

3.419 In short, three respected surgeons working independently of each other found very similar patterns amongst those cases they considered. There was evidence from witnesses of fact before the Commission that corroborated those findings. Witnesses gave evidence that Dr Patel's knowledge was out of date, that he was rough in his surgical handling, that he was rigid in his views and did not work well with other medical staff, that he was too quick to operate rather than consider other treatment paths, and that his operations seemed to be visited by an abnormal number of complications. In the end, some of the procedures were so

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<sup>999</sup> T 4337

<sup>1000</sup> T 4328

<sup>1001</sup> T 4336

<sup>1002</sup> T 4337

<sup>1003</sup> T 4342

<sup>1004</sup> Medical Expertise, Technical Expertise, Judgment, Communication, Collaboration, Management and Leadership, Health advocacy, Scholar/Teacher, Professionalism.

<sup>1005</sup> Exhibit 283, paras 22 and 23

bizarre that Dr Woodruff could not even attribute Dr Patel's decision-making to hubris.<sup>1006</sup> There was some other motivation being played out and it may well have been that he was trying to show that the restrictions placed in Oregon were unjust.

- 3.420 It will be recalled that, in the previous section of this report, I outlined some 20 complaints made to management, many on behalf of specific patients, in the course of Dr Patel's term. It is interesting that, when one considers the experts' finding, it is clear that almost all of those patient complaints were the subject of findings that the care provided was inadequate. That fact underlines something which should have been self-evident, namely that a health system which responds frankly to internal and external complaints will be much better placed to identify and improve shortcomings in clinical care and communication.

## Adverse findings and recommendations

- 3.421 I should also address one point that has been the subject of some speculation, namely that the executive at the Base received performance bonuses. The Commission explored this issue thoroughly and there was no basis for it. It seems that, to the extent management at the Base failed to act to a proper standard, they were motivated by an unhealthy culture or a desire to retain their jobs, rather than any more immediate pecuniary incentive.
- 3.422 One cannot help but have some sympathy for the conditions in which management at the Base worked. The evidence made clear that they had budgets that were effectively fixed, that fiscal considerations were a 'major focus' with Queensland Health and that there was, at the very least, a perception that a number of managers around Queensland had lost their jobs for failing to work within budget.<sup>1007</sup> They were faced with a scenario where, despite the legitimate claims of senior doctors like Dr Nankivell and Dr Baker for more resources, they could do little because corporate office, they believed, was unresponsive. The situation was more exacting still. Against the background of gross under-resourcing, many good doctors elected to leave or they became disenchanted so that our public hospitals lost much of the goodwill which was once, according to Dr Thiele, 'the oil in the cogs.' The managers were also required to work within a culture that was, as will be discussed later, seriously averse to public discussion, at least to the extent it might lead to negative publicity. As Mr Leck testified, they were required to make decisions by reference to a risk matrix which rated 'significant and sustained statewide adverse publicity' on the same level as 'loss

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<sup>1006</sup> T4281, T4287

<sup>1007</sup> T7129, Exhibit 468. In fact, the zonal manager, Mr Bergin, had informed Mr Leck that his job would be in peril if he did not bring the district in under budget. T6051, line 40

of life' (i.e. major) and 'sustained national publicity; QH reputation significantly damaged' on the same level as 'multiple deaths' (i.e. extreme)<sup>1008</sup>

3.423 There was, nevertheless, in my view, conduct which was unacceptable. I make adverse findings immediately below and also in Chapter 6. I make recommendations here based on those findings.

### **Dr Patel**

3.424 I find that:

- (a) Dr Patel knowingly misled the Medical Board of Queensland and Queensland Health by failing to disclose disciplinary action brought against him in the United States of America, and by falsifying his work history for the two years prior to December 2002.
- (b) Dr Patel repeatedly performed surgical procedures at the Base that he had been restricted from performing in the United States of America.
- (c) Dr Patel performed surgical procedures at the Base that were beyond his competence, skill and expertise, beyond the capacity of the Hospital and its staff to provide adequate post-operative care, and unnecessary.
- (d) As a result of negligence on the part of Dr Patel (and in accordance with Dr Woodruff's findings), 13 patients at the Base died and many others suffered adverse outcomes.
- (e) Dr Patel unreasonably failed to transfer patients to a tertiary referral hospital within an appropriate timeframe, causing adverse outcomes for many of those patients.
- (f) On many occasions, Dr Patel failed to adequately record in patient files the true details concerning material facts including the surgical procedures undertaken, complications arising from surgery, wound dehiscence, infections, the course of post-operative care, reasons for post-operative return to surgery.
- (g) As the Director of Surgery at the Base between 1 April 2003 and 1 April 2005, Dr Patel failed to ensure that the Department of Surgery conducted appropriate surgical auditing including the holding of effective morbidity and mortality meetings.
- (h) Dr Patel failed to refer 13 reportable deaths to the Coroner.
- (i) Dr Patel held himself out as a general surgeon when he lacked any specialist registration in Queensland.

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<sup>1008</sup> T7174, Exhibit 162, LTR4

3.425 I recommend that:

- (a) The conduct of Dr Patel in relation to securing registration with the Medical Board of Queensland and a position at the Base be referred to the Queensland Police Service for further investigation in relation to fraud (s408C *Criminal Code*) and attempts to procure unauthorised status (s502 *Criminal Code*).
- (b) With respect to the matters found by Dr Woodruff, Dr O'Loughlin and Dr de Lacy, Dr Patel's conduct be referred to the Queensland Police Service for further investigation in relation to the offences of assault (s335 of the *Criminal Code*), assault occasioning bodily harm (s339 of the *Criminal Code*), grievous bodily harm (s320 of the *Criminal Code*), negligent acts causing harm (s328 of the *Criminal Code*) and manslaughter (s303 of the *Criminal Code*).
- (c) The conduct of Dr Patel in holding himself out as a general surgeon be referred to the Medical Board of Queensland for further investigation in relation to s158 *Medical Practitioners Registration Act 2001*

### Dr Nydam

3.426 I find that:

- (d) Dr Nydam sought the appointment of Dr Patel under an area of need declaration when, in fact, there was an Australian qualified general surgeon willing to accept the position of Director of Surgery at the relevant time.
- (e) As the Acting Director of Medical Services at the Base immediately prior to, and at the time of, Dr Patel's appointment, Dr Nydam failed to check Dr Patel's references prior to his appointment at the Bundaberg Base Hospital.
- (f) Despite intending at all relevant times that Dr Patel fill the role of Director of Surgery at the Base, Dr Nydam represented to the Medical Board in January 2003 that Dr Patel would work as a Senior Medical Officer accountable to the Director of Surgery.
- (g) In completing a Form 55 *Sponsorship for Temporary Residence in Australia (non business)* on or about 8 January 2003 in relation to the proposed employment of Dr Jayant Patel as a Senior Medical Officer, Surgery, at the Base, Dr Nydam falsely represented that the position had been advertised a number of times over the past 6 months. There have been no Australian applicants.'
- (h) In applying for an area of need decision in relation to Dr Patel's employment as a Senior Medical Officer, Dr Nydam had no basis for

considering that the position fell within an area of need as that term is used in s135 of the *Medical Practitioners Registration Act 2001*.

- (i) Dr Nydam failed to maintain, or to encourage others to maintain, a credentialing and clinical privileging process in accordance with either Queensland Health policy or the practice established under previous Directors of Medical Services at the Base;
- (j) Dr Nydam failed to take steps to ensure, prior to, or immediately after the commencement of, Dr Patel's employment at the Base, he was subject to a process of credentialing and clinical privileging.

I make no recommendations in relation to Dr Nydam.

## Dr Keating

3.427 I make the following adverse findings with respect to Dr Keating:

- (a) He failed, from or about 14 April 2003 (when his employment at the Base commenced), to ensure compliance with good practice by ascertaining the terms of Dr Patel's registration and ensuring that he was an appropriate person to continue as the Director of Surgery.
- (b) He failed to comply with good practice from or about 14 April 2003 by ensuring that Dr Patel was the subject of a credentialing and privileging process, either in accordance with Queensland Health policy or on an ad hoc basis.
- (c) Dr Keating failed to take steps to ensure, prior to, or immediately after the commencement of, Dr Patel's employment at the Base, he was subject to a process of credentialing and clinical privileging.
- (d) From April 2003, Dr Keating was made aware of numerous complaints about the clinical practices and procedures of Dr Patel and his behaviour, including but not limited to, the following:
  - In May and June 2003, a complaint by Ms Toni Hoffmann and Dr Jon Joiner about the performance of oesophagectomies at the Base;
  - In May 2003, a complaint about incorrect topical treatment to a patient;
  - In June 2003, a complaint about Dr Patel operating on the wrong part of a patient's ear;
  - In July 2003, a complaint from a Dr Peter Cook about the performance of oesophagectomies at the Base;
  - In July 2003, a complaint from Ms Aylmer about a rise in the incidence of wound dehiscence;



- In October 2003, a complaint from Mr Ian Fleming about Dr Patel's treatment of him for diverticulitis;
  - In November 2003, a complaint about Dr Patel's personal infection control measures;
  - In late 2003, a complaint from Dr David Smalberger about the clinical and professional conduct of Dr Patel;
  - In the course of 2004, an audit of peritoneal catheter placements demonstrating that Dr Patel had a one-hundred per cent complication rate;
  - In March 2004, a complaint from Ms Toni Hoffman concerning Dr Patel's clinical conduct and professional behaviour and a complaint by Mr Geoffrey Smith about treatment provided by Dr Patel;
  - In April 2004, a complaint from Ms Vicki Lester about the treatment that she had received from Dr Patel;
  - In July 2004, complaints from staff about Dr Patel's involvement in the treatment of Mr Desmond Bramich;
  - In October 2004, a complaint from Ms Hoffman about Dr Patel's clinical conduct in relation to a number of patients;
  - On 2 November 2004, a complaint from Dr Jason Jenkins in relation to the treatment of P52;
  - In December 2004/January 2005, complaints from doctors and nurses at the Base about a further oesophagectomy;
  - In January 2005, concerns raised by Dr Stephen Rashford and Ms Michelle Hunter about the care provided to P26.
- (e) Dr Keating failed to take appropriate action to investigate these complaints, particularly having regard to their combined significance.
- (f) Notwithstanding Dr Keating's knowledge that Dr Patel had not been subject to the credentialing and privileging process, and that he had been the subject of various complaints, Dr Keating:
- Offered to extend Dr Patel's contract from 1 April 2004 to 31 March 2005, from 1 April 2005 to 31 July 2005 and, at one point, from 1 April 2005 to 31 March 2009;
  - Repeatedly advised the Medical Board (when renewal of registration was being sought) that Dr Patel's performance at the Base was competent, or better.

- (g) Between 29 October and 5 November 2004, the concerns raised by Ms Hoffman were given considerable support by Drs Berens, Risson and Strahan.
- (h) From 5 November 2004, Dr Keating failed to give any, or any adequate, consideration to revoking, or appropriately restricting, Dr Patel's right to conduct surgery in the Base.
- (i) Until early January 2005, Dr Keating repeatedly advised Mr Leck that Ms Hoffman's complaints were unjustified and largely personality driven when he should have appreciated (particularly in the context of other complaints) that they raised genuine and concerning medical issues.
- (j) On or about 5 January 2005, Dr Keating prepared a briefing note which acknowledged the veracity of many of the allegations made by staff at the Base about Dr Patel.
- (k) By a letter dated 2 February 2005, and in the circumstances set out above, Dr Keating offered Dr Patel a temporary full time position of locum general surgeon for the period from 1 April 2005 to 31 July 2005.
- (l) When, in early February 2005, Dr Keating wrote to the Medical Board seeking renewal of Dr Patel's registration, he provided an assessment of Dr Patel's performance completed which was knowingly false, failed to inform the Medical Board of any of the matters set out in the briefing note of January 2005, and failed to inform the Medical Board that a clinical audit was being conducted by the Chief Health Officer into complaints about Dr Patel.
- (m) On 1 February 2005, Dr Keating signed a Form 55 'application for sponsorship of visa' for Dr Patel and sent that form to the Department of Immigration and Multicultural Affairs wherein he stated that Dr Patel was to be employed as Director of Surgery at the Hospital for a further four years, in circumstances where that information was, to Dr Keating's knowledge, false.
- (n) On 14 February 2005, Dr Keating met with the Chief Health Officer and discussed Dr Patel with him but failed to mention any of the adverse matters canvassed in the briefing note, or otherwise to volunteer concerns that had been raised about Dr Patel's performance.

3.428 I recommend that:

- (a) Dr Keating's conduct with respect to the application for a four year visa be referred to the Australian Federal Police for investigation into whether he has committed an offence against s. 137 of the *Criminal Code* (Cth), on the basis that he may have knowingly or recklessly given false or misleading information to the Department of Immigration and Multicultural Affairs.

- (b) Dr Keating's conduct in relation to the renewal of Dr Patel's registration be referred to the Queensland Police Service for investigation and prosecution for a breach of s. 273 of the *Medical Practitioners Registration Act 2001*, as he may have given false or misleading information or documents to the Medical Board.
- (c) The Crime and Misconduct Commission prosecute Dr Keating for official misconduct.
- (d) Alternatively, or subsequently, the Director - General of Queensland Health consider taking action against Dr Keating under s.87 of the *Public Service Act 1996*, on the basis that he has performed his duties carelessly or incompetently, or has been guilty of misconduct.

## Mr Leck

3.429 I find that:

- (a) Mr Leck failed to ensure between October and December 2002 that Dr Jayasekera was appointed to the position of Director of Surgery at the Base in circumstances where he had applied for the position, he satisfied all the selection criteria, he was prepared to accept such position and the only other candidate who satisfied those criteria had declined the position.
- (b) Mr Leck permitted recruitment and registration of a medical practitioner as a Senior Medical Officer accountable to the Director of Surgery when he knew, or should have known, that immediately after the commencement of his employment it was intended to promote him to the Director of Surgery position.
- (c) Mr Leck failed to prevent Dr Nydam from misrepresenting to the Medical Board, details of the position Dr Patel would occupy and the level of supervision to which he would be subject.
- (d) Mr Leck failed to prevent Dr Nydam from misrepresenting to the Department of Immigration in the Form 55 Sponsorship for Temporary Residence in Australia the extent to which the position for which Dr Patel was sought had been advertised within Australia.
- (e) Mr Leck failed to prevent Dr Nydam misrepresenting to Queensland Health that Dr Patel was suitable for registration under the area of need provision of s135 of the *Medical Practitioners Registration Act 2001*.
- (f) Mr Leck failed to ensure, in accordance with good practice, and Queensland Health policy, that a credentials and clinical privileges committee existed at all times at the Base, that the general surgeons at the Base (including Dr Patel) were subject to consideration by the

committee between 2003 and 2005, and that such consideration occurred prior to the commencement of the surgeons' employment.

- (g) Due to the said failure the formal qualifications, training, experience and clinical competence of Dr Patel, amongst others, was not assessed and the opportunity was lost for such a committee to discover Dr Patel's disciplinary history and take appropriate action.
- (h) From February 2004 Mr Leck became aware of numerous complaints about the clinical practices and procedures of Dr Patel and his behaviour, including the complaint contained in Ms Hoffman's letter of 22 October 2004, and the corroboration subsequently given by Drs Berens, Rission and Strahan.
- (i) Upon learning of complaints and concerns about Dr Patel's competence, Mr Leck failed to ensure that they were investigated properly.
- (j) Further, Mr Leck failed to suspend or appropriately restrict Dr Patel's right to practise surgery at the Base or to take steps to ensure that Dr Patel was immediately assessed by a clinical privileges and credentials committee, when he should have done so at least by 5 November 2004.
- (k) On or about 23 March 2005, Mr Leck wrote a letter to the Bundaberg News Mail (Exhibit 473) which was deliberately deceptive in asserting that he had received no advice indicating that the allegations have been substantiated and that a range of systems was in place to monitor patient safety.
- (l) Mr Leck failed to consult with Dr Keating on a continual basis, as required by the latter's job description.
- (m) Mr Leck failed to ensure that Dr Keating did not make inappropriate offers of employment to Dr Patel or misleading statements to the Medical Board, as found above.

3.430 I recommend that:

- (a) The Crime and Misconduct Commission prosecute Mr Leck for official misconduct, in that he may have committed a disciplinary breach sufficient to warrant dismissal.
- (b) Alternatively, or subsequently, that his conduct be referred to the Director-General of Queensland Health for discipline under s.87 of the *Public Service Act* 1996, as he may have performed his duties carelessly or incompetently, or been guilty of misconduct.

## Final Remarks

- 3.431 I would take this opportunity to pay tribute to the former patients of Dr Patel, and their families. In the course of hearings at Bundaberg, evidence was received from 12 witnesses who had been patients of Dr Patel, or relatives of such patients. They made clear that, beyond the dry clinical summaries set out here, enormous suffering was occasioned by the events traced in this report. Mr Kemps' widow gave evidence going to her loss. Other witnesses like Mr Halter and Ms Swanson gave evidence of attending the Base for what they understood were routine operations, and then experiencing terrible pain, and near-death conditions, in the course of very long stays in Intensive Care. I did not hear that evidence personally but I have had the benefit of reading the transcripts, and speaking with counsel assisting. In consequence, I can only be impressed by the good humour and resilience with which those affected by Dr Patel (and there were many in a community the size of Bundaberg) have dealt with their misfortune.
- 3.432 I would also like to pay tribute to certain people whose care, passion or courage was instrumental in bringing to light the matters covered here. First and foremost of those is Ms Hoffman. She might easily have doubted herself, or succumbed to certain pressures to work within a system that was not responsive. She might have chosen to quarantine herself from Dr Patel's influence by leaving the Base or at least the Intensive Care Unit. Instead, and under the threat of significant detriment to herself, Ms Hoffman persistently and carefully documented the transgressions of Dr Patel. I would also pay tribute to Mr Messenger, the Member for Burnett. He provided a voice for staff concerns when no others seemed to exist and, although it has not been the subject of this report, he was forced, in the course of so doing, to endure animosity from a number of quarters.
- 3.433 Finally, I would like to thank the media for reporting the work of this Commission in a way which was generally responsible, and Mr Hedley Thomas of *the Courier-Mail* in particular, without whose persistence much of this story may have remained untold.
- 3.434 It will be observed that Bundaberg has occupied a large part of this report. The circumstances which recommend that approach were perhaps best encapsulated by Dr de Lacy in his evidence before the Inquiry:

I currently live in Bundaberg and Bundaberg isn't just an example of what's happening elsewhere in the State, even though it is that as well. Terrible things have happened there, not just to these people that I've mentioned today but to many others, many others, and in a community of less than 100,000 people, it really - it amounts to ... a tragedy. ...I hope that whatever changes are mooted for Queensland Health, can start in Bundaberg because though it's obvious that there are problems elsewhere, Bundaberg is where the patients have died and where all of these complications that I've listed and many others have occurred. And the problems of attracting staff to the regions and rural Queensland is

nothing compared to the problems that Bundaberg Base Hospital specifically is going to have to attract people after all this. So it's going - it is an acute, specific, urgent problem in Bundaberg right now and if it can be used as a case study, as a first step towards, ...ameliorating the problems which are statewide, it would be, you know, a very good thing for the community and for the - for all of us who have been trying to help put these things right which I understand we are all working hard to do...